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The Development of Social Behavior During Music Therapy: A Child Case Report

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ABSTRACT

Music therapy is often used to improve the social skills of children with autism. In this study, the development of social skills of an 8-year-old boy, diagnosed with an Autism Spectrum Disorder (ASD), was monitored before and during music therapy. At the start, he experienced many difficulties in his contact with other children, which made him lose more and more of his own self-confidence. He was offered 20 weeks of music therapy. The development was monitored by means of a weekly questionnaire completed by the boy's mother.

The weekly scores show significant progress compared to baseline in the areas of 'Making eye contact', 'Concentration', 'Coping with changes', 'Verbal communication', 'Joint Attention', 'Taking the other person into account', and 'Taking Initiative'. This progress is confirmed by the VISK scores of different informants, all showing significant progress. This case description offers an indication that music therapy may support development, although further research is required.

Keywords

Music therapy, Autism, Social skills, Non-verbal therapy.

Theoretical and Research Basis for Treatment

An Autism Spectrum Disorder (ASD) is already noticeable at an early age and has lifelong consequences. The most distinctive consequences are generally the limitations experienced in social interaction. The characteristics of ASD in DSM-5 [1] include permanent limitation in the areas of social communication and social interaction in various situations, as well as limited and repetitive patterns in behavior, interests, and activities. Music therapy is very regularly applied with children and adolescents with ASD. There are various studies that report significant effects that music therapy can have on this target group. The study conducted by Ghasemtabar et al. showed that the use of music therapy has a significant effect (SMD 1.06) on the social skills of children and adolescents with ASD. This is in line with the results of similar studies conducted by Vaiouli et al. [2], Gattino et al. [3], Katagiri [4], Kim et al. [5], Kern et al. [6,7], Wimpory et al. [8], and Edgerton [9]. Music is used to make contact and it offers the client unique opportunities to use ways of nonverbal communication

[10] and to take on the alternating role of initiator and imitator in a playful manner [11]. For children with ASD, it is often difficult to have direct social interaction. Music therapy can create a safe environment in which this can be practiced in an indirect way, through music. Furthermore, these children experience music as very pleasant and relaxing [12].

Music therapy already has long been used as an intervention with children and adolescents with ASD who experience serious problems in social and societal areas [13]. Music therapy is a form of therapy that is classified as a so-called expressive therapy. This treatment method uses music to offer the client experiences that may stimulate the developmental process. The therapist has the expertise to identify and interpret human reactions to music, by applying the musical elements of tempo, rhythm, melody, harmony, and tone by making use of musical instruments, voice, types of musical play, improvisation, and existing repertoire [14].

The studies conducted so far were mainly aimed at the social interaction and communication skills of this target group. Based on these studies, it is not possible to determine which intervention

would be the most suitable one for working with children and adolescents with ASD. There is insufficient information available about the types of music therapy available. Further research is required to make targeted choices regarding the type of intervention and the working methods that would be most suitable in this case.

Pater and Van Yperen [15] concluded that the many studies that were conducted so far show a number of shortcomings: they lack a clear description of the target behavior and it raises the question as to whether the right research designs were used to study the intervention adequately.

Even though a large majority of the studies include case studies or multiple case studies, research designs such as Controlled Clinical Trials (CCT) and Randomized Controlled Trials (RCT) are increasingly applied to study the effectiveness of music therapy with people with ASD. These trials also confirm the positive effect of music therapy on the social interaction of children and adolescents with ASD. RCTs are often considered to be the golden standard in terms of diligent research [16]. However, we need to ask ourselves whether this standard applies to every intervention study. Music therapy has yet to be developed into a more systematic intervention that can be tested for efficacy with rigorous research methods. In the meantime we have to clarify what music therapy is and if there are any indications that it has an effect on the child's development of social behaviour. N=1 research allows us to gain insight in the elements of music therapy and the change in the condition of an individual person during treatment.

By opting for the N=1 approach as a method, it is possible to monitor one client very intensively, before treatment (baseline) and during this process. The hypothesis is that, if the development of e.g. social behaviour improves (accelerates) significantly during treatment, compared to baseline, this is an indication that music therapy may have an effect. This claim of causality is still very weak. Repeating this study for different cases builds preliminary evidence that helps to decide whether or not the intervention is promising enough to test it in further and more rigorous research.

Case Introduction

At the start of the music therapy intervention, Simon (a pseudonym) was an 8-year-old boy diagnosed with ASD according to DSM IV.

Simon attends a school for children with special needs. This school provides education to students between the ages of 4 and 12 years old. The students at the school have behavioral, psychological, and/or psychiatric problems. The school offers these students an appropriate and individual education so that they can develop at their own level in a safe and comfortable educational environment.

Simon was born in the Netherlands. His parents originate from Suriname but have been living in the Netherlands for most of their lives.

Presenting Complaints

Simon's parents are concerned about his development. His behavior

is mainly that of a follower and he displays no individuality. He also finds it difficult to make contact with others and is unable to identify emotions. He displays hyperactive behavior and, even though he gives the impression of being a self-confident boy, he is actually very insecure, which also seems to be the reason for his hyperactive behavior. The music therapy was initiated at the request of the school psychologist.

History

Simon's parents noticed at an early stage that he was making less contact with others compared to the other children of parents they know. Being a young child, Simon has difficulty sleeping and is often hyperactive and restless. The child health clinic has referred them to a pediatrician.

Because Simon displays very little playful behavior, it is difficult to test him, but they suspected early on that he might suffer from ASD. The first toy he starts to play with is a toy that makes a sound and he soon gathers other toys that are musical instruments. Because of Simon's interest in music, his parents would like to give Simon the opportunity to develop his musical skills. However, they do realize that it would be difficult for him to attend regular music or dance lessons. He finds it very difficult to play with others and there is little reciprocity in communication. Because it is difficult for Simon to connect with other children at a regular school, he attends a school for children with special needs. The structure offered at this school helps Simon, but his parents also notice that, in addition to his hyperactive behavior, he copies other people's behavior and takes little or no initiative himself.

Assessment

For the case study, it is important to observe the client in his familiar environment. His mother was asked to complete a questionnaire once a week. In addition, people from Simon's personal network were approached to complete the VISK questionnaire at 3 specific moments. His parents have given their consent to participate in this study. They also suggested three observers who see Simon very regularly, so that they can observe him as well. These are his mother, his grandmother, and a counselor of the Medical Orthopedic Center. The fourth observer is the music therapist who offers Simon the music therapy. By using his personal network, Simon's behavior can be observed and rated from different perspectives, which will create the most realistic picture.

The developed Social Behavior Questionnaire consists of 10 observational behavior items that can be rated from 'never' to 'always'. The observer has the option to give some more nuance to the answers by ticking multiple boxes.

The Social Behavior Questionnaire is completed weekly and includes the following 10 items:

- Makes eye contact
- Is able to focus for 5 minutes
- Is able to cope with changes
- Behavior has adapted to the situation

- Communicates verbally
- Communicates non-verbally
- Is able to focus on something together
- Is able to take another person into account
- Takes initiative
- Has rigid behavioral patterns

Because the parents need to complete the questionnaire every week, for a period of 23 weeks, we tried to find a questionnaire that would not burden them too much. Since no suitable questionnaire could be found, the decision was made to use the above-mentioned version, created by the researchers. The VISK was used as a basis for this questionnaire.

VISK

The VISK questionnaire, the Questionnaire for the Inventory of Social Behavior of Children was developed with the intention to describe the problem behavior of children with (milder) forms of pervasive development disorders. This questionnaire includes a wide range of problems in various development domains, mostly focusing on social problems. A three-point scale was used to evaluate the 49 items of the assessment, which can be completed by the parents/caretakers themselves. The Dutch Committee for Testing (COTAN) deemed the reliability and the validity of the definitions of this questionnaire to be adequate.

The brief questionnaire was scored by the mother. To rule out that out that the effect that Simon's mother reported was based by a wish to see a positive development, three other people from Simon's network completed the VISK questionnaire (i.e. his music therapist, his teacher and his grandmother).

Case Conceptualization

An intake interview is conducted prior to the intervention. The purpose of this interview is twofold; on the one hand it provides the opportunity to get acquainted with each other and also to obtain a clear idea of the specific need.

The music therapy then starts with an observation period. This phase is intended to observe the client's behavior. The therapist looks at whether it would be feasible to achieve the treatment goals within the set period of time and to identify the child's musical preferences. This phase is also used to build a relationship between the child and the therapist. At the end of the observation period (5 sessions), the therapist makes an observation report in which the findings are described, and which includes the objectives of the therapy.

The activating music therapy begins in the treatment phase. Activating music therapy can be defined as jointly making rhythms, melodies, or music within a therapeutic relationship with the objective to obtain developmental improvement. This can be done by applying various methods to make music. Using percussion instruments to produce rhythm is an accessible method that is often used for this reason. Other methods are singing or the use of other instruments. The therapy will regularly focus on

improvisation, but it is also possible to use existing compositions. After making music, a conversation is often initiated about the experiences and/or feelings that were a result of making this music. Therefore, with active music therapy, the client goes through an experience by making music. The therapist chooses the work methods that focus on the problem(s) the client is coping with. These work methods often correspond to the different elements that people adopt in their development. Examples are playing, playing together, experimenting, improvising, and fantasizing. Within the active music therapy setting, a large variety of musical instruments is used. The therapist chooses or changes the instruments that are offered, based on the client's interests and the work methods that are used within the framework of the goals of the treatment.

In this case description, the music therapy includes both improvisation and fixed work methods. The used work methods are described in an intervention plan or manual (Pater, 2016). This plan contains 30 work methods that focus on the improvement of the social behavior of children and adolescents with ASD through music therapy.

The intervention is completely centered on the client and the therapist's approach is based on the client's capabilities. By linking the intervention to their capabilities, changes can be realized in the areas where the inhibitions are experienced. The music therapy focuses on the unconditional acceptance of the musical style and musical coordination. From this acceptance, the music therapist offers methods with which the client can connect. An example of this is the therapist copying the client's musical expressions by adjusting his own pace and dynamics to those of the client. This way, the music therapist communicates with the client on a musical level, often by improvising with the client. This work method often creates a safe foundation in a short period of time, in which the therapy can develop further. In the next phase, the therapist can also use a more stimulating approach and challenge the client to do new things.

The therapist keeps a log to monitor the client's progress. This log describes which work methods are used and what the results are. The work methods for the next session are based on this information.

Course of Treatment and Assessment of Progress

A retrospect from the log and the video analysis:

After the intake interview and the observation phase, the music therapist and Simon's mother establish the following goals during the evaluation: learning to focus his attention on what is being asked and improving his ability to make and maintain contact. The music therapy also focused on providing Simon with a way to express himself, in order to relieve his feelings of restlessness.

Because Simon, as described before, is an energetic and somewhat restless boy, it was extremely important to set clear boundaries during therapy. The beginning and end of the session were always clearly marked by an intro song and an ending song. In the 'intro song', Simon and the therapist were alternately welcomed to the

session by the line 'Hello Simon, we are going to make music again today, hello Simon, we are going to make music again today'. The 'end song' was to say goodbye by singing the lines 'Goodbye Simon, this was your music lesson, we are now finished, see you next week, goodbye Simon'. The sessions also largely followed a fixed pattern, from which could be deviated every now and then. After the intro song, played on the piano or guitar, during the main part of the session they would use recurring instruments and methods, often based on improvisation. Because Simon likes to play the harmonica, the therapist made sure that she brought one for Simon and that it was used in therapy. Furthermore, they would mainly sing songs that he liked together. At the end of the session, and if Simon had participated well, they would listen to a song from Simon's favorite TV show as a reward. In all, the therapy was well-structured and at the same time geared towards Simon's individual interests.

Within the setting of music therapy, it is also important to establish clear boundaries. In Simon's case, for example, he sat on a chair during the first sessions, instead of on a stool, which gave him more support, so that he would not get up from his seat too quickly. The therapist and Simon also made an agreement about handling the instruments with care and that Simon would not lie on the ground. To hold Simon's attention, the music therapist often varied in the musical parameters: when she was playing the guitar and she noticed that Simon's attention started to wane, she would start to play significantly louder or faster. Simon would often notice this change in music, which would draw his attention back to the therapist to see where the change was coming from. The therapist would also very often use large movements. When copying Simon's actions, she would enlarge his movements, or she would show him how to do something by using large movements. This would draw his attention and it often made him laugh.

As described before, music therapy often uses improvisation exercises. These are mainly focused on mimicking, taking turns in playing, and on playing together. One of the exercises that was often repeated during the therapy was mimicking a rhythm made by the other person on the djembe or hapi drum in order to work towards the objective of social interaction. This work method was first used during the second session of the observation phase. The therapist and Simon were each sitting on one side of the djembe and the therapist told Simon that she would play something and that he had to mimic what she played. While she begins with a rhythm of Pam Pampampampam, Simon already starts to beat the djembe while the therapist is still playing. The therapist says: 'Wait a minute, how do you know what to play if you've already started?' and she tries again. This time, Simon also starts too early and the therapist gently takes his hands and explains what he needs to do. The third time, Simon manages to wait a bit longer and he is able to mimic most of the rhythm, Pam Pampampam. The therapist complements him by saying 'Yes, well done'. However, after two more efforts, Simon's attention wanes and the therapist then says that he can play first and that she will mimic him. Simon plays the rhythm Pampam, and the therapist does the same. When the therapist mimics what Simon does, he looks up and smiles. He is

watching her closely to see if she really mimics what he does.

This exercise is repeated often during therapy, on different percussion instruments, and is gradually extended. At the start of the therapy, Simon still found it hard to wait for his turn. Over the course of the therapy, during the treatment phase, he managed to do the exercises longer, he was more and more able to await his turn, and he also used more variations in his own play. He played more complex rhythms and he varied in volume and pace. Pam tatatam PAMPAM. In session 18, he was even capable of alternating between who would play first, meaning that he had become more flexible in adjusting to what was asked of him. This shows a significant development in his ability to concentrate and an improvement of the reciprocity in the contact.

One of the objectives of the therapy was to offer Simon a way to express himself. A good example of where Simon was able to express himself through music, were the moments where they made sound recordings with the help of a microphone and a loop station, while Simon improvised with his voice or harmonica.

A loop station is a recording device that repeats short sound fragments which then creates a rhythm. By combining different loops, you get a complex rhythm. During the session, different sound fragments can be recorded, which can then be used to create your own unique song. The first time, Simon was a bit anxious to record the sounds and his attitude was hesitant. By showing him what to do and by complimenting him, the therapist encouraged Simon to experiment in making the sounds for the recording. Simon really enjoyed doing this and listening to what he had played, and he seemed to be proud of the recording. The recording was also shared with Simon's parents, so that they could listen to what he had done in the music therapy sessions.

	NAP	SMA Level change		SMA Slope 1	
		r	p	r	p
1. Makes eye contact	0,922	0,691	*	0,759	*
2. Is able to focus for 5 minutes	1,000	0,853	*	0,742	*
3. Is able to cope with changes	0,789	0,350	*	0,736	*
4. Behavior has adapted to the situation	0,672	0,026	*	-0,003	*
5. Communicates verbally	0,978	0,824	*	0,723	*
6. Communicates non-verbally	0,378	-0,138	*	-0,720	*
7. Is able to focus on something together	0,993	0,644	*	0,645	*
8. Is able to take another person into account	0,967	0,795	*	0,821	*
9. Takes initiative	0,961	0,659	*	0,782	*
10. Has rigid behavioral patterns	0,406	-0,182	*	-0,534	*

Statistical Analysis

In order to assess the development of Simon's social behavior before and during treatment, a quantitative analysis was conducted by using the NAP and the SMA. These techniques are applied to assess whether the trends in the data during the intervention phase differ from those during the baseline phase. The NAP measures the overlap of the measurements in the baseline phase with those of the intervention phase. When the score is between 0 and 0.65, the improvement compared to baseline is weak, a score between 0.66 and 0.92 shows moderate improvement, and if the score is between 0.93 and 1.0, the improvement is considered to be significant. When we look at the scores in table 2, we see that Simon shows a significant improvement in the areas of 'Concentration', 'Verbal communication', 'Joint attention', 'Taking the other into

account', and 'Takes initiative'. Additionally, he shows a moderate improvement in the areas of 'Making eye contact', 'Coping with changes', and 'Adjusted behavior'. Hence, an moderate or significant improvement is noticeable on eight of the ten items.

SMA can be used to assess a slope from two phases. In doing this, we used the pattern that we can expect in this study: after a stable baseline phase, the desired behavior increases during the intervention phase. This may be an indication of a therapy effect. In figure 1 we can see that the areas 'Making eye contact', 'Concentration', 'Coping with changes', 'Verbal communication', 'Joint attention', 'Taking the other into account', and 'Takes initiative' for the slope show a significant progression in the intervention phase compared to the baseline phase. To get a clear idea of whether this occurs during the intervention phase or if this trend had already started during the baseline, Tau-U was used to test for significance. None of the scores showed a significant trend in the baseline, whereas scores of the intervention phase did show a significant trend in the data. Based on this, we conclude that development has improved during music therapy.



Figure 1: Total score Friedman Test VISK.

Because development was measured with a self-compiled questionnaire, the results were compared with the results from the VISK that was completed at the start of the therapy, after 10 weeks, and upon completion. We see a decrease in the score, which means that there is noticeable improvement in the behavior. The total VISK score of the mother, in figure 2, also showed significant progress ($p < .05$) for Simon. He same was found for the other informants: all showed a significant improvement in the total score of the VISK. Gower coefficient was calculated to determine the consistency (i.e. inter-rater reliability) of the scores on the individual VISK items. For 78% of the scores, the consistency ranged between 0.81-1, which indicates a good consistency. For 22% of the scores, the consistency ranged between 0.61-0.80, which indicates a reasonable consistency. This indicates that the scores of the mother give a reliable view on Simon's behavioral development.

Follow-Up

The music therapy intervention included 20 sessions, after which it is ended. Simon's mother completed the VISK questionnaire again 6 months after the music therapy, as a follow-up measurement.

At follow-up, the VISK showed a mean of 57, a slight increase compared to the measurement after the 20 weeks of music therapy (55). This demonstrates that 6 months after ending music therapy, Simon shows a similar score and that he has been able to retain the

learned skills.

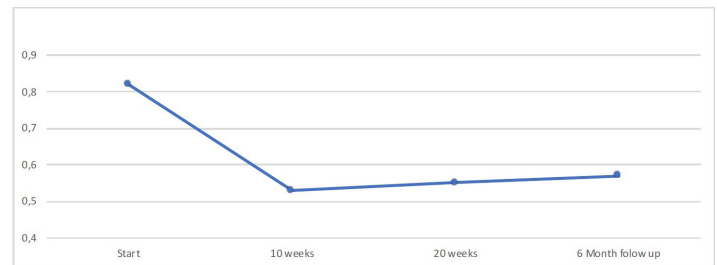


Figure 2: Follow-up meeting VISK.

Treatment Implications of the Case

It is very important, and it will become increasingly so, to provide insight into how music therapy interventions are structured, how they are applied, and why. So far, this has been quite difficult; the literature in this area does not provide all the answers and music therapists indicate that they initially work from their own intuition. Nevertheless, it appears that this practical knowledge can provide a lot of input for the development of an intervention and/or its guidelines. The substantiation from the available literature offers a good foundation, which can be complemented and assessed in practice.

The music therapeutic intervention has to be further and thoroughly researched in practice. By making use of the intervention manual, music therapists can offer the intervention in a uniform way, which will provide more insight into what is taking place during the intervention. This may help to raise hypotheses about the effective elements within this type of intervention.

Recommendations to practitioners and researchers.

It is crucial to further investigate the results of music therapy. This way, it can provide more clarity about the extent to which music therapy can contribute to the treatment of children and adolescents with ASD. This article discusses one case study. To obtain sufficient evidence, it is important that studies like these are repeated. If the same type of improvement can be found over and over again, indications that music therapy may have an effect are getting stronger and stronger. It will be important to investigate if this same patters occurs with other types of treatment, or if this is especially the case for music therapy. The latter may indicate that music therapy is especially suitable for the treatment of children with ASD, and make it worth wile to test the efficacy of this intervention with more rigorous research.

In order to get a good overview of the effects of the music therapy as it is now given in practice, it is important that the data is collected in this natural setting. A repeated single case study would be a good method for this. Practitioners may benefit from this type of study in two ways. In the first place, they learn how to assess the progress of the children in a detailed way. This is facilitated if they are trained to keep a log of the therapy and assess the target behaviors of the child prior, during, and after therapy. Second, by this training and this type of research, they are increasingly able to substantiate the value of their work. This may be a good step

towards more extensive research, like an RCT, that may help to further build a firm foundation of music therapy.

References

1. APA. Diagnostic and Statistical Manual of Mental Disorders – DSM-5, 5th ed. Washington: American Psychiatric Publishing. 2013.
2. Vaiouli P, Grimmet K, Ruich L. “Bill is now singing”: Joint engagement and the emergence of social communication of three young children with autism. *Autism*. 2015; 19: 73-83.
3. Gattino GS, Riesgo RDS, Longo D, et al. Effects of relational music therapy on communication of children with autism: a randomized controlled study. *Nordic Journal of Music Therapy*. 2011; 20: 142-54.
4. Katagiri J. The effect of background music and song texts on the emotional understanding of children with autism. *Journal of Music Therapy*. 2009; 46: 15-31.
5. Kim J, Wigram T, Gold C. The effects of improvisational music therapy on joint attention behaviours in autistic children: a randomized controlled study. *Autism Dev Disord*. 2008; 38: 1758-1766.
6. Kern P, Wolery M, Aldridge D. Use of songs to promote independence in morning greeting routines for young children with autism. *Journal of Autism and Developmental Disorders*. 2007; 37: 1264-1271.
7. Kern P, Aldridge D. Using embedded music therapy interventions to support outdoor play of young children with autism in an inclusive community-based child care program. *Journal of Music Therapy*. 2006; 43: 270-94.
8. Wimpory D, Chadwick P, Nash S. Brief report: musical interaction therapy for children with autism: an evaluative case study with two-year follow-up. *Journal of Autism and Developmental Disorders*. 1995; 25: 541-552.
9. Edgerton CL. The effect of improvisational music therapy on the communicative behaviors of autistic children. *Journal of Music Therapy*. 1994; 31: 31-62.
10. Kim J, Wigram T, Gold C. Emotional, motivational and interpersonal responsiveness of children with autism in improvisational music therapy. *Autism*. 2009; 13: 389-409.
11. Holck U. Turn-taking in music therapy with children with communication disorders. *British Journal of Music Therapy*. 2004; 2: 45-53.
12. Geretsegger M, Elefant C, Mössler K, et al. Music therapy for people with autism spectrum disorder. *The Cochrane Database of Systematic Reviews*. 2014; 6: CD004381.
13. Reschke-Hernández AE. History of music therapy treatment interventions for children with autism. *Journal of Music Therapy*. 2011; 48: 169-207.
14. Kern P, Humpal M. (Eds.) *Early childhood music therapy and autism spectrum disorders: Developing potential in young children and their families*. London and Philadelphia: Jessica Kingsley Publishers. *Journal of Music Therapy*. 2012; 51:126-129.
15. Pater M, Yperen, van T. *Muziektherapie voor kinderen en jongeren met ASS, Een overzicht van de relevante literatuur*. Kind en adolescent. 2017; 38: 233-259.
16. Offringa M, Assendelft WJJ, Scholten RJPM, et al. *Inleiding in evidence-based medicine: klinisch handelen gebaseerd op bewijsmateriaal, tweede druk*. Houten: Bohn Stafleu Van Loghum. 2003.