

**A MICROANALYSIS OF MUSICAL INTERACTIONS IN MUSIC  
THERAPY: CLINICAL IMPROVISATIONS OF AN ADULT WITH  
VISUAL IMPAIRMENT**

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Tiivistelmä – Abstract To date, published studies involving music therapy (MT) and clients with visual impairment (VI) are few. Adults with VI who experience MT are a less studied group, despite comprising majority of the visually-impaired population. The aim of this study was to investigate how significant musical interactions occur and change throughout the process of therapy in the form of a microanalytic case study of clinical improvisations between an adult client with degenerative VI and his music therapist. Results suggest that music improvisation involving musical interactions such as singing, humming, and shared playing of instruments (together or in turns) led to fruitful ways of working with an adult client with VI. Additionally, observing aspects of being in the musical space together and how the client and therapist musick the sounds, silences, and other emergent improvisational motifs provide insight to the way the relational or interactional dynamics change over time from dependent playing to musical partnership and independence.	
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# 1 INTRODUCTION

According to the World Health Organization (2017), approximately 253 million people worldwide are living with visual impairment with 217 million having moderate to severe visual impairment. In Finland 18,189 are registered living with visual handicaps. This number is projected to rise annually by 1,800-2,000 (Ojamo, 2016). Visual impairment is a spectrum, with differing levels of vision loss that correspond to sight functionality. The loss of sight poses various day-to-day challenges in people living with this condition. Distressing psychological issues such as depression, social withdrawal, and a decline in wellbeing may also affect these individuals (Moschos, 2014). These problems are some of the commonly addressed difficulties in music therapy; however, to date, published studies involving music therapy and clients with visual impairment are few. Up to now the sparse literature has focused mainly on music therapy with visually impaired or blind children and adolescents. Adults with visual impairment who experience music therapy are a less studied group, despite comprising majority of the visually-impaired population. To find out more about this area, this research will therefore be an exploration into the minute facets of a visually-impaired adult client's experience of therapy. To capture the details of working with this client, the music and its relational aspects in therapy will primarily be subjected to a closer look. A detailed description of representative sessions, a microanalysis of video clips from the most relevant session, an interview with the music therapist about the whole process, and a verbal commentary on the most salient moments will be conducted and further analyzed to find more about the musical interactions in therapy, their qualities, and any changes therein. In examining the details of the musical processes involved in therapy, this case study seeks to address the research gap in working with adults with visual impairment.

This thesis is divided into eight parts. The next chapter deals with the connections between music, music therapy, and visual impairment. It also provides a background into the music in therapy: the musical interactions that happen between therapist and client. The third chapter explains the goals of the research, while the fourth delves into research methodologies used in the study. The fifth chapter focuses on details of the case while the last three chapters discuss the findings of the microanalysis, the synthesis of all other data, and conclusions of the case study.

## **2 LITERATURE REVIEW**

### **2.1 Music therapy and visual impairment**

As children, we are taught the five basic senses: hearing, touching, smelling, tasting, and seeing. Eyesight or vision is one of many bodily senses that help us navigate this world. Perceiving is perhaps the most immediate sense, as light enters the eyes and images are reflected and interpreted by the brain. However, not everyone is able to see in the same way. Some individuals are born without vision. Some develop eye problems over time and are required to wear corrective glasses or even undergo surgery. Some have progressive conditions that are incurable or worsen over time. Depending on the condition, individuals are diagnosed by the level of sight function: “normal vision, moderate vision impairment, severe vision impairment, and blindness” with the latter three comprising vision impairment as a whole (Visual impairment and blindness, 2017). Visual impairment is characterized by an uncorrectable reduced functioning of vision. It “affects health-related quality of life by restricting functional ability, as well as having a detrimental effect on the psychosocial status of individuals.” (Watkinson, 2014, p. 16)

It is typically assumed that persons with some form of visual impairment or blindness are more sensitive to sounds than normally sighted individuals. To some extent, this claim has been supported by research such as in Doucet et. al (2005) and Dufour, Després, & Candas (2005), where blind participants (both congenital/early and late blind) were more accurate in locating the sound cues from echoes. It must be noted however, that sample sizes are small for the experiments. Cattaneo & Vecchi (2011) offer a comprehensive review of sensory compensation both in totally blind and low vision persons. Findings support the hypothesis that other remaining senses may develop “functional compensatory mechanisms”, albeit in differing levels, depending

on the severity of vision loss and age of onset. Regarding the experience of sound as music, a recent study compared the perception of music emotions between normal sighted and visually impaired adults. The group with visual impairment significantly differed from their sighted counterparts in that they preferred the sadness in music as an emotion with high arousal and intensity (Park & Chong, 2017). In a related study with a larger sample size comparing the attitudes and uses of music between the visually impaired and normal sighted individuals, findings suggest that people with visual impairment listen to music more often in their free time, rating singing as a preferred activity, while distinguishing music as an important means for group and interpersonal experiences with others due to lessened social interaction (Park, Chong, & Kim, 2015).

Even with the knowledge that individuals who are visually impaired are able to perceive sounds in a significantly different way than sighted people, one wonders why there exists only a limited number of published studies on music, music therapy and visual impairment. The keywords “visual impairment”, “music”, and “music therapy” were used in databases such as ERIC, Google scholar, JSTOR, ProQuest, RILM, SagePub, Scopus, and Taylor & Francis. Upon searching for the keywords, one finds that there are more articles written about the music education of visually impaired or blind children and adolescents. The remaining relevant literature on music therapy and visual impairment are mostly focused on children as well, however some are not fully accessible. These, along with the few articles regarding adult clients will be discussed later in this section. Before going further into the available literature, a brief overview of music therapy is necessary.

There are many existing definitions of music therapy. The most enduring one however, comes from Bruscia (2014): “Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of



change.” (p. xxii) Over the years, this definition has provided a view of health as a process. This interpersonal process is possible with the participation of at least two (or sometimes more) people: a therapist and a client. A relationship where one helps the other who seeks for it is attainable within the context of therapy. Health is promoted through music interventions with client goals in mind. Another definition by Bunt and Stige (2014) provides social context: “Music therapy is the use of sounds and music within an evolving relationship between patient/participant and therapist to support and encourage physical, mental, social, emotional and spiritual well-being.” (p. 18) Music therapy bridges disciplines, with an added layer of communication as a unique feature. As Ruud (1998) states, “The field of music therapy is a unique blend of art and science, medicine, and the humanities. It is a treatment profession in which experiences, relationships, reflections, dialogues, and processes are investigated through music communication.” (p. 19) In a more sociocultural context, music therapy provides “possibilities for action” in addition to the earlier definition in that it empowers and helps change some of the substantial factors that keep an individual in a disabled role (Ruud, 1998, 2008).

Although a relatively young profession, music therapy is now being practiced in different parts of the world and in different places such as communities, hospitals, institutions, schools, and elderly homes, to name a few. In the case of visual impairment, music therapy has been used to address developmental, social, communication, emotional, physical, and behavioral goals. Since music is an effective medium for holding ideas in a systematized way that elicits understanding, Michel & Pinson (2012) stress the need for communication through therapy. For instance, Metell (2015) describes her work with caregivers (mostly mothers) and their children with visual impairment and other diagnoses (ages 1-4) engaging in musical interaction. She found that music therapy results in positive bonding which may improve early interaction between the parent and child. Music affords pleasant experiences that

encourage more shared activity. Other vital findings include aspects of togetherness and early interaction in music: “synchronization, responsiveness, turn-taking, and attunement” as well as joint attention, and physical contact (p. 115). In this way music therapy encourages sensory stimulation, responses, and helps lessen isolation through socialization and relationships (Kern, 2006; Gourgey, 1998). Being aware of their environment through different sounds or instruments also illustrates the stimulating quality of music (Gourgey, 1998). Additionally, Kersten (1981) states that there is improvement of physical problems through music therapy, as well as coping better with or controlling frustration or anger. Music is noted for its relaxing potential as well.

Together with Stige, Metell takes into account the societal dimension of work with clients who have visual impairment. They propose the realization of participation and inclusion through health musicking (Metell & Stige, 2016); health musicking being “the common core of any use of music experiences to regulate emotional or relational states or to promote well-being” (Bonde, 2011, p. 121). In her work with children with multiple disabilities and accompanying visual impairment, Rainey Perry (2003) considers musical interaction in music therapy as communicative in that it fosters closeness among those experiencing it despite initial challenges. By using improvisation, precomposed songs, singing, playing together, turn-taking, and synchronization within some degree of session structure, she was able to gauge and match their levels of communication individually for a better understanding of their responses in therapy. Another case concerning participation and interaction in music therapy leading to higher self-esteem, responsiveness, and increased musical skills are shown in Shoemark’s (1991) work with Brian, an 8-year old boy who, in addition to having blindness also had some behavioral difficulties. Through piano improvisation, Brian was able to become more receptive to the therapist, expressing himself in the

music-making via initiating themes or responding. Ultimately, the positive effects of therapy are carried over outside his sessions.

Singing and songwriting in music therapy seem to have a special value for the visually impaired population. Arter & Lavelle Hill (1999) highlights self-acceptance, music as communication (especially in expressing emotions through song writing), and music as a means for exploring feelings. Emotional and cognitive needs are addressed in such music interventions (Gourgey, 1998). Bertolami & Martino's work (2002) also involves children and adolescents' developmental improvement through songwriting and performing. In his work with an adult woman with visual impairment and learning disabilities, Dauber (2011) describes his work with 26-year old Maria, who attended music therapy to improve her quality of life and emotional awareness. She had feelings of isolation and anxiety since she had difficulties forming relationships. She also felt pains within her body. Through musical contact and communication, growth of the therapeutic relationship was possible. He lists down three phases of therapy: 1) listening (to Maria's needs, and to her desire for using her voice), 2) singing as something meaningful and emotional (partly improvised, partly done with existing Greek songs) and 3) performing, which has therapeutic value for this client. In another case study of a 4-year old blind girl named Gabriela, music was used to reach out, connect, and engage (Salas & Gonzales, 1991). The two therapists and the client were able to share the world of music together as the sessions went by, lessening Gabriela's sense of isolation. Through singing and playing improvised melodies which often incorporated Gabriela's name, she was able to grow in self-confidence and expression. Later, as she went through the process of therapy, "she was able to establish coherence herself, quite masterfully shaping our improvisations with the introduction, development and recapitulation of themes" (p. 25).

## 2.2 Musical interaction and improvisation

Even before birth, every individual is already exposed to sound and its musical elements through his or her own mother. Robbins once wrote, “We do not understand what our mother is saying yet we learn to recognize her voice: its patterns of intonation, its timbre, and its rhythmic characteristics become imprinted within us.” (2005, p. 1-2) The idea of early interpersonal processes is based on Stern’s theories on infant research. As cited in Wigram, Pedersen, & Bonde (2002), Stern mentions the involvement of “elements of communication such as tempo, rhythm, tone, phrasing, form and intensity” in infants’ pre-verbal interaction (p. 86). Children are able to develop their sense of being-with-another through this process which contains highly musical qualities.

Interaction in music therapy is closely linked to communication. In individual music therapy, the therapist and client ideally form a therapeutic relationship mainly through musical interactions. Musical interactions are not only inevitable but also an integral part of the process (Spiro & Himberg, 2016). Both client and therapist enter a mutual space, bringing their individual selves together as one musical dyad. This sense of being together in the here-and-now promotes endless musical possibilities and exchanges. Human beings are fundamentally social, and music facilitates nonverbal interaction between those involved in it. There are many ways this could happen in therapy since the ability to interact and engage in some form of musical communication is something that all humans possess from birth. One example is active music therapy which involves the client and therapist playing instruments or singing together, often in an improvised manner.

Simply defined, improvisation is the act of doing something in the moment. The word derives from the Latin *improvisus*, or unforeseen (Improvise, n.d.). In music therapy, improvisation is one out of many kinds of musical experiences. For the sake of clarity

in this study, the term “improvisation” will refer to clinical improvisation as defined by Wigram (2004): “The use of musical improvisation in an environment of trust and support established to meet the needs of clients” (p. 37).

Improvisation has had a long history in music therapy. One of the earliest therapies to feature improvisation in working with young clients is Creative Music Therapy by Paul Nordoff and Clive Robbins. The pair started working almost 60 years ago in both the United States and Europe. Nordoff was a composer and proficient pianist while Robbins was a special education teacher. Together their way of working involved improvising music with the child. Cellist Juliette Alvin also pioneered work with children in the United Kingdom by using free improvisation therapy (which meant that improvisations were totally free of structure or rules) along with developmental approaches. Mary Priestley, a music therapist in Britain who worked with adults founded Analytical Music Therapy which uses symbolic music improvisation to “explore the client’s inner life so as to provide the way forward for growth and greater self-knowledge.” (Priestley, 1994, p. 3)

Bruscia, a prominent American music therapist describes improvisation as “inventive, spontaneous, extemporaneous, resourceful and it involves creating and playing simultaneously.” (1987, p. 5) Additionally, he considers improvisation as a reflection of a person’s way of “being-in-the-world”. He sees interaction as central to the dynamics in improvisational music therapy. These dynamics consist of elements such as the therapist, client, music instruments, and the music improvisation. Furthermore, he addresses the importance of analyzing how these elements interrelate. He lists the terms intramusical (within client’s own music), intrapersonal (within the client’s self), intermusical (between the client and therapist’s music) and interpersonal (between the client and therapist) as some of the possible interactions (Bruscia, 1987). This study focuses on the latter two.

Music, interaction, and communication are essentially comprised of similar elements. It is in therapy where they co-exist, overlap, and converge. The myriad intangible relationships that are formed within and between the client, therapist, and the music happen spontaneously and simultaneously. In this way, it is posited that improvisation together with listening can stimulate and mirror relational patterns (Wigram, Pedersen, & Bonde, 2002). Ruud (1998) relates music improvisation to other areas of life like identity and social interaction. He maintains that “the transitional nature of music can enhance play and fantasy, provide new means for exploring the client's inner life, and offer a mode for investigating life's possibilities.” Music improvisation is a “good metaphor for our understanding of the individual” (p. 28). This is because improvised music *can* represent the individual, and this representation acts as a frame for the therapist and client's interpersonal relationship (Wigram, 2004).

### **3 RESEARCH AIMS**

The aim of this study is to investigate how significant musical interactions occur and change throughout the process of therapy, particularly in clinical improvisations between an adult client with degenerative visual impairment and his music therapist. By looking at therapy through the lens of the music, meaningful, human exchanges come into focus, as well as insights into working with this population.

This study attempts to answer the following research questions:

- 1) What were the significant musical interactions in music therapy?
- 2) How did the significant musical interactions happen?
- 3) How did these musical interactions change over time, if there are any?

The literature on visual impairment and music therapy so far has highlighted the need to address the social aspects of working with the population. Determining which specific musical interactions are significant would therefore reveal what was meaningful, what exactly in therapy drove the process, or in other words: what worked. The music therapeutic interventions that led to these instances of connection and communication are also worth exploring in working with the visually-impaired because this goes both ways; as interactions are two-way, there is usually an intervention and a response, which may guide the future course of therapy. Naturally, it would be of importance to investigate how these moments of interaction came to be. In therapy, it is important to have goals from the beginning, and see how these goals were achieved. Along the way, there are typically signs of change, although this is never certain. This study therefore also aims to investigate if there are any changes in interaction, and how these changes potentially affect and reflect the process.

## 4 METHODOLOGY

### 4.1 Qualitative research

There is an emphasis on meaning rather than truth in qualitative research. In the qualitative world, there is not one truth but multiple lived perspectives. Qualitative research is defined by Denzin and Lincoln (2008) as:

..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 world 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. (p. 4)

This type of research considers the situated humanity of the researcher and the participant/s. Its nature is also exploratory, which is described by Bruscia (2005) as an emergent, personal, and interpersonal process. It places the researcher at a key position for being the primary instrument (Wheeler & Kenny, 2005). This means that I try to understand the subject at hand with all of my person, while keeping myself in check for biases.

The qualitative research tradition is strong within the world of music therapy. It is preferred by most clinicians as a method known for its flexibility. As Smeijsters (1997) states: “qualitative research is about organic, dynamic, multiple, complex, and idiosyncratic realities.” (p. 17) Music therapy research may be interpretivist in that “the purpose is to explore a particular phenomenon as it unfolds and reveals itself during the study, the aim being to explicate and understand the phenomenon” (Wheeler & Bruscia, 2016).



#### **4.1.1 Case study**

There are many ways to do qualitative research. The case study is one of them. According to Stake (1995), a case study is “the study of the particularity and complexity of a single case, coming to understand its activity within important circumstances” (p. xi). The focus of case studies are narrow, as they best answer the questions of how and why (Yin, 2003).

In this case study, I write with concepts of naturalistic inquiry, phenomenology, and hermeneutics in mind. The study is naturalistic in the sense that it occurs in the normal context of therapy, without the researcher altering, experimenting, or controlling what happens (Aigen, 2005). Aldridge (1996) states that phenomenology is the study of lived human experience as “unified wholes”. Forinash and Grocke (2005) further explains that the experience of ‘being in the world’ is taken as a whole and not separated into ‘being’ and ‘world’. Closely related to phenomenology in its interpretative stance is hermeneutics which is “characterized by deep reflection” where experiences may be interpreted in different ways, while remaining as close to the phenomenon as possible (Kenny, Langenberg & Loewy, 2005). The researcher collects observation data from videos of the sessions, taking personal notes and reflections, as well as checking in with the therapist’s own retrospective thoughts (Ridder, 2005). The flexible process of retrospectively understanding data are often utilized in hermeneutics, phenomenology, and case study research (Aldridge, 2005). These multiple sources will be useful for selecting data for microanalysis and possible interpretation later on.

#### **4.1.2 Microanalysis in music therapy**

In recent years, attempts to detail the processes within music therapy has steadily increased. One useful clinical tool that therapists have been using is microanalysis. In Wosch and Wigram’s (2007) pioneering book *Microanalysis in music therapy: Methods, techniques and applications for clinicians, researchers, educators and students*, various

methods of microanalysis that have been based on previous research are offered and discussed, with case examples and step by step procedures.

Wosch and Wigram (2007) defines microanalysis as

..a detailed method investigating microprocesses. Microprocesses are processes and changes/progressions within one session of music therapy. The amount of time can be one minute (moment) or five minutes (therapy event) of one session, one clinical improvisation (episode), or one complete session. To analyze process over time, several microanalyses can be undertaken to look at several events. (p. 22)

Aside from the six studies in chapters 2-7 in the book, there are a few published studies applying video microanalysis in music therapy with different populations (see Haslbeck, 2014; Kim, 2016; Lee & McFerran, 2015; Ullsten, Eriksson, Klässbo, & Volgsten, 2017). There is none yet for persons with visual impairment.

Among the techniques compiled in Wosch and Wigram's (2007) work, Ridder's chapter on communicative response provided the most appropriate starting point for microanalysis. She states:

The video analysis tools might be relevant to other groups of clients where it is important to form a clear picture of what happens in the therapy, so that other professionals, peers or the therapist him/herself is able to form an understanding of the therapeutic processes, and the clinician is able to document changes or responses. (Ridder, 2007 p. 54)

In her chapter, Ridder (2007) proposes 5 steps in video microanalysis: "1) digital recording of the music therapy session, 2) session-graph, 3) selection of short video clips, 4) microanalysis of video clip, 5) conclusion". (p. 55) In step 2, session-graphs act as "primary entrance to further analyses and explanatory purposes in research", which is related to the aim of this thesis. Originally intended for clients who were "difficult to engage" and "show little response" (Ridder, 2007), permission from the author Hanne Mette Ridder was obtained to use a simpler, modified concept of session-graphs for initial video analysis of the client-therapist interaction during the sessions.

Other parameters may be added to the graph depending on research aims. In step 3, clips will be selected by the music therapist. In step 4 of the process, the analyst/researcher watches the selected clips and completes a chart with 3 columns: column A will contain “what he or she watches, hears, perceives and detects”, column B will include “his or her subjective ideas”, and in column C “the analyst is asked to reflect on the client’s response to the music.” (Ridder, 2007, p. 60-61)

In cases like this study where a number of sessions were recorded, it is optimal to narrow down to only one session and select a few, very short clips for analysis with second to second description (H. Ridder, personal communication, January 7, 2018). The most relevant session chosen by the therapist who had worked with the client will be analyzed and discussed further in the next chapter.

## **4.2 Data collection**

The therapy conducted in Autumn 2017 was part of a 12-week clinical internship period for music therapy (Master’s degree) students at the University of Jyväskylä (JYU), Finland. The music therapy clinic is fully equipped with various instruments, as well as strategically located microphones and cameras for recording the sessions (Ala-Ruona, 2015). After obtaining necessary consent for participation in therapy, audiovisual recording, and research, the client attended a total of eleven 45 minute-sessions at the JYU music therapy clinic, 480 minutes of which were recorded.

In the preliminary informal interview with the therapist, she was asked to recount the most memorable session in her work with Mikko, the client. The 10<sup>th</sup> (penultimate) session was chosen by the therapist as the most relevant session in the whole process because of its exceptional content among all the sessions. The therapist perceived a change of mood in this particularly emotional session. To examine this observation in-depth, a thorough video microanalysis based on Ridder’s (2007) approach was

undertaken. For a more comprehensive view of the process, I chose the 1<sup>st</sup> and 6<sup>th</sup> sessions to illustrate the different phases of therapy; at first creating contact and then towards the working (middle) phase (Erkkilä, 2016). As Bonde (2007) states: “It is often both realistic and appropriate to limit data to comparable material from a few sessions, e.g. early– middle– late phases of the therapy” (p. 258).

In addition to video data, a semi-structured interview about the process and verbal commentary of the 10<sup>th</sup> session was conducted with the therapist, who is a colleague of mine.

### **4.3 Analysis**

With both audio and video data available, an in-depth analysis was possible. I reviewed all 11 sessions and purposely chose two sessions in addition to the 10<sup>th</sup> session (which was chosen by the therapist herself). I viewed all three sessions chronologically, without taking any notes at first, openly listening to the improvisations. After this initial listening I began taking down notes about what was happening between the therapist and client musically (describing the music, sometimes transcribing musical passages, etc.), and physically (facial expressions, body language) as well as my own reactions and thoughts. The notes from the sessions helped shape the microanalysis and the frame of the case. I then wrote descriptively about the case and applied the step-by-step process of microanalysis for the 10<sup>th</sup> session. After reviewing the data so far, I conducted the interview and commentary with the therapist to develop additional perspectives pertinent to the findings of the case.

## 5 THE CASE

Mikko (not his real name) is a Finnish man in his mid-20s. He came into correspondence with the therapist (who is my colleague at the University of Jyväskylä Music Therapy International Master's Program) during the recruitment period for clinical internship 2016-2017. His reason for coming to music therapy was to find a possibility for exploring 'soundscapes' since he could no longer see faces because of a degenerative visual impairment (the exact type was undisclosed). The therapist had formulated several goals based on their early musical interactions, namely: (1) fostering independence and (2) fostering self-expression (where the concept of exploring 'soundscapes' became a frame of working in creating a specifically sound-based environment).

It is vital to note that Mikko's *musical* communication was of importance in the music therapy process. He had mentioned in his e-mail that he did not talk much, and this was evident from the first session. Another possible contributing factor to the lack of verbal communication could have been that his first language was not English. Due to the near-absence of verbal processing within the sessions, the focus of microanalysis shifted to the qualities of music and musical (nonverbal) interactions with the therapist. This inspired me to investigate the music during the improvisations. As stated by Ruud (1998):

We could say that the music, because of its nonverbal characteristics, creates a context that makes possible the liberation and installment of an acting "I" by the client. Thus, music does not maintain the structures of power enforced by verbal language that so often in therapy lead to a subject-object relationship." (p. 23)

A typical session would include lengthy musical improvisations by the client and therapist on instruments ranging from the djembe, malletKAT, mbira, metal and wood xylophones, wood xylophone drum, as well as the digital and acoustic piano. The voice was also used in the sessions.

## 5.1 Session descriptions

### 5.1.1 1<sup>st</sup> session (44' 16'')

After welcoming Mikko into the room and sitting down on two chairs facing each other, the session begins with a mindfulness exercise focusing on different parts of the body. At 3' 50'', after the therapist says, "Now that we're done noticing ourselves...", the client hums a short low tune on "ooh". Possibly hearing the word "sing" instead of "noticing", he hums in a low tune again. The therapist acknowledges him with a slight nod, and asks, "Do you want to try singing, or just vocalizing?" The client responds by humming again. This begins a series of vocal melodies exchanged by the client and therapist which lasts for approximately three minutes. The "call and response" stops briefly when the therapist stands up to get two djembe drums nearby but resumes as soon as they have both drums. The improvisation starts (7' 38'') as notated below:

#### MUSIC EXAMPLE 1

The musical notation consists of four staves. The top staff is labeled 'T. Voice' and uses a treble clef. The second staff is labeled 'T. Djembe' and uses a tenor clef. The third staff is labeled 'C. Voice' and uses a bass clef. The bottom staff is labeled 'C. Djembe' and uses a tenor clef. The key signature has one flat (B-flat). The T. Voice and C. Voice staves show vocal lines with 'Ah...' lyrics, and the T. Djembe and C. Djembe staves show rhythmic patterns. The notation includes treble and bass clefs, a key signature of one flat, and various musical symbols like notes, rests, and slurs.

Start of the djembe-voice improvisation. Note the rising and falling contour of the melodies.

The improvisation commences with the therapist singing a short melody on "ah" and the client joining in the same measure. This rising and falling motif has been present in the first musical exchange with only the voices. It becomes clearer in this second improvisation. The therapist starts tapping the djembe in a moderately slow tempo—a grounding rhythm that the client soon follows. Their melodies rise in 5ths and then descend. Mikko frequently follows what the therapist sings and plays not only in

melodic contour but also in dynamics and tempo. This becomes more evident in the next few minutes as they stop singing and focus on drumming.

From 16 minutes onward, there is a further exploration of the djembe. The therapist asks if Mikko has played drums before, and Mikko shakes his head no. She then models different sounds on the djembe, which Mikko follows. She asks him to play to her his favorite sound on the drum. Without hesitation, Mikko plays with all his fingers in a fluttering motion, creating a continuous rolling sound. As the session proceeds, Mikko mirrors his therapist's movements on the djembe. There are pauses and silences in between, and it looks as if he is hesitating. He waits to see if the therapist plays something. If she does, after a split second he imitates her. This turn-taking on the djembes is likewise a form of call and response similar to the previous improvisations. Most of the session is centered on this imitative and explorative "dialogue" on the djembes.

Towards minute 38, the therapist begins to hum softly on a single note while playing the djembe. Mikko picks up on this and hums while playing as well. They do a "call and response" one last time with their voices, while constantly scratching the surface of the djembe slowly, as seen in the music example on the next page (notation starts from 39' 45" and ends at 42' 22").

One can immediately see the similarities in melodic contour between therapist and client. The pitch D is repeated on several downbeats, and the sung intervals are near in range. There is rapt attention from both Mikko and his therapist as one sings and the other waits to respond, in alternate fashion. After Mikko's "Ah oh" response, they keep playing the scraping sounds on the djembe, gradually slowing down and then stopping quietly. A 15-second silence ensues after both have stopped playing and taken their hands off the djembes. The session ends as the therapist breaks the silence, telling Mikko it is time to say goodbye.

## MUSIC EXAMPLE 2

**slow, rubato**

T. Voice *mp*

C. Voice *p*

Both Djembe

Ah..(slightly trembling on note)

(scraping/scratching drum)

9

Ah..oh..eh..ah..

Ah oh peh ah

Ah oh ah..

Ah oh eh ah

Ah oh meh ah

16

*mp*

Ah oh *mp*

Ah oh

Ah oh

Ah oh peh rah

Ah oh

Ah oh

rit. . . .

rit.

Excerpt from the ending of the first session's final improvisation (39' 45" - 42' 22").

### 5.1.2 6<sup>th</sup> session (40' 35")

By the sixth session, Mikko has experienced playing and improvising on instruments such as the malletKAT (3<sup>rd</sup> and 4<sup>th</sup> sessions), mbira (4<sup>th</sup> session), metal and wood xylophones and a wood xylophone drum (5<sup>th</sup> session). The therapist would sometimes be on a separate instrument (e.g. 2<sup>nd</sup> malletKAT, cabasa, shaker, ocean drum, piano, guitar, djembe, hand drum, triangle) or as in the case of the later sessions, they would share the xylophones and piano together. She would also move around the room, experimenting with distances, while improvising with Mikko to give a sense of space to the music. As the sixth session is replete with music-making and exploring, with only a few moments of silences or pauses in between, it is difficult to know where an improvisation begins and ends.



Mikko arrives a little late but looks visibly excited as the session begins. They are both sitting at the digital piano for the first time; Mikko is on the half with higher octaves, while his therapist is on the lower half. He begins to play softly using both hands at 37 seconds, often hitting keys G6 and B6. He plays some more, then the therapist joins at 1' 07", with a lilting open 5th (D2 & A2) bass line. They improvise with a moderately slow tempo on the white keys. Often, Mikko plays single-line melodies (note after note), mordents, and trills. The slow tempo in this improvisation lasts until 10' 33" as the therapist initiates a change by playing chords repeatedly. By the 12<sup>th</sup> minute, they are both playing with fluttering fingers that sometimes sound like chord tremolos. Soon they start using both black and white keys.

At 19'02" the therapist hums on a single note while both are playing single-line white key melodies with a moderately fast tempo. Mikko joins in, and they start a vocal exchange on vowels "eh oh". The therapist sings Mikko's name out loud, and he joins as if in a duet. At 23 minutes, they have slowed down the speed of their piano playing as well as their singing but intensified their volume to fortissimo and heightened the singing pitch. Tone clusters are played loudly on 4 hands with increasing speed (accelerando) as their music reaches a climactic point. Both smile as they stop at the same time (23' 35"). What follows is the first long pause (16 seconds) in the session.

Mikko breaks the silence, playing with his hands fluttering over several notes and going on a downward glissando. This fast new section is made up of fluttering tremolos and tone clusters, eventually decelerating around 25' 30".

The next improvisation (26' 17") happens on a metal 12-note xylophone. Mikko starts exploring the instrument with eyes closed, playing with one mallet at first. The therapist joins him at 26' 35", playing together up and down the xylophone in a moderately fast tempo. After 3 minutes of sharing the instrument, Mikko's therapist hands him her mallet, and transfers to the higher half of the digital piano beside them.

Mikko continues playing on the xylophone. The therapist accompanies him on the higher octaves of the piano. This section continues with the addition of a playful vocal duet on the Finnish word for music: “musikkia”. After this duet the therapist moves from the piano to the xylophone, sharing the instrument with Mikko (she has her own two mallets now). The music is fast, active and joyful. At 38’ 15” they sing a duet on the word “moikka”, which is a Finnish greeting that can be used as hello or goodbye. In this case, it acts as a goodbye song, signaling the end of the session. This last section of the improvisation (“moikka”) is done while both are singing and sharing the xylophone. They play very actively in a fast tempo, sometimes overlapping their mallets while singing and elongating the second syllable of “moikka”. Mikko is visibly moving his upper body to the rhythm while sitting down playing (still with his eyes closed). After their speed increases, a subito piano occurs. Eventually their playing and singing tempo decreases and matches their volume. After a few soft, sung moikka’s, their xylophone accompaniment diminishes in volume (diminuendo) until both stop playing at the same time (39’ 33”). There is a 7-second silence before Mikko raises his mallets and opens his eyes.

## **5.2 Microanalysis of the 10<sup>th</sup> session (45’ 44”)**

For this session, Ridder’s (2007) video microanalysis steps are applied. As stated previously this part will include the prescribed analysis form carried out by me, the researcher (a music therapy trainee and classically-trained musician). The form is illustrated through charts divided into 3 sections: column A for observations, column B for “subjective assessment and ideas”, and column C for the analyst’s own reflections on the client’s response, client/therapist’s relational meaning in therapy and other social contexts, and plausible implications on the individual and client group overall (Ridder, 2007).

In the penultimate session, Mikko and his therapist both sit side by side at the acoustic upright piano throughout. In the previous sessions (starting from the 6<sup>th</sup> session), shared playing on one instrument increased, and this is their fourth time together on a keyboard. Apart from the therapist inviting Mikko in the beginning or thanking each other at the end of the session, no other verbal exchange is observed. There are many silences in between playing. Another prominent detail is that he plays with his eyes closed for most of this session.

Right after walking inside and sitting down Mikko motions to position his left hand on the keys, hovering above them for a few seconds. He begins playing slowly on the upper octaves of the piano at 00' 56". The therapist joins in at 1' 10". This beginning (00' 56"-2' 10") is further analyzed in Table 1 (page 24). This beginning exemplifies Mikko's change from follower to leader, as he confidently takes to starting the improvisation. This initiative has been setting the scene starting from a few sessions before. The therapist's words echo this obvious change:

Over time you could see him developing his own creativity and making choices that were more designed for him where my role became more like a supportive role. I think our relationship definitely played into what was happening [...] I do think definitely by the end [of the whole process], he had the main control over what was happening musically whereas in the beginning that wasn't happening so much.

After the first improvisation, Mikko plays another soft and slow solo. The therapist joins him, and there is a break in the music indicated by silences. They pick up speed by the 11<sup>th</sup> minute playing on tremolos but continue with the "client's solo-duet-pause" form throughout the session. Trills, tremolos, and playing with fluttering fingers are featured in many parts of the 10<sup>th</sup> session, reminiscent of former improvisations in earlier weeks. In this session the therapist and client names it "mehiläinen" (Finnish word for bees) while improvising.

Starting at 18' 53", their tempo begins to slow down more. Chords are played in a prolonged manner, and there is a sense of wanting to remain in the sound. Both play together almost simultaneously with chords that are sustained for whole beats or more (19' 00"). Thus begins a new section in the improvisation, one that the therapist recalls as "potentially the most important movement" over the course of the 11 sessions. Table 2 (page 25) shows the microanalysis of this segment (19' 00"-20' 43"). Here, the therapist recounts:

There were a lot of emotions in the sessions throughout the whole process. Mostly based on joy and humor—this growing relationship between us; so to be in the full session of just sadness is a really striking experience and really confusing for me at that time. So I think the different moments of just raw sadness, that was really striking to me, especially the song.

After this solemn improvisation, the theme of 3-4 consecutive upward notes and a note of an interval (4<sup>th</sup> or 5<sup>th</sup>) below is played by Mikko in his solo (e.g. G4-A4-B4-F4). This motif has appeared in previous sessions and is also prominent here. The client starts to sing softly, and an improvisational vocal duet on "hei" begins. They accompany themselves with more movement in the piano part.

Another segment recalling "mehiläinen" occurs. This time, black and white keys are both incorporated into the trills and tremolos. By the 30<sup>th</sup> minute the therapist introduces a short song on "dibidibido". Soon, the song stops, and the playing speed slows down again. They stay in almost the same mood for the next 9 minutes. By 39' 12", it is Mikko's 24<sup>th</sup> solo on the piano. This segment starts slow, but eventually becomes faster. Table 3 (page 26) shows their interactions (40' 10"-43' 13") in more detail. This segment becomes playful, which is one of the most common characteristics of Mikko's improvisations. He also takes the lead in the apparent musical "chase", with numerous overlapping of hands. Here is the therapist's thoughts on the use of touch in relation to working with the client:

There's definitely a lot more touch in working with this client than with any other client I've worked with before. I didn't introduce it right away. I think I started with just placing a mallet in his hand and just sort of giving him things and making that a part of the process, or if I needed him to move to a different instrument or something, I could take his hand and move it, and he was totally willing. So it felt very natural and very comfortable. And then later that definitely became part of our interplay with the cross-hands sort of chasing. Basically it just became a better form of communication than verbalization.

In the last part of the session Mikko plays a short piano solo and is soon joined by the therapist who begins to sing the goodbye song ("moikka"). Their piano-playing feature fluttering fingers, gentle tremolos and some trills. Their singing is loud and joyful. Together they hold their breaths singing for as long as they could on the last syllable. A few tone clusters are sounded as the tempo slows down.

An earnest 15-second silence follows as the last chord fades. Mikko plays a soft, single staccato note (pitch: D5) which leaves a surprising sense of playfulness and wonder to the listener. He waits a little and opens his eyes. The therapist, looking closely at Mikko, closes the piano lid as they exchange their thanks. There is a small smile on his lips as he stands up along with the therapist and walks towards the door.

TABLE 1. (00' 56"-2' 10")

A (Observations)	B (Subjective assessment and ideas)	C (Reflections on musical response)
<p>Sequence 1 Client (C) begins playing with left hand (both hands are on the piano). He alternates between using one hand and the other.</p>	<p>He is confident while playing this "explorative" solo part.</p>	
<p>Sequence 2 Therapist (T) joins playing on the lower octaves. C continues to play, focusing on his left hand. <u>He settles on pitches F4-G4, playing it with different dynamics.</u></p>	<p>Even though it is repetitive, it looks like he is trying to vary the way he presses the keys.</p>	<p>The minute changes are indicative of C's sensitive way of playing.</p>
<p>Sequence 3 T introduces a melody in 16th notes. <u>C makes his own melody in the same values,</u> while still playing F4-G4 on the left hand.</p>	<p>He takes an idea from T and adds it to his own playing.</p>	<p>He is listening creatively to what is happening in the music.</p>
<p>Sequence 4 T's accompaniment mirrors him on G2-A2, but gradually gets a little louder. <u>C's playing also gets louder.</u> He starts playing gradually softer.</p>	<p>He immediately changes his dynamics to match T's. After this he initiates the decrescendo.</p>	<p>C is independent in the way he leads the musical dynamics towards a new direction.</p>
<p>Sequence 5 C plays a very soft G4 and lets his forefinger linger there. <u>His brows are furrowed in the 10-second silence.</u> All the time T is looking at C.</p>	<p>He looks as if he is concentrating hard.</p>	<p>Even though his eyes are closed, C is aware of the sounds they are both immersed in, and is comfortable to be in the silence with T.</p>

TABLE 2. (19' 00"-20' 43")

A (Observations)	B (Subjective assessment and ideas)	C (Reflections on musical response)
<p>Sequence 1</p> <p>T and C are playing chords on the piano slowly. T hums almost inaudibly, a single note (C4). <u>C starts to sing a single note as well (A4), a little louder than T.</u></p> <p>The section starts a vocal duet on long sustained notes with both T and C playing chords on downbeats.</p>	<p>C, with closed eyes, is relaxed while humming. His breaths are deep in between pitches.</p>	<p>C is responding musically by listening and taking part in singing and piano-playing.</p>
<p>Sequence 2</p> <p>T plays chords on the lower half of piano while singing, and <u>C plays his own chords and alters the pitch of his hummed note.</u> The humming becomes an open vowel "oh".</p>	<p>It is as if he is answering her, not merely copying, in the form of a sustained, overlapping call and response on both piano and voice.</p>	<p>In a way, this movement in pitch signifies an openness to more musical possibilities.</p>
<p>Sequence 3</p> <p>Together they sing on "ah" and "oh" while playing slow chords. <u>As the piano fades out, C's voice becomes louder.</u></p>	<p>He sings the pitches with a long breath, almost right after they press chords. The quality of piano-playing corresponds to the vocalizing.</p>	<p>Both are synchronized in the way that they improvise. The two individuals share in one musical space equally, which creates a safe, seamless atmosphere.</p>
<p>Sequence 4</p> <p>T plays a moderately loud chord on a downbeat and <u>C hums softly</u> on closed vowel "ooh" until his breath runs out.</p>	<p>There is a certain poignancy to the sadness in the music. C seems conscious of the contrasts in volume as he improvises.</p>	<p>C and T are both very attuned to each other and the music.</p>

TABLE 3. (40' 10"-43' 13")

A (Observations)	B (Subjective assessment and ideas)	C (Reflections on musical response)
<p>Sequence 1</p> <p>T and C play white keys in an ascending manner and end up with their hands overlapping. They play tremolos repeatedly. <u>C smiles as he stays on the same tremolo with his left hand.</u></p>	<p>C seems to be pleased about this type of sound or playing. There is something playful about this.</p>	<p>Playing familiar sounds bring joy to both T and C. Touch is also crucial for this interaction to take place.</p>
<p>Sequence 2</p> <p>Their overlapping hands break apart and C starts playing tone clusters on both hands. His arm movements are big.</p>	<p>He is very involved in the music-making, and his body language reflects this as well.</p>	<p>The physical space is as important as the musical space they are in. Music is embodied.</p>
<p>Sequence 3</p> <p>T plays tone clusters that includes more low notes. As she does this, <u>C moves his hands further apart</u>, producing a wider range of pitches on his half of the piano.</p>	<p>C finds it easy to take the lead in music-making. He is not afraid to experiment with the distance and mix of ranges.</p>	
<p>Sequence 4</p> <p>After T plays a loud downbeat on very low tone clusters, C plays clusters with both hands emphatically. His shoulders are also moving along with his arms, he is still smiling, and his eyes are still closed.</p>	<p>T provides C with support (her music seems to say "I am here") and he answers to this in his own way.</p>	<p>C might be relying more on senses other than sight as his condition worsens. His attentiveness and focus are mirrored in the music, his facial expressions, and movement.</p>
<p>Sequence 5</p> <p>T and C are playing tremolos with hands overlapped again. This time, <u>they move up and down the white keys together, and C smiles.</u></p>	<p>C is immersed in the experience of playing side by side with T.</p>	<p>Togetherness is central to both client and therapist.</p>
<p>Sequence 6</p> <p>While playing tremolos, T presses on the black keys. <u>C hastens his speed</u>, which leads to them to moving faster up and down the keyboard.</p>	<p>The music sounds like a "cat-and-mouse" chase here.</p>	<p>Client changes the pace of the improvisation, which shows that he is also engaged in its temporal aspect.</p>



## 6 RESULTS

The microanalysis of three different episodes in the 10<sup>th</sup> session (approximately 6' 33" in total) yielded several specifics in the significant musical interactions. Connecting these salient details to other available data gives another perspective to what transpired in Mikko's whole therapeutic process. Selecting segments based on the criteria "something important is happening here" (Bonde, 2007) and based on aggregated observations and thoughts by the music therapist (via verbal description and semi-structured interview), and my personal notes, these three episodes were exceptional in that they showed the client's change in being a follower in music to a leader and at times, partner. This is apparent in the way he interacts and responds to the therapist's music, and in the way he is in control of the improvisation and the direction of the music. Improvisation could be a daunting task, but for this particular client it came naturally, contributing to the organic quality of the nonverbal interaction. As described by Wigram, Pedersen, & Bonde:

Music in music therapy often unfolds in a non-verbal context. Clinical experience shows that musical improvisation can enhance the implicit dimension of an experience. Musical interaction is therefore considered a means of making clear the fundamental elements of interaction and thereby the basic ways of relating. (2002, p. 87)

The selection of these interactions was somehow akin to determining meaningful moments by Amir (1992) which "implies importance, impact, significance and possible transformation" (p. 5). The results of the microanalysis point to particular interactions made prominent in the 10<sup>th</sup> session, however these are also discussed in relation to the whole process.

## 6.1 Sound

### 6.1.1 Voice and instruments

In the sessions, singing and playing instruments, together, on their own, or in combination counted as significant sound interactions. Significant musical interactions concerning the use of voice were: 1) humming (either on vowels or non-lexical vocables) and 2) singing (both together and in turns), typically on a single word provided spontaneously by the therapist.

The humming duet that happens in the 10<sup>th</sup> session is soft, slow, and legato. The client and therapist accompany themselves on downbeats with tone clusters that bring to mind a kind of solitary sadness, a lamentation. Mikko uses his whole breath, exhaling deeply throughout the tone. His therapist supports him vocally, matching the intensity of his breath while keeping her pitch softer than his own. Here, the therapist recounts:

This is potentially the most important movement that we did over the entirety of our sessions. It's very obviously musically emotional. And it felt emotional doing it... I think at the time I felt a little bit lost and I was just sort of trying to go by what he was doing, and I wonder if feeling lost is actually sort of part of it, this is our second to the last session and obviously we couldn't really verbalize what that meant. But this was essentially right before we were going to have to say goodbye. And we had a really good relationship. So I think that a lot of what's happening here is that those emotions are coming through for both of us, and it's just sort of a raw expression of "this is what's happening and there's nothing we can do to stop it" but we just have to sort of let it. It's to me almost a grieving sort of song, it's also very beautiful.

Other significant musical interactions concerning the use of instruments occurred mostly by joint instrument-playing (duets and in turns). In the later sessions, the piano was the main instrument for both client and therapist. Michel & Pinson (2012) supports the view that "keyboard instruments are 'naturals' for most persons with visual impairment" because of its accessibility and logical tonal grouping. Sitting side by side and sharing this instrument afforded Mikko and his therapist a different level of closeness, nurturing the therapeutic relationship further. In the therapist's own words:

I think when we established the piano as the appropriate instrument, that was an important moment. He could definitely creatively express himself on many instruments and seeing him work on the Malletkat was really interesting. But I felt like the piano was where he seemed to express himself the best and especially with me sitting directly next to him where we had a connection that worked for the both of us.

### **6.1.2 Motifs**

Throughout the entire 11 sessions, there were sounded motifs that were noticeable in the client and therapist's instrument-playing. A motif (sometimes spelled motive) is a "small but recognizable musical unit" (Motif in music, n.d.). Typically, it consists of a combination of distinct pitches, rhythms, or other harmonic elements which must be recurrent. A motif is a pattern that even when altered, can still be recognized. Some important motifs from all the sessions include: 1) playing that resulted in either trills, tremolos, or a rolling/fluttering sound, 2) a short melody of 3-5 consecutive pitches rising and falling, and 3) tone clusters. These are clearly prominent in the 10<sup>th</sup> session, where the client improvises around them.

## **6.2 Silence**

In the music therapy sessions with Mikko and his therapist, one unexpected aspect of musical interaction I found as I watched and analyzed the videos repeatedly was the silence. My principal focus was musical interaction after all, and that meant I was listening to the music as sound. As I was noting down the description of sounds, I realized I had also noted the duration and description of silences as they happened. This led to a thought: music is not only in sound but also in silences. It is the interplay between these two that make up music. Silences are described by Sutton (2004) as "not only active components of music, but they are also not static within themselves." Accommodating both the sounded and silent parts of the improvisations in microanalysis expanded the focus of significant interactions.

## 7 DISCUSSION

Ruud (1998) points out the parallels between musical communication, improvisation, and interaction. Frohne-Hagemann and Schumacher (as cited in Kurstjens, 2009) also gives importance to interaction in improvisation. The former “regards the therapeutic relationship as an active and dynamic occurrence in which the therapist and client are interactively dependent on each other” (p.182). The latter develops this idea further and argues that there is a “continuous development of quality in interaction from no contact to mutuality in the relationship.” These dynamic moments are most visible in Mikko’s improvisations, and the resulting musical interactions between client and therapist—specifically the sounds, the silences, and the intangible space of togetherness in musicking.

As shown in Mikko’s therapeutic process, music clearly was not only a noun but also a verb. This concept of ‘doing music’ was first proposed by musicologist Christopher Small, in his 1998 book entitled *Musicking: The Meanings of Performing and Listening*. It has since been applied in different areas of music, as well as in music therapy. Musicking (sometimes spelled without ‘k’) is defined as:

to take part, in any capacity, in a musical performance. That means not only to perform but also to listen, to provide material for performance (what we call composing), to prepare for a performance (what we call practising or rehearsing), or to take part in any activity that can affect the nature of that style of human encounter which is a musical performance. (Small, 1999)

At the heart of musicking is something intuitive; an activity, a capacity that all humans possess. It is not performance in the traditional sense, rather it encompasses a broader experiential encounter between people.

Improvising together and in turns provided ample space for listening and responding. It acknowledges the presence of another, while recognizing one’s self. Safety, then, was of utmost importance to this interaction. The establishment of a good working

alliance had to be achieved through this trust in being seen and heard musically in a nonjudgmental way. As a possible by-product of this safe connection in musicking, oftentimes, client and therapist would also synchronize in their playing and stopping. Touch as a nonverbal communication also played a part in furthering the therapeutic relationship.

In music therapy, vocal and instrumental improvisations carried with them reflective, implicit meanings and emotions. The voice is considered to be the “primal instrument” which connects us to our innermost selves (Baker & Uhlig, 2011). It is a vehicle for communication and expression, and it may reveal a person’s emotions. Closely related to the use of voice is the use of breath. Breath is a vital part of life, connecting the psychological and the physical. We sing and breathe with our voices through our own bodily instrument. We resonate and are connected to the sound vibrations. “We make the music, we are immersed in the music and we are the music.” (Austin, 2008, p. 20) Evidently, the client and therapist’s voices mirrored their personal worlds, especially in the later sessions, in the melodic moments of improvising together. As the client takes the lead in humming and changing pitches, he invites her to his inner world. In a way, the vocal interactions enable the nonverbal sharing of selves.

The motivic episodes in music therapy featured rising and falling of pitches, a varied range of tempos, rhythms, and sounds that Mikko could associate himself with. These motifs arose spontaneously during improvisations and were established as seemingly preferred, or at the least, familiar sounds by the client. Mikko and his therapist would treat them as small units in their repertoire of sounds which they could order in any way they liked. More importantly, Mikko understood his liberty to recall, vary, and combine them as he improvised. Combining and creating motifs became a ground for endless musical possibilities. It also provided imagery and character to the overall musicking. This opportunity in music represented a possibility for where the interactions could thrive.

Silence, which is an important component of music renders itself naturally ambiguous, yet functional. It is the organic space which can be full or void of meaning all at the same time while helping shape the structure of music itself. In terms of Mikko's therapeutic process, silences changed quality over time, much like its sounded counterparts. Sutton (2007) observes that silence can indicate an "exchange of turn" and "a structural point in the music". Changes, either in pace or texture often go together with it. In earlier sessions where Mikko would often imitate what his therapist played, silences served as moments of waiting and hesitating in between the sounds, seeing who would play next. As the sessions progressed both became more comfortable and vulnerable in the silence, both took time for a section to start and finish; there was, in De Backer and Sutton's (2014) words, 'preparation silence' or 'anticipating inner silence' which "allows one to come into resonance with oneself and, in a music therapeutic context, with the other, where an inner space must be created, from which an authentic musical play derives" (p. 52). In addition to hearing the silence as part of the improvisation, it helped Mikko and his therapist integrate a mutual form into the musicking. In the therapist's own words, her experience of Mikko's silences went through changes as well:

At the beginning, I really struggled with those silences because I didn't want to interrupt him. I really felt that those silences were important to let them exist in their entirety, but I also felt like in the beginning it made pacing very difficult for me, and when it came to transitioning to something. It was very difficult because he wouldn't know if something was over or just in pause, so closer to the end, I was a lot more able to read the silences and I still didn't interrupt him; whether it was a pause or an ending, to allow him to be the one who broke it, especially when those later pauses are really breaks between movements, rather than endings.

As the sessions went on, it seemed that Mikko was able to be more himself within the entirety of music: sounds and silences included. His therapist confirms:

It's a deeply musical thing to be able to maintain something for 45 minutes, that's some short symphonies, it's a lot of music and it's all connected. What generally struck me most was that this client was creative and inherently musical.

Therapist and client's improvisatory musicking may have aided significant musical interactions to arise. Although 11 sessions in music therapy is a short time, it was enough for Mikko and his therapist to share in the free flow of musical exchanges something that is hard to describe in words. This thesis was an attempt to capture some of the significant moments that transpired between client, therapist, and their music in the hopes of exploring how the process occurred and changed. Because he was able to lead and structure the improvisation and thus the musical interactions in the later sessions more independently than before, it is possible that Mikko was able to reveal his innermost feelings through the music. Throughout his process there had been this atmosphere of joy and inquisitiveness in his playing that was always evident in the musical interactions. In the penultimate session, perhaps related to terminating the process and saying goodbye, or a sense of grief for coming to terms with his worsening condition, Mikko felt safe enough to explore with his therapist and venture into something unhappy yet still meaningful and creative.

## 8 CONCLUSION

Looking at the microlevel of musical interactions in music improvisations shows the exact points in time where music therapeutic interventions elicit responses that contribute to the achievement of individual client goals. In this study, those moments are found in the use of voice in singing and humming, playing instruments in a shared manner (together or in turns), along with motifs that resurface every so often. Moreover, sharing the musical space together through interaction offers an understanding into this particular client's process. The establishment of a good therapist-client relationship via musicking the sounds, silences, and other emergent improvisational motifs aided the client's progress. From turn-taking to playing together more often, to the client soloing and the therapist taking a more supportive role as they play together, musicking may further provide insight to the way the interactions grow and change over time. Some of these facets of working fruitfully have already been featured in the existing literature while some that are not may offer new insight in working with visually-impaired clients.

This case study explored and investigated the microprocesses within clinical improvisations of a person with visual impairment in the hopes of providing a closer look at the music in therapy with an under-researched clinical population. Further research in the future is still needed within this area, especially across ages and severity of impairment, as this study only focused on one adult client with late-onset visual loss, who may have had an undisclosed musical background. Another recommendation is to include several external analysts to strengthen the microanalysis.

On one hand, the use of microanalysis in music therapy is a step forward in showing how specific moments that make up music therapy may help clinicians, students, and maybe even professionals from other fields, to understand what happens within a



session (or sessions), in relation to the whole process. On the other hand, it is an incredibly time-consuming, arduous task that has been personally a challenge for me as a music therapy student with limited clinical experience. Nevertheless, this case study supports the view that music therapy alleviates and addresses possible issues for the visually impaired, who, as most existing studies have reported, are generally sensitive to sound, responsive to music, and are at risk for psychological distress. In this case, the microanalysis of Mikko's musical interactions during clinical improvisation in therapy shows that he was able to express himself, communicate emotions, and liberally explore his creativity through music over time.

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## Session graphs

