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Krøier, Julie Kolbe; Stige, Brynjulf; Ridder, Hanne Mette Ochsner

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Non-Verbal Interactions Between Music Therapists and Persons with Dementia. A Qualitative Phenomenological and Arts-Based Inquiry

JULIE K. KRØIER, PHD FELLOW — Department of Communication and Psychology, Aalborg University, Aalborg, Denmark
BRYNJULF STIGE, PHD — University of Bergen, Norway
HANNE METTE RIDDER, PHD — Aalborg University, Denmark

ABSTRACT: When music therapists are supervising caregivers in how to apply music in their interactions with persons with dementia, we may term this as indirect music therapy practice. Musical interactions are mostly happening through nonverbal, implicit, and embodied knowledge, and, therefore, there is a need for exploring and verbalizing such interactions for music therapists to be able to disseminate to caregivers and other professionals. In this qualitative study, we examine how 6 music therapists with clinical experience in dementia care experience nonverbal interaction with persons with severe dementia living in nursing homes. Explorative focus groups were conducted to study the music therapists' lived-experience descriptions about their nonverbal interactions with persons with dementia. Focus group transcripts were analyzed by a phenomenological approach, and the findings elaborated and peer validated by the use of musical improvisation as an arts-based analytic approach. The findings included five themes: vitality, disciplined subjectivity, attunement, therapeutic presence, and validation. The music therapists were guided by the vitality of the person with dementia, were aware of their own reactions, and sensed the needs of the person through disciplined subjectivity. They attuned to the person's nonverbal musical parameters (e.g., tempo pitch and volume) and cocreated an open and mutual field through therapeutic presence and validation. The findings are relevant for future development of direct and indirect music therapy practice but contain limitations due to a homogenous and small group of participants. This study highlights the challenges of exploring nonverbal and musical interactions with the use of language-based methods of inquiry.

Keywords: *indirect music therapy practice, non-verbal interaction, phenomenology, arts-based inquiry, reflection-on-action*

Introduction

According to the WHO (2020), 50 million people have neurodegenerative dementias worldwide, with 10 million new incidents reported every year. As a consequence of neurodegeneration, the ability to communicate often becomes challenged (Freberg, 2019). An important part of caregiving in severe stages of dementia is, therefore, to support the person in finding new meaningful ways to communicate and be socially engaged (Haak, 2002). WHO (2019) emphasizes that persons with dementia are supported to communicate, and this focus is linked to the person-centered approach to care, which stresses inclusion, attachment, and acknowledging the psychological needs of the person with dementia (Kitwood, 1997). Sensitive and attuned musical interactions in individual music therapy can help the person with dementia express themselves, reduce behavioral and psychological symptoms of dementia, and positively influence the quality of life (Fang et al., 2017; Ridder et al., 2013; van der Steen et al., 2018; Zhang et al., 2017).

The reason why music is effective in dementia care may be explained by the theory of communicative musicality developed by Malloch and Trevarthen (2009). Communicative musicality is an innate capacity that allows human beings to take part in nonverbal interplay expressed by pulse, pitch-contour, timbre, and narrative. Musicality is thus related not only to singing or playing an instrument but also to how we interact nonverbally through gestures, imitation, and tone of voice (Malloch & Trevarthen, 2009). The capacity to communicate musically may be explained by a surprisingly intact musical memory despite the cognitive degeneration in Alzheimer's disease (Jacobsen et al., 2015). This potential of music as a

Julie Kolbe Krøier is a PhD Fellow at Aalborg University, Denmark. She works clinically as a music therapist and supervisor in dementia care. She is an Associate Editor for the Danish *Journal of Music Therapy* and coordinator for the Danish Network of Music therapists in Dementia Care.
Brynjulf Stige, PhD, is a Professor of Music Therapy at the University of Bergen and Founding leader of POLYFON Knowledge Cluster for Music Therapy. He has founded two international peer-reviewed journals (*NJMT* and *Voices*), and his research explores relationships between culture, care, and community.
Hanne Mette Ridder, PhD, is a Professor of Music Therapy at Aalborg University, Denmark. She is the Head of the Doctoral Programme in Music Therapy, approved clinical supervisor, and past president of the European Music Therapy Confederation. Her research and publications are mainly focused on music therapy in a psychosocial understanding of dementia care.

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Address correspondence concerning this article to Julie K. Krøier, PhD Fellow, Aalborg University, A.C. Meyers Vænge 15 A, 2450 København SV, Denmark. E-mail: Jukk@hum.aau.dk. Phone: 0045-22999729.

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communicative medium may offer a relevant means to address psychosocial needs in persons with dementia (Kraus & Slater, 2016; Ridder, 2003).

The use of music to improve health in dementia care is well described (Baird et al., 2019; Bonde & Theorell, 2018; Stige & Ridder, 2016), and in a network synthesis report by the WHO on the role of the arts in improving health and well-being, Fancourt and Finn (2019) highlight the use of music in dementia care. Music interventions with individualized music listening on iPods (Music and memory, 2018) are increasingly applied by staff members in dementia care, although research shows only tendencies toward positive outcomes of this intervention and with no significant effects (Kwak et al., 2018). As with other methods, this might have failed to bring the expected outcomes because the guidelines were insufficient or because the method was not implemented according to the guidelines. This underlines that the use of music in dementia care is not just a matter of making music available. One way to ensure a beneficial use of music interventions may be the provision of professional supervision and support from trained music therapists. Music therapists guiding and supporting professional caregivers in applying music can be described as a type of *indirect music therapy practice* (Bunt & Stige, 2014; McDermott et al., 2018). Such indirect practice involves building health resources by working at an organizational and systemic level. In the context of care for older adults in nursing homes, it includes supporting the development of a person-centered culture that can optimize the benefits of the use of music. Indirect music therapy practice is not aimed at training professional caregivers to carry out music therapy but rather at enhancing the caregivers' awareness and sensitivity to communicative aspects with the aim of enriching their interactional repertoire with the person with dementia. In the development of indirect practices, music therapists need to be conscious of and able to verbalize *how* they interact with persons with dementia on a microlevel and be able to describe their practice to professionals outside the music therapy profession.

Body language, attunement, and empathy are important relational qualities when working as a music therapist. These qualities are often implicit for the practitioner (Ellis & Astell, 2017; Johns, 2018), and little research exists about attunement in dementia care (Krøier et al., 2020). The educational researcher Donald Schön described practitioners' way of doing specific actions over and over again and the knowledge gained from this process, as *knowing-in-action* (Schön, 1983). The knowledge about actions in practice is tacit, evolves spontaneously, and is difficult for the practitioner to verbalize and externalize. However, it is possible—during the process—to reflect upon the practice and to question what is happening. Schön (1983) called this process *reflection-in-action*, and the process of subsequently reflecting about practice, with the aim to improve practice, he called *reflection-on-action*.

Aim

Our aim for this study was to explore how music therapists experience nonverbal interactions with persons with dementia living in nursing homes. Exploring nonverbal interactions and transforming these into verbal explanations are a process of reflection-on-action aiming to create knowledge about what music therapists do and how they understand their practice.

Method

In order to explore music therapists' experience of nonverbal interactions in dementia care, we applied an interpretive, phenomenological approach, embracing knowledge creation at an idiographic level (Alvesson & Sköldberg, 2018; Jackson, 2016; Merleau-Ponty, 1945/1981). The idiographic approach, unlike the nomothetic, focuses on individual cases and on generating in-depth understanding of human phenomena (Ridder & Bonde, 2019). Based on the works of the German philosophers Husserl and later Heidegger, interpretive phenomenology is characterized by an attitude of openness to whatever is significant for the understanding of an explored phenomenon (Heidegger, 1927/2004; Jackson, 2016). We found the phenomenological approach relevant for discovering the music therapists' knowing-in-action of how they understand nonverbal interaction in dementia care. Thus, we applied an interpretative approach, taking the preunderstandings of the participants and ourselves into account. Methodologically, we are inspired by Law (2004) and Gilbertson (2015), who advocated for new forms of inquiry that give consideration to emotionality and embodiment. Nonverbal interactions are complex and multi-layered processes that unfold over time, and, according to Law (2004), the attempt to give clear, simple definitions of complex phenomena may instead increase confusion.

We strived to gather substantive accounts based on Engagement, Processing, Interpretation, and Critique and Self-Critique (EPIC) and to acknowledge preconditions and consequences of research by integrating continuous reflection on Social Critique, Usefulness, Relevance, and Ethics (CURE) of the research process itself. In this way, we allowed a more mutual approach, mediated by dialogue with participants and among the research team members. Thus, the research, and how it is reported, is based on the EPICURE approach to enhance the quality of qualitative research (Stige et al., 2009).

The first part of the study consisted of a phenomenological exploration of how music therapists experience nonverbal interaction with persons with dementia, through writing "lived-experience descriptions." In phenomenology, "lived-experience descriptions" refer to a representation of certain experiences of a given person and their reflections and knowledge gained from these experiences (van Manen, 1990). Experiences represent types of "data beyond talk" (Flick, 2014). We, therefore, needed data collection approaches that were not restricted to verbal reflection alone but allowed for first-hand information beyond talk produced in collaborative and *explorative focus groups*. Focus group research allows for constructing a mutual ground between researchers and participants through shared reflection and self-reflection (Kamberelis & Dimitriadis, 2008). The first author participated in the initial three explorative focus groups and wrote an epoché aimed at uncovering her preunderstanding and expectations. The epoché was used to understand the final findings.

In the second part of the study, arts-based methods were applied to further expand the nonverbal aspects of the research phenomenon (McNiff, 1998). According to Beer (2016),

arts-based research practices offer qualitative researchers rich, versatile means of collecting data that may embody the participants' experiences in systematic and inventive ways. Arts-based methods thus allow a wider range of forms of knowledge to inform the research process (Eisner, 2008). Research on music therapy practices implies an intrinsic dilemma of having to use words and verbal language to represent complex musical processes and their potential therapeutic effect (Ansdell, 1999). Music therapists are experts in using music to achieve insights, and we included musical improvisation as a way to explore nonverbal interactions in order to stay close to the music therapists' experiences with the research phenomenon. The research process is illustrated in Figure 1.

Researchers' Preunderstandings

As the current study is based on qualitative methodologies, it is important to illuminate the researchers' preunderstandings of the research topic and thus clarify how the researchers have influenced the findings. The authors are all qualified music therapists, music therapy researchers, and music therapy educators in Scandinavian Universities with a specific interest in psychosocial dementia care, and how the use of music might benefit the quality of life for persons with dementia. The first author has additionally worked as a professional caregiver in residential care homes for several years before she became a music therapist. We are inspired by the person-centered approach to care and believe that music could be applied in diverse contexts in dementia care, and that music therapists are obliged to support a reflexive, ethical, and relevant use of music.

Participants

For the first explorative focus groups, six Danish music therapists including the first author were chosen due to their clinical experience in dementia care, interest in the indirect practice of music therapy, and willingness to participate in the research project. The participants were divided into two groups of three persons according to their place of residence (see Table I for sample characteristics). The two courses of each three explorative focus group sessions in the first part of the study were led by a trained music therapist with clinical experience in dementia care and with an additional MA in philosophy and learning processes. The first author took part in a course with three focus group sessions as a participant and led the last focus group, including the final analysis. None of the participants were colleagues or personal friends, and all participants were informed of the aim of the study prior to the focus group sessions. The two music therapists, who were in the same group as the first author, were invited to participate in the last focus group.

Ethical Considerations

The study was registered at The Danish Data Protection Agency through Aalborg University and adheres to the Danish Code of Conduct for Research Integrity (Ministry of Higher Education and Science, 2014). The participants signed an agreement on the terms of participating in the study based on written and oral information provided by the researcher. The agreement included anonymization of data and the possibility to withdraw from the study at any time.

Part 1: Explorative focus groups with lived-experience descriptions

The first three explorative focus groups were held during a three-month period for each of the two groups and with the aim of exploring nonverbal interactions between music therapists and persons with dementia. One group met in a nursing home, where one of the music therapists worked. The other group met in a study room at the university. The participants were offered a meal and reimbursement for travel expenses in relation to their participation in the focus group sessions, each lasting three hours.

In the first focus group session, the participants introduced themselves and their background and were in further detail informed about the research topic. As preparation to the following focus groups, the participants wrote two "lived-experience descriptions" (van Manen, 1990): one about how they interacted with persons with advanced dementia and the other one about their indirect practices and how they disseminated the use of music in daily care to other professionals. In the focus groups, the participants shared their descriptions and commented on each other's experiences. Focus groups two and three included role play, where the participants embodied the lived-experience descriptions and afterward reflected upon the experience. All seven focus groups were audio-recorded.

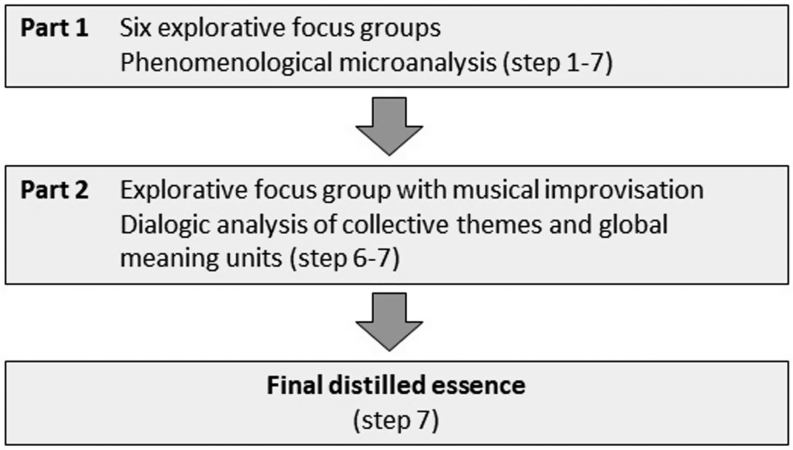

Figure 1. Structure of the research process.

Phenomenological microanalysis

The audio recordings from the focus group sessions were analyzed by applying a slightly modified phenomenological microanalysis in seven steps (McFerran & Grocke, 2007, p. 275), as shown in Figure 2. The first six focus group sessions were transcribed by an external person, and, later in the process, the last focus group was transcribed by the first author (step 1). All transcriptions were member checked by the participants. The software program Nvivo-12 (version 12, QSR, 2018) was used for identifying key statements and coding the data into structural meaning units (steps 2 and 3) and experienced meaning units (step 4). Individual distilled essences were developed by the first author and then subjected to peer debriefing in order to validate and evaluate the individual distilled essences (step 5). The peer debriefing group consisted of four researchers with expertise in music therapy in dementia care. Individual distilled essences are available in the Supplementary Material (Krøier, 2020). Finally, five collective themes were identified based on the individual distilled essences (step 6). The data analysis was done in Danish to stay as close to the original experiences as possible, and afterward translated from Danish into English by the first author in collaboration with the second and third authors, and finally proofread.

Being a participant in the first three focus group sessions and afterward analyzing the transcriptions, the first author found it difficult to transform the nonverbal interactions into lived-experience descriptions. The descriptions seemed inaccurate when she tried to recall the interactions sometimes days after they had happened. The other participating music therapists also struggled to verbalize the implicit nonverbal interactions of their practice and describing the interactions with words made them feel distanced from the tangible experience. All participants mentioned that it had been not only interesting but also time-consuming to write the lived-experience descriptions. It felt like a paradox to explore a nonverbal phenomenon with words only, as several aspects of such interaction are reduced. Therefore, we decided to add one more part to the study and include musical improvisation as an arts-based research approach.

Table I.

Sample Characteristics at Group Level (N = 6)

Sample Characteristics	
Mean age	46.3 years
Gender	Females
Length of time working in dementia care	1–5 years = 1 6–10 years = 1 >10 years = 4
Self-reported ethnicity	White European
Degree	5-year integrated MA in music therapy

Part 2: Explorative Focus Groups with Musical Improvisation

The method used in the second part of the research study was chosen based on participation and feedback from the first six focus group sessions and from knowledge gained through analyzing the focus group transcripts. In order to stay closer to the music therapists' primary artistic and expressive medium, we chose to further explore the music therapists' experiences of nonverbal interaction through musical improvisation in a seventh focus group. The focus groups were used as an elaborated peer validation, which allowed the music therapists to elaborate on and validate the five collective themes that had emerged from the initial phenomenological analysis (step 6) and in this way served as both an extension and an immersion of step 7 in the phenomenological microanalysis.

The last focus group took place in the music room at the University where two pianos were available. The two music therapists read the collective themes and commented on them. Then, they each chose one theme to explore musically. More themes could have been chosen, but, in order to narrow down the focus, the participants only chose the one that appealed most to them. The music therapists played pianos and used voices. They played in dyads from their own perspective and did not play a role as client or therapist. After each improvisation, the music therapists shared the new aspects that the improvisation brought to their minds.

Extended Analysis

The arts-based focus group was analyzed through a dynamic and dialogic process based on the knowledge gained from analyzing the first focus groups and identifying collective themes. The dialogic analysis process is described below:

1. The conversations before and after the musical improvisation were recorded, transcribed, and analyzed with a focus on new contributions and elaborations to the existing five themes.
2. New contributions and elaborations to the existing collective themes were coded.
3. The themes were merged into a final distilled essence aiming to describe how the music therapists experience nonverbal interaction with persons with dementia.
4. All six participants did a final peer validation of the final distilled essence.
5. The final distilled essence was translated into English.

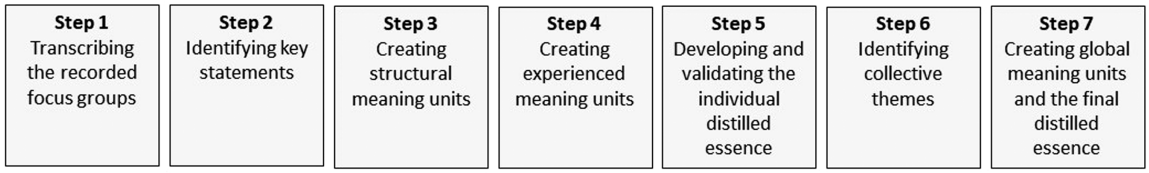

Figure 2. Phenomenological microanalysis adapted from McFerran and Grocke (2007, p. 275).

Findings

The altogether seven focus groups resulted in 11 hours of audio recordings and 321 pages of transcripts. Below, we present the five collective themes that emerged through the phenomenological analysis of the focus groups in the first and second parts of the study. Based on these, we describe the arts-based elaboration of the themes and present the final distilled essence describing how the six music therapists experienced nonverbal interaction in dementia care. Non-edited examples from the transcripts are added to the themes below in order to bridge to the original data. We observed that the music therapists were aware of the theoretical foundations of their work and often included references to theory when explaining their practice. In the following, we, therefore, integrate theory and theoretically informed concepts, however, only in the way they were used by the music therapists. When they referred to Danish theories, we have referred to the most recent descriptions in English texts. The collective themes (step 6) are interrelated and overlapping, but each has a different focus, as shortly presented in the following with selected quotations from the focus groups. The essentials of each theme are described in one sentence and placed as an introduction to each collective theme.

Collective Theme 1: Vitality

> The music therapists are guided by the vitality of the person and how this vitality is expressed in body language and the use of voice.

When interacting with the person with dementia, the music therapists sensed the forms of vitality that the person expressed. The music therapists directly referred to the work of Stern (2010) concerning forms of vitality, and how vitality is expressed in movement, time, force, space, and intention. They were sensitive to the vitality expressed through gestures and tone of voice when interacting with the person with dementia:

> Well, I look at the tempo of her walking, I look at the intensity of her movements; is it exited or relaxed, or somewhere in the middle? I listen to the sounds, I look at ... [Researcher:] Her mimic, face ...? Yes, and if she expresses excitement, relaxation, it is also what the music works with. When is there tension, when is there relaxation?

Due to their university training and clinical experience, the music therapists have developed a sensitivity to forms of vitality and are able to decode and match the vitality manifested. "I hear the relief in Else's voice. Her voice is also jerky and crispy, as if there is a laugh on the way."

Collective Theme 2: Disciplined Subjectivity

> The music therapists are aware of their own sensory and emotional reactions that arise in contact with the person with dementia. These reactions are used to sense the needs of the person.

The music therapists mentioned countertransference as an important way to receive information about the person with dementia and to understand the person better. Transference occurs when a client replicates relationship patterns from former relationships to the therapist. When the therapist reacts to these with feelings and sensations in the meeting with the client, the reaction may be understood as a countertransference (Pedersen, 2019). Due to the sensitivity that the music therapists have toward the vitality of the person, they are able to work with these experiences of countertransference in the interaction. The music therapists in the study were all trained at Aalborg University, following a psychodynamic approach to music therapy, and where self-experience is integrated into the education (Jacobsen et al., 2019). The educational background of the music therapists might explain why empathic countertransference experiences were described in all focus groups:

> I feel completely exhausted inside, feel how much energy Else really has, and I understand how much she must long to use some of all that energy. Because "nothing happens here," which she so often repeats!
>
> Her eyes are tired, and I feel her anxiety reflected inside me.

The participants described their countertransference experiences as bodily or emotional sensations happening due to an empathic identification with the person with dementia. The music therapists empathically resonated with the feelings of the person and sensed the feelings physically, like an instrument that vibrates in resonance. Emotional needs can sometimes be difficult to express verbally, especially for persons with dementia, and empathic countertransference, therefore, becomes an important way for the music therapists to gain information.

Based on the part 2 focus group with musical improvisation and the following peer feedback, the music therapists achieved consensus that the concept of disciplined subjectivity would better explain the theme than countertransference. One of the music therapists found the concept of countertransference to be an outdated Freudian term and described it like: "Countertransference is the part where you take it all over, you know, take it all over in yourself and then analyze what happens, and then you can say: Well, was it me, or ..." Instead, the music therapists suggested the concept of disciplined subjectivity as it was defined by Pedersen (2019) and used as an overall term for the conditions and movements characteristic of the music therapist's attitude in musical improvisation in clinical situations. Disciplined subjectivity is theoretically framed and related to empirical phenomenological research on the music therapist's understanding and application of countertransference in musical improvisation, so the concepts are related in the way disciplined subjectivity is described as a state where the music therapists are conscious about and take responsibility for the emotions that they encounter (Pedersen, 2019).

Collective Theme 3: Attunement

> The music therapists attune to the non-verbal musical parameters (such as tempo, timing, pitch and volume) in a reciprocal interaction with the person with dementia.

The music therapists use musical parameters such as tempo, timing, pitch, and volume in the process of attuning their interactions to the person with dementia. The use of musical

parameters can take place either by singing a known melody or by matching the rhythm and vitality that the person expresses in body movements or use of voice:

> Eva walks quickly, I follow Eva's rhythm, and we go, fast and easily, laughing down the hall.
>
> I follow and match her pace, and all the time I try to find her pace and energy, and she stands and knocks on the sink a little while they wash her like that.

Attunement is a dynamic process that takes place between the music therapists and the person with dementia and where they dialogically exchange communicative initiatives.

Collective Theme 4: Therapeutic Presence

> The music therapist facilitate interaction with the person with dementia by being open, present, and aware of communicative signs.

The music therapists emphasized that a precondition for a successful interaction was that they were present and fully aware of the smallest expressions from the person with dementia. The music therapist should be able to step away from a predefined agenda and from being in total control of the interaction and instead be present and open to the moment and the person with dementia:

> …when I think things work best for me, it's when I manage to have such a high degree of openness, so I also let go of my own expectations of contact …
>
> I give my joy or my grief or myself and my music, and my full 100% presence to them.

Collective Theme 5: Validation

> The music therapists strive to understand which psychosocial needs the person with dementia expresses and to share the mutual subjective experience.

Validation refers to affirming a person that his/her feelings and actions are acceptable and worthy. When validating, the music therapist attempted to share the person's subjective experience rather than just engage in a shared task and in this way empathically attune to the psychosocial needs of the person. Thus, the music therapist attempted to validate not only the actions and behaviors of the person with dementia but also the emotional needs behind those actions and behaviors:

> So I somehow mirror her expression ... by experience I know that mirroring gives an experience of being ... being someone or something, and thus also help the person with entering some kind of contact or relationship.

One way of validating the communicative initiatives could be to mirror and match a certain expression and, by doing that, create an interaction with the person with dementia.

Global Meaning Units

The final step in the phenomenological microanalysis contains the creation of global meaning units and the final distilled essence. In the part 2 focus group with musical improvisation, the two music therapists were presented to the five collective themes developed through part 1 of the analysis. The two music therapists expressed that they recognized themselves and their work in the collective themes but suggested revisions in regard to themes 4 and 5 which were discussed, peer validated, and then integrated into the themes. The musical improvisations revealed new aspects to the themes, which are illustrated with condensed summaries in Table II.

The additional aspects were incorporated in the final distilled essence suggesting how music therapists experience nonverbal interaction with persons with dementia. Both music therapists stressed that the themes were interconnected. For example, validation is created by attuning to the vitality of the person with dementia (themes 1, 3, and 5). The interconnectedness between the themes supports the decision of writing the themes into a

Final Distilled Essence

Music therapists' nonverbal interactions in dementia care are interconnectedly characterized by their awareness of the vitality of the person with dementia, their disciplined subjectivity, and by attunement, therapeutic presence, and validation. The music therapists are guided by the vitality of the person with dementia, and how this vitality is expressed in body language and the use of voice. They are aware of their own sensory and emotional reactions that arise in contact with the person with dementia—and through disciplined subjectivity, these reactions are used to sense the needs of the person. In reciprocal interactions, the music therapists attune to the person's nonverbal musical parameters (such as tempo, timing, pitch, and volume) and cocreate an open and mutual field of therapeutic presence by being authentic, aware of communicative signs of the person, and loyal toward own vitality, and how this is brought into the mutual space. Finally, the music therapists strive to understand which psychosocial needs the person with dementia express and to validate these by sharing the mutual subjective experience that happens through attunement, and when the music therapists are able to catch the moment.

Table II.
Additional Aspects to the Collective Themes that Emerged in the Musical Improvisation

Theme 4	Theme 5
- The music therapists are cocreating a mutual field of presence.	- Validation happens through attunement.
- To be present, the music therapist must be authentic.	- When validation happens, the music therapists are informed that the person with dementia is aware of the interaction.
- To be present, the music therapists are loyal toward their own vitality and aware of how they bring it into the mutual space.	- For validation to happen, it requires an ability to catch the moment and let go of control.

final distilled essence (step 7) that was validated by all six music therapists participating in the study (see Final Distilled Essence).

Discussion

In the study, we explored how six music therapists with experience in dementia care understand and talk about nonverbal interactions with persons with dementia living in nursing homes. By analyzing transcripts from the seven focus groups, we constructed an understanding of how the participating music therapists experience their practice and presented this in a final distilled essence. In the following section, we discuss and reflect upon challenges and insights from the research process and the emerged findings.

The Musical Sensitivity

The music therapists emphasized that acknowledging, understanding, and actively using nonverbal interactions require the full presence and attention toward the person with dementia and their special needs. Nonverbal communication can sometimes be characterized by ambiguity, which makes emotional consciousness and sensitivity toward the reactions of the person even more important (Ellis & Astell, 2017). Persons with dementia are not always able to express themselves verbally and, therefore, the empathic awareness of their actions, reactions, and personal boundaries becomes central for ensuring a reciprocal, respectful communication. The findings illustrate the importance of emotional awareness and consciousness to meet the psychosocial needs of the person with dementia.

While such qualities are often described among other helping professionals (Coates & Fossey, 2016; Isaksson et al., 2012), music therapists are specifically trained to use musical parameters such as tempo, timing, pitch, and volume to attune to the person. There is a range of "post-therapy" approaches to the analysis and interpretation of music's role in music therapy (Bonde, 2016), as well as interesting tools for "pre-therapy" reflections on the components of music, in order to facilitate the planning of intervention and evaluation (Hanson-Abromeit, 2015). We agree with these authors that characteristics of the music are important to therapeutic processes and outcomes. Tempo and dynamics (volume) might support engagement when corresponding to clients' arousal states and might speak to the emotional intent of any communication pattern. Pitch contour—the sequential patterns of ups and downs in a melody—also relates to the pitch pattern of spoken phrases.

The music therapists in this study reflect on the "within-therapy" uses of music, on "looking, listening and thinking *in situ*, in the middle of the musical action" (Ansdell, 2014, p. 26). The music therapists describe how they are highly aware of the musical expressions of the person with dementia and through this attentiveness create concrete ways of interacting nonverbally. This allows for matching personal needs of the person with dementia and enhances self-expression. Musical interactions thus offer a frame for nonverbal interaction, which may support reciprocity between the person and the music therapist (Ridder, 2003; Ridder et al., 2013). We suggest that the capacity of music to create mutual interaction could be used by other professionals as a way to support person-centered care, meet psychosocial needs, and prevent isolation for persons with dementia.

In the analysis, we interwove theories that the participating music therapists presented themselves. Their extensive use of theoretical references highlights the challenge of describing nonverbal interaction. It also suggests that existing theoretical thinking provided the music therapists with a useful language for unfolding their practice. However, involving theory in this way also contains challenges and may limit the way of describing own practice and, therefore, also the construction of new theories. When disseminating music therapy-informed techniques to other professions, it is both a resource and a challenge to be informed by theory and certain discourses (Alvesson & Sköldberg, 2018; Stige, 2002). On the one hand, the theoretically informed discourse may serve to help the practitioner communicate clearly and precisely, but could, on the other hand, exclude other professions. Such use of theoretically informed language also runs the risk of desensitizing participants to aspects of the interaction that do not clearly fit existing theory.

The Ineffability of Non-Verbality and Musical Interaction

During the research process, a parallel process became apparent to the researchers. As persons with advanced dementia struggle to express themselves, a similar process took place for the music therapists, who found it challenging to describe their practice and interactions. Even though the music therapists are skilled musicians and practitioners, they are not necessarily trained in describing and disseminating how they act and relate nonverbally. If we use the terms developed by Schön (1983), we may argue that the participating music therapists had considerable knowing-in-action but found it difficult to articulate this knowledge, which made the completion of the lived-experience descriptions challenging. The application of musical improvisation allowed the music therapists to reflect on their knowing-in-action, and it seemed to support the verbal reflection on their practice. Ansdell (1999) pointed at the "music therapist's dilemma," having to use words to represent complex musical processes. Ansdell (1999) and Aldridge (1996) described the differences between doing music therapy and talking about music therapy and wrote that the discursive practice differs from the actual experience. Professional caregivers may in the same way experience challenges in expressing in words the details of nonverbal care interactions. Their knowledge about practices is mostly tacit, which makes it difficult to reflect with colleagues on complex situations and, therefore, very challenging to improve practice. Indirect music therapy practice is based on music therapists' competencies to reflect-on-action, and to use this reflective practice with caregivers, giving them the tools to learn from such reflective processes. Thus, the need to translate complex nonverbal processes not only is a music therapist dilemma but also exists for caregivers. The knowledge that music therapists have gained in their training in regard to reflect on musical interactions may be highly useful for caregivers when they act in a nonverbal field. This puts a demand on music therapists to be able to disseminate clinical music therapy practice and to use this knowledge with other professions. In addition, it makes us speculate why arts-based methods are not used in the development of knowledge-on-action for caregivers as well.

In the process of exploring nonverbal interactions with persons with dementia, the aspect of distance in time, both as

resource and a problem, became clear. Music therapeutic interactions unfold over time, and because music is rhythmically organized, it has the potential to facilitate communicative synchronicity and, in this way, invite the persons involved in the music to share time (Trevarthen, 2002). This dimension explains the ability of musical interactions to create a space for shared, mutual intentions, attentiveness, and affective conditions that is meaningful and welcoming (Stern, 1998; Trevarthen, 2002). This characteristic about music does, however, also challenge the extent to which the interactions can be translated, after they have taken place. In the musical improvisations in the second part of the research, the music therapists could play an actual representation of different dimensions of nonverbal interaction and immediately reflect upon the experience afterward. The integration of musical improvisation, therefore, served to help the translation of the experiences of nonverbal interaction into representations in text that the music therapists felt were loyal toward their practice.

In the research process, the music therapists did negotiate the themes that they brought up from practice. Together the participants reflected upon and commented on the findings both in the focus groups of the first part of the research and with the use of musical improvisation in the second part. The music therapists all used a theoretical discourse of music therapy to express and translate the nonverbal interactions into verbal representation. This theoretical discourse required social negotiations between the participants and resulted in alterations of both representations and reflections, which underlines the constructivist implications of the study.

Future Implications

The current findings have implications for the knowledge about how music therapists comprehend nonverbal interaction in dementia care and for the development of music therapy theory. When music therapists are supervising professional caregivers and helping them to reflect upon *their* practice, we find it essential that they are conscious about their own knowing-in-action. The study revealed implicit knowledge of the participating music therapists and thus contributes to our awareness about the importance of clinical knowing-in-action. This knowledge is relevant to indirect music therapy practice, where the music therapist supports caregivers in how to interact musically with persons with dementia (McDermott et al., 2018). The findings from the study can serve as inspiration for future guidelines for the practice of sensitive nonverbal and musical interaction that other professionals could benefit from. When working with indirect music therapy practice, we do find it important to acknowledge that the use of music can be harmful for the person with dementia. Music can, for example, be overstimulating and cause reeexperience of trauma or painful memories (Silverman et al., 2020). Precautions should, therefore, be taken, and music therapists have a special responsibility for ensuring safe and relevant use of music and to guide caregivers when certain uses of music are contraindicated. The music therapists in the study showed advanced therapeutic skills in the way they addressed awareness of vitality and the ability to fine-tune their interactions with the person with dementia. Professional caregivers work in another context than music therapists and must adhere to various tasks and professional demands. These conditions could make it challenging for caregivers to perform the same kind of presence that music therapists experience as essential, and they would need to be guided and supported by a music therapist in an ongoing process.

Finally, the research process demonstrated new ways of combining research methodologies to develop an approach suitable for exploring diverse aspects of nonverbal interaction. The participating music therapists found musical improvisation appropriate and enjoyable for researching a relevant and complex phenomenon.

Limitations

In dementia research, there exists a need for involving persons with dementia in the research process in order to bridge the gap between current clinical research and the priorities of the persons themselves (Downs & Bowers, 2014). An interaction contains at least two persons, and this study only revealed the experiences of the music therapists. As a next step, we find it relevant to include persons with dementia and to observe nonverbal interactions between the music therapists and persons with dementia and how these evolve over time.

The first author participated in the study both as a subject and later as a researcher. We are aware of the double perspective and the inherent challenges it represents. However, we also agree with Long and Slevin (1999) who claim that problems with attempting to understand the meaning of life through other people will always be influenced by the researchers' own past and experience. The study has allowed us to explore tacit knowledge through the use of lived-experience descriptions and musical improvisation. The elaborations revealed a spectrum of nonverbal parameters that occurred between the person with dementia and the music therapist and presented a local discourse of the participating music therapists. It is important to stress that the developed themes and constructed essence are idiographic and may not be transferable to other contexts. They may, though, serve as inspiration for guidelines on indirect music therapy practice.

This study contributes with knowledge about how the participating music therapists understand their practice and what they consider to be central in nonverbal interaction in dementia care. The final distilled essence was constructed by the participating music therapists, the six of whom formed a highly homogeneous group. All were middle-aged, white women educated at Aalborg University in Denmark and working in similar institutional settings. It is relevant to perform the same study in other contexts with music therapists from different cultural and educational backgrounds and compare the findings with the present study.

Conclusions

In this study, we identified five interconnected themes describing the way six music therapists experience nonverbal interaction with persons with dementia living in nursing homes. We found that the music therapists are guided by the *vitality* of the person with dementia, and how this vitality is expressed in body language and the use of voice. The music therapists are aware of their own sensory and emotional reactions that arise in contact with the person with dementia—and through *disciplined subjectivity*, these reactions are used to sense the needs of the person. In

reciprocal interactions, the music therapists *attune* to nonverbal musical parameters (such as tempo, timing, pitch, and volume) and cocreate an open and mutual field of *therapeutic presence* by being authentic, aware of communicative signs of the person, and loyal toward own vitality and how this is brought into the mutual space. Finally, the music therapists strive to understand which psychosocial needs the person with dementia express and to *validate* these by sharing the mutual subjective experience that happens through attunement, and when the music therapists are able to catch the moment. Arts-based methods provided additional understandings to the phenomenological analysis of the nonverbal interaction between the person with dementia and the music therapist.

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Supplementary Material

Supplementary material is available online at Music Therapy Perspectives.

Supplementary material is available at https://vbn.aau.dk/en/datasets/supplementary-material

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