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How Music Therapists Experience Improvising with Nonspeaking Clients: A Thematic Analysis

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HOW MUSIC THERAPISTS EXPERIENCE IMPROVISING WITH NONSPEAKING CLIENTS: A THEMATIC ANALYSIS

A Thesis Submitted to Molloy University

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by

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A thesis committee has examined the thesis titled

HOW MUSIC THERAPISTS EXPERIENCE IMPROVISING

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And hereby certify that the thesis was read and approved by the committee.

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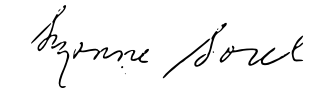

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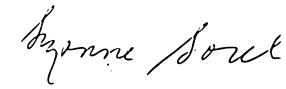

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ABSTRACT

The purpose of this study was to explore music therapists' subjective experience improvising with nonspeaking clients with intellectual disabilities. The research question addressed was: How do clinicians experience improvisatory music-making with clients who are nonspeaking? In music therapy, the client and the therapist both have significant roles to play within the therapeutic relationship. Three music therapists with at least five years of experience primarily using improvisation when working with nonspeaking clients with intellectual disabilities were chosen via purposeful sampling to participate in this study and were individually interviewed to discuss their subjective experiences. Data were collected through individual semi-structured interviews and was analyzed using thematic analysis. The themes that emerged among the participants from the data collected were: 1) *Value-driven approach to practice*, 2) *Reflexivity through internal dialogue*, and 3) *Connecting with nonspeaking clients through various types of relational communication*. The three themes brought forth by this study offer unique takeaways that may provide insight for therapists who work improvisationally with nonspeaking clients and for therapists who work in other approaches/settings. A more expansive understanding of the therapist's experience may provide therapists with nuanced insight on the interactions between the therapist, the client, and the music improvised within a session.

Keywords: Music therapy, intellectual disability, improvisation, therapist experience, nonverbal/nonspeaking client(s).

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CHAPTER 1: INTRODUCTION

This study aims to explore the subjective experiences of music therapists who work with nonspeaking clients that have also been diagnosed with intellectual disabilities. This topic piqued my interest throughout my undergraduate and graduate careers. My curiosity has since grown now that I am both completing my final year of graduate school and working professionally as a board-certified music therapist in a private practice setting primarily serving individuals diagnosed with varying intellectual disabilities.

My connection to this study began during my graduate-level internship at The Music Academy for Special Learners in Suffolk County, New York during my final year of my undergraduate career via Molloy University's dual degree music therapy program. At The Music Academy (under the supervision of Nick Farr, MS, MT-BC, LCAT), I had the incredible opportunity to work with diverse clientele and staff who expanded both my knowledge and personal philosophy about music therapy. It was at The Music Academy where I learned an immeasurable amount about working with those with intellectual disabilities. With the support of my supervisor, I was able to dig into research that inspired my own treatment planning. While combing through various academic journals, I discovered a plethora of studies regarding the music therapy method of improvisation as it relates to working with people with intellectual disabilities. After completing my internship, becoming credentialed, and starting work clinically and administratively at The Music Academy, my interest in improvising with nonspeaking clients continued to grow. Within my work so far, I have experienced meaningful connections that have existed solely within music-making, which makes me curious to know if and how other music therapists have perceived such musical connections.

I identify most with a humanistic approach to music therapy, as this approach best reflects both my training and current philosophy towards music therapy. According to Abrams (2015), humanistic music therapy refers to:

> …the psychotherapeutic space wherein the personal and transpersonal development of the person through sound and music is facilitated, using an approach emphasizing respect, acceptance, empathy, and congruence (p. 150).

When practicing from a humanistic perspective, I regard each of my clients "first as persons and, hence, as beings" (Abrams, 2015, p. 151). I appreciate humanistic music therapy's assertion that it is important to regard clients as "whole" people, as all clients "retain their personhood and their ethical rights to basic dignity and respect, regardless of biobehavioral status" (Abrams, 2015, p. 151). In my clinical work, I prioritize the "who" within client needs, as opposed to the "what" (Abrams, 2015). The idea that a "client's very existence as a person is relational" resonates with me (Abrams, 2015, p. 151). I work improvisationally within my sessions to foster environments where my clients can truly be themselves through interacting with me and with the music created. I value how, in music, clients can simply "be," in whatever way this looks for them. I understand this sense of being as related to a manifestation of someone's authentic self. From a humanistic perspective, music allows clients to engage in ways that are accessible and diverse (e.g., singing, dancing, playing, listening, and witnessing that feel genuine to their subjective experience). The authentic, meaningful interactions that occur in my sessions feel incredibly potent and make me curious about how other clinicians perceive their sessions when working improvisationally with clients with intellectual disabilities.

As a practicing music therapist, I understand that my own musical ideas and inclinations will come forth in sessions alongside those of my client's. I know that my client will not always

be the driving force behind every improvisatory interaction, and that the therapist plays an important role in establishing communication with clients via music-making. Digging into the clinician's perspective may add valuable understanding to the therapist-client relationship that inevitably develops between the two parties. Furthermore, I believe that exploring the clinician's point of view will add meaningful insight to the perceived interactions between the clinician and client.

CHAPTER 2: LITERATURE REVIEW

In order to fully explore the background of music therapy improvisation with nonspeaking clients who have also been diagnosed with intellectual disabilities, this literature review will identify definitions and relevant studies of music therapy, intellectual disability, and social communication; needs of individuals with intellectual disabilities; music therapy with individuals with intellectual disabilities; music therapy improvisation with nonspeaking clients; experiences of music therapists working in improvisation; and experiences of music therapists working with nonspeaking clients. The studies reflect both music therapy and non-music therapy research to provide comprehensive background to support this research study.

Definitions

Music Therapy

The American Music Therapy Association defines music therapy as "the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program" (Wheeler, 2015, p. 5). Bruscia (1998) adds that "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. 18). Bruscia (2013) separates the possible uses of music in music therapy into four main music therapy methods: improvisation, re-creative, compositional, and receptive.

Music Therapy Method: Improvisation

While there are many different working definitions of the word "improvisation," I have identified two resources that directly relate to my experience and understanding of specific

improvisatory ideologies as they pertain to clinical contexts. Gardstrom and Sorel (2015) acknowledge Bruscia's (2014) definition of improvisation:

> Improvisation in music therapy includes any experiences in which the client actively participates in spontaneous music making with the therapist and/or other clients--playing instruments, vocalizing, or sounding their bodies or other objects (p. 122).

Gardstrom and Sorel (2015) also state that "improvisation that is centered on meeting clinical goals is often referred to as clinical improvisation" (p. 122). McFerran and Wigram (2010) add that, within the therapeutic context, "musical improvisation is about stepping into a free musical space" (p. 140).

Nordoff and Robbins (2007), who first used the phrase *clinical improvisation,* describe the therapists' experiences in improvisation this way:

> ...intuition guides the will in how to act; inspiration then creates the music that realizes the intuitive impulse, gives it musical expression, and channels it into coactivity. When intuition is directly linked to musical inspiration, it manifests in new musical ideas, and in the timing and style of playing for the child (p. 41).

Nordoff and Robbins (2007) also provide insight into improvising with nonspeaking clients. They state that improvising offers creative ways for clients to develop relatedness and communication via instrument-play and musical conversations that further emphasize the human experience and "being" in the music (Nordoff & Robbins, 2007). Verbal directions are not always necessary in Nordoff-Robbins music therapy, as clients can be responsive to musical cues and naturally respond to the motivating aesthetic qualities of the music (Nordoff & Robbins, 2007).

Because Nordoff-Robbins clinicians consider their reactions and responses when working with clients, their experiences seem to be an important part of how they understand the efficacy of clinical improvisation, and thus support the exploration for this study. According to Nordoff and Robbins (2007), the question of "who" (the therapist or the music) is the catalyst for change within a music therapy session is described as follows:

> It is indisputably both; the therapist and his/her clinical musicing are inseparable. The energy is one creative whole. The musical improvisations are both the direct expression of the therapist's presence and style of approach, and simultaneously the medium through which he/she [they] explores a child's responsiveness and applies therapeutic intentions (p. 43).

This idea further supports the need for this study, as the therapists' perspectives are essential in developing the therapeutic relationship with clients. Because musical improvisations can be a direct expression of a therapist's style, it seemed salient to explore how the therapist experiences working with nonspeaking clients (Nordoff & Robbins, 2007). I aimed to explore how the therapist's perspective influences their work with their clients.

Intellectual Disability

There are differing lenses and models of disability that exist through which intellectual disability can be conceptualized. For example, the medical model views disability as a deficit (as opposed to a difference) within an individual (Pickard et al., 2020). The DSM-5, which reflects a medical model perspective, characterizes intellectual disability as "deficits in general mental abilities, such as reasoning, problem solving, planning, abstract thinking, judgment, academic learning, and learning from experience" (American Psychiatric Association [APA], 2013, p. 31). Said deficits generally result in impairments in adaptive functioning, in that individuals who

have been diagnosed with intellectual disabilities commonly face challenges in meeting standards for personal independence and social responsibility (APA, 2013, p. 32). These challenges can be seen during daily life, including but not limited to communication, social participation, and personal independence at home or in a community setting (APA, 2013, p. 33).

The social model of disability assumes that individuals with disabilities face barriers in their societies that inhibit their access to opportunities and equitable participation in society (Pickard et al., 2020). The social model urges us to examine how our understanding of intellectual disability has evolved as we re-examine the social contexts and constructs in which individuals live, are raised, and the services they have had access to. The American Speech-Language-Hearing Association [ASHA] (2022) states that the paradigm shift surrounding intellectual disability continues to move from a medical standpoint to more inclusive practices. For example, in the 1980s, it became increasingly more common for people to use the term "intellectual disability" instead of "mental retardation" when it came to referring to those with intellectual disabilities because of the negative stigmas associated with "mental retardation" (ASHA, 2022).

Related terminology has also evolved over time to reflect the "legal and social gains made by individuals with a disability and their families" (ASHA, 2022, para. 3). This evolution began in the 1970s, where advances in laws relating to the delivery of services to those with intellectual disabilities began, and continues to evolve in the present-day (ASHA, 2022). This can be most notably observed beginning in 1975 with The Education for All Handicapped Children's Act (PL 94-142), which mandated free, public education in the least restrictive environment possible for all children with disabilities (ASHA, 2022). (Language has since developed to negate the use of "handicapped" when describing disabilities.) Since 1975, new

laws have been passed in almost every decade to promote the most current contextualization of society's understanding of disability (ASHA, 2022). As a result, the social model of disability continues to reflect the continuously-evolving nature of understanding intellectual disabilities.

Nonspeaking Versus Nonverbal

In this study, I used the term nonspeaking instead of nonverbal. Past research often utilizes the term nonverbal to describe those who do not use spoken language. However, as language has developed and evolved over recent years, I have adopted a more inclusive term, nonspeaking, to describe individuals with these same challenges, including those who do not use spoken language, those who can vocalize syllables, and those who utilize other modalities to communicate (Guild For Human Services [GFHS], 2021).

According to the DSM-5, the term "nonverbal" is characterized under communicative disorders, which include language disorder, speech-sound disorder, social (pragmatic) communication disorder, and childhood-onset fluency disorder (APA, 2013). The nonverbal diagnostic can also be found in those with autism spectrum disorder and varying forms of intellectual disability, depending on diagnosis severity (APA, 2013). The DSM-5 states that when an individual is found to be nonverbal, this means that the individual communicates without using spoken language, which is otherwise defined as having "no intelligible speech" (APA, 2013, p. 53). To be deemed nonverbal, an individual must be evaluated via culturally appropriate standardized language tests (APA, 2013).

The term "nonspeaking" also refers to individuals as described above (under nonverbal), but this term more accurately portrays the spectrum of language that exists among individuals who are nonspeaking (GFHS, 2021). This term evolved in recent years, in response to the varying ways in which this community communicates. Nonspeaking refers to individuals who

are non-oral, non-vocal, minimally-speaking, and/or who utilize other modalities of communication (GFHS, 2021). Other modalities may include, but are not limited to, American Sign Language (ASL), picture symbols/cards, and Augmentative and Alternative Communication (AAC) technology devices (GFHS, 2021). In addition, the term nonspeaking gained traction because of its effort to avoid implying a lack of understanding of receptive language (GFHS, 2021). Overall, "nonspeaking" may offer a more inclusive way to describe the variety of ways that communication may exist, and may also provide groundwork for nonspeaking individuals to be seen as simply having different needs, without necessarily requiring these needs to be fixed (GFHS, 2021).

Contexts for Individuals with Intellectual Disabilities

Causes

Huizen (2020) explains that intellectual disabilities can typically develop as a result of injury, disease, or certain brain conditions (though precise causes are still unknown). Conditions that impact the head/brain from pre-birth to 18 years of age can cause intellectual disabilities. This means that intellectual disabilities may be evident right after birth, or develop later in life, depending on contributing factors (Huizen, 2020). The Centers for Disease Control and Prevention [CDC] (2022) states that examples of potential causes of intellectual disability include, but are not limited to, maternal infections during pregnancy, extreme malnutrition pre/post-birth, insufficient oxygenation during birth, exposure to toxins pre/post-birth, infections, genetic conditions, fetal alcohol syndrome, serious head/brain injuries, congenital/brain malformations, and insufficient medical care pre/post-birth (CDC, 2022). These factors can lead to an intellectual disability diagnosis that presents challenges in intellectual, practical, and social functioning (Huizen, 2020).

Areas for Support

While each person may have their own unique areas to be supported in, common domains impacted by an intellectual disability include intellectual, practical, and social functioning (Huizen, 2020). Individuals with intellectual disabilities can experience a range of impairments based on the severity of their specific diagnosis (Butler, 2020; CDC, 2022; Hines & Burrows, 2023; Huizen, 2020; MTCC, 2019). Challenges may include difficulty reaching developmental milestones, understanding social cues, communicating, and regulating emotions or behaviors (CDC, 2022). Those with intellectual disabilities may also experience educational challenges, such as underfunded special education programs or limited access to assessment/services, that may impact the development of motor, social, communicative, and emotional skills (Hines & Burrows, 2023). It is possible that people with intellectual disabilities may also face challenges in the workplace and may need additional support in finding employment opportunities and in carrying out workplace tasks (Savoie, 2022). In addition, people with intellectual disabilities may face many varied challenges related to life expectancy due to possible comorbidities, lack of applicable medical/psychological care, and/or the ability to obtain health insurance (Hines & Burrows, 2023).

In terms of broader areas of support within the community, there has been a shift in how people with disabilities self-advocate for rights, benefits, and recognition in society. Qualitative studies centering around individuals diagnosed with intellectual disabilities have highlighted how acceptance within an ableist understanding of intellectual disabilities is important to consider. Butler (2020) interviewed individuals with intellectual disabilities about their experiences with self-advocacy and found that self-advocacy and first-person voices are of utmost importance to this community. Butler (2020) also acknowledges the oppressive legal and societal systems that

generally surround the rights of those with intellectual disabilities, and voices the opinions of the community's members:

> The space to speak without ableist limitations in order to "destabilize common understandings" of people labeled with intellectual disabilities is an important condition… Using their voices through self-advocacy stories to raise awareness about their lives, and destabilize common understandings, also guards against other downsides of political voice (p. 238).

The Music Therapy Center of California [MTCC] (2019) adds that, from the perspectives of those with intellectual disabilities, "...it is essential to provide opportunities for self-expression" (MTCC, 2019, para. 2). Even if clients are nonspeaking, it is still important to provide them with alternative ways to express themselves in manners that allow them to exercise their agency and self-advocacy (MTCC, 2019). Similarly, Jeong and Darroch (2021) state that "observing behavior and listening to clients are essential…" (p. 36). Darroch is an autistic individual who directly discusses the need for opportunities for self-advocacy, regardless of communicative styles and abilities (Jeong & Darroch, 2021). This further emphasizes the importance of agency within this community. Understanding what ways, if any, music therapists provide opportunities for self-expression, communication, self-advocacy, and agency when engaging nonspeaking individuals in improvisation could shed light on the therapists' perceptions of this relational clinical work.

Communicating and Engaging with Nonspeaking Clients Through Improvisation

Improvisation can play an important role by providing clients with musical, embodied, and gestural opportunities to communicate. Goals areas commonly addressed in music therapy

can include the development of communication, conceptual, and social skills, all of which can be supported via improvisation.

Thompson and McFerran (2015) investigated the impact of music therapy on communicative behaviors in adolescents with profound intellectual disabilities. The researchers concluded that music therapy provided an interactive platform for the clients and therapist in a way that promoted positive interpersonal skills (Thompson & McFerran, 2015). Similarly, Graham (2004) emphasized music therapy interventions with adults with learning disabilities and communicative goals. An emphasis was placed on the different, unique ways the individuals communicated in terms of vocal and facial gestures, especially via improvisatory interventions. Graham (2004) also highlights how interactive relationships were developed through the therapists' vocal/facial imitation, reflection, extension, and repetition of the clients' improvisatory communication.

McLaughlin and Adler (2015) also address improvisatory communication in music therapy. The authors explain:

> By facilitating children's movement, singing, playing of instruments, and listening, music therapists are able to reinforce a range of communication skills that includes initiating communication, listening, sequencing, developing concepts, acquiring vocabulary, and vocalizing (p. 281).

McLaughlin and Adler (2015) assert that "music therapy plays an active role in providing an environment that supports the teaching and generalizing of social skills" (p. 282). Similarly, Swaney (2019) focuses on the impact of communication through music-making via improvisation on the emotional well-being of clients with intellectual disabilities. McLaughlin

and Adler (2015) add that, in improvisatory music-making, meaningful outcomes include optimizing musical participation and addressing goal areas within the therapeutic relationship.

In addition, Guerrero et al. (2015) delve into theories originally proposed by Nordoff and Robbins by stating that "music serves as the essential medium of communication and interaction" (p. 186). The authors note that improvisation is utilized to draw clients into musical interactions that "spark attention, active listening, and reciprocity" (Guerrero et al., 2015, p. 186). Nonspeaking clients may engage in improvisatory experiences that foster communicative interactions through spontaneous music-making or structural music-making, such as turn-taking or call-and-response techniques (Guerrero et al., 2015). McCord (2009) adds that improvisation can be seen as a "sophisticated form of self-expression," and can be utilized with all participants, regardless of ability (p. 25). McCord (2009) also states that, in her research, clients who were provided with reciprocal opportunities to improvise increased their communication skills as a result. Though the clients in her research were nonspeaking, improvisation provided them with the opportunity to express themselves and communicate more effectively (McCord, 2009).

The aforementioned literature focuses primarily on the clients' experiences in music therapy, as well as the results of music therapy interventions, rather than the therapists' experience. In this study, I aimed to learn more about how communication through improvisation is facilitated, if at all, from the therapist's point of view. Exploring the therapist's perspective provided meaningful insight into how communication is fostered, especially if the therapist is initiating much of the music-making or improvisational experience. Questions that came to mind when I designed this study included: When clients begin communicating via improvisation, how do therapists foster communication? How do therapists support clients in spontaneous music-

making to promote further communication? These are questions I also hoped to answer by studying the therapists' perspective.

Experiences of Music Therapists Working with Improvisation

The experiences of music therapists working in improvisation vary greatly, and themes have emerged in existing literature to address commonalities and differences. For example, McCaffrey (2013) explored how music therapists working within a range of clinical settings locate their sense of "self" when engaging in clinical improvisation. Five main themes that were revealed in the study were "mindful meeting of equals, importance of fundamentals, flexibility/adaptability, personal fulfillment, and balancing professional/musical selves" (McCaffrey, 2013, p. 308). The findings of this study suggest that there is a relationship between the improvisation that music therapists create and the senses of "self" that exist for music therapists, which can further impact the interactions between the therapist and client(s). Similarly, Chen (2019) studied themes that emerged among music therapists working in adult inpatient psychiatry who use clinical improvisation as a main music therapy method. Chen's (2019) results coincide with McCaffrey's (2013) findings in terms of a common theme: McCaffrey (2013) notes flexibility/adaptability to be an important part of the therapists' improvisatory experience, and Chen (2019) writes that "flow," in terms of intentional creativity, is equally important for the therapists to experience when working with clients (p. 162).

Bodner and Polansky (2016) provide a different point of view, as they focused on the therapists' opinions of the emotional qualities of improvisation in their research. Their study found that music therapists working from humanistic frameworks in a variety of settings may experience varying degrees of emotional connections to their improvisational work, and, depending on their client interactions, may see their emotional connections as either contributing

to or taking away from the improvisational experience (Bodner & Polansky, 2016). Meadows and Wimpenny (2017) similarly found that music therapists working in diverse clinical settings also experience clinical improvisation as a "representation of the psyche" (p. 188). Meadows and Wimpenny (2017) raised questions about how the theoretical differences among therapists may contribute to the way they experience and understand music in the therapeutic relationship with their clients.

In this study, I aimed to interview music therapists who may have diverse theoretical orientations to better understand how these orientations may inform their experiences and perceptions. Further, I was inspired to dive deeper into how improvisatory music may allow music therapists to develop their own sense of "self" while working with clients, especially in terms of therapists working primarily with those with intellectual disabilities.

Experiences of Music Therapists Working with Nonspeaking Clients

The experiences of music therapists working with nonspeaking clients also vary, though commonalities and differences have surfaced due to the expansive range of work that improvisatory music therapy encompasses. For example, Swaney (2019) states that, within her sessions with individuals with little to no expressive language, she often utilizes improvisation as the predominant music therapeutic approach. She states: "In my work with people whose disabilities are severe and profound, through musical experiences I seek to connect with a person's capacity for emotional relatedness" (Swaney, 2019, p. 70). Devlin (2018) also provides a detailed account in relation to working with individuals with intellectual disabilities by addressing the question, "How do I see you, and what does that mean for us?" (p. 234). By keeping this question at the forefront of every session, Devlin (2018) states that this creates an understanding of who her clients are as people and how this understanding informs her work

with clients. Similar to Swaney (2019), Devlin (2018) also reflects upon her research from a subjective perspective and examines her work to better understand her relationship with her clients. Through reflexive questioning, Devlin (2018) repeatedly evaluates how she sees her work as a clinician, and how this impacts the work she facilitates in her music therapy sessions.

Swaney (2019) and Devlin (2018) reflected on first-person observations of direct clinical work, which underlines the relevance of the clinician's perspective in the work. This perspective is similar to this study in that this study highlighted how a therapist's perceptions may provide insight regarding the clinical work. If specific decisions were made, I wanted to understand why and how, including the clinical intent and clinical rationale. These questions may provide insight into how the therapists' subjectively experience working with clients. The benefit to exploring the therapists' perspectives was to gain a more well-rounded understanding of how their choices impact their improvisatory work with nonspeaking clients.

CHAPTER 3: METHODOLOGY

This study sought to investigate the subjective experiences of music therapists working via clinical improvisation with nonspeaking clients who have been diagnosed with ID. The research question addressed was: How do clinicians experience improvisatory music-making with clients who are nonspeaking?

Research Worldview

An interpretive epistemology guided this qualitative research study, which focused primarily on the music therapists' lived experiences. According to Wheeler (2016), interpretivist research aims to uncover the world from the lens of how an individual might experience their subjective surroundings. An interpretivist epistemology can be analyzed via three main questions: 1) What is studied? *Experience*, 2) Who does the interpreting? *Researcher's and others',* and 3) How is the interpretive process undertaken? *Analysis of experiences.*

Abrams (2010) asserts that subjective research (within interpretive epistemology) aims to understand the meaning behind a participant's personal reality. This study aimed to help readers understand each participant's subjective experience by finding the commonalities and differences that exist among participants. Their statements were interpreted to draw connections to both the topic and each other, which further relates to a broader understanding of the therapist's experience.

Research Design

This study utilized a qualitative research design that implemented interpretivist methodology. As supported by Wheeler (2016), this study focused primarily on the music therapists' lived experiences and included interviews for data collection and thematic analysis for data analysis.

Participants

Three music therapists who met the inclusion criteria were chosen via purposeful sampling to participate in this study. The inclusion criteria for the therapists were as follows:

1. Must have completed a minimum of a Bachelor's Degree in music therapy.
2. Must be a credentialed music therapist (with at least 5 consecutive years of experience working as a music therapist) and currently conducting clinical work.
3. Must have at least 5 years of experience working with nonspeaking individuals diagnosed with intellectual disabilities.
4. Must have at least 5 years of experience implementing improvisation as a music therapy intervention within sessions.

Data Collection Procedures

IRB approval was first obtained from my university (See Appendix A). Purposefully selected individuals were then invited via email (see Appendix B for email invitation) to participate in this research. Interested potential participants reviewed a consent form detailing procedures, risks, and benefits of the research (see Appendix C for informed consent form). Once fully informed of the study procedures, they were invited to sign the informed consent form to confirm study enrollment.

Data was collected through individual semi-structured interviews lasting approximately 60-minutes. I conducted the interviews and asked questions about the therapists' educational background, theoretical orientation, and experiences improvising with nonspeaking clients (see Appendix D for interview questions). The primary purpose of the interviews was to explore the therapists' experiences improvising with nonspeaking clients. I facilitated the interviews to gather more detailed information about the topic within the semi-structured format of the

interviews. For example, I inquired about each therapist's theoretical orientation prior to discussing how they lead sessions to gain more context behind any clinical choices made. I also inquired about each therapist's education and experience to gain perspective into how their training impacts their work with nonspeaking clients. Understanding each participant's educational background provided deeper insight regarding the clinical choices they made and the feelings that resulted when they improvised with particular clients.

Data Protection Procedures

Audio recordings were collected through Zoom, transcribed verbatim, and then securely destroyed after transcription. Interview transcripts were de-identified and securely stored via a password protected Google Drive account managed by Molloy University to ensure privacy and confidentiality. Participants were assigned numbers to their transcripts to ensure anonymity. Access to audio recordings and interview transcriptions was granted only to myself, as the researcher, and to my thesis advisor.

Data Analysis

Data was analyzed using thematic analysis, which is an exploratory qualitative research approach that marks sections of text (e.g., interview transcripts) to look for any emerging themes within the data collected in a study (Hoskyns, 2016). According to Hoskyns (2016), the six steps for approaching themes within thematic analysis are as follows:

1. I first familiarized myself with the data.
2. I then generated initial codes.
3. After generating initial codes, I searched for themes.
4. I then reviewed the themes.
5. After reviewing, I defined and named the themes.

6. I finished this process by producing a scholarly report.

Step 1 was addressed after each interview was complete, to which I transcribed the interviews verbatim. I then completed Steps 2 and 3 by marking sections of text in the interviews to identify codes and explore common themes among the codes (Hoskyns, 2016). The idea of marking sections of text can be thought of as "analyst coding," which further helps to separate the interviews into themes (Hoskyns, 2016). To separate each interview into themes, I engaged in process-coding, which is defined as a method of coding that "uses gerunds ("-ing" words) exclusively to capture action in the data" (Saldana, 2011, p. 96). I applied a new code each time a new topic arose in an interview, and I repeated codes as similar subtopics emerged (Saldana, 2011).

In Step 4, I looked at emerging themes from codes across all three interview transcripts. to look for any commonalities. I shared my initial codes and emerging themes with my thesis advisor, who reviewed them and provided feedback that informed how I engaged in a second round of coding. After engaging in a second round of coding, with themes becoming more readily present, I created a theme table and narrative description that was sent to my thesis advisor, who reviewed and provided additional input and data analysis guidance on. I shared the theme table with participants to ask if the resulting themes resonated with them and if they have any suggested changes or edits to best capture their experience. This form of member-checking yielded no further changes or edits from the participants; all expressed agreement and resonance with the findings. Moving into Steps 5 and 6, I used the resulting themes to draw conclusions about how improvisation is experienced by different clinicians all working with nonspeaking clients.

CHAPTER 4: RESULTS

Presented below are participant demographics as well as thematic findings that demonstrate the various ways in which three music therapists experience improvising with nonspeaking clients. The individual interviews conducted with each music therapist were used for data analysis. Table 1 features demographic information and Table 2 details themes and subthemes, as well as example statements from each participant.

Table 1

Participant Demographic Information

Participant	Gender Identity/Other	Race/ Ethnicity	Years of Practice	Geographic Location	Clinical Setting
Participant 1 (P1)	Cisgender, Female/Disabled	White	9 years	Mid-Atlantic	Medical Hospital
Participant 2 (P2)	Cisgender, Female	White	16 years	Midwest	Private Practice
Participant 3 (P3)	Gender nonconforming, Male	White	6 years	Midwest	Children's Hospital

Table 2

Thematic Findings: Experiences of Three Music Therapists Improvising with Nonspeaking Clients

Theme and Description	Subthemes and Descriptions	Example Statements
Theme 1 - Value-driven approach to practice: Participants implemented their professional values into their improvisatory work to musically and	*Subtheme 1 - Professional values:* Participants described the influence of their professional values on how they interact and improvise with clients.	*Subtheme 1 - Examples:* - "My work is really heavily informed by disability justice, and in particular, I think about ways of being as valuing interdependence, collective access, and sustainability" (P1). - "I resonate with more of a humanistic or resource-oriented and music-centered approach

therapeutically collaborate with clients, and to affirm the clients' ways of being.		to music therapy" (P2). - "I draw a lot on development, developmental psychology, and psychodynamic work. When I work, those are kind of the areas that I ground myself in. I believe people can grow and change, no matter what, and that if we can just help remove those blocks that get in the way, growth and change will continue to happen" (P3).
	Subtheme 2 - Musical collaboration: Participants integrated client-led musical experiences within therapy.	*Subtheme 2 - Examples:* - "I've had the honor of collaborating with nonspeaking folks of all ages…Music was tailored to that person's learning preferences, which often involved different kinds of improvisational music making" (P1). - "We're in this collaborative experience together. If I just go in and lead, then we're gonna really miss out on hearing the client's ideas, the client's music, and their own creativity - their own creative expression and communication" (P2). - "Improvisation, for me, looks a lot like making spontaneous music that accompanies what we're [therapist and client] doing" (P3).
	Subtheme 3 - Therapeutic collaboration: Participants took on non-prescriptive approaches towards how to facilitate therapy.	*Subtheme 3 - Examples:* - "I would describe my work as hopefully striving to be desire-focused in the sense that I don't really want to dictate what somebody wants, or what somebody should get out of therapy." (P1) - "It [the therapeutic space] can be different every time" (P2). - "I think therapy is a process of being with someone rather than doing to someone, which influences a lot of my work. I'm not looking to change anybody. I'm not looking to fix anybody… I've been trying to work more psychodynamically, trying to understand how the music and how the relational dynamics are doing the therapy" (P3).

	Subtheme 4 - Affirming clients' ways of being: Participants incorporated the importance of understanding clients' realities of living into their clinical work by embracing clients' wholeness and not forcing clients to assimilate into the therapy space.	*Subtheme 4 - Examples:* - "Simply just having space to be, to exist in a place where no one is asking something of you and you're just free to explore your own identity and your own ways of being in an environment that is tailored to meet your access needs, is important" (P1). - "I wanted to be able to offer something different, and in my private practice I have often gotten referrals from people from other programs where the parents are like, 'they [client] just didn't fit the mold for what they [other program] wanted.' And I'm like, okay, you've come to the right place because your child is exactly how they're supposed to be, and we are gonna work with them" (P2). - "I think music therapy is one of those things that can help build a relationship that can add another layer of meaning to someone's life, especially if, like a lot of my clients, their whole life has been someone telling them what to do, where to go. Maybe they get to pick one or two things to do during the day. But overall, they don't have the kind of equal relationship that people should have" (P3).
Theme 2 - Reflexivity through internal dialogue: Participants engaged in internal negotiations when working with nonspeaking clients regarding their role in the therapeutic relationship, their personal emotions, mirroring clients' emotions, and the interconnectedness among these ideas.	*Subtheme 1 - Navigating the therapeutic relationship as the therapist:* Participants integrated improvisation as a way of connecting with clients, and discussed their internal processes when making these connections within their therapeutic relationships.	*Subtheme 1 - Examples:* - "I think improvisation often provides opportunities for us [therapist and client] to be together in a really relational way…We're just being together, meeting, connecting, and musically aware. I'm asking myself, in relation to the client: 'What do you want this space to be?' What would be meaningful for you to get out of this space?' 'How can I provide that?'" (P1). - "I really learned [through improvisation] to use improvised music to establish pathways for communication and connection. I think to myself, 'I really need to listen to you [client]. I need to ask you, what is your music?' And how can I be there to support your music?" (P2) - "I think I approach it [improvisation] from

	the angle of 'this person is as they are,' and so how can I be with them as they are? How can the music? How can the music help us meet each other?" (P3).
Subtheme 2 - Personal emotions versus mirrored emotions: Participants described the balance between feeling their own emotions and taking on clients' emotions within improvisatory experiences, and how these concepts may be interconnected.	*Subtheme 2 - Examples:* - "When you're making music with someone in a way that's really connected, you feel those feelings, and then those feelings soon wash over you" (P1). - "It's such an honor to be in those musical interactions with clients and have a shared experience. But then, there's the other side, if clients aren't with me [in improvisation], I think there are a lot of feelings that can come up. I think a lot of self-doubt can come up, like, what am I doing wrong, or do they need more structure, or do they need something else?" (P2). - "I can't get sucked into whatever they're [client] feeling. I have to remain calm, but I can still experience it and reflect it back to them in the music, although sometimes it's just a good idea to stop the music if they're really dysregulated, and just be" (P3).

Theme 3 - Connecting with nonspeaking clients through various types of relational communication: Participants described the different types of communication that may be implemented when working with nonspeaking clients.	*Subtheme 1 - Engaging in diverse types of communication:* Participants described their experiences with choosing to give verbal, musical, or physical affirmations.	*Subtheme 1 - Examples:* - "I might provide a verbal affirmation if that felt right, or I might acknowledge it [moment within improvisation] just with my physical presence, like my body language or with like eye gaze, if that was comfortable for that person, or by responding in some way musically - maybe I would mirror or incorporate something that person is playing as kind of like a musical affirmation" (P1). - "I just wanna make space for it [affirmations]. But also I don't want them [clients] to feel too exposed…It's more of a joining, intentional joining, or creating space. But it's sort of a balance depending on who you're working with" (P2). - "Anything is communication, right? Gestures, vocalizations, technology, anything" (P3).
	Subtheme 2 - Leading and following as forms of communication: Participants described their personal feelings towards when to lead or follow when engaging in improvisatory experiences.	*Subtheme 2 - Examples:* - "I think my feelings [towards leading or following] are really interconnected to the affective nature of each kind of individualized experience" (P1). - "And so it's about leading and following - if you just lead, you're gonna miss the clients, the essence of the clients. If you just follow, then there's that clinical responsibility we have to move somewhere and have that movement, that evolution, together as a musical dyad" (P2). - "I think I tend to be a follower in improvisations, but I am also leading at the same time. I'm following their [clients'] cues as best as I can to try to know what music to create" (P3).

Subtheme 3 - Responding in the music as a form of communication: Participants expressed the importance of being attuned to the improvisatory music created, and how to respond in the moment to reinforce communication between the therapist and the client.	*Subtheme 3 - Examples:* - "I think [improvisation] has offered possibilities that stretch beyond just using verbal speech in sessions... Improvisation can, when it's appropriate, create space for someone to explore aesthetics, explore identity, and to have their ways of being amplified…So I think it just creates opportunities for play that maybe don't exist, or don't exist in the same way" (P1). - "I'm responding [to an improvisatory experience]. I might still be using empathy techniques, but I'm responding to this in hopes of communicating that I love your [client's] idea. I'm joining you in this" (P2). - "I'm looking for the 'click' that lets me know when we're [therapist and client] together, because I know what it feels like to be in music with someone in a mutual musical relationship. And so, if that person can't tell me that they feel it too, I have to rely more on my internal sense of that" (P3).

Theme 1: Value-Driven Approach to Practice

Participants reported implementing their respective professional values into their improvisatory work with nonspeaking clients with intellectual disabilities. Their values were directly related to how they approached musical and therapeutic collaboration with their clients, and also to how they affirmed their clients' ways of being within music therapy sessions. In reference to professional identities, each participant identified how their theoretical orientations influenced their collaborative tendencies when improvising and connecting with clients. Participant 2 (P2) and Participant 3 (P3) both described their personal theoretical shifts from a behavioral standpoint to a more client-focused perspective, and how this shift affected their musical and therapeutic approaches when working with their clients. P2 and P3 discussed similar sentiments that relate to the depth of the therapeutic process. P3 stated:

> I try to divorce myself as much as possible from a behavioral model, from an activity-based model. I think that's a very simple way of working that doesn't really give people the depth of a relationship that makes life meaningful. I think music therapy is one of those things that can help build a relationship that can add another layer of meaning to someone's life.

Participant 1 (P1) and P2 echoed feelings of creating deep relationships with clients through person-centered approaches, especially through improvisation. All participants reported using client-led improvisatory experiences to connect with clients on a deeper level musically and therapeutically, as opposed to formulaically via activity-based models of working.

In regard to musical and therapeutic collaboration, all participants attested to the importance of working together with clients within the therapeutic process. All expressed implementing client-led musical experiences within their improvisatory work to develop

therapeutic relationships with clients and emphasized the value of collaboration as a means of highlighting a client's musical initiations and creativity. Music, within sessions, was described to be spontaneously made to parallel a client's mood or initiations, which also underlines the therapeutic values that all participants shared. P1 stated: "I personally think all therapy should be improvisation, not in a sense of we should always be improvising music, but we should always be improvising, like, as humans. We should always be responding to someone's needs and desires in real time."

All three participants emphasized the importance of creating a therapeutic space that is affirmative of a client's way of being. They described tapping into the reality of a disabled client's life in a world that is not always conducive to differences, and having empathy for the experiences that a client may have due to their challenges. P1 shared:

> I think nonspeaking disabled folks in particular often get the shaft. I think they have a lot of decisions made for them without actually being consulted. And, I mean, that is the result of ableism. It's the result of the systems that they move through. It's the result of societal beliefs about disability.

The participants underscored the value of embracing a client's wholeness, as they are, and not forcing a client to assimilate into the therapeutic space. P2 and P3 touched on providing musical experiences that promote a client's individuality, which also relates back to the integration of professional values within the therapeutic space. All three participants described improvisation as a means of accepting a client's whole identity as it is. They discussed utilizing improvisation as a means of supporting a client exactly the way the client presents themselves within any given musical moment. The flexibility that exists within improvisation, in terms of accepting and

supporting a client exactly as they are, allows for the therapist and the client to connect in ways where spoken language is not always necessary.

Theme 2: Reflexivity Through Internal Dialogue

All participants reported engaging in internal dialogue when working with nonspeaking clients related to their role in the therapeutic relationship, their personal emotions, their clients' emotions, and the interconnectedness among these concepts. In reference to their role in the therapeutic relationship(s) with their clients, the participants noted subjective ways of navigating their own perceptions and their clients' perceptions of them within the therapeutic space. They all stated that, in their work, improvisation served as a way to connect more deeply with nonspeaking clients. P2 stated:

> I love improvising with clients… I learn about myself in those moments of being just open to what happens, and noticing patterns that come in the music from the client, and from myself. I am curious about those patterns, and figuring out ways to meet the client's expressions inspires me to practice in different ways, too.

The participants spoke from their points of view and shared how their own lived experiences informed the way they interacted with clients. The idea of circular relationships surfaced as the participants acknowledged how their own emotions may influence their connections with clients. Improvisation was described to be a means of connection and communication between the therapist and the client. It was also described to be a relational pathway that allowed for each therapist and client to exist in the musical space without expectations. The improvisatory space provided opportunities for engagement in ways that were not predetermined, but rather were developed freely within each musical moment. Due to the participants' common thought-

processes of allowing the music to serve as the thread between the therapist and client, improvisation was expressed to be a way to validate the mutual music-making process.

The participants then described the balance between feeling their own emotions and taking on clients' emotions within improvisatory experiences, and how these concepts may be interconnected. P1 and P3 shared similar sentiments of being wary of personally taking on too much of a client's emotions. While the participants acknowledged the importance of empathy within the therapeutic relationship, they also described the potential danger of connecting too deeply to a client's feelings in a way that may take them out of a given therapeutic moment. P1 shared: "I think my role as a therapist…is to bear witness to what someone is experiencing - sometimes to hold space, sometimes to provide insight, sometimes to just be there, just to be there and to allow that person to shape the space in the way that they need to." P3 added: "I have to separate myself from it [a client's emotions] to stay present."

P2 and P3 also touched on the specific emotions that may arise, from the therapist's perspective, if the therapist and the client are not in sync during an improvisatory experience. Feelings of confusion, panic, and self-doubt were reported. The line between feeling personal emotions and inadvertently projecting said emotions onto a client was cautiously examined. These participants reported navigating this internal battle with their client's perceptions of them as the therapist. Feelings of uncertainty in how to understand what is being communicated by a client also arose. These feelings were often rooted in countertransference, as the projected ideas of what is expressed in the music may not be accurate to the moment itself. The participants also recognized how being grounded versus not grounded as therapists impacted the experience of the improvisation. All the participants acknowledged the natural tendency of a therapist to have empathy for a client, and how this therapeutic skill can be implemented when improvising with a

client. Feelings are interconnected to the affective nature of the individual's experience, as the feelings the therapists reported were connected to the feelings that the clients shared. The participants noted that taking in the experiences and emotions because of the interconnectedness of the improvisation can be a result of this empathetic nature. However, they also highlighted the importance of staying emotionally and musically present within the therapeutic space, and within self-reflection and internal dialogue, in order to provide a client with appropriate support.

Theme 3: Connecting with Nonspeaking Clients Through Various Types of Relational Communication

Participants described the different types of communication that may be implemented when working with nonspeaking clients who do not use verbal communication. The types of communication that were described related to musical, physical, and verbal affirmations. P1 acknowledged that the decision to provide affirmations is made spontaneously in the moment, based on clinical intuition and personal feelings within the improvisatory space. P1 stated: "I'm kind of shaping the music around the way that they're exploring the environment.," and added that, in reference to musical affirmations, communication and validation can be provided to acknowledge, mirror, or expand a client's musical idea(s). P2 and P3 shared similar thought processes in recognizing how any gesture, vocalization, affectual change, or movement could be considered communication, and that validating communication of any kind can establish a joint therapeutic space.

In reference to leading and following as forms of communication, the participants reported taking on both roles depending on what the improvisatory space called for within any given musical moment. The participants stated that their clinical choices to lead and follow were directly related to how the clients presented within the musical space. P2 described the internal

dialogue that was experienced when deciding whether to lead or follow within an improvisation. P2 discussed how choosing to solely lead may inhibit a client's original creativity, but how choosing to solely follow may inhibit a therapist's clinical responsibility to drive an improvisatory experience forward. P1 and P3 echoed this sentiment by emphasizing how musical communication, via leading and following, was client-led. Their choices to lead or follow were made based on the way the client presented in the musical moment, and interpreting the client's affective cues as a form of communication was the basis for these choices.

Questions arose regarding whether communication was received in the way it was intended, from the therapist's perspective. P3 asked: "Is the music I'm making accurately reflecting what they're [client] doing, not just on a physical level, which is sometimes where I get stuck, but on the emotional level underneath?" P1 and P2 emphasized this idea in their own descriptions of uncertainty with whether communication is mutually understood by both the therapist and the client. However, in exploring this further, the participants recognized how the communication between the therapist and the client could be reinforced without the use of spoken conversation by utilizing musical, physical, or verbal affirmations as means of relational communication.

The participants then expressed the importance of being attuned to the improvisatory music created, regardless of who (the therapist or client) is leading or following, and how to respond in the moment to reinforce communication between the therapist and the client. All three described attunement to the improvisatory music as a "joint space" that was co-created based on the mutual communication between the therapist and the client. The collaborative environment that was created between the therapist and the client via improvisation allowed for musical themes to arise. The participants stated that understanding how new themes may arise throughout

the therapeutic process can inform the therapist's choices to bring back or create new themes as the therapeutic relationship evolves over time. P1 and P2 described this type of collaboration as an affirmative way to validate the client's music-making and join the client in an expressive experience that is unique to that client. P3 expressed that this collaboration is indicative of a "click," which signals that the therapist and the client have established a "mutual musical relationship." The participants all stated that their responses to these musical moments, within a joint space of mutual music-making, were related to the improvised music created by both the therapist and the client.

CHAPTER 5: DISCUSSION

This study explored the subjective ways in which three music therapists experience engaging in clinical improvisation with nonspeaking clients. The data collected found three common themes that arose among the participants: 1) *Value-driven approach to practice*, 2) *Reflexivity through internal dialogue*, and 3) *Connecting with nonspeaking clients through various types of relational communication*.

In reference to Theme 1: *Value-driven approach to practice*, the music therapists in this study detailed their personal approaches to facilitating therapy. The participants stated how their professional values influenced their work and commitment to collaboration within music therapy sessions. Each participant described viewing the therapeutic relationship and the music created within sessions as interconnected. All discussed the importance of engaging in client-led improvisations and embracing clients in their wholeness within musical experiences in order to provide opportunities for their creativity and originality to emerge. These ideas align with research by Guerrero et al. (2015), who posit that improvisation can be used to draw clients into musical interactions that spark their creativity. The participants' ideas also support research by McCord (2009), who found that improvisation can provide clients with reciprocal opportunities to engage in self-expression. The participants in this study went on to describe how, from the therapist's point of view, utilizing improvisation to spark creativity and engage in self-expression can relate to the way therapists understand their work with their clients. The participants highlighted the importance of understanding a client's lived experience in order to fully collaborate with clients within the therapeutic space and affirm each client's way of being.

Theme 2: *Reflexivity through internal dialogue* refers to the way the participants engaged in internal negotiations when working with nonspeaking clients regarding their role and emotions

in the therapeutic relationship as the therapist. The participants described balancing their personal emotions while reflecting their clients' emotions within music therapy sessions. This echoes McCaffrey's (2013) study that discussed the importance of locating "self," as the therapist, within clinical improvisation. McCaffrey (2013) stated that the relationship between the music created by the therapist and the way the therapist experiences "self" within the session can impact the relationship that is developed with a client. This is connected to the way the participants in this study described internally battling to find the balance between expressing their personal emotions and taking on their client's emotions when improvising with clients, in order to provide a safe therapeutic space that is conducive to the clients' music-making. Devlin (2018) asked the question "How do I see you, and what does that mean for us?" (p. 234) in a study detailing the way reflexive questioning may be implemented in order to better understand clients as whole individuals. This relates to the participants' assertions that constant self-awareness, self-reflexivity, self-questioning, and self-evaluation must be explored when navigating the therapeutic relationship in order to best inform clinical work.

Theme 3: *Connecting with nonspeaking clients through various types of relational communication* is also consistent with themes from existing literature. The participants in this study described the different ways communication could be implemented when working with nonspeaking clients. Each participant discussed utilizing physical, musical, and/or verbal affirmations, as well as their tendencies in terms of leading/following within improvising and the ways in which they respond to clients' musical initiations. This relates to Graham's (2004) study that explored how vocal, facial, and gestural communication can be implemented to connect with clients in ways that are initiated by the therapist. Graham (2004) also suggests that interactive communication between the therapist and the client can deepen the improvisational connections

that emerge.

The participants in this study also discussed how their choices to lead/follow when engaging in improvisation experiences were deliberate. I explored details regarding the improvisational experience, including how the therapists' experiences within the music-making inform their choices when improvising with clients. This study offered an opportunity for self-reflection through the interview questions as I aimed to understand why therapists make certain choices within improvisatory sessions with nonspeaking clients. Each participant expressed the importance of being attuned to the improvisatory music created, and how to respond in the moment to reinforce communication between the therapist and the client. This type of attunement is also described by Jeong and Darroch (2021), who state that "observing behavior and listening to clients are essential…" (p. 36). The participants added to these ideas by describing their perspectives towards musically communicating with clients in ways that nonverbally show their clients that the therapeutic space created is safe for exploring identities, validating original ideas, and connecting in the music.

Implications for the Field of Music Therapy

In music therapy, the client and the therapist both have significant roles to play within the therapeutic relationship. A more expansive understanding of the therapist's experience may provide therapists with nuanced insight on the interactions between the therapist, the client, and the music improvised within a session. An in-depth account of the therapist's view may offer relatable information that validates a therapist's current experiences in their own clinical work. This study may also open discussions or provide further thought for therapists who may experience similar struggles or triumphs as the information presented here.

The three themes brought forth by this study offer unique takeaways that may provide

insight for therapists who work improvisationally with nonspeaking clients and for therapists who work in other approaches/settings alike. To begin, Theme 1: *Value-driven approach to practice* may spark music therapists to think about their professional values and how to center said values within their clinical practice, regardless of the setting in which they work. This may encourage therapists to consider how their clinical values may impact their therapeutic relationships with their clients. Secondly, Theme 2: *Reflexivity through internal dialogue* may provide validation for therapists who are experiencing internal negotiations as a natural part of their emerging clinical identity and reflexive practice. Thinking about reflexivity, as it relates to the inevitable internal conversations that therapists have with themselves when engaging in clinical work, may provide insight into how therapists can practice more relationally and empathetically with their clients. Lastly, Theme 3: *Connecting with nonspeaking clients through various types of relational communication* may provide therapists with a more nuanced and expansive understanding of what communication involves. This new understanding may impact the way therapists engage with their clients. Therapists who were previously unaware of the multiple pathways that communication can exist may begin to consider how a client is communicating with them in ways that may have been overlooked or misunderstood.

Recommendations for Future Research

The music therapists in this study described their personal experiences relating to their approaches to practice, their reflexivity within self-analysis, and use of various types of relational communication within their improvisational work. In regard to communication, the participants focused their responses on their interpretations of how communication may be implemented when improvising with clients. While the participants did share a great deal of self-reflexivity, none explicitly reflected on assumptions of communication that may be present when

a speaking individual works with a nonspeaking individual. A follow-up study could explore how communication is defined by speaking individuals, and what assumptions exist about the various types of communication that are used by speaking and nonspeaking people. Such a study could also explore how gestural communication is interpreted by speaking people and how this might connect to or differ from its intentions/implications when used by nonspeaking people.

While the purpose of this study was to examine the therapist's experience when clinically improvising with nonspeaking clients, another future study could be conducted to examine the experiences of nonspeaking people engaging in improvisation. This may also provide a deeper understanding of how the speaking therapist and nonspeaking client truly connect within the music-making, especially in terms of the nuances that exist between improvisation and the therapeutic relationship.

Limitations

The limitations of this study include a small sample size, a limited representation of theoretical orientations, racial homogeneity, and limited geographic representation. Three music therapists were selected to participate in this study. Although the participants possess different theoretical orientations and live in separate regions of the United States, the participants all share person-centered approaches to therapy and are located in the mid-Atlantic/Midwest regions. A larger sample with more diverse representation across a range of intersectional sociocultural identities, geographic location, and theoretical orientation could yield richer and more nuanced data on the experiences of therapists using improvisation with nonspeaking individuals.

CHAPTER 6: CONCLUSION

The purpose of this study was to explore music therapist's subjective experience improvising with nonspeaking clients with intellectual disabilities. Three music therapists who met this study's inclusion criteria volunteered to be interviewed. The data revealed three themes that arose among the participants: 1) *Value-driven approach to practice,* 2) *Reflexivity through internal dialogue,* and 3) *Connecting with nonspeaking clients through various types of relational communication*. While each of the participants shared their own unique experiences, feelings, and thoughts in relation to this study's research question, commonalities among the participants emerged. The participants discussed how they implemented their professional values into their improvisatory work to musically and therapeutically collaborate with clients, and to affirm the clients' ways of being. They shared insights about their internal conversations when working with clients in regards to their role in the therapeutic relationship, their personal emotions, mirroring clients' emotions, and the interconnectedness among these ideas. They also described the different types of communication that may be implemented when working with nonspeaking clients, such as engaging in verbal, musical, and physical affirmations; leading and following the clients within the improvisatory experiences; and attuning to and responding to the improvisatory music created to reinforce communication between the therapist and client.

The results of this study showcase a detailed account of the multi-faceted ways in which therapists experience improvising with nonspeaking clients. The therapist's experience within the musical improvisation, as well as within the therapeutic relationship with the client, is inherently connected to the client's way of being. The participants' own musical ideas and inclinations came forth in sessions alongside those of their clients'. Delving into the clinician's perspective adds valuable understanding to the therapist-client relationship that inevitably

develops, as well as to the clinician's experience within the session and to the music created. The findings are relatable to therapists working specifically with nonspeaking clients in that the data provides insight into how therapists can more deeply relate their own perspectives to how their clients uniquely communicate within improvisational music. Furthermore, this study provides a more expansive view of the therapist's experience and may provide other therapists with insight into how to better understand the interaction among the therapist, the client, and the music improvised within a session.

REFERENCES

Abrams, B. (2015). Humanistic approaches. In B. L. Wheeler (Ed.), *Music therapy handbook* (pp. 148-160). The Guilford Press.

Abrams, B. (2010). Evidence-based music therapy practice: An integral understanding. *Journal of Music Therapy*, *47*(4), 351-379. https://doi.org/10.1093/jmt/47.4.351

American Speech Language Association (2022). *Intellectual disability.* ASHA: American Speech-Language-Hearing Association. https://www.asha.org/practice-portal/clinical-topics/intellectual-disability/

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5* (5th ed.). Arlington, VA: American Psychiatric Association.

Bodner, E., & Polansky, E. (2016). The attitudes of music therapy of music therapy students and professionals regarding the emotional valence of improvisations in music therapy. *Nordic Journal of Music Therapy, 25*(3), 273-295. https://doi.org/10.1080/08098131.2015.1067248

Bruscia, K. E. (2013). *Defining music therapy.* Barcelona Publishers.

Bruscia, K. E. (1998). An introduction to music psychotherapy. In K. E. Bruscia (Ed.), *The dynamics of music psychotherapy* (pp. 18-29). Barcelona Publishers.

Butler, S. A. (2020). Self-advocacy, rights, and legislation: The experiences of self-advocates in Nova Scotia and Ontario. *CURVE: Carleton University Research Virtual Environment,* 1-315. https://doi.org/10.22215/etd/2020-14089

Chen, Y. (2019). Single-session improvisational group music therapy in adult inpatient psychiatry: A pilot study of the therapist's experience. *Nordic Journal of Music Therapy, 28*(2), 151-168. https://doi.org/10.1080/08098131.2018.1528560

Centers for Disease Control and Prevention (2022, May 10). *Facts about intellectual disability.* https://www.cdc.gov/ncbddd/developmentaldisabilities/facts-about-intellectual-disability/

Devlin, K. (2018). How do I see you, and what does that mean for us? An autoethnographic study. *Music Therapy Perspectives, 36*(2), 234-242. https://doi.org/10.1093/mtp/miy005

Gardstrom, S., & Sorel, S. (2015). Music therapy methods. In B. L. Wheeler (Ed.), *Music therapy handbook* (pp. 116-127). The Guilford Press.

Graham, J. (2004). Communicating with the uncommunicative: Music therapy with preverbal adults. *British Journal of Learning Disabilities, 32*(1), 24-29. https://doi.org/10.1111/j.1468-3156.2004.00247.x

Guerrero, N., Marcus, D., and Turry, A. (2015). Nordoff-Robbins music therapy. In B. L. Wheeler (Ed.), *Music therapy handbook* (pp. 183-195). The Guilford Press.

Guild For Human Services (2021, November 29). *Ask the expert: 'Nonspeaking' vs. 'nonverbal' and why language matters.* https://www.guildhumanservices.org/blog/ask-expert-nonspeaking-vs-nonverbal-and-why-language-matters

Hines, T., & Burrows, A. (2023). *Current issues and opportunities for individuals living with IDD.* Afia. https://afiahealth.com/current-issues-opportunities-individuals-living-idd/

Hoskyns, S. (2016). Thematic analysis. In B. L. Wheeler and K. M. Murphy (Eds.), *Music Therapy Research: Third Edition* (pp. 1120-1133). Barcelona Publishers.

Huizen, J. (2020). *What to know about intellectual disability.* Medical News Today. https://www.medicalnewstoday.com/articles/intellectual-disability

Jeong, A., & Darroch, B. (2021). Using letter boards in client-centered music therapy: "Autistics can teach if some are ready to listen." *New Zealand Journal of Music Therapy, 19,* 34-53.

https://www.musictherapy.org.nz/wp-content/uploads/2022/05/NZJMT2021No19-JeongDarroch.pdf

McCaffrey, T. (2013). Music therapists' experience of self in clinical improvisation in music therapy: A phenomenological investigation. *The Arts in Psychotherapy, 40*(13), 306-311. https://doi.org/10.1016/j.aip.2013.05.018

McCord, K. (2009). Improvisation as communication: Students with communication disabilities and autism using call and response on instruments. *Australian Journal of Music Education, 2,* 17-26. https://doi.org/10.3316/informit.039633311480212

McFerran, K. S., & Wigram, T. (2010). Using improvisation with teenagers. In K. McFerran and T. Wigram (Eds.), *Adolescents, music, and music therapy: Methods and techniques for clinicians, educators, and students* (pp. 139-147). Jessica Kingsley Publishers.

McLaughlin, B., & Adler, R. F. (2015). Music therapy for children with intellectual disabilities. In B. L. Wheeler (Ed.), *Music therapy handbook* (pp. 277-289). The Guilford Press.

Nordoff, P. and Robbins, C. (2007). *Creative music therapy: A guide to fostering clinical musicianship* (2nd ed.). Barcelona Publishers.

Meadows, A., & Wimpenny, K. (2017). Core themes in music therapy clinical improvisation: An arts-informed qualitative research synthesis. *Journal of Music Therapy, 52*(2), 161-195. https://doi.org/10.1093/jmt/thx006

Music Therapy Center of California [MTCC] (2019, December 18). Communicating with nonverbal clients. *MTCCA Music Therapy Blog.* https://themusictherapycenter.wordpress.com/2019/12/18/communicating-with-nonverbal-clients/

Pickard, B., Thompson, G., Metell, M., Roginsky, E., & Elefant, C. (2020). “It’s not what’s done, but why it’s done”: Music therapists’ understanding of normalization, maximization, and the neurodiversity movement. *Voices 20*(3). https://voices.no/index.php/voices/article/view/3110/3067

Saldana, J. (2011). *Fundamentals of qualitative research.* New York: Oxford University Press.

Savoie, L. (2022, March 30). Intellectual disabilities: Challenges in the workplace. *Diversified Support Services Blog.* https://www.diversifiedsupportiveservices.org/challenges-that-adults-with-intellectual-disabilities-face-in-the-workplace

Swaney, M. (2019). Four relational experiences in music therapy with adults with severe and profound intellectual disability. *Music Therapy Perspectives, 38*(1), 69-79. https://doi.org/molloy.idm.oclc.org/10.1093/mtp/miz015

Thompson, G. A., & McFerran, K. S. (2015). Music therapy with young people who have profound intellectual and developmental disability: Four case studies exploring communication and engagement within musical interactions. *Journal of Intellectual & Developmental Disability, 40*(1), 1-11. https://doi.org/10.3109/13668250.2014.965668

Wheeler, B. L. (2015). Music therapy as a profession. In B. L. Wheeler (Ed.), *Music therapy handbook* (pp. 5-16). The Guilford Press.

Wheeler, B. L. (2016). Principles of interpretivist research. In B. L. Wheeler and K. M. Murphy (Eds.), *Music Therapy Research: Third Edition* (pp. 294-314). Barcelona Publishers.

APPENDIX A: IRB Approval

MOLLOY UNIVERSITY

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www.molloy.edu

Patricia A. Eckardt, PhD, RN, FAAN
Chair, Molloy University Institutional Review Board
Professor, Barbara H. Hagan School of Nursing and Health Sciences
E: peckardt@molloy.edu
T: 516.323.3711

DATE:	January 20, 2023
TO:	Alexandra Timoshenko
FROM:	Molloy University IRB
PROJECT TITLE:	[1989951-1] How Music Therapists Experience Improvising with Nonspeaking Clients: A Thematic Analysis
REFERENCE #:	
SUBMISSION TYPE:	New Project
ACTION:	APPROVED
APPROVAL DATE:	January 20, 2023
EXPIRATION DATE:	January 19, 2024
REVIEW TYPE:	Expedited Review
REVIEW CATEGORY:	Expedited review category # 7

Thank you for your submission of New Project materials for this project. The Molloy University IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on applicable federal regulations.

You may proceed with your project.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require that each participant receives a copy of the consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a MINIMAL RISK project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this

procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of January 12, 2024.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact Patricia Eckardt at 516-323-3711 or peckardt@molloy.edu. Please include your project title and reference number in all correspondence with this committee.

Sincerely,

Patricia Eckardt, Ph.D., RN, FAAN
Chair, Molloy University Institutional Review Board

This letter has been issued in accordance with all applicable regulations, and a copy is retained within Molloy University IRB's records.

APPENDIX B: Email Invitation for Participant Recruitment

Dear _____(Name of Music Therapist)_____,

I hope this email finds you well! My name is Alexandra (Alex) Timoshenko, and I am a board-certified music therapist and current graduate student at Molloy University in New York State. In addition to working full-time in private practice, I am also in my final year in pursuit of my Master of Science in Music Therapy degree. As part of my graduation requirements, I am working towards the completion of my thesis research project under the academic supervision of Dr. Kate Myers-Coffman. The title of my thesis is "**How Music Therapists Experience Improvising with Nonspeaking Clients: A Thematic Analysis**."

I am passionate about the clinician's perspective within therapeutic improvisation, and I aim to discover the themes that may exist among practitioners working with those with intellectual disabilities. I plan to interview three music therapists who will provide meaningful insight to my research question. Your personal information will be kept confidential, and the answers you provide to the interview questions will be used for the purposes of this thesis research project only.

Please see the attached interview questions, as well as the Informed Consent Form, for more information. Thank you so much in advance for your consideration. I look forward to hearing from you at your earliest convenience.

Sincerely,
Alexandra Timoshenko, MT-BC
atimoshenko@lions.molloy.edu
Dr. Kate Myers-Coffman, PhD, MT-BC
kmyers-coffman@molloy.edu

APPENDIX C: Informed Consent Form

Music Therapy Department
1000 Hempstead Avenue, Public Square 220
Rockville Centre, NY 11570
516-323-3320

Title of Study:
How Music Therapists Experience Improvising with Nonspeaking Clients:
A Thematic Analysis

This study is being conducted by:
Alexandra Timoshenko, MT-BC; Email: atimoshenko@lions.molloy.edu
Academic Supervisor: Dr. Kate Myers-Coffman, PhD, MT-BC; Email: kmyers-coffman@molloy.edu

Key Information About This Study:

This consent form is designed to inform you about the study you are being asked to participate in. Here you will find a brief summary about the study; however, you can find more detailed information later on in the form.

This study will explore the subjective experiences of music therapists working via clinical improvisation with nonspeaking clients who have been diagnosed with intellectual disabilities. Data will be collected through individual semi-structured interviews lasting approximately 60-minutes. Participants will be asked about their clinical experiences working improvisationally with nonspeaking clients. Interviews will be conducted over Zoom, and they will be transcribed verbatim. All transcripts will be de-identified. Once interviews are transcribed, participants will be asked to read over their respective transcription to ensure accuracy. The data will be analyzed via thematic analysis.

Why am I being asked to take part in this study?

You are invited to participate in this research study because you have been identified as someone who meets the following inclusion criteria:

- a minimum of a Bachelor's Degree in music therapy;
- a credentialed music therapist (with at least 5 consecutive years of experience working as a music therapist) and currently conducting clinical work;

- have at least 5 years of experience working with nonspeaking individuals diagnosed with intellectual disabilities;
- and have at least 5 years of experience implementing improvisation as a music therapy intervention within sessions.

What will I be asked to do?

You will be asked to participate in one interview lasting approximately 60-minutes via Zoom. The interview will ask questions about your educational background, theoretical orientation, and experiences improvising with nonspeaking clients. The interview will be audio-recorded. You will also receive a written transcription of the interview via email and will have the opportunity to revise/add/edit your responses to send back to the researcher.

Where is the study going to take place, and how long will it take?

The interview will be conducted over Zoom. You are free to participate in the interview from the setting of your choice. The interview will take approximately 60-minutes.

What are the risks and discomforts?

There are no anticipated risks or discomforts for participating in this study. As the participant, you are free to choose what questions you would like to answer or skip. You are also free to provide as much or as little detail as you would like when responding to interview questions.

What are the expected benefits of this research?

There are no individual benefits to participating in this research study.

Do I have to take part in this study?

Your participation in this research is your choice. If you decide to participate in the study, you may change your mind and stop participating at any time without penalty or loss of benefits to which you are already entitled.

What are the alternatives to being in this study?

There are no alternatives to participating in this study. Instead of being in this research, you may choose not to participate.

Who will have access to my information?

Only the primary investigator (Alexandra Timoshenko) and the thesis advisor (Kate Myers-Coffman) will have access to your information.

How will my information be used?

The information collected through semi-structured interviews will be analyzed by the primary investigator via thematic analysis. To ensure accuracy, the researcher will record the interviews, transcribe them interview verbatim, and send the transcription to the respective therapist to

confirm the information is correct (e.g. member checking). Upon receipt of accuracy confirmation, the researcher will analyze the data. The data will then be categorized into themes and connections will be made between each of the participant's interviews. The participant's information collected as part of this research will not be used or distributed for future research studies.

To ensure that this research activity is being conducted properly, Molloy University's Institutional Review Board (IRB), whose members are responsible for the protection of human subjects' rights for all Molloy-approved research protocols, have the right to review study records, but confidentiality will be maintained as allowed by law.

Can my participation in the study end early?

All participation in this study is voluntary. If a participant wishes to end participation early, this can be done at any time. Any data that has been collected will be destroyed upon the participant's withdrawal.

Will I receive any compensation for participating in the study?

There is no compensation for participating in this study.

What if I have questions?

Before you decide whether you would like to participate in this study, please ask any questions that come to mind now. Later, if you have questions about the study, you can contact Primary Investigator Alexandra Timoshenko, MT-BC at atimoshenko@lions.molloy.edu or Academic Supervisor Dr. Kate Myers-Coffman, PhD, MT-BC at kmyers-coffman@molloy.edu.

What are my rights as a research participant?

You have rights as a research participant. All research with human participants is reviewed by a committee called the Institutional Review Board (IRB) which works to protect your rights and welfare.

If you have questions about your rights, an unresolved question, a concern, or complaint about this research you may contact the IRB contact the Molloy IRB office at irb@molloy.edu or call 516 323 3000.

Documentation of Informed Consent:

You are freely making a decision whether to be in this research study. Signing this form means that:

1. **You have read and understood this consent form.**
2. **You have had your questions answered, and**
3. **After sufficient time to make your choice, you have decided to be in the study.**

You will be given a copy of this consent form to keep.

_____ _____

Your Signature Date

_____ _____

Your Printed Name Date

I understand that my interview will be audio-recorded for transcription purposes.

_____ _____

Your Signature Date

_____ _____

Your Printed Name Date

_____ _____

Signature of Researcher Explaining Study Date

_____ _____

Printed Name of Researcher Explaining Study Date

APPENDIX D: **Interview Questions**

1. If you are comfortable, could you please share a bit about your personal background?
    a. What is your gender identity?
    b. What is your racial/ethnic background?
2. Could you please provide a bit of information about your background in music therapy?
    a. What is your primary instrument?
    b. What is your highest level of education?
    c. What credentials do you currently have?
    d. How long have you been practicing?
3. What is your personal philosophy or theoretical orientation as it relates to music therapy?
4. What is your experience working with nonspeaking clients with intellectual disabilities?
5. What is your experience utilizing improvisation as a prominent music therapy intervention?
6. What goal areas do you typically address, and how are these goals determined?
    a. How do you address your client's strengths, needs, and goals through improvisation?
7. What does a typical improvisatory intervention look like when you are leading?
8. How do you typically respond (verbally and/or musically) when a client takes the lead within an improvisatory experience?
9. How do you feel when you are improvising with your clients?
    a. In what instances do you lead and in what instances do you follow within your improvisations? Do you have a tendency to lead or follow?
    b. How do you know when you are in sync with your clients, and what does that feel like?
    c. What runs through your mind when you and your clients are not in sync? How do you respond within the music?
10. How do you experience improvisatory music-making with your nonspeaking clients?
11. Is there anything else you would like to add that may be relevant to this discussion?