Dialogue in the Music:
A music therapist's perspective on meaningful communication with people with severe and profound intellectual disability

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The emotional experiences that are connected to being in a meaningful relationship with another – that is, to be seen and recognised – is a need essential to every individual's sense of worth and wellbeing (Klein, 1987). Although it is now generally acknowledged that people with intellectual disability do experience the same kind of mental health needs as any other non-disabled person (Berry, 2003; Smiley, 2005), many continue to lead lives that are largely isolated from the community (Bigby & Wiesel, 2011). This seems to be particularly the case for persons with severe and profound intellectual disability, where meaningful interpersonal contact with others in their immediate network, e.g. co-residents, direct-care staff or family members, is even more limited due to the person's high support needs and presentation of less-developed communication skills (Blain-Moraes, Chesser, Kingsnorth, McKeever & Biddiss, 2013).

Music therapy is a therapeutic intervention grounded in the notion that every individual is born with an inherent capacity for communication and relationship (Trevarthen, 1979). While music therapy is diverse and employed in a variety of settings, its aims are generally directed towards positive changes in a person's health, functioning, and wellbeing (Australian Music Therapy Association [AMTA], 2012). Within the practice of music therapy itself, there are two components that are essential to any clinical work: the music (or musical experiences), and the therapeutic relationship (Boxhill, 1985). In the early stages of therapy work, the focus is on establishing a safe space within which a trusting relationship can be developed. From there the possibilities for change and growth are explored with the participant, offered in the form of musical experiences. The kind of methods employed, for example, instrumental playing, singing, improvisation, song writing, or receptive listening, will be dependent upon the population and individual needs. Presented within the therapeutic relationship, musical experiences become the primary mode of communication and agent of change; this is one of the distinguishing characteristics of music therapy from other spheres of music, such as performance or education.

In my work with people with severe and profound intellectual disability, the primary role of music therapy is to promote an individual's emotional health through engagement in shared musical experiences. Within the sessions, musical experiences target three specific areas relating to the person's emotional development: sense of

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self (the person's awareness of him/her self), self-expression (the person's ability to make him/her self known and understood), and inter-relatedness (the person's capacity to relate with another). Potential recipients of music therapy in this practice setting typically present with little to no expressive language and do not participate in regular group or individual programs. Many are described as being withdrawn, spending prolonged periods 'doing his/her own thing' – which may be observed as self-involved or ritualised behaviours and vocalisations. Although these types of idiosyncratic behaviours may appear to be without meaning, in many cases they are the person's coping strategy in response to the environment around them; its function could be self-stimulating in the absence of stimuli, or self-soothing where the surroundings are overwhelming and chaotic (Firth & Barber, 2011). The corollary of this is that, where the behaviour is perseverative and difficult to interpret, one may become further distanced from making connections with those in the world around them (Blain-Moraes & Chau, 2012). This solitary state seems to be the condition of most of the individuals I see for music therapy, despite all of them residing in group home environments and being constantly surrounded by peers and a team of support staff.

In this context, music therapy aims to present the possibility for a meaningful exchange by magnifying a person's non-verbal means of communication and reframing them within musical parameters. Words are set aside in the search for dialogue material as we look towards other expressive qualities of the person: gestures involving hands or head, posture or body orientation, eye gaze, vocalisations, facial expression, and movement (Cascella, 2005). Where perceived as arbitrary vocalisations, music hears tone, pitch, dynamics, and articulation; where perceived as idiosyncratic gestures or perseverative behaviours, music hears rhythm, pattern, repetition, and pulse; where perceived as nonsensical speech, music hears lyrics, melody ... song. The music therapy space at once is rich with material to build a platform for the beginnings of a shared exchange in the form of a musical experience.

For example, a therapist might see a person's habitual rocking and begin tapping the drum in time with the movement while singing the person's name. In response to perseverative speech phrases, e.g. 'J wants to go on the bus, J wants to go on the bus,' the therapist may begin improvising a song about J's favourite things to do. In hearing a person's ascending vocalisations the therapist might respond by first mirroring the vocalised sound, then improvising a counter-melody with a descending pattern. At all times the participant's presenting gestures, sounds and silences are approached with curiosity and responded to as if it were a conversation: with themes, with affect, and with room for development. In this sense, the therapeutic process is a constant expressing of the therapist's attempts towards a gradual understanding of the person's unique language, and speaking it back, now shaped within a musical context.

Thus, here in the therapy space unfolds the potential for a meaningful dialogue that is rooted in relationship. The experience itself takes on meaningfulness when a person recognises something of him or herself being offered back within the shared exchange as it is taking place. This process of being recognised by another is described as intersubjectivity, a developmental phase in early infancy and communication (Stern, 1985; Trevarthen, 1979). Graham (2004), drawing on similar influences in her extensive work with adults with intellectual disability who are non-verbal, writes that: 'An infant's communicative and social development depends on the intuitive skills of parents or care givers to provide an interactive framework within which his/her skills can grow' (p.25). By the same notion, the music therapist operates on this intuitive skill; the musical experiences act as the framework within which the participant is offered opportunities for exploration, movement, and growth.

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When evaluating the effectiveness of music therapy with a particular individual, the measures used by the therapist will be determined by one's theoretical orientation and the methods employed. This is what is described as the therapeutic process – the analysis and interpretation of what happens during the session and from session to session. With regard to my area of practice the therapeutic approach is grounded in psychodynamic theory, which examines the unconscious dynamics at play in the therapy space, beyond the 'seen and heard' content. Broadly speaking and in relation to a person's emotional development, positive changes are observed when the participant demonstrates increased levels of musical or non-musical contribution, tolerating a shared interaction, and spontaneity through engagement in the musical experiences.

Communication between individuals, at its core, involves the expression of self. This means that, sometimes in the music therapy space, there are moments where difficult feelings may surface. The role of the therapist in this case is not to counter these feelings with more 'happy songs'. Rather, it is to remain with the person in those particularly difficult-to-bear experiences. In the absence of verbal language, great sensitivity and care is required of the therapist to observe the momentary changes happening in the therapy space and make decisions on how to present a musical reflection (in song, instrumental improvisation, or perhaps even silence) that best responds to what the person might be experiencing.

Returning to the parallels drawn between the therapeutic relationship and the mother-infant dyad, paediatrician and psychoanalyst Winnicott (1960) describes this reflective function of the therapist as providing a 'holding environment', modelled in the same way by a mother's ordinary loving care when she allows for her baby's difficult or unbearable feelings to be expressed and managed safely. To that end, in terms of service provision for people with severe and profound disability, the experiences presented and facilitated by the music therapist are quite different from other music-related programs delivered by non-music therapists or non-musicians: 'music therapy with this population is an intense interactional exchange through the medium of music, requiring flexibility in presentation to respond to the participant moment by moment' (Cameron 2017, p.4).

One of the biggest challenges in working with people that present with limited expressive language is that we may never fully know of a person's true experience of the world around them. This has certainly been the case for me in my role as a music therapist with this group of unique individuals. In his article on the emotional lives of people with intellectual disability, Arthur (2003) comments on the general reluctance of healthcare professionals to attend to the emotional health of people with intellectual disability. Here he makes the challenging statement that, perhaps, we are faced with 'our own learning disability when confronted with complex behaviour that cannot be easily understood, communicated or treated in conventional ways' (p.26). In light of this acknowledgement, perhaps it is in this space that music therapy can play a valuable role: as a therapeutic intervention that is ultimately oriented towards an individual's emotional health, and where unconventional ways of understanding and communicating are permitted and – more importantly – can be facilitated within the safety of a trusting relationship.

The unique qualities offered by therapy in art is summed up by Ansdell (1995), who writes that: 'Art does not force or coerce: it offers itself as a possibility ... For in every new experience of creativity, communication or beauty there can be a glimpse of the possibility of growth, potential and transcendence' (p.19). These words capture the essence of the music therapist's work. With the continual offering of creative possibilities, the hope is that 'doing his or her own thing' will give

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way to 'doing our own thing'. I believe that these experiences of 'our', 'us', and 'we' – experiences of togetherness – are fundamental to enhancing the quality of 'the good life' for people with severe and profound intellectual disability. Participation in music therapy can promote positive developments in a person's emotional health; musical experiences presented within a therapeutic relationship are directed towards drawing a person out from a mostly solitary world into meaningful exchanges with another, thus enabling the pathway for those essential experiences of being seen and recognised.

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