

Music therapy and early intervention from a caring perspective

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Introduction

In the narrowest sense the term 'early intervention' (EI) refers to what is done early in the life of a child to influence its developmental course. EI refers to children from birth to the age of six and their families. The various definitions collectively emphasize the importance of influencing the developmental course of at-risk and disabled children with systematic interventions as early as possible. Interventions include various educational, developmental and therapeutic activities as well as support networks of a public and personal nature. (Innocenti 2000; Sigurðsson 2001; Shonkoff & Phillips 2001).

EI should emphasize helping caregivers becoming aware of ways and qualities of interaction helpful for the infant. Instead of focusing on the infant's problems the approach focuses on increasing the caretakers' awareness of positive qualities of interaction, and how to use these qualities to support the infant's learning, developmental and interactive capabilities. It works within the caretakers' own frame of reference helping them to discover their own resources. Focusing on the child often leave it's parents as forgotten component in the overall support and treatment schemas designed within EI.

This chapter endeavours to give insight into early intervention and describes from the perspective of research and clinical practice how music therapy can meet the varied needs of this fragile population, while attending to the psychosocial needs of the caretakers.

Early Intervention

Population served

Early intervention is aimed at families and young children (0-6 year old) who are either defined as at-risk, or with established disabilities. At-risk conditions are grouped as either environmental risk conditions or biological risk conditions. The types of possible environmental risk conditions vary between societies. The following are the most common ones: Caretakers unable to perform essential parenting functions due to a disease, young age or a handicap; upbringing in a shelter or a foster care environment; violent, neglecting or abusive caretakers; upbringing in an unstable home environment; legal guardian not established. Infants with biological risk conditions are those born prematurely, children who

fight life-threatening or chronic diseases, and children who become injured or exposed to drugs or other intoxicants (Innocenti 2001).

Children with established risk conditions are those born with chromosome abnormalities, neurological impairments, atypical developmental disorders, very low birth weight (less than 1000 grams), and a delay in cognition, physical/motor, speech and language, psychosocial, or self-help skills (ibid.).

The families of these children are also being served within the framework of early intervention. And they are as varied as they are many. The caretaker's, the sibling's and even the grandparents' life situation with regard to upbringing, education, experience, social- and work-status, and external support, are interwoven with culture and everything else that shapes a person, – his or her needs, dreams, hopes, personality, etc.

Within EI a tapestry of multiple relationships are thus formed. There are relationships between the infant and the parent (the mother or the father), between parents and the infant, between siblings, between grandparents and the infant, between the therapist and the caretakers, the therapist and the infant, between the different therapists and health professionals, etc. With regard to all the different relationships formed, both personal and professional, the clinical picture can become extremely complicated even to the extent that it hinders effective intervention. New role-relationships are formed, and reciprocal interpersonal relationships colored by different interactive patterns, affective qualities and needs at any given moment (Hougaard 1996/1997:132).

Defining features of today's EI

Cultural differences, the variety of available resources, implementation strategies, theoretical models, and a multidisciplinary research base, make the scope of EI broad and complex. Major premises of development, certain assumptions regarding services, and goals and principles of early intervention are however shared when EI is successfully implemented. In the following I present some of the core concepts, which reflect the prevailing views of researchers, theorists, and clinicians who study young children and their families.

Assumptions regarding services: Children at risk or with established disabilities have the right to specialized services to maximize their development and their possibility for success. Families of children with disabilities often experience special needs and stresses. The provision of earlier services might then mean the achievement of the most favourable outcomes for children and their families. Because of the unique characteristics, needs, and resources of each family, an individualized approach to service planning and delivery is essential. (Dunst, Trivette & Deal 1994; Shonkoff & Phillips 2001; Innocenti 2001).

Goals and principles of early intervention: The quality of a child's physical and social environment has a significant influence on the child's behaviour and long-term development. EI is effective in reducing the impact of disabling conditions. Parent involvement is essential in EI. It is most effective when professionals work together as an interdisciplinary team. Professionals

should focus on the child's strengths rather than its deficits. Intervention needs to be developmentally based. Individualized assessment is a necessary prerequisite to effective intervention. Skills taught to children with disabilities may not generalize to other settings unless specific planning and training is designed towards that end. (Dunst et al. 1994; Shonkoff & Phillips 2001; Innocenti 2001).

Empirically described qualities of caretakers-infant's communication, recognition of certain parent characteristics and family context variables, and different clinical theories launched the modern era of early intervention. Various private and public programs were developed to implement governmental laws and regulations. For example the Head Start program and the Handicapped Children's Early Education in the United States, the "Marte Meo" program in Holland and the "More Intelligent Sensitive Child" program (MISC) developed by professor Pnina Klein in Israel (Abidin, 1983/1995; Shonkoff & Phillips 2001; Rye 2001).

Rye (2001:7) refers to classical studies by Spitz (1946), Harlow (1962), Bowlby (1969, 1980, 1988), Vygotsky (1978) and Bronfenbrenner (1979) as well as studies by Antonovsky (1987) and Rutter (1985), which demonstrated the importance of opportunities for human contact, care and learning in the early years of children's development. In the interplay of various factors important for the infant's health, psychosocial development and learning, the quality of human relationship and the care experienced by the children seemed to serve a principal role. Attachment security became a central feature of early relationships, and concepts like 'attachment' and 'bonding' became the framework for studies in child-caregiver interaction. Research on clinically depressed mothers showed significantly elevated proportions of insecure attachments manifested as child's disrupted exploratory play, display of distress and anger upon reunion, and not being easily comforted. In the eighties, Trevarthen and Stern also described an incredibly fine-tuned reciprocal communication between infants and their mothers through mutual use of sounds, mimicking and movement (Stern 1985; Trevarthen 1986).

Based on findings such as those mentioned above the earlier emphasis of EI practices on the child and related medical issues shifted some fifteen years ago towards becoming family-centred. Family variables such as: family characteristics, family interactions, potential stressors for the family related to the child's disability, as well as the impact of social support, were studied empirically. Key concepts were revised and new approaches developed based on salutogenic way of thinking (Dunst 2000; Hooste & Maes 2003:296). The following summarizes the new emphasis:

- Instead of focusing on disorder, problem or disease and its consequence the focus is on *strength* and optimization of *competence*.
- Instead of depending on professional expertise for problem solving the focus is on *empowerment practices*, which create *opportunities* for development of *new competencies*.

- Instead of correcting people's weaknesses or problems *assets and talents* are recognized and used *to strengthen functioning*.
- Instead of relying primarily on professional services, a broad range of *community experiences* becomes a valuable resource.
- Instead of expert professionals who base their interventions on their own perspectives professionals become *sensitive to family's desires* and concerns and serve as *families' agents*.

Regardless of this change towards empowerment-based methods emphasizing strengths and competences the practices are different in many countries. The parents themselves and the potential psychological distress they experience are often a forgotten component in the overall support and treatment schemas designed for special-needs infants and their families (Barry & Singer 2001; Kingston 2007).

Music therapy within the framework of early intervention

Music therapy research within EI

Literature search reveals that empirical work done by music therapists or music educators evaluating the use of music in EI is relatively scarce. Early quantitative research studies focused mainly on the infant's physical responsiveness to musical stimuli. Chapman (1975) examined the effects of lullabies on weight gain and movements of newborns. He found 16% reduction in the total time it took premature infants to reach the weight criterion for discharge. Owens (1979) did a similar study with normal newborns from birth to three-days old. In her study no significant differences in variable values were found. Falb (1982) investigated the effects of music versus recorded heartbeat as a reinforcer for conditioned vasoconstriction in three multiply handicapped, nonresponsive, profoundly retarded infants. Both heartbeat and music were found to elicit response in these infants as manifested by overt signs of sucking at the end of the experimental period.

Witt and Steele (1984) assisted the mother of a fourteen-month-old multiply handicapped child over a period of sixteen weeks to use music and music related activities and objects in her interaction with the child. Behavioural observation of the following target behaviours: eye contact, purposeful reaching for objects, and response to own name, revealed a significant improvement. According to the mother a more important gain was that the family felt improvement in its ability to relate to the child in a helpful and a meaningful way.

More recent research done with premature infants in neonatal intensive care units (NICU) has advanced the application of music therapy with this fragile population. Besides using behavioural observation to measure physical gains affecting for example the length of hospital stay (Caine 1992; Kaminski &

Hall 1996; Schwartz & Ritchie 1999) researchers are also interested in examining interaction, communication and bonding between the infant and the parents (Standley 1991; Nöcker-Ribaupierre 1998). In a research study Trollidalen (1997:109; 2000:74) found that mutual recognition, meaning I am me and you are you, and we understand each other and share a relationship, is fundamental to processes of change. She also found that mutual recognition in a musical dialogue could promote a positive development. Frisk (1997) showed that a mother's singing and a conscious use of her voice elicited more focused eye contact from the child, which in return motivated further interaction. Frisk's study also revealed how important and beneficial supervision and early support can be for the caretakers of handicapped infants. These studies describe for example the parents' helplessness in handling their babies and their difficulties in engaging them. Only one study has been found which focuses solely on how music was used in therapy for mothers of older handicapped children (Webster 1992).

The studies referred to above disclose a vulnerable population and intense therapeutic moments. They reveal how music therapy can address the various needs of both caretakers and their special-needs infants dealing with issues such as relationships, development, change, sensitivity, emotions and context.

Music therapy practice within EI

The Head Start program and the Handicapped Children's Early Education in the United States, the "Marte Meo" program in Holland and the "More Intelligent Sensitive Child" program (MISC) developed by professor Pnina Klein in Israel are examples of early intervention programs/institutions serving special-needs infants and their caretakers available in many countries today. These programs/institutions have developed different perspectives and approaches in an attempt to meet the various needs and varying challenges of these families but to the best of my knowledge they do not particularly encourage the use of music, musicking or music therapy in their treatment schemas. According to Frisk (1997) an exception to this is a program started by a Norwegian psychologist, Anne Marie Rostad, in Nord-Trøndelag in 1993. Following the principles of EI it is interesting to note that Rostad advocates the use of children's songs, rhymes and poetry to support and stimulate communication between children and caretakers.

Music groups for infants/young children and their caretakers have been available in many countries for some years now. These groups are either run privately, run by different organizations or by official health care institutions. Sometimes different professionals run these groups together for example: music teachers/music therapists, nurses, physiotherapists, play therapists, etc. The structure and the outer framework of these groups/programs vary, i.e. the number of participants, duration of sessions, and the length of the programs; and so do the goals of these groups.

”Introducing a child and his or her parents to music can be like opening a curtain to let some sunlight pour in.” says Gascho-White (1991:61) who began running music therapy circles for babies at Plan and Learn Nursery in 1986. In her opinion the music sessions were at least as important if not more so for the parents as they were for the infants. According to her, there are two important considerations in this type of work. Firstly: How is music used to make contact with a child under the age of two? Secondly: How can a meaningful contact be made with the child’s parents?

Music is a natural part of the child’s world through which they can shine, says Marcia Humpal in an interview with Dr. Petra Kern (2005). Humpal is a music educator and a music therapist well known among music therapists and other professionals working in the field of early childhood education and EI. Humpal emphasizes that music therapy with this population works wonders. Following the child’s lead music’s adaptability makes it possible to build on the child’s strengths, influencing the whole of its development and thus reinforcing all other therapies. Humpal also stresses the importance of collaborating with parents, giving them ideas, strategies and music to use so that it becomes natural for the child to learn through musical play. Asked about the current status of music therapy in EI she mentions that music is being recognized as a wonderful avenue for young children and that more and more music therapists are working in EI settings. But more research needs to be done in order to gain credibility, she says (ibid.).

Music therapy for infants with special-needs and their caretakers within the framework of EI

What has music therapy to offer which can change the balance between risk and protection and can alter the developmental course in early childhood? How can music therapy meet the special needs and stresses often experienced by families of children with disabilities? How can music therapy influence complex behaviours involved in the expression of feelings and the control of impulses?

Meeting the needs of infants with special-needs

According to Dissanayake (2000:73) infants are guided by their instincts to look to elders in a search for what is meaningful. And research has shown that parents use preverbal communication or musical elements intuitively with their new-born not knowing about the importance of humming, singing, rocking and playfulness. This musical interaction supports the acquisition of speech, affects behavioural or emotional states in infants, and supports the development of musical, interpersonal and emotional intelligence. Parents do this most often without formal knowledge of its importance. At it’s best, it is done lovingly, carrying with it emotional states, and it is also done playfully, encouraging creativity and perhaps humour in later life, says Papousek (1996:46-50).

To take part in a music act is of central importance to our humanness. And ”to music” covers all participation in a musical performance, whether it is

active or passive, sympathetic or antipathetic, constructive or destructive, interesting or boring, says Small (1998:9). In Small's opinion every human being forms a kind of theory of musicking. That is, an idea of what musicking is and is not, and of the role it plays in our lives. But as long as it remains unconscious and unthought about, it can be both controlling and limiting (ibid.:13).

It can be the role of the music therapist to inform caretakers about the importance of their intuitive musicking or the music stimulation in which they partake with their infants. To make caretakers of infants with special-needs become aware of their "theories of musicking" in order to make better use of it for the benefit of themselves and their infants. Understanding musicking is a part of understanding our relationships and ourselves with other people; be it our infants or other human beings with which we share our planet, as Small stresses (ibid.). If through musicking we can bring into existence relationships in our world as we wish them to be, as Small suggests, then it is possible for caretakers with the guidance of a music therapist to use music to learn about themselves, their infants, and their experiential world of relationships in all its complexity. And by knowing their world they learn how to live well in it.

To avoid focusing narrowly on the often complicated clinical picture of the premature, the handicapped or the sick infant we can state that the new-born carries with it his/her own way of making sense of the world and its relationships. Before birth the infant may learn which relationships are of value and which are not, what to remember and what not, and how to order experience into categories. This is the result of an active engagement with the world controlled not only by genetics and environmental factors but also relationships and experiences. The physical development of the human brain and the neural pathways that embody memory for example are profoundly influenced by our experience. Those pathways that are used develop and combine, while those, which are not used, weaken and die. All sensations and relationships experienced, whether love, fear, security, or pleasure undergone in infancy when neural development is expeditious, can thus determine not only the very anatomy of the brain but also the habitual paths of thought, how we engage in the world and what we value (Small 1998:131).

According to Trevarthen, being part of culture is an innate human need. And the infant's inborn motivation to comprehend the world is kept alive by sharing experiences and purposes with others in relationships. It is in the interplay of 'protoconversations' between infants and their caretakers where emotions play a central role that meanings emerge. And it is also in relationships where cooperation and negotiation take place that the infant acquires the ability to think, understand and use language (Trevarthen 1995:5; Johnsen, Sundet & Torsteinsson 2000:68).

We cannot answer the question: How does the handicapped infant experience music? But like Small we can say, "If everyone is born musical then everyone's musical experience is valid" (1998:13). In his opinion the meaning of the act of musicking lies in the relationship. Not only the relationship between sounds and silences but between people who take part in whatever capacity. Caretakers sing differently when the infant is present compared to the way they

sing when it is absent. Where themes of separation and attachment preoccupy caretakers, the simple act of singing to and with the infant may prove both a positive and a successful intervention facilitating the infant's ability to thrive (Courtnege 2000:71).

The whole of musicking includes sensory stimulation ("experience-expectant" processes and "experience-dependent" processes), relationships and togetherness, representational worlds, moments of meaning, and intersubjectivity. The sensitive child born with "intuitive sympathy", capable of sensing the caretaker's motivations and intentions responds to them and communicates with them from the day it is born and vice-versa (Johnsen, Sundet & Torsteinsson 2000:68; Trevarthen 1993:54). Issues such as "trust, attachment, dependence, independence, control, autonomy, mastery, individuation, and self-regulation" are at each moment being worked on in accordance with the development and capacities of each partner (Stern 1995:70). These issues are life-long and so are the clinical ones stemming from them. The infant's development and growth however provide it with new behaviours and means for conducting the same issues, altering the form in which they are negotiated (ibid.:75). In all normalcies, the early experiences on which healthy brain development depends are everpresent in the infant's life. But as said before, concern needs to be devoted to those children who cannot due to a handicap or other risk factors obtain these experiences on which the developing nervous system depends (Shonkoff & Phillips 2001:184).

The newborn infants are capable of imitating the expressions of other persons. With astounding accuracy they can read emotions in the face or voice and they can hear and learn to prefer subtle differences in speech that identify their caretakers. As early as two-month-old, infants are capable and willing to enter protoconversations through varied coordinated expressions and gestures that sympathetic parents respond to (Trevarthen 1995:9). What happens if the infant cannot show its interest to others? What does the infant experience when it fails to squeal, growl, yell, laugh, and smile or move in response to attending caretakers? What happens if there is a lack of the cooperative skills? How does this failure influence the child's developmental course and well being? Just as we cannot know how the infant with special-needs experiences music we can only imagine the infant's subjective experience of being in an unfulfilling relationship, or what it is like to be trapped in one's own body.

Like other infants, the one with a handicap, the premature and the sick need to be nurtured and loved. They also need to be in encouraging relationships that compensate for their lack of motivation or anything else that hinders natural developmental course and well-being. The environment of their homes, the behaviour of their caretakers, but most of all their relationship with caregivers, who are emotionally invested in and consistently available to the infants, affect what they learn, how they react to the events and people around them, and what they expect from themselves and others. Early attachments are not only important for the caretakers-infant relationship. They set the stage for other relationships; they foster the exploratory behaviour that is vital to early learning and appear to have consistent and enduring influence on young children's social

and emotional development (Shonkoff & Phillips 2001:226-236). Without appropriate environment and relationships to shape, facilitate, and encourage their development young children may become further handicapped.

Research challenging the notion that children are relatively passive players in the socialization process has shown the many ways in which infants contribute to their rearing environments, including influencing the parenting they receive. In a complex manner parenting interconnects with the infant's inherited strengths and vulnerabilities to affect the pathways en route to adulthood. Another important finding is that infants and children have rich emotional/psychological lives and can suffer in ways that heretofore has never been realized. Parenting is always a challenging work and parenting a handicapped infant is much more so. This may be due to the fact that it is not clear what the infant needs or because the needs of the infants exceed the time, attention, and sensitivity that the parents can provide. The fact that the prevalence of atypical attachments to caretakers, and behavioural and psychological problems is more among individuals with special needs than the "normal" population tells a dramatic story (Sigurðsson 2001:42; Shonkoff & Phillips 2001:233f.).

It is a well-known fact that challenging life circumstances can result in an imbalance between what a parent can provide and what an infant needs. Chronic sorrow, depression, economic stress and marital conflict can hinder sensitive parenting and thus disrupt secure attachments. Thus prior to focusing on relationship building in early intervention a more appropriate first step might be mental health services or support groups of some kind for the caretakers. (Gerhardt 2004; Shonkoff & Phillips 2001).

The caretakers

The overemphasis EI perhaps places on influencing the developmental course of children with disabilities through systematic intervention as early as possible and the weight on the caretaker's role as being the child's specialist constantly reminds parent of their loss of the expected perfect child. Mothers are usually the main caretakers and they share this non-finite loss. This loss and the chronic sorrow it perpetuates are natural but need to be accepted and dealt with. We learn about the caretakers' feelings, their coping mechanisms, and how some of them survive by reading personal accounts in magazines and books (Rúnarsson 2004; Ragnarsson 1997). "Our insides are torn by such shock, grief, fear, and sense of loss that it feels like death," says Gill (1997:11, in Sorel 2004:23) when writing about the impact of finding out that one's child has a disability. When the caretakers are informed that their child has a disability, the loss of the ideal child and the discrepancy between expectations and reality can precipitate a crisis reaction characterized by feelings of grief and loss. The parent's identity is forever changed "the whole shape of ourselves and our lives is being pulled into a new form" (ibid).

In discussing premises influencing therapeutic approaches in helping individuals dealing with non-finite loss and grief, Bruce and Schultz (2001:170)

stress that the grieving process will involve cyclical themes of yearning and searching, protest/demand, defiance, despair/resignation, and integration; as well as anger, bitterness, and sadness. Guðlaugsdóttir (2002:40) found sorrow to be a significant component in the lives of mothers of autistic children. Experiencing sorrow initially at the time of diagnoses it recurred at almost every milestone and change in the child's life.

Although debated, chronic sorrow is a valid concept. Like Guðlaugsdóttir's study showed, Wikler, Wasow, and Hatfield (1981 in Flagg-Williams 1991) and Konanc and Warren (1984 in Ziolkó 1991) found that parents experienced grief at transitional periods such as the child's entrance into school and onset of puberty. Professionals need thus understand it and accept it as a normal response for parents, especially at significant life transitions because their parental responsibility never ends. An ability to channel and share negative and positive emotions productively can be a major factor in family success over the handicapped persons' lifetime. A chronic sorrow need thus not to be seen only from a negative perspective, but as one aspect of the emotional challenges facing these families. It should also be mentioned that although milestones may become a hindrance, families also experience great joys and triumphs over things that parents of non-handicapped children would pass unnoticed. Any milestones gain greater significance.

Stage theories introduced around the 1950s are still an accepted perspective for understanding parents of children with special-needs. The different stage theories have in common the notion that adjustment is accomplished by moving through predictable and sequential emotional states. Blacher (1984 in Flagg-Williams 1991:240) reviewed 24 different stage theories and found that they could be summarized using a three-phase model:

1. Initial phase of shock and denial regarded by some as a necessary aspect of the process of moving on.
2. Disorganization following the initial shock. Characterized by a wide range of feelings such as shame, ambivalence, anger, disappointment, guilt, and hopelessness. Disorganized emotional state in siblings is characterized by feelings of resentment, jealousy, and over-compensation.
3. Resolution into a state of acceptance or adjustment.

Ziolkó (1991) encourages grieving parents to express their feelings through talking, crying, exercising, or engaging in creative work. She also recommends that reassurance and support be received from other grieving people. Ziolkó emphasized that helpers need to recognize feelings of loss as normal and even encourage them. Helpers need to recognize that denial or anger may be the best coping mechanism available to those who are not able to progress to acceptance stage. Parents' feelings need to be accepted and constructively channelled into activities. Parents need to see that there is some value in being, even when no overt progress is being made. Parents back and forth movement between stages

should be accepted and they should be allowed to proceed through stages at their own pace.

Hope, meaning, feelings of communality and identity are components that contribute to a "good life", says Rustøen (in Ruud 1998:56). She suggests that being active, experiencing intersubjectivity, having a feeling of self, and having a basic sense of joy make an important contribution to the quality of life. It has been said above that parents of infants with special-needs are in the danger of losing their identity and becoming isolated. Their primary task is to take care of their infants, and they consciously or subconsciously get lost in their demanding role and isolate themselves from various community groups where parents meet. But what is important for these caretakers is to increase their felt sense of quality of life or their subjective feeling of well-being. Storr (1992:168) asks;

How is it that an art which promulgates no doctrine, which preaches no gospel, which is often entirely dissociated from verbal meaning, can yet be experienced as making sense of life?

Providing caretakers with opportunity to work through issues of loss and grief in a safe and creative environment with other caretakers may significantly alter their ability to cope with life. In contrast inhibited grieving may lead to illness or psychological disorder, which negatively affects the infant and the whole family.

According to Skewes (2001:17) the themes running through the grieving scenarios are the same; however the experiences are distinctly different. According to this each caretaker responds uniquely to his or her situation and potential gains from any help offered to them are related to the individual's responses, awareness, capacity, desire, current emotional state, etc. The literature encourages creative expression as a modality for addressing grief issues. The caretakers are the experts and their voices need to be heard. Within EI parents are the main consumers of services and their contentment has become a primary measure of the quality of health care plans. Considering their voices and listening to them within the full context of their experiences is thus crucial (Conner & Nelson 1999:347; Sandall, Smit, Mclean & Ramsey 2002:135).

Meeting the needs of the caretakers through music-caring

The parents of young children with special-needs draw our attention to the importance of meeting other parents who have a similar experience. They talk about non-finite loss, a grief that never perishes. They say that parents talk the same language, that they understand and receive the most important information from one another. They also tell us that parents of children with special-needs should not only be offered personal help but that such help should be mandatory.

Based on what the parents themselves have expressed, based on lack of services for caretakers of special-need children, motivated to develop means to meet the psychosocial needs of this population and believing in creative expression and the power of musicking to address grief issues, a research study was implemented in the fall of 2006. The participants were seven mothers and

the title is "The lived experience of a group of mothers having infants with special-needs, participating in a music therapy program defined as music-caring within the framework of early intervention." Music-caring in this framework was defined preliminary as an empathetic and emotionally supportive relationship that an act of musicking brings into existence. If successful, for example in changing the caretakers' negative feelings brought on by the non-finite loss, then it may have direct or indirect effects on all other elements in their relationships. It may change how the mother subjectively experiences herself both as an individual and a mother, and how she experiences her situation, thus changing her interaction with the infant.

Songwriting was used as a process and a central method in providing music-caring. In this context songwriting was defined as:

The process of creating, notating and/or recording lyrics and music by the client or clients and therapist within a therapeutic relationship to address psychosocial, emotional, cognitive and communication needs of the client. (Baker & Wigram 2005:16).

Songwriting has been described as "one of the most powerful methods in music therapy" (Ruud in Baker & Wigram 2005:9).

It seems like the song gives the client a new context, a freedom and strength to bypass his or her own vulnerability. The song form not only *affords* a range of possibilities for self-expression, but it equally *allows* one to touch on and warm to themes and relationships which have been deeply-frozen for a long time (ibid.:10).

According to Baker and Wigram songs assist in developing group cohesiveness, encourage social interaction, provide group support, provide opportunities for one to experience joy, and facilitate development of therapeutic relationships.

Songwriting provides an aesthetic context inviting clients to explore, within a new play-frame, their own life, their possibilities, their losses and their aspirations (ibid.:10).

In the sessions, music, laughing, crying, and talking was braided together creating an intimate and a strong relationship between the mothers. The mothers looked at song texts, sang them, talked about them, noticed how both the lyrics and the music affected them, and they brought their own favourite songs. They choose instruments to sound themselves, choose instruments and players to sound different words/feelings and thoughts, they used receptive music for relaxation, imagery and focusing, and gave each other musical gifts when sounding together optimism, hope and energy. So in many different ways both structured and improvised, words and music, music and feelings etc. were braided together and shaped into song lyrics. Forming not only a personal narrative in accordance with how they experienced reality but also eliciting a feeling of group belonging (Ruud 1998:3).

No amount of empathy can eradicate all the difficulties and sorrows that many caretakers of disabled infants are confronted with. But caretakers need to express their grief, to give it a shape and to share their grief and worries without embarrassment or fear. They must be given permission to communicate, through the medium they choose, their grief and their inconsolability. They need an opportunity for non-verbal/verbal self-expression, an opportunity to explore

their creativity and potential for growth and self-awareness. They need a place where they can be heard and accepted in a non-judgmental way and to feel accepted by an empathetic group. They need to cry with and to laugh with and to feel a support and a friendship from someone who has a similar experience.

An opportunity to express feelings and thoughts in a creative way without guilt and judgments, and in a way which can enhance their way of thinking towards themselves and their life's situation, is healing.

Conclusion

The immense diversity of the clinical population, to which early intervention and music therapeutic interventions can be applied, is overwhelming. Through musicking alone, with other caretakers, with their infants, with their music therapist, etc. the focus could be to prevent, cure, reconstruct, support, habilitate, rehabilitate, palliate, etc. But to maximize the positive outcome of EI services it is of paramount importance to recognize the often enormous emotional strain that parents encounter. And it is important to provide something, which addresses the resulting needs. This could for example be accomplished through music therapy with a group of caretakers who laugh, cry, or otherwise share empathetic understanding in a musical relationship or in a group where caretakers are informed about the importance of intuitive musicking for their children's as well as their own well-being. Supporting parents emotionally, respecting them and their relationship with their children, identifying and working through problems can all be done through music therapy.

Through the use of music and relationships music therapists are concerned with improving quality of life. And through engaging parents in music therapy group work where they are offered both structure and freedom, where they can form interpersonal relations with others who share similar experience, where they are encouraged to explore emotions and feelings in a creative and structured way, where their feelings are accepted and empathized with, then they will develop a stronger, more flexible and coherent identity needed for their optimal well-being. As a consequence EI may achieve its goal far better than it has managed hitherto.

It is hoped that in the near future the lived experience of the above mentioned research participants, while musicking in a caring context will provide music therapists with an understanding, which enables further work with this clientele. Furthermore it is hoped that through disseminating the findings organizers and specialists working within the framework of EI will come to realize the potential of music therapeutic work within this important clinical area. Having spoken, cried, laughed, listened, played instruments, sung, and in various ways created music and song lyrics a mother participating in the above mentioned research concludes by sharing with us some of her lived experience, her losses and aspirations as expressed in excerpts from her diary and one of her song lyrics.

I am excited to begin this program. It could turn out to be a dangerous one because emotions are in the foreground. It could become something good but it might also draw out some crying. Perhaps it will change my life.

After the first session there was a lot of emotional outburst – crying. The first meeting was truly an enjoyable experience. It was as I had expected but also in a way unanticipated. The next sessions will most likely be enjoyable and revealing. Perhaps one learns something new about oneself.

The session this morning was so interesting that time really flew away. Klambra said that we were lucky being participants in this first group. I agree with her for sure. I would have wanted to stay longer. It was boring having to stand up and say good-bye. I would have liked to write more words on the whiteboard. I look forward to the next session.

The session was good and I felt good afterwards. She has managed to contain the flow of tears. The music also plays a strong part in this experience and the music is nurturing. We express ourselves through sounds, tones, and rhythm. I enjoy singing and it is even enjoyable to cry. The emphasis shifted from our children to our selves. It is good to find support from all these different women, to find how tolerance and acceptance prevails in our interaction. There is a very beautiful and good spirit in the group. I want to gain as much as possible from these sessions, thus it is important to be sincere. I have sometimes not been able to discuss the things I would like because I fear starting to cry. It is so enjoyable to meet new people – true women that are willing to share and to give. This is a group of resourceful and creative women that think like I.

The music gives me tremendously – also making these song lyrics. Now I have started to do many things that I have not thought about since I was in school. I have come to realize that I need to do something for myself before I become weighed down. Discussions are good they create all kinds of ideas. One talks about things that one really did not know that one had been thinking about and even made decisions about. It is good to have a director that leads the process on. We talk, discuss and listen uninterrupted, but it is good not to become stuck for too long with the same issues and the structure in the sessions is good. It is a free kind of structure that has successfully been shaped – to intervene at the right moments.

It was a fun session this morning – much singing and talking. Music has been made to many of our lyrics. It is fun to sing these poems. Somehow they gain a new and a different life by doing that. This morning I felt that my poems needed some music - I saw how much the music gave the other poems.

There was no session this morning – strange. It somehow feels sad how we all are grateful for these sessions. We should not have to be so grateful. Not in a perfect world. It has been wonderful to be here these Saturday mornings. They have given me much. I feel almost like I am graduating from some learning program now that this is over. Emotionally I have shifted backwards and forwards. The diary has been a true soul saviour. I sense a great thankfulness and find myself lucky to have been able to participate. The thought of never seeing them again fills me with emptiness. (My own translation from Góá's diary):

Relief¹

Hesitantly
the notes flow out
alone
single
but fuse
hesitantly.

Then they boldly start to weave
bandages
for our souls,

we take in anxiety, fear, unease,
God
and Vera who is just a cat
black
and white and
dead

we tend the wounded
yet avoid
something

want to stay alive

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¹ Góa. The song lyric was translated from Icelandic to English by Bernard Scudder.

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