Master´s Thesis

The Individualized Music Therapy Assessment Profile as an initial assessment tool of social emotional functioning

by

Maija Salokivi

Master´s Degree Programme in Music Therapy

December 2012

Department of Music
Faculty of Humanities
University of Jyväskylä
Finland

UNIVERSITY OF JYVÄSKYLÄ

Tiedekunta – Faculty Faculty of Humanities	Laitos – Department Department of Music
Tekijä – Author Salokivi Maija	
Työn nimi – Title The Individualized Music Therapy Assessment Profile as an initial assessment tool of social-emotional functioning	
Oppiaine – Subject Music Therapy	Työn laji – Level Master´s thesis
Aika – Month and year October 2012	Sivumäärä – Number of pages 106 (79 + 27)

Tiivistelmä – Abstract

An assessment in music therapy clinical practice is an essential part of the therapy process. Based on the assessment the therapist is able to recognize the needs of the client and plan the influential interventions in the therapy. A music therapy assessment evaluates a client´s individual strengths and weakness in both musical and non-musical areas.

Many of the music therapy assessment tools have been created for a specific population, not as a comprehensive music therapy assessment tool. The IMTAP is one of the first comprehensive assessment instruments addressing a variety of diagnoses. It has been developed by a team of experienced music therapists in Music Therapy Wellness Clinic at California State University.

In this master's thesis research the IMTAP is applied with a child diagnosed with ADHD and phobic anxiety disorder. Focus of the research is on emotional, social and fundamentals of musicality domains of the IMTAP. The aims are to collect the experiences and perspectives of music therapy clinicians about using the IMTAP, to research if it is possible to apply the IMTAP to assess the social emotional functioning and is the IMTAP suitable to Finnish psychodynamic music therapy customs. The study is a multi-method qualitative research and it has been conducted by observations and assessing the video recorded therapy sessions, focus group interview and questionnaires.

This study offers a novel point of view on the IMTAP assessment tool, on music therapy assessment in general and also on some aspects of assessment method research. The IMTAP appears as a useful and ease to use assessment tool that helps the therapists to structure their work. In a focus group interview the clinicians bring out both benefits and needs of developing of the IMTAP, professional´s needs related to assessment and thoughts about best assessment style to assess social emotional functioning. Results of the IMTAP scoring forms and focus group interview brought up question about suitable rating scale to assessment.

Asiasanat – Keywords	Music therapy, Assessment, Assessment tool, IMTAP
Säilytyspaikka – Depository	University of Jyväskylä, Department of Music
Muita tietoja – Additional information	

TABLE OF CONTENTS

FIGURES

TABLES

1. INTRODUCTION

An assessment in music therapy clinical practice is an essential part of a therapy process. Based on the assessment the therapist is able to recognize the needs of the client and plan for influential interventions in the therapy. In the music therapy assessment the client´s individual strengths and weaknesses in both musical and non-musical areas are evaluated. The initial assessment usually lasts from three to five meetings at the beginning of the therapy process.

In music therapy literature an assessment is recognised as an important and natural part of the music therapy process but assessment practices are quite non-uniform at a clinical level. Music therapy assessment, as a topic of research, has not been under broad and systematic investigation but the situation is changing gradually.

The applicability of the Individualized Music Therapy Assessment Profile [IMTAP] as an initial assessment tool of social-emotional functioning of the child diagnosed with ADHD and phobic anxiety disorder is evaluated in this master's thesis research. The IMTAP is an assessment protocol developed by a professional music therapy team in the USA and it has been designed to be used in paediatric and adolescent settings. The IMTAP includes 10 main domains and several sub-domains. Three of the ten domains are studied in this master's thesis: emotional, social and the fundamentals of musicality domains.

Experiences of music therapy clinicians about the IMTAP and aspects they bring up about the topic are studied. The topic is touched by qualitative multi-method research frame and it is based on phenomenological and hermeneutics philosophy. Research data comprises of questionnaires, video observations, results of the IMTAP scoring forms and perspectives of the music therapy clinicians about the assessment tool expressed in a focus group interview.

As a result of the research the music therapy clinicians highlight both benefits and needs of development of the IMTAP assessment tool, professionals' need for the assessment tool at the moment and thoughts about ideal assessment tool to assess social-emotional functioning. In addition the clinicians bring up perspectives about the applicable research frames to the assessment method research. The results of the IMTAP scoring forms bring out interesting viewpoints to the applicability of the assessment tool to social emotional functioning.

This research report clarifies key concepts of the study and earlier studies and publications about the issue. The report describes also research questions, methodological choices, data conducting and analysis. Results of the research are presented through tables of the questionnaires, summaries of the scoring forms, summaries of the focus group interview answers and examples from the interview. The study offers a novel point of view on the IMTAP assessment tool, on music therapy assessment in general and also on some aspects of assessment method research. Also needs for the research with in this area in future will be discussed.

2. KEY CONCEPTS OF RESEARCH

2.1 Music therapy among children with social-emotional problems

2.1.1 Definition of music therapy

The American Music Therapy Association [AMTA] broadly defines music therapy as “the use of music in the accomplishment of therapeutic aims: the restoration, maintenance, and improvement of mental and physical health” (The American Music Therapy Association, 2009).

In the Music Therapy Services brochure, published by the Finnish Society for Music Therapy, music therapy is defined as " way of rehabilitation and treatment that uses the elements of music as an essential medium for the interaction to gain on individual therapy goals" (Ala-Ruona, Saukko & Tarkki, 2009).

Schmidt Peters (2000) underscores that music therapy is a carefully planned process with certain steps and procedures executed by an educated therapist. Music therapy is not just a series of random musical experiences that help a person to feel better. The first step of a music therapy process is that the therapist observes and assesses the needs and strengths of the client and based on this information the therapist (with the input of the client) sets goals and objectives. (Schmidt Peters, 2000.)

Also Bruscia (1998) describes music therapy as a systematic process of the music experiences for the health of a client, but also a client-therapist relationship is important. These two elements are the forces of change in the music therapy. The therapy involves three main components, which are assessment, treatment and evaluation. (Bruscia, 1998.)

2.1.2 Psychodynamic music therapy approach

The field of music therapy has always reflected various psychological and philosophical theories. These theories can be divided into several approaches e.g. biological, behavioural, psychodynamic,

humanistic, biomedical or neurological approaches. Usually the music therapist bases his/her work on one or more of these theories. (Ahonen, 1993; Scovel & Gardstrom, 2005.)

Theoretical orientation contributes how the therapy and its possibilities, goals, the role of the therapist and the methods are seen in the therapy process. The ways of thinking can vary a lot in the different background theories and they have an influence not only to the therapy process but also where and in which context the therapy is practiced. (Ala-Ruona, 2007.)

Bruscia (1998) describes psychotherapeutic music therapy as an application where "the primary focus is on helping clients to find meaning and fulfilment. This includes all those approaches that focus on the individual´s emotions, self-contentment, insights, relationship, and spirituality as the main targets of change, as well as those that address medical and didactic factors related to these issues. Practices in this are vary according to the breadth and depth of treatment, the role of music, and the theoretical orientation of the therapist (e.g. psychodynamic, behavioural, etc.)" (Bruscia, 1998.)

Psychodynamic music therapy emphasizes the meaning of the therapeutic relationship: the role of the therapist includes emphatic attitude and counter-transference feelings as a source of information. Problems of a client arise from the inner unconscious conflicts and therapeutic change happens when these conflicts are realised and solved. Therapeutic techniques can contain e.g. analysis of symbolic material and free association. (Scovel & Gardstrom, 2005.)

2.1.3 Phobic anxiety disorder of childhood, ADHD and therapy goals in music therapy

The client whose therapy sessions are assessed in this master´s thesis research has been diagnosed phobic anxiety disorder of childhood and ADHD, and the client has problems on social-emotional functioning.

These diagnoses are defined in the Word Health Organization´s [WHO] International Classification of Diseases [ICD-10] as follows:

F93 Emotional disorders with onset specific to childhood

Mainly exaggerations of normal developmental trends rather than phenomena, that are qualitatively abnormal in themselves. Developmental appropriateness is used as the key diagnostic feature in defining the difference between these emotional disorders, with onset specific to childhood, and the neurotic disorders (F40-F48).

F93.1 Phobic anxiety disorder of childhood

Fears in childhood that show marked developmental phase specificity and arise (to some extent) in a majority of children, but that are abnormal in degree. Other fears that arise in childhood but that are not a normal part of psychosocial development (for example agoraphobia) should be coded under the appropriate category in section F40-F48.

F90 Hyperkinetic disorders

A group of disorders characterized by an early onset (usually in the first five years of life), lack of persistence in activities that require cognitive involvement, and a tendency to move from one activity to another without completing any one, together with disorganized, ill-regulated, and excessive activity. Several other abnormalities may be associated. Hyperkinetic children are often reckless and impulsive, prone to accidents, and find themselves in disciplinary trouble because of unthinking breaches of rules rather than deliberate defiance. Their relationships with adults are often socially disinhibited, with a lack of normal caution and reserve. They are unpopular with other children and may become isolated. Impairment of cognitive functions is common, and specific delays in motor and language development are disproportionately frequent. Secondary complications include asocial behaviour and low self-esteem.

F90.0 Disturbance of activity and attention

Attention deficit:

- Disorder with hyperactivity
- Hyperactivity disorder
- Syndrome with hyperactivity

(WHO, ICD-10, 2010.)

Saukko (2008) refers to researches of Jackson (2003) and Layman, Hussey and Laing (2002) who have defined possible therapy goals or assessment areas for a client with ADHD or anxiety disorders. According to Jackson the main therapy goals with ADHD clients are in the area of

behaviour, psychosocial functioning or cognitive skills. Most often the therapists set their therapy goals to more than one of these areas. Layman et al. developed an assessment model for severely emotionally disturbed children and based on earlier studies they defined the main therapy goals for this client group as follows: emotional goals, communicative goals, social goals, cognitive goals and musical goals. (Jackson, 2003; Layman, Hussey & Laing, 2002; Saukko, 2008.)

2.2 Assessment in music therapy

2.2.1 Defining music therapy assessment

An assessment is recognized as an important and natural part of the music therapy process. The American Music Therapy Association [AMTA] has standards for the clinical music therapy work and an assessment is one part of these standards. The AMTA emphasizes the meaning of the assessment and gives some general starting points to the clinical assessment. According to the AMTA the music therapy assessment will include "the general categories of psychological, cognitive, communicative, social, and physiological functioning focused on the client´s needs and strengths. The assessment will also determine the client´s responses to music, music skills and musical preferences. All music therapy assessment methods are appropriate for the client's chronological age, diagnoses, functioning level, and culture(s). The methods may include, but need not be limited to, observation during music or other situations, interview, verbal and nonverbal interventions, and testing." (AMTA, 2009.)

Hanser (1999) divides a music therapy assessment into three parts: initial assessment, comprehensive assessment and on-going assessment.

1. "Initial Assessment is performed at the beginning of the therapeutic process to guide music therapy and establish a point at which to begin. This process is always indicated, and generally focuses on the treatment goal.

2. Comprehensive Assessment is used when an individual may be referred for music therapy assessment only. This is usually a more comprehensive effort to determine the feasibility of music therapy services and examine many aspects of functioning. It may also be advisable

when the individual has difficulty complying with other forms of standardized assessment. This is particularly the case with children who have very short attention spans, individuals who greatly distressed, and cognitively impaired older adults. Music therapy offers a less threatening environment where individuals may benefit from the structured and nonthreatening setting.

3. On-going Assessment is used in an on-going manner to evaluate music therapy. Assessment tools may be administered repeatedly throughout the course of therapy, usually pre-, mid- and post-treatment. Systematic observation is another useful way to examine behaviours over time. The nature of the target behaviours will determine whether a specific assessment tool or observation technique is most suitable."

(Hanser, 1999.)

An assessment is an essential and systematic part of clinical practice and it helps the therapist to know the needs of the client and then plan the influential interventions. The assessment reveals something about the nature of client's strengths and weaknesses in both musical and non-musical areas. The assessment may involve standardized tests or it can be based on observations or combination of both. The assessment process includes also other sources of information for example interviews and background information. (Chase, 2002;Hanser, 1999; Schmidt Peters, 2000.)

The music therapy assessment can bring extra value to the assessment of some particular client. Several other assessment methods are based on verbalization and yet especially many children have limited abilities in that. Nonverbal communication is a necessary alternative in some cases. (Layman et al., 2002.) In music therapy an assessment of a child is often able to bring out unexpected abilities and not just only difficulties. Children with communication disorders can work in the music therapy at a pre-verbal or non-verbal level and thus music works as an alternative communication system. (Wigram, 2000.)

Hanser (1999) comments also that the strength of the music therapy assessment situation is that clients do not feel common testing pressure and music therapy assessment offers variety of stimuli (Hanser, 1999).

Music therapists work in many different settings with various theoretical orientations. Due to these different settings and theoretical orientations it is challenging to define what is music therapy assessment straightforwardly (Chase, 2002). The background theories of the music therapy works contribute to the knowledge what a therapist collects in the assessment sessions; how he/she collects this knowledge, how she/he processes the knowledge and what kind of conclusions she/he makes based on this knowledge (Ala-Ruona , 2007).

2.2.2 Observations about music therapy assessment in professional literature

In music therapy the importance of an assessment has gotten less attention than in the other disciplines. Wigram (2000) supposes that it is due to the fact that music therapy has developed from empirical practice. He remarks that in the other professions an indicator for a treatment relies on an effective and systematic assessment. The questions of reliability and validity in the music therapy assessment have been usually in a minor part and a subjective opinion and observation of the therapist in a major part. This differs substantially from the psychology, the speech and language therapy and the neurology practices. There are several assessment models in the music therapy but there is no widespread use of any one of those models. (Wigram, 2000.)

Music therapy assessment has not been reported very widely in the scientific music therapy literature. Sabbatella (2004) has collected a literature review of the assessment topic, and according to her work this topic has started to develop and grow in the last years but specially the literature on theory and method of clinical assessment is still very exiguous. She found 76 writings in music therapy journals or in congress/conference abstracts. The number of the publications was low from 1985 to 2001. Sabbatella´s review also shows that the most of the articles are related more to an assessment of a client rather than to the assessment tool itself and to the theory of music therapy assessment. (Sabbatella, 2004.)

Five years later Berger (2009) describes in her article that the situation of the music therapy assessment is still non-uniform and there is not a clear assessment protocol to this profession. Currently the therapists and educators develop their own assessment practises. (Berger, 2009.)

Layman et.al (2002) mentioned this same issue:
"Many assessment tools in the music therapy literature have been created for a specific population (e.g., mentally handicapped, developmentally disabled, autistic, psychiatric, etc.), in order to measure domains of functioning distinctive to the population. A music therapist´s theoretical approach to practice (psychodynamic, behavioural, etc.) will be also reflected in the assessment tool, as the instrument is usually designed to measure domains that are commonly addressed during intervention. The technique refers to how music is used in the assessment session. Is the music improvisational or concretely structured with the use of written music? Finally, assessment instruments are often created to address a particular need of an institution. " (Layman et al. 2002.)

Chase (2002) didn´t find any assessment handbook in her survey of the existing literature - a handbook that focused primarily on the process and practice of music therapy assessment for any clinical setting. She also mentions that very few assessment tools are formal and standardized assessments with a scoring system are almost non-existent. (Chase, 2002.)

In Finland there has been even fewer scientific discussions about the music therapy assessment than in the international community. Ala-Ruona (2007) has written the only scientific research paper on the topic. He has reviewed the other publications which are at some level related to the topic from the Finnish viewpoint: Master´s thesis of Mattila (1999) relating to music therapy with handicapped children, master´s thesis of Riikkilä (1999) relating to music therapy with autistic children, Doctoral dissertation of Ahonen-Eerikäinen (1998) about working models of music therapy with children and Doctoral dissertation of Syvänen (2005) relating to dynamics of counter-transferences. (Ala-Ruona, 2007.)

Wigram, Saperston and West (1999) noticed that the music therapy profession should develop its assessment practices to more scientific level (Wigram,Saperston & West, 1999). This kind of development would support the growth and advancement of the music therapy profession (Chase, 2004).

Professional status of the music therapist is related to music therapy assessment. Through assessment the music therapists are able to show the progress and the need of music therapy services. The assessment process that is representative of the potential of music therapy work can establish credibility of music therapy profession. Music therapy assessment needs to be a primary focus in the music therapy education and practice. (Chase, 2002.)

“The profession consequently experiences a diminished respect, approval, and credibility due to the lack of formal tools and the increased reliance on informally designed music therapy assessments" (Isenberg-Grzeda, 1988).

2.2.3 Music therapy assessment in Finland

In Finland the music therapy assessment has been defined in various ways. This refers not only to different theoretical and cultural distinctions, but also the concept has not been clearly defined. The music therapy assessment in Finland is a very versatile phenomenon with various practices. The other side of this versatility is the possible misunderstanding in the professional communication when there are no coherent concepts, practices and theoretical frames. Also the development of profession and multidiscipline teamwork can be challenging without homogenous terms and conceptions. If some published assessment models would suit to the Finnish clinical practice, a localization process would be needed for the model to fit to Finnish music therapy culture. (Ala-Ruona, 2007.)

The Finnish music therapy does not have the same kind of practical, official standards to the music therapy assessment either as for example AMTA has. The need to develop the Finnish music therapy assessment standard practice is obvious.

In Finland the term “assessment” can be applied when one is talking about an initial assessment, an evaluation of a therapy process or when the therapist considers whether the therapy goals have been achieved. The terms "initial assessment", "on-going assessment" and "evaluation" are used. An initial assessment refers to the first 3-5 therapy sessions. During the initial assessment period the therapist will determine the suitability of the treatment, define the therapy goals and evaluate whether there could be a therapeutic alliance between the client and the therapist. An on-going assessment refers to the continuous assessment during the therapy process; evaluation means the inspection of the therapy results and influences. In addition there is a term "consulting assessment" that can be used for example in situations where the therapist performing the assessment is different from the one normally executing the therapy process. This situation can occur e.g. in a hospital where the client is in for a short examination period. (Ala-Ruona, 2007; Ala-Ruona et al., 2009.)

Practical situation of music therapy assessment in Finland is usually quite free, without structured tests, questionnaires or tasks that are planned in advance. The therapist encourages the client to try instruments, to sing, to choose music to listen or to discuss about the music. The main goal is to start an interaction and to observe the behaviour of the client in different situations. The role of the therapist is to activate, maintain the interaction and create a safe and trustful environment. After the assessment sessions the therapist writes a descriptive statement about his/her observations. When the therapist forms an assessment feedback he/she uses his/her own observations about the assessment situation, clinical work experience, and self-reflection of his/her transference feelings. Then the therapist compares his/her own experiences to the preliminary knowledge and understanding of the multidiscipline team. Also viewpoint of the client is taken into to account. (Ala-Ruona, 2007.)

Typical characteristics of the Finnish music therapy assessment are a process-orientation (several meetings), a customer orientation, an investigation to musical interaction and using the other disciplines knowledge about the client. The natures of the assessment processes are continuing and overlap. (Ala-Ruona, 2007.)

There are no simple solutions to the supremacy of descriptive or a rating based assessment tool but some rational tool is necessary for the analysis of the data in music therapy assessment. An ideal solution would be an assessment tool, which uses both descriptive and numerical assessment methods. The importance of the assessment is remarkable because it will define the rest of the therapy process. (Ala-Ruona, 2007.)

2.3 Music therapy assessment models and tools

2.3.1 Contents of term "assessment tool"

An assessment tool can be e.g. a test, device or form, which is developed for the purpose of measuring client´s strengths and weaknesses in various areas (Hanser, 1999). Also the terms "assessment instrument" and "asessment model" are used in addition to an "assessment tool". The term "assessment model" usually refers to more free-form assessment situation.

When assessment tools are discussed, their reliability and validity are also always discussed. Reliability (test-retest) means that the measurements that are made with some particular instrument are systematically consistent and it is possible obtain the same results the degree to which a test or observation is consistent. Validity of the measuring instrument means that the instrument is able to measure the variable it is said to measure. (Domino, 2000; Walsh & Betz, 1990.)

In addition to general terms "reliability" and "validity" there is a term "inter-observer agreement" which measures the reliability of observers; "the degree to which two or more observers concur that specific events or behaviours have occurred" (Hanser, 1999).

In the field of psychology every high-quality measuring instrument must be reliable and valid. There is also an ethical and professional standard for the quality of tests and assessments. These tools must be high technical quality and they have to include all needed information for how to use, evaluate and interpret them. It is also important to be aware of the cultural context of the tests. Human behaviour happens always in some cultural context and thus it is impossible to claim that any test could be culture-free. When tests are used cross-culturally it is important that a translation and a collection of the norms in the new population have been accomplished. (Domino, 2000; Walsh & Betz, 1990.)

Chase (2002) inserts to a definition of assessment tools terms "formal" and "standardized". She comments that these terms are used in health care mostly interchangeably and they suggest an assessment that is tested scientifically and contain specific testing and scoring guidelines. According to this there is an "informal" assessment, which means a tool that is not tested scientifically. When it comes to music therapy she defines that "informal assessment" is an assessment process that is not in a written form. In this assessment process the therapist observes the client based on the AMTA standards of clinical practice and keeps notes about client´s progress. Therapist may use informal assessment if he/she works e.g. in a group setting and does not want to assess each individual or if he/she has not found an assessment tool that works in his/her clinical practice. (Chase, 2002.)

In music therapy context Chase (2002) does not use "formal" and "standardized" terms interchangeably. She defines that "formal assessment" in music therapy means an assessment process, which is designed by music therapist, is based on AMTA Standards of Clinical Practice and is outlined in an article or book and includes an organized written product. Formal assessment

is most often designed to specific client population and is based on certain theoretical orientation. Assessment process is administered in a similar manner each time and covers specific skills, responses or behaviour. According to Chase (2002) the "standardized music therapy assessment" means an assessment process that is scientifically tested and includes implementation guidelines and a scoring system with numerical or descriptive norms. It can be used by many therapists with similar results and is comparable to a formal/standardized assessment in other health care professions. (Chase, 2002.)

Music therapy practises can vary widely by different theoretical backgrounds, client groups and how to apply the music in a therapy session. Discussion about the need of a standardized assessment tool encounters also this diversity: many therapists feel that music therapy is too individualized for a standardized assessment, while other therapists feel that it is necessary and feasible. A general assessment tool for the whole music therapy field can be difficult to implement. (Chase, 2002.)

Bruscia (1988) and Chase (2002) comment, that due to the lack of standardized music therapy assessment tools, the music therapists often use the standardized assessments tools from other disciplines or develop their own assessment tools that are based on a combination of related fields to help them to assess a particular client group. (Bruscia, 1988; Chase, 2002.) Scalenghe and Murphy (2000) remark that when therapists are adapting tools from the other disciplines it is always a compromise with the reliability and validity criteria (Scalenghe & Murphy, 2000).

Whatever assessment models/tools have been used, the results should outline the client´s needs and how music therapy will be used to improve the client´s functioning, quality of life and/or life skills. Assessment is also used to support the development of the treatment goals and the objectives and their achievement timeframes. (Scalenghe & Murphy, 2000.)

Bruscia (1998) comments that an effective music therapy assessment tool should ” a) have clearly defined objectives, b) be conducted by a qualified music therapists, c) offer unique clinical advantages, d) employ effective methods of data collection, e) produce reliable data, f) lead to valid conclusions, and g) adhere to ethical standards” (Bruscia, 1988).

Hanser (1999) describes that a discriminating assessment tool should "1) identify strengths and weaknesses, 2) give corroborating evidence of the suitability of the selected goal, 3) help determine

target behaviours and specific objectives to guide therapy, 4) disclose other potential goals, 5) detect information about the nature of the target behaviour and prerequisite skills and 6) pinpoint those tasks which the person can and cannot do (Hanser, 1999).

2.3.2 Music therapy assessment models/tools and alternative domain names

In Table 1. some music therapy assessment models/tools and their focus areas are presented. The models are presented in the order of publication year.

TABLE 1: Music therapy assessment models

Nordoff & Robbins	1977	Response, relationship and musical communicativeness
Bruscia	1987	Improvised music
Wells	1988	Emotionally disturbed adolescents (song choice, composition and improvisation)
Goodman	1989	Music Therapy Assessment for Emotionally Disturbed Children
Rajimaekers	1993	Diagnosis
Grant	1995	Cognitive, perceptual, motor and visual skills
Pavlicevic	1995	Musical interaction
Sikstrom &Skille	1995	Psychological function
Di Franco	1999	Sound-musical profiles
Colin Lee	2000	A nine-stage process of analysing improvisations
Lowey	2000	Music Psychotherapy Assessment
Layman, Hussey, Laing	2002	Music Therapy Assessment for Severally Emotionally Disturbed Children
Baxter, Berghofer, Nelson Peters, Roberts	2007	The Individualized Music Therapy MacEwan, Assessment Profile [IMTAP] (for paediatric and adolescent settings)

(Parts of the table from: Wigram, 2000; Wigram, Nygaard Pedersen, Bonde, 2002; Layman et al., 2002)

None of these models are widely used in music therapy clinical practice and none of them are scientifically re-tested, researched and developed to the standardized music therapy assessment tool. Based on definitions by Chase (2002), most of them are formal in their nature. Their aims of assessment vary: some assess certain skills, some musical or other behaviour, and some are targeted to certain client groups. The Individualized Music Therapy Assessment Profile [IMTAP] is the most general in its nature with several detailed domains, advancing scoring system and computer software. Other assessment models differ so substantially from the IMTAP that it is not possible to compare them directly with each other. However some of them could also be applied to the initial assessment as well as to the on-going assessment in a case of a client who has an ADHD and phobic anxiety disorder of childhood. The possible applicable models could be e.g. Wells (1988), Goodman (1989), Loewy (2000) and Layman et al. (2002). Many of these models cannot be applied to very young children who can not speak, read and write.

These four models are presented shortly in the order of publication:

Title: Music Therapy Assessment for Disturbed Adolescents
Author(s): Wells, 1988
Population: Adolescents with Emotional Impairments

This projective and supportive-diagnostic assessment contains three tasks: (a) song choice: the client chooses and sings songs from a pre-organized list that describes him or her, (b) story of music: the client writes a story to his/her choice of four classical music titles, and (c) instrumental improvisation: the client explores different instruments, chooses an instrument that best describes him or herself, improvises with the therapist, chooses an instrument for each family member, and then improvises again or sings a chosen song with the therapist. Each task lists several areas of assessment with asset and deficit items based on his/her response to the task. (Chase, 2002.)

Title: Music Therapy Assessment for Emotionally Disturbed Children
Author(s): Goodman, 1989
Population: Emotionally disturbed children

This music therapy assessment with the emotionally disturbed child, include the following:

1. Interview with the child regarding previous background in music; use of music with family members;
2. Assessment of developmental appropriateness of social-emotional functioning while in

music;

3. Assessment of ability to organize musical experience;
4. Following of content of musical behaviour;
5. Following changes in musical behaviour over the course of session(s) and the possible meaning of these changes (process-oriented);
6. Interpretation of musical behaviour in consideration of family history, presenting behavioural problems, affective developmental levels, presenting diagnosis, previous background in and associations regarding music;
7. Investigation of musical response(s) characteristic of particular pathology

(Goodman, 1989.)

Title: Music psychotherapy assessment
Author(s): Loewy, 2000
Population: Any client

Loewy´s Music Psychotherapy Assessment method is based on the following 13 Areas of Inquiry: (a) Awareness of self, others, and of the moment, (b) Thematic Expression, (c) Listening, (d) Performing, (e) Collaboration/Relationship, (f) Concentration, (g) Range of Affect, (h) Investment/Motivation, (i) Use of Structure, (j) Integration, (k) Self Esteem, (l) Risk Taking, and (m) Independence. The assessment approach employs structured and improvisatory musical experiences to initiate the therapeutic relationship and explore the different areas. The music responses are evaluated qualitatively and are used to assist in future treatment planning. (Chase, 2002.) The nature of this assessment tool is descriptive and interpretive and it can be used for many client groups.

Title: Music Therapy Assessment for Severely Emotionally Disturbed Children
Author(s): Layman, Hussey and Laing, 2002
Population: severely emotionally disturbed children

This assessment tool has been designed to assess children´s behavioural and social functioning, emotional responsiveness, language and communication abilities, and musical skills. These functions are measured along a continuum anchored by defensive/withdrawn behaviour on one pole and disruptive/intrusive behaviour at the other pole. In the middle of the continuum are target behaviours. (Layman et al., 2002.) The assessment tool has been created both for initial assessment and evaluating changes during therapy process.

Chase (2002) brings out the issue that the assessment process involves usually such domains as motor, communication, cognitive, affective and social domains. She notices that the names of these domains may vary in assessment models/tools depending on the speciality, educational background and client population. (Chase, 2002.)

In the following tables 2 and 3 some alternative domain names that are used in the assessment models have been collected:

TABLE 2: Alternative domain names

Domain	**Other names**
Motor	Physical; Perceptual/Motor; Psychomotor; Senso-Motor
Communication	Speech and Language; Verbal
Cognitive	Mental Awareness; Academic
Affective	Emotional/Psychological
Social	Interaction; Interpersonal; Relationship

(Chase, 2002.)

TABLE 3: Domains and possible music therapy goals of domains in question

DOMAIN	SAMPLE GOALS To improve:
Psycho –Social	Self-awareness Self-esteem Self-concept Awareness of environment Insight Adjustment Motivation Coping mechanisms Interpersonal interaction Family relationships Cooperation Compliance Self-discipline Impulse control
Emotional	Expressivity Creativity Spontaneity Mood
Musical	Musical ability Musical potential Musical repertoire Freedom to express musically Peak, music experiences

(Hanser, 1999)

2.3.3. The Individualized Music Therapy Assessment Profile [IMTAP]

The IMTAP is an assessment protocol developed by a professional music therapy team specializing for the needs of at-risk, behaviourally and emotionally disturbed adolescents, the Nordoff-Robbins method, a special education, a speech – language pathology and a paediatric population. It has been designed to use in paediatric and adolescent settings. The IMTAP can be used as a treatment plan, a tool to develop goals and objectives, a means to address and assess target skill sets, as an indicator of overall functioning to provide a baseline for the treatment, as a research method and as a communication tool for the parents and the healthcare professionals. The IMPTAP begins with

intake and ends with a computer-based graphing and report system. (Baxter, Berghofer, MacEwan, Nelson, Peters & Roberts, 2007.)

Berger comments that the IMTAP is coming close to be "one of the first most comprehensive approaches to discovering specific characteristics of behaviours through extensive cross-sections of observable characteristics. The IMTAP is an excellent across-the-board instrument addressing a variety of diagnoses, but is mainly applicable to children´s functions." She writes that the IMTAP in not suitable for assessing all kinds of adult diagnosis, for example dementia patients, psychiatric diagnosis or pain management. (Berger, 2009.)

The IMTAP includes 10 main domains and several sub-domains. Using all main domains and subdomains together one can provide a systematic profile of 375 skills. The main domains and their sub-domains are the following:

1) Gross motor skills
    A. Fundamentals
    B. Perceptual/visual/psycho motor

2) Fine motor skills
    A. Fundamentals
    B. Strumming
    C. Autoharp/Q Chord
    D. Guitar/dulcimer
    E. Piano
    F. Pitched percussive/mallet

3) Oral motor skills
    A. Fundamentals
    B. Air production

4) Sensory skills
    A. Fundamentals
    B. Tactile
    C. Proprioceptive
    D. Vestibular
    E. Visual
    F. Auditory

5) Receptive communication/auditory perception
    A. Fundamentals
    B. Direction following
    C. Musical changes
    D. Singing/vocalizing

E. Rhythm

6) Expressive communication
- A. Fundamentals
- B. Non-vocal communication
- C. Vocalizations
- D. Spontaneous vocalizations
- E. Verbalizations
- F. Relational communication
- G. Vocal idiosyncrasies

7) Cognitive skills
- A. Fundamentals
- B. Decision making
- C. Direction following
- D. Short-term recall/sequencing
- E. Long-term recall
- F. Academics

8) Emotional skills
- A. Fundamentals
- B. Differentiation/expression
- C. Regulation
- D. Self-awareness

9) Social Skills
- A. Fundamentals
- B. Participation
- C. Turn-taking
- D. Attention
- E. Direction following
- F. Relationship skills

10) Musicality
- A. Fundamentals
- B. Tempo
- C. Rhythm
- D. Dynamics
- E. Vocal
- F. Perfect and relative pitch
- G. Creativity and development of musical ideas
- H. Music reading
- I. Accompaniment

(Baxter et al. 2007.)

Domains of the IMTAP can be used independently or together so that it is possible to create an in-depth profile of an individual. Using of the IMTAP does not presume to use certain music therapy methods or activities. (Baxter et al 2007.)

The IMTAP consists of several components:

- The **IMTAP Intake** is completed with the client or the parent/guardian, and it is used to pinpoint assessment domains and plan assessment sessions.
- The **IMTAP cover sheet** summarized the intake data and indicates the domains to be assessed.
- The **IMTAP session outline form** is used to plan assessment sessions, allowing the clinician to plan activities, which directly assess the domains indicated during the intake process.
- The **IMTAP domain scoring forms** collect data on the domains of the functioning. Within each domain there are various sub-domains, which further clarify how the client is functioning.
- The **IMTAP summary sheet** provides a means to summarize assessment data, resulting in subsets of client strengths and needs to facilitates a deeper understanding of client abilities.
- The **IMTAP goals and objectives form** provides a clear process for creating goals and objectives to address client needs.
- The **IMTAP quantification module** provides a quantified replicable score on a single skill, which can be used for research and documentation purposes.
- The **IMTAP computer software** allows the therapist to centralize client information, score the assessment electronically, creates reports and graphs, and track progress.

(Baxter et al, 2007)

3. PROCESS OF RESEARCH

3.1 Research questions and premises

The purpose of this master´s thesis is to study the emotional and social domains of the IMTAP and the fundamentals of musicality domain. The aim is to study them as an initial assessment tool of social-emotional functioning of a child diagnosed with ADHD and phobic anxiety disorder.

Research questions for this master´s thesis study are the following:

1. What kind of perspectives and experiences do the music therapy clinicians bring up about the application of the IMTAP, based on video recorded therapy sessions?

2. Is the IMTAP a useful initial assessment tool to assess social emotional functioning of a child diagnosed with ADHD and phobic anxiety disorder?

3. Is it possible to apply the IMTAP assessment tool to an initial assessment situation without changing the normal Finnish psychodynamic music therapy customs?

In this master´s thesis an initial assessment definition follows the definitions of Wigram (1999) and Hanser (1999): The first three sessions of the therapy that are used to guide to music therapy and focused on the treatment goals. (Wigram, 1999; Hanser, 1999.)

Practical situation of the initial assessment in this research was not planned in advance; methodological choices were based on wishes of the client and on an intuition of the therapist. This follows the definition of Ala-Ruona (2007) about the Finnish initial assessment situation: " Music therapy initial assessment is usually quite free situation without structured tests, questionnaires or tasks that are planned in advance. The therapist encourages the client to try the instruments, to sing, to choose music to listen or to discuss about music. The main goal is to start an interaction and to observe the behaviour of the client in different situations. The role of the therapist is to activate and maintain the interaction and create a safe and trustful environment. " (Ala-Ruona, 2007.)

Researcher of this master´s thesis has worked several years as a music therapist among children with psychiatric or neurological problems. Initial assessment situations of this research were part of actual therapy processes. Psychodynamic approach acts as a background theory in the researcher´s clinical work and in methodological solutions of the initial assessment therapy sessions.

This master´s thesis research uses three of the ten domains of the IMTAP: social and emotional domains and the fundamentals of musicality domain. The decision to use these domains was based on presumption and background information of the needs of the client. Musicality domain is included because it is a recommendation of the IMTAP guideline and because music is naturally a main medium in the music therapy. However only the fundamentals part, not other sub-domains, are included because in the Finnish psychodynamic music therapy context assessing musical skills in details (for example: reading the rhythm, right pitch or accompaniment) is not a general practise.

Chase (2002) has mentioned about the importance of assessment of the music. "Because music therapists use music as their primary treatment modality, a global music therapy assessment will also include *music* as a domain area. The music therapist needs to assess the client´s musical abilities, responses to music, and their music preferences, including style, instruments, and sound. This area is very important part of any music therapy assessment because understanding the client´s music preferences and abilities will help you decide how to assess the other areas most effectively through music." (Chase, 2002.)

Music therapy goals of the client were 1) expression of emotions and 2) decrease of fears and anxiety. Decisions of the therapy goals were based on an assumption of main challenges of the client. An understanding of the main challenges was built by interviewing the guardian, familiarizing oneself with the official client record and clinical working experience of the researcher oneself.

3.2 Research strategy

This master´s thesis research studies a certain phenomenon (initial assessment) that is part of researcher´s own professional working field (music therapy) and the purpose is to find both

descriptive and numeral information about the phenomenon through the questionnaires, summaries of the IMTAP domain scoring forms and focus group interviews.

Above-mentioned starting point leads to choose mainly the qualitative research as a perspective of the research. It is a typical characteristic of qualitative research that the area of the topic is conducted through researcher´s personal experience and engagement (Wheeler, 2005). As a starting point for the interest of this topic is researcher´s need to develop more structured assessment practises in own music therapy work. In the background was also a hope the IMTAP could be suitable assessment tool to psychodynamic music therapy.

Also the manner of collecting empirical material is qualitative in this research: observations, focus group interview, use of video recorded material and the use of personal experiences (Denzin & Lincoln, 2005). However the research includes also questionnaires and numerical data. Based on these manners of collecting data, this research has a multi-method qualitative research design.

Denzin & Lincoln (2005) define the qualitative research as follows: " Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible. These practices transform the world. They turn the word into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them." (Denzin & Lincoln, 2005.)

This master´s thesis qualitative research design is partly naturalistic inquiry: the initial assessment therapy sessions happen in an actual therapy setting and the research does not change the situation. Even focus group interview situation is not in a completely naturalistic setting, it attempts to capture normally thoughts, feelings and interactions of the participants (Wheeler, 2005.) Natural setting and the goal of understanding those meanings what the participants of focus group interview gives for the phenomenon (initial assessment and the IMTAP assessment tool), leads the research to tradition of phenomenological and hermeneutics philosophy.

3.3 Phenomenology and hermeneutics background philosophy and manner of thinking

Tradition and idea of qualitative research in phenomenology and hermeneutics include such essential concepts, as experience, meaning, communality, understanding and interpretation. Experiences of humans take shape in those meanings that humans give to them and those meanings are the subject of phenomenological research. Sensibility to study meanings based on presumption, that human function has a purpose and mind. Hermeneutics dimension to phenomenological research comes through understanding and interpretation of these meanings; hermeneutics is a theory of understanding and interpretation. (Laine, 2007.)

It is not possible to describe phenomenology and hermeneutics as a regular method and a manner of processing. It is applied in every research in different way and it is more as a background philosophy and a manner of thinking. Phenomenological research does not use predetermined theoretical framework in the meaning of leading study. (Laine, 2007.)

An important point of view in hermeneutics and phenomenology is a pre-stance of the researcher. This means that the researcher has natural insights about the subject of research beforehand. This kind of knowledge of the topic is a premise of understanding meanings. Phenomenological and hermeneutics research have two levels: basic level is an experienced life with pre-stance of it and the second level is the study of the first level. (Laine, 2007.)

Researcher should share his/her motivation, preliminary expectations of the results and his/her relationship to the study (personal and professional experiences and education, concerns, needs, reactions, thought, feelings, values, beliefs, culture, language and philosophy). All these can have an effect on the perspective of the results. Emphatic neutrality and mindfulness are important points of view in a qualitative research. Researcher is a primary instrument of research and he/she has a close relationship to the participant´s professional field. In spite of this, researcher should preserve the distance that it is possible to perform trustworthy study. (Wheeler, 2005; Bruscia, 2005; Laine, 2007)

Empirical knowledge develops in a dialogue with research data. An investigative dialogue is a circle on the move between research data and researcher´s interpretations and the understanding about the phenomenon should come deeper during this movement. The aim is to find most likely

and credible interpretation. This movement is so called hermeneutics circle. The result of analysing data is account of several aspects of the meanings and nature of the experience. (Laine, 2007.)

It is not possible to bring out all possible variables about phenomenon although perspective is holistic. Analysing data is looking for pattern, themes and relationships (Wheeler, 2005). Relationships of meanings give a picture of phenomenon; some are in more important than others (Laine, 2007).

Peculiar to hermeneutics research is to find out point of view of research participants; researcher wants to find meanings that participants give to phenomenon (Kiviniemi, 2007). This kind of inner contents analysing approach is called inductive analysing (from one to general). However, pure inductive analysing is in question: new theory cannot arise only from observations. Third, abductive logic is needed. According Alasuutari in Tuomi and Sarajärvi (2009) this logic assumes that the theory is possible to create with some theme or clue. (Tuomi & Sarajärvi, 2009.)

Abductive logic has same meaning as in Eskola and Suoranta (1998) theory-guided (teoriaohjaava in Finnish) logic. Theory-guided logic has the theoretical connections but it is not directly based on the theory or theory can help in analysing. Researcher has to recognize the effect of early information but the meaning of this information is not to test a theory but open new perspectives. In theory-directional logic analysis units are chosen from the data but early information direct and help in analysing. (Eskola & Suoranta, 1998.)

In phenomenological and hermeneutics tradition researcher should be aware of him/her pre-stance also during analysing process so that analysis would happen based on stipulations of the participants not based on pre-stance (Eskola & Suoranta, 1998).

3.4. Research data

Master´s thesis study included the following steps to conduct research data:

1. Five (5) music therapists compose a professional group and they answer questions about their theoretical background in therapy work and what fields of assessment they emphasize in their clinical practise.

2. Therapists see three (3) video recordings and edited therapy sessions about one (1) child. Each video is about 20 min.

3. They assess the therapy sessions by using the IMTAP assessment forms (emotional and social domains and the fundamentals of musicality domains and scoring forms). These forms are translated to Finnish.

4. After above-mentioned steps the therapists have a focus group interview of their experiences about the IMTAP assessment tool. The focus group interview is video recorded.

5. The data from the IMTAP assessment forms is entered into the IMTAP computer software and then it is possible to compare the answers of the therapists with each other.

6. Focus group interview video material is managed by Hyper Research qualitative analysis tool (version 2.8.3) for coding and analysing.

3.4.1 Permissions of research

Ethical aspects are important to protect the rights of the client in therapy research. Therapy sessions were executed with a real client in a private music therapy clinic and a therapy process was conducted through normal therapy protocol. Part of the therapy sessions was video recorded. A payer of the therapy was Social Insurance Institution (KELA).

Appropriate permissions were asked from the child, parents, and from principal physician of Kela Southwest Finland. In addition the principal physician of the ethics committee of the Hospital District of Southwest Finland was consulted.

Commitment to ask the permission from an underage child is based on self-determination of the child in United Nations´ Convention on the Rights of the Child (Article 12) and in The Constitution of Finland (6§). (Convention on the Rights of the Child 1990, article12; The Constitution of Finland 1999/ 731, 6§)

Research plan and report of the ethical aspects were sent to the KELA and hospital district for the approval. Permission-forms for the child and parents and announcement-form for the parents were modified to this master´s thesis research from the models of Finnish Investigators Network for Paediatric Medicines [FINPEDMED].

Aim of the research and all practical executions were explained for the child and parents and they had also possibility to deny the participation. Also privacy protection and coverage were informed for the parents.

Finnish permission forms, announcement for the parents and report of ethical aspects are placed in appendices numbers 1-4.

3.4.2 Music therapist participants in research

Invitations to the master´s thesis research were sent to nine (9) music therapists via email and after second round of invitation five (5) music therapists were able to participate. The study was carried out in one research day. The day was about 6 hours long and it was divided in an orientation and an execution parts. The orientation included a description of the study and the IMTAP (2h), the execution part included questionnaries, observations from therapy videos, assessing the videos by the IMTAP (2 hours) and focus group interviewing (2 hours).

Participants to this study were chosen based on their homogenous educational background and at least 3 years of working experience was also expected from the participants. Educational background of the participants was in broad based ("laaja - alainen") music therapy. Finnish "laaja-alainen" music therapy education is not committed tightly to some particular therapy framework but

it is possible to find quite strong psychodynamic and psychoanalytic thinking from the background. Also learning- and developmental theories are applied. (Ala-Ruona, 2007)

Participants in the study were music therapy professionals who were supposedly able to offer the information about the research subject. Qualitative research strives to describe, understand or give a theoretically meaningful interpretation to a phenomenon and because of this it was important that participants of the research know and they have experience about the subject (Tuomi & Sarajärvi, 2009). Participants were represented as a purposeful sampling.

Purposeful sampling means that research participants are selected because of they can bring something to research question, not because they are typical group of some field, a purpose is not generalized (Wheeler, 2005). In this master´s thesis research this phenomenon can been seen in research participants: it was not defined if these therapists were typical representatives of the Finnish music therapists as a basis. Every one of them brought a unique perspective to this study.

3.4.3 Questionnaires for the participants

Participants answered the questionnaires about their theoretical background in music therapy work and which fields of initial assessment they usually emphasize in the clinical practice of their own. Questionnaires were structured and there were multiple-choice questions. Questionnaires were conducted before assessment of therapy sessions and focus group interview.

These questionnaires were conducted in order to get more detailed information about the starting point of the therapists. A presumption was that despite of the same kind of music therapy education background it might be possible that the therapists would emphasize different approaches in their clinical practice. A second presumption was that these differences might have an effect on the opinions of therapists about the IMTAP assessment tool.

The options for the questions about the theoretical background of the therapist were behaviouristic, cognitive, humanistic-existentialistic, psychodynamic, holistic, bio-medical and neurological approaches. In addition there was possibility to chose an option " something else" and describe it by oneself. Definitions of approaches were based on Scovel & Gardstrom (2007). Definition of neurological approach was based on spoken definition of master´s thesis

supervisor Esa Ala-Ruona. Participants were asked to choose 1-2 approaches that they feel to be the closest to their own clinical work. Approaches were described by therapeutic change, role of therapist, therapy technic and definition of malady.

Question of theoretical background is in appendix number 5.

The options for the question about the assessment fields that the therapist emphasize in their own music therapy work were interaction, behaviour, musical expression, expression, emotions, experiences of client, motoric function and cognitive managing. Definitions of each are based on Ala-Ruona (2007). Participants were asked to choose 1-3 options.

Question of assessment fields in participant´s own clinical practice is in appendix number 6.

After assessing video recorded therapy sessions and applying the IMTAP, participants answered also to question about how easy they thought that the IMTAP was to use. The scale was from 1 to 5 and each choice was already defined: 1= very difficult, 2= quite difficult, 3= not difficult or easy, 4= quite easy, 5 = very easy. This question was asked before the focus group interview.

Questioner of how easy it was use to the IMTAP is in appendix number 7.

3.4.4 Video recorded initial assessment situations and translation of the IMTAP

The therapists saw three (3) video recordings and edited therapy sessions of one (1) child. Each video is about 20 minutes. The videotaped therapy sessions were the first three therapy sessions of the client and the researcher edited these recordings. Important and meaningful video clips from the therapies were chosen and the decision to include a video clip was based on music therapy working experience of the researcher.

The video material from the initial assessment sessions was essential for this therapy research: it offers a possibility to observe interaction between the therapist and the client. The video brings out also non-verbal communication such as face expression and gestures. All these are important in therapy work and also in hermeneutic research. Hermeneutic research also focuses particularly on human communication and its different manifestations (Laine, 2007).

The music therapists who observed the initial assessment sessions used the IMTAP scoring forms. The original language of the IMTAP is English and because the participants were Finnish, it was necessary to translate the assessment tool to participant´s own language.
The IMTAP categories and scoring forms from emotional, social and fundamentals of musical domains were translated to Finnish. Master´s thesis supervisor checked the translation and in addition to an intelligibility of the contents was confirmed with the music therapist participants of the research. The description and the meaning of each domain and sub-domain were checked and discussed together before starting the initial assessment. The scoring system of the IMTAP was taught to the participants and they had a possibility to ask questions and make sure that they had understood how the scoring system is conducted.

Finnish translations of the social, emotional and fundamentals of musicality -domains and of the IMTAP scoring forms are in appendices numbers 8-11.

3.4.5 Focus group interview

Focus group interview was a methodological choice for the group interview. The aim of the focus group interview is a discussion and an interaction between the participants to get different points of view about the issue. An interviewer is not in a main role, his/her task is to prepare a topic guide and develop stimulus material to encourage interaction. Appropriate participants have some commonalities with each other but also differences so that they are able to bring out various opinions and viewpoints. (Barbour, 2007.)

Qualitative, phenomenological research includes an idea about communal human being. This means that reality opens up for us through community (Laine, 2007). This idea was also one reason why a focus group interview as a data collection method was chosen to this study: group of professionals could arouse versatile information about the research subject through the communal group interaction.

Design flexibility means that research design is not set completely beforehand and it may change according to new information that is learned during the research (Wheeler, 2005). In this master´s thesis research the emergent design flexibility can been seen particularly in the situation of focus

group interview. The interview situation had main themes that were set in advance but the participants brought out additional questions. Questions in the interview were quite open and the participants have lots of space to express what they want.

The interview situation was also video recorded. The video offered a possibility to see non-verbal communication and expression (Laine, 2007).

The focus group interview outline is in appendix number 12 (in Finnish).

3.5 Process of analysing data

Qualitative analysis is both analytic and synthetic in its nature. The analytic part can be seen as categorization and structuring data systematically to different theme domains, otherwise in coding data to interpretative domains. In practice this phase needs several analysis steps and it gets its shape little by little. (Kiviniemi, 2007.)

The analysis means that the researcher structures data to meaningful ensembles. In the first phase the language of description strives to retell the language of participants. The aim is to bring out the individuality of participations as authentic than possible. After this the data is structured for meaningful domains by stipulations of data in a frame of research questions. The aim in this last phase is to create an overall picture of the phenomenon. (Laine, 2007.)

The aim of analysis is to thematize, structure and narrate what was discussed. This does not mean abstracting in the meaning of generalizing so that unique characteristics would be faded out and only common meaning ensembles for all participants would be preserved. Hermeneutics strives to understand and interpret the diversity of phenomenon; hermeneutics does not to strive statistical generalization. (Laine, 2007; Tuomi & Sarajärvi, 2009.)

Tuomi & Sarajärvi (2009) structured the phases of analysis as follows:

1. What is interesting?
2. Lettering of data and coding
3. Themes and forms

4. Summary
(Tuomi & Sarajärvi, 2009).

Doing themes stresses what is said about each theme. Qualitative data is divided and grouped, and this enables one to compare themes. The idea is to find a suitable view to a certain theme. If the data is based on a theme interview it is quite easy use the themes of interview as a structure to the data. Forming means that the data is grouped to different forms. Inside of certain theme is looked for common characteristics and through this is able to see a type example of this theme. (Tuomi & Sarajärvi, 2009.)

Focus group interview data from the video was first transcripted and after that data were coded and done themes by using Hyper Research qualitative analysis tool (version 2.8.3). Hyper Research is a software tool for qualitative data analysis. Hyper Research has code-and-retrieve data analysis features, report-generating capabilities, multimedia support (for data including graphics, video, and audio as well as text), and theory-building tools (Dupuis, 2002).

Codes of the interview were based on verbal expression of participants as it was and after that codes were divided on themes based on focus group interview questions. Through analysing answers to focus group questions it was possible to divide them to three new main topics which participants dealt with: the IMTAP assessment tool, assessment in general and research frame.

As for the IMTAP scoring forms were analysed by using the IMTAP computer software, which is fully automated system of client management, data collection and assessment scoring (Baxter et al., 2007). All the results of the domains scoring were entered into the computer programme which counted the results of the client. Through this it was able to compare the scorings that participants gave to the client from each domain, based on their initial assessment observations.

3.6 Summary of methodological solutions of research

Music therapy is a diverse field and music therapy research increasingly reflects that diversity and even in a simple qualitative research design, complexity is built onto the study and must be explicitly considered, giving transparency to the interpretive process (Wheeler, 2005).

Wheeler´s (2005) comment fits also to this research. Research includes various types of data: verbal, nonverbal, musical and numerical. Great part of the data in this study has arisen from human interaction that is always challenging and multidimensional research subject. In this study the data is recorded, transcribed, translated and analysed through various analysis methods.

How the research methodology is comprised in this research is shown in the Figure on the next page. The figure is based on the model of Laine (2007) about phenomenological-hermeneutics research.

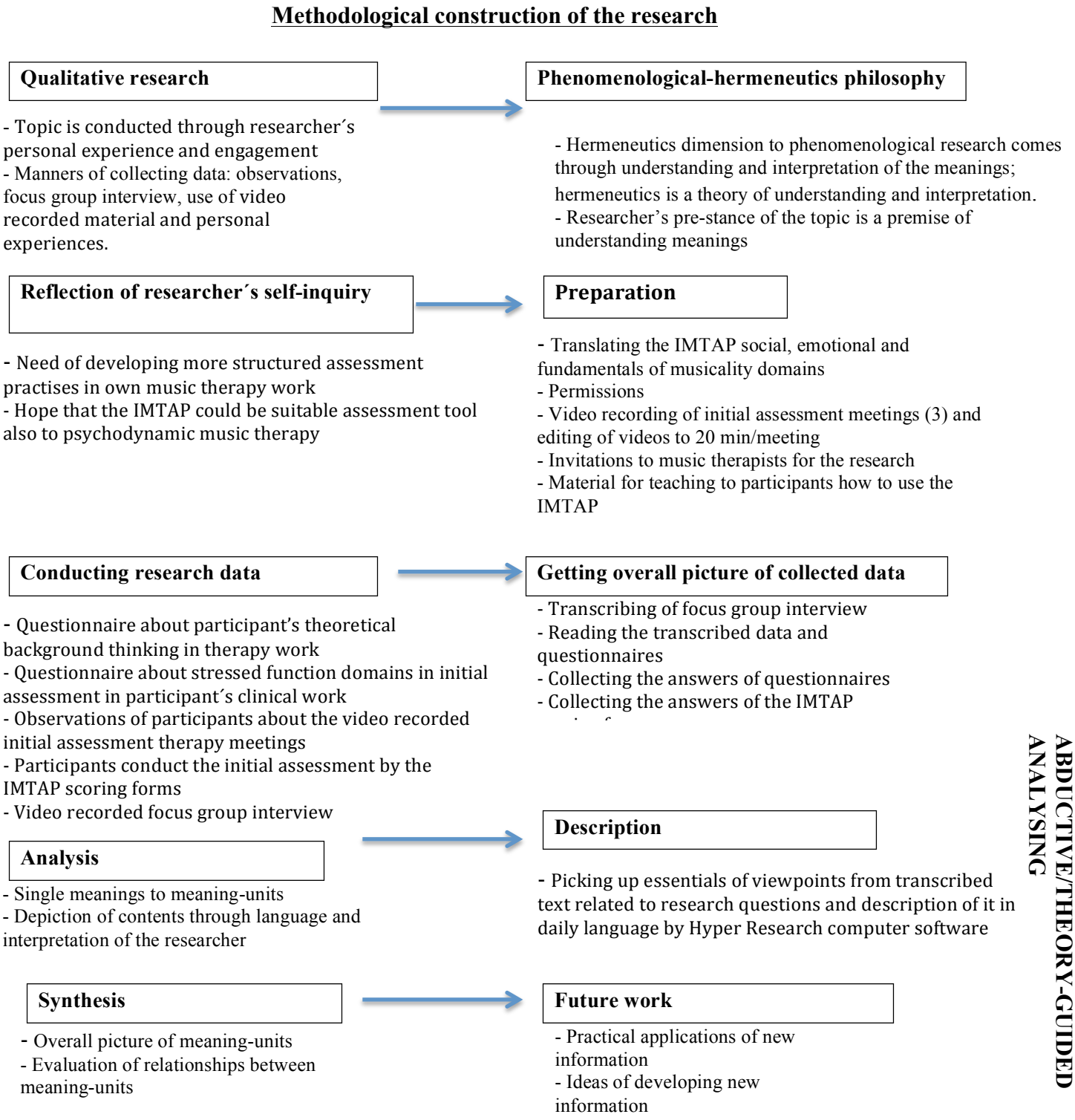

FIGURE 1: Methodological construction of the research

4. RESULTS OF THE STUDY

4.1. Theoretical backgrounds and typical assessment areas

Questions of the theoretical background and typical assessment areas are presented below as tables. An overall picture of the answers in a nutshell is shown in the Tables.

Answers to the questions of the participant´s theoretical background when they were asked to choose 1-2 approaches that describe and suit best to their clinical work:

TABLE 4: Theoretical background of the participants

Theoretical background	**Participant 1**	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**
Behaviouristic					
Cognitive					
Humanistic-Existential	X	X (a)	X	X	X (b)
Psychodynamic		X (b)	X		X (a)
Holistic					
Biomedical					
Neurological				X	
Other	X "Combination of different theories according to client and situation"				

(a) and (b) = order of importance

The theoretical background of the participants was mostly humanistic-existential approach, but also psychodynamic approach and neurological approach got support. One participant said that he/she uses many approaches according to a client and situation.

None of the participant use behaviouristic, cognitive, holistic or biomedical approaches in their own clinical music therapy work.

The definitions of the theoretical approaches are described in appendix 5 (in Finnish).

Answers to the question of typical assessment areas in clinical work when participants were asked to choose 1-3 areas that suit best for them:

TABLE 5: Typical assessment areas in participant´s own clinical work

Area of emphasis	**Participant 1**	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**
Interaction	X	X (a)	X	X	X (a)
Behaviour		X (c)	X		
Expression of musicality	X			X	X (b)
Expression			X	X	
Emotional life	X				X (c)
Emphasis of experiences		X (b)			
Motoric					
Cognitive functioning					

(a), (b), (c) = order of importance

All music therapists thought that interaction is an essential part of the assessment in their work. Expression of musicality is also important. Other kind of expression, behaviour and emotional life as an assessment area were also chosen. One respondent also emphasises the experiences of the client.

The definitions of assessment areas are described in appendix 6 (in Finnish)

4.2. Domain scorings

The IMTAP computer software calculated results of the answers on the domain scoring forms, except fundamentals of musicality domain. Fundamentals of musicality domain were calculated manually because the computer software does not compute partly filled domains.

The IMTAP computer software presents the results of the client in percentages, based on scoring form answers. The best possible result is 100%.

4.2.1 Emotional domain

Emotional skills examine emotional or feeling states of an individual within the music therapy session. The various sub-domains, which assess these skills, are presented below.

A. Fundamentals:

i. Demonstrates range of affects
ii. Demonstrates appropriate affect

B. Differentiation/expression:

i. Expresses emotions appropriate to circumstances
ii. Expresses emotions using instruments
iii. Expresses emotions verbally
iv. Demonstrates emotional sensitivity to musical components

C. Regulation:

i. Tolerates Music Therapy situation without distress
ii. Calms with support (musical/verbal/physical)
iii. Tolerates transitions
iv. Self regulates within one activity
v. Emotional states fluctuate appropriately

vi. Remains regulated when limits are set

D. Self-awareness of emotional states:

i. Demonstrates recognition of emotional states

ii. Demonstrates ability to explore emotional states

iii. Demonstrates ability to discuss emotional states

iv. Initiates emotional content appropriately

v. Demonstrates desire to better oneself or life circumstance

(Baxter et al., 2007).

TABLE 6: Results of the emotional domain scoring forms

Emotional	**Participant 1**	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**
Total	**96 %**	**91 %**	**87 %**	**85 %**	**82 %**
Fundamentals	100 %	100 %	88 %	88 %	75 %
Differentiation/Expression	100 %	90 %	85 %	80 %	80 %
Regulation	95 %	100 %	90 %	95 %	71 %
Self Awareness	93 %	83 %	87 %	80 %	93 %

Summary of emotional domain scoring:

- The total scoring of the emotional domain ranged from 82 to 96%
- The scoring for the Fundamentals subdomain were 75 -100 %
- The scoring for the Differentiation/Expression were 80 -100%
- The scoring for the Regulation were 71 - 100%
- The scoring for the Self -awareness were 83 - 93%

According to the table 6, the client´s performance is most often (18 times) in the IMTAP grading system area "Consistent 80-100%". Only two (2) times it was reviewed as "Inconsistent 50 - 79%".

The range of the lowest and highest answers of each sub-domains are in total scoring 14 %, in fundamentals 25 %, in differentiation/expression 20 %, in regulation 29 % and in self-awareness 10 %.

The Finnish translations of the emotional domain and scoring forms are described in appendices 8 and 9.

4.2.2 Social domain

Baxter et al. (2007) define the IMTAP social domain as follows:
The social domain measures the ability of the individual to interact and communicate with others. These skills range from the basic fundamental skill of responding to one´s name to the advanced relational skills of exploring external social relationships. Sub-domain includes participation, turn taking, attention, direction following, and relationship skills. (Baxter et al., 2007.)

The various sub-domains, which assess these skills, are presented below.

A. Fundamentals

i. Responds to own name
ii. Demonstrates awareness of therapist
iii. Demonstrates interest in presented activities
iv. Demonstrates joint attention
v. Interacts appropriately with therapist
vi. Uses socially appropriate greeting
vii. Uses socially appropriate goodbye
viii. Uses socially appropriate eye contact
ix. Socially references others
x. Demonstrates understanding of rules and structures
xi. Demonstrates awareness of appropriate physical space
x. Demonstrates confidence in MT situation

B. Participation

i. Enters room with minimal prompting
ii. Remains in room for duration of session
iii. Attempts new tasks when given opportunity
iv. Initiates new activity when given opportunity
v. Tolerates transitions

vi. Participates in structured activities
vii. Is flexible in developing activities
viii. Extends activities appropriately
ix. Works towards identified goals in session

C. Turn-taking

i. Anticipates own turn
ii. Waits for turn
iii. Sustains turn-taking with prompts
iv. Requests turn when appropriate
v. Sustains turn-taking without prompts

D. Attention

i. Sustains activity length attention span
ii. Demonstrates sustained attention to therapist
iii. Returns to activity after distraction with prompts
iv. Returns to activity after distraction without prompts

E. Direction Following

i. Follows one-step verbal direction
ii. Follows two-steps verbal direction
iii. Follows simple musical cues

F. Relationship Skills

i. Tolerates direct interaction
ii. Tolerates redirection
iii. Tolerates musical contact
iv. Plays in parallel with therapist
v. Plays in imitation of therapist
vi. Sustains musical interaction
vii. Sustains two-way communication
viii. Works cooperatively with therapist
ix. Demonstrates flexibility in interactive musical play
x. Demonstrates flexibility within familiar interactive structure

xi. Can assume leadership role in activity

xii. Moves between independent and interdependent skills

xiii. Able to explore external social relationships (Baxter et al., 2007).

TABLE 7: Results of the social domain scoring forms

Social	**Participant 1**	**Participant 2**	**Participant 3**	**Participant 4**	**Participant 5**
Total	**91 %**	**99 %**	**92 %**	**80 %**	**87 %**
Fundamentals	95 %	100 %	92 %	90 %	90 %
Participation	91 %	100 %	100 %	91 %	82 %
Turn Taking	85 %	100 %	95 %	50 %	75 %
Attention	92 %	100 %	85 %	85 %	77 %
Direction Following	91 %	100 %	91 %	100 %	100 %
Relationship skills	91 %	96 %	87 %	75 %	93 %

Summary of social domain scoring:

- Total scoring of social domain ranged from 80 to 99 %
- Fundamentals were 90 -100%
- Participation were 82 - 100%
- Turn Taking were 50 - 100%
- Attention were 77 - 100 %
- Direction following were 91 -100 %
- Relationship skills were 75 - 96 %

According to the table 7, the client´s performance is most often (26 times) in the IMTAP grading system area "Consistent 80-100%". Only four (4) times it was reviewed as "Inconsistent 50 - 79%".

The range of the lowest and the highest sub-domain answers are in total scoring 19 %, in fundamentals 10 %, in participation 18 %, in turn taking 50 %, in attention 23 %, in direction following 9 % and in relationship skills 21 %.

The Finnish translations of the social domain and scoring forms are shown in appendices 8 and 10.

4.2.3 Fundamentals of musicality domain

Baxter et al. (2007) define the IMTAP musicality domain as follows:

"The musicality domain is intrinsic to the IMTAP and should be included in every assessment. This domain examines an individual´s innate response to various musical mediums and his or her ability and desire to participate in each. Assessment of these areas acts as a prescriptive focus, allowing the music therapist to develop truly individualized interventions that involve the client in the musical experience directly. The fundamentals assess the individual´s general interest in, reaction to, and enthusiasm for the music medium." (Baxter et al., 2007.)

Despite of the importance of music in music therapy this master´s thesis study includes only the fundamentals of musicality domain from the IMTAP. This is because the Finnish psychodynamic music therapy context rarely is interested in musicality as a skill of e.g. right pitch or notation reading skills.

Fundamentals of musicality are presented below.

A. Fundamentals

i. Is alerted by music
ii. Expresses enjoyment of music
iii. Indicates desire to play/touch instruments
iv. Plays instruments when presented
v. Explores instruments
vi. Vocalizes in response to music
vii. Moves rhytmically in response to music
viii. Plays instruments spontaneously
ix. Sings spontaneously
x. Responds to simple musical cue

xi. Engages in interactive musical play

xii. Regulates with musical support

(Baxter et al., 2007).

TABLE 8: Results of the fundamentals of musicality domain

Musicality	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Fundamentals	90 %	88 %	80 %	63 %	78 %

Summary of fundamentals of musicality domain scoring:

- Results range from 63 to 90%

According to three participants (as shown in table 8), the client´s performance in the IMTAP grading system is "Consistent 80-100%" and according to two participants in the "Inconsistent 50 - 79%"category.

The range of the lowest and the highest answers are in fundamentals 27 %.

The Finnish translations of the fundamentals of musicality domain and scoring forms are shown in appendices 8 and 11.

4.3 Analysing focus group interview

The order of the questions in the focus group interview defines an outline for this analysis report. Answers are presented so that below each interview question there is a summary of the projected opinions. After opinions is a citation example from the interview related to the presented opinion.

Focus group answers to the each domain are divided in three main points of view. These main points of view were formed after a thorough analysis of the answers: participants created those areas spontaneously by themselves in their discussion during the each domain. The main points that the focus interview participants always commented are 1) the IMTAP assessment tool, 2) music therapy assessment in general and 3) research frame in an assessment research.

Context of analysing focus group interview is presented in the order of focus group interview questions and in above-mentioned three subcategories.

Focus group interview questions are listed in appendix 12 in Finnish.

Before reviewing the answers of the focus group interview the results of the question about the ease of use the IMTAP are presented.

4.3.1 Ease of use of the IMTAP

Question: Ease of use of the IMTAP assessment tool ___
(scale 1-5: 1= very easy, 2= quite easy, 3= neither easy nor difficult, 4= quite difficult, 5= very difficult)

Participants' answers to the question whether the IMTAP assessment tool was easy to use are shown in table 9.:

TABLE 9: Ease of use the IMTAP

Ease of use	Participant 1	Participant 2	Participant 3	Participant 4	Participant 5
Very difficult					
Quite difficult					
Not easy or difficult	X				
Quite easy		X	X		X
Very easy				X	

Questioner is appendix number 7 (in Finnish).

All participants considered the IMTAP to be very easy - not easy or difficult.

Most of the participants thought that IMTAP was "quite easy" to use.

4.3.2 Emotional domain

Question: What is your opinion about the applicability of the assessment tool in regards to emotional expression and functioning of the client in question?

Opinions:

Assessment tool:

- Emotional domain didn´t bring out the problems of the client: client got good points from problem areas.
- Emotional domain brings out the strengths of the client
- Emotional domain is adequate and it contains more than usually in an initial assessment
- Emotional domain helps to structure the initial assessment
- Emotional domain produces information in black and white
- Scale of scoring was too rough
- More sub-categories are needed
- Need for open description
- Possibility to get information how the client reacts to different feelings is needed

" 4: Client got surprisingly good points from problem areas from me and I suspect that client has problems in emotional skills. This (assessment tool) didn´t bring it out clearly...
5: I found the problem from the emotional skills (1,3 and 4 react: Yes, so did I!)
1: But not based on those questions.
4: It came from other way.
3: Yes.
4: If I would use this I would add open description or would add or change some questions."

Assessment in general:

- Basically the emotional things are difficult to evaluate
- There would be a need of this kind of assessment tool in own clinical work

" 5: This would help to structure. I have thought this kind of system to my work. Why it (assessment) has to be sometimes so vague?
Interviewer: You have missed a tool to structure assessment?
5: Yes, this would be most welcomed at least to me."

Research frame:

- An interaction between the therapist and the client is important in a therapy and the video provided a good tool to observe both the therapist and the client.
- To get really all information from the client it would be necessary to be a therapist by oneself: this would bring out transference feelings.
- Interventions in assessment would be good to plan beforehand so that it is possible to answer to all points in the IMTAP domain.

"2: I thought that when I was not the therapist in this situation this was more like studying visual and auditory observations (by video). If I would be the therapist for my own client it would be possible to study own experiences more deep.... transferences (1, 3 and 4 echo)
1: That what the therapist think after the therapy session.
4: That is missing: electricity, smell and taste.
3: That which is in live-situation
1: Taste of life. That ´s why it (assessment tool) feels so superficial (4 and 5 echo)"

4.3.3 Social domain

Question: What is your opinion about the applicability of the assessment tool with regards to social expression and functioning of the client in question?

Opinions:

Assessment tool:

- Lots of points and material
- No need to supplement

- Scale was too rough
- Point of view is narrow but enough for initial assessment

" 1: It was quite narrow but maybe enough for an assessment. This gives you rough guidelines but it is enough for an initial assessment
5: (echo) Enough
4: And to assess changes if you will do this. You get percentages to answer and it is concrete evidence to payers.
1: But 0 % and next 50%, it is certainly too rough scale."

***Assessment in general*:**

- Social domain was easier to assess than emotional domain: social functioning is always part of music therapy work; interaction is easier to observe than emotions.

" 4: Social domain was easy to assess (1, 3 and 5 echo)
Interviewer: Was it easier than emotional domain?
4: Yes (1, 3 and 5 echo)
1: It was more concrete than emotional domain because you can see what the other one is doing. (3, 4 and 5 echo) I didn´t feel that something is missing."

"5: In my work it comes visible easier. Emotional things are most difficult to my client group but interaction starts easier. I felt more comfortable in this area."

Research frame:

- Problems in social functioning were not seen in video.

"4: Interaction is often problematic in social relationships and there are problems in school, at home or with friends. You were not able to see that from the video."

4.3.4 Fundamentals of musicality domain

Question: What is your opinion about the applicability of the assessment tool with regards to musical expression of the client in question?

Opinions:

Assessment tool:

- Assessment tool does not bring everything out.
- Receptive communication in music can not be seen
- Enough categories
- Analysis of improvisations would be interesting but it would be more part of emotional domain than musicality

" 2:This was labour -intensive
4: This was enough or it depends on client. I think that with an adult client there could be more categories if you could improvise with piano.
5: I think it was enough.
3: But that goes to emotional domain (points to answer of 4.)
1: It depends what you are looking for.
5: But if we start to study music too much, where we are going? We always say that it is not important if a client is musical.
1: There is not at all receptive communication. How the client accepts music and how he/she goes with it; that is what I want to know about music. Not like this---pitch or something like that."

Assessment in general:

- Musicality is not essential
- Music is a medium: but more expressivity than musicality
- Music tells about interaction and emotions
- Meaning of musicality depends on what is your goals in therapy and in assessment

"1: These fundamentals are enough to me.
4: Depending on therapy goals. If you want to improve cognitive skills, for example reading skills, it is important to know how the client handle the rhythm."

"1: Music is way of expression, not: is it a right pitch?. Improvisation tells. It is not musicality. More expressivity or receptiveness."

" 2: I don´t want to go so in details. Of course it is meaningful how client reacts, how he/she acts with rhythm and melody or some other musical element. However more important is what kind of needs come up in this kind of situation."

4.3.5 Necessity of the IMTAP assessment tool

Question: What you think about the necessity of this assessment tool to you own music therapy work?

Opinions:

- The IMTAP would be necessary to own clinical work
- The IMTAP helps to structure the work
- The IMTAP could create common language between the music therapists if it would be a shared assessment tool
- The IMTAP would help to set therapy goals
- The IMTAP would help in writing the therapy report
- The IMTAP would be useful learning tool to music therapy students
- The IMTAP alone is not enough but with some other tool it could be useful
- Experienced clinician do not need ready model to assessment and assessment include same areas anyway
- Music therapists would need this kind of assessment tool in addition to observation

" 4: I think this would be necessary. (1, 3 and 5 echo)
1: At least to initial assessment.

2: I believe that it is ok to do quite informal assessment. I could take some handy, systematic model because then it would be possible to put to therapy report something else also than just my own name under the conclusions. Systematic model should be more near some well-known psychological test. It should be trustful. This informal assessment style (which is usually in Finland) is so flexible than you can trust you own experience. (Others echo)"

4.3.6 Additional thoughts relating to the IMTAP

Question: What other thoughts do you want to share about this assessment tool?

Opinions:

- Assessment tool produces lots of material and it is adequate to initial assessment
- Assessment tool is clear and quick to use
- Assessment tool would need to be standardized and localized
- Assessment tool should be in Finnish for it to be used
- Scoring categories were not defined clearly enough
- It is good that it is music therapy´s own assessment tool
- Video is essential to do the IMTAP assessment: all problems were not noticeable just based on questions; video helped to conceive

" 4: This does not come to common use here if this is not in Finnish.
2: We should discuss about this with multi-professional team and localize this. We should develop this to certain level."
"2: It takes time to study and test and discuss among profession: how we act and what we support."

Research frame:

- In the video it was not possible to see all the time if the client has an eye contact or not
- When the client was not own, there were missing intuitions, transference, own experience of interaction and preliminary knowledge of the client
- Only a part of the IMTAP assessment tool was in use, maybe rest of the tool would complete the missing knowledge

" 3: Again I thought how it would have felt to be the therapist in this situation. For example now I didn´t see if the client keeps an eye contact all the time: did the client look and how long time. That feeling would be important and I would have it if I had been the therapist. Now I did an interpretation that the client did not look too often. I don´t know if saw it right.
2: I thought that the client kept an eye contact intermittently. (1, 4 and 5 echo) "

4.3.7 Aspects relating to music therapy assessment in general

Question: What other thoughts you want to share about music therapy assessment in general?

Opinions:

- Assessment tool does not remove responsibility
- Current assessment practice where everyone can produce their own assessment is very flexible and bring out personal ways to assess
- Music therapists should not assess the same areas as some other professional groups already do
- Music therapy produces information to assessment of emotions
- Music therapy profession needs assessment tools to professional credibility
- Music therapists would need common language
- Qualitative description and a test would be good combination
- Music therapists should specialized more

"4: It would be nice if we would have common language. (5, 1 and 3 echo)
5: It would be important and it has been missed sometimes from my own work. I have thought that other therapist have assessments models but where is our things? (3 and 4 echo). It is expected from us and they ask why we don´t have anything.
3: Evidences (1 and 4 echo)
1: It is maybe the demand of employer, it is already exists. (1, 3 and 5 echo). We don't have to satisfy that demand but.."

"1: We should be everything: we should do diagnosis and we should know what development has happened and we should do music psychotherapy and write informal therapy report about our experiences.

5: We usually say that we can do it, but who believes us!

3: Yes, who believes us! We would need more credible."

5. REFLECTION OF RESEARCH RESULTS

The research produced viewpoints to the research questions, about the situation of the music therapy assessment in general and how to study therapy assessment. In addition the questions about the participating therapist´s background theory and assessment areas in their own clinical practice produced interesting information about Finnish music therapy field.

As a revision the research questions for this master´s thesis study were the following:

1. What kind of perspectives and experiences the music therapy clinicians bring up about the application of the IMTAP based on video recorded therapy sessions?

2. Is the IMTAP useful initial assessment tool to assess social emotional functioning of a child diagnosed with ADHD and phobic anxiety disorder?

3. Is it possible to apply the IMTAP assessment tool to an initial assessment situation without changing the normal Finnish psychodynamic music therapy customs?

5.1 Questions about background theory and assessment areas

Questions about the theoretical background of the participants were included to this research for to be on the safe side about the answers of the domain scoring forms. If answers would have been very disconnected with each other's, this questionnaire might have given the explanation for it.

The participants had a possibility to choose 1-2 alternatives that they felt to be most closely to their own thinking. Most of the answers to the theoretical backgrounds were humanistic-existential, second to psychodynamic and some also to neurological approaches. One participant said to use many approaches depending on the client and the situation.

It seems that Finnish music therapists have some common theoretical values in their work but also differences. The same kind of educational background, which traditionally includes lot of psychodynamic thinking, does not mean completely parallel theoretical thinking in clinical practise but certainly some kind of tendency it seems to give. However participants did not tell to support

behaviouristic, cognitive, holistic or biomedical approaches in their work. These approaches seem to be most unfamiliar to their work.

Definitions of the background theories are in appendix 5 (in Finnish).

The question about the typical assessment areas in a clinical work was included to this research for the same reason as the question about the theoretical background. It would have given needed information about the possible reasons for the strong versatile of scoring forms.

Answers to the question of the typical assessment areas in therapist´s clinical work showed, that interaction is the most essential assessment area in the clinical work of Finnish music therapists. Also the expression of music, other kind of expression, behaviour and emotional life were told to be important in assessment. Motoric and cognitive functioning was not on the focus of the participant´s music therapy assessment. This is in line with the therapist educational background.

Question of typical assessment areas is in appendix 6 (in Finnish).

5.2 Perspectives and experiences about the application of the IMTAP

The focus group interview was executed for dividing discussion areas according to the emotional, social and musicality domain of the IMTAP.

Emotional domain was experienced to be most challenging part of the initial assessment. Some participants thought that more sub-categories would be needed but some thought that it was adequate as it is and contains more information than usually in initial assessment. Possibility to get more detailed information about reactions to different feelings was missed. Need for open description was also mentioned.

Social domain produced lots of material and there was no need of supplementing at least for initial assessment use. The social domain was regarded to be easier to assess than the emotional domain because the social behaviour is more visible than the emotions. Observation of social functioning was also perceived as one of the basis of music therapy work and it felt very familiar area for the interview participants. Some participants experienced that the point of view in the assessment tool

was anyway quite narrow to this domain. One point was that the problems of social functioning could not be seen on video or in questions because problems appear usually in different context, at school or with peers, not in the therapy situation.

Fundamentals of musicality domain were considered not to bring all possibilities out even the therapists felt that there was enough categories. Possibility to assess receptive communication more in detail by music was missed, because it was considered as an important part of assessment. Improvisation was experienced as an important method, which would tell a lot about the client, but participants though that in the IMTAP context it would assume to be more suitable part of emotional domain than musicality. Participants thought that musicality in general is not essential in music therapy: music is a medium and it is important what it tells about an interaction and emotions, not about an ability to keep the rhythm or right pitch. However the therapy goals have always an influence what therapist wants to emphasize in a therapy.

The IMTAP in general was found to be useful and it helped to structure the initial assessment and produced information in black and white. Therapist thought that there would be a need of this kind of assessment tool in own clinical work, at least together with some other assessment tool, which would supplement some areas. The IMTAP could supplement observation based assessment style, which is in use typically in Finland.

The IMTAP assessment tool could also help to create therapy report because it is possible to use the language of the assessment tool. A common language between the therapists could be developed, in case IMTAP would be a shared assessment tool among professionals. At the moment every therapist use his/her own terms to describe therapy process and this can create heterogeneous impression about music therapy profession. Ala-Ruona (2007) also comments about possible challenges in the professional communication if there are not coherent concepts, the practises and theoretical frames with homogenous terms (Ala-Ruona, 2007). Focus group interview brought up a hope about the use of common language in music therapy assessment reports.

Loewy`s (2000) music psychotherapy assessment model has developed one possible language to the music therapy profession. Loewy´s starting point to her research was the thought that neither the language of psychotherapy nor music is completely suitable to music psychotherapy; music psychotherapy has it´s own language. Assessment areas in Loewy´s model (Loewy, 1994) are based on research that studied how music therapists, who worked with emotionally disturbed children and

adolescents, collected, analysed and reported music therapy assessment sessions. In the other words: how they interpreted and translated a music therapy experience. Loewy comments: " Music may be medium under which healing can occur, but words are the tools that an assist in how we comprehend and communicate what we are doing." (Loewy, 2000.)

According to focus group interview the IMTAP could be very useful as a learning tool, especially to the music therapy students or new professionals. It could help to observe the different functional areas of the client and it also would help to structure an assessment and might help to set therapy goals. However some participants thought that experienced clinicians would not need necessarily a particular assessment tool for their work because they own descriptive assessment includes same areas anyway, based on their clinical knowledge.

All participants experienced that the IMTAP assessment tool was quite easy to use. None of them answered that it was quite or very difficult to use. Participant felt also that the IMTAP was clear and quick to use.

In addition a positive side of the IMTAP was that music therapists have developed it; the IMTAP is a real music therapy assessment tool and functioning of a client is perceived through musical activities. However if the Finnish music therapists would start to use the IMTAP in their work, it should be in Finnish and it should be localized as well as standardized.

As a practical point of view the participant felt that all categories were not enough clearly defined in scoring forms: they had to go back to definition paper to ensure the meaning of some points.

Participants felt also that the video is essential to do the IMTAP assessment: all problems were not able to see just based on questions in scoring forms.

5.3 Feasibility of the IMTAP to assess social emotional functioning

The client in the video recorded therapy sessions was a 9 years old boy, diagnosed with ADHD (F90.0) and phobic anxiety disorder of the childhood (F.93.1). Therapy goals were set in social emotional area.

Participant's answers to the IMTAP domains scoring about the functioning of the client were mainly quite parallel with each other's answers; in general they were not completely different or opposed results in some domain scorings. The IMTAP rating scale is the following: Never= 0%, Rarely =under 50%, Inconsistent= 50 -79% and Consistent 80-100%.

Answers in all the sub-domains in emotional, social or fundamentals of musicality were in range of 50 -100 %. However 50 % was mentioned only once in Social domain in turn taking. Apart of this one exception, all of the other answers were in range of 71 - 100% for the client´s total functioning. This means that the function of the client is all the time in the areas "Inconsistent 50 -79 %" or "Consistent 80 - 100%".

Big difference in social domain´s turn-taking question might be possible to explain with the fact that it was not always easy to answer directly to all questions because the assessment situation was not planned to fit especially to the IMTAP questions. In this case the assessment situation did not include certain tasks to observe a turn taking. Answers can include changeable interpretations about the situations and how to apply the certain question.

When the answers from tables 6, 7 and 8 are analysed more it is possible to see that the answers in the "Inconsistent 50 -79 %" area are more few and far between than the answers in the "Consistent 80 -100%" area. Ratio of Consistent to Inconsistent are in emotional domain 18/2: in social domain 26/4: and in musicality domain 3/2.

This is quite surprising from the perspective that the domains to this research were chosen related to supposed problem areas of the client who has an ADHD and phobic anxiety disorder of childhood. Problems of the client did not come up clearly by this assessment tool: he seems to manage quite well in his problem areas.

Most often the answers about the managing of the client ranged from 71% to 100% in the sub-domain answers. In some case maximum difference was 29% between the highest and the lowest results in the same area and minimum difference only 9 %. A 29 % difference in the answers is quite notable but as the IMTAP rating scale only has 4 categories with a scale from 0% to 100% (Never= 0%, Rarely =under 50%, Inconsistent= 50 -79%, Consistent 80-100%) it is not so notable. One step of scaling can include broad variations of the percentage values.

Phobic anxiety disorder of childhood (F 93.1) means, that the client has strong fears relating to some issues. This kind of information was not revealed with the IMTAP emotional domain questions. Also other problem area, disturbance of activity and attention (F90.0) did not come up during initial assessment sessions and the IMTAP social domain questions. Based on domain scoring it would seem that the client has not particular problems in these areas.

To be able to be aware of client´s problems the therapist should have preliminary knowledge from the parents and other health care professionals who have worked with the child. Also the point, that this particular client functions very well in daily life because of a supportive guardian and ADHD medicine, is meaningful.

Effect of the ADHD medication was possibly the one explanatory factor that the IMTAP social functioning domain did not reveal the problems in a social functioning. Medication works well with this client and the problems in interaction come up at home at evening time when the level of medication in client's brain system is low. Other place where problems usually could be seen is a peer group. A calm therapy situation in private with the therapist does not produce the same kind of social challenges to the client. However the relationships with other people and how the client manages different feelings in social situations would be important to clarify in psychotherapeutic assessment some how (Enckell, 2005).

Based on the preliminary knowledge, the client´s fears were straddled special at the nighttime and the client was very shamed about them and tried to hide them in the daily functioning and speaking. If the therapist wants to work with his fears the client has to really trust the therapist and the therapy process has to be longer before the client is able to bring them up. An initial assessment situation was at a very early face of the therapy and at that point it was not yet possible to handle this kind of mental challenges.

In this research frame the participants did not know the diagnosis of the client, they just knew that the client is in a music therapy because of mental reasons. The meaning of this "blind test" was to see if the IMTAP would produce the information about the social emotional problem areas without preliminary knowledge of the client. This starting point was very different from a normal initial assessment situation where the therapist has quite a lot of background information about the client. Information gathering beforehand is a normal part of psychotherapy assessment (Enckell, 2005).

An interesting finding was that the participants were able to see part of the client's problems by observing the video but not by the IMTAP assessment tool. This supports a participant's comment that it would be beneficial to use the IMTAP assessment together with the video. Even though the therapist is involved in the real therapy situation by her/himself it is possible that he/she would not be able to observe everything at the moment of action, but afterwards the video would bring out important things. The possibility to enter own comments was also requested and this is a natural reaction when the participants felt that they see important things outside of the assessment tool question.

One aspect of the IMTAP assessment domain in the social emotional areas is that the assessment tool brought up maybe more strong areas than problems of the client. Focus group interview participants also mentioned this point. One solution would be to have more categories in the rating scale, and with a finer scale one could come up with more detailed information about the abilities of the client. The IMTAP rating scale was considered to be too rough.

5.4 Applicability of the IMTAP to the Finnish psychodynamic initial assessment situation

The experiences about the IMTAP tell that the IMTAP brings some benefits to the assessment. Professionals felt that the IMTAP helps e.g. to structure the assessment work and could help to develop common language between the professionals. The professionals thought that the IMTAP was easy to use. They liked particularly the point that the IMTAP produces information about the emotions in black and white.

Some participants thought that more sub-categories are needed but some though that the IMTAP contains more than usually is in an initial assessment. The possibility to get the information about the reactions for different feelings was missed.

Based on the results of the domain scoring it seems that emotional, social and fundamentals of musicality domains were not completely sufficient to the psychodynamic music therapy context. The client functioning was mostly in "Content 80 -100 %" area. The scoring forms did not bring out clearly enough the information about the challenges of the client. On the other hand the possibility to get information about the strengths of the client should not been underestimated.

There can be many reasons for the above-mentioned result. One aspect and possible explanation for this is that the therapy assessment sessions were not planned before hand based on the IMTAP questions. This might have affected the fact that the participants were not able to answer completely to all questions of the IMTAP or they did different interpretations of the situations on the videos. A decision about the nature of the assessment situation was based on typical Finnish assessment customs. The comment of the IMTAP´s developers in the manual supported that it was possible to do this decision. Baxter et al. say in the manual that domains of the IMTAP can be used independently or together, and using of the IMTAP does not presume to use certain music therapy methods or activities (Baxter et al 2007).

Also the IMTAP´s rating scale can be one reason for the result: percentage variation in one level of functioning is possibly too broad and there is no possibility to see fine differences. Also the fact that only one client was assessed is meaningful and the result could be different with bigger sampling. Also the amount of the assessing therapists could change the result.

It is not possible to use the IMTAP as it is directly to Finnish music therapy practice: to answer all the questions completely, the therapy assessment sessions should be planned beforehand based on the IMTAP questions. If all questions need to be answered well, therapy interventions, tasks and methods should at least partly be planned beforehand. This would differ a lot from the typical Finnish music therapy assessment style. If the Finnish therapists are willing to apply the IMTAP they have to change their present working style. This is not necessarily the problem, because based on the focus group interview it seems that the therapists have a need of an assessment tool and they would be ready to develop their initial assessment practices. Therapists thought that the IMTAP together with some descriptive assessment method could be the good combination.

5.5 Perspectives to music therapy assessment in general

Focus group interview produced versatile discussion about an assessment in Finland. Participants explored good and bad sides of current descriptive assessment style in Finland and also they brought up their needs relating to the music therapy assessment.

Finnish music therapy assessment style is mainly based on observations and a subjective interpretation of the therapist. This is quite general style in psychodynamic music therapy also in other countries of Europe and also in the USA. Wigram (2000), Sabbatella (2004) and Berger (2009) have all talked about the issue. (Wigram, 2000; Sabbatella, 2004; Berger, 2009.)

Participants experienced that the current free and descriptive assessment style is very flexible and it brings out personal ways to assess. The strength and special value of music therapy assessment is that it usually produces information about the emotions. Clinicians thought also that if music therapists would have some assessment tool it does not remove the responsibility from the therapist: therapist has to always contemplate the client broadly based on own clinical knowledge and experiences.

Participants thought that qualitative description and some assessment tool or test together might be a good combination. Loewy (2000) emphasizes also an assessment situation that uses both structured and non-structured music experiences. "How a person responds to a structured piece of music or a spontaneous, non-structured improvisation may reveal a great deal about the dynamics of his/her relationship with the self as well as with others. A combination of these two experiences, structured and free flowing, may provide for the optimal experience of assessing the therapeutic needs of a new client within an initial session. Since beginnings are typically stressful, a musical ritual may be useful in providing formality that can assist the client and therapist through the initial contact." (Loewy, 2000).

The participants brought up also an idea, that music therapists should not assess the areas of the functioning, which are already assessed by other professionals. This opinion is not completely in line with the idea of psychotherapy assessment in general (e.g. Enckell, 2005) where the idea is that therapist has to do his/her own therapy assessment that he/she is able to see if his/her therapy approach is able to help the client. The therapist has a responsibility of the therapy; responsibility is not on assessment tool or on assessment of other professions.

Participants thought that music therapy, as a profession would need the assessment tools to get more professional credibility among the other professions and service payers. They also thought that music therapists should be more specialized. Participants thought that it is not believable that therapists try to be everything to all. They cannot have knowledge about all diagnosis groups and therapy needs, even the basic education has a wide standpoint. Based on focus group interview, it

seems that there is a need of professional credibility and a need to develop the assessment to a more scientific level. This has been mentioned earlier in music therapy literature and articles (e.g. Wigram (1999); Chase (2002); Isenberg-Grzeda (1988).

Ala-Ruona´s (2007) viewpoint about the need of localization and combination of descriptive and some structured, measuring assessment method seems to be in uniform with the opinions of Finnish music therapy clinicians at the moment (Ala-Ruona E. , 2007).

5.6 Perspectives to study therapy assessment

The focus group interview produced comments about the research frame and brought up several points of view that are important to take into account when the therapy assessment is studied.

Interaction between the therapist and the client is essential in music therapy and especially in psychodynamic music therapy. The therapist always explores his/her own transference feelings that are come up in the therapy session. The video was useful and necessary to get information about an interaction between the therapist and the client but it was not enough to bring out the transference feelings and all that information which is in those. If the therapist would be in a therapy session by her/himself, he/she could have own intuition feelings and own experience of interaction and also preliminary knowledge about the client. All this would give deeper experience about the situation than was now possible to get by the videos. Even though the videos were essential it was not always enough to show whether the client had an eye contact or not. This information would be important when the quality of interaction is studied.

Research of music therapy assessment is challenging due to many reasons. Human interaction with music as a creative element in a process oriented therapy context includes many variables related both to the therapist and the client and their interaction. It is always a challenge to study the influence of the therapy work and how the changes in the therapy can be seen in daily life. Often the clients are not able to assess their own wellbeing (e.g. children).

When just part of some assessment tool is studied, it is possible that rest of the tool could complete the missing knowledge and would give a more complete picture about the client´s functioning. If

just a part of some tool is taken it could be useful to analyse the rest of the content and reflect them to the parts that are chosen.

6. DISCUSSION

In this master´s thesis research the Individualized Music Therapy Assessment Profile was applied as an initial assessment tool for the therapy meetings of a 9 years old boy who has an ADHD and phobic anxiety disorder of childhood. The focus of the research was on emotional, social and fundamentals of musicality domains. The aim was to collect the perspectives and experiences of music therapy clinicians about the application of the IMTAP in above-mentioned areas based on video recorded therapy sessions. The goal was to examine if the IMTAP is an applicable assessment tool to social emotional challenges and also to get knowledge if it is possible to apply the IMTAP to the music therapy assessment situation without changing the normal Finnish psychodynamic music therapy customs.

This study was a phenomenological-hermeneutic multi-method qualitative research. It studied experiences, meanings, understanding and interpretations about a certain phenomenon, in this case the IMTAP assessment tool. The study was conducted through the questionnaires, video observations and a focus group interview. As a result of the study above-mentioned research strategy offered both qualitative information and also some quantitative data: information from the questioners, analysed data from focus group interview and also numerical data from the IMTAP scoring form results.

Mapping the assessment literature showed that the music therapy assessment is still quite undeveloped area of the profession and there are no homogenous practices or extensive use of any available assessment models/tools internationally or in Finland (e.g. Ala-Ruona, 2007; Berger, 2009; Chase, 2002; Layman, Hussey, & Laing, 2002; Sabbatella, 2004; Wigram, 2000). Most of the available models/tools are related to some particular diagnostic group or some specific music therapy practice. None of them are so comprehensive of their nature as the IMTAP.

The need to develop music therapy assessment to a more scientific level has been noticed in music therapy literature, and also the scientific discussion is growing in the area. However so far the assessment is not yet in very notable part in the music therapy publications.

Even though the IMTAP was published in 2007, there are no published studies relating to the use of it and applicability to the different contexts. As a result of current situation this master´s thesis

discussion part focus mainly on producing novel information about the IMTAP because it is not possible to interconnect the results with other IMTAP studies.

6.1 Perspectives and experiences about the application of the IMTAP

The research brought out both benefits and developmental suggestions to the IMTAP assessment tool and to the music therapy assessment. The IMTAP in general was considered to be useful and easy to use and it helped to structure the initial assessment. Therapists thought that there would be a need of this kind of assessment tool in their own clinical work, at least together with some other assessment tool. The IMTAP could supplement observation based assessment style, which is in use typically in Finland. However if the Finnish music therapists would start to use the IMTAP in their work, it should be in Finnish and it should be localized too.

Focus group interview brought up a hope about the use of a common language in music therapy assessment reports. The IMTAP assessment tool could help to create therapy reports because it is possible to use the language of the assessment tool. With this tool a common language between the therapists could be developed. This kind of advancement would require a wide use of the IMTAP among the music therapy professionals.

According to the focus group interview the IMTAP could be very useful as a learning tool to music therapy students or new professionals. It could help to observe the different functional areas of the client and it also would help to structure an assessment and might help to set therapy goals. These points of views hopefully will encourage the music therapy educations to use the IMTAP in educational functions.

The fundamentals of musicality domain was experienced that it does not bring all possibilities out. The possibility to assess receptive communication more in detail by music was missed. Improvisation was experienced as an important method, which would tell a lot about the client.

As a practical point of view the participant felt that all categories were not clearly enough defined in the scoring forms: they had to go back to defining paper to ensure the meaning of some point. This problem may diminish later when the therapist will be familiar with the assessment tool.

It is not possible to use the IMTAP as is directly in the Finnish music therapy practice: to get all the questions answered completely the therapy assessment sessions (interventions, tasks and methods) should be planned beforehand based on the IMTAP questions. This would differ a lot from the typical Finnish music therapy assessment style. This is not necessarily the problem, because based on the focus group interview it seems that the therapists have a need of the assessment tool and they would be ready to develop their initial assessment practices to more structured direction.

6.2 Feasibility of the IMTAP to assess social emotional functioning

The assessment of emotional functioning is a challenge in all kind of therapy work. Also in this research the emotional domain was experienced to be a challenging part of an initial assessment because the emotional things are not so visible than external functioning. Observation of social functioning was easier and it was perceived as a basis of music therapy. Some participants thought that point of view in the assessment tool´s emotional domain was quite narrow and more sub-categories would be needed. The possibility to get more detailed information about reactions to different feelings was missed.

Sometimes problems of the client were revealed partly based on observations from the video but not through the answers of the scoring forms questions. This supports the participants' comments that the IMTAP assessment would be always good to carry out based on the videos. In the IMTAP manual a video recording is a recommendation, not an essential precondition.

The IMTAP seems to be quite reliable assessment tool even there are also needs of development and also challenges consequent upon the nature of a therapy work, client´s personal attributes and the research frame. Results to the IMTAP domains scoring were quite parallel with each other's. Surprisingly the client got good results from the problem areas and that seems to mean that problems of the client did not come up by this assessment tool.

There are many reasons for the client´s good results. More detailed scoring rating might be needed to be able for the tool to bring out more information. At the moment a percentage variation in one level of functioning is quite broad and there is not a possibility to see fine differences. The effect of the ADHD medication during the daytime was one possible explanatory factor that the problems in

a social emotional functioning were not clearly visible by the IMTAP domains. Also the fact that the client was very shamed about his fears and tried to hide them in the daily functioning and speaking induced to observations about the initial assessment situation. Therapy process has to be further before the client is able to bring fears up. Initial assessment situations were a very early face of the therapy and the client was not yet ready to handle this kind of mental challenges.

A fact that also has an effect to this result is that it was not always easy to answer directly to all questions because the assessment situations in this research were not planned beforehand to fit especially to the IMTAP questions. The decision not to plan the assessment based on the IMTAP was made because the IMTAP manual says that using of the IMTAP does not presume to use certain music therapy methods or activities. Because of the above-mentioned situation answers can include changeable interpretations how to apply the certain question.

6.3 Perspectives to music therapy assessment in general

Participants experienced that current free and descriptive assessment style is very flexible and it brings out a personal way to assess. A strength and special value of music therapy assessment is that it usually produces information about the emotions. Clinicians thought also that if music therapists would have some assessment tool it does not remove the responsibility from the therapist: therapist has to always contemplate the client broadly based on own clinical knowledge and experiences.

Participants thought that qualitative description and some assessment tool or test together might be a good combination to develop the assessment practices. Loewy (2000) and Ala-Ruona (2007) emphasizes also an assessment situation that uses both structured and non-structured music experiences.

Participants thought that music therapy, as profession would need the assessment tools to get more professional credibility among other professions and service payers. They also thought that music therapists should specialize more because it is not credible that therapists try to be everything to all.

6.4 Strengths and limitations of this study

This master thesis offers a broad view of information about the IMTAP assessment tool, a music therapy assessment in general and a music therapy assessment in Finland. In addition the research produced aspects how to study therapy assessment. The collected information is based on strong working experience of music therapy professionals and it gives the reader a possibility to notice new side of the IMTAP assessment tool and other related aspects.

Focus group interview as a methodological choice for the group interview proved to be successful solution to get different points of views about the issue. Participants were able to bring out various opinions, viewpoints (cf. Barbour, 2007) and a unique perspective to this study. Professionals produced also material by the discussion and they created new aspects to this study: opinions about an assessment in general and about the research frame.

Video material from the initial assessment sessions was essential for this therapy research: it offered a possibility to observe interaction between the therapist and the client and also a non-verbal communication such as face expression and gestures. All these are important in therapy work and also in hermeneutic research. However the video was not enough to bring out the transference feelings of the participants. Also an eye contact would be important to see more clearly. This information would be essential when one wants to study interaction in a therapy and quality of it.

Master´s thesis multi-method nature proved to be fruitful but quite challenging to manage and quite laborious. Research produced lot of information and some parts of research could have been as a topic of one master thesis e.g. translations process of the IMTAP scoring forms. Also the fact that there were not any other studies about the IMTAP or from other available assessment model made the investigating quite challenging. There was no model to follow.

Anyhow the process was very educational and gave a broad picture about the qualitative research. For the results of this research the fact that there was only one client assessed is meaningful and the results from the scoring forms could be different with bigger client sampling. Also the amount of the assessing therapists might change the result. On the other hand five experienced therapists give already some preliminary knowledge about the direction. Also the fact that the therapists saw more than just one therapy meeting gave them a possibility to get a look of the whole initial assessment period and more deep understanding.

This research studied just part of the IMTAP assessment tool and it is possible that rest of the tool could complete the missing knowledge and would give a more complete picture about the client´s functioning. If just a part of some tool is used it would be maybe useful to analyse the rest of the content and reflect them to the parts that are chosen.

Also the fact that the IMTAP is not a localized assessment tool sets the inevitable consequences to the research data from the IMTAP scoring forms.

6.5 Future research

Master thesis research produced several ideas for the future research. However before the IMTAP assessment tool could be studied completely in Finland it should be localized to Finnish music therapy context.

This research brought out that it is not possible to apply IMTAP to a completely free, not beforehand planned, initial assessment situation. It might be productive to study the IMTAP in the therapy meetings that have been planned based on the IMTAP questions.

To test the reliability and validity of the IMTAP larger number of clients should be studied, with various diagnoses and with multiple therapists.

Based on this master´s thesis research the development of the IMTAP rating scale to be more detailed would be another interesting and necessary study.

This research produced also some quantitative data. This kind of data with the larger number of answers would be interesting to analyse further by quantitative analysing computer software.

Social-emotional functioning is challenging assessment area but essential in psychodynamic music therapy context. For this purpose it would be interesting to compare the results of the IMTAP and some descriptive assessment tool with the same client.

FINNISH SUMMARY

Arviointi on osa musiikkiterapian kliinistä käytäntöä ja oleellinen osa terapiaprosessia. Arviointi voidaan jakaa kahteen pää luokkaan: alkuarviointiin ja terapiaprosessin arviointiin. Alkuarviointi sijoittuu terapiaprosessin alkuun ja käsittää tavallisesti 3-5 tapaamista. Alkuarviointiin perustuen terapeutti tekee huomioita asiakkaan tarpeista ja suunnittelee terapian interventioita. Musiikkiterapia arvioinnissa kiinnitetään huomiota asiakkaan vahvuuksiin ja haasteisiin sekä musiikillisilla että ei-musiikillisilla alueilla.

Musiikkiterapiassa arvioinnin tieteellinen tarkastelu on ollut vähäisempää verrattuna muihin lähialoihin. Musiikkiterapia arviointia ei käsitellä kovin laajasti tieteellisissä musiikkiterapia artikkeleissa tai kirjallisuudessa ja myös kliinisen työn tasolla käytännöt ovat vaihtelevia. Huolimatta epäyhtenäisistä käytännöistä arvioinnin merkitys on tunnustettu tärkeänä ja luonnollisena osana musiikkiterapiaprosessia.

Tämä pro gradu-tutkimus tarkastelee IMTAP (The Individualized Music Therapy Assessment Profile) arviointityökalun soveltuvuutta lapsen sosio-emotionaalisten taitojen alkuarviointiin. IMTAP on musiikkiterapia ammattilaisten kehittämä työkalu ja se on suunniteltu käytettäväksi lasten ja nuorten musiikkiterapiaan. IMTAP sisältää 10 pääluokkaa ja useita alaluokkia. Tässä tutkimuksessa tarkastellaan tunnetaitoja, sosiaalisia taitoja ja perusteita musiikillisista taidoista. IMTAP arviointityökalua sovelletaan lapsen yksilömusiikkiterapiaan ja tutkimusasiakkaan diagnoosina ovat ADHD sekä lapsuuden pelko ja ahdistushäiriö.

Tutkimuksessa tarkastellaan musiikkiterapeuttien kokemuksia ja heidän esille tuomiaan näkökulmia IMTAP arviointityökalun käytöstä tutkimusvideoiden observointiin perustuen sekä musiikkiterapia arviointiin laajemminkin. Tutkimus on kvalitatiivinen monimenetelmäinen tutkimus, jonka taustaajatteluna on fenomenologis-hermeneuttiseen tieteen filosofia. Tutkimusaineisto koostuu kyselyistä, terapiavideoiden observointiin perustuviin IMTAP pistetaulukoiden tuloksista sekä fokusryhmähaastattelun esille tuomista näkökulmista. Fokusryhmähaastattelu on metodi, jossa ryhmän tavoitteena on keskinäinen vuorovaikutus ja keskustelu, jossa tuodaan mahdollisimman monipuolisesti aiheeseen liittyviä näkemyksiä esille.

Tutkimuksen tuloksiin perustuen IMTAP näyttäytyy hyödyllisenä ja helppokäyttöisenä arviointimallina, joka auttaa musiikkiterapeutteja jäsentämään heidän työtään. Kliinikot toivat keskustelussa esille mm. sekä IMTAP:n hyötyjä että kehittämistarpeita, tämän hetken ammatillisia tarpeita arvioinnin suhteen sekä ajatuksia sosio-emotionaalisten taitojen arviointiin parhaiten soveltuvasta arviointitavasta. IMTAP pistetaulukoiden tulokset sekä fokusryhmäkeskustelu nostivat esille myös kysymyksen arviointiin soveltuvasta pisteytys-skaalasta. Lisäksi kliinikot toivat esille mielenkiintoisia näkökulmia, joita voi hyödyntää arviointityökalujen tutkimusasetelmia suunniteltaessa.

REFERENCES

Ahonen, H. (1993). *Musiikki sanaton kieli.* Loimaa: Loimaan kirjapaino.

Ala-Ruona, E. (2007). *Alkuarviointi kliinisenä käytäntönä psyykkisesti oireilevien asiakkaiden musiikkiterapiassa.* Jyväskylä: Jyväskylä University Printing House.

Ala-Ruona, E., Saukko, P. & Tarkki, A. (2009). *Musiikkiterapiapalvelut-esite*. Jyväskylä: Finnish Society for Music Therapy.

Barbour, R. (2007). *Doing focus groups*. London: SAGE Publications Ltd.

Baxter, H., Berghofer, J., MacEwan, L., Nelson, J., Peters, K. & Roberts, P. (2007). *The Individualized Music Therapy Assessment Profile.* Philadelphia, PA: Jessica Kingsley Publishers.

Berger, D. (2009). On developing music therapy goals and objectives . *Voices: A World Forum for Music Therapy, 9* (1). Retrieved from https://normt.uib.no/index.php/voices/article/viewArticle/362/285

Bruscia, K. (1998). *Defining music therapy* (2nd ed.). Gilsum: Barcelona Publishers.

Bruscia, K. (2005). Designing qualitative research. In B. Wheeler, *Music therapy research* (pp. 129-137). Gilsum: Barcelona Publishers.

Bruscia, K. (1987). *Improvisation models of the music therapy.* Springfield, IL: Charles C. Thomas.

Bruscia, K. (1988). Standards for clinical assessment in the art therapies. *The Arts in Psychotherapy*, *15*, 5-10.

Chase, K. (2004). Music therapy assessment for children with developmental disabilities: A survey study. *Journal of Music Therapy, 51*, 28-54.

Chase, K. (2002). *The music therapy assessment handbook.* Columbus, MS: SouthernPen Publishing.

Denzin, K. & Lincoln, Y. (2005). *The Sage handbook of qualitative research.* Thousand Oaks, CA: Sage Publications, Inc.

Domino, G. (2000). *Psychological testing: An introduction.* Upper Sadle River, NJ: Prentice Hall.

Dupuis, A. (2002). *HyperResearch, a software tool for qualitative data analysis.* Retrieved from www.sagepub.com/mssw3/resources/Updated_HyperResearch.pdf

Enckell, H. (2005). Psykoterapiatarpeen arviointi ja terapeuttinen sopimus. In Brummer & Enckell, *Lasten ja nuorten psykoterapia* (pp. 71-87). Juva: WSOY.

Eskola, J. & Suoranta, J. (1998). *Johdatus laadulliseen tutkimukseen.* Tampere: Vastapaino.

Finnish Investigators Network for Pediatric Medicines [FINPEDMED]. (2009) Retrieved from www.finpedmed.fi

Finnish Society for Music Therapy. (2009). Retrieved from www.musiikkiterapia.net

Goodman, K. (1989). Music therapy assessment of emotionally disturbed children. *The Arts in Psychotherapy, 16*, 179-192.

Hanser, S. (1999). *The new music therapist´s handbook.* Boston: Berklee Press.

Isenberg-Grzeda, C. (1988). Music therapy assessment: A reflection of professional identity. *Journal of Music Therapy , 25*, 156-169.

Jackson, N. (2003). A survey of music therapy methods and their role in the treatment of early elementary school children with ADHD. *Journal of Music Therapy , 40*, 302-323.

Kiviniemi, K. (2007). Laadullinen tutkimus prosessina. In Aaltola & Valli, *Ikkunoita tutkimusmetodeihin II* (pp. 70-85). Jyväskylä: PS-kustannus.

Laine, T. (2007). Miten kokemusta voidaan tutkia? Fenomenologinen näkökulma. In Aaltola & Valli, *Ikkunoita tutkimusmetodeihin II* (pp. 28-45). Jyväskylä: PS-kustannus.

Layman, D., Hussey, D. & Laing, S. (2002). Music therapy assessment for severally emotionally disturbed children; a pilot study. *Journal of Music Therapy , 39*, 164-187.

Loewy, J. (2000). Music psychotherapy assessment. *Music Therapy Perspectives , 18*(1), 47-58.

Sabbatella, P. (2004). Assessment and clinical evaluation in music therapy: An overview from literature and clinical practice. *Music Therapy Today , 5*(1). Retrieved from www.wfmt.info/Musictherapyworld/modules/mmmagazine/showarticle.php?articletoshow=88

Saukko, P. (2008). *Musiikkiterapian tavoitteet lapsen kuntoutusprosessissa.* Jyväskylä: Jyväskylä University Printing House.

Scalenghe, R. & Murphy, K. (2000). Music therapy assessment in the managed care environment. *Music Therapy Perspectives: A Special Issue: Assessment in Music Therapy ,18* (1), 23-30.

Schmidt Peters, J. (2000). *Music Therapy, an introduction* (2nd ed.). Springfiled, IL: Charles C Thomas Publisher, LTD.

Scovel, M & Gardstrom, S. (2005). Music Therapy within the Context of Psychotherapeutic Models. In R. F. Unkefer & M. H. Thaut (Eds.), *Music therapy in the treatment of adults with mental disorder: theoretical bases and clinical interventions* (pp. 117-132). Gilsum: Barcelona Publishers.

The American Music Therapy Association. (2009). *AMTA standards for clinical practice*. Retrieved from www.musictherapy.org/standards.html

The Constitution of Finland. (1999). L 11.6.1999/731. Retrieved from www.finlex.fi/fi/laki/kaannokset/1999/en 19990731

Tuomi, J. & Sarajärvi, A. (2009). *Laadullinen tutkimus ja sisällön analyysi.* Helsinki: Tammi.

United Nations´ Convention on the Rights of the Child. (1990). Article 12. Retrieved from www2.ohchr.org/english/law/crc.htm

Walsh, W. & Betz, N. (1990). *Tests and assessment* (2nd ed.). Englewood Cliffs, NJ: Prentice Hall.

Wells, N. (1988). An individual music therapy assessment procedure for emotionally disturbed young adolescents. *Arts in Psychotherapy , 15*, 47-54.

Wheeler, B. (2005). *Music therapy research* (2nd ed.). Gilsum: Barcelona Publishers.

Word Health Organisation[WHO]. (2010). *Classifications ICD-10*. Retrieved from www.who.int/classifications/icd/en

Wigram, T. (2000). A method of music therapy assessment for the diagnosis of autism and communication disorders in children. *Music Therapy Perspectives: A Special Issue; Assessment in Music Therapy*, *18*(1), 13-22.

Wigram, T. (1999). Assessment methods in music therapy: a humanistic or natural science framework? *Nordic Journal of music therapy , 8*(1), 6-24.

Wigram, T., Nygaard Pedersen, I. & Bonde, L. (2002). *A comprehensive guide to music therapy - theory, clinical practice and training.* London: Jessica Kingsley Publishers.

Wigram, T., Sperston, B. & West, R. (1999). *The art and science of music therapy: A handbook.* Amsterdam: Harwood academic publishers.

APPENDICES

Appendix 1 Permission for the research (child)

LAPSEN SUOSTUMUSASIAKIRJA MUSIIKKITERAPIATUTKIMUKSEEN

Tutkimuksen nimi:_____

Tutkijamusiikkiterapeutin nimi:_____

Musiikkiterapeuttini on pyytänyt minua mukaan tähän tutkimukseen. Sopisin tutkimukseen, koska_____

Tutkimuksessa selvitetään onko amerikkalainen musiikkiterapian tavoitteiden suunnitteluun tarkoitettu ohje hyvä myös tänne Suomeen.

Tutkimusta varten videoidaan 3 ensimmäistä musiikkiterapiakäyntiäni loka-marraskuussa 2011. Nämä videot näytetään toisille musiikkiterapeuteille yhden kerran. Tarkoituksena on kokeilla huomaavatko musiikkiterapeutit ohjeiden avulla musiikkiterapiavideoista sellaisia asioita, joita he tarvitsevat työssään, kun he suunnittelevat minkälaista musiikkiterapiaa kannattaisi lasten kanssa tehdä.

Musiikkiterapeuttini on kertonut minulle tästä tutkimuksesta. Olen saanut kysyä mieleeni tulevia kysymyksiä.

Olen saanut kertoa, haluanko osallistua tähän tutkimukseen. Tiedän, ettei minun tarvitse osallistua, jos en halua.

Jos haluan myöhemmin lopettaa tutkimukseen osallistumisen, ei kukaan ole siitä minulle vihainen. Silloin minun pitää kertoa _____tai _____, että en tahdo enää olla mukana. Musiikkiterapiani hoidetaan silti parhaalla mahdollisella tavalla.

Minun tutkimusasioitani pääsevät näkemään vain minä, _____, musiikkiterapeuttini ja tähän tutkimukseen osallistuvat aikuiset.

Jos haluan osallistua tähän tutkimukseen, kirjoitan nimeni tähän suostumukseen.

Nimeni: _____

Päivämäärä ja paikka: _____

Musiikkiterapeutin nimi: _____

ja allekirjoitus: _____

Tämä asiakirja on laadittu kansallisen lastenlääkkeiden tutkimusverkoston (FINPEDMED) suostumusasiakirjamallin pohjalta (Alaikäisen 6-10 vuotiaan lapsen suostumusasiakirja lääketutkimukseen)

Appendix 2 Permission for the research (Parents)

HUOLTAJAN SUOSTUMUSASIAKIRJA MUSIIKKITERAPIATUTKIMUKSEEN

Olen saanut tätä tutkimusta koskevan tiedotteen ja suullista tietoa tästä tutkimuksesta ja ymmärtänyt tutkimusta koskevan tiedon. Minulla on ollut riittävästi aikaa harkita lapseni osallistumista tutkimukseen. Tiedot antoi_____
Olen saanut myös esittää hänelle kysymyksiä tutkimuksesta. Myös lapselleni on kerrottu tästä tutkimuksesta ja hänen myönteinen mielipiteensä on selvitetty siten, kuin se hänen kehitystasonsa huomioiden on mahdollista.

Minulle on kerrottu, että tutkimuksen kannalta oleellisia tietoja lapseni kuntoutusasiakirjoista (terveydenhuollon ammattilaisten lausunnot) käytetään osana tätä tutkimusta.

Kaikkia tämän tutkimuksen osapuolia sitoo salassapitovelvollisuus. Tutkimustiedot käsitellään luottamuksellisina, sekä niin etteivät lapsen henkilökohtaiset tiedot (nimi, henkilötunnus) ole muiden kuin allekirjoittaneen tutkijan käytössä.

Ymmärrän, että lapseni osallistuminen tähän tutkimukseen on vapaaehtoista ja voin perua tämän suostumuksen, ja keskeyttää hänen osallistumisensa tutkimukseen milloin tahansa ennen tutkimuksen päättymistä. Olen tietoinen myös siitä, että keskeyttämiseen mennessä kerättyjä tietoja käytetään osana tutkimusaineistoa. Tutkimuksen keskeyttäminen ei kuitenkaan vaikuta millään tavoin hänen mahdollisesti tarvitsemaansa hoitoon. Olen nähnyt ja lukenut myös lapseni allekirjoittaman suostumusasiakirjan ja kuullut hänen myönteisen mielipiteensä osallistumisesta.

_____ Olen keskustellut tutkimukseen osallistumisesta lapseni toisen huoltajan kanssa ja hänen myönteinen mielipiteensä on huomioitu.

Annan suostumukseni siihen, että lapseni osallistuu tähän tutkimukseen;

Lapsen nimi ja syntymäaika

Lapsen osoite

Huoltajan allekirjoitus

Nimen selvennys *Päiväys*

Olen kertonut tästä tutkimuksesta tutkimustiedotteen mukaisesti sekä lapselle että hänen huoltajalleen ja otan vastaan tämän suostumuksen;

Tutkijamusiikkiterapeutin allekirjoitus *Paikka ja päiväys*

Nimen selvennys

Tätä suostumusasiakirjaa on tehty kaksi kappaletta, joista toinen annetaan huoltajalle ja toinen arkistoidaan tutkijamusiikkiterapeutin tutkimuskansioon.

Tämä asiakirja on laadittu kansallisen lastenlääkkeiden tutkimusverkoston (FINPEDMED) suostumusasiakirjamallin pohjalta (Alaikäisen (alle 15-v.)lapsen huoltajan suostumusasiakirja lääketutkimukseen

Appendix 3 Research announcement for the parents

TUTKIMUSTIEDOTE HUOLTAJALLE

Tutkimuksen tekijä

Nimi:
Osoite
Puhelin: sähköposti:

Tutkimuksen taustaorganisaatio ja yhteyshenkilö

Musiikkiterapian maisterikoulutusohjelma
(Music psychology training, music therapy master´s degree programme)
Musiikkiterapian opetus – ja tutkimusklinikka
Humanistinen tiedekunta, musiikin laitos
Jyväskylän yliopisto

Nimi:
puhelin:
sähköposti:

Tutkimussuunnitelman riippumaton arviointi ja hyväksyntä

Varsinais-Suomen sairaanhoitopiirin eettisin lautakunnan vastuulääkäri xxxxxx
Kansaneläkelaitoksen Lounais-Suomen vakuutuspiirin ylilääkäri xxxxxxx

Tutkimuksen nimi

The Individualized Music Therapy Assessment Profile as an initial assessment tool of social-emotional functioning

(IMTAP sosio-emotionaalisen toiminnan arviointityökaluna)

Tutkimuksen tarkoitus ja toteutus

Tutkimus on musiikkiterapian maisteriopintojen päättötyö (gradututkimus). Tutkimuksen tarkoitus on kokeilla amerikkalaisen IMTAP- arviointityökalun soveltuvuutta lapsen sosio-emotionaalisten taitojen alkuarviointiin musiikkiterapiassa. Kokonaisuudessaan IMTAP sisältää kymmenen eri arvioitavaa toiminnan osa-aluetta. Tämän tutkimuksen kohteeksi on näistä kymmenestä valittu kolme; sosiaalinen, emotionaalinen ja musiikillinen toiminta musiikkiterapian alku-arvioinnissa.

Tutkimus toteutetaan musiikkiterapian yksityisvastaanotolla _____ ja tutkimuksen koostuu yhden asiakkaan kolmesta ensimmäisestä musiikkiterapiakäynnistä, jotka videoidaan. Tutkimukseen osallistuvat musiikkiterapian ammattilaiset tekevät videoihin perustuen havaintoja asiakkaan emotionaalisesta, sosiaalisesta sekä musiikillisesta toiminnasta käyttämällä IMTAP- arviointityökalua. Tutkimuksessa verrataan terapeuttien tekemien havaintojen yhdenmukaisuutta sekä keskustellaan heidän näkemyksistään arviointityökalun käyttökelpoisuudesta.

Tutkimukseen osallistuminen

1. Asiakkaan osallistuminen tutkimukseen on vapaaehtoista. Asiakkaalta ja hänen huoltajaltaan pyydetään kirjallinen suostumus ja heille kerrotaan sekä suullisesti että kirjallisesti tutkimuksesta.
2. Asiakkaalla/hänen huoltajallaan on oikeus keskeyttää tutkimukseen osallistuminen halutessaan.
3. Tutkimus ei aiheuta muutosta asiakkaan normaalin hoitoprosessin toteutukseen tutkimuksen aikana tai sen jälkeen.
4. Asiakkaan osallistuminen tutkimukseen ei aiheuta hänelle fyysisiä tai psyykkisiä terveysriskejä
5. Asiakkaan henkilöllisyys ja muut tunnistetiedot (nimi, osoite, henkilötunnus, syntymäaika, kotipaikkakunta ja perheen koostumus) pidetään salassa, poikkeuksen tästä muodostavat ääni ja kuva, joiden mukana olo observoitavassa videomateriaalissa on välttämätöntä havaintojen tekemiseksi asiakkaan toiminnasta.
6. Tutkimuksen toteutukseen liittyvät henkilöt ovat asianmukaisen koulutuksen saaneita musiikkiterapian ammattilaisia, joita sitoo vaitiolovelvollisuus.
7. Osia kuvatuista videoista saatetaan näyttää tutkimustyöhön liittyvässä seminaarissa Jyväskylän yliopistolla. Tilaisuuteen osallistuvia musiikkiterapian maisteriopiskelijoita sitoo myös vaitiolovelvollisuus.

Tutkimuksen kulku

- Tutkimus toteutetaan asiakkaan normaalien terapiakäyntien puitteissa loka-marraskuussa 2011. Asiakkaan kolme ensimmäistä musiikkiterapiatapaamista videoidaan.
- Tutkimus ei aiheuta normaaliin hoitoprosessiin kuulumattomia lisätapaamisia asiakkaan tai hänen huoltajansa kanssa

Tutkimuksen tietosuoja

- Tutkimusta koskevat tiedot ja asiakirjat ovat luottamuksellisia ja asiakkaalla ja hänen huoltajallaan on tietojen tarkistusoikeus
- Tutkimuksessa kerätty tieto säilytetään asianmukaisella tavalla
- Kerätty videoitu tutkimusaineisto hävitetään asiakkaan normaalin hoitoprosessin päätyttyä
- Tutkimusta varten kerättyä tietoa ei käytetä muuhun tarkoitukseen kuin mitä tässä selvityksessä sekä asiakkaalta pyydetyssä kirjallisessa luvassa on määritelty
- Tutkimuksen kirjallinen raportointi toteutetaan siten ettei kirjallisesta kuvauksesta ole mahdollisuus tunnistaa tutkimukseen osallistuvia.
- Asiakkaalle/hänen huoltajalleen ei informoida tutkimukseen osallistuvien musiikkiterapeuttien havaintoja. Tämä siksi, että käytetyn arviointityökalun luotettavuutta ei ole vielä tarpeeksi tutkittu ja testattu ja näin ollen sen tuottamaa informaatiota asiakkaasta ei voida pitää yksiselitteisen luotettavana.

Tutkittavan vakuutusturva

- Terapeutilla on voimassaoleva toiminnan vastuuvakuutus
- Tutkimus ei aiheuta lisävakuuttamisen tarvetta

Paikka ja aika Terapeutin nimi

Appendix 4 Account of ethical aspects of the research

SELVITYS TUTKIMUKSEN EETTISISTÄ NÄKÖKULMISTA

Tutkimuksen tekijä

Nimi:
Osoite:
Puhelin: sähköposti:

Tutkimuksen taustaorganisaatio ja yhteyshenkilö

Musiikkiterapian maisterikoulutusohjelma (Music psychology master degree program)
Humanistinen tiedekunta, musiikin laitos
Jyväskylän yliopisto

Nimi:
puhelin:
sähköposti:

Tutkimuksen nimi

The Individualized Music Therapy Assessment Profile as an initial assessment tool of social-emotional functioning

Tutkimuksen tarkoitus ja toteutus

Tutkimus on musiikkiterapian maisteriopintojen päättötyö (gradututkimus). Tutkimuksen tarkoitus on kokeilla IMTAP- arviointityökalun soveltuvuutta lapsen sosio-emotonaalisen toiminnan alkuarviointiin musiikkiterapiassa. Tutkimus toteutetaan musiikkiterapian yksityisvastaanotolla _____ ja tutkimuksen koostuu yhden asiakkaan kolmesta ensimmäisestä musiikkiterapiakäynnistä, jotka videoidaan. Tutkimukseen osallistuvat musiikkiterapian ammattilaiset tekevät videoihin perustuen havaintoja asiakkaan emotionaalisesta, sosiaalisesta sekä musiikillisesta toiminnasta käyttämällä IMTAP- arviointityökalua. Tutkimuksessa verrataan terapeuttien tekemien havaintojen yhdenmukaisuutta sekä keskustellaan heidän näkemyksistään arviointityökalun käyttökelpoisuudesta.

Tutkimuksen vaikutukset asiakkaaseen

1. Tutkimus ei aiheuta muutosta asiakkaan normaalin hoitoprosessin toteutukseen
2. Asiakkaan osallistuminen tutkimukseen ei aiheuta hänelle fyysisiä tai psyykkisiä terveysriskejä
3. Asiakkaan osallistuminen tutkimukseen on vapaaehtoista
4. Asiakasta sekä hänen huoltajaansa informoidaan tutkimuksen tarkoituksesta ja tutkimukseen osallistumisesta pyydetään häneltä/asiakkaan huoltajalta kirjallinen lupa
5. Asiakkaan henkilöllisyys ja muut tunnistetiedot (nimi, osoite, henkilötunnus, syntymäaika, kotipaikkakunta ja perheen koostumus) pidetään salassa, poikkeuksen tästä muodostavat ääni ja

kuva, joiden mukana olo observoitavassa videomateriaalissa on välttämätöntä havaintojen tekemiseksi asiakkaan toiminnasta.

6. Tutkimusta varten kerättyä tietoa ei käytetä muuhun tarkoitukseen kuin mitä tässä selvityksessä sekä asiakkaalta pyydetyssä kirjallisessa luvassa on määritelty
7. Tutkimuksessa kerätty tieto säilytetään asianmukaisella tavalla
8. Tutkimuksen toteutukseen liittyvät henkilöt ovat asianmukaisen koulutuksen saaneita musiikkiterapian ammattilaisia

Paikka ja aika

Terapeutin nimi

Appendix 5 Questionnaire about background theory

MINKÄLAINEN TAUSTATEORIA ON LÄHIMPÄNÄ AJATTELUASI? VALITSE 1 TAI 2 ITSELLESI PARHAITEN SOVELTUVAA, KLIINISESSÄ TYÖSSÄSI ESILLE TULEVAA TEOREETTISTA VIITEKEHYSTÄ

1.BEHAVIORISTINEN
Muutos: toivotun käyttäytymisen vahvistaminen, ongelmallisen käyttäytymisen vähentäminen
Terapeutin rooli: direktiivinen
Tekniikka: käyttäytymisen analyysi, mallittaminen, halutun käyttäytymisen vahvistaminen
Sairauden määritelmä: patologisuus määräytyy seurausten perusteella

2. KOGNITIIVINEN
Muutos: ongelmat vähenevät muuttamalla ajattelua
Terapeutin rooli: ohjaava
Tekniikka: rationaalisuuteen haastaminen, kotitehtävät, joilla testataan olettamuksia, behavioristiset tekniikat
Sairauden määritelmä: ongelmat johtuvat irrationaalisesta ajattelusta itsestä ja muista

3. HUMANISTIS-EKSISTENTIAALINEN
Muutos: oman vastuun vahvistaminen, tässä ja nyt - läsnäolon vahvistaminen
Terapeutin rooli: Hyväksyvä, vuorovaikutussuhteeseen valmis
Tekniikka: läsnäolon ja itseilmaisun kehittäminen, merkityksellisyyden vahvistaminen
Sairauden määritelmä: ongelmat johtuvat vääristymistä kehityksessä ja kasvamisessa, merkityksen löytämisessä ja vastuullisuudesta itselle.

4. PSYKODYNAAMINEN
Muutos: Konfliktin oivaltaminen ja ratkaiseminen johtaa persoonallisuuden muutokseen, terapeuttinen suhde tärkeä
Terapeutin rooli: empatia, eläytyminen, vastatransferenssit tiedon lähteenä
Tekniikka: symbolisen aineiston analysointi, vapaa assosiaatio
Sairauden määritelmä: ongelmat johtuvat sisäisistä tiedostamattomista konflikteista

5. HOLISTINEN
Muutos: Asiakas näkee itsensä kasvavana ja muuttuvana ja uskoo voivansa itse vaikuttaa omaan hyvinvointiinsa. Kivun ja stressin hallinta, kasvava mielenrauha.
Terapeutin rooli: Kannustaa asiakasta olemaan aktiivinen paranemisprosessissa
Tekniikka: itsetietoisuuden kehittäminen, terveellinen ravitsemus, sopiva lepo, stressin hallinta ja liikunta.
Sairauden määritelmä: Ongelmat johtuvat mielen, kehon ja hengen yhteyden toimimattomuudesta

6. BIOMEDIKAALINEN
Muutos: Kun löytyy taudinaiheuttaja, geeni tai biokemiallinen syy ongelmaan.
Terapeutin rooli: Ymmärtää diagnoosia, oirekuvaa ja suositella asianmukaista hoitoa.
Tekniikka: Osoittaa psykososiaalisten ja neurofysiologisten prosessien suhde.
Sairauden määritelmä: Sairaus on ruumiin sairautta, joka johtuu taudinaiheuttajista, geeneistä tai biokemiallisista muutoksista.

7. NEUROLOGINEN

Muutos: parempi suoriutuminen kognitiivisella, motorisella tai emotionaalisella, päivittäis-toiminnan osa-alueella.
Terapeutin rooli: direktiivinen
Tekniikka: erilaiset harjoitteet, vaiheittain vaikeutuvat tehtävät,
Sairauden määritelmä: sairaus ilmenee aivotoiminnan poikkeamana/häiriönä tai aivovamman aiheuttamana toimintavajeena.

8. MUU, mikä_____

Lähteet:
Scouvel & Gardstrom (2007); in Unkefer & Thaut (Ed.)Music therapy in the treatment of adults with mental disorders.
Suomennos: Maija Salokivi ja Tiinapriitta Savela
Neurologisen musiikkiterapian määritelmä: Esa Ala-Ruona

Appendix 6 Questionnaire about assessment areas in clinical work

MINKÄLAISIA ALUEITA PAINOTAT OMASSA TYÖSSÄSI MUSIIKKITERAPIA-ARVIONNISSA?

VALITSE 1-3 ITSELLESI PARHAITEN SOPIVAA VAIHTOEHTOA

1. Vuorovaikutus
Asiakkaan ja terapeutin keskinäisen vuorovaikutuksen ja siinä esiintyvien ongelmien ja vahvuuksien arviointi (sanallinen, ei-sanallinen ja musiikillinen ilmaisu. Kontaktiin hakeutuminen tai sen välttely, yhteistyösuhteen rakentuminen ja toimivuus).

2. Käytös
Ulkoisesti havaittavan käyttäytymisen arviointi (piirteet, valmiudet ja ongelmat eri alueilla)

3. Musiikillinen ilmaisu
Musiikillinen tekeminen, kokeminen, valmiustaso ja musiikkisuhde

4. Ilmaisu
Kehollinen, sanallinen, ja musiikillinen ilmaisu sekä ilmeet ja eleet.

5. Tunne-elämä
Tunne-elämän nykytila ja tausta sekä tämän alueen patologiset piirteet. Tunne-elämän dynamiikka sekä tyypilliset reaktiot ja säätelykeinot.

6. Asiakkaan kokemuksia painottava
Asiakkaan kokemusmaailman olemuksen ja piirteiden (myös vielä tiedostamattomien) selvittäminen.

7. Motorinen toiminta
Kehon toiminnan sujuvuus hienomotorisella ja karkeamotorisella tasolla.

9 Kognitiivinen suoriutuminen
muisti, oppiminen, ajattelu, havaitseminen, tarkkaavaisuus, luovuus ja ongelmanratkaisutaidot.

Appendix 7 Questionnaire about the IMTAP ease of use

ARVOINTITYÖKALUN HELPPOKÄYTTÖISYYS? ____

(Asteikolla 1-5: 1= erittäin vaikea, 2=melko vaikea, 3= ei helppo eikä vaikea , 4= melko helppo, 5= erittäin helppo)

Appendix 8 Translated IMTAP domains of the research

GRADU-TUTKIMUKSESSA OLEVAT IMTAP-OSIOT (IMTAP: The Individualized Music Therapy Assessment Profile)

IMTAP jakaantuu useisiin arvioitaviin alueisiin, joista tässä tutkimuksessa ovat mukana

- Tunnetaidot (perusteet ja ala-kategoriat)
- Sosiaaliset taidot (perusteet ja ala-kategoriat)
- Musikaalisuus (perusteet)

ARVIOITAVIEN ALUEIDEN JA OSA-ALUEIDEN YLEINEN MÄÄRITTELY

Tunnetaidot (TT)
Tunnetaidot tarkastelevat asiakkaan tunnetiloja ja tunnereaktioita musiikkiterapiassa. Ala-kategorioiden avulla arvioidaan seuraavia taitoja; *erottelukyky/ilmaisu*, joka arvioi yksilön kykyä ilmaista eri tunnetiloja; *säätely,* joka arvioi asiakkaan kykyä vastata normaalin(yleisesti hyväksytyn) tunneilmaisun rajoissa ja tarkoituksenmukaisella kontrollilla ja muuntelulla; sekä asiakkaan *tietoisuus omista tunnetiloistaan.*

Sosiaaliset taidot (SOS)
Sosiaalisten taitojen kategoria mittaa yksilön kykyä olla vuorovaikutuksessa ja kommunikoida toisten kanssa. Nämä taidot lähtevät omaan nimeen vastaamisen perustaidosta, ulottuen edistyneempään taitoon tarkastella ulkoisia sosiaalisia suhteita. Ala-kategoriat sisältävät *osallistumisen, vuorottelun, huomion suuntaamisen, ohjeiden noudattamisen ja ihmissuhdetaidot.*

Musikaalisuus (MUS)
Tämä kategoria tarkastelee yksilön luontaisia reaktioita musiikillisiin ilmaisukeinoihin ja välineisiin ja hänen kykyään ja haluaan osallistua niihin. Tämän alueen arviointi toimii fokusta ohjaavana, antaen mahdollisuuden suunnitella yksilöllisiä interventioita, joiden avulla asiakas voi osallistua musiikilliseen kokemukseen.
Musikaalisuus alueesta käytetään tässä tutkimuksessa ”Perusteet” -osiota, joka arvioi asiakkaan yleistä kiinnostusta, reaktiota ja intoa musiikilliseen ilmaisuun. Täydentäviä ala-kategorioita ei käytetä niiden laajuuden vuoksi.

TAITOJEN MÄÄRITELMÄT

TUNNETAIDOT (TT)

A. PERUSTEET

I. Ilmaisee erilaisia tunteita
Asiakas ilmaisee eri tunteita kasvojen ilmeillä, kehon kielellä ja äänen sävyillä.
Asiakas ei ilmaise tunteita rajoittuneesti tai laimeasti.

II. **Ilmaisee tunteita tarkoituksenmukaisesti**
Asiakas ilmaisee tunteita kasvojen ilmeillä, kehonkielellä ja äänen sävyillä tilanteeseen sopivalla tavalla. Ei tarkoita että asiakas ilmaisee vain positiivisia tunteita.

B. EROTTELUKYKY/ILMAISU

I. **Ilmaisee tunteita tilanteeseen sopivalla tavalla**
Asiakas ilmaisee tunteita tai mielialaansa sanallisesti, sanattomasti tai musiikillisesti tilanteeseen sopivalla tavalla.

II. **Ilmaisee tunteita käyttämällä instrumentteja**
Asiakas ilmaisee tunteita tai mielialaansa käyttämällä musiikillisia elementtejä (rytmi, äänensävy tai dynamiikka)

III. **Ilmaisee tunteita sanallisesti**
Asiakas ilmaisee tunteita tai mielialaansa käyttämällä sanallisia ilmaisuja.

IV. **Ilmaisee emotionaalista vastetta musiikillisiin elementteihin**
Asiakas ilmaisee havaittavan muutoksen katseessa, tunnetilassa, hengityksessä, kehon liikkeissä jne., reagointina musiikin sisältämiin selviin emotionaalisiin elementteihin kuten sävelasteikkoon, sävellajiin, tempoon tai dynamiikkaan.

C. SÄÄTELY

I. **Sietää musiikkiterapiatilanteen ilman ahdistusta**
Asiakas kykenee olemaan läsnä musiikkiterapiatilanteessa ilman selviä merkkejä järkyttyneisyydestä tai ahdistuneisuudesta itkien, valittaen tai huutaen.

II. **Rauhoittuu tuen avulla**
Asiakas kykenee vähentämään ahdistusta saadessaan terapeutilta musiikillista, sanallista tai fyysistä tukea.

III. **Kestää siirtymätilanteet**
Asiakas vaihtaa toimintoa ilman ahdistusta tai kieltäytymistä.

IV. **Itsesäätely yhden toiminnan aikana**
Säätely onnistuu ilman näkyvää ahdistusta, itse-stimulaatiota tai häiritsevää käytöstä.

V. **Emotionaalinen tila vaihtelee tarkoituksenmukaisesti**
Asiakas ei ilmaise tilanteeseen liittymättömiä nopeita mielialan heilahteluja tai tunteiden vaihteluita.

VI. **Säätely säilyy kun rajat on asetettu**
Asiakas kykenee säilyttämään säätelyn kun terapeutti on esitellyt menettelytavat, säännöt ja rajat. Säätely

onnistuu ilman näkyvää ahdistusta, itse- stimulaatiota tai häiritsevää käytöstä.

D. TIETOISUUS ITSESTÄ

I. **Ilmaisee tunnistavansa tunnetiloja**
Tunnistaa tunteita ja ilmaisee sen verbaalisesti tai nimeämällä omia tai muiden tunnetiloja; kykenee valitseman tunnetilaa vastaavan kuvan; tai soitettu musiikki liittyy emotionaaliseen tilaan.

II. **Kykenee tarkastelemaan tunnetiloja**
Kyky tarkastella omia tai toisten tunnetiloja ilmenee asiakkaan puheesta; emotionaalisiin aiheisiin perustuvista musiikillisista tuotoksista; tai esim. tunteiden tutkimisesta laulun sanojen kautta.

III. **Osoittaa kykyä keskustella tunnetiloista**
Asiakas kykenee keskustelemaan omista tai toisten tunnetiloista sanallisesti tai vaihtoehtoisia kommunikointikeinoja käyttäen.

IV. **Tutkii tunnesisältöä tarkoituksenmukaisesti**
Annettaessa tilaisuus, asiakas aloittaa musiikillisen tutkimisen tai sanallisen pohdinnan tunnesisällöistä. Ei juutu tunneaiheiden käsittelyyn välttääkseen tai häiritäkseen muita aktiviteetteja.

V. **Tuo esille toiveen kohentuneesta voinnistaan tai elämän tilanteestaan**
Asiakas aloittaa sanallisen pohdinnan tai esim. laulun sanojen tekemisen, josta käy esille toive muutoksesta elämässä tai olosuhteissa, kuten oppia taitoja auttaa itseään tai kehittää valmiuksiaan osallistua esim. luokkatilanteeseen.

SOSIAALISET TAIDOT

A. PERUSTEET

I. Vastaa omaan nimeensä
Asiakas reagoi oman nimensä käyttöön keskustelussa tai musiikissa. Reaktiot voivat sisältää esim. terapeuttiin päin katsomisen, meneillään olevan toiminnon pysäyttämisen, huomion uudelleen suuntaamisen, tai sanallisen vastaamisen.

II. **Ilmaisee olevansa tietoinen terapeutin läsnäolosta**
Asiakas katsoo terapeuttia saadakseen ohjausta tai ohjeita, puhuttelee sanallisesti terapeuttia tai seuraa terapeutin antamia musiikillisia vihjeitä.

III. **Ilmaisee kiinnostusta meneillä oleviin toimintoihin**
Kiinnostus tulee esille asiakkaan hakeutumisena kohti toimintoja tai esiteltyjen soittimien soittamisena; pyytämällä tiettyä toimintaa tai laulua; tai ilmaisemalla odotettuja tunnereaktioita osallistumisen aikana.

IV. **Pyrkii kiinnittämään terapeutin huomion**
Asiakas käyttää sanallista tai sanatonta kommunikointia, katsekontaktia, ja/tai eleitä sosiaalisesti, tarkoituksenaan jakaa kokemuksia ja viestejä.

V. **On tarkoituksenmukaisesti vuorovaikutuksessa terapeutin kanssa**
Asiakas osallistuu terapiaan osoittamatta terapeuttiin kohdistuvaa sanallista tai fyysistä vahingoittamistarkoitusta.

VI. **Käyttää sosiaalisesti sopivia tervehdyksiä tullessaan**
Esimerkiksi ”Hei”, ”Moi ” tai ”Mitä kuuluu?” Tervehdys voi olla eleen muodossa, mutta ei ole jargonia tai yhteyteen muuten sopimatonta.

VII. **Käyttää sosiaalisesti sopivia tervehdyksiä lähtiessään**
Esimerkiksi ”Hei”, ”Moi”, ”Nähdään”. Tervehdys voi olla eleen muodossa, mutta ei ole jargonia tai yhteyteen muuten sopimatonta.

VIII. **Käyttää sosiaalisesti sopivaa katsekontaktia**
Asiakas käyttää katsetta normaalin pituisen ajan (esim. enemmän kuin vain ohimennen, mutta ei kuitenkaan myöskään juuttuvasti).

IX. **Sosiaalisesti yhteydessä toiseen**
Asiakas hakee katsekontaktilla terapeutilta vahvistuksen tai arvioidakseen hänen reaktionsa ennen toimintaa, sen aikana tai sen jälkeen.

X. **Osoittaa ymmärtävänsä säännöt ja rakenteet**
Asiakas seuraa ohjeita, aloittaa ja lopettaa toiminnan ohjauksen mukaisesti ja käyttää soittimia aiotulla tai kuvaillulla tavalla.

XI. **Osoittaa olevansa tietoinen fyysisestä tilasta**
Asiakas sopeuttaa etäisyyden terapeuttiin toiminnan kontekstin mukaan. Esimerkiksi istuu melko lähellä pianopenkillä tai liikkuu kauemmas esim. laululeikissä tai tilassa tapahtuvassa liikkeessä.

XII. **Suhtautuu luottavaisesti musiikkiterapiatilanteeseen**

Asiakas osallistuu toimintoihin ilman tarvetta huomattavaan rohkaisuun tai sanalliseen tukeen.

B. OSALLISTUMINEN

I. **Tulee terapiatilaan helposti**
Asiakas saapuu terapiaan kolmella tai vähemmällä suostuttelukerralla tai kehotuksella

II. **Viipyy huoneessa terapiatapaamisen ajan**
Asiakas viipyy terapiahuoneessa tapaamisen alusta loppuun.

III. **Yrittää uusia tehtäviä kun tarjotaan mahdollisuus**
Asiakas osallistuu entuudestaan vieraisiin toimintoihin tai kokemuksiin, kun terapeutti niitä tarjoaa.

IV. **On aloitteellinen uusissa toiminnoissa kun tarjotaan mahdollisuus**
Asiakas vaihtaa toimintaa itsenäisesti edellisen toiminnan jälkeen, siirtymän aikana tai terapeutin kehotuksesta. Asiakas voi tavoitella uutta soitinta, toivemusiikkia tai uuden toiminnan aloittamista.

V. **Sietää siirtymätilanteet**
Asiakas vaihtaa toimintoja ilman ahdistusta tai kieltäytymistä.

VI. **Osallistuu strukturoituihin toimintoihin**
Asiakas osallistuu toimintoihin, jotka ovat selkeästi määritellyt tai sisältävät tietyt säännöt ja/tai ohjeet toimintaan. (Esim. laululeikit, pelit)

VII. **On joustava toimintojen kehittymisessä**
Asiakas osallistuu toiminnan kehittämiseen tai muuttamiseen ilman ahdistusta tai kieltäytymistä.

VIII. **Kehittää toimintoja tarkoituksenmukaisesti**
Asiakas kehittää toimintoja ilman juuttumista tai kieltäytymistä toiminnan lopettamisesta.

IX. **Työskentelee määriteltyjen tavoitteiden mukaisesti terapiatapaamisen aikana**
Asiakas tekee fokusoituneesti töitä saavuttaakseen hänelle istuntoa varten asetetut tavoitteet, esim. laulun oppiminen kitaralla tai pianolla, tai tietyn rytmin hallinta.

C. VUOROTTELEMINEN

I. **Oman vuoron ennakointi**

Asiakas osoittaa ennakoivansa oman vuoronsa ottamalla sen tarkoituksenmukaisesti hyvin ajoitettuna, säilyttämällä katsekontaktin, tai reagoimalla oikea-aikaisesti toiminnassa, joka edellyttää ennakoivaa tilanteen luentaa.

II. **Odottaa vuoroaan**

Asiakas antaa terapeutin viedä loppuun oman vuoronsa ennen kuin aloittaa soittamisen tai muun toiminnan sellaisessa tekemisessä, jossa vuorottelu on tiedossa oleva toimintatapa.

III. **Pitää yllä vuorottelua ilman eri kehotusta**

Osallistuu vuorotteluun neljän tai useamman vuoron ajan. Kehotus toiminnan ylläpitoon voi olla visuaalinen, sanallinen, kehollinen tai musiikillinen.

IV. **Pyytää vuoroa tarkoituksenmukaisesti**

Asiakas pyytää vuoroa sanallisesti tai eleillä. Ei kuitenkaan asiakkaan toistuvaa vuoronpyytämistä terapeutin vuoron aikana tai meneillään olevan toiminnan estämistä.

V. **Ylläpitää vuorottelua ilman kehotusta**

Osallistuu vuorotteluun vähintään neljän kierron verran ilman visuaalista, sanallista tai fyysistä kehottamista. Ei sisällä musiikillisia kehotteita, kuten lopukkeita, toistuvia musiikillisia motiiveja tai rytmillisiä kulkuja vuorovaihdossa.

D. TARKKAAVAISUUS

I. **Pitää yllä tarkkaavaisuutta toiminnan vaatiman ajan**

Asiakas osallistuu toimintaan alusta loppuun; esim. pysymällä lähettyvillä, ei osoita levottomuutta tai häiritse toimintaa.

Ei sisällä toimintoja, jotka eivät ole tyypillisesti iänmukaisia ja ylittävät siten kohtuullisuuden rajat terapeutin mielestä.

II. **Osoittaa tarkkaavaisuuden ylläpitoa terapeuttiin päin**

Asiakas suuntaa tarkkaavaisuuden terapeuttiin vähintään minuutin ajaksi ilman itse-stimulaatiota, juuttumista tai tehtävään kuulumatonta käytöstä. Asiakkaan katsekontakti voi kuitenkin katketa hetkellisesti.

III. **Palaa kehotettuna toimintaan häiriötekijän jälkeen**

Häiriö tarkoittaa visuaalista, auditiivista tai kehollista toimintaan liittymätöntä tekemistä. Kehottaminen

tarkoittaa sanallista, visuaalista, musiikillista tai fyysistä kehottamista.

IV. **Palaa häiriötekijän jälkeen toimintaan ilman kehotuksia**
Häiriö tarkoittaa visuaalista, auditiivista tai kehollista toimintaan liittymätöntä tekemistä.

E. OHJEIDEN SEURAAMINEN

I. **Seuraa yksiosaista sanallista ohjetta**
Asiakas toimii yksiosaisen sanallisen ohjeen mukaan, kuten esim. kehotus: ”pidä tätä mallettia”.
Ei sisällä valinnantekoon liittyviä ohjeita, kuten ”Valitse jokin soitin”.

II. **Seuraa kaksiosaisia sanallisia ohjeita.**
Asiakas toimii terapeutin laulullisen tai sanallisen ohjauksen mukaan. Esimerkiksi: ”Istu ja soita tätä soitinta” tai ”Marssi pöydän luo rumpua soittaen”.
Ei sisällä valinnantekoon liittyviä ohjeita, kuten ” Istu alas ja valitse jokin soitin itsellesi.”

III. **Seuraa yksinkertaisia musiikillisia vihjeitä**
Asiakas toimii terapeutin musiikillisen ohjauksen mukaan. Musiikilliset vihjeet voivat olla esim. aloitus/lopetus, kysymys/vastaus, lopuke tai avoimeksi jäävä melodinen kulku.

F. SUHDETAIDOT

I. **Sietää suoran vuorovaikutuksen**
Asiakas ei ahdistu tai vastusta kun hänelle lauletaan, soitetaan tai puhutaan.

II. **Sietää muualle suuntauksen**
Asiakas pystyy suuntamaan huomion toisaalle ilman vastustamista tai ahdistumista.

III. **Sietää musiikillisen kontaktin**
Asiakas kykenee kuuntelemaan tai osallistumaan musiikkiin ilman vastustamista tai ahdistumista.

IV. **Soittaa yhtä aikaa terapeutin kanssa**
Asiakas soittaa samanaikaisesti terapeutin kanssa.
Ei edellytä asiakkaan soittavan oikeassa tempossa, rytmissä, oikeassa sävelessä tai muuten mukautuvan terapeutin tuottamaan musiikkiin.

V. **Soittaa terapeuttia imitoiden**
Asiakas imitoi terapeutin musiikillisia ideoita. Imitointi voi olla rytmillistä, melodista, tunnelmaan liittyvää tai soittotapaan liittyvää.

VI. **Pitää yllä musiikillista vuorovaikutusta**
Asiakas soittaa tai laulaa terapeutin kanssa vähintään minuutin ajan.

VII. **Ylläpitää kaksisuuntaista kommunikaatiota**
Asiakas osoittaa kykynsä terapeutin kanssa kommunikoimiseen vähintään minuutin ajan. Kommunikointi voi tapahtua keskusteluna, eleinä, merkkeinä tai avustavia kommunikointikeinoja käyttäen.

VIII. **Työskentelee yhteistyössä terapeutin kanssa**
Asiakas osoittaa kykyä työskennellä terapeutin kanssa kohti yhteistä tavoitetta, kuten esim. yhteisen tempon ylläpitäminen terapeutin soittaessa melodiaa, tai session suunnittelu yhdessä terapeutin kanssa.

IX. **Osoittaa joustavuutta vuorovaikutteisessa soitossa**
Asiakas kykenee sopeutumaan muutoksiin improvisoidussa, strukturoimattomissa musiikillisissa kokeiluissa, liikkeissä, soittimissa, tarvikkeissa tai äänessä, joita tuottaa terapeutin kanssa, ilman ahdistusta tai vastustamista. Esimerkiksi äänen liu´uttaminen tai puhallinsoitin tai ksylofoni -kokeilut.

X. **Osoittaa joustavuutta tutuissa vuorovaikutuksellisessa struktuureissa**
Asiakas kykenee sopeutumaan muutoksiin tutuissa toiminnoissa terapeutin kanssa ilman ahdistumista tai vastustamista, kuten esim. tutun laulun sanojen muuttaminen, musiikillisen pelin sääntöjen muuttaminen, tai vaihtamalla instrumentteja musiikillisessa toiminnassa.

XI. **Pystyy omaksumaan johtajan roolin toiminnassa**
Asiakas osoittaa kykenevänsä ohjaamaan tai johtamaan vuorovaikutusta tai toimintaa.

XII. **Vaihtelee itsenäisten ja toisesta riippuvaisten taitojen välillä**
Asiakas osoittaa kykynsä vaihdella itsenäisen tai toisesta riippuvaisen roolin välillä toiminnassaan. Asiakas ei osoita vastustamista tai ahdistumista itsenäisessä tai toisesta riippuvaisessa toiminnassa.

XIII. **Kykenee tarkastelemaan terapian ulkopuolisia sosiaalisia suhteita**
Terapian ulkopuoliset sosiaaliset suhteen tarkoittavat esim. suhdetta ystäviin tai perheen jäseniin. Aiheen

tunnustelu voi ilmetä keskustelussa tai musiikillisessa tuotoksessa.

MUSIKAALISUUS

A. PERUSTEET

I. **Huomioi musiikin**
Asiakas osoittaa olevansa tietoinen musiikista havaittavissa olevilla muutoksilla esim. katseessa, tunteissa, hengityksessä, kehon liikkeissä.

II. **Ilmaisee nauttivansa musiikista**
Asiakas ilmaisee mielihyvää musiikin aikana tai sen jälkeen. Tämän voi havaita kasvojen ilmeestä, eleistä, kehon liikkeistä, merkeistä, äänteistä tai sanallisesti. Esim. hymyily, nauraminen, jalan liikkuminen rytmin mukana tai tanssiminen.

III. **Osoittaa halua soittimien soittamiseen tai koskettamiseen**
Asiakas osoittaa halua soittimien tutkimiseen suuntaamalla katseensa soittimiin tai sanallisesti ilmaisten.

IV. **Soittaa soittimia kun niitä tarjotaan**
Asiakas soittaa soittimia kun terapeutti niitä tarjoaa.

V. **Tutkii instrumentteja**
Asiakas tutkii ääniä, äänen sävyjä, äänten välisiä eroja, soittimen muotoa tai soittimen asentoja.

VI. **Reagoi äänellisesti musiikkiin**
Asiakas reagoi äänellisesti musiikin aikana tai sen jälkeen. Äänellisesti tarkoittaa mitä tahansa suulla tuotettavaa ääntä.

VII. **Reagoi rytmikkäillä liikkeillä musiikkiin**
Asiakas liikkuu säännöllisessä, pysyvässä tempossa; esim. keinuminen, heiluminen, huojuminen, tanssiminen, hypyt, napsutukset, nyökkäilyt musiikin aikana tai sen jälkeen. Ei edellytä asiakkaalta musiikkiin sopivaa tempoa.

VIII. **Soittaa spontaanisti soittimia**
Asiakas soittaa spontaanisti soittimia ilman visuaalista, sanallista tai fyysistä kehotusta. Musiikillinen aloite terapeutin taholta voidaan esittää

IX. **Laulaa spontaanisti**

Asiakas laulaa spontaanisti ilman visuaalista, sanallista tai fyysistä kehotusta. Musiikillinen aloite voidaan terapeutin taholta esittää.

X. **Vastaa musiikilliseen vihjeeseen**

Asiakkaan käytöksestä on huomattavissa reagointi musiikilliseen vihjeeseen musiikin aikana tai sen jälkeen, esim. katse, tunne, hengitys, kehon liikkeet. Musiikillinen vihje voi olla aloitus/lopetus, kutsu tai vastaus, lopuke tai avoimeksi jäävä melodinen kulku.

XI. **Osallistuu vuorovaikutteiseen soittoon**

Asiakas osallistuu strukturoimattomaan improvisoituun musiikilliseen äänten, liikkeiden, soittimien, tarvikkeiden tutkimiseen terapeutin kanssa. Esimerkiksi äänen liu´uttaminen, puhallinsoittimen tai ksylofonin kokeileva soittaminen.

XII. **Pystyy itse -säätelyyn musiikillisella tuella**

Kun asiakas ei pysty tunteiden itsesäätelyyn (esim. osoittaa ahdistuneisuutta, jättää työskentelyalueen, käyttäytyy tehtävään kuulumattomasti), hän kykenee palamaan toimintaan, ottamaan osaa toimintaan tai ei reagoi ahdistumalla, vastauksena musiikilliseen tukeen, esim. musiikillinen vihje, tuttu laulu, asiakkaan tunnetilaa vastaava musiikki tai muutos musiikillisissa elementeissä.

Appendix 9 Translated the IMTAP emotional domain scoring forms

IMTAP-Tunnetaidot

Pisteytys

E=Ei koskaan=0% H=Harvoin= alle 50%

V=Vaihtelevasti=50-79% S=Säännöllisesti= 80-100%

A. PERUSTEET (Tunnetaidot)							
i. Ilmentää erilaisia tunteita		E 0	H 2	V 3	S 4		
ii. Ilmaisee tunteita tarkoituksenmukaisesti		E 0	H 2	V 3	S 4		
Sarake yhteensä							
					Kaikki yhteensä		
Toiminta/muistiinapanoja							

B. EROTTELUKYKY/ILMAISU						EA	
i. Ilmaisee tunteita tilanteeseen sopivalla tavalla		E0	H2	V3	S4		
ii. Ilmaisee tunteita käyttämällä instrumentteja			E0	H3	V4	S5	
iii. Ilmaisee tunteita sanallisesti			E0	H3	V4	S5	
iv. Ilmaisee emotionaalista vastetta musiikillisiin elementteihin				E0	H4	V5	S6
Sarake yhteensä							
					Kaikki yhteensä		
Toiminta/muistiinpanoja							

C. SÄÄTELY						EA	
i. Sietää musiikkiterapiatilanteen ilman ahdistusta	E0	H1	V2	S3			
ii. Rauhoittuu tuen avulla (mus/verb/fyys)	E0	H1	V2	S3			
iii. Kestää siirtymä tilanteet	E0	H1	V2	S3			
iv. Itsesäätely yhden toiminnan aikana		E0	H2	V3	S4		
v. Emotionaalinen tila vaihtelee tarkoituksenmukaisesti		E0	H2	V3	S4		
vi. Säätely säilyy kun rajat on asetettu		E0	H2	V3	S4		
Sarake yhteensä							
					Kaikki yhteensä		
Toiminta/muistiinpanoja							

D. TIETOISUUS ITSESTÄ						EA	
i. Ilmaisee tunnistavansa tunnetiloja				E0	H4	V5	S6
ii. Kykenee tarkastelemaan tunnetiloja				E0	H4	V5	S6
iii. Osoittaa kykyä keskustella tunnetiloista				E0	H4	V5	S6
iv. Tutkii tunnesisältöä tarkoituksenmukaisesti				E0	H4	V5	S6
v. Tuo esille toiveen kohentuneesta voinnistaan tai elämän tilanteestaan				E0	H4	V5	S6
Sarake yhteensä							
				Kaikki yhteensä			
Toiminta/muistiinpanoja							

YHTEENVETO

Osa-alue (Tunnetaidot)	**EA**	**Pisteet**	**Max**	**Lopullinen**
A. Perusteet			: 8 =	%
B. Erottelukyky/ilmaisu			: 20 =	%
C. Säätely			: 21 =	%
D. Minä-tietoisuus			: 30 =	%
Osa-alue yhteensä (Tunnetaidot)			: =	%

Appendix 10 Translated the IMTAP social domain scoring forms

IMTAP-Sosiaaliset taidot

Pisteytys

E=Ei koskaan=0% H=Harvoin= alle 50%

V=Vaihtelevasti=50-79% S=Säännöllisesti= 80-100%

A.PERUSTEET (Sosiaaliset taidot)							
i. Vastaa omaan nimeensä	E0	H1	V2	S3			
ii. Ilmaisee olevansa tietoinen terapeutin läsnäolosta	E0	H1	V2	S3			
iii. Ilmaisee kiinnostusta meneillä oleviin toimintoihin	E0	H1	V2	S3			
iv. Pyrkii kiinnittämään terapeutin huomion	E0	H1	V2	S3			
v. On tarkoituksenmukaisesti vuorovaikutuksessa terapeutin kanssa	E0	H1	V2	S3			
vi. Käyttää sosiaalisesti sopivia tervehdyksiä tullessaan	E0	H1	V2	S3			
vii. Käyttää sosiaalisesti sopivia tervehdyksiä lähtiessään	E0	H1	V2	S3			
viii. Käyttää sosiaalisesti sopivaa katsekontaktia	E0	H1 H1	V2	S3			
ix. Sosiaalisesti yhteydessä toiseen	E0	H1	V2	S3			
x. Osoittaa ymmärtävänsä säännöt ja rakenteet		E0	H2	V3	S4		
xi. Osoittaa olevansa tietoinen fyysisestä tilasta		E0	H2	V3	S4		
xii. Suhtautuu luottavaisesti musiikkiterapia tilanteeseen		E0	H2	V3	S4		
Sarake yhteensä							
					Kaikki yhteensä		

Toiminta/muistiinpanoja

B. OSALLISTUMINEN						EA	
I. Tulee terapiatilaan helposti	E0	H1	V2	S3			
ii. Viipyy huoneessa terapiatapaamisen ajan	E0	H1	V2	S3			
iii. Yrittää uusia tehtäviä kun tarjotaan mahdollisuus	E0	H1	V2	S3			
iv. On aloitteellinen uusissa tehtävissä kun tarjotaan mahdollisuus	E0	H1	V2	S3			
v. Sietää siirtymätilanteet	E0	H1	V2	S3			
vi. Osallistuu strukturoituihin toimintoihin		E0	H2	V3	S4		
vii. On joustava toimintojen kehittymisessä		E0	H2	V3	S4		
viii. Kehittää toimintoja tarkoituksenmukaisesti			E0	H3	V4	S5	
ix. Työskentelee määriteltyjen tavoitteiden mukaisesti terapiatapaamisen aikana				E0	H4	V5	S6
Sarake yhteensä							
					Kaikki yhteensä		

Toiminta/muistiinpanoja

C. VUOROTTELEMINEN						EA	
i. Oman vuoron ennakointi	E0	H1	V2	S3			
ii. Odottaa vuoroaan		E0	H2	V3	S4		
iii. Pitää yllä vuorottelua ilman eri kehotusta		E0	H2	V3	S4		
iv. Pyytää vuoroa tarkoituksenmukaisesti		E0	H2	V3	S4		
v. Ylläpitää vuorottelua ilman kehotusta			E0	H3	V4	S5	
Sarake yhteensä							
					Kaikki yhteensä		

Toiminta/muistiinpanoja

D. TARKKAAVAISUUS						EA	
i. Pitää yllä tarkkaavaisuutta toiminnan vaatiman ajan	E0	H1	V2	S3			
ii. Osoittaa tarkkaavaisuuden ylläpitoa terapeuttiin päin	E0	H1	V2	S3			
iii. Palaa kehotettuna toimintaan häiriötekijän jälkeen	E0	H1	V2	S3			
iv. Palaa häiriötekijän jälkeen ilman kehotusta		E0	H2	V3	S4		
Sarake yhteensä							
					Kaikki yhteensä		

Toiminta/muistiinpanoja

E. OHJEIDEN SEURAAMINEN						EA	
i. Seuraa yksiosaista sanallista ohjetta	E0	H1	V2	S3			
ii. Seuraa kaksiosaisia sanallisia ohjeita		E0	H2	V3	S4		
iii. Seuraa yksinkertaisia musiikillisia vihjeitä		E0	H2	V3	S4		
Sarake yhteensä							
					Kaikki yhteensä		

Toiminta/muistiinpanoja

F. SUHDETAIDOT						EA	
i. Sietää suoran vuorovaikutuksen	E0	H1	V2	S3			
ii. Sietää muualle suuntauksen	E0	H1	V2	S3			
iii. Sietää musiikillisen kontaktin	E0	H1	V2	S3			
iv. Soittaa yhtä aikaa terapeutin kanssa		E0	H2	V3	S4		
v. Soittaa terapeuttia imitoiden		E0	H2	V3	S4		
vi. Pitää yllä musiikillista vuorovaikutusta		E0	H2	V3	S4		
vii. Ylläpitää kaksisuuntaista kommunikaatiota		E0	H2	V3	S4		
viii. Työskentelee yhteistyössä terapeutin kanssa		E0	H2	V3	S4		
ix. Osoittaa joustavuutta vuorovaikutteisessa soitossa			E0	H3	V4	S5	
x. Osoittaa joustavuutta tutuissa vuorovaikutuksellisissa struktuureissa			E0	H3	V4	S5	
Xi. Pystyy omaksumaan johtajan roolin toiminnassa			E0	H3	V4	S5	
xii. Vaihtelee itsenäisen ja toisesta riippuvaisten taitojen välillä			E0	H3	V4	S5	
xiii. Kykenee tarkastelemaan terapian ulkopuolisia sosiaalisia suhteita				E0	H4	V5	S6
Sarake yhteensä							
					Kaikki yhteensä		

Toiminta/muistiinpanoja

YHTEENVETO

Osa-alue (Sosiaaliset taidot)	**EA**	**Pisteet**	**Max.**	**Lopullinen**
A. Perusteet			: 39 =	%
B. Osallistuminen			: 34 =	%
C. Vuorotteleminen			: 20 =	%
D. Tarkkaavaisuus			: 13 =	%
E. Ohjeiden seuraaminen			: 11 =	%
F. Suhdetaidot			: 55 =	%
Osa-alue yhteensä (Sosiaaliset taidot)			: =	%

Appendix 11 Translated the IMTAP fundamentals of musicality scoring forms

IMTAP-Musikaalisuus

Pisteytys

E=Ei koskaan=0%
V=Vaihtelevasti=50-79%
H=Harvoin= alle 50%
S=Säännöllisesti= 80-100%

A. PERUSTEET							
i. Asiakas huomioi musiikin	E0	H1	V2	S3			
ii. Asiakas ilmaisee nauttivansa musiikista	E0	H1	V2	S3			
iii. Asiakas osoittaa halua soittimien soittamiseen tai koskettamiseen	E0	H1	V2	S3			
iv. Asiakas osoittaa soittimia kun niitä tarjotaan	E0	H1	V2	S3			
v. Asiakas tutkii instrumentteja	E0	H1	V2	S3			
vi. Asiakas reagoi äänellisesti musiikkiin	E0	H1	V2	S3			
vii. Asiakas reagoi rytmikkäillä liikkeillä musiikkiin	E0	H1	V2	S3			
viii. Asiakas soittaa spontaanisti soittimia	E0	H1	V2	S3			
ix. Asiakas laulaa spontaanisti		E0	H2	V3	S4		
x. Asiakas vastaa musiikilliseen vihjeeseen		E0	H2	V3	S4		
xi. Asiakas osallistuu vuorovaikutteiseen soittoon		E0	H2	V3	S4		
xii. Asiakas pystyy itse-säätelyyn musiikin tuella		E0	H2	V3	S4		
Sarake yhteensä							
Kaikki yhteensä							

Toiminta/muistiinpanoja

YHTEENVETO

Osa-alue (Musikaalisuus)	**EA**	**Pisteet**	**Max.**	**Lopullinen**
A. Perusteet			: 40 =	%
Osa-alue yhteensä (musikaalisuus)			: =	%

Appendix 12 Focus group interview

FOKUS GROUP INTERVIEW HAASTATTELURUNKO

1. MITÄ MIELTÄ OLET KÄYTETYN ARVOINTITYÖKALUN SOVELTUVUUDESTA HAVAINNOITAESSA KYSEISEN ASIAKKAAN EMOTIONAALISTA ILMAISUA JA TOIMINTAA? (MITÄ PUUTTUU, MITEN HALUAISIT TÄYDENTÄÄ)

2. MITÄ MIELTÄ OLET KÄYTETYN ARVOINTITYÖKALUN SOVELTUVUUDESTA HAVAINNOITAESSA KYSEISEN ASIAKKAAN SOSIAALISTA ILMAISUA JA TOIMINTAA? (MITÄ PUUTTUU, MITEN HALUAISIT TÄYDENTÄÄ)

3. MITÄ MIELTÄ OLET KÄYTETYN ARVIOINTITYÖKALUN SOVELTUVUUDESTA HAVAINNOITAESSA KYSEISEN ASIAKKAAN MUSIIKILLISTA ILMAISUA JA TOIMINTAA? (MITÄ PUUTTUU, MITEN HALUAISIT TÄYDENTÄÄ)

4. MITÄ AJATTELET TÄLLAISEN ARVOINTITYÖKALUN TARPEELLISUUDESTA OMAAN MUSIIKKITERAPEUTIN TYÖHÖSI?

5. MUITA AJATUKSIA JOITA HALUAT JAKAA TÄHÄN KYSEISEEN ARVOINTIMENETELMÄÄN LIITTYEN

6. TAI YLEENSÄ MUSIIKKITERAPIAN ARVIOINTIKÄYTÄNTÖIHIN LIITTYEN