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TE ROOPU PUORO WHAKAORA O AOTEAROA

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The New Zealand Journal of Music Therapy

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The New Zealand Journal of Music Therapy is a journal for music therapists and other professionals interested in music therapy in all fields of health, social services, and education. NZJMT publishes articles of direct relevance to the eclectic practice of music therapy in New Zealand. The full text of NZJMT is available online through the EBSCO Host interface, Informit, and RILM.

Submissions (previously unpublished) are welcomed and will be evaluated by peer reviewers prior to possible acceptance for publication. Guidelines for contributors may be found on the back inside cover of this journal or the website.

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Editorial

Kia ora koutou. Welcome to the 2018 issue of the NZJMT.

This issue focuses on clinical practice articles, documenting the lived experience of positive change through engagement in music therapy and, in one article, music listening for self-care. The journal reflects the intentional eclecticism of New Zealand music therapy (Croxson, 2003) and includes six articles, six book reviews, and a publications alert.

Our first article, by Maybelle Swaney, a UK-trained New Zealander practising in disability services in Australia, provides an insightful account of improvisational music therapy group work and reflective practice, illustrated by an online audio recording. New Zealand music therapist Maharani Allan describes a music therapy pilot project for people with dementia and their care partner, a timely contribution in the context of an ageing population likely to benefit from music therapy services. Our Australian colleagues have recently been awarded a large research grant for music therapy research in dementia care (Gill & Crump, 2018) which I hope will encourage both research and service provision in New Zealand.

Joan Webster and Daphne Rickson offer a thought-provoking personal account of music listening experiences during illness, with implications for self-care and for music selection in clinical practice and research.

Music Therapy New Zealand is pleased to publish two winning entries from the inaugural (2017) Morva Croxson Prize for Emerging Writers. These essays, by Nolan Hodgson (first prize) and Oliver Lowery (second prize), were highly rated by our esteemed panel of judges (Denise Grocke, Claire Molyneux and Vini Olsen-Reeder). Both authors, now registered music therapists, submitted work arising from their Master of Music Therapy student placements. The competition acknowledges Morva Croxson, President Emeritus of Music Therapy New Zealand, who has offered the following reflection:

> It was an especial pleasure to read the two papers that came through as leading entries in the writing award that bears my name. Nolan Hodgson and Oliver Lowery both have skills that do credit to them and auger well for the future development of music therapy in this country.
>
> The two essays were totally different in style, yet each conveyed evidence of deep thought, careful reflection and effective practice. Sensitivity and scholarship were evident, and both students and music therapists can learn from the content in each paper.
>
> Oliver had a modest approach to his own role in a limited clinical placement situation with an elderly client in palliative care. Nolan enhanced my awareness of the practices and innate philosophy of Māori musical expression. His gathering of a wide range of accessible and enlightening material was rich and powerful.
>
> Do read these two papers carefully and often! They are special.
>
> (M. Croxson, personal communication, June 18, 2018)

Hodgson's article has prompted a preliminary review of the NZJMT's language policy, and I thank Vini Olsen-Reeder for conversations and advice. We have agreed not to italicise most words in te reo Māori, as these are commonly understood, and italicisation may impede the flow for the reader. Explanations are included in the text, where necessary, and Hodgson has appended a glossary for international readers and others unfamiliar with te reo Māori.

A further student article, by Emma Johnson (now a registered music therapist) and her supervisor/co-author, Daphne Rickson, focuses on songwriting with young people experiencing mental health difficulties. Incorporating varied methods, song examples and reflective journal entries, this is a valuable resource for music therapists and a helpful example of writing clinical practice.

Our six book reviews represent only a small proportion of the music therapy books and related literature published internationally each year. I am pleased to note that *Only Connect* (Molyneux, 2017) and reviewed here by Caroline Miller, has now been reprinted by Jessica Kingsley Publishers under a new title, *Tales from the Music Therapy Room: Creative Connections*,

available in both paperback and e-book formats. The other books have been selected for their relevance to professional practice in New Zealand.

Finally, the journal includes a publications alert, listing scholarly writing (beyond NZJMT) by New Zealand music therapists. Readers experiencing difficulty accessing any of these publications are advised to contact the author directly.

I draw your attention particularly to the proportion of new authors and book reviewers contributing to this issue, and congratulate each of them on their courage and commitment to the publication process. Each article or book review enriches professional practice, provides foundational knowledge for future research, and contributes to the evidence base as we collectively advocate for music therapy provision for all who might benefit. I also thank our team of editorial advisers – experienced New Zealand and international professionals who have provided constructive feedback for our authors and for me, as editor.

Alison Talmage
Editor

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The *New Zealand Journal of Music Therapy*

invites submissions for the 2019 edition

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For inquiries or to discuss alternative submission dates, please contact the Editor before the due date:

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Clinical Improvisation in Group Music Therapy with Adults with Severe Brain Injury: A Space Where Everything Can Happen, or Nothing Can Happen

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Keywords:

Clinical improvisation, group music therapy, moderate-severe brain injury, emotional rehabilitation, long-term care

Abstract

This paper is a reflective piece on group music therapy with adults with brain injury. The author draws on her experience of facilitating an open group music therapy programme at a long-term care facility for people with moderate to severe neurological conditions. Particular attention is given to the meaningfulness of improvised musical experiences in the group therapeutic process, as well as the challenges of remaining attentive in a space where, at times, nothing appears to be happening. The paper also explores the positive impact of music therapy on non-group members, e.g. volunteers, and its implications beyond the therapy space.

Introduction

When working with individuals with severe brain injury, sometimes the therapist may detect in him or herself an emerging sense of hopelessness as one is reminded of the reality that, in almost all of the cases, the damage to the brain is permanent and its consequences for the person largely irreversible. This realisation can be compounded by feelings of ambivalence at the kind of contribution the therapist can make in the lives of such individuals, which would both be meaningful and have rehabilitative worth.

This paper explores the validity and value of music therapy and – in particular – improvised musical experiences in music therapy, in group work with adults with acquired brain injury. I will be drawing on my experiences of facilitating an open group music therapy programme over a five-year period at a neurological care facility. As this paper is intended to be a reflective piece, the case material discussed is a personal account; group members are portrayed as a composite client group (of adults with brain injury) rather than anonymous individuals.

Background

My work was based at a long-term care facility for adults with moderate to severe conditions of brain injury and neuro-disability. The service model would be best described as slow-stream rehabilitation within a multi-disciplinary setting. However, from the time when music therapy was established as a service, it has operated as an independent unit, i.e. separate from the allied health team. This autonomy carried both advantages and disadvantages. On one hand, we were independent to determine our own goals (emotional rehabilitation), casework priorities (individuals who presented with the greatest need and received the least therapeutic input), and standards for carrying out clinical work (long-term, typically twelve months or longer). The privileges afforded by this freedom, however, came at the cost of isolation. Without the support structures of team meetings and open communication between clinicians, the therapist's work is sometimes about managing the feelings of insignificance and incompetency that presides over one's role.

On site, the day-to-day life of the individuals are structured around activities of routine care and meal times. Many of the residents have been living with the consequences of their brain injury for over ten years; this was their home, and the staff and co-residents their family. During the day the recreation team runs group activities, which are open to all residents. The music therapy group featured in this paper was the only music therapy session offered on the recreation programme. The group had already been meeting together weekly for four years before I took on the facilitator's role – initially as co-therapist and, shortly after, sole music therapist.

As a music therapist working in this environment, it often felt like we occupied a rather peculiar space – neither considered allied health, nor specifically recreational. This rather peculiar space became my own journey of locating the distinctiveness in the therapeutic value that music therapy can offer a person with severe brain injury in long-term residential care.

Emotional Rehabilitation with People with Severe Brain Injury: The Therapist's Role

The event of severe brain injury causes enormous upheaval to one's life. Most inescapable, perhaps, is the experience of loss. This loss is multi-layered and spreads across areas of a person's independence, physical appearance, communication, status, future, financial control, family role, and ability to participate. The emotional self of the individual, although less visible, also undergoes its own trauma as one is confronted with the irreparable reality of life after brain injury: "The degree to which a TBI has derailed an individual from his or her expected trajectory represents most likely the primary source of emotional pain" (Ruff, 2013, p. 773). Typically, this emotional pain is accompanied by feelings of grief, isolation, guilt frustration, and self-blame, which can lead to resistance to rehabilitation (Miller, 1991), social withdrawal, (Baker & Tamplin 2006), and ongoing mental health concerns such as anxiety, depression, and poor psychosocial functioning (Chan, Parmenter, & Stancliffe 2009).

In the years and decades following the initial impact, a kind of normalcy in this "life after brain injury" establishes itself. In many cases of severe brain

injury, rehabilitation interventions are exhausted as a person's functional independence reaches its limit. Given the magnitude of losses that a person has experienced and the challenges he or she continues to encounter in living daily with the consequences of physical, cognitive, and communicative impairment, it seems even more paramount that rehabilitative efforts turn towards a person's internal world and its potential to respond to therapeutic work in the face of severe neurological damage. As Tamplin (2006) notes, "The expression and processing of feelings following a traumatic event is necessary for healthy emotional well-being" (p. 181).

Gilbertson and Aldridge (2008) propose that relationships – and the right to relationship – should assume the core narrative in a person's rehabilitative journey. Here the authors assert that the true value of rehabilitation is found in supporting people with brain injury to participate in relationship with other people in their lives: "Having been lost, this participation becomes a privilege" (p. 144). Framed within the context of a person with severe brain injury residing in long-term care, perhaps one can approach the therapist's role as this: to present a space where experiences of being in relationship with another are made available, in the process of attending to areas of emotional needs specific to the individual.

In this space, the music therapist can harness the potential of music to elicit motivational and emotional responses in another (Altenmüller & Schlaug, 2013; Magee, 1999; Tamplin, 2000). For people with severe neurological impairments that limit their ability to communicate effectively with others, music transcends this barrier: "The deficiencies of finding and understanding of words, which usually exclude patients with cerebral lesion from society, are not relevant in this medium" (Jochims, 1995, p. 22). Through one's experiences of "my sound in the world", validated in a therapeutic space with a seeing, hearing, and responding other, a person can begin to reclaim his or her sense of identity as someone with something meaningful to contribute.

Group Music Therapy

Group work, in this sense, provides experiences of "our sound in the world". Through shared experiences, feelings of isolation, and disconnectedness from the world are alleviated as individual personalities draw nearer to one another (Borzcon, 1997; Davies & Richards, 2002). In group work with people with disabilities, Davies and Richards (2002) suggest that these shared experiences give recognition to the idea of disability as a "shared responsibility" between both the speaker and the receiver: "Disability is not so much in the individual but a problem between one person and another" (p. 22). Group music therapy work with individuals with brain injury, therefore, should facilitate a potential space that allow both speaker and receiver to participate meaningfully in their roles.

Clinical Improvisation in Group Music Therapy

With regards to the music therapy group, the primary purpose of clinical improvisation[1] is to encourage self-expression and attend to emotional experiences as they present in the here-and-now. Assuming the responsibility of the receiver, the therapist applies a discrete manner of listening to the expressive self of each group member. This means the idiosyncratic sounds, gestures or behaviours that typically identify a brain-injured person become the very material for constructing the musical piece. A seemingly unintentional, yet repetitive, raising and lowering of a person's leg, now makes contact with the chimes. A person's perseverative high-pitched vocalisations, shaped within an improvised melody. Another's head

[1] I am using the term "clinical improvisation" to describe the experience of spontaneous music-making between the therapist and participant(s) in the therapy space. The therapist is concerned with the interpersonal elements that are expressed in the participant's music – the quality of the playing, the gestures and sounds, the level of engagement, roles of leadership/following, and the extent to which the participant is being influenced by the therapist's "voice". The therapist's spontaneity comes from a place of intuition in "reading" the musical events as they unfold, and finding an appropriate response that best meets the participant's need in that moment. The distinctions between the use of use of improvisation in music therapy and in non-clinical uses of improvisation, e.g. jazz improvisation, is addressed by Pavlicevic (1995).

movement – the remaining independently functioning part of his physical body – now activates the Soundbeam[2]; it is the soaring, arpeggiated solo of an electric guitarist.

In the group experience, these sounds are unique and yet deeply connected to each other. With a renewed attentiveness, those arbitrary movements and sounds have a place among others:

> There is a particular sense of belonging when a musical improvisation is shared in a group where the instruments and many voices of sound seek a place to be alongside each other, affecting or resonating with each other rather than being indifferent. Here the uniqueness of the individual sound or instrument makes up the meaning of the whole.
>
> (Davies & Richards, 2002, p. 23)

Talmage (2016) describes how the therapist, through improvisation, provides experiences that support the awareness of self and others. The therapist musically emulates the process of "attunement" (Stern, cited in Talmage, 2016), where a baby's every expression is matched by its mother, thus creating a mirroring experience for the baby's feeling states. In group work, these experiences are further enriched with and by the recognition of others: "Group work enhances this experience as participants witness other interactions and are, in turn, observed" (Talmage, 2016, p. 155). Indeed, the other part of the group process – of playing, of speaking – is the experience of being heard. Klein (1987) describes the transformative experience of recognition:

> To be recognised is part of the healing process, whether it be recognition of good or of bad things [. . .] Just the experience of going to pieces, of being lost, furious, disgusting, terrified, ignored, yet safe and known and accepted, may be what a person

[2] The Soundbeam is an electronic device that uses a motion sensor to convert body movement into sound and music. See http://www.soundbeam.co.uk.

> is after, just the experience of being so in someone else's presence and not having to do anything about it.
>
> (Klein, 1987, p. 408)

Of course, there are a number of other purposes for group improvisation, for example, social interaction (Nayak, Wheeler, Shiflet, & Agostinelli, 2000), improving mood state (Magee & Davidson, 2002), active listening (Chen, Hannimal, Xu, & Gold, 2014), taking part in a creative group process (McFerran & Wigram, 2002), developing sense of self (Loth, 2002), exploring group roles (Durham, 2002), and sustained engagement (Magee, 2009). When addressing the emotional needs that typically accompany the reality of living with severe neurological damage, I have found that the most meaningful experiences have come from the immediacy of acknowledgement and response to emerging feeling states. To this end, clinical improvisation promotes proximity of emotional selves in and through the spontaneous sound dynamics in the therapy space.

Methodology

Theoretical Orientation

My approach in clinical practice evolved out of my music therapy training[3], which was rooted in a psychodynamic orientation. Somewhat fittingly, it was during the audition process that I first encountered free group improvisation. Sitting amongst unfamiliar faces of other hopeful candidates, we were asked to choose an instrument and "just play out how you are feeling today". Bewildered by this request, my competitive self desperately wanted to play well, while the timid part of me dreaded failure. That day I had a second opportunity to improvise, this time on my own. Away from the seeing eyes and hearing ears of peers, I sat at the piano and entered into a space of spontaneous freedom that was at once familiar, for it was there (at the piano, on my own) that I had spent countless hours,

[3] I completed my music therapy training at Anglia Ruskin University (UK) in 2011.

where those very personal and real feelings arrived at my fingertips far more naturally than they did in words.

During training I learned to associate sounds (and non-sounds) with feeling, feeling with meaning, and then to find the words to express this. Later, these skills were transferred to the therapeutic relationship. This marked the beginning of my understanding of psychodynamic concepts of thinking, where the client's unfolding thought and feeling experiences in the therapy space are observed as a microcosm of a person's being-in-the-world: "Therapy focuses on the internal world of individuals in order to gain deeper understandings into their relationships and experiences, and into how they come to relate to and view the world around them" (Kim, 2016).

In this meeting of two minds, the therapist's self holds the dual roles of participant and observer – what Yalom (2017) describes as "the therapist's chief professional tool" (p. 118). Operating this tool requires making oneself a receptor for the conscious and unconscious dynamics at play during this encounter, which are then acknowledged and made use of in the context of the client-therapist relationship. The process of learning to bear with the weight of what the client brings into the space, is part of becoming a therapist. Kahn (1997) describes this as "taking on the awesome responsibility for facing oneself" (p. 40).

Kahn's words have returned to my thoughts again and again, particularly in the group process when this responsibility has meant facing myself in response to the chaos, destruction, and nothingness that have sometimes gripped the therapy space. In those moments of feeling a bit stuck, relief was found in giving myself permission to articulate the exact feelings as they were. As Winnicott (1971) acknowledged, sometimes the therapist's work is to do with bringing clients out of a state where they are unable to play. This may involve a period of waiting together, while sitting among others' unspoken, unexpressed thoughts.

The references to psychodynamic literature are perhaps more aligned with psychoanalytic principles of therapy work. I drew upon these concepts in my attempt to find ways of shaping my waiting and sitting. Kim (2016) observes that, in psychodynamic thinking there will always be an element

of unknowing, thus "the capacity to bear and accept uncertainty is required of any therapist working from psychodynamic perspectives".

The Music Therapy Group

Attendance

The group operated within a long-term, open-group framework. While this meant that attendance was unpredictable (anywhere from two to twenty members) there was a core group of fifteen members, and efforts were made to support their attendance each week.

Therapy assistants (volunteers)

Over the five years that I facilitated the group we were supported by a number of volunteers with varying degrees of commitment and engagement. The role of the therapy assistant was to provide "just enough" support to clients in instrumental playing, prompting, and/or verbal encouragement. The purpose was to maximise the client's potential to participate in group experiences according to his or her individual capacity.

In hindsight, I had overlooked the potential influences of music therapy on non-client group participants. I will return to this aspect of the work later in the paper.

Session format

Sessions were one-hour and generally followed this structure: offering instruments; greeting song; two group music-making experiences; free group improvisation (which was recorded); listening to the recorded improvisation; and to end, music listening (pre-recorded song chosen by the group). Duration of these musical experiences varied depending on attendance, levels of participation and the general state of the group members.

Aim

As mentioned earlier, the purpose of the group was to explore possibilities of being in relationship with one another. In this space, musical and non-musical elements aim to encourage a person's capacity to express oneself as well as to draw connections between group members. Positive changes were observed when group members demonstrated the ability to make themselves known or show acceptance towards the self-expression of others (which may sometimes be in conflict with a person's usual levels of comfort).

Some Considerations on the Open Group Context

Maintaining the therapeutic space

The unpredictability of group attendance meant that, as much as possible, special care was taken to maintain a safe therapeutic space. Many songs were composed for the group and adapted to each session. Lyrics focussed on the here-and-now (e.g. "It's a new day and it's time for a new song") and on describing particular experiences (e.g. "Jane is playing the drum"). Having these parameters of sameness, or what Winnicott (1971) referred to as a "holding environment", allowed me to shape particular experiences to the changing group dynamics from week to week.

Use of verbal dialogue

One of the challenges of facilitating a large group is preserving a sense of "groupness" throughout the session. Quite often there was a feeling that we "lost" group members along the way. For example, one member will be hitting the drum continuously, but appear disconnected with the group experience. Others would remain unmoving unless their name was spoken. This felt need for individual and sustained attentiveness coming from several directions was initially overwhelming, as though I was responding to multiple individual sessions all at once.

One way of alleviating this pressure was to make verbal observations on the growth, changes and developments taking place in the therapy space

(e.g. between therapist and individual member, between group members, between group and music), and invite the group to think about those various dynamics together. This constant reference to the group "happenings" (or non-happenings) in the here-and-now provided a gentle yet firm reminder that the therapy space was shared amongst all members; any intimate moments still occurred within the seeing and hearing distance of a larger, less private, group context. In this sense, every member belonged to each event in the space, whether as an active participant or on a receptive level.

Clinical Improvisation and the Group Therapeutic Process

In this section I will describe how I facilitate free group improvisation in the sessions and reflect on its meaningfulness to the therapeutic process.

To start, I pose a question to the group – for example, "What kind of sounds should we make today?" This usually prompts a word or thought from members who could verbalise, generating some discussion. In times where the question is met with silence, I might offer some observations on the general mood among the group, or recall a particular interaction earlier in the session. Once the group has decided on a theme (e.g. "courage", "springtime", "feeling down"), I would introduce this as the title of the piece, and let the sounds unfold. Apart from signalling the ending (e.g. "Let's make an ending together"), I generally refrain from giving verbal prompts during the experience. The group typically responds with enthusiasm when I ask for permission to audio record the piece.

Of all the musical experiences presented, the free group improvisation was the most unstructured and unpredictable part of the session. Each week, upon arrival at this moment, it felt like we were entering foreign territory once again. This was also the task that demanded the most from its group members, for the space was absent of structure, pre-composed content, or therapist instruction. Completely exposed, each participant was equally responsible for the sound that would eventuate out of nothingness. As Bion (1967) observed, "In any session, evolution takes place. Out of the darkness and formless something evolves" (p. 272). And so, in this space, the therapist waits.

Listening to the Silence, Listening to the Sounds

In the process of waiting for something to unfold in this space week after week, I learned to become more at ease with – and more attentive towards – the "different flavours of silence" (Sinason, 1989, p. 9). This required a shift away from thinking about my own discomfort, to acknowledging what may potentially be going on in the minds of the group members. Although one could not always see or hear the response (which would have been satisfying the therapist's own expectations and desires), my role was to extend trust to the group members to each bring his or her contribution. In the same way that a composer understands and makes use of the qualities of silence in a musical piece, the music therapy session is also filled with rests and pauses, each taking on its own particular meaning (Borzcon, 1997). Stephens-Langdon (1995) describes this process of attending to silence as part of the therapist's work in cultivating intuition, where "the development of a respect and sensitivity for the silences in the music therapy session is the way to listen for the deeper messages within a session" (p. 69).

The group experience of listening to the recorded improvisation has been an invaluable part of the therapeutic process. During the improvisation experience, there may be a myriad of musical and non-musical happenings taking place. It was surprising how often those particularly spontaneous moments were captured in the recording: one member's exasperated complaints about another's high-pitched vocalisations; a casual dialogue on shoe sizes between a member and a volunteer; and yet a gentle downstroke guitar strum – the one gesture from that member in the entire piece.

When listening, group members were relieved of their responsibilities as musical participants and could now contemplate the piece as an artist to his or her completed masterpiece. Immediately recognisable sounds brought about different responses. Sometimes it was a smile, or an expression of glowing pride as a certain member's contribution is pointed out. It might be a rippling chorus of laughter on hearing those earlier complaints and off-the-cuff remarks, now a shared moment of humour. It was that sense of "Oh! There I am. That's me!"

It was remarkable to observe the group's embrace and celebration of all the sounds, despite these at times causing irritation during the music-making process. To reiterate the words of Davies and Richards (2002), the improvisation captured the uniqueness of each member's sounds making up "the meaning of the whole: (p. 23); the listening experience further brought this to the group's awareness.

The combined process of group improvisation and post-improvisation listening has been essential in cultivating a strong sense of ownership amongst the group, where "my sound" became "our sound", and "my experience" became "our experience". While the most apparent commonality shared by group members was brain injury, this factor seemed unimportant and secondary to the feelings that surfaced and were expressed in and through the musical experiences. Group members noticed one another and – more significantly – were affected by one another. In a space where the darkness and formless often evolved into chaos or silence, it was here that I repeatedly encountered the enormous capacity of music to hold, to steady, and to find the appropriate resolution through those moments.

Case Vignette

The following case vignette illustrates a group improvisation taken from one session.[4] Read the unfolding dialogue (below) and listen to the online audio recording (Swaney, 2013) of the improvised music experience.[5]

[4] Consent was given for this work to be shared with the public.

[5] This improvisation was also presented as a video art piece and included in the Purple Orange Perspectives Art Exhibition as part of the South Australian Living Artists Festival. The Perspective Art Exhibition showcases themes relevant to people living with disability and is a celebration of the work of artists living with disability as well as non-disabled artists.

MTh: Let's think about what kind of sounds we should make in our piece. How is everyone feeling today?

P1: Elvis!

P2: Nah, not Elvis.

P3 I know. You know what I'm feeling today. I'll tell you. I'm feeling great. I'm feeling on top of the world, like I'm flying.

P2 No, I don't agree. I'm not feeling like that at all.

MTh: Can you say a bit more about what it's like for you today?

P2 I'm feeling a bit flat actually … Being stuck in this same shit every day.

Impact of the Group on Non-Group Members

After nine years together, the group's journey came to an end when I was due to take extended leave. Our final session concluded with a song presentation and afternoon tea, which was attended by families of group members, volunteers, and staff.

Shortly after the group ended, I received written personal correspondence[6] from one of our volunteers, Grant[7], who had been with the group for eighteen months. Although I did not know much of Grant's background, I had observed his sincerity and willingness to offer the kind of "just enough" support that greatly assisted the sessions. In his message Grant described his early experiences of undertaking a placement at the facility, and encountering people with disability for the first time. He explained that, at the time, he was deeply depressed and feeling "very certain disability was not something I wanted to be involved with". Grant then recounted his first experience of attending the group music therapy session:

[6] Shared with permission

[7] Pseudonym

> On Day 2 […] I got to observe your group for the first time and witnessed something that I found so contextually and emotionally moving, I almost left the room immediately in tears (it involved the sound-beam). I found that moment so profound that it stuck with me ever since. From that day onwards, I was able to see what was possible for people with a disability.

Grant went on to describe how this shifted perception of people with disability impacted the way he interacted with residents:

> My strategy for connecting with residents changed from this point from asking residents about favourite sport teams [. . .] to asking about favourite music e.g. "Would you like to listen to Elvis/The Beatles/Bob Marley with me?" I also began to sing a bit to residents (even if they thought I was terrible at singing as that way I could make fun of myself and lower some perceived social barriers).

This led to further discovery of music, and in particular songs, to facilitate meaningful connections on an emotional level:

> I began to learn the lyrics to a lot of the residents' favourite songs [. . .] One of the big lessons I learned [. . .] is [that] words to certain songs have very deep subjective meanings for particular residents. In some cases they express what "reality of life" is like. In other cases they express mood. In others they express aspiration and so on . . . A lot of these types of interactions allowed the resident to open a type of bridge with me which made it possible to connect deeper in future interactions.

Grant's words and their revelation of his experiences of the group have been an unexpected moment of learning for me. Indeed, the therapy space is always alive with material to work with, and the potential for change imminent – even when they sometimes emerge undetected. The impact of music therapy on non-group members, such as Grant, is evidence of the kind of significant changes that can extend beyond the therapy space and into the client's day-to-day life.

Towards a State of Renewed Health

When addressing the emotional dimension of individuals with severe brain injury, one of the issues commonly faced by the music therapist is presenting data that demonstrate the validity of the work. Sometimes this internal dilemma of responding to external demands can lead to a sense of reluctance in the therapist to explore therapeutic interventions that focus on emotional rehabilitation and, instead, opt for function-oriented interventions (Magee, 1999).

Even when undertaking assessments, there is a complexity that typically surrounds those who present with severe and multiple disabilities (Churchill & McFerrin, 2014) or is in low awareness states (Magee, 2007). In such cases, clinicians across disciplines struggle to find appropriate protocols of identifying and measuring responsiveness when dealing with issues that can impact outcome reliability. Sensitivity of measurement tool, establishing purposefulness of responses, fatigue, and idiosyncratic communicative repertoire are just some of the factors the therapist needs to consider.

To this end, it is the therapist's responsibility to consider the potential value and meaningfulness implicit in the rehabilitative approach chosen:

> Showing outcomes of intervention is becoming increasingly necessary for many therapists working within medical settings. This, however, must not cause us to use music solely as an adjunct to functional rehabilitation, thereby losing sight of the potentially emotional experience of music which motivates, facilitates and structures interaction, and addresses qualitative issues.
>
> (Magee, 1999, p. 26)

Thus, we return to the foundational value of rehabilitation as set out earlier – of a person's right to relationship. In the case of a person with severe brain injury, relationship may be one of the few experiences that one can participate in and be his or her own agent of change. Improvised musical experiences within a therapeutic context aim to locate the person and provide a framework that makes sense of one's sounds and gestures, and

in doing so, be promoting a state of renewed health: "By promoting creative coping responses we may be establishing the possibilities for renewed health. These are based on the creative qualities of the whole person that promote autonomy" (Aldridge, 1996, p. 58).

The nature of our work with this group of individuals is that some approach each therapy session as if it were the first time; significant moments that occur on one particular afternoon cannot be assumed in the following week. In this sense, perhaps the therapist can respond to those events similarly – as if they were for the first time: "Every session attended by the psychoanalyst must have no history and no future" (Bion, 1967, p. 272). Having no memory or desire helps the therapist to maintain a sense of wonder at the privileges offered by music to bring about relational possibilities to a group of individuals, who otherwise would be disconnected from the world.

Conclusion

At the start of this paper, I described the climate of slow-stream rehabilitation in long-term residential care, and the peculiar space occupied by the music therapist with regards to the meaningfulness of one's role. The reflections drawn from my experiences of facilitating group music therapy in this context hold several layers of purpose.

Firstly, this paper aims to draw attention to the emotional health of a person with severe brain injury as an area with much potential for movement. Sometimes the emotional dimension of a person's rehabilitative journey can become lost among the more apparent, visible impairments sustained from the brain injury. Experiences in group music therapy aim to encounter these hidden aspects of a person's self, and in doing so, foster a process of identity building where sounds, and not impairments, become the way a person is known by others.

Secondly, I wish to demonstrate the qualitative benefits of clinical group improvisation for promoting experiences of participating in relationship, particularly with individuals who have severe impairments in communication or expressive language. Overall, it provides experiences of

recognition and belonging, inherent qualities in the very act of being and participating in relationship. The group's therapeutic process illustrates the immense value in those moments of responsiveness being observed, shared, and celebrated in the presence of peers.

Finally, I hope to advocate for the inclusion of music therapy in slow-stream neurorehabilitation services. In an environment that can sometimes appear to be in a state of pervasive sameness, music offers an incredible tool with which one can steadily carve changes in those that encounter it. Whether this is momentary in a spontaneous musical exchange with a person with severe brain injury, or perhaps a lifetime impact on the perceptions of a person without brain injury on "what was possible for people with disability" – *this* is the distinctive quality to the music therapist's role. My journey throughout this work has been sustained by an unyielding faith in the music to bring about movement. In a space of multiple minds, however tumultuous or barren it may appear at times, the therapist continues to conduct, with patient vigour, all the way to its ending.

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Community Music Therapy to Support the Relationship between Family Carers and People Living with Dementia: A Pilot Project

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Dementia, Community Music Therapy groups, relationships, identity music, family carers

Abstract

Currently, 70,000 people are living with dementia in New Zealand. This is expected to rise to 170,212 in 2050, with an associated cost of $1.7 billion climbing to $5 billion. The people who face living with this disease face the accompanying effects on cognition, and declining psychological and behavioural function. Those that support them face the challenges that come from a changing relationship, from that of partner to carer. When relationships are resilient, families are able to cope for longer in their homes with less support from the government, making sense both economically and for quality of life. The purpose of this project was to look at whether community-based group music therapy sessions would support the relationship needs of couples, where one is affected by the onset of dementia and the other has become the carer. Four couples were recruited (eight participants), with one couple dropping out, reducing numbers to three couples (6 participants) from week 5. The ten sessions were run weekly for 1½ hours by a trained music therapist, with two volunteers supporting. Sessions were based on themes to evoke reminiscing between couples and the group. Visual cue cards, and specific songs relating to those themes, were prepared for each session. The music therapist had extensive experience in group leading in dementia settings such as closed

units and hospitals. Those techniques and skills were used in the sessions to shape the conversations and music to match the needs of the participants during each session. Music technology (such as Spotify and amplification) was used when appropriate. Clinical notes revealed that group dynamics changed over time, showing an increased participant ownership of the group and increased support between couples. Pre and post questionnaires in this project aimed to measure the relationship needs of the carer over time, and a final evaluation form provided insight into what the participants valued from these sessions. Previous international research suggested that music therapy could provide many benefits for the emotional needs of both the person living with dementia and those supporting them. As dementia needs are transferable, regardless of country or culture, we expected a similar outcome. This is the first music therapy focused project in New Zealand which looked to extend our understanding of the needs of both the person living with dementia and the person supporting them. Qualitatively, this project provided rich stories of relationship support; but, quantitatively, it was limited by the small scale and the ability to adjust for a predetermined declining scale.

Background

This pilot project was the second music therapy project to be funded by Eastern Hutt Rotary; it was supported by two district grants in collaboration with Dementia Wellington[1]. The first Music for Life project was a close collaboration between Emma Fromings, from Dementia Wellington, and me, Maharani (Rani) Allan[2], a music therapist running a private practice in Lower Hutt. It involved eight participants who were living with the early stages of dementia at home. They were provided with individual music therapy sessions to collect and preserve each participant's "identity music' on a specially made device called a "Simple Music Player"[3]. "Identity music" is music from someone's "reminiscence bump" (Baird, Brancatisano, Gelding, & Thompson, 2018) – the period from ten to 30 years of age, when a person forms their own identity. Music during this time becomes central to that identity, reminding them of key moments in their life. "Identity music" is a term that I use to describe songs that are more than familiar. These songs are central to that person's history and identity – they are songs that have deep meaning for that person, and are recalled immediately, with an associated memory.

As part of the first project, participants were asked to attend two workshops: one at the beginning, which was used to describe the project for participants, and let them get to know each other, ask questions, and if necessary withdraw; and one at the end, a celebration for participants on finishing the project, and also a chance to share and get some feedback from the participants and family. The pilot project was filmed, and this recording was edited and shared, with encouraging feedback from those involved and those who watched the film (O'Leary, 2017). In the final evaluation, after the project had finished, participants were asked, "If an

[1] At the time of this project, Dementia Wellington was known as Alzheimers Wellington. To ensure that the project is clearly linked with this organisation, the current name is used throughout the article. However, the name Alzheimers Wellington appears in the project documents presented in the appendices. For further information, see https://www.dementiawellington.org.nz

[2] Previously Maharani (Rani) Heath, as named in the appendices

[3] See http://www.dementiamusic.co.uk

activity was offered by Dementia Wellington, what would participants prefer: (1) yoga, (2) cognitive stimulation therapy, or (3) music therapy?" Music therapy was rated most preferred overall, with the participants most valuing the group music therapy sharing sessions.

With the first project such a success, the following year a second grant was offered to extend what we had learned in the previous project. We looked back on the evaluations and could see the need for a group-focused intervention. From a professional viewpoint, I was also interested in the role I had played in the home visits, where my experience in this field enabled me to gently prompt and facilitate learning about the participants' personal music choices for their music players (Allan, 2012). I was welcomed into the homes and personal lives of people who were learning to cope with the challenges a diagnosis of dementia brings. I also started to notice some similarities between the couples I had visited. All experienced extensive strain on their relationships, and some of the carers emailed me after my visits to thank me for the session and for being there to remind them of good times. I witnessed the stresses dementia created for couples where the relationship of partner changed to carer as the dementia progressed. Research has shown that dementia behaviours contribute to emotional reactions, feelings of anxiety, and relationship deterioration (Braithwaite, 2000). I was intent on seeing if music therapy could have a role in easing those stressors and create space to support and build resilience in those relationships. I looked first to what had been achieved in the music therapy field overseas, and then designed a project to extend that knowledge.

Previous Research

There is a growing number of articles, research papers and clinical reviews on dementia and music interventions – fortunately this field of work is growing, to match the dementia statistics. There is a worldwide crisis, in terms of people who will be living with dementia in the future, and finding enough care and ways to help them live well. There are many different focuses for research, including brain health, dementia choirs (Osman, 2016), and both quantitative and qualitative research..

The recent Cochrane review found 22 research articles (in total, 890 people) that met their strict inclusion criteria (van der Steen, Smaling, van der Wouden, Bruinsma, Scholten, & Vink, 2018). The authors concluded that "providing people with dementia who are in institutional care with at least five sessions of a music-based therapeutic intervention probably reduces depressive symptoms and improves overall behavioural problems at the end of treatment". Their review also showed music interventions could improve "emotional well-being and quality of life and reduce anxiety but may have little or no effect on agitation or aggression or on cognition". This was promising, but not specific enough to our research question, as the studies did not look at community-based settings or the relationships between the person living with dementia and the family carer.

Another piece of research in the United States looked at the effects of music therapy on engaging couples with dementia, and there was substantial evidence that "music therapy applications are effective in increasing mutual engagement in caregiving with care receiving couples" (Clair, 2002). However this particular study only looked at people in later stages of dementia, where they were already established in a rest home facility. Both Dementia Wellington and I were interested in how we could support those in earlier stages at home where they possibly had less support. The evaluations from the previous project also showed that participants valued being part of a group. My own previous research showed that group music therapy could fill the basic needs of those living with dementia in a locked assessment unit (Allan, 2012) but what about for those in earlier stages, still living in the community?

Baker and Ballantyne (2013) talked about the importance of being in groups and being socially connected with others: experiencing "belongingness" has been linked to health and wellbeing outcomes. They looked at whether group song writing and performing affects perceived quality of life and connectedness among retirees in Australia. They focused on positive psychology and reminiscence group work saying "if telling one's life story is important in maintaining happiness later in life, then music has the capacity to facilitate this when memories are more difficult to access" (Baker & Ballantyne, 2013). Accessing and retelling your identity through special and unique "identity music" was one outcome of our first project. Being able

to share this with family, and connect with both their own identity and then a partner, is what Dementia Wellington and I hoped to provide for couples in this second project.

Although Baker and Ballantyne found that the effects of song writing were brief, the sessions were reported to enable clients to express emotions and temporarily overcome their cognitive, memory and language deficiencies. This study did not specifically look at people's relationship, as the authors were more interested in group dynamics. However, they did highlight the importance of social connectedness, and how temporarily overcoming some dementia symptoms might allow connections with family members, where the relationship has been affected by the dementia diagnosis.

An interesting home-based music therapy study, which did look at family relationships, considered music protocols that family caregivers could provide for someone with dementia (Hanser, Butterfield-Whitcomb, & Kawata, 2011). These music therapists set up a specific music protocol to look at reducing stress between caregivers and people with dementia, while enhancing satisfaction in their relationships. The study had a high dropout rate, and caregiver satisfaction failed to improve over time; however, caregivers and care recipients both expressed improved relaxation, comfort and happiness, with caregivers showing the most benefit. They admitted that one limitation that could be addressed in future research was more direct intervention by a music therapist, rather than the carer being taught to provide the music themselves. Hanser et al. (2011) wanted to test a music programme administered by caregivers, but discovered that this created an additional burden on an already stressed caregiver. Having a music therapist provide that direct facilitation would be key in future work.

This led me to Active Music Therapy (AMT), a term coined by Vink, Birks, Bruinsma and Scholten (2004). AMT not only provided direct music therapy intervention, but also proved to reduce behavioural and psychological disturbances (BPSD) for a person with dementia. Links have been suggested between AMT techniques and improvements in the relationship between the person living with dementia and their family caregiver (Raglio, Fonte, Reani, Varalta, Ballandi, & Smania, 2016). In AMT, recipients are actively involved in the music-making, by playing on small instruments, for

instance. They may be encouraged to participate in musical improvisation with instruments or voice, in dance, in movement activities, or in singing. This study used a music therapist as a facilitator between the person with dementia (PWD) and family caregiver (FC), and focused specifically on the possible effects of music therapy in reducing BPSD in PWD and improving psychological and stress conditions for the FC. Results showed that the AMT approach had a positive effect for both the PWD and their FC. The FC in particular reported that the intervention was an "important support" in the management of BPSD, and that it reduced their feelings of frustration and burden caused by the management of the symptoms from the disease.

Here in New Zealand, behavioural disturbances are also a "significant source of carer stress and can negatively impact on the quality of life for both the person living with dementia and their carer" (Jones, 2016). These are the leading causes of placement in aged residential care. This suggests that early intervention could be an important area to investigate, and that this should focus on the relationship between FC and PWD. The Music Moves Me Trust[4], also suggests the need for research examining the future direction of music therapy dementia care.

A recent Australian music therapy study focused on the very same issues as the 2017 project described in our Music for Life project (Tamplin, Clark, Lee, & Baker, 2018). Tamplin et al. conducted the "Remini-Sing" pilot research project which looked at the feasibility of group singing for community dwelling people living with dementia and their family caregivers. They used active music making sessions over 20 weeks, and used pre and post-test quantitative data to consider the acceptability of their approach. No statistically significant outcomes were found, but measurements of participants' wellbeing were sustained. As a feasibility study, the research identified supportive themes (group participation and social connectedness) and limitations That they needed more typical caregiver burden measurement models as the positively framed measurement used didn't reflect the stresses family carers felt.

[4] http://www.musicmovesmetrust.co.nz

Music Therapy Methods

Building on this knowledge of previous research, the focus and aim of this project was to provide a relational, person-centred AMT pilot group, which would look at filling both the needs of the family carer and the person living with dementia. It was also investigative as Dementia Wellington and I wanted to find out whether providing active group music therapy sessions would fill a need in the community for couples, a gap identified by our first project.

This project was set up and run by myself, the music therapist. Dementia Wellington's role was to support, and to recruit participants by sharing the information sheets (Appendix A). (However, due to changes in staff structure, the music therapist recruited participants.) [Organisation] provided the grant to fund the therapists' hours and room hire. Two volunteers also supported the music therapist and couples during the sessions. The project grant was approved in August 2017, and information sheets sent out the same month for participation recruitment. Recruitment took longer than in the previous project, something we had not expected, and so the start date was delayed until October. Participants were asked to attend ten weekly 1.5 hours sessions. A total of four couples (eight participants) were recruited, but at week 5 (after attending only two sessions) one couple dropped out. A total of three couples (six participants) and two volunteers completed the project with me.

The pilot project used a mixed methods approach to evaluation. Quantitative data and qualitative comments were collected through pre-post questionnaires completed by the family carer. Thematic analysis of clinical notes provided further qualitative data. Volunteer feedback was also sourced as outsider insight into the process and included in the qualitative data. The questionnaires were designed prior to the pilot project and used relationship categories drawn from our previous . The evaluation forms at the end of the project were designed to provide feedback into the overall project outcomes and what worked well and what needed improvement.

The Group Sessions

The weekly group sessions were focused on themes, from "Childhood" to "Life Celebrations", including end of life, and was based on previous experience of group sessions in dementia units. These community sessions were slightly different from the sessions in dementia units as there were equal numbers of family carers and people living with dementia; family participation is rare in unit sessions, and I observed there was more talking during the sessions in this project. Most of the participants with dementia had each been diagnosed two to three years earlier and, with support, were able to communicate verbally. Each session started with a "Hello Song" (which the group had chosen in our first session) to warm everyone up to music and sharing. Each couple were also encouraged to bring visual prompts, such as photographs, for the sharing that specifically related to the week's theme, to help the couples engage and to help refocus the discussions. This was supported by very recent Australian research, which looked at visual prompts compared to musical prompts (Baird, et al., 2018). Music was actively sung and played using percussion instruments – building on the work of Raglio et al. (2016), discussed above. A music searching programme (Spotify[5]) and good quality speakers were employed when songs suggested by participants needed a specific sound to induce a personal memory. For instance, one couple had spent some time in Fiji and requested a specific song that I (the music therapist) did not know; it was more appropriate to play a recording on a good quality speaker at the time it was suggested, rather than later in a further session when the moment had already passed. The songs were supported with the use of a guitar and vocals by the music therapist, volunteers and participants. (A piano was available in the room, but unfortunately the condition was not good enough for it to be used in the sessions.) The volunteers assisted by helping participants with instruments and by getting up and dancing.

[5] https://www.spotify.com/nz

Evaluation: Data Collection

Quantitative data were collected using pre and post questionnaires (Appendix B) completed by the FC. This approach of asking the FC instead of the PWD was chosen because of the degenerative nature of dementia and the decline over time. Qualitative data were collected in the comments sections in the questionnaires and in evaluation forms that both the family carers and people with dementia completed at the end of the project (Appendix C).

The questionnaires contained six categories: *Happiness, Emotionally Connected, Socially Relaxed, Comforted, Enjoyment* and *Coping*. Each question had a rating scale from 1 (lowest) to 10 (best) for respondents to circle to indicate their level of sentiment about each subject, and a comments section was provided for further elaboration. This approach reflected other data collection methods in this field (Hanser, Butterfield-Whitcomb, & Kawata, 2011). Every FC completed the pre-project questionnaire. One post-project questionnaire was only partially completed, and follow up was not possible due to unforeseen health circumstances for this participant. Adjustments were made to show true combined scores for the data graphs.

The evaluation forms were similar to the questionnaires but focused on the sessions, rather than how they felt about their relationship. They also had a comment section allowing as much space as possible for open-ended answers. Because we wanted to really engage and understand why people might circle a particular word, there was a comment section below asking "Why is that?" Each question was framed to answer wonderings that had arisen from my clinical notes. Wording was mostly neutral. One section was positively framed, with a list of words that could be circled and did not require any further writing - we hoped that the PWD would be able to answer this section. The FCs completed all of the evaluation forms and some of the PWD also completed some sections.

Feedback from the volunteers and my own clinical notes also contributed to the project data. The volunteers provided written open-ended feedback

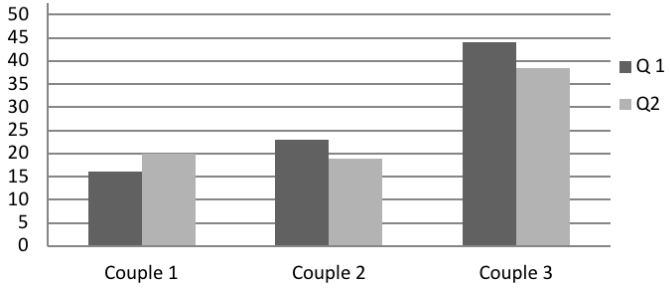
on what they had witnessed, which was meaningful as both came with experience in music therapy and dementia.

Results

Quantitative results

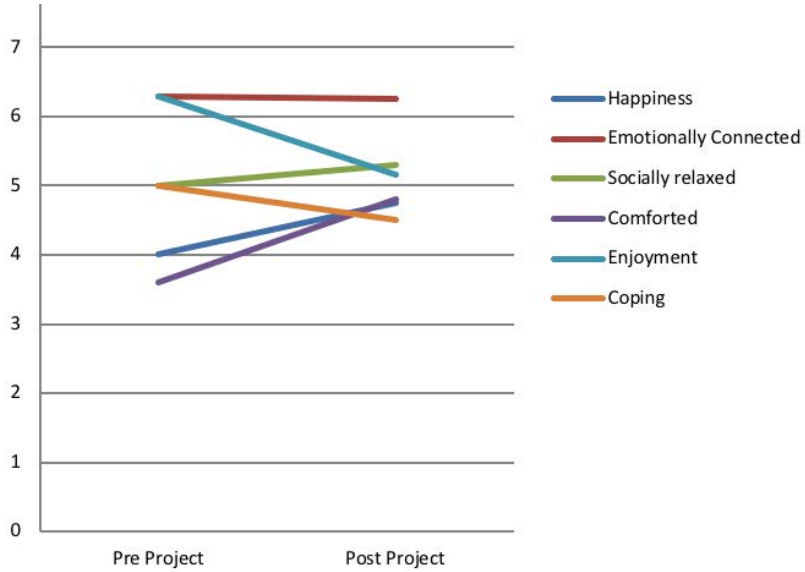
The quantitative results show a small drop in overall pre to post scores from two of the couples, but one couple improved over the ten weeks (Figure 1).

Figure 1. *Questionnaire totals pre (Q1) and post (Q2) project.*



When looking in detail at the six relationship category questions, further insights can be seen, i.e. which areas were maintained, which fell and, encouragingly, what improved over time during the project. The combined couples' results revealed that, over the ten-week pilot project, only two categories declined (Coping and Enjoyment), one remained the same (Emotionally Connected), and three improved (Socially Relaxed, Comforted and Happiness) (Figure 2). This shows that during the course of the project specific areas of their relationship improved.

Figure 2. *Couples' combined mean scores.*



Qualitative results

The comments in the questionnaires and evaluation forms, plus the clinical notes from each session, provided the qualitative data for this pilot project. These were thematically coded (Braun & Clark, 2006) to reveal the complexity of emotions and difficulty in being able to quantify how a relationship is coping. Three over-riding themes were identified: Group Dynamics, Community Connection, and Safe Space.

Group Dynamics

The clinical notes helped provide an observational view of the group dynamics. Like many groups, as the weeks went on group dynamics established, for this one, strong forms of connection and support grew. The group became truly established in Week 5, after one couple dropped out after attending only two sessions. This showed the importance of attendance and willingness to give time and participant wholly. I had been concerned with the group size but it was more important that people were

consistently turning up I found. They also started to become invested in the group, asking what our theme was for the next week and suggesting ideas, slowly taking ownership of the group.

Community Connection

Connected to Group Dynamics was the second theme, Community Connection. The cohesiveness in the group led to couples supporting each other and asking each other how they were doing and coping. They started providing physical and emotional support with hugs.. I also witnessed the care between FCs start to form with two of the carers getting up and dancing together, supporting each other with touch and verbal reassurances. They talked about how this group allowed them to be free of worry. That it didn't matter if one of their partners said something inappropriate here as they all understood and could support each other.

Safe Space

Creating a safe space allowed participants to participate fully, without fear of others not understanding. It was a space to safely let down their guard, relax and be spontaneous again. This was seen within the duration of a single session: often participants would arrive showing stress, body behaviour tense, sometimes quiet and withdrawn, but as the session progressed those behaviours and body language became relaxed, and often there was laughing and dancing. This "Safe Space" allowed very personal stories to be shared and intertwined with music and dancing, making a rich tapestry of emotional connections, reminiscence and meaningful movement.

Discussion

The qualitative results show the benefits of the group music therapy sessions for the participants, but the quantitative results were unexpected. Some commented that "It is different day by day," suggesting that this is something very difficult to measure, due to the disease presentation fluctuating, with some days better than others – certainly a difficult measure for family supporters. Some scores were very high in the

questionnaires, suggesting they were doing well, but the written comments were somewhat conflicting – e.g. "I'm coping ok – I call it surviving!" Reflecting on the measurement showed some shortcomings in accurately showing what was happening for the couples. In the evaluations, their own words showed that due to the type of disease, measuring things over time is very difficult because it changes from day to day. Depending on the day, and how it was going, may have influenced what was put down on the forms. I also realised after collating all the data that scores would still decline, because we were asking them to reflect on a relationship with someone who was still declining due to the dementia – a predetermined declining measure. Even if the carers themselves were not directly affected by the disease, that relationship was still affected. The scope for accurately measuring quantitatively this field of work, taking into account all these facets, needs the resources of a larger study then this current project.

There are always limitations in a small project, and several were identified here:

- A larger group would have provided more opportunities for sharing and making couples feel less "put on the spot". In the few sessions where a couple were absent, the group felt too small for the hall. Dementia Wellington had had some recent changes to staff structure, and there was not the direct recruitment that we had had in the first project, and participants were actually recruited by the music therapist;
- This was the first music therapy group offered, and there was not enough marketing to explain music therapy and the project to potential participants;
- The information sheet clearly stated that there was an investigative approach to this project, which may also have discouraged some potential participants; and
- In the evaluation form, the words list (chosen from clinical notes and session themes) showed only positive words; more neutral and negative words should have been offered too.

Feedback from participants after the project had finished also showed many changes for them. For two of them, it was the last period when they lived together, as some went into care shortly after. Perhaps opening the group to couples diagnosed earlier than two to three years previously would have offered more significant variation in the results.

I found most meaning in the participants own words. For example:

> "It's fun to sing – it makes us happy."
>
> "It provided a venue for us to participate together."
>
> "I am grateful for being given some time, which is precious".

The evaluations showed that perhaps a measure *in* time, rather than *over* time would be more appropriate, highlighting what happens in those meaningful moments.

The participants and volunteers reported that the sessions that focused on happy times in their lives were the most enjoyable. They suggested organising a larger group next time – which we had originally hoped for. Everyone agreed that it was the right setting, and the comments about what they would take away from the sessions were quite moving:

> "It's ok to laugh and have fun. Nice to be in a situation where any inappropriateness of [my] partner didn't matter."
>
> "How important music is to memories, and what emotions can be triggered by hearing music from the past."

One participant with dementia wrote:

> "Relationships with the group, and lovely Rani, whom we all enjoyed so much".

The volunteers reported similar observations, for example:

> It was amazing to see the participants come out of their shell as the weeks progressed and form bonds not only with each other but also reconnect with their loved ones through story and song. The evoking of memories was really special and I especially enjoyed the session when the participants spoke about places

> they had travelled too, would like to return to, with Rani following through with a song which each person could identify with. The playing of instruments allowed participants to express themselves and it always amazes me how a person with dementia can have trouble with day to day conversation but when a familiar song is sung they know all the words. There was lots of laughter, some dancing and many stories shared. It was a pleasure and privilege to share this journey with the group and witness the power of music. Rani provides a gentle, calm and relaxed environment and I would love to see these sessions being run on a regular basis.

This feedback suggests that, for the participants involved, the format of the project was relatable and successful in terms of creating a safe space to connect socially and provide support and that it was something they valued.

Conclusion and Recommendations

The previous research and the data from this pilot project confirm that music therapy can have an effect on both a person living with dementia and a family carer. Quantitatively, overall scores from the six relationship questions dropped for two out of three couples, but further investigation showed that some areas (Socially Relaxed, Comforted and Happiness) improved over this time for all couples. A recommendation for future studies would be to investigate why those particular areas of the relationship improved while others did not, as well as considering the differences a measurement in time rather than over time would produce. The qualitative results showed the importance of "Community connections" and "Safe spaces", but the words of the participants themselves that showed true meaning; for example, "It has been an hour of total togetherness".

This was the first project in New Zealand to look at the relationship between a family supporter and person living with dementia. It revealed the importance of group support and a safe space to support these relationships, and the facilitative skills of a music therapist. Although it was

a very small pilot project, there were sufficient data to show its strengths and weaknesses, and to make recommendations for the future.

The music therapy project was the only activity at the time that was offered for both the family carer and the person living with dementia, while living in the community. This triggered some wonderings at why more is not more offered for couples jointly. Are separate treatments isolating them further from each other? Where is the spontaneity and joy of being together, and how do we find the right time to offer this?

The qualitative data highlighted how group music therapy might contribute to the participants' needs for social acceptance; for feeling supported, relaxed and connected emotionally; and, most importantly, remembering better times together and making sure new ones were made, filling the room with spontaneous dancing and laughter.

Further research is recommended, to answer the questions highlighted above. This would provide further, helpful insight into the use of music therapy in supporting the relationship needs of those living with dementia and their family carer.

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Appendix A: Participant Information Sheet

CALL FOR EXPRESSIONS OF INTEREST FROM PEOPLE LIVING WITH DEMENTIA AND THEIR SUPPORT PERSON

RESEARCH: Music Therapy with Adults who are Living with Dementia

My name is Rani Heath and I am a Registered Music Therapist at Music for Life and have worked alongside Alzheimers Wellington in previous music therapy projects.

I am a MA graduate from Victoria University and am doing a research project to look at how music therapy can build resilience in adults and their supporters who are living with dementia in the community.

I am looking for people to join me for free music therapy sessions who are willing to be participants in my research project.

There is mounting evidence that if people with dementia are offered frequent access to the music in which their past experience and memories are embedded, it can:

- Improve present mood
- Improve awareness
- Improve ability to understand and think
- Help sense of identity and independence

What does the project involve?

- I will provide Group Music Therapy sessions for eight (8) adults who have dementia and their respective supporter/partner/family member. Each adult will attend up to 15 group therapy sessions being one session per week between the September and December period.
- There is no charge for the music therapy sessions thanks to a grant by Eastern Hutt Rotary.
- The participants will be asked to complete a short questionnaire at the start and end of the project so I can assess how successful music therapy is at supporting people living with dementia and their respective support person.
- Clinical notes will also be kept of each session with possibly some short video/photos of the sessions.
- In agreeing to have music therapy at no cost, families will also be agreeing in good faith to allow their case study to be used as data for this research. The music therapist will request informed consent from each family, for information to be shared in this way.
- The participants can choose to remain anonymous and pseudonyms will be used for the research results.
- Families who give informed consent to share case studies will be able to withdraw their permission at any time. But if it is part-way through project they will no longer be able to access the free sessions.
- The music therapy sessions are designed to support the relationship between both supporter and the person living with dementia.
- At least one supporter/partner/family member will be invited to provide feedback on how useful the music therapy sessions were from their perspective.
- I will analyse the evaluations to determine the effectiveness and value of music therapy and disseminate the findings.

How can you help?

- If you or someone you know lives with early stage dementia at home and is interested in attending along with a close supporter for weekly music therapy sessions please contact me for consent and information forms. Sessions are likely to be run Thursday mornings from 10:30 – 12.00 in the Lower Hutt Region.
- We are also looking for volunteers to support the music therapist in setting up the room and co-ordinating the participants. Please contact me for further information.

For further information on Music for Life previous project see:
http://www.alzheimers.org.nz/regions/wellington/news/music-for-life-video

If you have any questions or problems, who can you contact?
If you need further information or have any questions about this research please feel free to contact me at 027 783 3881 or email me at raniheath@gmail.com. Or visit www.musicforlife.co.nz

Appendix B: Questionnaire

Music for Life Questionnaire 1

Name(s):……

How long have you both known each other/been together……

How long has your partner been diagnosed with dementia?……

How would you describe your *relationship* currently?

……
……

When thinking about *happiness* in your relationship how do you feel currently?

1 2 3 4 5 6 7 8 9 10

Depressed Satisfied Happy

(Other Comments)

……
……

When spending time together how *emotionally connected* do you feel currently?

1 2 3 4 5 6 7 8 9 10

Not at all Some what Connected

(Other Comments)

……
……

When spending time together *socially* how *relaxed* do you currently feel?

1 2 3 4 5 6 7 8 9 10

High Anxiety ok Relaxed

(Other Comments)

……

……

When together how *comforted* do you currently feel?

1 2 3 4 5 6 7 8 9 10

Alone ok Supported

(Other Comments)

……

……

When together how much *enjoyment* do you currently feel?

1 2 3 4 5 6 7 8 9 10

No enjoyment Some enjoyment Very enjoyable

(Other Comments)

……

……

How do you feel you are currently *coping* at home?

1 2 3 4 5 6 7 8 9 10

Not Coping Coping Coping well

(Other Comments)

……

……

Thank you!

Appendix C: Evaluation Form

Music for Life Evaluation Form

(One per person)

Name:……

How do you feel the *music therapy sessions* have been helpful/unhelpful?

……
……
……

Why is that?

……
……

Please circle any or none of the below *words* that you feel you *experienced* as part of the project:

- Emotional connection (to your partner or someone else in the room)
- Joy
- Physically connected
- Relaxed
- Comforted
- Reminiscing
- Thought about the future
- Playful
- Supported
- Socially accepted

Tell me more about the words you have circled or any other's that might not be there:

……
……
……

Suggested citation

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Selecting the Best Music for Patient Listening while Unwell: A Music Therapist's Personal Experience

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Keywords:

Music therapy, music medicine, receptive methods, music preference, personal narrative

Abstract

Receptive music therapy methods, music medicine (pre-recorded music administered by medical professionals) and patient self-selected music are regularly used to support patient recovery in a wide range of medical settings. Music therapists generally accept that it is helpful to engage music therapy participants in interacting with or listening to their preferred music. However, people who are unwell may find their use and experience of music changes over time. Using a brief vignette of a music therapist's personal experience of listening to music during a period of being unwell, we highlight the complex nature of the effects of music listening and ask readers to consider the prospect that previously preferred music might have negative effects, and the possibility that "no music" might be the right option for some patients at particular times.

Introduction

The knowledge that music can influence us in profound ways has led to music being used in medical practices across different cultures (Västfjäll, Juslin & Hartig, 2012). Scientific evidence suggesting that music listening has beneficial effects on emotion, stress, and pain perception is mounting, and the use of music in the treatment and amelioration of ill health is increasingly accepted (Hanser 2010; MacDonald, Kreutz & Mitchell, 2012).

Pre-recorded music administered by patients, nurses, or other medical staff, known as music medicine (Dileo & Bradt 2005; Trondalen & Ole Bonde, 2012; Waterworth & Rickson, 2017) has been widely used in nursing applications towards various goals including pain relief, the reduction of anxiety about clinical procedures (Biley, 2000; Hallam, 2012; Vargas Rohr & Aparecida Titonelli Alvim, 2016; Waterworth & Rickson, 2017), and the reduction of agitation in dementia patients (Ridder, 2005). The popular movie "Alive Inside" (Rossato Bennett, et al., 2014) documents the use of digital devices loaded with preferred music, to demonstrate the ways in which patients who have dementia, and are withdrawn and/or memory impaired, can be revitalised through music listening. After the documentary won the audience award at the 2014 Sundance Film festival, it became an internet sensation (Dopp, 2015) which in turn led to a proliferation of similar "programmes" in rest homes and hospitals throughout the world.

Music therapists can also be involved in supporting patients' music listening, and there are times too when music therapists create playlists for patients, before the patient listens to the music own their own (O'Callaghan et al., 2016). Usually, however, in contrast to music medicine, music therapy programmes involve a process of assessment, treatment and evaluation, and the music therapist uses the relationship they have developed with the patient to gain greater understanding of the patients' experiences. This in turn enables them to support patients' choice of music, music listening, verbal processing and reflection (O'Callaghan et al., 2016; Waterworth & Rickson 2017).

The general population also often use music for self-care; that is, they develop listening strategies that they anticipate will provide them with

personal support. The development of digital recordings and devices has made music listening readily available and highly individualised, increasingly enabling individuals to use music in personally beneficial ways (Hallam, 2012; Mitchell & MacDonald, 2012; Ruud, 2010; Williamson, 2014). Music is an integral part of many people's lives and may be providing health benefits to a significant proportion of the population, simply because positive emotions typically dominate when people are listening to self-selected music (Hallam, 2012; Västfjäll, Juslin & Hartig, 2012).

At various times and across people, music can be a lifeline in its support of biopsychosocial and spiritual well-being (O'Callaghan, 2016) with large numbers of people using music as an emotion regulation strategy, most often "to relax" (Hallam, 2012; Västfjäll, Juslin & Hartig, 2012). Self-directed music can also be helpful when undergoing and following diagnostic procedures and treatment in oncology, and when undergoing palliative care (O'Callaghan et al., 2016). As a pain intervention, music listening has been proposed specifically as a low-cost, widely available treatment, useful both in conjunction with basic treatment and at times when medication is less effective, not desired, or has not had time to come into effect (Mitchell & MacDonald, 2012). Music in particular medical circumstances can promote endurance, improve quality of life, and reduce isolation. Familiar music can feel like a friend, and transform anxiety into relaxation (O'Callaghan et al., 2016, p. 424).

Music can also turn anxiety into energy. It can provide distraction and enable movement through the rhythmic entrainment mechanism (Tierney & Kraus, 2015). Oliver Sacks (1984), in recounting the extreme trauma of profoundly injuring his leg while climbing in Norway, cites two instances of being enormously helped by music. Once when he was descending the mountain to get help, he sang the "Volga Boat Song", and the rhythm and pace of it took over his physical pain and weakness and enabled him to move down the mountain. The second time was when he was in hospital, still paralysed in that injured leg because of nerve damage. He needed to learn to walk again. In his head, from frequent listening, was Mendelssohn's Violin Concerto in E minor. This music, while it filled his head, enabled him to take steps. The music took him over.

However, despite all the encouraging potential outlined above, the mechanisms associated with music's significant potential are complex (Jiang, Linshu, Rickson, & Jiang, 2013; Jiang, Rickson, & Jiang, 2016). Music arouses emotions in listeners, and emotions are significantly related to physical health (Västfjäll, Juslin & Hartig, 2012). Cognitions also play a mediating role, as music may be linked with particular experiences in our lives which elicit pleasant or distressing memories (Hallam, 2012). Västfjäll, Juslin & Hartig (2012) developed a multi-mechanism framework that suggests emotional reactions to music can come from seven different sources: brain stem reflexes, involving 'pre-wired' responses to simple acoustic characteristics of the music, such as loudness and speed; rhythmic entrainment as internal body rhythms move towards external rhythm in the music; evaluative conditioning which involves pairing of a piece of music to other positive or negative stimuli; contagion which is related to internal "mimicry" of the perceived emotional expression of the music; the visual imagery conjured up by the listener; specific memories that are evoked by the music; and music expectancy, the expected or unexpected ways in which the music unfolds (Västfjäll, Juslin & Hartig, 2012). A further mechanism may relate to the autonomy and control patients experience when able to listen to their preferred music. An important implication of this summary is that a given piece of music may not actually be the same stimulus for different listeners, or even for the same listener in different circumstances (Västfjäll, Juslin & Hartig, 2012).

Human beings have varied physiological, motor, intellectual, aesthetic, or emotional changes in mood or arousal in response to music (Hallam, 2012; Sloboda, 2005; Williamson, 2014). Music experiences occur in a complex interplay between the listener, the music, and the context; and depending on the mechanism(s) activated, people's response may be completely different (Sloboda, 2005; Juslin and Västfjäll 2008). Hallam (2012) suggests that even though there are some general trends, these complex and interacting factors make it difficult to predict the exact effects of any particular piece of music on any individual.

The experience of being unwell can also alter the experience and benefits of music listening. For example, Ridder and Aldridge (2005) note that it is important to consider that persons with frontotemporal brain damage

might change their musical. Dramatic changes in musical taste have been reported in patients with dementia (Geroldi et al., 2000; Ridder & Aldridge, Sellal et al., 2003) and after surgery for epilepsy (Sellal et al., 2003). Sellal et al.'s patient, in the year following surgery, found the rock music he listened to before his operation sounded ''too hard, too fast, and too violent'' and, instead, he developed a preference for Celtic or Corsican polyphonic singing. Music can become elusive or may need to be avoided because of intensified emotional evocation or symptom-related memories (O'Callaghan et al., 2016, p. 424).

O'Callaghan (2016) has found that Cancer patients tend to avoid specific or all music during particular periods because it can become difficult to experience, even though they are likely to re-engage with their music later; and that usage when people are unwell can remain incident, continue normally and/or change (O'Callaghan et al., 2016 p. 399).

> Thus, there are no "pure" effects of music that will invariably occur regardless of the specific listener or situation. The response will depend on factors such as the listener's music preferences and previous experiences, as well as on the specific circumstances of the context (e.g. current activity, other people present, function of the music, features of the physical environment).
>
> (Västfjäll, Juslin, & Hartig, 2012, p. 408).

A Personal Story

The following is Joan's personal account of listening to music during a period of being unwell. Joan brings a unique perspective; having had approximately thirty-two years' experience working alongside people who needed music therapy support, first as a music specialist and later as a registered music therapist.

> *This story describes my individual personal experience, and the sort of music which suited me when I was going through a very difficult time. It is not meant to be prescriptive - there is no list of music which fits all. My search for my music was persistent*

with many failures along the way, until finally, listening to Concert FM, I came upon the right music by accident.

About ten years ago I suffered a number of illnesses closely following each other. Struck first with a severe viral illness, it then migrated into secretory diarrhoea, for which I was hospitalised. At the same time I was attacked by chronic fatigue syndrome. This was not diagnosed until many months later, but its effects were already being felt. I experienced a super sensitivity to sound, light, touch and taste. The hospital noise was unbearable. And I underwent extreme frustration at not being listened to. My attempts to explain what admittedly very complex and difficult experiences were, were not heard. I felt very ill – a sense of wanting, no needing, to shut out the world and retreat into my suffering self. Along with this was a strong sense of suffering with the suffering world. The suffering world was inside me. I thought of myself as a snake in the board game, Snakes and Ladders – there was always another snake to slide down. Would that deterioration never end? Was endurance going to be needed forever?

During this worst phase, the ONLY music which met me was intense, personal, tragic, and searing. Isolde's aria from Wagner's Tristan and Isolde. I threw my suffering self into Isolde's suffering. In the searing music I felt a melting of my own identity into Isolde's. I was at one with her suffering. It entered me and I felt a deep connection. Yet it was an intensely alone time. In the music, this music, I off-loaded my anguish. Music, this music, took my load into itself, a deep sharing of mental pain, and a sense of being accompanied in it, and of being at one with the suffering world. The music HAD to be searing – so-called calming music was completely wrong. I had to experiment until I found this right music. Normally I find Wagner's music too intense to the point of being unsettled and troubled by it. But in this situation, it was the only music which enabled a very profound sharing, and in this way provided some comfort and purpose... the music took me over.

Once home from hospital, when I was making some progress toward health, my music needs underwent further changes. Isolde's aria was no longer needed. I still needed to be taken "right inside" the music, to be taken over by it, but not at such an extreme level. The right music was tricky to find, it needed to be more middle ground, still with emotional content, not despairing or grief-ridden, but more moderate. Tchaikovsky's Symphony No 5, Beethoven's Piano Sonatas, and Violin Sonatas, some Mozart, sometimes filled this middle ground.

Interestingly, vocal and choral music were a complete 'no-no' for me. It's hard to know why. The choral world has been an important part of my world for as long as I can remember. I've been in choirs all my life and it's a deep love. But at this time for some reason, it was the wrong sort of music. Another 'no-no', easier to understand because it is still not a great love of mine, was spiky modern music. It was somehow too reflective of the fractured modern world, and it added to the visual kaleidoscope in my head. I needed something to hold on to. Rhythm - but not blatant, just there as part of the structure, was important. I needed some structure, and some emotion. NEVER was soothing relaxing music right. It was a no-no 100% of the time.

The worse I was feeling, the more emotion I needed in the music. NOT sentimentality, but true human emotion that speaks of the yearning of the suffering, but not despairing, heart. Beethoven's piano and violin sonatas sometimes filled this middle ground. NOT Tchaikovsky's Symphony Pathétique! Dvorak's Piano Quintet Op. 81 in A major took over my headaches - entered my head and became the focus. The first movement was quite strong, and the strength was needed. It was followed by the more lyrical second movement - a necessary follow-up to the strength of the first movement. It seemed to be reflective of moving forward, some progress in my state.

My experience was not unique. The right music is very powerful. Music enabled me to enter the world of suffering humanity and suffer alongside – truly the deepest possible connection. But my response to music varied depending on how I was feeling. Every individual's music, the right music, will be an expression of their inner need. Only they can determine the rightness and feel a consequent connection – or lack of it. I cannot emphasise this too strongly. Music that is not right is wrong. Therefore, we cannot put music into categories and assume it will fit the patient's need and be helpful. The wrong music is not only unhelpful, it is harmful.

Discussion

As Joan has indicated, her experience is not unique – and this is understandable given the complexities highlighted in the literature. It is widely recognised among both scholars and lay people that music can influence listeners in profound ways – ways that are both positive and negative (Hallam, 2012; Västfjäll, Juslin, & Hartig, 2012).

Understanding the music experiences of people who are affected by chronic illness can strengthen music therapists' and other professionals' ability to empathise and to offer appropriate support, and can "contribute to the appropriate, and ethical, development and application of music-based supports in healthcare services beyond music therapy" (O'Callaghan et al., 2016, p. 404).

> Altered music habits can signify vulnerability and, if patients or carers are avoiding music because of emotional evocation, their reconnection with music's therapeutic qualities may be enabled through empathic support, and sharing music together.
>
> (O'Callaghan et al., 2016, p. 422).

O'Callaghan et al. note that some cancer patients' descriptions of music in self-care were affected by their previous music therapy experiences. There is no doubt that Joan's experience as a music therapist who continuously reflects on her constant music listening and music making, will have had

an impact on her experience of music listening during illness. Music is related to identity (MacDonald, Hargreaves & Miell, 2009; Ruud, 1998) and formal music training affects responses to music perhaps, among other things, because of this relationship (Hallam, 2012). It is possible that if supported by a sensitive music therapy clinician, Joan's experiences would have been different again. Yet as we discussed drafts of this manuscript, Joan argued that the feeling of being intensely alone with the music seemed to be a necessary starting point in the healing journey, and that the presence of a music therapist might not have been welcome at that point.

It is clearly important for patients to maintain autonomy and control over their situation as much as possible, which suggests that health professionals, including music therapists, need to take care not only in offering their therapeutic presence, but also in offering support with music selection. Mitchell & MacDonald (2012) propose the act of selecting and listening to one's chosen music may facilitate a sense of heightened control in unfamiliar or threatening situations. They also argue that the 'associative' context is extremely important as highly personal meanings and memories are connected with the music; patients are therefore unlikely to be as emotionally involved with music chosen by someone else (Mitchell & MacDonald, 2012; Williamson, 2014). Yet it was very difficult for Joan to find the 'right' music, even from a very wide repertoire of music which had previously been "preferred".

Nevertheless, Joan's sophisticated relationship with music meant that she was able to find music that "worked for her", at a deep level. Sanfi and Christensen (2017) note that music can relieve pain on five therapeutic levels, ranging from simple distraction to deeper psychotherapeutic processing. It can (1) distract or redirect attention from pain; (2) enhance the patients' personal resources for dealing with pain; (3) support them to express the experience, suffering and emotional aspects of having pain; (4) support them to find meaning or new ways of conceptualising the pain experience; or (5) transform, as the patient dialogues and forms a relationship with the pain. Joan's experience of her identity melting into Isolde's, and being at one with her suffering, seemed to be based on an internal "mimicry" of the perceived emotional expression of the music (Västfjäll, Juslin & Hartig, 2012), and suggests that she had begun to

connect with and to transform the pain (Sanfi & Christensen, 2017) through the "deep sharing" and anguish.

> To listen to music is to be in the company of music; that is, to be with a long-time companion who ultimately aids in accommodating the unanticipated arrival of chronic illness.
>
> (Nicol, 2002, p. iii)

Joan's experience reinforces the suggestion that it is essential for medical staff to elicit patient feedback on the effect of the music (Waterford & Rickson, 2017). Further, O'Callaghan and colleagues stress that music therapists and other health workers need to be aware and respectful of the possibility that patients will need to avoid all music. Music therapists can advocate for the careful consideration of music resources to ensure that patients have opportunities to support themselves and others through music; educate health professionals about the potential for people to approach or withdraw from music when unwell; and should themselves consider carefully what changes in music behaviours might mean for the patient (O'Callaghan et al., 2016).

> Talking to patients and carers, including bereaved carers, about their music preferences and usages, all staff, including music therapists, may convey interest in, and care of, the whole person.
>
> (O'Callaghan et al., 2016, p. 422).

Hallam (2012) argued that exposure to calming music in a genre which is alien to an individual may increase rather than reduce arousal (Hallam, 2012). Joan's rejection of all calming music was different, more aligned with the ISO principle (Altshuler, 1944) which ensures that music is selected that matches the mood of patient initially, and gradually changed to match the intended mood (Wigram, Pedersen, & Bonde, 2002). The music must be attuned or connect with the individual's current mood state (Heiderscheit & Madson, 2015). Music therapists are familiar with the iso principle and will be unsurprised by Joan's adamant declaration that calming music was not right when she was in such a distressed state. But other medical professionals, such as nurses, might not.

It is important for all professionals to remember that music can have indirect effects on health and wellbeing through the behaviour it can elicit, and in some cases it can cause extreme distress (Hallam, 2012).

> Music has a very powerful impact on arousal, emotions, and moods and as a result can influence behaviour. The full implications of this are still emerging. While music can be used to positive effect to enhance health and wellbeing this is not always the case, negative effects are frequently found when individuals do not have control of the music and it is a poor "fit" in relation to their self-perceptions and needs.
>
> (Hallam, 2012)

Conclusion

By situating Joan's powerful narrative in the context of existing literature, we have been able to reveal the complexities of determining optimal music for patients to listen to when they are unwell. While the principles of enabling patient choice and control remain valid, we have signalled how important it is for music therapists, other professionals and patients themselves to consider the potential for their listening experiences to change during illness and recovery, and to adapt their choices accordingly.

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He oro waiora: Music therapy and well-being in adolescent mental health

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Keywords:

Music therapy, kaupapa Māori models of health, wairua (spirit), mental health, taonga puoro (Māori musical instruments).

Abstract

This paper discusses the practice of music therapy in relation to kaupapa Māori models of health and how these models articulate the means whereby musical activities can address and support a person's wairuatanga within modern mental health practices. Contemporary international music therapy theories that have extended from early medical and humanistic models to embrace ecological and community orientations are also acknowledged. The relationship between kaupapa Māori frameworks and these recent music therapy concepts will be discussed with a particular focus on Durie's (1998) Te Whare Tapa Whā and Pere's Te Wheke (1991). To complement these, a link with indigenous understandings of well-being and music therapy is provided through the writings of Kenny (2006) and a discussion centring around uses of taonga puoro, traditional Māori musical instruments.

Āio Mauritau Āio

Nā Te Manaaroha Rollo

Āio mauritau āio
Tiaki tinana, manawa, hinengaro, āio
Honoa tō wairua ki te atua
Te aorangi me te taiao
Kei reira te mauriora
Kia mau tonu ki te hauora
Āio mauritau āio.

Āio Mauritau Āio

By Te Manaaroha Rollo

Peace, tranquillity and serenity
Care for your physical, heart and mental health
Connect spiritually with god
The universe and the natural world
There (you'll find) life everlasting
Maintain well-being
Peace, tranquillity and serenity.

(Rollo, 2013a, pp. 6-7)

This waiata was gifted by Te Manaaroha Rollo (2013) to Music Therapy New Zealand and New Zealand School of Music, Te Kōkī, during a keynote address (Rollo, 2013b) as a song that we could use to care for and nurture our own wairua while working as music therapists. In composing and presenting this waiata, Rollo demonstrated the relationship between music and hauora (well-being) according to mātauranga Māori (Māori epistemology). This waiata illustrates the broader understandings of health and well-being that we endorse as Māori, by encouraging us to sustain not only our physical health but also to nurture our mental and spiritual well-being in order to maintain our health. This resonates well with the Māori

models of health examined within this research, Te Whare Tapa Whā (Durie, 1998) and Te Wheke (Pere, 1991) as well as the contemporary ecological approaches to music therapy advocated by Kenny (2006) and Ansdell (2014).

These approaches incorporate a much broader view of health than the predominant medical model provides for. They also imply a flexibility that is able to embrace unique cultural understandings of health, the relationship of music with these and also the many different forms or functions of music within different contexts or communities. This paper examines the relationship between these ecological approaches to music therapy and Māori models of health. It is based on a research project that I completed as part of my Master of Music Therapy, while on placement in an acute mental health unit for adolescents within a local hospital (Hodgson, 2014).

Research Setting and Methodology

While situated within this unit for 2-3 days a week over a period of nine months, I ran individual and group music therapy sessions and co-ordinated my work to complement that of the wider multidisciplinary team. The unit had space for 13 people at any one time and capacity for a further 8 to attend the therapeutic day programme. I worked alongside nurses, kaumātua (elders), occupational therapists, support workers, psychologists, psychiatrists, school teachers and other specialists to support the young people living within the unit. These rangatahi (young people) had a variety of mental health diagnoses, including schizophrenia, depression, eating disorders, bipolar disorder, drug and/or alcohol dependence, anxiety disorders, and autism spectrum disorders. The rangatahi were aged 13-18, and the length of their stay within the unit varied from a few days to over one year.

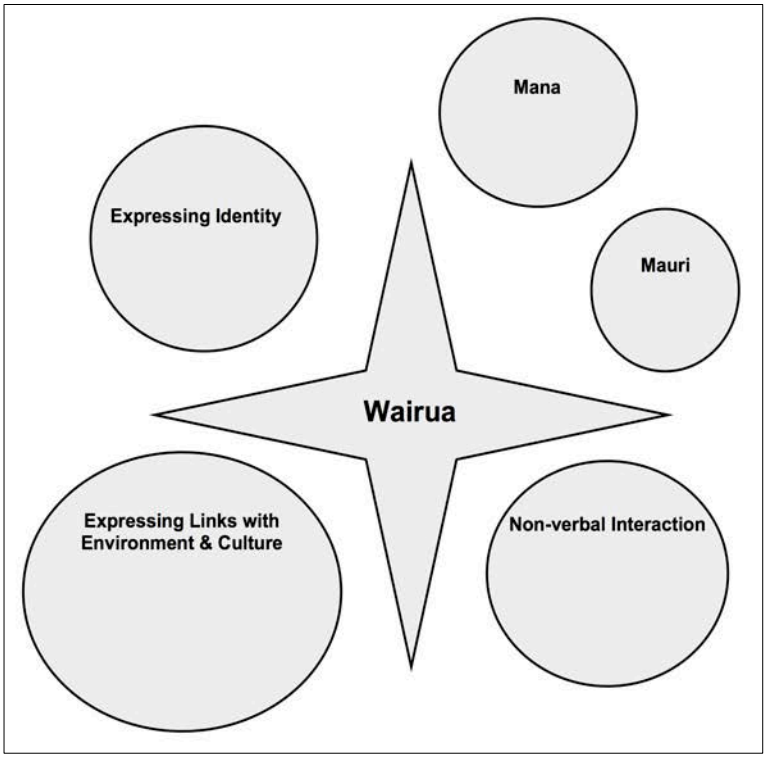
I was fortunate that Durie's (1998) Te Whare Tapa Whā was used as an assessment framework within multidisciplinary team meetings, so I was able to experience using this within a contemporary healthcare environment. For this reason I used the four pillars of health identified within this model - whānau (family, social communities), hinengaro

(thoughts and feelings), tinana (physical body) and wairua (spirit, soul) – for the deductive analysis of my data. The data consisted of my clinical notes, taken while I was working as a student music therapist. I analysed three data samples, each consisting of one month of notes.

In my analysis, the four dimensions of Te Whare Tapa Whā provided central themes, and any activity or process described within the data was then assigned to one of these dimensions, and coded and categorised accordingly. This process produced four constellations, one for each dimension of Te Whare Tapa Whā, and each constellation had its own associated categories. An example of the "Wairua" dimension (Figure 1) shows the associated categories of mauri, mana, expressing identity, non-verbal interaction, and expressing links with environment and culture. Within each of these categories exists a subset of codes which represent interactions exhibited in the data sets. For example, within the category of "Expressing Identity" the codes listed were: sharing music, song-writing, improvisation, vocal work, and musicianship.

Deductive analysis was used when the coding processes fit comfortably within *Te Whare Tapa Whā*, and inductive analysis was used when unique codes emerged from the data that did not appear to fit with this model. As these codes emerged, further searches for relevant literature were conducted, so that their relationship to kaupapa Māori models of health could be defined. This process was based on techniques drawn from constructivist grounded theory (Charmaz, 2014); however, the examiners suggested that this process was closer in practice to interpretative phenomenological analysis (Ghetti, 2016). This approach aims to understand how an individual makes sense of particular experiences or phenomena within a specific context and acknowledges that the act of research is a dynamic process that is informed by the researcher's perspective.

Figure 1. *The "Wairua" dimension and constellation of categories.*



Music Therapy Practice

During our music therapy sessions within the unit, we engaged in a very broad range of activities involving singing, listening, improvising, playing instruments, and sharing or discussing music. One activity that was particularly successful at engaging rangatahi during group sessions was a waiata tītī tōrea[1]. This involved everyone in the group sitting or kneeling in a circle on the floor while tapping, throwing and catching rākau (short

[1] Tītī tōrea are also commonly known as tī rākau and refer to a mode of waiata using rākau (sticks). *E Papa Waiar*i is a waiata very well known within Aotearoa that belongs to this group.

sticks) in time with a song. As a traditional Māori activity, waiata tītī tōrea are emblematic of the connection between Māori practice and music therapy, and emphasise how all four dimensions of *Te Whare Tapa Whā* can be manifested within a single musical activity.

To illustrate this, I have provided the lyrics of a waiata tītī tōrea (Figure 2) and a brief précis of this activity and its relationship to the four dimensions *of wairua, hinengaro, whānau,* and *tinana* (Figure 3).

Figure 2. *Waiata tītī tōrea lyrics.*

Tēnei te waiata tītī tōrea
O te mātauranga
Me te whakangahau o ngā rangatahi
Te tītī tōrea.
Whiua ki runga
Whiua ki raro
Patupatu ngā rākau e
Kia pai ai ō mārama
E te iwi e.

(Translation)
This is the tītī tōrea song
For educating
And entertaining youth
The tītī tōrea.
Toss them up
Toss them down
Beat the sticks together
To master this song
Everyone together.

Figure 3. *Description of the waiata tītī tōrea activity.*

All of the rangatahi involved live at the unit, and we encourage them to think of their peers and staff within the unit as a whānau. This tītī tōrea activity reinforces that whānau atmosphere as we all sit on the floor and work together, rangatahi and staff alike. We take two rākau, one for each hand before I would begin singing, "Tēnei te waiata tītī tōrea," and going through the first few actions. These involve tapping both rākau against the floor, flipping and catching them and tapping them together or against a neighbouring person's rākau. We work collaboratively and use our tinana to support the mauri (vitality) of the waiata by singing and accentuating the 3/4 rhythm with the tapping of our rākau.

Initially it is difficult to sing and complete the actions correctly so the rākau are often tossed around or used to whack others in jest. These cheeky little interactions decrease as the group's competence builds and new actions are invented or remembered from childhood. There is laughter and excitement as we all make mistakes and slowly begin to master the mental and physical aspects of the activity. We draw on our hinengaro (mind) to memorise the kupu (words) and coordinate our tinana so that we perform the correct sequence of actions in time with the rest of the group. We work through each section of the waiata, leaving a few minutes of practice between each before we go through it as a whānau from the beginning. Everyone is included and all are able to participate as they feel comfortable. Our wairua are supported by our engagement with others, the chance to express ourselves through singing and movement and our connection with the natural world through the rākau.

The entire activity is woven together by the waiata, with the rhythm and melody acting as the foundation. We synchronise our tinana around the beat and this rhythm provides a common pulse that holds us together as a whānau. The melody stimulates our hinengaro and helps us to commit the song and actions to memory. Through these we physically, emotionally and spiritually express our kotahitanga (unity) and develop our whanaungatanga (sense of belonging). We also have the opportunity to connect with our environment and culture by practicing an activity unique to Aotearoa and using rākau from our indigenous flora. This sustains our wairua by emphasising our spiritual or non-physical connection with others, with our local environment and with our unique culture and heritage.

Waiata tītī tōrea are used to encourage dexterity, strengthen wrists, enhance hand-eye coordination, and promote unity and comradeship within groups. They are fun, challenging, and a familiar pastime for many people who grew up or attended primary school in Aotearoa. The rākau used during my sessions were roughly 30 centimetres long and made from the kōrari (flower stem) of harakeke (flax) that I had collected from my home near Maungatautari in Waikato.

This activity clearly demonstrates the interrelated nature of the four different domains of Te Whare Tapa Whā and how stimulation or support in one area flows through to support other aspects of our well-being. This is particularly explicit in this activity whereby our tinana supports our hinengaro as the physical action of moving the rākau helps us to remember the words. The physical interactions also support our sense of belonging as a whānau as rangatahi are physically invited to participate when others start tapping their rākau or sit alongside them and tap their neighbour's rākau as the actions require.

Many of the rangatahi involved in these sessions had experienced feelings of isolation from their peers or families due to their symptoms or simply because they were living far away from their whānau while at this unit. Therefore, their participation in any activity that enabled them to interact positively with others was often a significant achievement. The benefit of these activities to the health of the rangatahi involved can be seen by referring to the needs and aims of this music therapy group (Table 1).

The identified needs of self-expression and exploring emotions were particularly relevant to the activities in our music therapy sessions. While conducting the analysis for this project, it became clear that improvisation on musical instruments and sharing of favourite songs or compositions were activities that were strongly represented within the data. When relating these to Pere's Te Wheke model of health, the concepts of mauri, mana and whatumanawa were identified as significant as they readily articulated the benefits of improvisation, self-expression and creativity to an individual's health. These three concepts within Te Wheke all relate to the dimension of wairua within Te Whare Tapa Whā and enabled us to

Table 1. *Identified needs and aims for a music therapy group in an acute mental health facility for adolescents* (Hodgson, 2014).

Identified Needs: • Self-expression • Positive engagement • Enhance self-awareness • Build co-operation/teamwork skills • Explore/express emotions
Aims of group: • To engage rangatahi in musical activities. • For rangatahi to express themselves vocally or using their preferred instrument. • For rangatahi to interact positively with each other. • To enhance self-awareness and self-confidence of rangatahi by engaging them in musical activities where they must listen and respond to each other. • To provide leadership opportunities for rangatahi within certain activities. • For rangatahi to explore/develop their identity through musical expression.

demonstrate how musical activities and interactions were able to support an individual's wairua within music therapy sessions.

Mauri is the life essence that joins the physical and spiritual realms, unifying and animating our being. It is a dynamic force, realised through a network of interacting relationships (Durie, 2001). The respected tohunga (chosen expert), scholar and minister, Māori Marsden, characterised it by explaining that "Mauri is that life principle which is latent in all things… an energy behind all things… the elemental force that binds things together and gives them being" (Metge, 1986, p. 73). Within music therapy sessions, the existence of mauri was evident in the mauri of the individuals involved and also in the mauri of the waiata, song and activity that were happening at any given moment.

This is perhaps best illustrated through the mauri of a specific song. Songs are bound together by rhythm and melody, and these combine to carry a specific affect or aesthetic quality. This can be supported by different combinations of chords, bass lines or harmonies. When all of these elements are cohesive and being expressed fluidly and confidently, the mauri of the song is strong. If the rhythm is disrupted, an incorrect chord is played or any quality of a song is not expressed harmoniously, the mauri of the song is affected negatively. This concept is pertinent as those songs or activities with a strong mauri are more attractive and invite participation more than those played badly or perceived as incorrect or inauthentic.

There were times when our group music making sessions were very chaotic, however, allowing us to abandon specific modes or strict adherence to a time signature. This free improvisation with no preconceived ideal for what the music should sound like was a very common method within individual music sessions as well. These were some of the most powerful moments I experienced while making music with rangatahi, as the mauri of these pieces had an absolute singularity and immediacy to them that was unique to that specific moment.

Just as a song has its own mauri, so too do we as individuals have a vitality or life principle that waxes and wanes. All of the rangatahi involved with this research were experiencing significant difficulties with their mental health, and this often manifested itself in withdrawn, anxious, shy, apathetic or inwardly reflective behaviour. These presentations can be considered as a state of mauri moe (Whakaatere & Pohatu, 2011) or inactivity that is detrimental to health. Conversely, a state of mauri ora (dynamic well-being, vitality) is associated with being actively engaged and highly motivated to participate. The ability of music to invigorate and engage individuals therefore assists in moving them from a state of mauri moe towards a state of mauri ora. This was identified within this research through the change in presentation exhibited by some rangatahi during and following musical activities. This was particularly evident in the period immediately following group music therapy sessions.

There were many instances where, when we had finished and most rangatahi were leaving the room, one or two would remain behind and

continue playing, request further instruction with an instrument, or simply engage me in conversation. While these interactions may appear insignificant, they often occurred with rangatahi who were particularly reticent and disengaged. For some the interaction we had following a session was the first time I had ever spoken to them. Others began playing an instrument when they had appeared incapable of doing so during the group session. The change in presentation in these cases was stark and this effect occurred on a number of occasions with different rangatahi.

Similarly, the concept of mana related to a broad range of activities conducted within my music therapy practice in both positive and negative ways. Positively, the mana of participants was enhanced or acknowledged through their contribution to songs and musical activities or improvisations. There were many talented and skilled musicians admitted to the unit whose mana was acknowledged when their peers and I commended their performance or when others requested they play a certain song or instrument. Others began learning instruments within individual music therapy sessions and their mana was positively affected as they mastered these and were able to share their improved skills with their peers in group sessions. Negatively, it was exhibited when participants became physically or socially isolated by symptoms of their illness that affected their ability to interact with others. Examples of such symptoms are when rangatahi presented as non-verbal, lethargic, aggressive or abusive, having difficulty concentrating, being distracted by internal thoughts, feelings or hallucinations, unable to physically touch objects, or engaging in self-harming or self-sabotaging behaviours.

In a keynote delivered to the New Zealand Psychological Society, Royal (2006) asserted that mana lies at the heart of human well-being, enabling us to feel empowered and illuminated. In practice, Royal describes a mana-inspired way of acting as one that enhances connections and harmonises relationships with others. The connection with improvisation is revealed when Royal construes the Māori view that the fullness or peak of life is experienced when mana flows into the world and into people. He argues that a person's creativity and the way they apply their unique skills and talents provides evidence for the presence of mana within the individual. In this way, we can view the practice of creative improvisation within music

therapy sessions as facilitating the flow of mana within the rangatahi we are working alongside.

The ability to engage in free and uninhibited expression through musical activities is also acknowledged as a necessary activity for the maintenance of health through the concept of whatumanawa, one of the eight tentacles of Te Wheke. This appears to resonate strongly with the valuing of creative expression within music therapy and articulates the relationship with creative endeavour and well-being very cohesively. Through this valuing of creative expression, the experience of particularly strong or overwhelming feelings or emotions is not regarded negatively, but is valued for providing creative impetus and encouraging individuals to express their identity (Pere, 1991).

If we refer back to the tītī tōrea activity, we see that it sustained and supported participants' wairua by fostering connections with the wider group (or whānau), the environment and with our unique heritage here in Aotearoa. This affects our wairua by affirming our identity and acknowledging these non-physical or spiritual connections that shape and inform it. As our mauri is that part of us connecting the physical and spiritual realms, it is supported and enhanced when we physically embody these relationships through song and action. As participants' abilities in this activity improved, their mana was expressed through their proficiency with the tītī tōrea, and this was acknowledged when others sought their help or commended their performance. The physical and musical components of this activity allowed rangatahi presenting as non-verbal, due to their illness, to interact with others and express themselves appropriately within the music therapy session.

Theoretical Stance

Through the use of these concepts of mauri, mana and whatumanawa, we are able to see how music therapy sessions can support a person's wairua in a way that is consistent with *Te Wheke* and *Te Whare Tapa Whō*. When using these kaupapa Māori models of health, it was important to maintain an appropriate theoretical stance. Therefore, this research project was conducted within an indigenous research paradigm informed by Wilson

(2008) with an epistemological stance that describes the creation of knowledge as a relational process that occurs between the researcher or participants and the environment they are in.

As a Kaupapa Māori research project, the theoretical stance was heavily informed by the writings of Linda Smith (2012), Graham Smith (2012), Pihama (2001) and Durie (2012). This enabled me to live and research as Māori and foster relationships with those involved in this project in a manner consistent with my own values, and consistent with the axiology of relational accountability described by Wilson (2008). This also ensured that Māori ways of enquiring into and understanding phenomena such as the *Te Whare Tapa Whā* and *Te Wheke* health models were valued equally, alongside traditional medical understandings of health or well-being.

Ecological Models of Music Therapy

Linking this theoretical stance with the field of music therapy are the writings of Kenny (2006) and Ruud (2010). In his book *Music therapy; A perspective from the humanities*, Ruud describes the "relational turn" (2010, p. 21) within psychotherapy and developmental psychology and how this has informed music therapy praxis. Ruud posits that our experiences and understandings of phenomena are created relationally and holds that this requires us to maintain an interpretivist stance that is inherently reflexive. As therapists and researchers, we must therefore remain cognisant of the ways in which our own culture, belief systems or preferred discourses impact our work by affecting the way we relate to people, environments and ideas that we encounter.

As a Professor of Human Development and Indigenous Studies, as well as a music therapist, Carolyn Kenny consistently published material linking her own indigenous ways of being and understanding with her music therapy practice. Beginning with *The Mythic Artery; The Magic of Music Therapy* (2006), Kenny lamented the disjunct between art and science within the dominant medical model of health, and advocated for broader understandings that involve an awareness of spirituality and emphasise our connection with the environment. Following on from this, her theoretical contributions to music therapy such as *The field of play* (2014) rejected

labels such as “disabled” and continuums of “health vs. illness” in favour of more holistic or relational approaches to well-being.

These approaches focus on balancing the interplay between dynamic environmental, cultural, psychological, emotional, physical and spiritual aspects of ourselves to maintain our well-being (Kenny, 2002). This ecological approach resonates with the kaupapa Māori health models of *Te Wheke* and *Te Whare Tapa Whā,* with their multiple domains of health that interact to form an overall picture of our well-being. These ecological understandings of health are strongly advocated for by the cultural sociologist Tia DeNora (2013), and her conceptual tools are discussed in relation to music therapy by Gary Ansdell (2014).

The concepts of “musical affordances” and “musical appropriations” are two such tools discussed by Ansdell. Musical affordances include everything that a particular musical process or experience offers, dependent on our personal situation. For example, music affords dancing or self-expression but this is regulated by our personal or sociocultural realities. Similarly, musical appropriations describe our unique interactions with a particular musical experience and the ways we actively participate in a musical process. While an orchestral performance may afford dancing, it is unlikely we would appropriate the experience in this way because of the social expectations in a concert hall.

Ansdell (2014) also applies these concepts to non-physical phenomena, explaining that music affords clarifying identity, communicating emotion or enhancing personal relationships. He describes how particular features of music can create a personal link with these extra-musical things, and adopts the term “para-musical”, as introduced earlier by Bruscia (1998), to refer to these associated phenomena. This para-musical domain refers to all physical, mental, individual, relational, social or political phenomena associated with musical activities in a specific social, cultural or environmental context (Ansdell, 2014, p. 40).

These terms incorporate the unique relationship an individual has with a musical experience at any given moment and acknowledge how this changes in different environments or communities. These para-musical relationships inform every individual’s experience of a piece of music.

Conceiving of music in this way allows us to articulate how a musical experience can affect a person's well-being by interacting with their own unique social, cultural and environmental milieu. This encourages us as music therapists to engage with the individuals we are working with, and develop relationships and styles of working with them that acknowledge and are responsive to their unique social, cultural and environmental circumstances.

Taonga Puoro

Here in Aotearoa, these para-musical relationships can be expressed through activities such as the waiata tītī tōrea and also through the use of taonga puoro, our traditional Māori musical instruments which are inspired by and created from our unique environment. Within the waiata tītī tōrea we see how the rangatahi appropriate the activity at first by tossing the rākau around, hitting things or having sword fights, using them as playthings before they learn the actions and apply themselves to the musical activity. We also see how this activity affords expressing and supporting the different dimensions of *Te Whare Tapa Whā* and *Te Wheke*, and how these align with the identified needs and aims of the music therapy group to support participants' health. These para-musical elements are fundamental to Māori musical practice and the use of music within health, educational and spiritual contexts is common and an area of continued research for contemporary *taonga puoro* players and researchers (Nunns, 2001).

The leading figures in the revival of these instruments are the late Hirini Melbourne along with his contemporaries Richard Nunns and Brian Flintoff. As a culture where knowledge is transmitted orally, the use of song, of rhythm, of movement, sound and other musical devices is central to preserving and communicating knowledge. This is articulated by Richard Nunns in the following quote:

> It reminds us that, this whole vehicle of culture is via the medium of music, is via the medium of song. The Whare Pūrakau, the learning house of the deep south, the Whare Maire, the wānanga of the north; all of that material was learned, obviously, rote, by memory, but in the vehicle, in the form, of song.
>
> (Melbourne, Nunns, & Yates-Smith, 2003).

Further to this, music is situated at the very core of mātauranga Māori by Matiaha Tiramorehu in the phrase "Kei a te pō te timatatanga o te waiatatanga mai o te atua. Ko te ao, ko te ao mārama, ko te ao tūroa" which is recited by Hirini Melbourne (Melbourne et al. 2003) and translated as: "It was in the night that the god sang the world into existence, from the world of light, into the world of music". This phrase acknowledges that music literally brought about the beginning of time and space as we know it, that it was the medium by which the universe was born. It also implies that we can use music to commune with atua and interact with our physical and spiritual environment.

This notion is intimated in the lyrics and supported by the melody of Te Manaaroha Rollo's waiata that opened this article, *Āio Mauritau Āio,* which invites us to *"*Honoa tō wairua ki te atua, te aorangi me te taiao*"* (Connect spiritually with god, the universe and the natural world). The melody of this line reflects the lyrical content as the pitch ascends through 'Honoa tō wairua' (connect spiritually) to its highest point at "te atua" (with god) before descending back down to 'te aorangi me te taiao' (the universe and the natural world). This connection with the natural world was discussed in a lecture by Charles Te Ahukaramū Royal at the New Zealand School of Music (17 May 2013) where he argued that using the environment as a source of inspiration is an intrinsic feature of Māori music. He likened two different song forms, first the ngeri, to the sound of wind, and secondly the pātere, to the sound of water rapids. The development of different song forms drawn from natural phenomena is particularly relevant to taonga puoro.

This is because the reo, the voice of all of these instruments are created with materials drawn from specific environments and have associated atua who are the kaitiaki or guardians of that environment. If we refer back to

the waiata tītī tōrea, the use of kōrari (flower stems) of harakeke (the flax bush) for the rākau (sticks) connects us with Haumia-tiketike, the atua who is kaitiaki (guardian) of this plant. The pā harakeke (clump/group of flax) is also commonly known as a metaphor representing whānau/family, made up of different generations who support and sustain each other. Using these rākau within this activity is ideal therefore as they are culturally relevant symbols of positive whānau support. Their physical characteristics are ideal as well as they are very light & soft so can be thrown around or hit against another person without causing injury. They are firm enough to make a satisfying sound when hit together without making a sharp 'crack' and they grow in abundance with straight sections over a metre in length so they are very easy to locate and prepare for use.

The use of readily available natural materials was strongly encouraged by Richard Nunns when I met with him and discussed the therapeutic potential of taonga puoro (personal interview, October 2013). When I questioned him about how he thought taonga puoro might be used within music therapy, he immediately endorsed the idea of the music therapist going and collecting taonga with the person or people they are working with. He explained that this was how many of his hui or workshops began. For the first day of a week-long hui he had coming up he said he would be sending everyone out along the beach to find their own taonga; to experiment and listen to the reo of any rocks or shells or driftwood they found before bringing them back and learning how to use and interact with that unique voice. As an example, he brought out a large pōhutukawa root he had been using recently while performing with a dance group (Figure 4).

Resembling a crooked leg or hip, this piece was found at a local river mouth and was peculiar in that it had a stone embedded within it. From this single piece, a large variety of percussive sounds and effects could be created and Richard praised it for this versatility and valued it highly as it singularly fulfilled the role of a much larger repertoire of percussion instruments. Besides its polishing and some small detailing carved into it, this piece remains largely as it was found.

Figure 4. *Pōhutukawa root belonging to Richard Nunns.*

Taonga such as this can be found all over Aotearoa, and Richard and I discussed how these could be valuable in therapy as they "afford" a physical connection to a place or locality. They can also be "appropriated" to create music with other people to reflect that connection. This connection with the natural environment is a strongly held tenet amongst taonga puoro practitioners (Lowe & Fraser, 2018), and the discovery, creation, and performance of any taonga is always undertaken with due reverence to the environment that has bestowed these taonga and the atua or kaitiaki associated with that environment.

In this way a relationship is established with these particular atua or kaitiaki or with particular localities or environments. As discussed by Lowe & Fraser (2018), a dialogue is created that develops both our connection with and our understanding of the natural environment while simultaneously allowing us to share this with others. The reciprocal nature of this

relationship is evident as the taonga are provided by the environment for us to discover and we are able to assist them to sound their voice which is thereby shared with that environment and its associated atua or kaitiaki. This sustains and supports our wairua by strengthening our connection to that particular place or atua and allowing us to express this musically. This serves to bolster our own mauri but also serves to bolster the mauri of the environment that we are in, or of the taonga that we are using. Richard Nunns describes how he experienced this many times when he was called to play taonga puoro not for a human audience, but for the landscape itself (Nunns, 2001). This reciprocity engenders a positive spiral whereby our own practices to maintain our health also benefit the health of the environment that we inhabit while simultaneously engendering a greater intimacy with that environment.

Conclusion

The use of taonga puoro within music therapy here in Aotearoa provides possibilities for us to embrace the indigenous cultural, social and environmental reality that we inhabit and to foster methods of practice that celebrate and reinforce these. The use of kaupapa Māori models of health such as Te Whare Tapa Whā and Te Wheke encourage the incorporation of broader understandings of health in this way and we can see parallels between these and the ecological approaches to music therapy espoused by Kenny and Ansdell whereby an individual's overall wellbeing is recognised as something that is dynamic and affected by a range of different domains. Music is an activity which often transcends a range of these different domains, as illustrated in the waiata tītī tōrea, while it can also be incredibly responsive to an individual's social, cultural and environmental reality. Of course, the incorporation of particular musical forms does require familiarity with and respect for that form. Unfortunately, in relation to taonga puoro, much of the traditional practice and tikanga governing their use has been lost. If we follow in the footsteps of Hirini Melbourne, Richard Nunns and Brian Flintoff however, we can assist to revitalise these taonga puoro, these singing treasures and ensure that the para-musical benefits of their reo are not lost to future generations.

Glossary

Atua	Ancestor with continuing influence, god, demon, supernatural being, deity, ghost, object of superstitious regard, strange being – although often translated as 'god' and used for the Christian God, this is a misconception of the real meaning. Many Māori trace their ancestry from atua and they are regarded as ancestors with influence over particular domains. These atua also were a way of rationalising and perceiving the world.
Harakeke	New Zealand flax, Phormium tenax
Hauora	Health, vigour, well-being
Hinengaro	Mind, thought, intellect, consciousness, awareness
Kaitiaki	Guardian, caregiver, keeper, steward
Kaumātua	Elder, a person of status within the whanau
Kōrari	Flower stem of the flax
Mana	Prestige, authority, control, power, influence, status, spiritual power, charisma
Mātauranga Māori	Māori epistemology
Mārama	Light, clear transparent, easy to understand
Mauri	Life principle, vital essence
Mauri moe	Inactive, withdrawn
Mauri ora	Motivated, aware, active, alive
Rangatahi	Adolescents, youth
Rākau	Stick
Reo	Voice
Taonga	Treasure, anything prized
Taonga puoro	Singing treasure, musical instrument
Tikanga	Custom, correct procedure
Tinana	Physical body
Tītī Tōrea	Stick game

Tohunga	Skilled person, chosen expert, priest, healer
Waiata	Song, chant
Wairua	Spirit, soul
Whānau	Extended family, family group, In the modern context the term is sometimes used to include friends who may not have any kinship ties to other members.
Whanaungatanga	Relationship, kinship, sense of family connection – a relationship through shared experiences and working together which provides people with a sense of belonging.

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Case Study: Individual Music Therapy with an Elderly Man in a Residential Care Setting

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Music therapy, stroke, elderly, case study, student music therapist

Abstract

This case study describes the processes involved in the development of a relationship between a student music therapist and John, a 69-year-old man who lives in the hospital wing of a home for the elderly. As a result of a cerebrovascular accident (also known as stroke), John's physical and verbal abilities were severely limited and he had become very isolated and withdrawn. Over the course of the student music therapist's placement, John was engaged in eleven 20-40 minute music therapy sessions that encouraged communication and improvement in overall wellbeing. Both the student music therapist and the facility staff noted improvements in John's general wellbeing and socialisation, and made links between these and music therapy.

Introduction

John1 was a 69-year-old man who lived in the hospital wing of a home for older people requiring care. I worked with John for a total of eleven sessions over three months during my student practicum and have written permission to present this case study2.

John was born in New Zealand (NZ) and lived a very social life before experiencing a CVA (cerebrovascular accident, commonly known as a stroke) while living by himself in housing corporation accommodation. A CVA occurs when an artery in the brain becomes blocked, causing a lack of oxygen access to the brain. This can cause the sudden death of brain cells, which affects neurological function (Davis, 2012) and results in an acquired brain injury (ABI). This type of injury is prevalent in the elderly population, with 75% of strokes in NZ experienced by people over the age of 65 (Stroke Foundation of New Zealand, 2014). In NZ, strokes are the most common cause of severe adult disability, with an estimated 60,000 people requiring post-CVA support (Stroke Foundation of New Zealand, 2014).

John experienced a left middle cerebral artery stroke, which affected the left side of his brain, correlating to partial paralysis of the right side of his body. Limited use of his right leg required him to use a wheelchair, controlled independently by his left arm and leg. His right arm was in a splint and rested on his thigh with no independent movement. He suffered chronic pain in this affected limb and had been known to become extremely agitated during routine treatments. John had global aphasia, a language disorder; he could understand simple sentences, but could only vocalise simple vowel sounds. This had a large impact on his ability to express himself and communicate effectively. He also required assistance with some activities of daily living, such as showering and dressing. As a result of these impairments, John was admitted to the hospital wing of an elderly care facility where he had resided for two years prior to this study. The

[1] A pseudonym has been used to protect client confidentiality.

[2] This case study is based on the summative project for a music therapy practicum at Victoria University of Wellington – New Zealand School of Music, Te Kōkī.

hospital wing residents present a wide range of needs and are provided with a palliative approach to care. A dedicated recreation team engages residents in daily activities including games, walks, dancing, reading, entertainment and music therapy.

John had healthy hearing and eyesight, and enjoyed country music and war films. According to staff, he had previously enjoyed spending his time with mates at the pub and playing the harmonica and musical spoons, but these activities had become difficult since his CVA. Unfortunately, as a result, his social circle had also been significantly impacted due to difficulties in communication and access. John's sons were unable to visit, and his sister, who was his power of attorney and most common visitor, had recently passed away. As a result, John had become very isolated and withdrawn. He spent most of his days sitting in his wheelchair at the back of the TV room, watching TV shows. He declined to take part in group activities and had been known to cause difficulty during his personal cares, becoming aggressive and violent towards staff. His general practitioner reported a risk of depression, and prescribed anti-depressant medication. The facility set a number of goals, intended to improve John's quality of life: these included encouraging effective communication, fostering spiritual wellbeing, and maintaining an acceptable level of behaviour. I aimed to address these goals through our music therapy sessions.

Music Therapy and Stroke in the Literature

The use of music therapy as a treatment for people who have experienced a CVA is not a recent innovation and has been used to address physical, communicative, and emotional needs of this population. There is increasing interest in this field in NZ (Robinson, 2017; Wade, 2017). Using the elements of music, such as rhythm and melody, music therapists have been able to motivate clients to improve the motor skills of limbs affected by CVA (Cofrancesco, 1985; Schneider, Schönle, Altenmüller, & Münte, 2007; Staum, 1983). Increased understanding of neurology and brain plasticity[3]

[3] Brain plasticity: the ability of the brain to adapt to environmental pressures, such as a stroke (Johansson, 2011)

has impacted both research and practice (Johansson, 2011) and there has been greater focus on cognitive rehabilitation through neurological restructuring. Durham (2002) discusses the potential for musical structures to retrieve language and access long-term memory through brain reorganisation.

The literature also encourages the use of music therapy as a treatment to address clients' emotional needs. A Cochrane review (Bradt, Magee, Dileo, Wheeler, & McGilloway, 2010)[4] outlines the inherent need for the use of music therapy with this population, citing increased depression risks, isolation, and subsequent behavioural changes as an implication of their severely reduced communication capabilities. Bradt et al. found that rehabilitation of mobility is a primary goal, with communication, mood, emotions, social skills, pain and behavioural outcomes as secondary goals due to the loss of mobility impacting on a person's independence. Nayak, Wheeler, Shiflett, and Agostinelli (2000) associate music therapy with decreased levels of depression and anxiety, and demonstrate an overall improvement in mood levels for people who have experienced CVAs. Randomised controlled trials and single subject design pilot studies have also revealed positive change due to music therapy – both decreased depression (Hanser & Thompson, 1994) and improved mood states (Magee & Davidson, 2002).

As a non-invasive and non-pharmaceutical intervention, music therapy offers a low risk treatment strategy (Chan, Wong, Onishi, & Thayala, 2012; Hanser, 1999). Both physical functions (movement of affected limbs, speech and swallowing) and emotional issues (depression, isolation, anxiety and mood) have been demonstrated as areas where music therapy can influence change to improve the quality of life for people who have experienced a CVA.

[4] A more recent update of this Cochrane Review has been published since this case study was completed (Magee, Clark, Tamplin, & Bradt, 2017).

Stage I: Assessment

I was first introduced to John by my clinical liaison[5], the recreation co-ordinator. John was described to me as a particularly isolated man who did not like taking part in the normal group activities offered by the recreation team. At 69 years old, he was much younger than many of the other residents and came from a working-class background, with little commonality in interests. His limited communication contributed to his difficulty socialising, loss of motivation, and social withdrawal. He was referred to music therapy as his clinical notes suggested that he enjoyed country and western music and may have even played the spoons before his CVA restricted his right-hand use. Individual sessions were recommended, to meet his unique personal interests and focus on communication.

Our first of eleven sessions took place in week 4 of my 14-week placement. The recreation co-ordinator led me to John, who was sitting alone at the back of the TV room watching an infomercial. Crouching to his eye level, she introduced me, and John acknowledged me by raising his left arm and vocalising a "(y)eah" sound[6]. The recreation co-ordinator then told him that I played guitar and suggested he come with us to play some music. As expected, he was reluctant, scrunching his face, grumbling and using dismissive hand gestures. She suggested that he "give it a go". With a shake of his head and a sigh, he unlocked he wheelchair and led us to his room. John's body language and behaviour showed that it was an effort for him to take part in such an endeavour, perhaps due to a loss of self-confidence and/or motivation.

This first session involved a small amount of interaction by John as I sang (with guitar) the few country and western songs I knew. He sat tolerantly, occasionally tapping his left foot without sound for short periods. As I finished each song, he would take a deep breath and say, "(Y)eah we(ll)" with a slight smile and thumbs up. When I suggested playing another song,

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[5] Clinical liaison: a professional support person in a facility hosting a NZSM music therapy practicum, when there is no on-site music therapist

[6] Letters in brackets were implied but not heard.

he would use dismissive motions, indicating that he would rather I didn't. I quickly determined that if I thought another song would be beneficial, then I needed to be firm and just play it. It seemed he was eager for the session to end, though he would patiently wait through songs. The session lasted roughly fifteen minutes and only included two or three songs, but I was pleased as this was our first session and I had been told to expect resistance. I began to develop a communication style with John that involved colloquial, "bloke-to-bloke" language and an "easy going" approach to exchanges. This firm but informal approach seemed to elicit a positive response.

The musical artefacts filling John's room had a large impact on my initial assessment. On his shelf, next to five or six CDs, sat a set of small figurines playing New Orleans jazz and blues instruments. He also had a set of three figurines of monkeys playing. I interpreted these items as statements of John's interests that represented fragments of who he was – an exhibition of his musical identity. John's early resistance was discouraging and my instincts – as a nervous and inexperienced student music therapist – were to discontinue our sessions. However, these items indicated a potentially very musical person who might be just a little harder to reach, and so I persevered.

My image of John after this first session was of an extremely withdrawn, frustrated man. The recent loss of his sister was likely to have caused him grief, and difficulty in expressing this had the potential to cause great distress. His social interests and communication difficulties had caused him to become very isolated and resistant to social interactions as a result of experienced difficulty. His clinical notes recorded several incidents of John becoming verbally and physically distressed with nurses, mainly as a result of misunderstandings. Alongside this image of isolation and frustration, however, I was also developing an image of a man for whom music had certainly played a part in his life, and that music therapy was a potentially useful way of communicating with John and working on his pre-determined goals of encouraging effective communication, fostering spiritual wellbeing, and maintaining an acceptable level of behaviour.

Stage II: Development of client-therapist relationship

In Sessions 2 and 3, I was visited by both of my music therapy supervisors who observed and where appropriate participated in our sessions. I was able to learn techniques from them that helped me to communicate with John at a vital stage in the development of our client-therapist relationship. When we approached John in the TV room, he dismissed our invitation and showed resistant body language by turning away and gesturing for us to leave him. However, by using a cajoling approach and adjusting the power dynamics we created a more attractive proposition – instead of asking him to come along for "his" music therapy, we told him that my supervisor needed to see me working with somebody, and asked if he could help us by being that person. He responded with a sly grin, appearing amused, and obliged. This was a helpful (but non-coercive) way of encouraging John to attend sessions, which I adapted and used throughout the development of our relationship. The cajoling also helped to develop a set pattern of me coming to see him for music every Wednesday afternoon and he became used to the routine. It became clear through my experiences that John would engage best over a 20 – 40 minute period and so the recreation co-ordinator and I decided that I would work with John on a weekly basis for around half an hour in the afternoon.

My sessions with John were based around pre-composed, familiar songs from the country and western musical canon. In my song folder (for use throughout the facility) I included a special section of songs that I thought would appeal to John, based on his CDs and discussion with staff. In these early sessions I was unsure of how to engage John in the music and would, at a basic level, try to meet his emotional level with similarly sensitive songs. From there I would initiate discussion about the artist or the meaning of the song. John often responded and tried to vocalise a word or phrase, but sometimes became agitated by his communication difficulty. At these moments my therapeutic approach drew on Bowden (2001) who discusses the importance of not letting the client feel they are not understood, whilst still encouraging further explication. This involved the

use of supportive body language and affirming paralanguage[7]. Through these communications, John was able to verbalise to me "(r)oc(k) a(nd) (r)o(ll)" as another preferred genre, and he appeared to take great pleasure in my understanding and responding – "Oh, you like rock and roll?" This was a noteworthy moment in the development of our relationship as it was not only a significant vocalisation, but also John sharing something about his identity with me. His autonomy benefitted from his creative direction of the kinds of music I played with him.

At the end of each song, John often responded with a smile, a thumbs up, and a "(Y)eah" of affirmation. I began to notice that this affirmation came faster and faster. He could clearly recognise the musical cues as each song came to a conclusion, as I slowed or used a harmonic cadence/resolution, and by the end of the session he would give his affirmation before I had even stopped playing. This prompted me to consider his motivations for the affirmation. My first thought was that he was becoming bored or tired of the session and less patient, trying to communicate that he was ready for the session to end. However, after discussion with my supervisor, I considered the possibility that he was becoming more engaged in the music and was listening more attentively, rather than just waiting for the sound to finish before giving affirmation. It is impossible to know what his true motivations were, but by considering multiple theories I was able to continue with my practice with an open mind, avoiding my own apprehensiveness.

In Session 3, I tried to engage John musically by bringing two wooden "clappers" suitable for one-handed use. Initially I simply introduced them before putting them on the table; however, when it became clear he was not going to join in on his own accord, I asked him to play them along with me. He pushed them away, pointing to my guitar to tell me just to play. I felt that John thought the instrument was too childish – his response to the facility's other activities – so I set about finding a more appropriate but

[7] Paralanguage: wordless verbal communications (such as "mmm") which rely heavily on pitch and intonation to convey their meaning.

accessible instrument. It was important to engage with him on a developmentally appropriate level that he was comfortable with.

Stage III: Active musical engagement

When one of the staff told me that John may have played the harmonica in his younger years, I decided to bring along my own harmonica to play. This gained a positive response, with John appearing interested and paying more attention than usual as I showed it to him. I used the harmonica in John Denver's "Leaving on a Jet Plane" (Denver, 1969) and noticed John leaning forward as if reading the lyrics. However, when I slid the songbook towards him, he pushed it away and mumbled, as if denying reading, and signalling for me to perform. He tapped along with his foot, but immediately stopped if he noticed me looking. I felt that he was in the early stages of exposing himself to take a more active part in the music, but was still apprehensive and hesitant to fully engage. We talked about the harmonica and he mimed himself playing the harmonica and said, "(Y)eah," when I asked if he used to play, before telling me once again, "(R)oc(k) a(nd) (r)o(ll)". We talked about his figurines and whether they were rock and roll or blues players, and I played a small bluesy excerpt. Unfortunately, hygiene protocols prevented me lending John my harmonica, so I set about sourcing one for him.

Session 4 was the first in which John became actively engaged in playing an instrument. I managed to source a set of spoons that were connected at the handle so they could be used like a real set of spoons, but allowed the user to play with only one hand by tapping them on their leg or opposite hand. John seemed surprised and open to trying them, raising his eyebrows and saying, "Ohh (y)eah?" with a slightly amused expression. He was initially confused about how they worked and tried squeezing them to make a sound, with a focused but frustrated look on his face. I offered to demonstrate by tapping them on my leg, which he quickly imitated, falling into a medium tempo pulse. He remained very focused on maintaining a full sounding "clack" while I supported his playing with a rhythmic strumming pattern on the guitar. I slowly transitioned this into "I Walk the Line" by Johnny Cash (1956). As soon as I sang the first line, John looked up from the spoons with an enormous smile across his face. He seemed

delighted to be a part of a musical moment, while slightly surprised about how he had found himself in such an engagement. His timing was perfectly even and stable and lay on the syncopated off-beats – a skill that comes with experience and is not expected of a beginner. It became apparent that the spoons were a potentially useful way to encourage motor skills and small arm exercises with John. His musical skill and enjoyment were clear and it became a very useful way of engaging him musically.

Between our fifth and sixth sessions I approached the facility about funding to buy a harmonica for John. I explained the potential social and physical benefits for John and we purchased a beautiful Hohner harmonica in G. I excitedly bought this along to our sixth session; however as a result of external influences, John appeared very tired. I had noticed him asleep in the TV room earlier in the day, so returned when he was awake. He was slightly more resistant than usual when I approached him, but after negotiating a plan, I sat and watched television with him for five minutes before heading to his room for our session. We played a few of our usual songs, with John playing the spoons, but his facial expressions and reduced eye contact indicated that he was less engaged than usual. He appeared very interested in the harmonica and thanked me for it by offering a handshake. He agreed to John Denver's "Take Me Home, Country Roads" (Denver, 1971) with me. I was amazed at John's harmonic accuracy – holding the harmonica in his left hand, he blew and drew[8], moving up and down the instrument to suit the harmony. The draws were slightly delayed as though more effortful, but this quickened as the song progressed. By the end of the song John seemed exhausted and placed the harmonica on the table with an expression of great satisfaction. His musical skills demonstrated a clear history on the instrument and I saw this as a potentially beneficial way of addressing John's sense of identity and history, while also working on physical exercises with his arm, mouth and lungs.

As John was very tired, he rested while I played him a song. Each week I had been expanding my repertoire, based on our discussions, and this week I had bought along Hank Williams' "I'm so Lonesome I could Cry" (Williams,

8 *Drawing* and *blowing* are the terms for inhaling and exhaling on a harmonica

1949). I segued the lyrics of the song into a discussion about a painting that sat above John's bed, telling him how it reminded me of the song. The painting depicted a farmer sitting on a log in front of a forest staring contemplatively across an empty meadow. The image reflected my image of John – a lonely, sorrowful man with a history expectant of rugged toughness. I talked about the painting with him and asked him where it had come from, to which he attempted to respond but became caught up in a "wi-wi-wi-wi" vocalisation and gave up, pointing at his mouth in frustration. Although I could not interpret this communication, it was encouraging to see him making more of an effort to converse. I was unsure whether his frustration about verbal communication would make him withdraw further, or whether his continued supported attempts would lead towards verbal expression – a question I discussed with my supervisor. It became clear that John was slowly but surely opening up to me, allowing me to challenge him; removing this encouragement to vocalise might isolate him further. I decided to continue to encourage vocalisations, but remained conscious and observant of his frustration levels to avoid pushing him too much and causing excessive frustration.

Until session 7 I had been using a firm but cajoling attitude to encourage John to attend music therapy, often reducing the power dynamic through a "bloke-to-bloke" approach request for help (as discussed above). I was pleased that John began leading me to his room without being asked. Among contributing factors, I felt that our routine gave him predictability and stability, and becoming more musically involved increased enjoyment. I placed the spoons and John's harmonica on the table in front of us and began to play "I'm So Lonesome I Could Cry". John spontaneously picked up the harmonica and began playing along. I was astonished to hear not only the harmony, but also parts of the melody coming through. I felt that the harmonica was becoming an effective way of John having a voice. Through the rest of the session, John spontaneously switched between the spoons and harmonica, remaining musically engaged and responsive to musical cues, such as dynamics, pulse changes and final cadences. I noted that John was far more communicative and used more varied facial expressions than in previous sessions. I felt that his musical engagement was a dominant factor in the formation of our therapeutic relationship.

At the end of Session 7 I suggested a new song, “Always On My Mind" (Carson, Christopher, & James, 1972), originally made famous by Johnny Cash. I asked John if he would play harmonica on it and though he seemed tired from the greater than usual interaction, he obliged, picking out several of the melody notes. I repeated the final line three times, and on the final repeat John vocalised along with me in a deep, crackly voice, “You were a(l)ways on my min(d),” before producing a heart-warming smile. I found it hard to contain my amazement at this – I did not want him to feel patronised, but shared my joy with him as he too expressed satisfaction. His vocalisation opened up the potential of speech skills, which I began to incorporate in our ongoing aims and goals. John replied positively to the idea of returning for music therapy the next week. Previously, I had felt that I was taking him away from the TV, something he enjoyed, but as our relationship developed it seemed to provide a “safe place”. Encouraging him out of his comfort zone into another safe environment was something that might help him build confidence and help with socialisation.

Stage IV: Closure

John continued to attend music therapy sessions willingly, and continued to play the spoons and harmonica. Although conversation involved considerable interpretation on my part, I felt there was a mutual understanding when we talked. John laughed at jokes and responded appropriately to discussion, indicating competent listening and comprehension. Having built what I experienced as a strong bond with John, I had difficulty contemplating the closure of our sessions. I began reflecting on the purpose of my work with John. Why was I working so hard to bond with John if I knew I was not going to be staying around? Would this increase his feelings of loss and isolation, causing further withdrawal? Would he have been better off without me? I considered how my role as a student music therapist impacted my purpose and our relationship. I had hoped that the music therapy relationship would offer a means of communication, confidence and greater self-esteem, and improve his quality of life. Through this self-refection I was able to find meaning in the closure of our work, though I recognised the importance of a planned and structured ending.

I decided to tell John during Session 9 that we had three sessions left. I chose to bring up the subject in the middle of our session so that he was not unsettled immediately as we began, nor left surprised and alone had I left it until the end of the session. Mid-session, in a moment of connectedness, I was able to support him should any issues arise. I worried that he might become frustrated, feeling let down, and refuse to participate; however, this was a necessary risk. If he reacted negatively, I was mentally prepared, understanding that he had every right to communicate this. However, he reacted in quite the opposite way. He seemed surprised and appeared to understand, but did not immediately show any signs of withdrawal. In fact, when I began the next song, "Leaving on a Jet Plane", he straightaway began singing the first three lines of the verse with me in his deep, throaty voice. It felt as though he had realised we had limited time and was putting in more effort. One of the most moving moments was John joining in for an entire chorus. Although he sang very clearly and melodically, his voice was weak and each line was clearly tiring. Over the next two sessions he continued to sing one to three lines of several songs, while the volume and apparent confidence in his verbal communication increased steadily. I noticed him swaying and tapping his foot when too exhausted to sing, clearly less apprehensive about engaging musically with me.

In discussion with my supervisor, I decided that it might be beneficial to make John a CD playlist of music we had shared. We related the concept to the documentary film "Alive Inside" (Rossato-Bennett, 2014) where elderly people were given recordings of music they had listened to in their youth. I felt that it was important for both John and myself to leave him with a reminder of our time together. John seemed open to this idea, nodding his head with his eyebrows raised and thumbs up. I decided to listen to the CD with John and ensure he knew how to use his CD player – to ensure the CD could be used and encourage a moment of collaborative reflection with a more equal power dynamic.

Unfortunately, for our last session John was quite unwell and unsettled as a result. After discussions with staff, I postponed our session by an hour to allow him to calm down. He welcomed me into his room but expressed discomfort, pointing to the affected area and appearing dismissive to the

idea of playing any music. I expressed understanding and showed him the CD I had made, suggesting we just listen to that instead of playing music. He agreed and appeared touched by the CD, reading the message with a great smile and shaking my hand in thanks. As we played the CD, I talked about some of the artists and John expressed his own likes and dislikes of certain songs. I strummed lightly along to one of the songs and invited John to join on the spoons – given his discomfort today, I was surprised that he did.

For our final song together John joined me on the harmonica as we played *"Leaving on a Jet Plane"*. He did not play as strongly as recently, most likely because of his physical discomfort, but his participation was significant – a recognition of the significance of this song in our relationship. As I left, John had a slight smile across his pained face and appeared somewhat calmer than earlier. He offered a handshake, and I wished him well, leaving him listening to the CD.

Discussion

While this case study illustrates positive outcomes for John, we cannot assume that these techniques will always yield the same results. Every person has an individual approach, and their personal traits and styles impacts on the way clients respond. However, two particular aspects of the work may be relevant for my future work – the use of artefacts and the use of a "bloke-to-bloke" approach.

The use of artefacts was a recurring theme through John's music therapy sessions. I used them as reference points for discussion and segues relating to the music being played throughout many of our sessions. They were a part of John's portrayed identity that I was able to clearly acknowledge, address and use as a means of communication. Later I was able to introduce new artefacts, such as the harmonica and CD, as a recognition of our own relationship. The harmonica met many definitions of an "instrument" – both a source of musical expression and a tool for physical rehabilitation, identity formation and self-expression. John could also keep the harmonica on his shelf as a memory of our relationship, with the option of picking it up to play if he chose to. I discussed the harmonica with the recreation

coordinator – she agreed that it was a valuable tool for boosting his quality of life. I provided a list of John's songs, which she was able to use with him to encourage the continued use of the harmonica. This handover process was helpful in giving the facility tools and prompts for working with John.

As a young male using a "bloke-to-bloke" approach, I was able to connect with John in a way that many of the female-dominated staff team could not. John's predispositions may have contributed to his resistances, and this "blokey" approach allowed a stronger connection. This is not to say that all I did, and all that was needed, was to be a male. I had to develop a role from my own identity that appealed to John's needs but remained authentic – without authenticity there are no grounds for true therapeutic bonds. This concept of genuineness applies well to the notion of client-centred therapy, which is at the core of our professional Code of Ethics (Music Therapy New Zealand and New Zealand Music Therapy Board, 2012).

My work with John taught me a lot about my own music therapy practice and the power of music as a vehicle for the formation of a strong client-therapist relationship. On reflection, I feel that the real breakthroughs we experienced began when I was able to actively engage John in the music. It was only once I bought along "real" musical instruments that he felt comfortable enough to play, and this was when we connected and communicated more productively. Once we had both become more comfortable in our shared environment, our connections became more fluid and communicative. For myself, it was difficult to bring about closure after such a short period – I remained professional by ensuring John's needs were met, while using clinical supervision to process my own feelings. My restraint in allowing our relationship to exist in those eleven sessions and not attempting to continue it through diluted communication pathways has been beneficial for both John's security and my own ongoing professional wellbeing. Our connection through music was exciting and inspiring, and I hope that John remains as responsive to music in everyday life as in our work together.

Conclusions and Recommendations

My work with John and the preparation of this case study have been important reflective experiences in my training as a music therapist. Case studies provide a valuable description of the processes of music therapy and I have learned not only from my interactions with John, but also through clinical supervision, discussion with my clinical liaison, engagement with the literature and self-reflection. Based on this work, I make the following recommendations for my own future work and for other music therapy students and new graduates:

Forming and nurturing a genuine therapeutic relationship is the foundation to a meaningful music therapy intervention. One way of supporting the formation is by making connections between the therapist's and client's presented identities. For myself a "bloke-to-bloke", cajoling approach to interactions helped me to create opportunities for further interaction.

Artefacts can play a significant role in forming a therapeutic relationship, as well as supporting closure. John's CD collection and assortment of musical figurines provided insight into his musical identity, which I was able to use as a springboard to our collaborative musical exploration. The introduction of a harmonica supported his identity and provided a memento of our time spent together along with his customised CD playlist.

Clinical supervision is essential to safe clinical practice and provides opportunities for personal and clinical reflection, thus encouraging clinical reflexivity. I found supervision to be especially important when deciding how to manage the ending of our therapy, and it allowed me to process my thoughts and feelings away from the sessions whilst remaining therapeutically 'present' for John.

Reflecting on clinical work through the writing of case studies benefits both the writer/therapist and the greater music therapy community. I would encourage students and new graduates to recognise their work as important and relevant, and for them to document and disseminate it as appropriate in order to support their own professional development and the current voice of music therapy in literature.

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Songwriting with Adolescents who have Mental Health Difficulties: One Music Therapy Student's Experience

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Abstract

This paper describes the specific songwriting techniques a music therapy student used in her group and individual music therapy sessions, at an educational facility for adolescents who had various mental health difficulties. It is based on research findings generated from secondary analysis of data (Heaton, 2004). Each music therapy process began with an exploration of how the adolescents would prefer to approach their songwriting, and thereafter involved the integration of methods and techniques specifically tailored to meet their needs. Facilitation of both individual and group sessions involved listening to students' songwriting ideas and supporting them to choose specific tools to further their musicality and creativity. The young people's confidence increased when the student shared her own ideas and examples of her songwriting work, and when they were able to produce products that were meaningful to themselves and to others.

Introduction

This paper reports findings from original research (Johnson, 2016) undertaken by a student music therapist, Emma (first author) who was working on placement at a transitional school for adolescents with mental health issues. Daphne (second author) supervised the work which was undertaken under the auspices of the New Zealand School of Music – Te Kōkī, at Victoria University of Wellington. We have emphasised our genuine collaboration and Daphne's contribution to writing this paper, by presenting our work in third person narrative. The training programme at the New Zealand School of Music is predominantly grounded in humanistic, music-centred, resource and community music therapy philosophies. This is also reflected in our description of music therapy participants, rather than clients, and our focus on individuals' strengths and interactions, rather than clinical diagnoses.

The transition school, where this work took place, provides education and health support to young people returning to studies following a period of deterioration in their mental health, who are not yet ready to attend their regular/local school. Staff members include an offsite principal, onsite vice-principal, two full-time teachers, one part-time teacher, an occupational therapist, a mental health nurse, and support staff. Case managers and visiting therapists also attend, as required. Staff members work closely with educators at the young person's regular school, parents/whanau, and other health professionals involved in the care process, such as general practitioners, therapists and psychologists.

Each morning during school term time, a therapeutic workshop was run at the school by staff members. Topics include learning about mindfulness, helpful sleeping habits, and personality behaviours. The young people were supported by staff to decide which workshops they felt would benefit them the most. Emma offered music therapy groups as part of this routine each Tuesday morning, and on other mornings offered individual music therapy sessions (usually 30-40 minutes). The sessions involved a variety of methods, including listening to and discussing music, listening to music and drawing, listening to music during relaxation and breathing exercises, and learning to play and improvise on instruments. However, Emma had a

particular curiosity regarding the potential of songwriting in this context, since she personally experienced it as a relaxing and creative outlet. When she noticed that the young people seemed to lack the ability or desire to describe or discuss their emotions, she felt that songwriting could be a useful method to facilitate their self-expression.

Background

Adolescence encompasses the second decade of life, usually including the last year of primary school, secondary school years, and the move into tertiary education (Rutter, 2012). During this period, young people develop new identities, becoming increasingly independent as they move toward adulthood (Erikson, 1968; Rutter, 2012). They often use music to express themselves, to gain self-understanding, and to help others understand them (McFerran, 2010). Adolescence can be a turbulent time, amid pressures and expectations from many different directions (Wise, 2004). Those in the mental health system can experience particularly difficult emotions, or have particularly difficult experiences, which can be hard to describe and to control (Fisher, 2015).

Adolescents "exist on the cusp between expression and articulation" (McFerran, 2010, p.137). Therapies which aim to increase understanding, self-awareness or insight largely rely on verbal approaches (Dogra, Frake, Gale, & Parkin, 2008), yet verbal communication can be limiting, irrespective of the persons verbal ability (Dogra, Frake, Gale & Parkin, 2008; Green, 2007). Additional vehicles such as drama, art, and music are increasingly used to support self-expression (Samaritter, 2018) which "sometimes takes established routes, [while] at other times it takes novel forms" (Green, 2007, p.18). Music therapy can be especially helpful for people who already have a strong relationship with music, problems expressing themselves, and/or difficulty with verbal therapy (Bruscia, 1996; Cobbett, 2009; Rolvsjord, 2005). It can also be particularly helpful for adolescents, since self-expression is an important factor in resolving identity crisis (Frisch, 1990).

> The integration of music therapy in inpatient treatment of adolescents is feasible and acceptable, and is valued by staff and patients as a complement to "talking therapies". Participation is enjoyed and associated with outcomes including improvement in mood, expression of feelings and social engagement consistent with recovery.
>
> (Patterson, Duhig, Darbyshire, Counsel, Higgins, & Williams, 2015, p. 556).

Self-expression has been defined as "the expression of one's feelings, thoughts, or ideas, especially in writing, art, music, or dance" (Oxford Living Dictionary, 2016), and "one's representation through speech, action or written words" (Tshivhase, 2015, p. 378). For example, the soft dynamics of a shy person's musical play can be expressions of their personality, similar to the way they express themselves verbally (Wigram, Pederson & Bondi, 2002). If self-expression involves articulating something about the person who is doing the expressing, links between self-expression and identity – and the relevance of music therapy for adolescents – becomes clear.

People attending music therapy are often motivated and open to the idea of creating songs, because of the status that songs hold in society (Baker, 2015). Songwriting is a particularly popular method with young people (Baker, 2015; McFerran, 2010) often undertaken as a group activity (McFerran, 2010). Songwriting in a group setting involves participants working together to create something meaningful to them as a whole. Writing songs can provide opportunities for the composers to use metaphors and symbolic language to describe situations that are difficult to articulate verbally. Songwriting methods can be adjusted to support adolescents' development, acceptance and/or understanding (McFerran, 2010). Songs are a common form of expression, can be performed over and over again, shared, and/or kept and stored away (Rolvsjord, 2005). They can also provide opportunities for participants to experience joy during times when they might find joyous occasions few and far between (Baker & Wigram, 2005).

Lyric substitution is a popular strategy in the song-writing process (Baker, 2015; McFerran, 2010). The Fill-in-the-Blank (FITB) technique requires that therapist or participant choose a song and remove specific words, and the participant decides on replacements. FITB and parody, where the words of a song are replaced entirely, can demystify the songwriting process. Baker (2015) explains, "FITB, parody, and strategic songwriting can function as a preparation for original songwriting by illustrating that, with the support of a therapist, anyone can create a song that has personal meaning" (p. 108).

Rolvsjord (2005) suggests three additional techniques for writing lyrics with participants: selecting words from lists, using participant self-generated words and using participant poems. Specifically, when participants are having difficulty with expressing themselves verbally, the therapist can create a list of words or symbols for them to choose from and include in the song. The therapist might suggest that participants write some words down, and then work to create open and poetic lyrics to assist them to continue the lyrics themselves. The third option involves participants contributing their words in the form of a poem which can be changed and edited, sometimes with sections repeated to conform to song structures.

Within all aspects of songwriting there is an opportunity for participants to create something that they feel is meaningful. Employing relatively easy to use computer programmes, such as GarageBand, LMMS and MusicMaker Jam, can increase songwriting accessibility for music therapy participants and support them to create a product that they can keep after the therapy process has ended. Therapist knowledge and skill in effective use of basic recording equipment "has the capacity to capture and convert transitory live music moments, into lasting memories, even within the shortest of sessions" (Magee et al., 2011, p. 151). Creating something tangible can be a comfort for some.

Research Design and Method

The chosen methodology was secondary analysis of qualitative data[1]. Heaton (2004, p.3) explains that "the first and most rudimentary principal of secondary analysis is that it involves the use of pre-existing data". Relevant documents from a five-month period of practice, including the therapists' reflective journal, clinical notes and observations from music therapy sessions, as well as review statements for student review meetings, have been analysed for this study. Data were subjected to thematic analysis, a process which involves rigorous examination of data in search of meanings and patterns (Braun & Clarke, 2006).

Findings

In the paragraphs below, we demonstrate how Emma facilitated songwriting processes to support the self-expression of adolescents who have mental health difficulties. Methods include Fill-in-the-blanks and parody, improvisation, lyric writing, performance, and song planning.

Fill-In-The-Blanks (FITB)

FITB was a helpful way to begin when working in a group setting. Emma created a worksheet that she felt would be appropriate and accessible for students in her groups. She encouraged them to contribute lyrics by sharing her own examples, and gave them opportunities to explain and demonstrate ideas to peers. When a song was complete, the group sang it using a YouTube backing track.

Students who needed more support came to individual sessions where Emma could take time to explain the task more fully, and encourage the student to participate, enjoy and more fully express themselves through the song lyrics. The worksheet was tailored to each individual, in terms of

[1] Informed consent was gained from the school and from individual participants for clinical data to be reused as research data. The research was approved by the Human Ethics Committee of Victoria University of Wellington (Approval #22131).

music preference and language ability. There also was more freedom with language when working individually, as school rules prohibited the use of swear words in the group therapy space. However, swear words were part of everyday life for many of the students, and songwriting was a place where they could express that side of themselves. As Baker (2015) explained:

> Society has condoned the use of songs as a form of freedom of speech, where people can describe what might be otherwise considered taboo. Lyrics may incorporate profanity and reference events that may be difficult or inappropriate to describe in face-to-face conversations. (p.20)

Sometimes while students filled in their worksheet, Emma completed the sheet herself and asked the student to assist her to reflect on her choice of words. She modelled first, so they could see she was willing to share her thoughts. When Emma asked students to "help" her, activities seemed less intimidating and they seemed more ready to participate. The FITB sheets enabled discussion of the emotional themes that were increasingly prominent throughout their work. For example, one student recognised that the mood of their music and lyrics might contrast over time, and learnt how to express those different moods through language and sound.

Emma regularly prepared specific plans for students' individual sessions, to ensure they were working towards the objectives suggested on the school's therapeutic plan. However, over time working with the FITB method, Emma began to leave plans more open to accommodate students' choice. This meant they could work together to remove lyrics to be replaced. Emma began to realise that encouraging student autonomy was critical in a process which aimed to encourage self-expression (Figure 1).

Figure 1. *Recognising student autonomy.*

> The student chose the song and we listened to it repeatedly, and discussed the lyrics. Then she decided which lyrics to remove and replace. I had not done this before as I had always organised the song and decided which words to remove myself. Planning this work together opened a natural discussion on an emotional motif and provided the opportunity to explore ideas and emotive language. Giving her further choice resulted in a much more open conversation than we had had in sessions previously, and perhaps offered her more space to be truly expressive in her work.
>
> (Reflective journal, 3rd June 3, 2016)

Song Parody

Emma often used parody as a songwriting technique, mainly with younger students, as an opening activity. Like Baker (2015), Emma found that singing about some light-hearted or nonsense topic was a good way to start the session. They began by removing most of the lyrics of a song, and chose a theme for their new version. Sometimes they began with a skeleton of the song, because some students felt this helped them to write something "good".

When working with the parody method, Emma found that she was trying to steer away from pre-recorded music, preferring to accompany with guitar, keyboard or ukulele. Students sometimes played ukulele too, and Emma played and sang alongside them. However, this attempt to make the experience more musical and personal – more "real" – was sometimes rejected by students who preferred using pre-recorded music. This preference for recorded music could signal a need to maintain distance, or it could just have been that pre-recorded music was more like the original and thus felt more authentic to them.

Emma noticed that younger students needed more time to create their songs, because they were more changeable and appeared less content with their decisions. However, many enjoyed the process to the extent that it became a focus of their day. They appeared to experience the work as enjoyable, safe, comfortable, accessible and expressive. One even said that

songwriting was the reason they came to school. When songs were complete and the therapy was due to finish, Emma provided a laminated copy of the lyrics for students to take away, so that they might remember this positive time in their lives. Occasionally Emma also facilitated students performing a song to a trustworthy audience, such as peers, teachers, and/or other therapists, if they expressed interest in doing so.

Original Lyric Writing

Original lyric writing can encourage self-expression and reflection on current, past or invented situations, using words and sounds. In group settings Emma offered participants opportunities to collaborate and make creative choices collectively as a group. She noticed that it could be difficult for the group to find an idea or theme that satisfied everyone (Figure 2).

Figure 2. *Group work.*

> Finally I suggested (off the top of my head) that we start a rap from scratch. I was concerned this would be quite difficult and people would be intimidated by the task, but they all appeared very keen. We decided to use the same beat as last time and got discussing what the rap could be about. A long discussion ensued about rap music and how to write it. A couple of the students were really quite knowledgeable about rap and hip hop music, which was a very helpful start. Overall, they didn't want a plan or theme to the rap, so I suggested we all write a line about something that happened this morning, either something real or something made up. Everyone gave their ideas and I put them up on the board. We worked together to create rhyming words and fit the syllables.
>
> (Clinical notes, June 14, 2016)
>
> (See Appendix A)

In individual sessions, Emma often suggested that the student choose a theme based on emotion, by either naming it aloud or pointing to a word list. This sheet enabled students to point at one or more words describing emotions, without having the pressure to verbally communicate. She also provided suggestions of lyric writing techniques, such as writing down examples of sentence openings (Figure 3), to encourage and support students to begin.

Emma supported student musical choices by writing melodies, and accompanying their songs. When the projects were considered finished, she offered to create recordings. Listening back to the lyrics appeared to help students to reflect on their work in greater depth, as the recording created separation between the creative process and the objective experience of listening back to it.

Figure 3. *Prompting.*

> The student appeared slightly overwhelmed and didn't know where to start with writing lyrics, but they knew they wanted to do something original. So I wrote down some prompts to get them going, such as "If I were…", "I would…", "If I knew…", "If I had…", "Why am I…", or "They said…" With some help and encouragement, the student began to write some thoughtful lyrics.
>
> (Clinical notes, June 17, 2016)

Improvisation

> Improvisation is a much freer and more flexible way of creating music than either playing by ear or playing 'in the style of…' It can be more simple, but also more complex, as well as essentially original and idiosyncratic.
>
> (Wigram, 2004, p. 25)

Green (2007, p.8) notes that "self-expression is something that we either do or allow [and it is] often spontaneous". Given its spontaneous nature, improvisation is therefore a form of self-expression; and it is an expression of identity (Sansom, 2007). It is also an integral part of the activity of composing and performing (Epp, 2007) which can be used as a technique to help people move forward in the therapy process, unblocking songwriters' moments of being "stuck" (Baker, 2015).

Emma used improvisation regularly with the young people, often as a warm-up exercise, because she perceived it to be a way to help them recognise they were being fully listened to. Even though improvisation was unfamiliar for many of them, it seemed to be less intimidating than talking, especially at the beginning of a session. When offering improvisation to a student for the first time, or if Emma felt it was suitable, she might suggest

a theme, a "play-word", or some other structure. A musical exercise which involved call and response, for example, sometimes made the improvisation more accessible for students. Emma would offer the instrument she was playing, or choose another during the music, demonstrating how it was possible to change one's expression by using alternative instruments or voice. Students usually accepted improvisation as an opportunity to try something new; it seemed like a new game for them. Sometimes the improvisations could be quite playful, but they always seemed to demonstrate a lot about how a student was managing on a particular day.

Emma found that for some students, this "game" could be utilised as an introduction to songwriting (Figure 4). As they experimented freely on their instruments, students gained songwriting ideas. Musical dialogue emerged as they improvised with her; as themes were repeated and expanded; as she posed musical questions and left space for a response; or answered their musical questions. Moreover, the use of dynamics enabled the young people to express and/or release emotional energy.

Figure 4. *Facilitating emotional expression.*

> She began to strum the ukulele quickly up & down, and I drummed alongside her at the same pace. She kept the same rhythm going for several minutes, so I stayed with her on the drums. Eventually I picked up the guitar and played a bass line along with her (F sharp, A, G sharp, B), wondering if that could make our music feel more connected. We got into a rhythm together and after a few minutes I added a few more notes into my bass line for depth. Once we stopped I asked her to reflect back on our music and she noted that "when we play together, I can play louder and harder".
>
> (Clinical notes, April 12, 2016)

The emotion sheet could also be used to inspire the emotional theme of the improvisation. For example (Figure 5), students could express emotion, enjoyment and creativity as songs emerged from the improvisation.

Figure 5. *Utilising the word sheets.*

> I asked her to pick three feelings from the emotion words sheet. She chose "energised", "happy" and "up". I suggested we improvised 'happy'. She chose the ukulele and I moved to the keyboard. She played a rhythmic strum on open strings, which we both described as "island sounding", and I played chords (C, F, G) in the same rhythm. I then picked up the ukulele to join her and she changed instruments to shakers, which was perhaps a sign that she wanted to be playing something different to me, maybe to be the main performer, and maintain a separate identity. I carried on with the chord progression C, F, G on the ukulele and she used the shakers and hitting sticks to keep a rhythm. She began singing: "I'm happy, happy, I feel good, good", and I repeated this. As we continued, I asked her in song what she had for breakfast.
>
> "I had Weetbix",
>
> "With milk?",
>
> "Of course with milk!" "What did you have?"
>
> "I had a banana, but I wish I had Weetbix".

Emma offered to record the students' ideas either on paper (e.g. a chord progression) or electronically (audio recordings on her laptop). She almost always used the music-making to encourage reflection and discussion by using the emotion sheet or asking specific questions, such as:

- Did you keep thinking of the play-word throughout the music?
- Did you find changing instruments changed the mood or sound of the music?
- Did you feel limited by the play-word?
- How did you feel when you were playing?
- Shall we give it another go?

In group settings, Emma asked individuals to suggest a theme or play-word, and the group worked with that choice. She found this more helpful than asking the group to decide on something together, to ensure that quieter students had opportunities. For example (Figure 6), a student seemed to be expressing his need to be heard by playing loudly during the improvisation; Emma matched his beat to create a strong foundation which also supported others in the group. Following group improvisations, Emma facilitated

reflection and discussion, asking similar questions to those posed to individuals, described above.

Figure 6. *Improvising.*

> This improvisation was approximately three minutes long. People were talking during it, some saying "Emma – I don't know what to do" whilst playing, while others were playing instruments quietly, or hitting drums and percussion very loudly. Emma matched the beat established by one student on the djembe, playing more quietly on the bongos. It seemed that the student was keeping the whole group together. He had had a difficult morning, so perhaps he was finding it necessary to be heard by playing the loudest. He was clearly in charge here, as he ended the improvisation by hitting the djembe very loudly. Discussions ensued – "Was anyone listening to anyone else?"
>
> (Reflective Journal: 17th May 2016)

Composition

In this context, "composition" refers to writing music to create (or begin creating) a song, to enhance existing lyrics, or create music without lyrics. This is important because "Music plays a key role in expressing and holding the feelings of the songwriter so that they can be experienced, fully expressed, illuminated, clarified and resolved" (Baker, 2015, p. 80). When beginning an original composition with a student, Emma often suggested improvising with instruments, and she might support students' music-making by beginning the improvisation herself and allowing a simple bassline or chord progression to develop. In response to student requests, she might also teach them some basic chords or notes.

For example (Figure 7), a student and Emma had been working together on some lyrics, but had become stuck. She suggested that writing some music might help them determine where they might go with their lyrics. The chord progression, although simple, is emotive. The contrast in the progression of major and minor chords, supports the lyrics well, in that the lyrics appear to alternate between uplifting ideations and confusion (Appendix B). The chorus seems to contain the idea that amidst this confusion, music can be relied upon. However, it may be helpful for the reader to know that the

verses and the chorus were all written in separate sessions; therefore the student was presenting in a different way each time.

Figure 7. *Beginning with music.*

> I asked the student to pick up the guitar and have a play around with the chords they were going to choose. I joined her, playing a quiet and simple bass line on the other guitar. After playing for 10 minutes, I suggested we start recording the chords so that we could try singing different melodies over the top. We recorded a bass line, guitar chords, and a lead guitar part all in one session! The student was energised by this and explained that this was very exciting. I asked them whether they would like to work with the lyrics that they had been writing separately. As we put the words to the music the student became concerned that the lyrics contained too many questions. We discussed the theme that was inherent in the lyrics, i.e. that of being lost, and recognised together that the student was experiencing a sense of being lost and of loss.
>
> (Clinical notes, June 29, 2016)
>
> (See Appendix B.)

Independent Composition and Performance

Independent composition and performance provided an opportunity for the students to express themselves creatively and honestly. Several students began to write music and songs independently of Emma, and brought their songs back into therapy sessions for further development. This confirmed her observation that this population really benefits from and can be inspired by songwriting. Emma had not anticipated that independent composition and performance would feature in her practice.

Emma provided equipment and knowledge of basic recording, enabling students to record and listen to their music. Using music technology can ensure that participants meet goals while creating products that are aesthetically pleasing (Magee et al., 2011). Emma found that, within this setting, basic recordings regularly resulted in discussion as students reflected on lyrics and music.

There are advantages and disadvantages of using performance in music therapy with adolescents (McFerran, 2010). While performance is more common in contemporary music therapy practice, working towards a performance may conflict with being in the moment with a client. However, Emma noticed that students frequently wanted to perform songs they had composed, both inside and outside of therapy, to her as well as to trusted people from outside the therapy room, such as teachers, close friends, and on one occasion the whole student body. In one case, a student sang an original song to their teacher when it was time to leave the school, thus supporting a difficult transition. However, while performances were always initiated by the students, they were often nervous about taking this step.

Facilitating performance therefore became another way to support students' sense of identity and levels of self-confidence, and was considered part of the songwriting process. Emma asked the students what they might need to make it easier for them to share their music. She might change her body position to avoid directly facing students or making eye contact. She listened intently to the students' performances, and asked open-ended questions to aid reflection, such as:

- How did you go about writing the music?
- What are the lyrics about?
- Can you tell me about the meaning behind this sentence?

Students were already feeling safe enough to share their personal work with Emma, so the conversation generally came naturally.

Song Planning

Discussing songwriting options and planning songs became a vital way for students to express themselves, their creative ideas and their personality. To facilitate the songwriting process, and to ensure students had choice and could take control of the creative process, Emma provided them with short examples of each method. However, with so many choices available, some students had difficulty deciding how to proceed. Mind-mapping was helpful for bringing things together – to plan instrumentation, emotional feel, mood, and any other ideas the student had. Emma supported musical ideas on the guitar, keyboard, ukulele or percussion, and again used audio

recording to help students remember ideas for future sessions. It was helpful to see how students were able to manage organising their ideas to create something that was meaningful and expressive.

Discussion

This work employed all three main categories of songwriting identified by Baker (2015): methods that emphasise lyric creation, methods that emphasise lyric and music creation, and methods that emphasise music creation. Emma facilitated the songwriting by providing examples and options, using tools such as mind maps, accompanying students' musical ideas on various instruments, and using basic recording equipment to capture emerging ideas; techniques also described by Baker.

In this context, the therapist's roles involved listening to students' songwriting and idea choices, supporting them musically, and creating specific tools for individual or group sessions. Improvising was a helpful way to begin to create the music. Students' confidence and beliefs that they could create something meaningful through songwriting were also enhanced when Emma shared her ideas and examples of her own work. Nevertheless, she increasingly understood that the process of songwriting needed to be owned by the student. We found, as did Rolvsjord (2010) that a focus on achieving mastery, self-esteem, and self-efficacy through songwriting contributed to the students' beliefs in their own capabilities and thus their overall confidence. Recordings of their songs were important, not only as a prompt for reflection on the work but as a way of celebrating it.

Planning was central to the songwriting process, although a client-centred, flexible approach was needed to respond the diversity amongst this population – a person's age, gender and personality has an impact on how the songwriting process unfolds (Baker, 2015). While song-writing is task-oriented and might therefore be considered directive, students were given as much control of the process as they could manage. For example, they expressed themselves through their choices, creative outputs, personal interests and generation of ideas. While Emma was considerate and responsive to the demands and rules of an education setting (which

included individual therapeutic plans), she recognised the importance of promoting student autonomy and allowing the songwriting process to emerge according to individual and group needs and resources.

Getting started on writing original lyrics seemed difficult for this population. For many of the students, the processes of FITB and parody seemed to be more manageable and containing, and less intimidating, than other songwriting methods. Parody and FITB both seemed to provide what was sometimes a helpful distance between the writer and what was being written – that is, while the adolescents were contributing their own ideas, they were also drawing on "someone else's" music and/or lyrics and reflecting on a shared product. From a resource-oriented perspective, this is important: the frameworks are resources they can draw on to support their growing autonomy. While the ultimate aim of therapy might be to strengthen links between the student and their words, it seemed that keeping a distance between themselves and the writings might have helped them feel safe in the early stages of therapy. Creating a shared product with the student therapist might have felt less challenging, while still enabling expressions of confidence, personality and interests, thoughts and opinions, and enjoyment. Ultimately, students still appeared to feel as if the song was theirs, and to experience the sense of ownership crucial in a resource-oriented process (Rolvsjord, 2010).

The students' physical state and psychological wellbeing also influenced their participation in the songwriting process (Baker, 2015) and may have had a significant impact on the material that arose in the sessions, particularly the lyric content. As noted above, we avoided focusing on students' diagnoses, since this pathologises the songwriters and is incongruent with some schools of contemporary thinking (Baker, 2015). Nevertheless, Emma found that each student's presentation, how they were feeling and managing at any given time, affected the ways they were able to engage with songwriting and find an expressive outlet. The "up and down" nature of their ability to express themselves creatively seemed to reflect the confusions present in in their lives, especially lives affected by mental health issues. Songwriting enabled them to express some of that confusion as they explored emotions, conveyed who they were and how they felt, and were brought closer to others (Baker & Wigram, 2005; Bruscia,

1998). This is exemplified by the song which helped a student uncover their sense of being lost, and of loss (Appendix B).

This research reports just one music therapy student's reflections on her own work at one unique transition school for adolescents who have mental health difficulties, and cannot be generalised. We also recognise that more experienced music therapists may have different or more in-depth ideas about how to approach and interpret the work. However, the rich description Emma has provided of her work is likely to be of help to others who are working in this field.

Conclusion

Adolescents are transitioning between childhood and adulthood, and can be like children in one situation and adults in another. They are often being told what is best for them, and what to do and when. Yet they are also being challenged to develop a new identity that will enable them to become independent adults (Erikson, 1968; Rutter, 2012). The confusion and difficulties associated with typical adolescence are intensified in young people who are experiencing mental health difficulties. Our findings suggest that the songwriting process has significant potential to support their self-expression, confidence, and developing identity.

In this case, the process involved finding out how participants might like to approach their songwriting, observing social communication, such as eye contact and body language, as well as verbal communication, and suggesting musical frameworks to match their choices, abilities, and apparent affect. Methods and techniques were tailored to the needs and abilities of groups or individuals. The student music therapist had a genuine interest in what the young people were able to write, both independently and collaboratively with her, and respected everything they shared and contributed.

In turn, the students were able to express themselves through their personality and behaviour, creativity, interests, ideas, thoughts and opinions, choices, levels of confidence, emotional responses, including enjoyment, and levels of independence and autonomy. The song writing process enabled them to be heard and responded to in a new way, and gave

them a channel through which to express material that may have remained suppressed. It promoted their sense of capability, confidence and mastery and, presumably, gave them increased hope.

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Appendix A: Group Rap

I woke up at 6 in the morning,
got to school and at class I was yawnin',
Dawnin, on me that I was late for the day,
didn't have time to eat so now I just feel cray.

My dog was barking his name is Beau,
He woke me up and licked my toe,
I look at my clock and I really gotta go,
I run to work say "catch you later bro".

I didn't sleep well so I'm not feelin' so swell,
I walk into the kitchen and I smell a bad smell,
The sink is full of dishes and it looks like hell,
This place is just a mess and I want to yell.

I missed the rain, 'cause I got the train,
I can feel the pain and it's pounding in my brain.

I dropped my pennies on the ground and I'm looking around,
People crowding round but my music surrounds,
Homeless man on the ground laying with his hound,
All the people in town are giving him a frown.

I'm walkin' in the city and I'm feelin' pity,
Every day is a rerun, technology's advanced,
I can see that times have grown,
But still I'm mind blown.

Appendix B: Putting Lyrics to Music

Chord progression: D F#m Bm G

We're gonna lift this world up
Make it better,
Make it better than it's ever been
We're trying to understand the meaning
We have it in our hands
What am I really feeling?

I seem to help other people
But I can't help myself
Are we going insane?
Or are we really real?

Chorus: E G#m C#m A

We are uncertain, we are unknown
Keep the rhythm going, we can't say no
We are uncertain, we are unknown,
Just keep on moving, to the rhythm of your soul

Suggested citation

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Book Review[1]

Molyneux, C. (Ed.). (2017). *Only Connect: Poems and Stories from New Zealand Music Therapy.* Nelson, NZ: Mountain Girl Publishing.

Molyneux, C. (Ed.). (2018). *Tales from the Music Therapy Room: Creative Connections.* London, England: Jessica Kingsley Publishers.

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Only Connect (Molyneux, 2017), republished as *Tales from the Music Therapy Room* (Molyneux, 2018), is a collection of stories and poems written by music therapists, in response to their music therapy encounters with a variety of clients.

The book is edited by Claire Molyneux, with a foreword by Sarah Hoskyns. There are individual contributions from Claire Molyneux, Marie Willis, Caroline Ayson, Nolan Hodgson, Heather Fletcher, Shari Storie, Libby Johns, Alison Talmage, Roger Hicks, and Ajay Castelino. The cover art is by Anne

[1] An early online version of this review was published in the Music Therapy New Zealand MusT newsletter, March 2018, retrieved from http://www.musictherapy.org.nz.

Bailey; cover-design by Stephanie Nierstenhoefer; illustrations by Robina Adamson; and design and layout by Chris Rutter. All the writers focus on their music therapy experiences in New Zealand (NZ), but the book has a universality which has international relevance. The contributions are in three sections, under the headings "The Therapy Room", "Poems and Stories from Music Therapy", and "Personal Journeys".

Claire Molyneux in her introduction says, "This collection of writing is about love, values and journeys. It has been born out of my personal preoccupation with balancing the demand for objective evidence with the poesis of the therapeutic endeavour" (2018, p.14). Claire has been influential in the music therapy world in NZ; as a therapist, writer, researcher, supervisor and mentor to many of the other writers in the book. In the Introduction, she further writes, "An encounter in the music therapy room exists beyond, within and without words and yet our efforts to communicate what takes place are often reduced to words" and "goals and focus areas and written reports are a tool that show only part of the encounter" (2018, p.113).

Claire continues, "I put out a call for expressions of interest to NZ music therapists to contribute writing that subjectively described the lived experience of music therapy in a way that celebrated the poetic and lyrical nature of the work" (p. xvi). The number of writers who responded and contributed to the book is testament to the chord Claire struck in expressing the desire to share stories of therapeutic encounters in forms which go beyond the required report writing and somewhat circumscribed written forms those reports require. In every therapeutic encounter things happen which are difficult to describe or quantify or convey to others. Yet every therapist can respond to the stories and poems of Only Connect because they are universally recognisable as reflecting the heart connections, the deeper recognitions that therapists and clients can find in the therapeutic encounter, the surprising and heart-warming moments of deep connection, the playfulness and fun which are crucial elements of therapy, and the moments of true recognition of each other. The book contains accounts of personal journeys of music therapists working with their clients, and attempts to convey the essence of that joint work in art-based language and form, in a similar way to arts-based research methods

or with echoes of ethnographic research. In my view (Miller, 2017) a number of alternative approaches provide evidence for the arts therapies, and I encourage music therapists and arts therapists to continue to develop the role of therapist/researcher.

I have worked with music therapists in a number of ways, and most closely in the writing of Assessment and Outcomes in the Arts Therapies: A Person-centred Approach (Miller, 2014) and Art Therapists in Multidisciplinary Settings: Working Together for Better Outcomes (Miller, 2016). From these contacts, I hold music therapists in high regard for their musical ability, their excellent training in music therapy, their scrupulous work with clients, their writing skills, and their commitment to research and to providing evidence for the effectiveness of music therapy (for example, Rickson, Castelino, Molyneux, Ridley, & Upjohn-Beatson, 2017). In addition, I now hold them in high regard for their courage in attempting to express the inexpressible, to communicate the uncommunicable essence of therapist/client encounters in poetry and music. The poetry paints pictures, and the poetry and prose evoke a musical response. In reading the book, I seemed often to hear music. Some songs are accompanied by musical notation. Many seem to reflect the music therapists' skills in improvisation, which they use widely with clients, as the writers improvise with language and form to find a freedom of expression to communicate some of the less recognised elements of therapy. In her Foreword, Sarah Hoskyns writes, "The writers have worked often in a different and new way to communicate a truth, a careful thought, a feeling" (2018, p. 10).

The writing also reflects the NZ environment and culture which both influence the way the therapists work, and then how they express this work. As examples, the cover illustration shows three significant songbirds which are native to NZ, whose songs have an influence on NZ music. The illustrations through the book are delicate black and white sketches of local birds and plants, which match the delicacy of much of the writing. In addition, several writers acknowledge the impact of the Māori culture on their work, and reflect the NZ training programme which meets rigorous international standards while honouring the customs and musical traditions of the Māori people.

The voice of one client, who is a member of the CeleBRation Choir, is included. This is one example of how music therapists work as co-creators and collaborators with clients. The impact of the CeleBRation Choir is also the focus of research projects, which have involved choir members being willing participants and co-researchers in tracking their own voice changes which have occurred through participation in the choir.

This book will appeal to all music therapists and to other arts therapists, as reflecting the soul work of the arts therapies. It has a wider appeal to all therapists who work in person-centred ways, who will recognise those moments of tentative engagement, of bringing magic into rooms designed for more mundane experiences, and for bringing alive the power of connection. The writers use accessible language to capture moments of warmth, humanity and connection which means that the book could also be attractive to family members, teachers and members of other professions, and to music therapy clients. While this writing does not replace the need for research, the concise expression needed for reports, the need for academic publication, it honours parts of the therapeutic experience which are sometimes seen as being outside of those areas, but which are integral to the therapeutic process.

As Carolyn Ayson writes:

> I struggled, I did, to write your reports.
> So much so that I stopped.
> Progress had little place here, every week was played by ear.
> I could feel the importance of the sessions,
> but on paper only one thing felt pleasing to write.
> That together you danced to my guitar.
>
> (2018, p. 151)

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Book Review

Whitehead-Pleaux, A., & Tan, X. (Eds.). (2017). *Cultural Intersections in Music Therapy: Music, Health, and the Person.* Dallas, TX: Barcelona Publishers.

Reviewer: May Bee Choo Clulee

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Culture has always fascinated me, as someone with a myriad cultural intersections in my own personal and professional life. I am of Chinese and Peranakan1 heritage; I grew up in a multiracial society in Singapore, a former British colony, and English is my first language. I completed my music therapy training in England and now live and work in New Zealand (NZ), married to a "Kiwi" of English and Scottish heritage. I thus welcomed the invitation to review a book that explored the topic of culture and music therapy from a personal perspective. I also felt that, more important than what I could speak about this book, this book had something to speak to me, and to those of us who live and work in NZ, where conversations about culture often challenge the dominant discourse.

Cultural Intersections in Music Therapy: Music, Health and the Person is a book exploring culturally competent music therapy, through the first-person voices of music therapists. Written mainly for the North American context, the book brings together contributions by music therapists from

[1] The term *Peranakan* generally refers to people of mixed Chinese and Malay/Indonesian heritage. Many Peranakans trace their origins to 15th-century Malacca where their ancestors were thought to be Chinese traders who married local women. While some Peranakans have retained many of their particular cultural practices, many have assimilated into the larger Chinese community today. For further information, see http://eresources.nlb.gov.sg/infopedia/articles/SIP_2013-08-30_181745.html.

around the USA and Canada – plus one from the Kingdom of Bahrain – each with personal and professional experiences of minority cultures, the focus of the text. The book had its beginnings in 2006. Whitehead-Pleaux and Tan shared similar wonderings about how to develop cultural competency in their music therapy work with people from different cultures. They co-chaired the Multicultural Music Therapy Institute at the American Music Therapy Association's 2012 conference. The Institute featured a panel of 12 presenters who contributed to a manual for participants, eventually expanded and published as the present 298 page book.

I was already drawn in after reading the first paragraph of the preface: the editors described how Ken Bruscia accepted their book proposal within two hours of submission! With tremendous anticipation, I continued to turn the pages, and although the book was challenging I was not disappointed. The authors address issues which are at times deeply personal and confronting, and evoked personal experiences for me which resonate alongside the narratives within these pages.

The purpose of the book is:

> To bring to the forefront of our consciousness the notion that the world is becoming more culturally pluralistic, that it is becoming increasingly challenging to define and pigeonhole any one individual into a cultural corner fenced in by myths, assumptions and stereotypes. (p. xi)

This bold purpose at times reads with a sense of urgency. It is something we may find uncomfortable to engage with, but it urges us to confront these issues personally and professionally, that we might be both better people and better therapists. This purpose is worked out clearly and methodically through the book's thoughtfully considered design and content. It is well organised into three broad sections:

- Unit I, "Understanding discrimination, oppression and bias" provides an understanding of the current systems that limit the minority voice from being heard;
- Units II-V examine different aspects of culture (discussed below); and

- Unit VI is solution-focused, addressing issues of inclusion in music therapy education and practice, and urging active participation from the music therapy community as advocates for minority cultures.

Unit 1 introduces the reader to some of the current thinking around oppression and discrimination, microaggression, and personal bias, by drawing from relevant models in psychology, multicultural counselling, and critical race theory[2]. It challenges the reader to self-reflection around personal bias in everyday professional practice, and the need for self-awareness and to take personal responsibility to address and navigate potential culturally complex situations wisely. These terms and concepts are used in discussions in other fields, such as education, racism, and Kaupapa Māori[3] research, and are beginning to impact music therapy.

The first chapter, "Discrimination and Oppression", by Whitehead-Pleaux, sets the scene by first defining key themes of oppression and discrimination. The author introduces the theory of the matrix of domination, developed by Patricia Collins a Black[4] feminist writer (Collins 1990). This matrix encompasses different forms of oppression, and can be used as a tool for self-examination. Collins also introduced the concept of intersectionality – the interaction of the various forms of oppression. Whitehead-Pleaux and Tan allude to this term in the title of their book.

The 23 chapters of the next four units, "Cultures of Heritage", "Cultures of Religion", "Cultures of Sexual Orientation and Gender", and "Cultures of Disability and Survivorship", are all structured similarly around ten themes, to highlight the intersections of culture, health, music and the individual:

[2] Critical race theory is a framework that may be used to examine racial bias in institutional structures. Central to this theory is the concept of colour-blindness, which is described as a white resistance to seeing issues of race (MacDonald & Reynolds, 2017, p. 48).

[3] Kaupapa Māori: Māori worldview

[4] The book uses the terms *Black* and *White* to describe a person's ethnic heritage, as commonly used in the North American context.

- Personal reflection or epoch;
- Introduction;
- Worldview of the culture(s);
- Historical realities versus popular myths;
- Diversity within the culture(s);
- Acculturation and assimilation;
- Minority stress, minority discrimination and microaggressions;
- Meaning of medicine and well-being in the culture(s);
- Meaning and function of music in the culture(s); and
- Conclusion.

This structure made it easy to locate information.

While I have not yet read every chapter in its entirety, I found that reading a number of key themes in each chapter provided a good overview of each culture. I read in particular detail the chapter on East and South East Asia Culture, which I identify with, and found myself disagreeing with some aspects of the text – which demonstrates the diversity even within a particular narrowly defined culture! Overall, I feel that these chapters provide an excellent starting point to exploring many minority cultures. Despite being written for the North American context, they have many overlaps with our context, and speak in one way or another to our bicultural heritage and increasingly multicultural landscape.

I found the overall style of the book accessible. The central arguments are compelling and warrant further study and research. Every chapter is supported by current references and other useful information about the cultures discussed. To underscore the context of the individual's voice, each chapter begins with a narrative about the author's own experiences of culture, oppression and discrimination. This provides important insights to the author's point of view, grounded in personal experience. It brought to mind the Māori mihi[5], in which speakers introduce themselves to establish links with other people, with reference to their whakapapa[6] and places of significance.

[5] Mihi: speech of greeting and introduction

[6] Whakapapa: genealogy

The book is in US letter size (a common, large textbook size) and formatted in a double column style. The simple visual layout sharpened the focus on the content. While the overall format facilitated ease and speed of reading large chunks of text, at times I found the small font and narrow spacing an uncomfortable read. The narrow margins also do not allow much room for "scribblers" (of whom I am one!) to make our own annotations. The book makes a number of references to North American organisations, events and cultural icons that may not be familiar to the international reader – perhaps in a future edition these could be footnoted.

The book is "designed to be a journey for the reader" (p. xiii) and it is hard not to be impacted by this book in some way. In the Conclusion, the editors suggest that the path towards culturally competent music therapy involves more than just awareness, learning and listening. An invitation is issued to look honestly inward at who we are and how we relate to others, and to reflect on our responses to issues of power and privilege.

The main takeaway for me from this book is that we need to continue the conversations that have been started about cultural intersections in music therapy in our NZ context. In light of this I was prompted to do a brief literature review on the topic of culture, music and music therapy in the NZ context. One of the contributors to Cultural Intersections in Music Therapy, Sangeeta Swamy (chapter 6) has presented and published in NZ (Swamy, 2013, 2014). I encourage readers to explore this and NZ thinkers in music therapy and related fields (Ayson, 206; Bowden, 2015; Fletcher, 2014; Hodgson, 2017, 2018; Hoskyns & Hadley, 2013; Kahui, 2008; Kahui & Hadley, 2013; McIvor, 1998; Nunns, 2001; Rollo, 2013, 2015; Stevenson, 2009; Storie, 2017; Willis, Watson & Talmage, 2014). See also Molyneux's (2017) review of an indigenous approach to mental health.

I am still taking time to consider the theories and arguments put forth in this book, which has shone a spotlight on a challenging topic. I highly recommend this book to everyone who wishes to explore these issues more fully.

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Clulee, M. B. C. (2018). [Review of *Cultural intersections in music therapy: Music, health, and the person*, by A. Whitehead-Pleaux, & X. Tan (Eds.).] *New Zealand Journal of Music Therapy, 16,* 145–152.

(2018). *New Zealand Journal of Music Therapy, 16,* 153-156.

Book Review

Higgins, L., & Willingham, L. (2017). *Engaging in Community Music: An Introduction.* New York, NY: Routledge.

Reviewer: Fiona Hearn

BMus, MMusTher, NZ RMTh

Wellington Early Intervention Trust and private practice.

I welcomed the opportunity to read and review *Engaging in Community Music: An Introduction* (Higgins & Willingham, 2017), as I was about to reconnect with some past music therapy work with a community based mental health organisation. I was hoping the book would give me a fresh insight to working with a strong community focus. I particularly looked forward to reading the chapter titled "Wholeness and Well-Being" with its section on community music therapy and interview with Phoene Cave, a music therapist, about her work with the Singing for Breathing project through the British Lung Foundation.

The co-authored book is primarily written as a textbook for university students, in community music programmes and related fields, and provides a strong focus on the processes involved in developing a practice. The authors are both university community music professors and have written and edited similar books on the topic including *Community Music: In Theory and in Practice* (Higgins, 2012) and *Creativity and Music Education* (Sullivan & Willingham, 2003). Throughout the book, 26 practitioners are interviewed from the diverse field of community music working within areas of education, justice, health and with different cultural groups. These illustrations are woven through the framework of the book and serve to bring the theory of each chapter to life. The authors also provide practical explanations, case examples and "how to" activities, as well as questions

and topics for discussion at the end of each chapter which may be more useful for students.

The book is organised into nine chapters, with the first two focusing on music and meaning and diverse pedagogical approaches in community music contexts, with illustrations from intergenerational settings. The third chapter discusses the inclusive and empathetic nature of community music and emphasises the hospitable and "open-door" policy that is emphasised in community music settings.

As a music therapist, I found Chapter 4, "Strategic Leadership and Facilitation", very relevant to reflect on, as it discusses the tool-kit of qualities and skills that community facilitators felt were essential in their work. These qualities included being passionate, empathetic, patient, creative, resourceful, resilient, organised and energetic. Skills that were considered essential to a good community facilitator were the ability to improvise, think on your feet, remain calm, have a high level of musicianship, "read" a room quickly, and engage in intentional listening. Although a potentially overwhelming list, I felt that these qualities and skills also cross over strongly with the ones needed in being a good music therapist.

I was intrigued by the interview with Doug Friesen, and his work in facilitating music workshops grounded in intense, intentional listening. I particularly liked his facilitation strategy of asking participants to breathe, relax and recall an early sound memory. He then asked them to share these sounds and imitate them as close as possible, then shaping them into a more musical sound and encouraging them to react to each other's sound and add movement. This idea reminded me of Dr Diane Austin's (2017) experiential workshop at the Music Therapy New Zealand Symposium, where we were asked to imitate the vocalisation and movement of the person on our left, then let it shape into something new before passing it on to the person on our right.

In the fifth chapter, "Mindfulness, Activism and Justice", the dual roles of contemplative practice and activism in community music are explored. This chapter included examples from community choirs in multi-faith settings and prisons.

Community music therapy (CoMT) gets a thorough description in Chapter 6, "Wholeness and Wellbeing", with discussion of definitions and theory from Ansdell (2014) and Stige (2012). The case example of the work of Phoene Cave was fascinating to read and to hear how this field has grown. It describes her training of 30 other Singing for Lung Health practitioners to set up other groups in hospitals and communities across the UK. Phoene also stresses the essential qualities of "patience, patience, patience and empathy, empathy, empathy aided by the confidence and a passion and knowledge for what you are doing" (p. 115). There was a very brief description of Simon Procter's CoMT work at Way Ahead, a non-medical community resource centre in London for people with experience of mental health problems. I would have liked more detail about his work in drawing members into "co-musiking" to achieve empowerment and enablement.

The chapter concludes with a more detailed case illustration of an intergenerational choir in Canada. It has a beautiful description of how this choir brings together five sectors of society: persons with dementia, their caregivers, high school student singers, their music teacher and several Sisters of St Joseph, in whose home they meet.

The seventh chapter, "Culture of Inquiry", acknowledges that community music can now be known as a field of study because of its emergent scholarly arm. It provides examples of current research practices as well as hypothetical vignettes to illustrate possible research scenarios. Chapter 8, "Careers and Management", is a practical chapter focusing different ways of developing and sustaining music projects and exploring the relationship between music and business. I found this chapter relevant to my own music therapy business, especially the discussion on how the arts and business worlds can learn from each other.

Finally, Chapter 9 concludes the book by summarising the previous chapters and proposing ways forward within the field of community music and a discussion how it intersects with CoMT.

In conclusion, *Engaging in Community Music: An Introduction* (Higgins & Willingham, 2017), provides readers with a wide range of ideas and practical examples located within a breadth of contexts and different environments. I particularly enjoyed reading the different interviews with

community music practitioners and case examples from such a variety of contexts. I would recommend it for anyone interested in working in a community-based context as well as for students and new graduates wanting to reflect on the qualities and skills needed in facilitating community music groups. For these purposes, it is best read by dipping into the relevant individual chapters rather than reading it cover to cover.

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Book Review

Polen, D. W., Shultis, C. L., & Wheeler, B. L. (2017). *Clinical Training Guide for the Student Music Therapist* (2nd ed.). Dallas, TX: Barcelona Publishers.

Reviewer: Oliver E. L. Lowery

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When I was a music therapy student, I initially found myself overwhelmed by the technicality and level of detail in the majority of the literature I came across, and had difficulty situating the information within a coherent framework. When I came across the first edition of the Clinical Training Guide of the Student Music Therapist (2005), I felt like I had found something that not only explained the elements of music therapy in plain language, but that provided an overview of music therapy as a whole with a consistent viewpoint over all of its many components. It categorised the histories, the processes, and the elements in and around music therapy practice in the same way my brain categorises information, and provided a map from which I was able to delve further into each topic and fill in the detail. Because of this I truly credit it with so much of my early learning. So when the opportunity to review the second edition of one of my most recommended books came up, I put my hand up straight away.

The *Clinical Training Guide for the Student Music Therapist* organises a wealth of knowledge into several distinct areas. The first three chapters focus on exploring what music therapy is, how it works, and the pathway of a music therapist's career. Chapters 4 to 7 outline the process of music therapy from planning, through assessment, goal-use, and strategies for implementation. The eighth to eleventh chapters cover the different experiences used to facilitate sessions such as improvisation, composition, and listening. And finally chapters 12 to 18 cover a broad range of topics

that needed their own space to discuss, such as facilitation and working in different settings, through to documentation and self-assessment strategies for music therapists at all stages in their career.

The second edition of this book expands on the usability of the first edition firstly by bringing the literature into the present day. Reference material has been contextualised by including it in the body of the text, rather than placed as "further reading" at the end of each chapter. The authors achieve this without impacting the flow of the writing (which is important considering the intended reader) and this encourages the reader to seek further knowledge in relation to particular topics of interest. The demand for music therapists to support their claims with reputable evidence is an important, and the authors provide the reader with the tools to do so.

One significant addition to the second edition is an entirely new chapter on the essential aspects of becoming a music therapist. This chapter (Chapter 3 – "Essential Aspects of Becoming a Music Therapist: Education, Clinical Training, and Related Areas") prepares the student for the personal and academic development they face as they work towards their chosen career path. The value of professional organisations and supervision is outlined clearly, though largely with reference to American practice. While acknowledging the fact that it would be impossible to provide this information on an international scale, the authors still provide plenty of information that is of relevance to students in New Zealand (NZ) and other countries as they discuss the importance of supervision, professionalism, ethics, and academic engagement. Assignments and references can also be easily adapted to suit the students' countries by substituting the documents with those of their own country – e.g. replacing the AMTA Code of Ethics (American Music Therapy Association, 2015) with the NZ Code of Ethics (Music Therapy New Zealand and New Zealand Music Therapy Registration Board, 2012).

The assignments component of each chapter is a very useful guided approach to synthesising the information with the student's own experiences, with suggestions for reflection and discussion. The authors have chosen to remove the three learning levels used in the first edition, and this provides for a gradually sequenced educational approach. This more flexible structure also makes the assignments more applicable for

non-American student training programmes that have different pathways for learning. The assignments support the students' practical music therapy placements and sit nicely as embellishments to a traditional training course, as opposed to being standalone activities.

It is clear that the the three authors provide a combined wealth of knowledge and experience that not only allows them to provide a detailed and wide overview of music therapy, but to do so in a way that is approachable and motivating for students coming into the world of music therapy. While this book is designed for students studying through American training programmes, the authors are aware of this, and the book still provides great value to music therapy students worldwide who follow a similar training pathway. I would strongly recommend the use of this book, not only for those already involved in their study, but for instructors, supervisors, and people interested in understanding music therapy as an intervention and as a career.

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Book Review

Adler, R. S., & Samsonova-Jellison, O. V. (2017). *Music Therapy for Multisensory and Body Awareness in Children and Adults with Severe to Profound Multiple Disabilities: The MuSense Manual.* London, England: Jessica Kingsley Publishers.

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In my first year as a new professional in the beginning stages of gaining clinical experience, literature with the keyword "multisensory" has always caught my eye, as understanding the sensory needs of clients is an important part of my professional development. Written by Adler and Samsonova-Jellison, *Music Therapy for Multisensory and Body Awareness in Children and Adults with Severe to Profound Multiple Disabilities: The MuSense Manual* (MuSense) is a resource for all professionals interested in viewing music therapy through a multisensory lens. Adler is a music therapy educator and clinician, and author of a musical assessment tool designed for music therapists working in aged care (Adler 2001). Samsonova-Jellison is a music therapist and music educator who owns and directs a music studio that provides music lessons. Both authors are certified in Neurologic Music Therapy and work in California. They have authored a book that is versatile and has a three-fold purpose: (1) to educate the audience about the sensory needs of individuals with severe to profound intellectual disabilities, (2) to act as a reference and resource for music therapy interventions and activities, and (3) to provide relevant case study material useful to those implementing the sensory activities.

This publication is organised into three distinct sections. Part I details the foundations of sensory processing and development of individuals with severe to profound disabilities, providing a clear resource. Part II informs the reader of the MuSense programme and contains musical resources and activities for music therapists. This section includes structured MuSense activities and repertoire and explains how the different parts of the body process sensory information. Part III includes case studies representing different populations, with clear treatment plans and results. In addition to detailing how the MuSense programme is implemented, this section provides readers with case studies that show how it can be adapted and incorporated as part of an established therapeutic process. The overall structure and clarity of the book make it accessible for music therapists to use, both as a resource for enhancing their clinical practice and as a reference resource for multisensory-based clinical practice.

As a new professional who is gaining insight and experience in clinical practice, I found the first section to be the most helpful. In Chapter 1, the authors lay out the building blocks of sensory development, focusing on scientific aspects of sensory processing and later connecting it to music. The authors explain, in a way that is simple and informative, how the brain and body process sensory information. While music therapists are the intended audience, allied professionals and educators would benefit from reading the first section of the book. Adler and Samsonova-Jellison take great care in explaining through examples and analogies, conveying their ideas and research with straightforwardness and simplicity that makes *The MuSense Manual* user-friendly. Vignettes that vary in length and content about clients' music therapy experiences are woven throughout the chapter, adding more depth and reality to the MuSense programme. Chapter 1 is linked in Chapter 2, which discusses the sensory difficulties experienced by individuals with intellectual and developmental disabilities, and how a multisensory approach can be applied within music therapy practice. It was evident to me that they placed value on the relational aspect of music therapy, understanding that the client-therapist relationship greatly contributes to the therapeutic experience. Adler and Samsonova-Jellison recognise the importance of the client-therapist relationship and offer music therapy examples through the lens of the multisensory approach.

Part II details how to implement the MuSense programme within clinical practice. The authors include reference tables regarding how therapists should assess clients. The assessment information provided in the chapter gives examples of the varying levels of behaviour and functioning. Music activities and song repertoire are provided alongside session plans that focus on a body awareness. While many of the songs provided are well known in the USA, they may not be as culturally relevant in Aotearoa New Zealand. For example, *America the Beautiful* is a suggested song for colours, but would not be well-known in Aotearoa New Zealand. However, the authors also include original songs that are adaptable and have musical depth and variety, and are especially useful for new music therapists looking to expand their music therapy toolkit.

The last section of the book, Part III, gives five contrasting case studies (representing different populations and age groups) and detailed more outcomes-based examples of implementing and incorporating MuSense. The case studies are written by Samsonova-Jellison and music therapy interns, with a focus on measuring client progress. This focus on data collection and client observations provides the reader with the expected client outcomes, which is clearly displayed in a chart. The focus in all of the case studies is on the outcomes and responses of the clients. As a new professional, I appreciate and gain more insight reading case studies that include the clinician's thoughts and strategy changes than when I read result-based case studies.

The book also includes chapters not only regarding implementing the MuSense programme but also incorporate it into an already established therapeutic process. The neutral tone of the case studies allowed the focus to be on the results and progress towards goals and clearly conveys how to implement the MuSense programme. However incorporating more material about the therapeutic journey may have added depth and contextualised the case studies for the intended audience of music therapists.

I recommend this book to music therapy students, new professionals, and experienced music therapists adapting to a new clinical population, as a resource providing helpful assessment procedures for recording client background information and data collection charts. I plan to adapt the original music provided in the book into some of my sessions that are

focused on body awareness. Clinicians who are interested in implementing a multisensory approach will be able to after reading the clear introduction in *The MuSense Manual*. While the book is based in a behavioural approach and psychoanalytical music therapists might not find use out of the behavioural methods, music therapists working in an eclectic approach will find it useful and adaptable for their sessions where it is useful. Overall, this book is valuable resource that can strengthen and enhance a music therapist's clinical practice.

Reference

Adler, R. (2001). *Musical assessment of gerontologic needs and treatment: The magnet survey.* St. Louis, MO: MMB Music.

Suggested citation

Gac, V. (2018). [Review of *Music therapy for multisensory and body awareness in children and adults with severe to profound multiple disabilities: The MuSense manual*, by R. S. Adler, & O. V. Samsonova-Jellison.] *New Zealand Journal of Music Therapy, 16,* 161-164.

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Book Review

Moreno, J. J. (2017). *The Lives of Music Therapists: Profiles in Creativity, Volume 1.* Dallas, TX: Barcelona Publishers.

Mahoney, J. F. (2017). *The Lives of Music Therapists: Profiles in Creativity, Volume 2.* Dallas, TX: Barcelona Publishers.

Mahoney, J. F. (2018). *The Lives of Music Therapists: Profiles in Creativity, Volume 3.* Dallas, TX: Barcelona Publishers.

Reviewer: Alison Talmage

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This series of e-books presents profiles of an array eminent music therapists (129[1]in total), often pioneers in their home countries and influential in the international field. In a profession that values lived experience, biographical and autobiographical writing provide valuable forms of knowledge, while challenging us to reflect on our individual and collective, past, present and future practice. Astonishingly, Moreno initiated this book project two decades ago, yet found no publisher until approached recently by Barcelona Publishers.

A discussion of each individual contribution is beyond the scope of this review, but a full contents list is available from the publisher's website.[2] When considering where to begin reading, I recalled Bunt and Stige's (2014) reflection that "naturally we will all choose different people for our inspiration" (p.69). Some readers might explore the profiles systematically, in published order; others might seek out familiar names or models of

[1] This includes two profiles of Clive Robbins, focussing on his work in the USA and the UK.

[2] http://www.barcelonapublishers.com

therapy. My own curiosity drew me first to the known, to grasp the aims and format of the books, and then to less familiar names and places. I was curious about the range of countries represented.[3] Understandably, the books include a high proportion of profiles from the USA, but there is a genuinely international flavour. From a New Zealand (NZ) perspective, I was pleased to encounter Daphne Rickson (NZ), Sarah Hoskyns (UK/NZ), Robert Krout (USA, but the inaugural head of the NZ Master of Music Therapy programme), many distinguished Australians[4], and an array of other international figures.

The profiles vary in style, honouring each person's voice, story and perspective, but follow a broadly common pattern of formative musical and professional experiences, clinical approaches, vignettes and publications. I commend the authors for their candid accounts of the interplay between the personal and professional, and the local and the global – the importance of individual interests, family and culture, and the cross-fertilisation of ideas and influences across our international field of practice.

Every writer highlights a significant relationship with music, usually from a young age and often featuring their primary instruments. For example, Benenzon[5] recalls the influence of his Russian heritage and his mother's singing, but also recounts with humour his discovery of improvisation:

> My parents signed me up for piano lessons at the age of 4. […] My mother used to place a clock on top of the upright piano so that I would do musical exercises for exactly one hour. One day, however, I discovered that I could improvise and create my own

[3] Argentina, Australia, Belgium, Brazil, Canada, China, Denmark, Finland, France, Germany, Greece, Ireland, Israel, Italy, Japan, Netherlands, New Zealand, Norway, Spain, Sweden, UK, USA and Venezuela.

[4] Ruth Bright, Denise Grocke, Felicity Baker, Jane Edwards, Helen Shoemark, Susan Hadley (USA based), Wendy Magee (USA, and previously UK, based), Alison Short, and (incorrectly listed as UK) Clare Callaghan.

[5] Benenzon Music Therapy has been an important of model of psychoanalytic music therapy internationally, but rarely discussed in NZ. For further information, see this profile or Wheeler (2012).

> melodies and rhythms. From that moment on, the process was reversed and my mother would beg me to stop playing the piano in order to eat. (Vol. 1, p. 134)

Ken Bruscia's expertise as a pianist is revealed through three audio recordings. The value of music in our self-care is highlighted by his observation that, while caring for his unwell mother, "My piano lay silent for months. This did not feel like the right time to be expressing myself at the piano; of course, later I realized that I had been wrong" (Vol. 1, p. 657).

Some profiles and vignettes are enhanced by clinical recordings, particularly the examples of Creative Music Therapy[6], and additional examples would enrich the books. Claus Bang's videos, in English and International Sign Language, are drawn from his extensive multimedia publication[7]. It was stimulating to watch Serafina Poch Blasco's videos, narrated in Spanish with English subtitles. I wondered whether publication in English might both support and limit accessibility for readers in different parts of the world, and whether it is feasible for these books to be translated.

What advice do these experts offer? I found much encouragement to develop my own voice, and to prioritise collaboration and communication:

> Challenge yourself to grow and develop; find meaning in what you do; respect all people and professions—don't have a "chip on your shoulder" that music therapy is somehow the best profession; find support, use supervision, and be aware of transference and countertransference issues; keep fit mentally and physically; be a lifelong learner; never stop engaging in reflective practice; and, finally, be bold, try new things, and push the boundaries! (Alison Short, Vol. 3, p. 1396)

Research was also emphasised by some contributors:

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[6] Paul Nordoff, the first of two accounts of Clive Robbins, Carol Robbins, Alan Turry, and Michele Schnur Ritholtz

[7] The original Danish and subsequent English editions are available from http://www.clausbang.com.

> I would advise new music therapists not to sit back and relax. As soon as they get their qualification, they need to start working and researching. […] Without research you don't really realize what work you're doing. I'd also say that they should share their professional work with the other colleagues. […] Communication, the sharing of knowledge, is what makes a profession grow. (Serafina Poch Blasco, Video 1, Vol. 1, p. 170)

Ruth Bright extends this to "the joy of sharing ideas with other music therapists from around the world!" (Vol. 1, p. 545), a theme that permeates these books. I appreciate the authors' generous sharing of their own lives and significant contribution to the history of music therapy, a collective responsibility highlighted by Bunt and Stige (2014).

Each author concludes with their hopes for the future, responding to the question "What will music therapy be like in 2050?" Rickson acknowledges our eclecticism, and focuses on our role in empowering others to engage musically:

> While there are many valid ways of thinking about and practising music therapy, my practice and research have gradually led me to emphasise the ubiquitous and relational nature of music and the ways in which it brings individuals, groups, and communities together, invites participation, and fosters positive relationships. I believe that everyone, rather than a privileged few, should have the opportunity to musick. […] I have a passion to increase the number of music therapists working in early childhood centres and schools who can resource others to reclaim or maintain their natural musicality through ongoing musical "play." […] The challenge is to respond to […] employers who remain focused on evidence-based practice and to find ways of convincing them that other types of evidence are equally valid. (Vol. 3, pp. 1120-1123)

The thoughts of Brazilian music therapist, Lia Rejane Mendes Barcellos, emphasising the local context, also resonate in bicultural and multicultural Aotearoa NZ:

> It is my belief that it is not possible for music therapy to have an overall global trend of development. This, in my opinion, is due to the different cultural environments which influence the way music therapy develops in any particular country […] It is possible to find similarities in the music therapy profession but no global trend, even though we are now living through a time of globalization. (Vol. 1, p.119)

I recommend these books to students exploring the variety of professional practice, experienced music therapists seeking renewal, and everyone with an interest in music therapy. While I would have loved a "coffee table" hard copy, this would be expensive given the scope of the project, and the e-book format is enhanced by video links. I noticed slight discrepancies between the contents list and actual order of profiles in Volume 1, and hope that e-publication eases opportunities for revision.

I hope that these books will not only deepen our appreciation of colleagues and refresh our professional practice, but also prompt the telling of our individual and collective NZ stories. I encourage NZ music therapists to explore the profiles and interviews published in *MusT*[8] and *Connections*[9], and other NZ writing in related genres (Croxson, 2003, 2007; Fletcher, 2016; Hoskyns & Hadley, 2013; Kahui & Hadley, 2013; Molyneux, 2018; Stevenson, 2009) and to consider our potential future individual and collaborative writing and documentary projects.

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[8] *MusT*: Music Therapy New Zealand newsletter, available from http://www.musictherapy.org.nz

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Talmage, A. (2018). [Review of the books *The Lives of Music Therapists: Profiles in Creativity*, by J. J. Moreno (Ed.) (Vol. 1), & J. F. Mahoney (Ed.) (Vols. 2 & 3).] *New Zealand Journal of Music Therapy, 16,* 165-170.

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Publications Alert

This section of the journal highlights recent scholarly publications (beyond the *NZJMT*) by New Zealand registered music therapists. For publications in the *NZJMT*, please refer to the *NZJMT Index*, updated annually, available from www.musictherapy.org.nz/journal.

Alison Talmage
NZJMT Editor

2017

Note, earlier 2017 publications were listed in *NZJMT 15.*

Hoskyns, S. (2017). Profile 19, Sarah Hoskyns, United Kingdom & New Zealand. In J. Mahoney (Ed.), *The lives of music therapists: Profiles in creativity* (Vol. 2) (pp. 388-412). Dallas, TX: Barcelona Publishers.

2018

Edgar, J., Tsiris, G., & **Rickson**, D. (In press). "The screams crashed into silence": A therapeutic songwriting project for young adults with life-limiting illnesses. In A. Ludwig (Ed.), Making music, sharing life: Music therapy in children's palliative care. London, England: Jessica Kingsley Publishers.

Molyneux, C. (Ed). (2018). *Tales from the music therapy room: Creative connections.* London, England: Jessica Kingsley Publishers.[1] (Original work published 2017)

[1] This book includes contributions by the following NZ RMThs: C. **Ayson**, A. **Castelino**, H. **Fletcher**, N. **Hodgson**, L. **Johns**, S. **Storie**, A. **Talmage,** M. **Willis**, and foreword by S. **Hoskyns**.

Rickson, D. (In press.) Interview with Bunt, Hoskyns, & Swamy: The 2nd Edition of Handbook of Music Therapy. *Approaches: An Interdisciplinary Journal of Music Therapy.*

Rickson, D. (2018). Profile 33, Daphne Rickson, New Zealand. In J. Mahoney (Ed.), *The lives of music therapists: Profiles in creativity* (Vol. 3) (pp. 1091-1128). University Park, IL: Barcelona Publishers.

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Rickson, D., Legg, R., & Reynolds, D. (2018). Daily singing in a school severely affected by earthquakes: Potentially contributing to both wellbeing and music education agendas*? New Zealand Journal of Teachers' Work, 15*(1), 63-84. https://doi.org/10.24135/teacherswork.v15i1.243

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Tsiris, G., Papastavrou, D., **Rickson**, D., & Pasiali, V. (In press). A review of Approaches: Analysis of the journal's first decade and its contribution to music therapy and the broader field of music and health. *Approaches: An Interdisciplinary Journal of Music Therapy*.

Policy of the NZJMT

The purpose of the New Zealand Journal of Music Therapy is to extend the knowledge of music therapists, and develop their understanding of their own profession and of the context in which they work. It should also help to promote understanding of the use of music and the place of music therapy in the wider health professional community.

Articles may be accepted which arise from research, clinical and professional perspectives, case studies, interviews of interest, or from experience in music therapy or in related professions. Reviews may be accepted of books, software and DVDs. The journal will publish only original material, except where reprint rights have been sought for an article of particular relevance to New Zealand practice.

Peer Review

All articles will be anonymously peer-reviewed by two or more reviewers, with at least one of them being a music therapist. The Editor shall select reviewers on an annual basis, according to the nature of articles submitted.

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Authors submitting articles for consideration for publication in the *NZJMT* are asked to consult the guidelines in the *NZJMT Handbook*, available from www.musictherapy.org.nz/journal.

Submissions should be accompanied by a cover sheet, available in the *NZJMT Handbook*.

The preferred length of articles is 3500–5000 words (plus abstract, references and optional appendices.) The preferred length of book/resource reviews is 500–1000 words.

Authors should prepare manuscripts in accordance with the *Publication Manual of the American Psychological Association (APA)* (6th ed.), particularly with regard to headings and referencing – but using NZ English or Te reo Māori (with an English translation also provided).

Submissions should be prepared in doc, docx or rtf format, using Times New Roman N12, with double spacing, left-aligned text, and margins set to 2.54cm. Number the pages. Insert a running header (top right of each page) stating the (full or shortened) title, but not your name.

Graphs, tables and figures may be included, if presented appropriately. Authors may need to provide the raw data for graphs. Musical examples should be created with music notation software, such as Sibelius. Both high quality graphics and the original files should be provided.

Submissions received by the editorial team will be acknowledged promptly and sent for peer review. Authors will be asked to respond to the reviewers' feedback, and to work with the editor to revise accepted manuscripts. Once an article has been accepted for publication, the author is required to assign rights to Music Therapy New Zealand.