A PHENOMENOLOGICAL STUDY OF THE INTERPERSONAL RELATIONSHIPS BETWEEN FIVE MUSIC THERAPISTS AND ADULTS WITH PROFOUND INTELLECTUAL AND MULTIPLE DISABILITIES

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INTRODUCTION

In my early years as a music therapist, working with adults who have Profound Intellectual and Multiple Disabilities (PIMD) brought me a range of emotions and questions. Without any previous experience with this group of people, I was shocked at the severe impacts of multiple disabilities on the lives of the clients. I also felt challenged to engage with them because I could not understand the idiosyncratic non-verbal behaviors. While interacting with them regularly over time, however, I realized that most people with PIMD also experience various emotions through music just like the other people without disabilities. From then on, I was able to share in their emotions by playing various songs, and these shared emotions enabled us to communicate better.

I wondered, then, whether music therapy was helpful in improving the communication skills of my clients. To answer this question, I conducted a research project (Lee, 2009; Lee & McFerran, 2012). While trying to answer the research question, I also wanted to show that music therapists provide an important service to adults with PIMD, and that the effects of music therapy are beneficial. Furthermore, I personally felt that our work in the field of disability was not acknowledged enough. In the community settings where I worked, the disability support workers or parents often called me “music teacher,” and some of them seemed to consider me as an entertainer. Working environments for my colleagues and me were not ideal as well. The organization that employed us did not seem to treat us as health professionals. Many of my colleagues were soon disappointed and left. All these factors motivated me to challenge the question. For me, conducting the research was to have a hope for a better future so that our music therapy sessions are acknowledged and valued as an essential therapeutic intervention for adults with PIMD. While I was satisfied with the results of my research project, I realized that a single research study is insufficient to demonstrate the value of music therapy.

After working with same clients for over six years, I still face various questions. However, I feel like I am in a different position now. I feel more confident as a clinician and I experience more pleasure, joy, and happiness when I go to meet my clients and their caregivers. I believe that the relationships that I have established with each of them over a long time have made a positive difference to us. These interpersonal relationships

seem to support the clients' emotional and social needs and ultimately help them improve their quality of life. In the present study, I explore other music therapists' experiences to find the meanings and essence of our experiences. The findings of this study will also provide fresh knowledge and insight to others who support clients with PIMD, such as parents, disability support workers, allied health professionals, and service providers.

LITERATURE REVIEW

The Need for Specific Care

The disability rights movement started in the United States of America (USA) and the United Kingdom (UK) in the late 1960's, and has positively influenced the lives of people with disabilities (Mertens, Sullivan, & Stace, 2011). Groups of people with disabilities or family members of the disabled persons gathered to fight for the basic human rights of people with disabilities. Advocating organizations were formed and they influenced governments' social policies. For example, in UK, the *Fundamental Principals of Disability Booklet* (Union of Physically Impaired Against Segregation, 1976); the green paper *Care in the Community* (UK Department of Health, 1981); and the white paper *Valuing People* (UK Department of Health, 2001, 2009) were published. The disability paradigm shifted from the medical model to the social model (Mertens et al., 2011). Under the medical model, having a disability is considered a problem that would lead an individual to seek medical treatment. In contrast, the social model, developed in the 1970s, views a disability as part of the human condition that is the responsibility of the society (Carson, 2009). The social model expounds the view that people have impairments, not disabilities. When the society makes barriers between people with and without disabilities, the affected people experience dis-abilities in those situations.

In 2006, the United Nations declared *the Convention on the Rights of Persons with Disabilities* (United Nations, 2006), which had the worldwide impact of increasing public awareness of the rights of people with disabilities. Recently, the World Health Organization (World Health Organization, 2011) published the *World Report on Disability*, summarizing the current status of the lives of people who have disabilities and highlighting the importance of conducting more research and investing in specific interventions and services. Despite the major improvements in general attitudes towards the disability, people with PIMD still are "the most excluded and little valued people" (Watson, 2007, p. 99) and "an ignored minority" (Samuel & Pritchard, 2001) in our society. This is demonstrated by the fact that most guidelines on disability focus on people with mild and moderate intellectual disabilities and fail to articulate the complicated and specific care needs of people who have PIMD (PMLD Network, 2003). To promote social inclusion and participation of everyone including people with PIMD and their families, more sensitive and comprehensive views and approaches to them should be provided.

Terminology and Definition of PIMD

The number of people with PIMD is increasing 1.8 % every year and is expected to be just over 22,000 by 2026 in the UK (UK Department of Health, 2010). Although the demand for more services is significant (Parrott, Tilley, & Wolstenholme, 2008), the use of a range of terminologies, and lack of clarity or a generally agreed-upon definition of PIMD causes some issues in identifying the individuals who belong to this group and planning service delivery (Bellamy, Croot, Bush, Berry, & Smith, 2010; UK Department of Health, 2010). Terms such as, "Profound Intellectual and Multiple Disabilities (PIMD)", "Profound and Multiple Learning Disability (PMLD)," "Profound Multiple Disabilities (PMD)," and "Profound Intellectual Disabilities and Multiple Impairments" are used interchangeably to refer the same group of people (Carnaby, 2004). Two essential words common to these terminologies are "profound" and "multiple." These must be included in the definition as they define the severity and complexity of the condition (Carnaby, 2004). In 2008, the term PIMD was recognized as the most accurate way of describing the group (Pawlyn & Carnaby, 2009) and used by the Profound Intellectual and Multiple Disability Special Interest Research Group (PIMD-SIRG) formed by the International Association for the Scientific Study of Intellectual Disability (IASSIS) (Forster, 2011). Therefore, I prefer using the term PIMD.

To study a range of definitions and develop the most appropriate definition of PIMD, the researchers at the Joint Learning Disability Service in Sheffield, UK (Bellamy et al., 2010) interviewed 23 caregivers, service managers, and health professionals who take care of people with PIMD. The participants were asked to compare ten different definitions of PIMD and choose the most appropriate definition, providing a reason of their choice. Based on the participants' feedback on the most chosen definition[1] by Samuel and Pritchard (2001), the researchers suggest a new definition as follows:

> People with profound and multiple learning disability (PMLD):
> - have extremely delayed intellectual and social functioning
> - may have limited ability to engage verbally, but respond to cues within their environment (e.g. familiar voice, touch, gestures)
> - often require those who are familiar with them to interpret their communication intent

[1] Children and adults with profound learning disability have extremely delayed intellectual and social functioning with little or no apparent understanding of verbal language and little or no symbolic interaction with objects. They possess little or no ability to care for themselves. There is nearly always an associated medical factor such as neurological problems, physical dysfunction, or pervasive developmental delay. In highly structured environments, with constant support and supervision, and an individualized relationship with a carer, people with profound learning disabilities have the chance to engage in their world and to achieve their optimum potential (which might even mean progress out of this classification as development proceeds). However, without structure and appropriate one-to-one support such progress is unlikely. (Samuel & Pritchard, 2001, p.39)

> - frequently have an associated medical condition which may include neurological problems, and physical or sensory impairments.
>
> They have the chance to engage and to achieve their optimum potential in a highly structured environment with constant support and an individualized relationship with a carer. (Bellamy et al., 2010, p. 233)

Although this definition uses the term PLMD, not PIMD, I find this definition useful as it effectively explains the impairments, abilities, as well as support needs of people with PIMD. It stresses that the context and individual relationships with caregivers are important for people with PIMD, and highlights that they are able to respond to familiar voice, touch, and gestures rather than merely stating the possible impairments.

Interpersonal Relationships and Quality of Life

As stressed in the above definition, people with PIMD are dependent on others for daily living; hence their Quality of Life (QOL) is dependent on others. Accordingly, some researchers are interested in measuring the QOL of people with PIMD to evaluate the quality of services provided to them (Petry, Maes, & Vlaskamp, 2005, 2009a, 2009b). As QOL is affected by multi-dimensional factors, Schalock (2004) reviewed 16 QOL studies and found the top eight domains that affect QOL. These are interpersonal relations, social inclusion, personal development, physical well-being, self-determination, material well-being, emotional well-being, and rights. “Interpersonal relations” was found as the most referenced indicator of QOL. In short, having meaningful relationships with close others can be an indicator of good QOL.

Building an interpersonal relationship, however, takes time as it is determined by “the history of all the separate interactions” (Stern, 2002, p. 117). For people with PIMD, who have many challenges interacting with others due to the non-verbal nature of their communication, building interpersonal relationships can be limited to certain people and to certain contexts. To understand the nature of their relationships, Hostyn and Maes (2009) reviewed 15 studies that examined the interactions between individuals with PIMD and their caregivers. Video observations and interviews were the most frequently-used data collection methods in the reviewed studies. The studies were qualitatively analyzed using narrative synthesis. As a result, four key elements, which were frequently observed or reported in positive interaction processes, were found: sensitive responsiveness; joint attention; co-regulation; and emotional component. Being sensitive to a person’s needs, preferences, and wishes, and sharing a repertoire of utterances and affective cues as joint attention were essential elements for successful interactions. Co-regulation was represented by mutuality, reciprocity, turn-taking, matching each other's behaviors, and altering them. Attunement was also found to be a form of co-regulation.

With regard to the emotional component, some parents claimed that a successful interaction was characterized by mutual feelings of contentment, appreciation, and joy. Similarly, three disability support workers described their relationships with one female

client with PIMD and reported emotions, such as sympathy, warmth, and closeness in a phenomenological study (Forster & Iacono, 2008). Attachment and emotional bonds were also mentioned to support these feelings. Furthermore, the study by Hostyn and Maes (2009) revealed the influencing factors on the interactions and relationships with the people with PIMD were: the personality of persons with PIMD and their responses to the interactions, the communication partners' interactive strategies, perception of their roles, and knowledge of interaction in general and the particular person with PIMD.

The Experiences of Music Therapists

Music therapists are a group of health professionals who have supported various needs of people with disabilities since the 1950's. Using clients' preferred music and non-verbal interactive strategies, they often successfully report the benefits of music therapy for people with PIMD (Agrotou, 1994, 1998, 2000; Elefant, 2001; Ghetti, 2002; Graham, 2004; Lee, 2008, 2009; Lee & McFerran, 2012; Oldfield & Adams, 1990, 1995; Pujol, 1994; Ritchie, 1993; Watson, 2007; Wigram, 1992, 1996; Wigram, McNaught, Cain, & Weekes, 1997; Wigram & Möller, 2002). "Vibroacoustic therapy", a therapeutic method using music and vibration, has been reported to support the physical needs of people in institutional settings (Wigram, 1992, 1996; Wigram et al., 1997; Wigram & Möller, 2002). Some research studies have demonstrated positive outcomes, such as improved non-verbal communication skills (Lee, 2009; Lee & McFerran, 2012), increased attention span, and improved participation in musical activities (Oldfield & Adams, 1990, 1995).

Intensive individual and group case studies also have been reported using qualitative approaches (Agrotou, 1994, 1998, 2000; Graham, 2004; Ritchie, 1993; Watson, 2007). These studies describe nonverbal and musical interactions, and the long-term effect of these on the client-therapist relationship over several years. By sharing their feelings with the music therapists, clients who were isolated in institutional settings gained social abilities, including interacting with other people and successfully participating in social activities in the community. The music therapists claim that a humanistic and psychodynamic approach is beneficial for the clients with PIMD, as this approach values clients' non-verbal communications such as facial expressions, sounds, and movements by interpreting them musically or verbally.

Researchers have described the emotional difficulties that music therapists experience in the early stages of relationships. For example, Agrotou (1994) felt despair and fear that she might not be able to reach the client. Graham (2004) felt sadness and distress from two clients while musically vocalizing with them. Similarly, Watson (2007) described that the clients showed absence and rejection to the instruments and music therapists in group sessions. She further stresses the importance of the music therapists' experiences, stating "the therapist's musical approach may need to be adapted in order to work meaningfully with clients who have profound disabilities and barriers to communication, and who are likely to play little music" (p.102). So far, however, there is no empirical study exploring a group of music therapists' lived experiences working with clients who have PIMD. Providing the details of these experiences would provide knowledge and insight to some music therapists who do not have any experience with people with PIMD.

To explore the lived experiences of music therapists in clinical practice, phenomenological approaches have been applied. Phenomena explored are various such as, "experiences of music therapists working with children in coma (Dun, 1999); "being effective as a music therapist" (Comeau, 2004); "being present as a music therapist" (Muller, 2008); "the spiritual moments in music therapy" (Marom, 2004); "pivotal moments in music therapy" (Grocke, 1999); and "music therapists' dual roles" (Ghetti, 2011). Interviews were used to obtain rich descriptions. These studies explored particular experiences that are personal, implicit, and remain in the non-verbal areas (Stern, 2002), and resulted in deep understanding of the experiences of the music therapists. Similarly, but using an heuristic approach, Wheeler (1999) explored her personal experience of pleasure from working with nine children with severe disabilities. By analyzing *exciting spots* in seven video recorded sessions, Wheeler identified four factors leading to a therapist's feelings of happiness: *intentionality*, *emotionality*, *communication*, *and mutuality*. Based on her findings, Wheeler highlighted the intersubjective nature of non-verbal interactions and argued that music therapists' subjective feelings could be considered as a reflection of clients' feeling states in an intersubjective perspective. On the other hand, some studies explored the experiences of the clients (Forinash, 1990; Grocke, 1999; Hogan, 1999; McFerran, 2001; Trondalen, 2005) which provided valuable insight; however, the client participants in the current study could not verbalize or express their opinions in a formal way. As an interpersonal relationship is a shared experience between two people, exploring the music therapists' experiences may also be helpful in understanding the clients' experiences.

In summary, the review of the relevant literature indicates that people with PIMD need more specific care; interpersonal relationships are an indicator of good QOL; and there are key elements and influencing factors on the positive interactions and relationships between people with PIMD and their caregivers. In the field of music therapy, some music therapists have described the processes of building meaningful relationships with the clients in detail (Agrotou, 1994, 2000; Graham, 2004; Ritchie, 1993). However, the context of music therapy practice has also changed since these studies were published, and there is no empirical study exploring the expertise of music therapists in contemporary practice. Methodologically, it has been demonstrated that qualitative approaches facilitate rich descriptions and foster deep understandings of the phenomena. Particularly, phenomenological approaches have been often used insightfully in investigating the lived experiences of music therapists. Consequently, I chose a qualitative and phenomenological approach for the current study.

Purpose Statement

The purpose of the current study is to explore five music therapists' experiences of interpersonal relationships with adults who have Profound Intellectual and Multiple Disabilities (PIMD). Five music therapists, who are qualified and registered in Australia, participated in this study with their clients. The five pairs had been practicing music therapy together for over a year before being involved in the study. In-depth face-to-face interviews were conducted with the therapists to solicit rich descriptions of the lived experiences. The main research question guiding the study is:

"What is the experience of the interpersonal relationships between five music therapists and their adult clients who have PIMD?"

Sub-questions are:

1. How do the five music therapists describe their experiences of building interpersonal relationships with adults who have PIMD?
2. Are there any common features underlying the experiences described by the music therapists?
3. What meanings and essence could be distilled using the phenomenological methods?

METHOD

Study Design

The current study takes the form of a qualitative inquiry informed by phenomenology. Phenomenology, a method of examining lived experiences, is the most common qualitative approach used in the field of music therapy (Aigen, 2008). Aigen (2008) assumes that this is because phenomenology is closely related to psychology and explores inner experiences of people. It is also claimed to be suitable to "studies of complexities and mysteries of life that require thoughtful, reflective approaches" (Forinash & Grocke, 2005, p. 324). In the current study, phenomenology was used as both philosophical and methodological guide to find meanings and essence of the music therapists' lived experiences. As a philosophical approach, phenomenology suggests a researcher look at a phenomenon with open, fresh, and wondering eyes by identifying and putting aside any pre-assumption and bias (Finlay, 2011; Lewis & Staehler, 2010). As a methodology, phenomenology seeks rich descriptions of individual experiences to explore implicit and explicit meanings, and find the essence of the experiences. Phenomenological methods have been applied to studies in the fields of psychology, education, and social science, and six distinct methods of phenomenology are developed: descriptive empirical phenomenology; hermeneutic phenomenology; life world approaches; Interpretative Phenomenological Analysis (IPA); first-person approaches; reflexive-relational approaches (Finlay, 2011). In the current study, the descriptive empirical approach (Giorgi, 2009) has been taken to describe the music therapists' lived experiences in detail and find similarities in them.

Ethical Precautions Taken

This study required the participation of adults who have profound levels of intellectual disabilities. As they could not make their own decisions to participate in the study, a careful and considerate approach was taken with them and also with their legal guardians

and parents. Ethics clearance was obtained (# 1136760) from the Human Ethics Committee at the University of Melbourne. The five music therapists and the parents and legal guardians were provided with a plain language statement and consent form. A request for a study approval was also submitted to the not-for-profit organization, which hosted the study with four pairs of music therapists and their clients. One pair withdrew from the study due to illness during data collection.

Recruitment Process

As the focus of the study was on the music therapists' lived experiences, selecting the music therapists who had the interpersonal relationships with adults who had PIMD was the priority of the participant selection process. The inclusion criteria for the music therapists were a person who: a) was qualified or registered as a music therapist with the Australian Music Therapy Association, and b) had work experience of more than a year with a client who had PIMD. Any music therapist who did not meet these two inclusion criteria was not invited to participate. Applying purposeful sampling strategies (Patton, 1990, 2001), I used my professional contacts from clinical networks and professional meetings. I also searched for music therapists through the "Australian Music Therapy Membership Directory 2012 (Australian Music Therapy Association, 2012)". I identified a total of 12 music therapists who stated their areas of practices as "adult disability" or "adults with special needs" in the membership directory, and I contacted them through emails and phone-calls.

Once a music therapist agreed to participate, I asked him or her to identify a client who met the inclusion criteria. The inclusion criteria for the adults with PIMD were a person who: a) was between 19 and 60 years old and diagnosed with profound levels of two or more major disabilities/impairments in physical, intellectual, sensory, and medical areas; b) had been attending music therapy sessions for more than a year with the participating therapist; and c) was reported to have an interpersonal relationship with the music therapist. Any adult client who did not satisfy these inclusion criteria was not invited to participate. Once a client was identified, I contacted parents and legal guardians of the client through phone calls to provide information about the study. If they were interested or agreed to participate, I sent them a plain language statement and consent form via post. Most parents and legal guardians willingly supported their adult child or client to participate in the study. The adult clients attended a single music therapy session with their own music therapist whilst I recorded it. Finally, a total of five pairs of music therapists and clients were successfully recruited during November and December 2012.

Participants

Collectively, the average number of years that the five pairs had been practicing together was four years. Only one music therapist participated with two clients who have been practicing small group sessions together over many years. Table 1 shows the details of the five pairs at the time of data collection in December 2012 and January 2013. All names are pseudonyms.

Table 1
Information about the Participants

	RMTs	Gender/ Age	Clinical Experience	Clients	Gender/ Age	Diagnoses
Pair 1	Frances	F/40s	6 Years	Amy	F/19	Rett Syndrome, Epilepsy
Pair 2	Steve	M/30s	3 Years	Eva	F/22	Moya Moya Brain Disease, Cerebral Palsy (Spastic Quadriplegia), Epilepsy
Pair 3	Erica	F/50s	15 Years	Mark	M/22	Cerebral Palsy (Spastic Quadriplegia), Renal Failure - Blind right eye
Pair 4	Darren	M/30s	6 Years	Lyn	F/28	Rett Syndrome, Epilepsy
				Mia	F/29	Mitochondrial Cytopathy, Movement Disorder, Epilepsy, Metabolic Disorder
Pair 5	Owen	M/30s	5 Years	Nelson	M/46	Cerebral Palsy, Severe Developmental Delay, Epilepsy, Arthritis, Oesophageal default

Data Collection

Once I received the written consent forms, I contacted the music therapists to arrange the interviews. The interviews took place at the most convenient time and place for the music therapists. Most music therapists suggested their music therapy office or studio and one music therapist preferred his home. I used two recording devices to record interviews: Roland audio recording device 24-bit WAVE/MP3 recorder "Edirol R–09" and Samsung Digital Audio Player "Yepp YP-T8." The former was the main equipment and the latter was used as a backup for unexpected situations. The average interview time was 82 mins.

Epoche

An epoche was undertaken before collecting data. The word "epoche" originates from a Greek word "epochein", and it means "suspend, refrain, bracket" (Lewis & Staehler,

2010, p. 14). In phenomenology, constructing an epoche requires the researcher to identify his/her "prejudgments, biases, preconceived ideas" (Moustakas, 1994, p. 85) about the phenomenon of the study, and to suspend and bracket them from influencing the processes of data collection and analysis. In the current study, I identified my pre-assumptions and biases about the interpersonal relationships with adult clients who have PIMD in music therapy, which had developed through my own clinical work, research project, and knowledge from the literature. The following two ideas are a summary of the full epoche, and I assumed that these key ideas might appear in the interviews:

1. Most music therapists may recall that working with adults who have PIMD is challenging and emotional. However, they may report that once the inter-subjective communication routines are established, the interactions with them provide the music therapists and the clients rewarding and positive emotions.
2. When asked to describe their experiences with the clients, the music therapists may describe the characteristics found in successful relationships, such as sensitive responsiveness to each other, joint attention, co-regulation, and emotional component (Hostyn & Maes, 2009).

Phenomenological Interviews

Interviews are the most common method for collecting data in phenomenological studies (Englander, 2012; Forinash & Grocke, 2005; McFerran & Grocke, 2007). I conducted in-depth face-to-face interviews (Kvale & Brinkmann, 2009) to obtain rich descriptions of the five music therapists' experiences within this study. For this study, I developed an interview guide, which was divided into two sections. In section one, I asked, "can you tell me about your clinical experience as a music therapist in working with adults with PIMD?" In section two, I asked two questions: "can you tell me about the client?" and "can you reflect any specific moment or a session in which you felt you have a meaningful relationship with the client?" The first question was used as a warm-up question that opened up the conversation. By asking a general, broad, and undirected question about the clinical experience, the music therapists entered the conversation freely. This enabled them to talk about when and where they had been working. The first question prompted the therapists to talk about the clients, which naturally evolved into the second and third questions being asked. I often commented by summarizing their views to confirm what they were talking about and I also asked subsequent questions to prompt more information (Kvale & Brinkmann, 2009). Some questions such as "can you tell me more about that?" and "how did you feel about that?" were frequently asked to get more detailed descriptions of the lived experiences.

Data Analysis

The aim of the descriptive empirical approach used in the current study was to develop detailed individual descriptions of the experiences to find implicit, explicit meanings and essence of the experiences. Finlay claims "there is no clear-cut recipe explaining how to

engage phenomenological analysis, although guidelines are available (2011, p.28)." I followed the seven steps developed by McFerran and Grocke (2007) for phenomenological music therapy studies. The seven steps generated are based on the ideas of Giorgi's (1975) procedure model of analysis, Colaizzi's (1978) method of verification of the analysis, and Moustakas' (1994) use of terminologies (McFerran & Grocke, 2007). All of these are rooted in the philosophy of Edmund Husserl (Husserl, 2002). The details of the seven-step microanalysis (McFerran & Grocke, 2007, p. 275) are below:

Seven-Step Microanalysis

Step 1. Transcribing the interview word for word
Step 2. Identifying key statements
Step 3. Creating structural meaning units
Step 4. Creating experienced meaning units
Step 5. Developing the individual distilled essence
Step 6. Identifying collective themes
Step 7. Creating global meaning units and the final distilled essence

The aim of the first five steps was to develop an individual distilled essence for each music therapist's experience. The last two steps comprised a group analysis through which I identified common themes and developed global meaning units. The aim of the last two steps was to arrive at a final distilled essence of the phenomenon. The following section explains how I conducted each step.

Step 1. Transcribing Word for Word

After completing the interviews with each of the five music therapists, I downloaded the audio files into the computer software "Express Scribe" (NCH Software, 2013). This software helped me to manage the audio files, control the talking speeds of interviewees, and dictate the words into the system. Once I completed the transcriptions, I saved them as Microsoft Word files and emailed to the interviewees to read and amend any incorrect use of words or sentences. Most interviewees corrected some spelling and grammar errors, which were minor changes. These amended versions of the transcriptions were fixed as raw data, as recommended (Giorgi, 2009).

Step 2. Identifying Key Statements

I read the transcriptions again and again to identify key statements. Moustakas (1994, pp. 120-121) calls the key statements *invariant constituents* and suggests testing each statement according to two requirements: a) does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it? and b) is it possible to abstract and label it? Any repetitive and overlapping statements were removed, and any statements that were complicated or unclear in meaning were also removed or amended

appropriately. The following example from Frances's interview is a good example for the latter case.

> Original statement:
> *"So it can be really challenging because you are not getting that… you…you sometimes not getting that feedback. Umm…to know whether you are doing right thing or not. Umm…yes that's the thing I found most challenging with working with this particular group." (Frances)*

In this statement, Frances talks about the most challenging aspect of her work. However, as she spoke, her thoughts were developing over several sentences and I thought this idea could be succinctly put into a sentence such as:

> Changed statement:
> *"The most challenging thing is not getting some feedback from the clients because I don't know whether I am doing right or not." (Frances)*

Dwelling on the transcriptions by repetitively reading each statement and letting the important statements appear (Finlay, 2011) produced several updated drafts for each transcription. Each time, a number of key statements were removed. After several attempts, when I intuitively felt that I had undertaken sufficient *phenomenological reduction*, I moved to the next step.

Step 3. Creating Structural Meaning Units (SMUs)

In this step, I categorized the key statements identified in Step 2 into meaning units. With the guiding question "*what* was the interviewee talking about?," I identified that each meaning unit consisted of several key statements which described similar experiences. For example, the following statements were classified into a structural meaning unit:

> *"I think that familiarity is ultimately the core of the relationship, which is being familiar with what goes on in the session, the therapist, the music and a familiar routine; "Ok let's play this song, I know you like this song, you're gonna have this reaction. And we will do that every session to establish that strength of relationship." So once you understand the person, you're building on that strength of relationship, and then just making that deeper and delving in a little bit deeper and finding out more while evolving the relationship." (Steve)*
>
> *"It's always gonna be challenging to work with the profoundly lower functioning people as it's just less to work with. But in the middle stages of the relationship, once you understand the person more, they*

> *know what you are doing and are familiar with that. You're building on that relationship to make it more solid and really creating familiar ground for them, a familiar relationship for them." (Steve)*
>
> *"Familiar is the word I like to use. Once you establish the relationship, then it's about making it more familiar routine to them. That's less of a challenge than the initial start phase." (Steve)*

I titled this meaning unit as "familiarity is the core of the relationship and it's built in the middle stage of the relationship development" to represent all the statements. When I titled the meaning units, I used interviewees' direct words as recommended by McFerran and Grocke (2007). Through the iterative processes, I produced several updated drafts of SMUs for the data from each interview. In Steve's individual analysis, seven meaning units were created as follows:

SMU 1: Working with adults with PIMD is always challenging.
SMU 2: I'm looking for any reactions as an engagement when working with adults with PIMD.
SMU 3: It takes different stages over time to build relationships with adults with PIMD.
SMU 4: Familiarity is the core of the relationship and its built in the middle of the relationship.
SMU 5: Meaningful moments with Eva are those familiar moments in every session.
SMU 6: Significant moment is when something new, unexpected, and pivotal happens.
SMU 7: I believe that our relationship is definitely obvious, positive, and meaningful to both of us.

Step 4. Creating Experienced Meaning Units (EMUs)

The purpose of analysis in Step 4 was "to seek possible meanings through the utilization of imagination, varying the frames of reference, employing polarities and reversals, and approaching the phenomenon from divergent perspectives, different positions, roles or functions." (Moustakas, 1994, p. 97) This process is called *imaginative variation* and considered a significant aspect in eliciting meanings of the experiences in phenomenology (Finlay, 2011; Moustakas, 1994). With a guiding question "*how* did the interviewee experience the phenomenon?," I tried to re-live the interviewee's experience as suggested by Finlay (2011). As I had over six years of clinical experience as a music therapist with adult clients who have PIMD, I was able to put myself into the interviewee/music therapist's position, and feel the natural emotions induced by the described situations. For example, the following two statements, one from SMU 5 and the other from SMU 7 were selected and contemplated:

> *"(It is also meaningful for me) as a music therapist absolutely. It's validating to know that what you do is important, and has repercussion far beyond the session that you were involved with. In my view, I'm helping her, I'm improving her quality of life and that's a really obvious thing." (SMU7)*
>
> *"Just also finding out from her mom that there was change in her as soon as she found out that she had music that day. She was bit tired or something, then when she found out about music, she got more excited. That was a nice moment to know about because there's anticipation of the session as well, which means she's familiar with it, she knows what to expect, it's comfortable, it's familiar and its' an environment that she can be free to express herself." (SMU 5)*

The statement of SMU 7 made me think that being validated is important for Steve and SMU 5 made me think that it describes a good situation where he most likely felt the validation. Steve said that it was a nice moment but I believed that it could be a validating moment as well. Therefore, a statement, "Steve feels that his work is validated when Eva's mother explains Eva's positive reaction to music therapy" was developed and became Steve's EMU 10. In this way, I considered several statements from different SMUs via multiple perspectives and contemplated them as a whole. It enabled me to explore implicit meanings of the experiences that were not said and hidden in the unconscious level. I also adopted an element of Giorgi's (2009) method in this step by articulating the statements in the third person. Instead of using *I* in the titles of the meaning units, the name of the interviewee was used when creating the titles of EMUs. In this way, I was able to indicate that the interviewees' experiences were now viewed and analyzed from my point of view. For Steve, a total of ten EMUs were developed from seven structural meaning units as follows:

EMU 1: Steve believes that the initial stage is the most challenging time because of the low functioning levels when working with adults with PIMD.
EMU 2: Steve notices that no matter how much they are disabled, adults with PIMD receive music well and display observable reactions.
EMU 3: Steve looks for any reaction in the initial stage of the relationship, but as he understands the client more, Steve identifies certain reactions as key behaviors.
EMU 4: Steve believes that meaningful relationships with adults with PIMD can be established while finding a way to understand the person better.
EMU 5: Steve thinks the relationship with Eva is in the middle stage because they have created a familiar routine.
EMU 6: Steve believes that the familiar vocal interactions with Eva are the core of their relationship.

EMU 7: Steve identifies that meaningful moments and significant moments are different; meaningful moments are when the interaction is familiar and significant moments is when the interactions is unexpected.
EMU 8: Steve believes that Eva enjoys his attention in music therapy because it is not feeding or toileting.
EMU 9: Steve finds the staff's support helpful in establishing meaningful relationships with clients with PIMD.
EMU 10: Steve feels that his work is validated when Eva's mother explains Eva's positive reaction to music therapy.

Step 5. Developing Individual Distilled Essence

"The interweaving, the rhythms of noema-noesis, creates a harmony and an integral understanding of an experience" (Moustakas, 1994, p. 74). In this statement, *noema* refers to SMUs, and *noesis* refers to EMUs in the current study. By following Moustakas' explanation, the titles of SMUs and EMUs were integrated to form the individual distilled essences. The following is the first paragraph of Steve's individual distilled essence.

> For Steve, the interpersonal relationships with adults who have PIMD are experienced while finding a way to understand the person better and it takes different forms over time. Although it is always challenging because of the low functioning level, Steve considers the initial stage the most challenging time. Steve looks for any reaction as an engagement in this initial stage of the relationship because he believes that no matter how much they are disabled, adults with PIMD receive music well and display observable reactions. As he understands the client more, Steve can identify certain reactions as key behaviors.

The full versions of Steve's distilled essence and the other four music therapists' essences can be found later in the result section. All the individual distilled essences were examined by my primary supervisor. She compared the titles of structural and experienced meaning units with my epoche and validated that the results of the individual analysis were not forced or influenced by my pre-assumptions and biases.

Step 6. Identifying Collective Themes

In this first step of collective analysis, I examined the titles of EMUs of all the five interviews, and searched for *common, significant* and *individual* themes. McFerran and Grocke (2007) define each theme as follows:

- Common theme: Experiences that all the five music therapists described.
- Significant theme: Experiences that several music therapists described.
- Individual theme: An experience that only one music therapist described.

The nature of qualitative research is not to value agreed perspectives any less than individual perspectives, hence each type of collective theme was considered to be meaningful. The following section explains how I identified a common theme. After browsing the titles of EMUs of all five interviewees, I found that all the five music therapists described the impacts of settings and supports from staff and family on their experiences of interpersonal relationships. Erica stated why she preferred an individual setting to a group setting:

> *"In an individual session, I have the time, and I can follow their lead much more."*
>
> *"Getting to know someone in depth isn't quite possible in a group situation."*

Darren explained why the family setting was important for him when establishing the interpersonal relationships with Lyn and May:

> *"The family support is an important factor."*
>
> *"So every time when you walk in, you feel like you are part of the family."*
>
> *"There are few examples that are quite interesting. The way they communicate with me (smiles) makes me feel…it's creating this atmosphere. So it makes me feel that "Ok, you are part of this little family". Not like the real family, but you are like one of the important, not just a therapist or other medical staff. That's the difference. It's lots of relationships going on there, so that's the experience."*

Steve and Frances described how they found it helpful to receive the staff and disability support workers' assistance in the community and home settings:

> *"I'm always happy to receive information from them (staff) and they are always very helpful making me understand these people better." (Steve)*
>
> *"Having Julia, supportive worker in music therapy is really positive for me because she's enthusiastic and supportive. I've built up a relationship with her as well which has been good for me." (Frances)*

Owen was the only music therapist working in an institutional setting, and he explained how he perceived the negative impacts of this setting on the staff' attitudes toward the adult clients with PIMD:

> *"Change is a very gradual process here. People get very established. And that largely would be part of the institutional setting. It's very structured so introducing something new takes quite a while."*
>
> *"When I first meet someone, I will try and work out what type of music they actually like. Because the standard response when I do my regular intake survey is "Oh, just play them Abba" because everyone loves Abba here and they always have."*
>
> *"I guess no one's found something else for him that he gets so involved in."*

After identifying the common theme, I searched for appropriate academic and professional language in the related academic literature that could precisely label all the collective descriptions. Not taking one interviewee's language in this step was important in this step (McFerran & Grocke, 2007). The word "context" was selected for referring to the settings and the supports from staff and families. The phrase "the quality of interpersonal relationship" was also used for the title of the common theme 1, which is "the context in which music therapy happens impacts the quality of interpersonal relationship for all the music therapists." In this way, I identified two common themes, six significant themes, and one individual theme. The details are reported in the result section.

Step 7. Creating Global Meaning Units and the Final Distilled Essence

In this final step, I categorized the nine collective themes identified in the step six into global meaning units. I applied *imaginative variation* similarly to the way it was used in the creation of EMUs in step 4. For example, the following two themes were categorized into one of the global meaning units:

- The context in which music therapy happens impacts the quality of interpersonal relationship for all the music therapists. (Common theme 1)
- Two music therapists believe that the degree of profound disability will always impact the quality of interpersonal relationship. (Significant theme 5)

The music therapists described the significant impacts of the settings, supports from family and disability support workers as well as the severity of disability on their relationships. Consequently, global meaning unit 1 was titled "the conditions, such as contexts and severity of disability, exert significant influence on the quality of interpersonal relationships."

To create the final distilled essence, the titles of the global meaning units were integrated appropriately. The global meaning units and final distilled essence are reported in the results section.

Verification and Validation of the Analysis

To validate and verify the results of individual and group analysis, I used two methods. First, I used a *member-checking* process (Lincoln & Guba, 1985; Robson, 2011). The five music therapists/interviewees were asked to validate the interview transcriptions by reading and amending any errors. In addition, each was invited to verify his or her individual distilled essence. This idea of returning to the participants with the analysis result is recommended by Colaizzi (1978) and adopted in the phenomenological seven steps analysis (McFerran & Grocke, 2007). The music therapists were encouraged to provide feedback on the individual distilled essence and suggest different words or phrases to replace any part of the original essence. In this way, they became members who actively participate in constructing the meanings of the phenomenon of the present study. Second, I asked experts in the field of music therapy to verify the processes and outcomes of individual and group analysis. My primary supervisor supervised all the processes of analysis and entered into a dialogue about the accuracy and transparency of the individual and group analysis. A group of music therapy researchers at The National Australian Music Therapy Research Unit also provided critical feedback and advice throughout the analysis process.

RESULTS AND DISCUSSION

This section reports and discusses the results of individual and group analyses. First, I will present the five individual distilled essences and the results of the member-checking verification. Then, I will report the results of the group analysis, discussing collective themes and global meaning units. At the end, I provide the final global distilled essence and a brief conclusion.

Individual distilled essences

Steve

For Steve, the interpersonal relationships with adults who have PIMD occur while finding a way to understand the person better, and they take different forms over time. Although building interpersonal relationships with adults with PIMD is always challenging because of the clients' low functioning level, Steve considers the initial stage the most challenging time. In this stage of relationship, Steve looks for any reaction as a sign of engagement. He believes that no matter the level of disability of adults with PIMD they receive music well and display observable responses. As he understands each client better, Steve can identify certain reactions as key behaviors.

According to Steve, familiarity is the core of the relationship and it is built in the middle stage of relationship. As Steve and Eva have created a familiar routine, he believes that their relationship is in the middle stage. Steve considers that *meaningful* and *significant* moments in the interpersonal relationships are different: meaningful moments are when interactions are familiar and significant moments are when interactions are

unexpected. Therefore, the meaningful moments with Eva are those familiar moments in every session and the familiar vocal interactions with Eva are the core of their relationship. Steve believes that Eva enjoys attention that is meaningful rather than functional, like feeding or toileting. When Eva's mother explained how Eva reacted positively to attending music therapy, Steve felt that his work was validated. He also finds the staff's support helpful in establishing the meaningful relationships with Eva. For Steve, the experience of the interpersonal relationship with Eva is definitely obvious, positive, and meaningful for both of them.

Frances

For Frances, the experience of building an interpersonal relationship with an adult who has PIMD is like a journey. When there is no response from a client, Frances feels confused and lost, not knowing where to go. However, when she finally gets small responses, such as eye contact and smiles, she feels relieved and it is like she is getting somewhere. For Frances, the journey is rewarding as much as challenging. It also takes a long time and the progress is gradual.

The experience of the interpersonal relationship with Amy is a positive experience for Frances. She finds working with Amy easier than other clients because Amy offers so many recognizable responses. Amy's progress has been gradual over the years, and Frances never expected that she would experience this remarkable progress with Amy. Frances feels grateful for the support of Amy's caregiver in music therapy sessions because it is helpful in Amy's progress. Frances cannot pinpoint a particular meaningful moment with Amy. However, when Amy offers lots of eye contacts and smiles, Frances finds these small interacting moments as meaningful. Once when Amy was really sick, Frances realized that her condition was degenerating, and she was reminded that one day it would have to end either because Amy becomes sick or Frances leaves the organization. Although Frances is aware that getting attached to a client is a natural process in this journey, Frances tries not to get overly attached.

Erica

For Erica, building interpersonal relationships with adults with PIMD is enjoyable and fascinating in individual settings. As a result of years of experience, she is now much more patient, relaxed, and confident about the process. Erica also has learnt that music therapists should be both quick and alert yet patient when documenting the small changes upon which a fluid relationship can be built. The experience of the interpersonal relationship with Mark is a process of getting to know him deeply by working out and trying different things with him. Erica believes that it is possible because they have individual sessions that allow time and space for Mark to reveal who he is. In the initial stage of the interpersonal relationship, Erica did not underestimate Mark and observed the behaviors and responses to understand his communication. Erica then discovered that Mark could vocalize in the tonality of the music and anticipate certain points in songs.

Erica now knows Mark's various behaviors and the meanings in different situations. It is helpful for Erica to understand which songs Mark prefers and when he

wants to vocally interact with her. Accordingly, Erica believes that her role is to find those preferred songs and particular parts that excite Mark to vocally interact with her. She considers this part of her role is a key difference to the role of an entertainer. One meaningful session with Mark was his last birthday session as Mark enjoyed listening to all of his preferred songs. But Erica thinks that it was an unusual session because she didn't meet him at an intellectual or cognitive level but more like an entertainer. There are still things Erica wants to achieve within the relationship with Mark. For example, Mark's behavior of keeping her at arms' length seems like a defensive behavior and Erica believes it is because he doesn't trust her enough. Although it seems unrealistic, Erica wants to help Mark overcome this behavior. Erica wishes the relationship with Mark would develop into more fluid and equal relationship in the future.

Darren

For Darren, the experience of interpersonal relationships with adults who have PIMD can be influenced by clients' physical conditions. When a client's physical condition is good, the client and Darren have ongoing interactions and he feels very rewarded. When a client is ill however, both Darren and the clients can be frustrated because they cannot control these things. Accordingly, Darren believes that maximizing opportunities to make choices and control over the environment is important for adults with PIMD.

Darren's experience of the interpersonal relationships with Lyn and Mia in a home setting is different from and more positive than his previous experiences in hospital and aged care settings. Because of the 8 years of music therapy experiences together, Lyn, Mia, and their families are one of the most understanding people. The way they communicate with Darren makes him feel like he is part of this little family. For example, when walking into the house for sessions, Darren feels like he is their brother rather than a therapist. This makes him feel happy. Therefore, Darren believes that the family support is a crucial factor in building the interpersonal relationships with Mia and Lyn. In the family setting, the parents willingly assist him anytime whenever there are difficulties. The family's introduction to Lyn and Mia's non-verbal behaviors was really helpful for Darren as well because it reduced the time understanding them. Darren believes that communicating with each other through two-way interactions is important when building the interpersonal relationships. He is learning their language and they are also learning his language. Darren has learnt to read Mia's emotional expressions and he feels great to know her in person. Meaningful moments with Lyn and Mia have similarities. They were so sick that they could not participate in music therapy for a period of time. Darren felt worried and realized that he was emotionally attached to them. When they became well and actively participated in the session he was relieved from the worries and it became meaningful sessions. For Lyn and Mia, music therapy now has become a part of their lives. Darren feels lucky to have this valuable experience with them.

Owen

For Owen, the experience of building interpersonal relationships with adults who have PIMD is about trying different things slowly over a long time and getting to know each client's interest and preference better. Depending on a personality and mood, each client needs a unique interactive approach and they can be sociable and independent in interactions. Owen believes that people with PIMD need human interactions and socialization in addition to personal cares although the profound level of physical disability limits what the adults with PIMD can do. In the institutional setting, staff do not seem to consider each individual differently and the experience of developing and learning new skills is missing for clients. Consequently, he believes that the rigid institutional environment is not ideal for adults with PIMD. Owen works differently from other staff in the institution and finds it interesting when some staff and parents are very surprised by the progress that the adults with PIMD achieve in music therapy.

The experience of the interpersonal relationship with Nelson is difficult for Owen to explain, but certainly he has a special connection with Nelson. Owen prioritizes Nelson over other clients because he is isolated. Nelson also has impressed Owen as he continued to develop his musical expression and the capacity as a drummer even after he became very sick. Meaningful moments with Nelson occur each time when Owen returns after being away overseas for his holiday. Nelson shows his particular cheeky facial expression that looks as if asking Owen, "Where have you been?" Interpreting the behaviors of the non-verbal clients and judging how much is his subjective imagination are challenging. Sometimes it is difficult for Owen to keep motivated to work because it is not musically rewarding. However, at the same time, Owen feels proud of his professional skills when he sees the progress of the clients. Owen believes his role as a music therapist is different from a musician playing in a pub because he is conscious of how to play music and meet a client in a therapeutic relationship.

Member-checking

I emailed the individual distilled essence and a letter requesting to verify the document to each music therapist. I asked them to comment on the distilled essence and suggest any other word or phrase for replacement if a change was needed. Table 2 presents the music therapists' feedback on their individual results.

Table 2
Music Therapists' Feedback on the Individual Distilled Essences

Frances	*What I read is pretty accurate, and reflects what I remember we discussed during the interview.*
Darren	*What I have read is very accurate. I believe that the video recording of music therapy session will also help to confirm the small details of communications and any unclear descriptions of the experiences.*

Steve	*As for the distilled essence, I feel that you interpreted my experience well and have detailed the process accurately. Key words like familiarity, key behaviours, challenging and meaningful relationship have been included and are explained well. The idea of a process is true, and put in the context of music therapy as a process, then assessment, treatment (familiarity) and then evaluation (progress) would be the three stages of the process with Eva. You didn't include much about the third stage, but I would say it's the progression of familiar routines, so that the repetition/familiarity is varied slightly in order to produce a positive development of behaviours.*
Owen	*I find it interesting to see other's perception of my view. I do come across very critical of the established culture within my workplace. I guess I do find the institutional culture extremely challenging, perhaps I haven't completed the institutionalization process yet, many of the staff I work with have worked at the same facility with the same clients in excess for 20 years, a few longer than 40 years. Your distillation captures my underlying goal of accessing people on an individual level and providing more than the basic (though very important) needs of shelter and food. This is something which I find challenging to implement in such a medical environment.*

As can be seen, most music therapists replied that the essence well captured what they described in the interview. Therefore, none of the original essence was changed. Erica was the only music therapist who suggested changes of some words and questioned some parts of her essence.

Erica's Suggestions

Erica suggested changing two phrases to make them more appropriate. For example, she suggested changing the phrase "as an experienced music therapist" to "as a result of years of experience" and "at the initial stage of interpersonal relationship" to "at the initial stages of the interpersonal relationship." As these minor suggestions were reasonable, they were incorporated into Erica's individual distilled essence. Erica, furthermore, commented on two sentences:

> Original sentence 1: Erica thinks that Mark's behavior of keeping her in his arms' length is a *clear negative* behavior, and believes it is because he doesn't trust her enough. Erica commented:
>
> > *"I'm really not sure of this statement though I know that this was in the interview. Being at arms' length is a saying meaning not letting someone get too close. As for it being a negative behavior, it really is a defensive behavior on his part but I don't take it personally. I hesitate*

> *on reading this, to extrapolate his intention because really he lacks so many skills to express closeness and he is also tactile defensive."*

Original sentence 2: Although it seems *unrealistic*, Erica wants to help Mark overcome this *negative* behavior. *Erica commented:*

> *"Is this in your opinion or in mine? It isn't an aim of mine for his therapy at all and in fact I am happy to see him happy and vocalizing as he arrives, evidence that he knows where he is coming and enjoys the experience. I don't know if you can pull this statement or not but it really isn't accurate overall though I know I said it at the time. I think I was 'Clutching at straws' at the time of the question."*

Erica seemed uncomfortable about those underlined words such as *negative* and *unrealistic*. Erica asked whether these are her opinion or my opinion. The word "negative" was not said by Erica, however, she stated that she classifies Mark's behaviors into positive, negative, and neutral. Through utilizing *imaginative variation* in step 4, I assumed that the particular behavior of keeping her at arms' length is more likely a negative behavior. In this particular case, however, Erica mentioned the word "defensive" in her comment and this word seems more accurate than the word "negative." Consequently, I changed the word "negative" into "defensive" in the final distilled essence.

With the second inquiry, Erica admitted that she did speak the word "unrealistic" but explained that she was "clutching at straws" in the interview. The process of analysis was all based on what Erica said during the interview, and the aim of the analysis was to find the hidden meanings of the experience in the interviewee's unconscious. Giorgi (2009) argues that the interviewees often cannot understand the result of the analysis because they do not know how the researcher has analyzed the transcriptions with a *phenomenological attitude*. Therefore, considering this fact, accepting only a reasonable suggestion seems appropriate and I decided only to remove the word "negative," as decided when discussing the first enquiry.

Results of the Group Analysis

By analyzing the EMUs of the five music therapists as a group, I identified nine collective themes and developed three global meaning units and a final distilled essence.

Collective Themes

The nine collective themes consist of two common themes, six significant themes, and one individual theme. The following section presents these collective themes.

Common themes

Common theme one: The context in which music therapy happens impacts the quality of interpersonal relationship for all the music therapists.

The music therapists described how the settings and assistance from the family members and disability support workers influenced their relationships with the clients. The details of the identification of this theme are explained in the method section. Frances and Darren were working at their clients' homes and described how the family members and a disability support worker assisted them to understand the clients better. Steve was working at the community day-care centre and reported that the staff helped him to understand Eva better by providing information. Erica believed that the individual setting was important for her to develop the relationship with Mark because it provided them enough time and space. Owen was the only music therapist working in the institutional setting and reported his negative perspective on working in this environment. He believed that the rigid environment and negative staff attitudes in the institution are not ideal for adults with PIMD. In conclusion, all the music therapists perceived the environment where the music therapy happened significantly influenced their relationships with the clients. It appears that the home and community settings create better environment for the long-term benefit of music therapy to develop than the institutional setting in this study.

Common theme two: All the music therapists are heartened by the clients' commitments in music therapy.

The music therapists reflected on the clients' progresses over the several years and explained how they were heartened by the clients' commitments in music therapy. For example, Owen stated:

> *"He's one guy at that point he would play really anything. But he was really quite actually felt more, at times with Nelson it was almost like colleagues in terms of musicians. And he was actually more accurate in terms of tempo and articulation. He was probably the most accurate drummer that I had working with here, I actually probably working with about 15 different drummers at the time."*

It appears that Owen was impressed by Nelson's musical achievement as a drummer. Frances reflected Amy's progress that she never expected:

> *"It's interesting to see how things have progressed and now she is gotten older. When I first started there, we were singing the wiggle songs and now we are singing more adult stuff. We have moved through so that's been an interesting part of the relationship as well. Because of her condition, I've never expected to see huge changes and I think it's about improving the quality of life."*

Similarly, Darren explained how his clients taught him to read their emotional expressions:

> *" I was actually learnt to read their emotional change from them. At the very beginning, I didn't know them well so I didn't know what to expect. So it was hard for me to read their language. Then the longer I spent time with them I knew their personalities and characters. Now, I know when they respond in particular ways what that means. So actually I know them in person."*

For Erica, describing Mark's progress over the last six years was a pleasure. She kept smiling while comparing their interactions in the past and present:

> *"In the past I moved away from encouraging him to touch the instruments. Then I've worked a lot of encouraging him to indicate that he wants more of a song, so whether was 'more' or 'not' and then also turn-taking or that vocal interplay of singing one after another or harmonizing together. He moves into the tonality of the pieces so it's nice to change the keys."*
>
> *"There's sense of he is listening, he is still, he is upright, and then he might throw his head back, sometimes he will move his arms or he might move his legs and there is a whole blurting and 'Ah~!!'s. Often he will do it after the song as well. If he's really enjoyed it he will sing and he does blurting and he vocalises 'ah~~' and 'um~~' if he's really enjoying it."*
>
> *"I get that anticipation at the start, I play and I can see he's getting short of breath and anticipation just because he takes a little gasp in. Then he will maybe blurt, or maybe smile comes in to his face. Maybe he will start moving his arm around and I've got some singing happening and then I just can sustain it. When I just sustain the interaction and that connection in the music and I just keep going with it until the end. Even then if I have the end, I might ask him if he wants some more and it will be a sigh and then I play 'Dreamer' all over again (smiles)."*

In these statements, it is obvious that Erica changed her strategy to interact with Mark in the past. Now she knows when Mark is ready for the vocal interplays, and this development in their relationship gives her joy. In a similar way, Steve explained the nice moment when he found out the fact that Eva was excited about attending music therapy:

> *"Just also finding out from her mom that there was change in her as soon as she found out that she had music that day. She was bit tired or something then when she found out about music she got more excited. That was a nice moment to know about because there's anticipation of the session as well which means she's familiar with it she knows what to expect, it's comfortable, it's familiar and it's an environment that she can be free to express herself."*

In the above statements, it is evident that all the music therapists reflected with pleasure on the clients' progress, which induced positive feelings in them. Nelson became an accurate drummer; Amy developmentally progressed into adulthood; Lyn and Mia taught Darren how to read their emotional expressions; Mark now displays when he is available for vocal interplays; Eva was excited about attending a music therapy session. In addition, the music therapists seem to have heart-warming feelings such as feeling impressed and proud (Owen), pleasantly surprised (Frances), grateful (Darren), excited (Erica), and nice (Steve) for their clients' commitments in music therapy. Consequently, I found "heartened" the most appropriate word for describing the music therapists' general feelings.

Significant themes

Significant theme one: Four participants believe that music therapists have unique roles in meeting the psychological needs of their clients.

Owen, Darren, Steve, and Erica described their roles of being music therapists. For example, Darren stated:

> *"The adults with PIMD have a very few skills to connect with other people. So it is our job to maximise and enlarge their potential abilities and improve their quality of life through music."*

Erica described her role as being patient to document clients' small changes and finding appropriate songs that motivate the clients to interact:

> *"It just takes time for the person to reveal themselves and for you to actually develop that relationship where they are going to express themselves fully. So I found it a very slow process of being very patient to try to record and document the small changes that are happening and building upon those."*

> *"So then I try and work out whether he will vocalise in particular parts of the pieces where he gets a bit of a thrill out of it, and I can tell when he gets some thrills and he will go 'Oh, yes that's my favourite bit.'"*

> *"It's really up to me to find those songs which are going to stimulate those moments again and again. So that's why I play the same songs over the several weeks and encourage it at certain points. I know he's going to sing at that point."*

Steve claimed that Eva enjoys his attention in music therapy because it is different from personal care:

> *"I think it's definitely a positive relationship for her. I think she has a meaningful engagement with me as a therapist. And I think she values the times we have and she benefits from that. I think she's happy to get some different attention that's not feeding or toileting."*

Similarly, Owen argued that Nelson needs not only personal care but also human interaction and socialization:

> *"'It's isolation and he's not going to recover if he is isolated.' So that became the key thing. Establishing some contact with him that wasn't personal care. It wasn't just feeding, toileting, and shaving."*

> *"Obviously his physical situation always needs someone to help feeding and bathing that sort of basically daily skills. I think he would've been more independent in his interactions and socially."*

In summary, the music therapists defined their roles as maximizing clients' potential abilities and improving their quality of life (Darren); being patient to record small changes and finding appropriate songs to motivate interactions (Erica); providing a different attention that is not personal care (Steve and Owen); and providing human interaction and socialization (Owen). Most of these roles are related to improving psychosocial wellbeing of the clients.

Furthermore, three music therapists compared the role of a music therapist with a classical music player (Darren); an entertainer (Erica); a musician playing in a pub (Owen) to distinguish the unique role of being a music therapist. For example:

> *"As a classical music player in background, what I cared was 'how this music sounds? how do I make the music sounds beautiful?, or how do I please people with my music?'. But as a music therapist, I'm more into 'what can I do for the clients through music?.' What we can do is to maximise their choices, help them to get more control, assist them to manipulate anything they want to do, and make the things become closure to their ideal outcome." (Darren)*

> *"I suppose just giving Mark all of his favourite stuff is a nice thing to do for his birthday but again it's bit like turning on the switch, anyone*

> *can put on his favourite music. That's not satisfying for me overall and potentially it would be satisfying for him, but then what are we doing in the therapeutic sense for him? Are we being therapists or being entertainers? So that's bit a conundrum for me." (Erica)*
>
> *"I guess if I did that all the time, I would feel like I was there just being any musician or being an entertainer, isn't challenging or exploring other avenues what they are capable of. So that session isn't how I would potentially always want to work. I know a lot of people want me to just provide them with a joyful experience and that can be valid too but as a therapist I want to explore, challenge, meet other needs within that person as well or give them an opportunity for choice." (Erica)*
>
> *"I'm obviously not playing for me cause I'm a therapist. I actually meet that person in that therapeutic relationship. I have to be very careful about how I play. If I play just for fun, it won't have that same quality of interaction, they might like it but then they might get that on Monday night Disco. So to get that high quality interaction I really have to be careful and conscious about how I execute the music. So the Bossa I played with Nelson this morning would be very different from a Bossa that I would play in a pub." (Owen)*

The critical fact to consider in the above statements is that the three music therapists have dual roles. In short, Darren plays a violin as a classical music player, Owen plays in a pub as a Jazz guitarist, and Erica teaches piano. Accordingly, it is clear that they do not underestimate other musicians' roles in comparison to the music therapists' roles. Rather, these statements show how clear and strong their professional identities are and how seriously they perceive their roles in meeting clients in the therapeutic relationships. Moreover, as Erica mentioned, "*I know a lot of people want me to just provide them with a joyful experience,"* the music therapists seem aware of the expectations from others to provide entertainment. They claim that their roles are not only to provide joyful experiences but also to explore and maximize the clients' potential developments and to support their psychosocial needs. The frequent misperception of music therapy by the public seems to be the main reason that they articulated and stressed their roles so strongly by comparing them with public expectations or closely related roles. Promoting awareness of the benefits of music therapy for adult clients with PIMD and providing education about the therapeutic roles of the music therapists to people who take care of the clients—including parents, disability support workers, and service managers—would be crucial for positive improvement in the future.

Significant theme two: Three music therapists experience emotional bonds and attachments with the clients.

Frances, Owen, and Darren reported that they experienced emotional bonds and attachments with the clients. They explained how their clients became special for them:

> *"Although Amy has a profound disability I like working with her because she does give you response. A lot of the time, I know when she likes a song." (Frances)*

> *"I'm not sure exactly what it is but there is some connection and the nurses comment on that. They always laugh cause whenever I've come back, I always set up and say 'How's Nelson?' I don't know if he is my favourite but certainly someone that's always on top of the list and someone in clinical perspective, I do prioritise because of his isolation. He only really goes from his bedroom to the lounge room. The same six people he lives with and there is a pool of nurses that come through but there is no other environment and no other stimulation. He isn't actually my favourite, I don't think. It's inappropriate at any point in the relationship. Perhaps it is because I've seen him so long." (Owen)*

> *"Lyn and Mia are one of the most understanding clients due to their previous experience. They have been receiving music therapy since 2008, so they had seven or eight music therapists. They are fully aware of what music therapy is and what this can do for them. So they've been very supportive, which is very valuable experience for me. It's very difficult to find clients like these two." (Darren)*

In addition, Darren and Frances explained how they felt emotionally attached to the clients when they were sick:

> *"Especially when they were sick or in hospital, I found myself getting worried: 'Oh, what is happening?' 'Is she gonna be all right?' I find it interesting because from my previous experience in an aged care, I did have that feeling but because it's run by a facility, I didn't approach the family members directly. I didn't share with them or I didn't get attached to them that close. But Lyn and Mia are in a different setting. It does bring some personal relationship into it. But of course, as a professional, you won't really show them that. This is like a personal experience that I share with other therapists. That's something that I find quite fascinating too." (Darren)*

> *"The flip side of the relationship with Amy is that one day it will have to end, either because she gets sick or I leave the organization. Especially last year when Amy has got really sick, it has reminded me that it may happen one day. So I'm careful not to get attached but it's a part of my job. I do get attached in a way and that's natural." (Frances)*

The music therapists used the phrases such as "like working with her," "get attached" (Frances); "some connection," "my favourite," "always on top of the list," "I do priorities"

(Owen); "get attached," "got worried," "personal experience," "difficult to find clients like these two" (Darren). These expressions clearly show the strong emotional bonds and attachments between the music therapists and clients.

Furthermore, from these statements, it is evident that the three music therapists responded differently to the attachment issue. For example, Frances admitted that she was getting attached to Amy. She revealed her worries of ending the therapeutic relationship with Amy one day, and then stated that this attachment was "*part of her job and it is natural*". Similarly, Darren accepted the fact that he was emotionally attached to Lyn and Mia, and explained how it was different from his previous experiences in different settings. Later, however, he stated, "*as a professional, you won't really show them that. This is like a personal experience that I share with other therapists.*" Thus, it is obvious that Darren believed that showing his emotions to his clients is not a professional behavior.

In contrast to Frances and Darren, who admitted their emotional bonds and attachments to their clients, Owen expressed a strong denial about getting attached to a client: "He isn't my favourite, *I don't think. It's inappropriate at any point in the relationship. Perhaps it is because I've seen him so long."* Owen, however, seemed to experience some minor internal conflicts, because other times he stated: *"I'm not sure exactly what it is but there is some connection and the nurses comment on that." and "I don't know if he is my favourite but certainly someone that's always on top of the list."* I assume that the fact that Owen worked in the institutional setting placed him in a difficult situation to discuss this attachment issue because it is against policy. Considering the fact that Frances and Darren were employed by the community disability organization and worked in the clients' homes seemed to make this difference among the three music therapists.

Significant theme three: Two music therapists consider the inter-subjective interactions meaningful in their relationships.

Frances stated:

> *"It's hard to say any particular moment when I feel we have a meaningful relationship. I get that feeling just in general from when I work with her rather than any specific moment."*
>
> *"I get a lot of eye contact from her. I show all the pictures and she's looking at the picture and me. I also get big smiles when I arrive to have a session. Especially when I come back after some period due to break or sickness, she knows 'it's all again'. I love that side because it's clear she not only recognizes me but also recognizes what that means."*

According to these statements, Amy used eye gaze to indicate her choice of a song and smiled to express her happy feelings when Frances comes to have a music therapy session. By receiving these intentional or affective responses in particular

situations and contexts, Frances seems to understand the implicit meanings hidden behind Amy's non-verbal responses. For instance, the following statement demonstrates that: "*she knows 'it's all again.' […] it's clear she not only recognizes me but also recognizes what that means*." Frances felt she knew what Amy was thinking and feeling by observing her smiles and demeanours. Similar interactions are also described in Steve and Eva's experiences:

> *"Meaningful moments with Eva are those familiar moments. I don't think there's been any really huge moment with Eva. Because I think vocalisation is significant in it, but that happens every session or I try to get that to happen every session. I don't think there's a really huge moment where you go 'Wow, that's above and beyond than expected'. It's just more about that familiar relationship and familiarity of what goes on."*
>
> *"I think that familiarity is ultimately the core of the relationship, which is being familiar with what goes on the session: the therapist, the music, and a familiar routine, 'Ok, let's play this song. I know you like this song, you're gonna have this reaction. And we will do that every session to establish that strength of relationship.' So once you understand the person, you're building on that strength of relationship and then just making that deeper, delving in little bit deeper, and finding out more while evolving the relationship."*
>
> *"So as for moment, those are the moments where she will vocalise. Just the other week, she was doing two syllables, 'I-yee-yha', "I-yee-yha'. It's something that's usually different. Usually it's high-pitched vocalisation like 'Ah- Ah- Ah'. And I always say, 'Ah, you're gonna sing for me today. Ah, it's good to hear you singing Eva. Playing shaker and singing! Oh! good to hear you.' So they are the moments that I guess really define the relationship. It's the interaction and then vocalising, making eye contact, and trembling. Then interaction increases during the hello and good-bye songs and there are more reactions as well."*

Eva used vocalizations and eye contact to intentionally communicate with Steve and also displayed affective responses such as trembling of her whole body to express her excitement. The kind of interactions described by Frances and Steve can be referred as intersubjective communication. In the field of developmental psychology, Trevarthen (1999, p. 413) defines intersubjectivity as "the process in which mental activity including conscious awareness, motives and intentions, cognitions, and emotions—is transferred between minds." Stern (2010, p. 43) defines intersubjectivity as "the sharing of another's experience" and further argues, "the sharing of another's vitality forms is probably the earliest, easiest, and most direct path into another's subjective experience". According to Trevarthen and Stern, the inter-subjective interactions described by the music therapists

clearly show how the intersubjectivity is experienced with the adult clients with PIMD in music therapy. Through matching and mirroring each other's behavior and sharing affect attunement, they exchange each other's emotions and intentions successfully. The sharing of the vitality forms is the essential element of the intersubjective interactions and evidenced by the four key elements in successful interactions: sensitive responsiveness, joint attention, co-regulation, and emotional component (Hostyn & Maes, 2009). As the benefits of these intersubjective interactions are considered crucial for infants to develop physically, psychologically, intellectually, emotionally, and socially, the adult clients with PIMD also receive significant benefits from these interactions. So far, viewing the interactions with the adults with PIMD from the intersubjective philosophical framework has not been discussed in the field of music therapy. Consequently, more studies on these inter-subjective moments would improve our understanding of the meaningful relationships with adults who have PIMD.

Significant theme four: Two music therapists have struggled before developing confidence in the relationships.

Frances described how she felt confused and lost at the initial stages of the relationships:

> *"Working with adults with PIMD is confusing at times because you are not sure where to go. But you do feel getting something out of it anyway."*
>
> *"(When I do get the response), It's like 'Oh yeah, I'm getting somewhere… something'"*
>
> *"Working with adults with PIMD is challenging when there is no response all the time. But it's also rewarding to work with adults with PIMD when you do get a response after a long time. Sometimes you suddenly get some eye contact, you might get a rocking in response to music, or you might see a smile."*

Similarly, Steve compared how it was different working at the initial and middle stages of the relationships:

> *"I think at the start it's always hit and miss, it's very difficult at the initial stage. But as the relationship goes on, it's definitely a lot easier to tell certain behaviours are the key behaviours you're looking for."*
>
> *"Not having a lot to work with is the challenge, and then while trying to find a way in to work with that person you can get a meaningful relationship established."*
>
> *"In the middle stages of the relationship, once you understand the person more, they know what you are doing and are familiar with that.*

> *You're building on that relationship to make it more solid and really creating familiar ground for them, a familiar relationship for them."*

Table 3 summarizes Frances and Steve's statements.

Table 3
Changes in the Initial and Middle Stage

	Initial stage	Middle stage
Frances	Confused	Relieved
	Feeling lost	Getting somewhere
	Getting no response	Getting some responses
	Challenging	Rewarding
Steve	Hit and Miss	Certain behavior became a key behavior
	Very difficult	A lot easier
	Unfamiliar	Familiar
	Not having a lot to work with	Finding a way in to work with that person

As presented in Table 3, Steve and Frances generally felt confused and found it difficult in the initial stages of the relationships because the clients with PIMD did not respond to them. However, with regular and consistent engagements, the clients slowly began to show responses, such as suddenly making eye contact and smiling, which made the music therapists feel relieved. These particular behaviors became key behaviors, and by facilitating these moments again and again when the clients displayed these key behaviors, the music therapists were able to build familiar interaction routines and develop meaningful relationships while building the inter-subjective interaction routines over several years. These descriptions seem very helpful in understanding what happens during the initial and middle stages of building relationships with adults who have PIMD.

Significant theme five: Two music therapists believe that the degree of profound disability will always impact the quality of interpersonal relationship.

Steve stated:

> *"Working with adults with PIMD is always pretty challenging, the less functioning someone has, the less interaction there can be in a way."*

> *"It's the different functioning levels that make it challenge right throughout the whole relationship."*

Similarly, Owen explained difficulties when working with non-verbal clients who have intellectual disabilities:

> *"Not every session is so clear that it's a successful session. Some sessions and clients I really gotta think, people with this type of disabilities can be difficult to read and judge how much is my own subjective opinion. You might think that it was great, then you talk to someone and they say, 'Ah - they do that all the time.' So a lot of it is really trying to get to know someone better over time so you know what's good and what's not."*

> *"The people I work with here often don't have a level of insight where we can discuss things with like other areas of work. I don't get to deconstruct things with my client, what could this mean in other areas of life, because often they don't have the communication skills to have that discussion."*

Steve explained how the severely limited physical and intellectual abilities of the person facilitate less interaction and challenge the whole process of building the interpersonal relationships. Owen also described how non-verbal communications sometimes caused confusion and frustration for him. He raised an important issue about getting conflicting opinions on clients' non-verbal behaviors with other staff. This is a practical issue that will persist when working with non-verbal clients in the world outside of institutions. A provision of peer de-briefing or supervision from experienced therapists would be helpful in managing these issues.

Significant theme six: Two music therapists think that adults with PIMD are more capable than they appear.

Erica described how she believes that adults with PIMD have potential abilities:

> *"I always try to assume that the person, especially someone like Mark who's got cerebral palsy, has got the ability too. I try to remember that how that person presents isn't potentially what they're fully capable of for whatever reason. They might not be able to express what they are capable of or they might not trust you enough to reveal all of his capacity as well."*

Similarly, Steve also described the clients' capacities to display observable reactions:

> *"There's always receiving going on. Sometimes you don't see and it's not very obvious, and you think they are not listening. But it's hard to turn your ears off."*

> *"Eye-contact is usually a good one, movement of arms, limbs towards the therapist if you're not facing that direction. They are smiles, laughs, and vocalizations. It's always good if it is a purposeful vocalization that is a direct result of music cause they are not there otherwise."*

Steve and Erica stressed the clients' hidden abilities such as having intact hearing abilities; displaying affective responses such as smiles and laughs; presenting intentional behaviors using eye contact and vocalization. Erica furthermore explained the possible reasons why the clients do not show their full abilities in the initial stage of the relationship: "*they might not be able to express what they are capable of or they might not trust you enough to reveal all of his capacity as well."* Consequently, it seems important for the music therapists to be patient and provide sufficient time and appropriate atmosphere for the clients to reveal their hidden and potential abilities.

Individual themes

Individual theme one: One music therapist wishes the interpersonal relationship with her client to keep growing further in the future.

Erica was the only music therapist who expressed the wish for the interpersonal relationship with Mark to keep growing further in the future:

> *"There are still things I would like to do within the relationship to make it. If I can say that he would allow me to help him or overcome his tactile defensiveness I feel it really. But that's actually unrealistic probably."*

> *"Certainly now he says 'more', but there are still things I want to achieve with him, so it's not as fluid as I still really like it to be. I still feel like I'm working on the relationship too. I still feel there's things we could do together."*

Erica and Mark spent six years in individual music therapy and Erica used the word "still" five times in the above two statements. It is obvious that Erica really wishes their relationship to grow further and progress to the next level where she described it as a "fluid" relationship. Erica's attitude toward the future seems very clear and determined when compared to the other music therapists. Despite their emotional bonds and attachments with the clients, Frances, Darren, and Steve were considering leaving the organization in the future at the time of data collection because of the poor work environment. In a similar way, Owen did not think his work environment was ideal for

him, and the institution was expected to be closed in the following year. Hence, these music therapists were not actively planning their future with the clients. Consequently, improving the work environment for music therapists seems like a critical issue to be addressed, in order to promise a better future for the clients with PIMD as well as the music therapy profession.

Global Meaning Units (GMUs)

Based on the collective themes, three global meaning units were created.

Global meaning unit one: Conditions such as contexts and severity of disability exert significant influence on the quality of interpersonal relationships.

GMU 1 was created based on common theme 1 and significant theme 5. The development of this meaning unit was explained in the method section. These two themes indicate the factors that positively and negatively influenced the quality of relationships. According to the five music therapists, the positive contexts were the home (France and Darren), community (Steve), and individual settings (Erica). The factors that negatively influenced the relationships were the institutional setting (Owen) and the severity of physical and intellectual disabilities (Steve and Owen). With regard to the institutional setting, many clients in Melbourne have been already relocated into small group homes. Owen was in Sydney and his institution was also about to be closed in the time of data collection (January 2012). It is anticipated that many other institutions around the world will close in the near future. Therefore, discussing the negative impact of institutions might not be worthwhile at this time. However, more studies should be conducted to investigate how to work effectively in the small group homes, clients' private homes, and the community settings. The relationships with the clients' caregivers, including parents and disability support workers, are an influential factor as well in these settings. For example, in the current study, the music therapists working in the clients' homes and community settings reported positive relationships with the caregivers and its positive effect on their relationships with the clients.

Furthermore, two music therapists (Steve and Owen) expressed the difficulties working with clients who have severe levels of physical and intellectual disabilities. Obviously, inexperienced music therapists working with adults with PIMD for the first time seem to undergo various emotional distresses as well as some practical challenges, such as understanding idiosyncratic non-verbal behaviors. In Australia, these issues do not seem to be addressed in music therapy training and there is little literature discussing these issues. More studies of successful and unsuccessful case examples might help our understanding of these issues. In addition, guidance and support from experienced music therapists could help new music therapists have more meaningful experiences when working with adults who have PIMD.

Global meaning unit two: The process of building an interpersonal relationship requires mutual efforts over time.

This meaning unit was created based on the following four collective themes:

- Two music therapists struggled before developing confidence in the relationships. (Significant theme four)
- Two music therapists think that adults with PIMD are more capable than they appear. (Significant theme six)
- All the music therapists are heartened by the clients' commitments in music therapy. (Common theme two)
- One music therapist wishes the interpersonal relationship with the client to keep growing further in the future. (Individual theme one)

These collective themes indicate how music therapists perceived the process of building interpersonal relationships. Frances and Steve described how they struggled at the initial stages of relationships. Erica and Steve explained how they believed that the clients were more capable than they appear. All five music therapists described how their clients made great efforts and showed commitment and progress. Erica wished her relationship with Mark to keep growing in the future. These themes seem to indicate a general tendency in the process of building the relationships with the adults with PIMD such as:

1. Struggling to understand each other at the initial stage;
2. Getting to know each other more, then realizing that the clients are more capable than they appear;
3. Recognizing the clients' commitments and feeling heartened; and
4. Getting pleasure from the relationship and wishing to grow the relationship further.

Another critical fact to notice in this meaning unit is that the interpersonal relationships had been built not only by the music therapists' efforts but also by the clients' efforts. The clients' interests in musical activities and the trust established with the music therapists seemed to be the most important factors for successful relationships in music therapy.

Global meaning unit three: Inter-subjective interpersonal relationships foster the psychosocial wellbeing for clients, and music therapists play a significant role in promoting these benefits.

GMU three was created based on the three collective themes:

- Three music therapists experience emotional bonds and attachments with the clients. (Significant theme two)

- Two music therapists consider the inter-subjective interactions meaningful in their relationships. (Significant theme three)
- Four participants believe that music therapists have unique roles in meeting the psychosocial needs of their clients. (Significant theme one)

These collective themes stress that the interpersonal relationship is characterized by emotional bonds and attachments and familiar inter-subjective interactions between the pair. Feeling connected, being together, becoming special persons to each other, and having meaningful moments definitely foster the psychosocial wellbeing of the clients. Moreover, these positive relationships with the clients seem to promote psychosocial wellbeing for the music therapists. I observed the music therapists' non-verbal behaviors and emotional responses during the interviews. It was obvious that all the music therapists expressed joyful and excited feelings when talking about their clients and their inter-subjective relationships. Smiles and laughter were frequent. For instance, Frances smiled when she stated, "she's such a sweetie." Darren kept smiling while describing how the clients and their parents made him feel like a part of their families. Erica was excited as she explained moments of musical interplay with Mark. Owen was enthusiastic while explaining Nelson's progress and the development of their relationship in music therapy although he was critical about the institutional setting. Steve was also excited when describing familiar vocal interactions with Amy in group music therapy sessions. Furthermore, the music therapists expressed their positive relationships with the clients' parents and disability support workers. Consequently, the psychosocial benefits of the interpersonal relationships for everyone involved in music therapy are apparent, and the significant roles of music therapists seem crucial when understanding the experiences of interpersonal relationships with adults who have PIMD.

Final Global Distilled Essence

Based on the three global meaning units, the following global distilled essence was developed for the interpersonal relationships of the five pairs of music therapists and the clients with PIMD:

> For the five music therapists, the experience of interpersonal relationships with adult clients who have profound intellectual and multiple disabilities is a process that requires mutual effort over time. The interpersonal relationships foster psychosocial wellbeing for the clients, and the music therapists play a significant role in promoting these benefits. Conditions such as context and the severity of disabilities also exert significant influence on the quality of interpersonal relationships.

In conclusion, the present study explored five music therapists' lived experiences of building interpersonal relationships in music therapy with adult clients who have PIMD. In-depth, face-to-face phenomenological interviews were facilitated to obtain rich descriptions of the lived experiences. The individual and group results show that the

music therapists have unique roles in establishing interpersonal relationships. However, for the continuing development of the quality of music therapy services in the future, music therapists should have a more active role in managing their contexts, communicating with staff and family members effectively to maximize the benefits of music therapy, and collaborating with other health professionals.

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