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CHAPTER 1

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Music therapy and parent infant bonding

Building the bonds of love in a secure relationship in the early years is considered essential to making a good start in life. Part of the repertory of interaction involves easily identified music elements. This predisposes the music therapist to having a strong basis on which to support therapeutic interventions that promote secure bonding between vulnerable infants and their caregivers. By providing a musical container, or skin, in which both the parent and infant can be held, music therapy can offer the dyad a chance to safely encounter and explore one another anew. Music therapists have rich resources for supporting this capacity sensitively and joyfully with their clients.

This chapter presents some of the theoretical formations and research that supports the work of qualified music therapists in promoting healthy and secure attachment between parents and infants where disruption to a secure relational bond has occurred, or is vulnerable in some way. Characteristics of the innate musicality of the very young infant is considered, and the mutual regulation potentials of music making between caregivers and their developing infants is discussed. For the purposes of this review and indeed this book, the definition of infant used is the broadest possible; from birth until 3 years and 11 months of age.

The caregiver-infant system is considered a developing dyadic or triadic structure (Stern 2000; Corboz-Warnery *et al.* 1993) with one or both parents or other caregivers playing an essential role in the formation of a secure base in interaction with the infant. The infant's need for external support is evident, leading Winnicott to deduce that 'there is no such thing as a baby' (Winnicott 1952 p.99). That is, a baby depends for its survival on being part of a care system involving one or more adults who have responsibility for providing security, support, and nurture. As Ham and Tronick (2009) have described, infants '...require regulatory input from others to sustain even basic homeostatic and physiological processes such as body temperature, sleep cycles digestion and motor stability (p. 621). This regulation is provided through the relationship with the primary caregiver(s).

As Schore has elegantly stated, 'Development may be conceptualized as the transformation of external into internal regulation' (Schore 2001 p. 205). Through the early years the infant depends on external support to develop the capacity for managing their internal state. Interpersonal and intrapsychic regulation are crucial to a healthy start to life, and these processes are interdependent (Beebe and Lachmann 1998).

In a healthy relationship the caregiver '...affords emotional access to the child and responds appropriately and promptly to his or her positive and negative states.' (Schore 2001 p. 205). This supports the adaptation of the infant towards internal regulation functions which relate to 'the regulation of arousal, the maintenance of alertness, the capacity to dampen arousal in the face of overstimulation, the capacity to inhibit behavioral expression, and the capacity to develop predictable behavioral cycles.' (Beebe and Lachmann 1998 p. 485). This interpersonal and intrapsychic regulation of the parent-infant dyad is considered interactive; 'Interactive regulation flows in both directions, on a moment-to-moment basis, so that each experiences influencing, as well as being influenced by, the other's behavior.' (Beebe and Lachmann p. 500)

Promoting the use of music as a means to enjoy and explore parent infant relations is not new. However, the impact of music therapy interventions on the development of the bonds of attachment is increasingly of interest within the music therapy community of practitioners working with vulnerable parents and infants , especially in the early intervention setting (Jonsdottir 2002; Edwards *et al.* 2007; Nicholson *et al.* 2008).

Music therapy

Many descriptions of the use of music in health and healing contexts have appeared in the historical record prior to the formalisation of the field now known as music therapy (Gouk 2000; Edwards 2007). The current established professionalization of music therapy primarily developed in the 20th century as a post-war phenomenon. 'Musical therapy' was enthusiastically championed by musicians and music teachers to support the needs of the large numbers of returned servicemen from the two World Wars (Edwards 2007; Sullivan 2007). This led to calls from qualified healthcare professionals for appropriate and specialised training to be provided in order to practice music therapy. The resultant development of university based courses around the world from the mid 1940s can be traced to the recognition that a range of psychosocial care needs were able to be addressed through interactions and opportunities observed and recorded in the music sessions in which these returned soldiers participated (Edwards 2007).

The field of music therapy has subsequently benefited from theoretical perspectives provided from psychoanalysis (Streeter 1999), humanistic psychology (Noone 2008), and therapeutic

approaches to the treatment of psychological distress (Edwards and Kennelly 2011). Providing a therapeutic relationship with a qualified practitioner where co-created music making is the basis of interaction has been shown to provide therapeutic benefits for people receiving care in many medical, community and education settings. Research studies and reviews have shown that music therapy is effective for many client groups including people who have mental disorders (Edwards, 2006), children who have autism (Gold, *et al.* 2006), pain management for burn patients (Tan 2010), and for people who have dementia (Raglio *et al.* 2008).

Parent-infant work in music therapy has gradually developed as a professional interest with recognised leaders (for example Abad and Williams 2007; Oldfield and Flower 2008; Shoemark and Dearn 2008), and specialist conferences. As in other related therapy practices, music therapists began to see the benefits and relevance of the inclusion of family members in work with children, and expanded their practice to treat dyads (Oldfield 1995; Trolldalen 1997). Music therapy programmes for the support of attachment behaviours between vulnerable parents and their infants have been founded, notably the Australian programme *Sing & Grow* (Abad and Edwards 2004; Abad and Williams 2005; Abad and Williams 2007).

In the context of parent infant work, music therapy can be described as a process of developing a relationship with a caregiver/dyad in order to support, develop and extend their skills in using musical and music like interactions including vocal improvisation, chants, lullabies, songs, and rhymes, to promote and enhance the sensitivity and mutual co-regulation between infant and caregiver, in order to create the optimal environment for secure attachment to be fostered. Music therapy for parent-infant bonding is practiced in groups, and in dyad or triad based parent infant sessions.

In the Australian programme *Sing & Grow* music therapy is offered through short-term weekly sessions for groups of up to 10 families (Abad and Williams 2007). The purpose of music therapy is to 'strengthen parent-child relationships through increasing developmentally conducive interactions, by assisting parents to bond with their children, and by extending the repertory of parenting skills in relating to their child through interactive play' (Abad and Williams 2007 p. 52).

The musically primed infant

Extensive research studies have identified distinctive and surprising aspects of early musical capacity in the human infant. It is well established that the newborn infant can distinguish elements of rhythm, pitch, and melody (Papoušek 1996). As they develop infants use this knowledge to learn about the world around them, and to acquire language (Vosoughi *et al.* 2010).

Newborn cries recorded within 5 days of birth showed that German and French infants differed in the contour of their cries (Mampe *et al.* 2009). The French babies produced cries with a predominantly rising contour, and the German babies showed a falling contour in their crying. These findings suggest that infants are influenced by the rise and fall in the tonality of the language they hear spoken while in the hearing phase of their development in utero (Mampe *et al.* 2009).

Infants' early cry stabilises at a pitch that is relatively constant with individual infants showing only a semitone variation by 3 months of age (Wermke *et al.* 2002). These findings have indicated that for the human infant 'linguistic and musical channels are likely to be equally accessible and not discrete' (Cross 2009). This suggests that infants may not be discriminating between music and speech but instead are drawn to the types of vocal interplay that they experience as more meaningful and recognisable.

There is a substantial body of evidence to show that infants prefer music to speech. They especially show preference for their own mothers' singing rather than her speaking (Nakata and Trehub 2004), and prefer this singing when it has infant-directed features (Trainor 1996).

In a study of father's singing infants did not show a greater preference for either audiovisual recordings of their father's singing that was infant-directed, or for songs recorded without the infant present (O'Neill *et al.* 2001). In the same study a comparison of infants who watched a recording of their father's singing and their mother's singing, indicated that infants paid greater visual attention to fathers (O'Neill *et al.* 2001). Informal observation led the researchers to propose that this may have been due to some performance elements of the father's singing described as 'vigorous' and 'exuberant' with elements of self-consciousness that were not perceived in the mother's performances (O'Neill *et al.* 2001 p. 422).

Other examinations of musical preference in infancy have shown further discrimination abilities. In tests of 6 and 7 month old infants using head turning as a measure of preference it was demonstrated that unfamiliar lullabies were preferred when sung at a lower pitch and unfamiliar playsongs were preferred when sung at a higher pitch (Tsang and Conrad 2010). Previous research showed infants preferred lower pitched renditions of unfamiliar lullabies (Volkova *et al.* 2006). Even at the age of 2 months infants have been shown to remember a short melody and then be able to distinguish between the familiar melody and a novel melodic phrase (Plantinga and Trainor 2009).

The infant's musical capacities develop alongside all of their rapidly progressing motor, language, and social developmental changes in the early years. Musical skill acquisition has a regular developmental sequence (Hargreaves 1982; Briggs 1991). Briggs used an extensive literature base of studies of music in the early years to propose a phased model charting this development in the four areas of capacity, 1. auditory, 2. vocal/tonal, 3. rhythmic, and 4. cognitive. Infants first use their

abilities in listening and vocalising during the 'reflex phase' from birth to nine months. They then develop skills in being able to copy musical phrases and learn snatches of songs during the 'intention phase' until around 18 months. The next 18 months of the 'control phase' shows rapid development of the ability to control musical elements and in the final 'integration phase' are able to learn a music instrument, and rapidly learn songs, rhymes, rhythms and chants (Briggs 1991).

As with language abilities, perception and reception develop first and then the ability to perform musical tasks including singing and use of instruments (for a review see Miyamoto 2007). Loewy (1995) elaborated the musical stages of speech development in a study of the pre-verbal skills in infancy and the relationship of these to music therapy work with clients who do not speak. As hearing, vocalisations, and the musical perceptual system is well developed in infancy, it is common sense to consider the ways in which musical play can offer a means to engage and communicate with vulnerable infants.

The musical parent

Since the infant has the neurological and auditory maturity to discriminate pitch and to increasingly recognise the emotional intention of vocal timbre (Bergeson and Trehub 1999), it is understandable that caregivers worldwide soon realise that the infant will best attend and respond to requests for playful interactions through offering stereotypical 'sing song' vocalisations. This particular ways of singing and speaking when interacting with infants in order to capture their attention and promote reciprocity (Bergeson and Trehub 1999; Bryant and Barrett 2007) is known as 'infant-directed'¹ in that it is distinct from the way adults use their voice in interaction with older children and with each other (Trehub *et al.* 1993). The way that the infant responds to this playing easily promotes feelings of loving intimacy for the caregiver which is vital to bonding (Gerhardt 2004). For example, this 'emotional musicality' or singing quality was not present in an acoustic analysis of the vocalising of a depressed mother as compared to a mother with no mood disturbance (Robb 1999), and a review of studies of interactions between parents and infants from 3-6 months of age showed that depressed mothers use less infant-directed speech, and show difficulties with the synchrony of their timing in vocal interplay with their babies (Field 2010).

Prosody is the rise and fall of pitch in speaking that is similar to the pitch changes in a melody. Adults use distinctive pitches and exaggerated prosodic contours in producing infant-directed speech. Infant-directed singing similarly includes features such as 'final phrase syllable lengthening' (Trainor 1996 p. 89), placing emphasis on certain words, and using a 'loving tone of

¹ This term has also previously been termed 'motherese' or 'baby talk'

voice' (p. 90), that is probably a function of smiling while singing (Trainor 1996). This type of singing is used by children as young as 3 years of age when singing to younger siblings (Trehub *et al.* 1994).

It has been demonstrated that individual mothers create distinct 'signature tunes' (Bergeson and Trehub 2007) by using the same pitch in the rise and fall of their utterances to their infants. Caregivers 'across cultures use broadly similar pitch contours to express their arousing, soothing, and disapproving intentions...' (Bergeson and Trehub 2007 p. 648). It is proposed that this pitch stability creates a way for the infant to recognise the mother's voice and this recognition serves to 'enhance reciprocal emotional ties' (Bergeson and Trehub 2007 p. 649).

Mothers singing songs to their 4-7 month old infants recorded one week apart were shown to produce the exact pitch and rhythm in both renditions (Bergeson and Trehub 2007). Adult capacities for pitch perception, recognition, and recall have been shown to be stable even in people who have not developed absolute pitch² and do not have musical training (Levitin and Rogers 2005; Schellenberg and Trehub 2003) suggesting that this ability is retained and continues to be used as a perceptual skill beyond infancy.

Many parents also learn that a lullaby can be used to aid relaxation, soothe distress, and invite sleep (Trehub and Trainor 1998). However, the lullaby is rarely used as an exclusive soother in promoting sleep. For example, in a study of the experiences of using lullabies for 18 first time mothers, MacKinlay and Baker (2005) found that 'Patting, stroking, rocking, bouncing, or walking around the room while singing to babies were common techniques...' (p. 88). Music and movement are allies when searching for ways to soothe and comfort a tired infant.

Malloch and Trevarthen (2008) have linked this parent-infant 'musicality' metaphorically to movement citing evidence to support their view that we 'live, think, imagine and remember in movement' (p. 1). In music therapy work with mothers and their infants it has been noted that the function of 'recognition' between parent and infant requires the presence of sound, gesture and movement (Trolladalen 1997); 'That is, timing,...dynamics,...and narrativity' (Trolladalen 1997 p. 26). Additionally Papoušek has noted that these musical interactions between parents and their infants are usually multimodal, not only involving auditory based melodic and vocal interplay but also having rhythmic, physical movement, and visual aspects (Papoušek 1996). So while this chapter explores the capacities of musical interaction and music-like interactions in parent-infant bonding, it is recognised that nonverbal and tactile aspects of this interaction are present for the parent and infant when learning each other's 'rhythmic structure' (Schore 2009).

² Absolute pitch is the ability to attach a letter name to a note on hearing the note played

Musical relating in parent-infant communication

Malloch and Trevarthen (2008) described four decades of mainly observational research about playful communicative interactions between mothers and infants. They noted how interactions were observed by many researchers to be highly ritualised, leading to descriptions of these interactions as 'musical' or 'dance like' (Malloch and Trevarthen 2008 p. 1). For example Papoušek noted how in transcribing infant directed speech into pitch classes she was tempted to also record the musical 'connotations' of these interactions 'such as crescendo/diminuendo, rallentando/accelerando, legato/staccato, dolce, or agitato' (Papoušek 1996 p. 94). As the music therapist Mercédès Pavlicevic has noted, parents and infants create highly expressive interactions where both partners 'negotiate and share a flexible musical pulse between them, constantly adapting their tempi, intensity, motion, shape and contour of their sounds, movements and gestures in order to "fit" with the communicating partner' (Pavlicevic 2000 p. 274)

As the infant does not have a shared understanding of words, considering these vocally playful interactions between parents and pre-verbal infants to have musical characteristics and qualities adds a useful dimension in examining the functions and benefits of these exchanges . Papoušek has proposed that adults use of these melodic contours in infant-directed speech is a 'communicative code' (Papoušek 1996 p. 96). This 'communicative musicality' (Malloch 1999) affords the infant and caregiver a way to express and exchange information about emotional states; fundamental to strengthening the bonds of love.

Stern has explained that the success of the adult's interaction with the infant is generally dependent on three aspects; 'the extent of their repertoire of infant-elicited social behaviours; the manner of performance of these behaviours (richness, variety, and fullness of displays); and the subtlety of timing of these behaviours so they are most effective' (Stern 1977 p. 41). This playful interaction has further been noted to have the temporal features of 'signalling, synchrony, and attunement' (Ham and Tronick 2009 p. 620). Since all musical performance requires attention to timing, pitch and synchrony, musical elements can easily be heard in the playful interactions between caregivers and infants.

Sandra Trehub has observed that in relation to caregiver and infant music making 'Music is not communicative in the sense of sharing information. Instead, it is concerned with sharing feelings and experiences and the regulation of social behaviour' (Trehub 2003 p. 672). This capacity of musical exchanges such as singing nursery songs or lullabies to convey feeling states offers a means to experience mutually satisfying and meaningful interactions, and is therefore highly relevant to the practice of music therapy in parent-infant work. Additionally, the musical qualities of vocal interplay

between parents and pre-verbal infants has a resonance with the type of improvised music created in music therapy with patients of all ages (Pavlicevic 2000).

Through observing minute by minute interactions between parents and infants during their long research careers Colwyn Trevarthen (2001a; 2001b) and Daniel Stern (2000) have found that 'communication with an infant is, from the beginning, intersubjective and emotional, valuable to both infant and adult in itself as an interpersonal exchange of feelings and state of animation, no matter what the language content' (Trevarthen 2001a p. 103). Influenced by her doctoral studies with Daniel Stern, Beatrice Beebe also pursued an extensive research career making links between early face to face parent infant interactions and the capacities for psychoanalytic therapy to offer support and change to vulnerable adults (Beebe and Lachmann 1998).

Stephen Malloch is a trained musician who worked with Colwyn Trevarthen as a postdoctoral researcher in the 1990s. While watching and listening to recordings of interactions between mothers and their infants he was struck by the musical aspects of these co-created events leading him to suggest that '...a mother and her infant can jointly create a musical piece – both are musical partners within their communication space' (Malloch 1999 p. 47). Malloch and Trevarthen concluded that 'these "musical" narratives allow adult and infant, and adult and adult to share a sense of sympathy and situated meaning in a shared sense of passing time' (Malloch and Trevarthen 2008 p. 4).

Dissanayake also noted the musicality of these communicative encounters. She proposed that this playful interaction is 'proto-musical' and is a foundation source for the universals of human musical behaviour (Dissanayake 2008). In her view, the proto-musical features of 'formalization, repetition, exaggeration, dynamic variation, and manipulation of expectation' (p. 176) contribute to emotional bonding because they impact on the infants 'visual, vocal, and kinesic signals that enable their emotional bond with their mother' (Dissanayake 2008 p. 176).

The use of these musical elements to co-create mutually satisfying encounters between parents and their offspring is increasingly understood to contribute to healthy and optimal growth through the early years; and these positive interactions in turn create a strong foundation for future capacities for intimacy and positive relating, with these positive early relations influencing later mental health (Maselko *et al.* 2010).

Parent-infant bonding

It might seem unnecessary in a contemporary presentation of this topic to search for evidence that a supportive, secure, and intimate relationship with a primary caregiver is an essential start to healthy progression through life. However, many theorists in the middle of the 20th century

devoted their working lives to proving the essential role of attachment in infancy. A summary of the necessity for attachment can be found in the British psychiatrist John Bowlby's report to the World Health Organization (Bowlby 1951). 'The infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment' (Bowlby 1951 p. 13). Working with Bowlby, Mary Ainsworth (1978) and James Robertson (1953; Bowlby and Robertson 1952) provided evidence that maternal deprivation caused significant stress for infants and young children with lifelong consequences. Although it took decades to achieve, their research findings changed hospital practices to allow parents visiting rights (van der Horst and van der Veer 2010), and became influential in how the needs of vulnerable children were perceived (Bretherton 1992).

Throughout last century a series of influential figures gave further credence to the necessity for a secure parent-infant base to support the development of lifelong capacities for psychological stability and the capacity to form intimate relationships successfully with others (Winnicott 1965; Stern 1998; Beebe and Lachmann 1998; Trevarthen 2001a). It has become increasingly evident that attachment behaviours have specific purposes and require sensitivity and responsiveness on the part of the caregiver. The figure of the mother or other primary carer must behave in what Winnicott has described as a 'good enough' way to contain the infant's anxieties and fears of, 1. Going to pieces, 2. Falling for ever, 3. Having no relationship to the body, 4. Having no orientation; and 5. Complete isolation because there is no way to communicate (Winnicott, 1965, p. 58)

The development of the ability to relate and communicate has been described as a series of building blocks or developmental phases of intrapsychic and interpersonal capacity that he described as having various 'domains' that include the 'Emergent self' from birth until 2 months, 'Core self' from 2- 6 months, the 'Subjective self' that emerges in the period from 7-15 months, the 'Verbal self' at 15 -18 months, and then the 'Narrative self' at around 3 - 3.5 years (Stern 2000 p. xxv).

The expectation of the infant that emotionally sensitive interplay will be available to them is supported by experiments where mothers were instructed to play with their one year old infants and then present a blank and motionless face for some minutes while still staring at their infant (Ham and Tronick 2009). The resultant behavioural response from the infant can include fussing, crying and general perturbation until the mother re-engages again. The results from measures of skin conductance and respiratory sinus arrhythmia showed that at re-engagement the mother first

calmed herself, and then calmed her baby. This finding provides support for the hypothesis that mutual co-regulation supports the infant's emotional equilibrium (Ham and Tronick 2009).³

When the ability to seek or maintain this communication is absent or impaired in the relationship urgent support and help is needed. A qualified music therapist can work in gentle non-intrusive ways to help parents and their infants discover and strengthen their capacity for relating through the musical play that is part of the usual repertory of parent infant interactions.

Parent-infant music therapy

It is difficult to trace the exact starting point for music therapists' interest in providing supportive parent-infant interventions to vulnerable infants and their carers. Abad and Edwards (2004) reported the start up of the *Sing & Grow* programme in Australia and proposed that 'the use of music therapy to assist parents to extend their repertory of successful and nurturing parental behaviours in interaction with their young children' was 'relatively new' (Abad and Edwards 2004 p. 14), and 'under reported and researched' (p. 5). Oldfield and Bunce (2001) had also described that music therapy work with mothers and young children was unusual. Family-centred music therapy had been provided in a playgroup programme with early intervention goals some years earlier in Australia (Shoemark 1996).

Music therapists have reported work with families in a range of contexts. The medical settings of the Neonatal Intensive Care Unit, and work in burns and oncology have particularly highlighted the need for an understanding of the role of the family as a central resource as well as the focus for music therapy interventions (Edwards 1998; Daveson and Kennelly 2000; Shoemark and Dearn 2008; Stewart 2009).

Many music therapists have noted the connections between the creation of music in the client therapist relationship in music therapy and early mother infant interactions (Pavlicevic 1990; Heal 1995). Therefore, the adult's experience in infancy of the capacity to develop a creative vocal dialogue is considered by some to be reflected later in the relationship evolving in the musical interactions in music therapy. Diane Austin, for example, has described her music therapy approach as 'vocal psychotherapy' (Austin 2008). She has suggested that certain types of vocal techniques in the early stages of therapy work with adults are often similar to parent infant vocalisations, giving

³ When this study was presented at a NICU Summit at Beth Israel Hospital New York (Ham 2010) footage was presented of a dyad where the infant turned the still face part of the experiment into a game, becoming highly vocally humorous and eventually repeatedly 'breaking' his mother's motionless face resulting in both of them, and indeed the summit delegates, collapsing into helpless laughter.

the patient the opportunity to experience 'an emotionally present, attuned mother' (Austin 2008 p. 149).

A music therapy pilot project sought to determine the effects of structured group music involvement with children between the age of 12 and 24 months and their parents (Standley *et al.* 2009). Findings showed that children in the music group benefitted in cognitive and musical development compared to matched controls. This study included parents and so is of interest to this review. However, the focus of the study is on infants' developmental skills rather than parent-infant interactions. By comparison, Abad and Williams (2007) reported the benefits of supporting parents in group music therapy programmes to engage musically with their young children to promote attachment. A report of a music therapy group programme with self-referred 'well' families reported benefits with offering social support and additional ways to deal with parental challenges (Mackenzie and Hamlet 2005). Other music therapy programmes with mothers and their infants have shown benefits in the quality of interaction observed, and self reported satisfaction with participation in the sessions (Oldfield and Bunce 2001; Oldfield *et al.* 2003). Observations in music therapy sessions with mothers and their infants from the asylum seeker community in Limerick, Ireland showed that interactions and interpersonal engagement improved for these vulnerable, 'preoccupied' mothers and their children (Edwards *et al.* 2007).

Additionally, Bargiel (2004) has made a number of recommendations about the development of early intervention music therapy programmes to support parents and their infants. Specifically she proposed that the first interaction be the therapist and dyad, with a group programme only commencing after twice weekly sessions for 10 weeks and a follow-up assessment (Bargiel 2004).

The first study to evaluate a short term early intervention music therapy parent-infant programme using validated measures found that for 358 parents and infants, a number of significant benefits impacted the parent and child in a range of areas including education in the home and parental mental health (Nicholson *et al.* 2008).

Conclusion

Building the bonds of love in a secure relationship in the early years is considered essential to making a good start in life. Part of the repertory of interaction in a loving parent-infant relationship involves easily identified music elements. This predisposes the music therapist to having a strong basis on which to support therapeutic interventions that promote secure bonding between vulnerable infants and their caregivers.

Parent-infant interactions do not necessarily have musical intention but recognition of the musical features of this interplay provokes further reflection about music therapy dynamics. The process of musical improvisation in music therapy sessions reveals much about the communicative of relationship available between the client and therapist (Pavlicevic 1990). The music created can be considered a 'by-product' rather than being the intended outcomes of the work of building the relationship between the therapist and client (John 1992). The music therapist works with the client to evoke musical narratives of his or her emotional and interpersonal life experiences (Austin 2008). The music that is created is less relevant as a cultural symbol than a deeply affective emotional communication channel. For a child or adult with a disability that has prevented their development of language as a means of communication, this interaction offers a 'lifeline to human sociality' (Malloch and Trevarthen 2008 p. 6). For adults seeking support for psychological distress, it is possible that in the incoherence they experience in trying to make meaning from what they feel, this musical interaction can offer a supportive holding place for the incomprehensible of the feeling world until it is ready, like the infant's eventual development of words, to become the story that can be told.

By providing a musical container, or skin, in which both the parent and infant can be held, music therapy can offer the dyad a chance to safely encounter and explore one another anew. Music therapists have rich resources for supporting this capacity sensitively and joyfully with their clients. Further research and development work is needed in order to understand how to optimise and promote this work more widely, especially with the inclusion of potential co-collaborators from related disciplines.

Further distinctions between, and a deeper understanding of theoretical approaches will help in providing specific training and supervision support for practitioners. For example, distinctions and the overlap between music therapy as a preventive approach or as a treatment approach are not always clear. The role of the therapeutic relationship between the therapist and the dyad and how this is established, fostered and maintained in a music therapy context, including in group programmes, could be further elaborated. Measurement and evaluation of outcomes has received some attention (for example Nicholson *et al.* 2008; Standley *et al.* 2009). However, standardized evaluation tools for routine use in music therapy parent-infant programmes could be usefully developed.

Since it is possible that anyone can sing with a baby it is sometimes challenging to claim expertise in musical interactions, and to promote the benefits of and need for a particular music therapy perspective. Increasingly musicians and musical organisations promote a range of add-on benefits for music in society and daily life in order to justify access to public funding (Edwards 2010).

Negotiating our shared interests while claiming a distinct specialist role without marginalising or becoming marginalised can be challenging. As we add our voices to the community of therapy practitioners who care for and offer support to vulnerable caregivers and their infants, it is hoped that the points of connection will be stronger than any moments of divergence, and that the developing nature of this work can be given due credence and opportunity.

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