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Are Community Music Therapy Principles Relevant to my Work with Large Groups of Older Adults in a Residential Care Facility? Finding from a Student Action Research Project

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Community music therapy; older adults; residential care; community music; group music therapy

Abstract

This research focuses on the second-year student placement of my master's programme, at a residential care home. A significant part of my work there was facilitating large, open groups, and due to my background in community music I was interested in whether community music therapy principles would have relevance in this context. I conducted three action research cycles, and in each I collected my practice notes over approximately six weeks. I used thematic analysis to examine this data, and generated actions from the emerging themes for the next cycle. I found that large group music therapy sessions could provide the opportunity for participants, both staff and residents, to experience a shared social space which enabled moments of connection and promoted inclusion, creativity, self-determination, and expanded identities. This suggested that the groups had therapeutic value for the participants. In this article I discuss differences between my community music and music therapy practice, including the possibilities for individual work and use of music therapy theory. I believe that community music therapy principles were relevant to this work, and in particular that taking an ecological perspective was significant. I recommend further research into community music therapy in residential care settings.

Introduction

Prior to starting my Master of Music Therapy degree in 2017, I worked for several years as a community musician in a variety of settings. One of my roles was co-facilitating music sessions for older adults in care homes. These sessions were a cross between a concert and a sing-along, held in the lounge area and open to any residents, staff and visitors who wished to take part. On starting my second-year music therapy placement at a care home, I was again asked to run music sessions for large groups of older adults in communal areas of the home. The groups were open and usually had 10-15 residents involved at any one time, and sometimes visitors or staff would also join in. Participants would vary from week to week, although each group had some regular attendees.

I wondered if I was doing anything differently as a trainee music therapist than in my previous role as a community musician, and whether these groups could really be considered a form of music therapy. I was interested in how I could improve my practice and add value to my work, and I began thinking about community music therapy as an area which might be relevant. Pavlicevic and Ansdell (2004) refer to people they have met who have moved from community music to music therapy. They suggest that community music therapy may be a way of "integrating their past and present professional identities in new ways", and that community music therapy can provide a "conceptual umbrella" which is able to grant legitimacy to a wider variety of music therapy practices (p.17).

I decided to investigate how community music therapy principles might relate to large group work in a residential care home, and whether this framework could help me to develop new skills. Through this research I also hoped to contribute to the wider conversation around the distinction between community music and music therapy, and how these two fields could enhance and support one another.

Literature Review

The Ministry of Health reports that around 10% of people aged 75 and over require residential care (Ministry of Health, 2017). Although this percentage has reduced over the last five years, the number of people entering residential care has increased as the New Zealand population ages. It is estimated that by 2050 around 25% of the population will be aged 65 years and over (Statistics New Zealand, 2016). The 2017 Health and Independence report highlights that "As our population grows and ages, we are seeing more New Zealanders living with disability, long-term physical and mental health conditions, and increasing multimorbidity" (Ministry of

Health, 2018, p.109). The latest Health and Independence report identifies the ageing population as a challenge which will increase the demand on health services (Ministry of Health, 2019).

Music Therapy in Care Homes

There is interest among the professional communities of nurses and caregivers in using music to improve residents' lives, and to improve not only residents' wellbeing but the wellbeing of those caring for them (Eells, 2014; Mendes, 2015; Ray & Fitzsimmons, 2014). A recent meta-analysis of papers investigating the involvement of care staff in creative arts activities with people with dementia in residential care suggested that arts activities had the potential to "facilitate enhanced interactions and improve care strategies", leading to the "recognition and validation of personhood in residents with dementia" (Broome et al., 2017, p.1979). Studies into formal training also show benefits such as increased confidence reported by staff (Beer, 2017; Burrows, 2009; Hsu et al., 2015).

There is also evidence that taking part in music therapy might improve the relationships between residents and caregivers. Melhuish et al. (2017) investigated the experiences of care home staff taking part in music therapy and dance movement therapy with residents living with dementia, over a period of six weeks. These were relatively large, open groups with 8-12 residents attending each week. The researchers found that staff discovered more about residents' abilities and feelings, learned new skills which impacted their care practice, and increased their sense of connection with residents. Similar insights were found for those who attended music therapy and those who attended dance movement therapy.

Pavlicevic et al. (2015) studied improvisational music therapy work by six experienced practitioners in dementia care homes. They found music interactions happening on a person-to-person or micro level, a meso level outside the dedicated session time, and a macro level throughout the care home (p.659). They suggested that community music therapists in a residential care home setting "strategically ensure that work drifts around the entire social and physical space, throughout the day" (p.674), contrasting this to an approach where music therapy is delivered only to certain residents in a specific time and place. The metaphor of the "ripple effect" (from Pavlicevic & Ansdell, 2004, p.16) is used to describe this expansion of music therapy work which is embedded in everyday life in the home. Pavlicevic et al., (2015) also suggested that residents, staff, and visitors can experience expanded identities beyond these roles through taking part in music.

Some studies have focused on the views of care home residents about their experiences in music therapy. Chen et al. (2009) conducted focus groups with nursing home residents in Taiwan about their experience of group music therapy, and found that strength derived from the group dynamic and enhanced quality of life were the main themes identified. McDermott et al. (2014) conducted interviews and focus groups in two care homes in the UK with people living with dementia, and their families, care home staff, day care clients with dementia and music therapists. The interviews focused on the musical experiences of the people living with dementia. The researchers identified three areas in which music had an impact on the individual: it was accessible in the "here and now", it was linked to identity and personal history, and it built relationships or "connectedness" (p.714). Music was also considered to have short term positive effects on mood and to improve the environment of the care home.

Tuckett et al. (2015) conducted focus groups with care staff and family members from three residential care homes about group music therapy sessions. Carers noted that the timing of music therapy groups impacted significantly on their day and their ability to complete their care tasks. Benefits of music therapy were seen to be that it is an activity and social gathering which promotes cognition and exercise. Although there was no clear agreement on the effects of music therapy, there was a general consensus that more music therapy would be beneficial.

In summary, the literature shows that music therapy in a care home environment impacts on, and is impacted by, the wider context in which it takes place. There is evidence that care staff have an interest in music therapy and music techniques, and can enhance their practice by taking part in music therapy sessions or further training. Music therapy is generally seen to increase social connection in care homes and improve understanding of residents' emotional needs. Residents, family members and care staff consider music therapy to be a positive addition to life in a residential care home.

Community Music Therapy

Gary Ansdell's seminal article Community Music Therapy and the Winds of Change (2002) was one of the first works to identify and define community music therapy as a distinct approach, and to contrast it to the "consensus model" of music therapy based on psychotherapeutic methods. Ansdell suggested community music therapy as a "third way" which combines music therapy and community music approaches. He identified the guiding principles of community music therapy as happening wherever music or

music-making is needed, cultivating musical community in the client's context, and working with the natural tendencies of engagement with music.

Community music therapy can be seen as an important way to widen music therapy practice, and to include an awareness of music as a social and cultural phenomenon (Ansdell, 2004). Stige (2012) identifies the ecological perspective, on which community music therapy is founded, as a distinctive element which separates it from other areas of practice. Community music therapy can also be considered as a way to bring music therapy closer to more naturalistic ways of interacting with music, such as learning instruments and performing (Aigen, 2012).

Although a distinction has been drawn by many theorists between community music and community music therapy, in my opinion the boundary is still unclear. Ansdell distinguished community music therapy from community music by the therapist's "experience and expertise in working with pathology and its manifestations" (Ansdell, 2002). O'Grady and McFerran (2007a) interviewed community music therapists and community musicians and identified that community music therapists were more likely to work with people in the acute stages of their illness, to prioritise the individual's ownership and self-expression rather than the final musical product, and to adhere to external ethical guidelines.

In reflecting on her own transition from community musician to music therapist, Powell (2004) considered a community music project to be driven by the performance or product created, whereas in community music therapy the performance is a "by-product" of the therapeutic process (p.181). She also identified the process in community music therapy as being created and owned by the community, more so than a community music project. However, community musicians may not agree with this characterisation; community music theorist Lee Higgins has stressed that the ownership of a community music workshop is shared by all those taking part (Higgins, 2012). Equally, Aigen (2005) argued that creating a performance or product such as a recording can be a natural impulse when engaging in music and a worthy focus in music therapy (pp.116-117).

In reviewing some of the literature in this area, I felt that distinctions between community music and community music therapy could sometimes unfairly characterise community musicians as being product-driven and less responsive to participants. Aigen (2012) suggested a continuum of traditional music therapy, community music therapy, therapeutic community music, and community music. He acknowledged that specific examples of practice may be hard to precisely locate on this scale, and it could be argued that which label one chooses is ultimately of no great consequence, except where it relates to gaining funding or legitimacy.

Community Music Therapy Principles

Community music therapy can be difficult to define as it encourages diversity in approach relative to individual context (Pavlicevic & Ansdell, 2004). However, important qualities or principles which characterise community music therapy work are shared between different approaches. The key principles of community music therapy are often summarised using the acronym PREPARE, which was introduced by Stige and Aarø (2012). PREPARE stands for Participatory, Resource-oriented, Ecological, Performative, Activist, Reflective, and Ethics-driven (Stige & Aarø, 2012, p. 18):

- ***Participatory*** refers to how participation is valued and supported, and the opportunities provided for individual and social participation;
- ***Resource-oriented*** refers to the use of personal strengths and available social, cultural, and material resources;
- ***Ecological*** highlights the influence between individuals and their environment, and how each can affect the other;
- ***Performative*** refers to music performances and also to the ability of participants to perform relationships and identities through music (Steele, 2016);
- The ***Activist*** principle acknowledges that an individual's problems are related to limitations in society, and aims to change this in some way. It also recognises how the attitudes implicit in the music therapy work contribute to wider social change;
- ***Reflective*** practice should include ongoing questioning of the work, individually and with others, to gain better understanding; and
- ***Ethics-driven*** practice recognises the values behind the work, and how it is based in human rights.

Ansdell and Stige (2016) present community music therapy as a movement, reflecting how it has developed in multiple areas and functioned as both a critique of established methods and inspiration for new practice and theory. Community music therapy principles can be considered within a particular context to develop new perspectives and challenge assumptions, with an acknowledgement of how the wider social, cultural and institutional environment impacts on the music making (Pavlicevic, 2012). Community music therapy encourages questioning of who we are as music therapists and what the scope of our role and work is, this being the process I was going through as a music therapy student in a new environment.

A clinical music therapy model would arguably characterise the group music sessions I was facilitating as community music, not music therapy. Aigen (2014) describes some of the clinical practices which music therapy adopted as it differentiated itself from other musical activity. These included regular meetings held with privacy and confidentiality, and working with individuals and small groups in order to have specific individual goals. These did not apply to the large group sessions I was facilitating in communal areas. Community music therapy, however, has different boundaries and practices which encompass a greater range of work.

Research Question

As I considered how to develop my practice from my previous community music work, I felt that community music therapy principles could be helpful. This led to the development of my research question "Are community music therapy principles relevant to my work with large groups of older adults in a residential care facility?"

Methodology

I decided to use action research as it is an orientation towards the research process which focuses on real-world change (Stige & McFerran, 2016). Action research uses action undertaken in context as a way to generate and test new knowledge and practices (Greenwood & Levin, 2007). I conducted three action research cycles where I first collected data for a period of around six weeks. I then used thematic analysis to examine this data, decided on the emerging themes, and generated actions from the themes I could implement in the next cycle to improve my practice.

My main data source was my placement practice notes, including reflections and ideas for improvement. I analysed notes from around 25 group sessions in each cycle, and of these around half were sessions held in the secure dementia unit. In this placement I had time for three research cycles, which moved outwards in focus: from me and my facilitation approach, to the group dynamics, to the facility as a whole.

During the thematic analysis I followed the six-step process outlined by Braun and Clarke (2006), and expanded upon by Terry et al. (2017). This process involves the researcher familiarising themselves with the data; generating initial thematic codes based on interesting features of the data; collating codes into potential themes; reviewing themes for coherence and distinction from one another; defining and naming themes; and producing the final report with selected extracts.

reviewed and approved by the New Zealand School of Music Postgraduate Committee. As I undertook this research as part of the Master of Music Therapy degree, the project was covered under the ethical approval gained from the university ethics committee for the programme (Ethics Approval: 22131). Practitioner action research is covered by this approval. This project was judged to be low risk and consequently was not separately reviewed by any Human Ethics Committees. Pseudonyms are used in all data extracts provided.

Findings

In Cycle 1 I asked "What strategies are effective for engaging large groups of older adults in music sessions?" I found that it was important to "expect the unexpected" and allow space for residents to participate in the session in various ways, which were often unexpected and creative. Enabling communication through a variety of means, including through music and body language, provided more opportunities for residents to participate in the session. I found that music sessions provided opportunities for moments of connection, both for residents to connect with each other and for residents to connect with others, including staff.

In Cycle 2 I focused on encouraging these moments of connection, and asked "How can I facilitate moments of connection between residents, and between residents and staff or visitors?" I found these moments could disrupt typical patterns of behaviour and interaction and allow for something new to occur. Musicing[1] provided opportunities for social connection and inclusion of diverse individuals, and this supported participants to develop and perform expanded identities and social rituals together.

In Cycle 3 I considered how I could encourage music-making to continue after my placement finished, asking "How can I encourage and support staff and visitors to continue music-making after I leave the facility?" I found that shared moments between staff and residents traversed the typical role boundaries, within a flexible environment that promoted autonomy and self-determination. Experiencing the power of music to draw us into a shared

[1] Although it is common in the music therapy literature to use Small's (1998) interpretation of the word *musicking* when describing music-making, I have instead decided to use the related *musicing*, as suggested by Elliott (1995) and used by Ansdell (2004), and more recently updated by Elliott and Silverman (2015). *Musicking* is a broad term according to Small, who defines it as "to take part, in any capacity, in a musical performance", including setting up instruments, cleaning up after performances and taking tickets (Small, 1998, p.9). *Musicing* is more focused, meaning "all forms of music making ... in all types of cultural situations", including playing, arranging, recording, moving and listening (Elliott & Silverman, 2015, p.16). I feel this term is more appropriate for my context, where participation and music-making was the focus of our sessions.

physical, cognitive, and emotional space might have encouraged staff to continue music-making with residents. I have summarised my findings from all three actions cycles into four key statements below.

1. **Large group music therapy sessions can draw people together into a shared physical and mental space, where individuals with diverse needs can be included, participate together, and be supported to communicate with others.**

Residents could find it difficult to connect socially, and music provided opportunities to be social and together with others. This supported the assertion by Stige and Aarø (2012) that music is intrinsically social, and brings people into a social space where interaction is then possible. Participation in the music promoted this social connection. The following example from my notes illustrates this connection:

> Mary and Pat were sat next to each other and I felt that Pat's singing encouraged Mary to join in as well ... At one point they were singing together in between the main lines of O, When the Saints, and they were looking at each other at times so I feel that they were aware of each other. They sang Pōkarekare Ana strongly in harmony.
>
> (Clinical notes, March 28, 2018)

2. **Flexibility in sessions allows space for participants to be creative and experience self-determination.**

Residents did not generally have much opportunity to make choices, so having space for creativity and choices gave them back some of that power. It also allowed them to take ownership of the group and decide on their level of engagement. In this example, a resident chose a Christmas song although the session did not take place near to Christmas:

> I asked for requests during the session and Emily suggested that Richard might have an idea. I spoke to him and he said that we could do a Christmas song "just for a bit of fun". I suggested *Jingle Bells*, as earlier Emily had been commenting on how the bells sounded like sleigh bells. Many residents sang along, particularly with the chorus.
>
> (Clinical notes, September 25, 2018)

3. **Group music therapy sessions provide opportunities for moments of connection, which can disrupt the usual patterns of communication and traverse the boundaries between the roles of staff and residents.**

Shared jokes, memories and experiences of songs were particularly important here, as music allowed staff to join in with residents as equals. Pavlicevic (2010) discussed this feature of certain important moments in group work, stating that "the (socially assigned) identities and roles of therapist and clients seemed to meld: all became people doing 'magic' music" (p.100). A similar levelling effect seemed to happen between staff and residents at my facility, as in this moment:

> One of the caregivers walking past stopped to watch us with the parachute. She suggested going underneath, and hid under the parachute, waving her hand through the hole in the middle. Some residents smiled or laughed and it was a playful moment.
>
> (Clinical notes, August 28, 2018)

4. **Participants can also expand these roles to experience musical identities and social rituals together and perform them for the group.**

Social rituals included good morning songs, shaking hands and clapping after songs. Stige and Aarø (2012) suggested that "shared attention and increased emotional energy" can result from these "interaction rituals" (p.134). These rituals can confirm identity as a group member. Some rituals, such as shaking hands or applause, are also established cultural practices which can be a form of communication. Musical identities included residents who identified as musicians, but also encompassed wider musical experiences. For example, through sharing songs residents were able to share part of their musical identity with the group tied to the time and place those songs came from, revealing something about themselves to others (Stige et al., 2010), as in this example:

> Bethany sang 'come over here nurse and hold my hand', with minimal accompaniment from me, and Kiss Me Goodnight, Sergeant Major which several other residents joined in with.
>
> (Clinical notes, June 13, 2018)

This moment led to a discussion between residents about wartime songs, providing more opportunities to share musical identities.

Discussion

Community Music or Music Therapy?

Through this research I found that large group music therapy sessions could provide opportunities for participants to experience a shared social space, which enabled moments of connection, and promoted inclusion, creativity, self-determination, and expanded identities. In reflecting on my music therapy practice during this period, I felt that it was distinct from my previous community music work in three main ways: I had some ability to transition and direct residents between individual and group work; I was able to draw on music therapy theories; and through studying I had increased personal resources and skills to bring to my work.

My previous community music work was mostly conducted via monthly or fortnightly sessions, as funding allowed. However, during my placement I was attending my facility three days a week, which provided me with much more time to form relationships with the residents and staff, and to work individually with some residents. This gave me greater flexibility in arranging my schedule and in considering what would best meet the needs of different residents. For example, a resident in one group at first found it difficult to be in the group space or to connect with others, becoming very anxious and starting to loudly insult or threaten others in the room. I started seeing her for individual sessions as I felt that this protected one-to-one space might help her to feel more secure, and she responded well in this environment. Staff in the facility wanted her to continue to attend group sessions, to maintain social participation, so we decided on a combination of individual and group sessions. Wood et al. (2004) suggested that individual therapy might be a gateway to group therapy, and over time we did see an improvement in this resident's ability to tolerate and participate in group sessions.

Pavlicevic et al. (2015), when discussing music therapy in dementia care homes, argue that a focus on individuals with an awareness of the wider context could still be said to be music therapy for the community, as the ripple effect means that individual moments and interventions can ripple out into the wider community. In the example above the group sessions were affected by the resident's experience in individual sessions. Dennis and Rickson (2014) describe how the music therapy process can move between individual, small group and community music therapy, to suit participants' needs and desires and to support them in different stages of health and illness.

O'Grady and McFerran (2007a, 2007b) propose that health can be viewed as a continuum, moving from acute illness or crisis, through rehabilitation

and community support to wellbeing. They suggest that for those experiencing acute illness, who are prevented by symptoms or circumstances from being able to function as they normally would, clinical music therapy may be the most suitable approach. Community approaches then become more relevant as the person moves along the health-care continuum towards wellbeing. Most residents live in a care home because they are experiencing acute illness and require a high level of care. It could be argued that a clinical approach with individuals or small groups would generally be most appropriate in this setting, due to the high needs of many residents.

However, the authors recognise that limiting the techniques used with a participant may in fact risk unnecessarily pathologising them if they are ready for more. They also acknowledge that it may not be possible to determine objectively where a person is on the health-care continuum. Excluding all community approaches carries an implicit assumption that those experiencing acute illness cannot access the benefits of musical community and are restricted from experiencing this aspect of wellbeing. In community music therapy wellbeing can be seen as a "situated process" of being, or feeling, well in a situation (Ansdell & Stige, 2016, p.608). There are examples of community music therapy work with participants experiencing acute illness, such as Aasgaard's work with children in paediatric hospital wards, including those with life-limiting illnesses (Aasgaard, 2004). He writes:

> A Community Music Therapy approach in the paediatric hospital involves working towards creative networks wider than the patient–therapist dyad also when curative treatment has failed and palliative care takes over. […] Even very sick patients are often capable of doing more than, simply, suffering and being patient; hospital communities must not make people more helpless than necessary. (p.162)

I felt that even residents who were experiencing an acute level of illness benefitted from large group sessions and the ability to connect with others, even if it was simply through a shared moment of eye contact or touch. One of my findings from cycle three was that music brought people together, and this included my observation that some residents who were often tired or had low energy would seem to be encouraged to participate by a lively group atmosphere. As discussed in the literature review, there is evidence that staff understanding of residents' abilities, feelings and needs can increase when they see residents participating in music therapy (Broome et al., 2017; Melhuish et al., 2017). However, I appreciated having the option to include some residents in small group or individual therapy where this seemed appropriate for their needs.

I also recognised the benefits of being able to draw on other music therapy theories alongside community music therapy. In particular, I was interested in music-centred music therapy as a model which aligned well with community approaches. Aigen (2005) describes music-centred music therapy as an approach where "the musical experience is self-justifying and the primary focus of the therapist's efforts" (p.49). The experience of the musical process is the therapy, and verbal processing is not necessary. I found music-centred theory particularly helpful when working with residents who had advanced dementia, as the music itself was the place where we could connect and communicate when other forms of communication were difficult or impossible. Being able to draw on a variety of perspectives in different areas of my work strengthened my understanding and ability to provide suitable experiences for residents.

Relevance of Community Music Therapy Principles

In each of my action research cycles community music therapy principles had relevance, both in providing context to what I had observed and in encouraging me to look further outwards and increase the scope of what I considered part of my music therapy practice. In particular, exploring music as milieu and ecological perspectives influenced my thinking and practice.

In my large groups I was focused on creating a supportive environment for communal musicing, rather than achieving specific clinical goals for individual residents. Within a smaller group, individual goals can be prioritised and used to direct the group activities. However, in a community-focused group, aims may be directed at the group more generally, such as enhancing group bonding and feelings of belonging (Pavlicevic, 2003). Stige and Aarø (2012) suggest that in community music therapy music should be seen as more than a means (to change a person's feelings, thoughts or behaviour), or a medium (for actions and interactions), but also as milieu, "a setting that includes actors engaged in performance and participation" (p.119). I found that music created a social space where those taking part could perform relationships and experience social inclusion. In these large groups a particular music activity was unlikely to act as means or medium for all participants in the same way; however, music could provide a supportive environment for participants to build community together.

Community music therapy prompted me to take a more ecological view of my work and to consider how the wider environment impacted the residents, rather than just focusing on their diagnoses or individual presentation. Issues which initially seemed secondary, such as where and when sessions took place, were far more important than I had first realised, as the whole

environment of the care home had to be accounted for. I realised how much of an impact my sessions could have on staff; music sessions could be an opportunity for fun and connection or they could make it more difficult to carry out daily tasks. I became more aware of the pressures which reinforced the roles of staff and resident, and how music could provide opportunities to step outside these identities. I saw for myself how music therapy practice in this context is influenced by "cultural, clinical, communal, and industrial forces" (Wood, 2016, p. 90).

"Jointly and Severally"

I have identified some aspects of my practice which reflect the differences of a community music and music therapy approach, and ways in which community music therapy principles were relevant to my work. However, rather than attempting to define clear boundaries between the fields of community music and music therapy so that we can remain in our separate territories, I believe a more helpful approach would be to encourage greater collaboration and sharing between our respective disciplines. This might seem to threaten our separate identities, particularly in music therapy which has historically fought for greater recognition. However, through exploring our similarities I believe our points of divergence and unique skill sets will become clearer, helping us to avoid "unnecessary battles for professional legitimacy" (Tsiris, 2014, p.4). Wood and Ansdell (2018) use the legal analogy of acting "jointly and severally" (p.453): being able to work together or autonomously in a shared area of interest and responsibility. Community music therapy reflects a willingness to expand the limits of what we consider music therapy and to learn from other areas.

Widening our practice as therapists and increasing collaboration with others can also provide greater opportunities to the people we are working with. Participants can then experience therapeutic and community-based music-making as appropriate to them, and be supported to move along a therapy to community continuum (Wood et al., 2004) as they move along a health continuum (O'Grady & McFerran, 2007a), or experience both community and clinical approaches as necessary. The matrix model developed by Wood conceptualises how various "formats" or modes of music-making, such as individual music therapy or workshops, can be equally important and interconnected, and have therapeutic value for participants (Wood, 2006, 2016).

A flexible approach which responds to local needs and makes use of local resources may result in practitioners collaborating or moving themselves along Aigen's (2012) continuum of traditional music therapy, community music therapy, therapeutic community music, and community music. In this

way we can “follow where people and music lead” (Ansdell, 2014, p.206), rather than placing boundaries which we will not go beyond, and collaborate with others to provide a range of pathways into different musical experiences. I hope to be able to approach my work this way in the future, and as a result perhaps fully integrate my identities as community musician and music therapist.

Limitations

I only had time to conduct three action research cycles during my placement, rather than being able to continue investigating. I also decided to use secondary analysis of data, and therefore to wait until all my data for the cycle was collected before starting analysis. I recognise that this may have reduced my flexibility; however, I wanted to ensure that my process was straightforward and transparent. My actions were also restricted to what I could achieve as a student coming into the facility for a limited time. This research reflects one student music therapist at one facility, and further research is needed to determine whether results are applicable to other contexts.

Conclusion

My impetus for this research came from my concern over whether large open groups for residents with varied needs could be considered a valid form of music therapy. Through this research I found that these sessions provided the opportunity for participants, both staff and residents, to experience a shared social space which enabled moments of connection and promoted inclusion, creativity, self-determination, and expanded identities. This suggests that these groups do have therapeutic value, particularly where they are part of a broader spectrum of therapeutic and community-based music experiences.

Findings from this research suggest that community music therapy principles can be relevant for large group work with older adults in residential care. In particular, the concept of music as milieu and taking an ecological perspective were especially relevant in my context. My large group music therapy practice differed from my previous community music work in a few key ways: I had some opportunities to transition residents between individual and group work, depending on what seemed to be best suited to their needs, and I was able to draw on music therapy theories to gain different perspectives and a deeper understanding of the work.

There are areas of convergence and points of difference between all professions who work with people in music. There is a temptation, however,

for music therapists to isolate themselves from others in a bid to protect the status of the profession. My research suggests that it would be helpful instead to pursue productive ways of working with other professions in order to provide the most appropriate musical support to those who need it, regardless of the forms it takes.

Implications for Future Research

Large group music therapy work is cost effective and attractive to residential care homes, and further research is recommended exploring the realities of this work and the different approaches which are taken. In particular, community music therapy in residential care and dementia care is an area which could be explored further. Research investigating the possibilities for collaboration between music therapists and community musicians could help to encourage greater dialogue in this area.

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Appendix

Mind Maps of Individual Cycle Questions and Themes

Figure 1

Cycle 1: What strategies are effective for engaging large groups of older adults in music sessions?

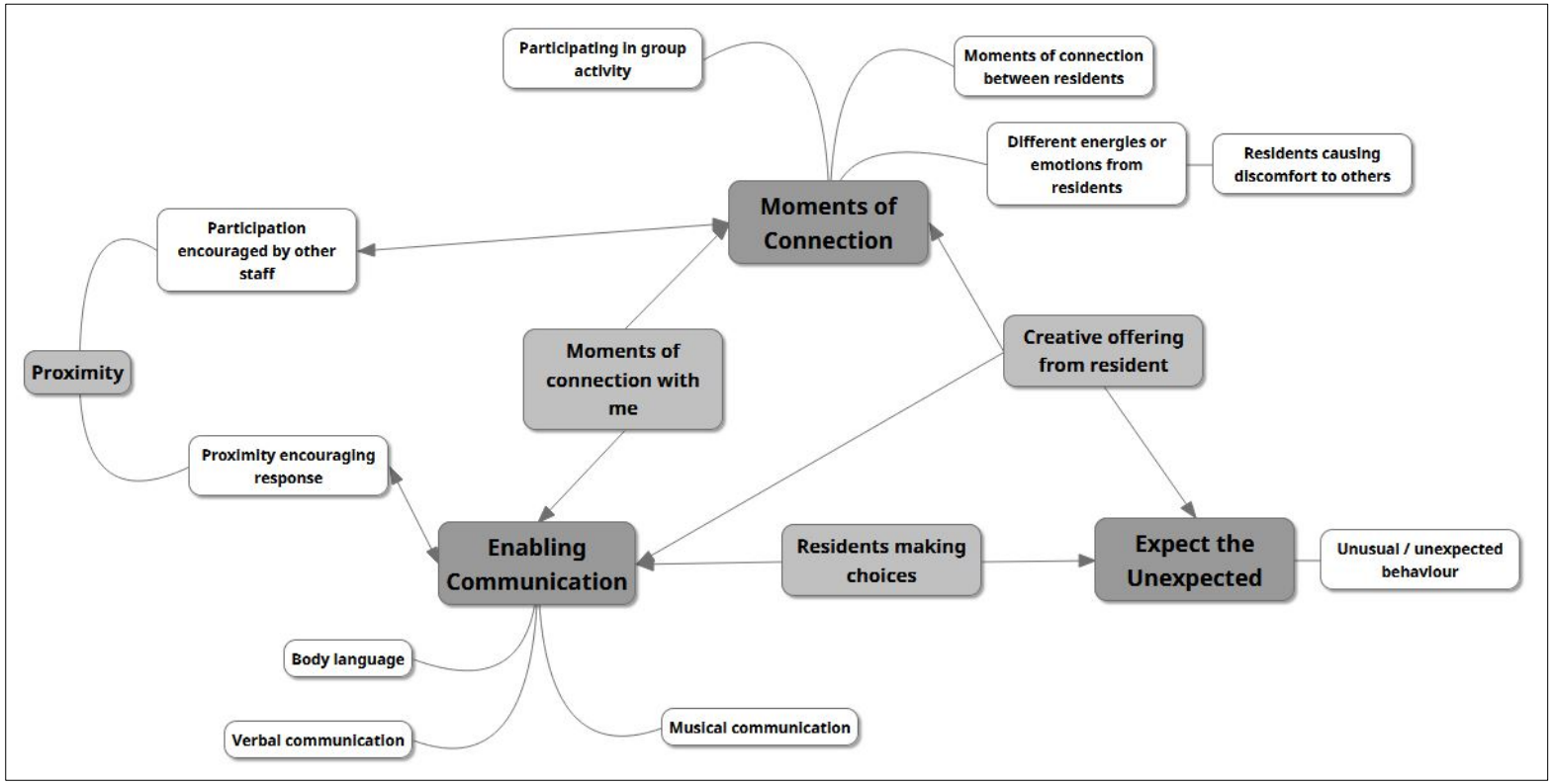


Figure 2

Cycle 2: How can I facilitate moments of connection between residents, and between residents and staff or visitors?

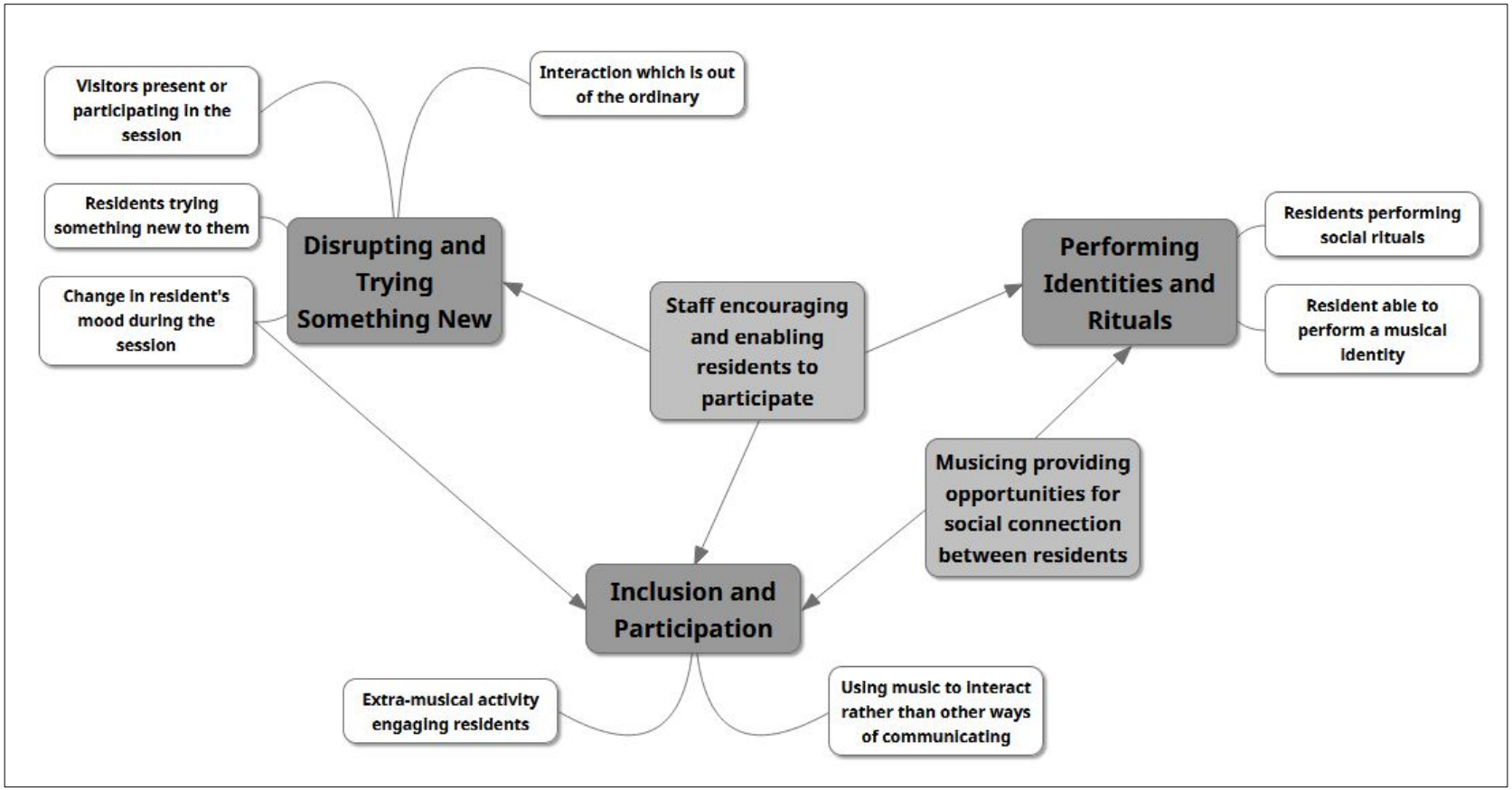
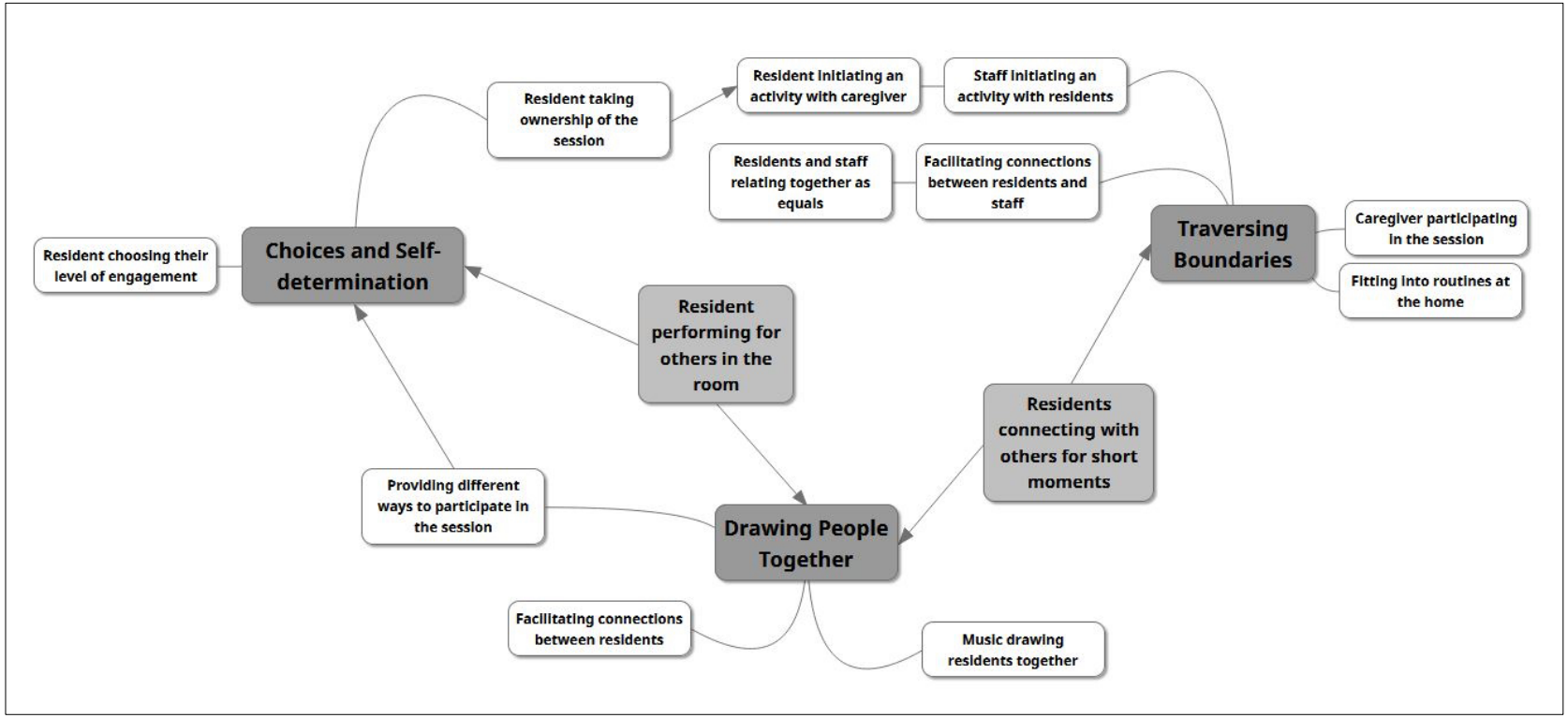


Figure 3

Cycle 3: How can I encourage and support staff and visitors to continue music-making after I leave the facility?



Alt Text for Figures 1-3

The following themes and subthemes are displayed in text boxes in the figures. These bulleted lists are slightly simplified as the visual displays some additional links between subthemes. Asterisked subthemes were identified as particularly important, and occasionally subthemes are repeated.

Figure 1: Alt Text

Cycle 1: What strategies are effective for engaging large groups of older adults in music sessions?

1. **Moments of connection**
    - * Moments of connection with me
    - * Creative offering from the resident
    - Participating in group activity
    - Moments of connection between residents
    - Different energies or emotions from residents
        - Residents causing discomfort to others
    - Participation encouraged by other staff (links with proximity)
2. **Enabling communication**
    - * Moments of connection with me
    - * Residents making choices
    - Proximity encouraging response
    - Body language
    - Verbal communication
    - Musical communication
3. **Expect the unexpected**
    - * Creative offering from the resident
    - * Residents making choices
    - Unusual / unexpected behaviour

Figure 2: Alt Text

Cycle 2: How can I facilitate moments of connection between residents, and between residents and staff or visitors?

1. **Disrupting and Trying Something New**
    - * Staff encouraging and enabling residents to participate
    - Interaction which is out of the ordinary
    - Visitors present or participating in the session
    - Residents trying something new to them
    - Change in resident's mood during the session

2. **Performing Identities and Rituals**

    - * Staff encouraging and enabling residents to participate
    - * Musicing providing opportunities for social connection between residents
    - Residents performing social rituals
    - Resident able to perform a musical identity

3. **Inclusion and Participation**

    - * Staff encouraging and enabling residents to participate
    - * Musicing providing opportunities for social connection between residents
    - Extra-musical activity engaging residents
    - Using music to interact rather than other ways of communication

Figure 3: Alt Text

Cycle 3: How can I encourage and support staff and visitors to continue music-making after I leave the facility?

1. **Choices and Self-determination**

    - * Resident performing for others in the room
    - Resident taking ownership of the session
    - Resident initiating an activity with caregiver
        - * Staff initiating an activity with residents
    - Providing different ways to participate in the session
    - Resident choosing their level of engagement

2. **Traversing Boundaries**

    - * Residents connecting with others for short moments
    - * Staff initiating an activity with residents
    - Facilitating connections between residents and staff
        - Residents and staff relating together as equals
    - Caregiver participating in the session
    - Fitting into routines at the home

3. **Drawing People Together**

    - * Resident performing for others in the room
    - * Residents connecting with others for short moments
    - Music drawing residents together
    - Facilitating connections between residents
    - Providing different ways to participate in the session

Suggested Citation

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