

Music

Music:
Promoting Health and Creating Community
in Healthcare Contexts

Edited by

Jane Edwards



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FOREWORD

MUSIC AT THE HEART OF THINGS

I heard a story recently of a little boy who came home from school and told his mother excitedly that he had learned how to play ‘a gold flute with a green top’. Further investigation revealed that this was a tin whistle! Perhaps it was the same little boy who went up to a musician after his performance and said ‘that must be very hard to play because it’s very hard to listen to’. At any rate, both stories have to stand in line with the one where an innocent but curious music follower asked a world famous classical music virtuoso: ‘do you read music or are you gifted’? These stories carry something of the magic of music, of its mystery, of its humour, and of its unquestionable power – not least its power to heal.

This book resonates with the central themes of the Irish World Academy. Our Academy seems to be about many things – about transitions, mediations, flowings, voicings, birthings, and rebirthings. In these times of rapid change, a central concern is how we might contribute to the local-global dynamic. I call this dynamic ‘lobal’. Lobality is a kind of listening. How can we resonate with this location in such a way as to strike a resonance in the whole earth? For us at the Academy, our listening to the traditional arts of music and dance in Ireland seems to empower us to mediate the duality of the ear and the eye – where the ear listens to the eye’s power, and the eye observes the mystery of pure sound. These flows between orality and literacy are global flows. The integration of the one with the other is a global challenge. The invention and reinvention of the river banks of our structures and institutions is a call we all hear, a challenge we all see.

At the Irish World Academy of Music and Dance we equally enable gesture – from the foot-focus of close-to-the-ground traditional dance, through its various manifestations, and across contemporary and post-modern dance.

Another of our passions lies in the play between, transcendence and spirit – however you understand it. Our grounding is in chant and its ritual context. Again, we come quickly to a meeting of the motions and emotions of healing, with the deconstruction of our struggles and sufferings into a hope-filled remembering of our existence.

And in at the heart of that healing is Music Therapy. Our engagement with it began in 1996. Leslie Bunt and Tony Wigram were our early pivotal figures but carrier of the flame was Kaja Jennsen, at that time Head of Music Therapy at Southern Methodist University in Dallas. In February 1996 I was drawn down to Dallas to meet with her and to look at the program there. My initial impressions of the graciousness of her energy were quickly grounded when in her office I spotted a framed certificate on the wall declaring her to be the best teacher in SMU. I left after making her promise to come to Limerick to help us set up our program. Within months my colleague Helen Phelan and I had brought Leslie, Tony and Kaja together, and something unstoppable started its growth. Two years later, the first professional degree program in Music Therapy in Ireland commenced, and rapidly became a focal point for research, discussion, networking, learning, teaching, and clinical training; with a miraculous return of Kaja Jensen that saved the day when the helm was unmanned in the first semester of the program in 1998.

It was at this early point that the Australian ticket kicked in! Firstly there was Wendy Magee who became our first fulltime faculty member in Music Therapy in the first half of 1999. Rising star that she was, when Wendy moved on at the end of the first year of the course she seemed to create an Australian chorus in her wake – even if a brief Nordic presence warmed the chair for a while through the presence of Bent Jensen and Anne-Steen Møller in the Autumn of 2001; and of course, the arrival of Jane Edwards in October 1999 had copper fastened the process. Australian Angels flapped their wings most provocatively: Vicky Abad, Kat McFerran, and Jeanette Kennelly, all took a turn in the driving seat while the program steadied itself and came to ground.

Now it is Jane's vision that has drawn this book together. In many ways the *Music and Health* gathering at which the idea for this book was hatched was a rite-de-passage for Music Therapy in Ireland. It opened us out to a world of like-minded people. It connected our place with the places of the participants and the authors represented in this text, and in so doing it creates a new shared global space of human dialogue and heartfelt listening about music.

Let me end with a story and with a poem. The story is from ancient Ireland and tells how the Irish hero, Fionn Mac Cumhaill, was debating

with his warriors as to what the finest music in the world might be. His son Oisín thought it might be the cuckoo calling from the highest tree. Another, Oscar, thought it was the ring of a spear on a shield. Others thought of the belling of a stag across water, the baying of dogs in the distance, the song of the lark, the laugh of friendship, or the whisper of a loved one.

‘They are all good sounds’ said Fionn. ‘But tell us’ they said, ‘what do you think?’

‘The music of what happens’ said the great hero, ‘that is the finest music in the world’.

Such a music of course is almost by definition a music that we never would have known to listen for. Seamus Heaney’s first poem in his collection *Seeing Things* is entitled ‘The Rain Stick’, and this is the synesthetic sound we see in our imaginings. Indeed, it may also be one of the quintessential sounds of healing and as such is a fitting sound for the foreword of this book.

The Rain Stick

Upend the rain stick and what happens next
Is a music you never would have known
To listen for...

Who cares if all the music that transpires

Is the fall of grit or dry seeds through a cactus?
You are like a rich man entering heaven
Through the ear of a raindrop. Listen now again.

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*Based on the welcoming address to the ESF Music and Health symposium
at the Irish World Academy, Limerick, September 19th, 2005*

INTRODUCTION

Playing live music with people who are ill to promote optimal states of health and well being is as at least as enduring as the written historical record. Alongside burgeoning music therapy developments internationally there is an energetic movement to provide a broader range of arts practices in healthcare. In Ireland this has been progressed over recent years with funded projects developed in a range of hospital sites nationally, reflecting a similar movement in hospital arts in the UK. Potentially tensions could arise between aspirations held for the ongoing development and progress of the profession of music therapy and other arts health initiatives. An inquiring navigation of these potential tensions is undertaken here through presentation of some of the contemporary practices in the use of music to promote health and well being from authors in Australia, Denmark, Germany, Ireland, the UK, and the USA.

The idea for this book was developed following a symposium held in September 2005. Sixteen colleagues from 8 countries met at the University of Limerick on the theme *Music and Health* in an exploratory research workshop funded from the European Science Foundation. While ESF workshops encourage discussion rather than paper presentations as the basis for these exploratory events there were some short presentations given at the start of seminars to stimulate the group members thinking and debate. All participants who attended were invited to contribute to this book and chapters included here are by colleagues who responded positively to the invitation.

When examining contrasts between the orientation and expertise of these music practitioners, and the contexts in which their arts health initiatives are developed and practiced, as well as the range of ideas as to what constitutes successful outcomes for these developments, it is possible that confusion might arise. However, it is hoped that the reader's reflection on what is interesting and valuable about each of these approaches to the work represented in the book will enlighten them as to the multiple possibilities for music therapy, music and health, and arts health initiatives for people in hospital.

The provision of music as therapy or as an arts health practice in hospital based services is the main focus for this book. However some wider contexts are included; for example the reports of work with the refugee and asylum seeker community in Ireland (Chapter 10) and music therapy in a post war setting (Chapter 9).

In the opening section, programs in three countries are described. Clare O’Callaghan outlines her work as a qualified music therapist in one of the largest cancer hospitals in Australia. Hilary Moss, a qualified music therapist who works as an Arts Officer in a large Dublin hospital, gives an overview of the ways she has creatively developed arts provision for patients. Joanne Loewy is the director of a successful musicians’ wellness clinic, and reflects on developing a role for music therapy in a large hospital service in New York over the past 12 years.

In the next section, Kari Batt-Rawden, Susan Trythall and Tia DeNora provide their sociological perspective on health musicking. Betty Bailey and Jane Davidson present the benefits of group singing.

Researching and evaluating music practices in these contexts is addressed in most chapters however three authors have focused specifically on this topic. Norma Daykin positions music therapy as one type of practice under the umbrella of arts health initiatives in medical care and provides evidence for the ways music therapy and other music practices are perceived in cancer services in the UK. Lars Ole Bonde reports use of a mixed method design in approaching the evaluation of a music therapy project in Denmark with six women who are cancer survivors. Wendy Magee presents her experiences in development of research in music therapy at a London hospital.

The final section provides information about music therapy work with war survivors, older people, and Mothers and their infants from the refugee and asylum seeker community. Susanne Metzner and Constanze Bürger describe music therapy in a post war setting. Alison Ledger presents three cases in which opportunities for musical relating in music therapy addressed psychosocial needs of older adults in long term care. Maeve Scahill, Helen Phelan and I report project work with refugee and asylum seeker mothers and their infants.

The book concludes with a review of some historical sources from the 1890s to the 1940s that have described the use of music in healthcare.

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CHAPTER ONE

MUSIC THERAPY INSPIRED TRANSIENT WARD COMMUNITIES IN ONCOLOGY

CLARE O'CALLAGHAN PHD RMT

Fifty-six year old Rachel was sitting on her bed at Peter MacCallum Cancer Centre (Peter Mac), Australia's only sole cancer treatment and research hospital. She had just been told that her cancer had spread to her bones. We arranged that I would return later to play her favourite hymn and other requests. Rachel smiled as her neighbour, who was recovering from surgery and had overheard our conversation in the four bed room, said she that would also like to listen. Brenda told Debbie, 45, who was later admitted into their shared room for intravenous nutrition, and Debbie then told 42-year-old Dan, in another room, undergoing chemotherapy and radiotherapy following partial tongue removal for a tumour. On my return, Debbie found Dan. Another patient, 48-year-old Peter, was sitting in bed hunched over a bowl, vomiting behind his bed curtain. When I approached and asked whether it was alright to play music in the room he turned his head toward me and nodded repeatedly.

After they applauded "Amazing Grace" varying requests were made: Brenda for Buddy Holly, and Dan for the Eagles. All except Dan sang a few words as I played. In amongst joking banter and memories Dan said that he used to regularly sing in a band. He'd had a good voice but added, "That probably won't happen again now." Dan's speech was dysarthric (slurred) and he was drooling.

I suggested that different vocal cavities can be used when singing and that his singing might be clearer than his speaking. "I might give it a go," he laughed. I then noticed that Dan was quietly singing the next song, Elton John's "Daniel". Led by Debbie, Dan was urged by the others to sing more and, eventually, Dan came and sat with me at the piano and sang. Brenda correctly suggested that we slow down to help Dan's singing. With "Daniel," Dan's voice became stronger, his dysarthria barely

noticeable, and his face was elated. “I didn’t think that I’d sing again,” he said. The patients were cheering him, one was crying, and two nurses arrived and joined in with the singing and danced. I popped my head behind Peter’s curtain and he lifted his head up from the vomit bowl to say that the music was “great”.

Rachel had been smiling and laughing audibly. Her nurse later asked how I “got on” with Rachel. After I described the session, her nurse said, “Well that’s great because she has been miserable the whole time she has been here.”

Music Therapy and Community

A community can be defined as a group of people united by a cooperative spirit. The foundation for conceptualising how music therapy can inspire adult hospital ward communities was established for me in 1981, when I interrupted my music therapy training to gain a social work degree. When teaching in the subject, “Human Behaviour in the Social Environment”, Professor Dorothy Scott showed a family of Russian dolls to illustrate Bronfenbrenner’s (1977) influential paper on how one should consider the “person-in-situation” configuration when aiming to reduce clients’ vulnerability, promote their resilience, and help them to be more content within their ecological system context. Bronfenbrenner introduced the idea that health worker’s attention should focus on the individual and their sociocultural and political contexts, conceived in four levels: 1) microsystem: that is, relations between the person and their immediate setting such as their family; 2) mesosystem: that is, a system of microsystems, such as how the individual’s family interacts with others in their the hospital setting; 3) exosystem: that is, social structures that influence the microsystem and mesosystem (for example hospital institutions); and 4) macrosystem: society values, and ideologies, which can affect music therapy’s existence. Bronfenbrenner’s theory illustrates how the individual client can be helped through clinical, managerial, or political initiatives at any of these levels. It has remained fundamental to how I imagine, and experience, music therapy helping people with life threatening conditions.

The concept of “community”, as used in this paper, is intended to denote the helpful social connections potentially emergent from music therapy being offered in hospital contexts where the focus is on the individual in cancer treatment and palliative care. It should be distinguished from “community music therapy”, a widely used phrase in the music therapy literature for depicting varying conceptions of music

therapy practices with “goals and interventions relat(ing) directly to the community in question” (Stige, 2002).

My professional music therapy experiences over the past 20 years have included neurological, acute oncology, and palliative care settings. My aim is to offer music therapy methods to help patients, and those close to them, cope with arduous illness and treatment experiences. This may be through “catching the moment”, as in the earlier described ward session, but it can also be through long term music therapy relationships. While I have aimed to help patients at the exo- and macrosystemic levels, for example, through lobbying for music therapy funding and actively promoting the improved status of music in health care initiatives in our society, the focus of this paper is on the individual within their micro- and mesosystems. In the cancer and palliative care contexts I have worked, sessions are primarily conducted at patients’ bedsides, sometimes in single but mostly in multibed wards. Here beds are close together and conversations seldom private. I usually wheel in an electric piano and offer up to 7000 songs and classical pieces, alongside music therapy methods which include music based supportive counselling, music relaxation and imagery, therapeutic music lessons, and song writing.

Music Therapy in a Cancer Treatment Context

In the cancer hospital, patients can be highly distressed as they a) endure what can be devastating illness and treatment consequences, b) navigate uncertain prognoses, and c) witness their families’ attempts to cope with their own fears and possible role changes. For example, a spouse may need to take over the role of family breadwinner if the patient can no longer work. I try and fit into the patients’ often busy routines, continuing music therapy sessions as nurses attend to drips, clinical observations, and so on. I usually offer to step out during medical ward rounds and medical specialist visits. Occasionally, however, they say that they will return later, and sometimes even say that what I am doing is more important. Often sessions cease when orderlies come to take patients for X-rays, radiotherapy, and other treatments or tests.

In a multibed ward, if one patient wants music therapy, neighbours who might overhear are consulted for their approval. Alongside receiving music therapy referrals from staff and session observers, I also directly offer opportunities for music therapy to patients, and their visitors, at their bedsides. If other patients also want music therapy, a group session may ensue. However, if the original patient indicated their wish for private time I would sit close to that person and may offer music therapy to other

patients in the room later. Negotiating sessions in multibed wards can be a delicate business.

An 80 year old cancer patient, Angela, welcomed my arrival but Mary, a patient opposite, said she didn't want the music in her room. Angela whispered, "She always gets her way." As Mary did not look in physical discomfort, I asked her whether I could play for Angela very softly for no more than 10 minutes. Mary reluctantly agreed. As I played Angela's song memories, I declined Angela's requests to turn the volume up. But as I packed up to leave 10 minutes later, Mary said, "Please play some more ... have you got 'Edelweiss' and can you turn the volume up?" I did. But then Angela whispered in a louder voice, "See what I mean!"

The potential for music therapy to enable ward communities that help people encounter life-threatening conditions has not received much attention. Deborah Salmon (1989) described "Partage", which was an inpatient palliative care group which she developed at Montreal's Royal Victoria Hospital's Palliative Care Unit. In this regularly held structured psychosocial group patients, visitors, and staff shared inspired reflections about their lives through music and other creative media.

Group song writing with people with advanced neurological conditions enabled mutually supportive expressions, including: a) messages of positive regard for each other; b) shared tributes and grief expression when a significant person died; and c) and shared expressions of humour and camaraderie (O'Callaghan, 1994). A group of patients with advanced neurological illnesses wrote and sang a song to celebrate a wine making kit's arrival to their specialised nursing home.

The New Wine Kit

Chorus: Our new wine kit's asleep
 And we don't know what to think
 At the moment we're having a peep
 And hope that we'll get a drink
 Verse 3: Don't be thinking it's lemonade
 For this brew the roof will raise
 Lifting the rafters with all our laughs
 It'll suit both us and the staff¹

¹ Altered to protect patient identities, which is acceptable and important when describing clinical practice (Mulder and Gregory, 2000).

The patient composers with recent memory loss also remembered their group songs' lyrics with greater ease than when trying to remember standard conversation. This is a phenomenon reported in varying music and cognitive impairment contexts (O'Callaghan, 1997; Prickett and Moore, 1991; Wallace, 1994), and is likely to heighten the therapeutic outcomes of the sessions, improving self esteem and collective enjoyment.

In 1999 Aasgaard questioned, "What can the role of music therapy be when it comes to creating favourable environments?" (p. 31) and proposed that music therapists, who offer activities in the "open spaces" of institutions, have the potential to both disturb people, as well as to create a "therapeutic environment". In hospice contexts, music therapists might be either involved in "prepared sessions" or need to creatively improvise both musically and environmentally. Aasgaard (1999) described one example where a therapist and patient were singing and playing together in a hospice. Overhearing patients outside the room gradually joined in and sang together, improvising and recording their creation.

"There are no antagonisms between an individually directed music therapy and one mainly directed towards the environment. The best possible music therapy in hospices and in hospital is probably a combination of the two perspectives." (Aasgaard, 1999, 41) "Musical environmental therapy" is

A systematic process of using music to promote health in a specified environment A healthy environment ... fosters self-growth and creativity, ... and (is) where people are mutually helping one another to experience hope, joy and beauty. (Aasgaard, 1999, p. 34)

To measure effects (of "musical environmental therapy") ... with quantitative parameters is probably impossible. But to study the *meaning* ... seem far more relevant. Any meanings are connected to the experiences of people, (including) ... patients, relatives, staff and the music therapist's own subjective knowledge. (Aasgaard, 1999, p. 35).

Aasgaard (1999) proposed that music therapy in open ward contexts can enable unplanned therapeutic interactions whereby people, through coming together, help each other. Similarly, I have also found that music therapy methods can inspire these transient (or temporary) ward community interactions, in oncological and palliative care contexts, that is, supportive and enlightening social interactions, which help the patients', visitors, and staff, biopsychosocially and spiritually (O'Callaghan, 2001).

It is not only music therapy that can enable transient ward communities. An exercise or painting initiative may enable them also. In my experience, however, music therapy methods offered in open wards, where patients, staff, and visitors may stay, or come and go, can be very

effective in enabling the development and engagement of transient communities.

Perhaps Aasgaard (1999) and I are describing a comparable music therapy process, but our backgrounds (the Bronfenbrenner system that informs our clinical thinking) lead to semantic differences in how we describe them and how others will also in the future.

Research: Music Therapy Enabling Transient Ward Communities

Doctoral research examining the relevance of my 16-hour-a-week music therapy program, at Peter Mac, provided evidence for both a) how the music therapy program enabled these transient ward communities, and b) how they were helpful (O'Callaghan, 2001; O'Callaghan and McDermott, 2004). Please note that, in this research, I did not aim to investigate these communities in a predetermined manner: their presence emerged in my inductive analysis of the collected data.

Peter Mac comprises mostly three or four bed hospital rooms. In 1999, over a three-month-period, anonymously written feedback about people's perceptions of the relevance of music therapy (that is, what it did and whether it helped) was collected from patients who experienced music therapy (128: 76% response rate), patients who overheard it (27: 50%), visitors (26: 61%), and staff (72 responses). Responses were placed in sealed feedback boxes. I also analysed a 100 000 word clinical reflexive journal, recording my memories and reflections about music therapy's relevance during this time (O'Callaghan, 2005).

Thematic analysis, informed by grounded theory, was used to examine the five sets of data. The textual data was inductively labelled (coded) by me. This means, I did not examine the data for evidence of predetermined labels. Related codes were grouped to inform categories, also developed by me. Related categories were then grouped to inform themes. In this way the vast amount of textual data were systematically condensed into representative themes depicting what varied people thought about music therapy over a three-month period. While these findings have already been published (O'Callaghan and McDermott, 2004; O'Callaghan, 2005), this paper will detail segments of the findings that specifically indicated how music therapy inspired transient, therapeutic ward communities at Peter Mac. These findings can also be used to make logical (but not predictive) generalisations about what music therapy can enable in other comparable cancer and music therapy settings (O'Callaghan and McDermott, 2004; O'Callaghan, 2005; Popay, Rogers and Williams, 1998).

Firstly, anonymous quotes from patients, visitors, and staff that illustrate evidence for the existence, and helpfulness, of music therapy inspired ward communities will be presented. Relevant findings emergent from my clinical journal will then be outlined.

Interestingly, patients and visitors reflected mostly about what music therapy did for themselves as individuals, whereas staff and I reflected more on both individual and ward effects. This can possibly be explained by how health professionals study group therapy (Plach, 1980; Yalom, 1985), rendering it more likely that we would consider group effects as a helpful component of the program.

Anonymous hand written feedback included from patients who experienced music therapy included:

It was a lovely peaceful time that the whole room enjoyed together. (male; 45-69 yrs; 8 sessions)

... I noticed for the remainder of that day everybody in the room was very happy ... and it was also talked about a lot that day with interest ... we actually had a good sing song also in one room with our nurse of the day and I am sure from our talks with each other that day it brought back memories to them as well. (male, 45-69; 1 session).

Also three of us entered an interesting conversation about illness, feelings, desires etc. I found also soul. ... I remembered It was great experience! (female; 20-44; 2 sessions)

It brought the whole ward patients and visitors together for a sing-a-long and a dance. (female; 20-44; 1 session)

Marvelous - stimulating – had others in the room communicating with each other. (male; 70+; 1 session)

... Settles your mind and nerves. As a patient make new friends with a sing a long in the room and talk of the past and the friends you made on the day (male: 45-69; ? sessions)

“Patient overhearers” were patients who were in shared rooms while music therapy sessions were being conducted with others. Feedback included:

... Even joined in and sang (male, 45-69; 2 sessions)

The music played seems to bring back positive memories for everyone and most people sing along to the tunes. (female, 45-69, 3 sessions)

My friend was singing and that made me feel happy. (male: 45-69; 1 session)

Enjoyed the pleasant atmosphere (male: 45-69; 1 session)

Visitors' comments included:

... Had my grand-child with me and to hear "Twinkle Twinkle Little Star" as a request was memorable. (female; 45-69; 1 session)

It joined myself + my mother (patient) in other aspects of ourselves which are overlooked in the hospital routine; + the seriousness of the illness routine. (female; 45-69; 1 session)

Good to see the patients enjoy the music – they joined in singing. ... (female; 45-69; 1 session)

I waited for 2 hrs while mum was elsewhere and hearing the music + people singing along told me that Peter Mac is a sharing + caring place. ~ It's great to see the smiles/happiness a person actually playing and singing brings. (female; 45-69; 2 sessions)

... Everyone in the ward sang along ... + thoroughly enjoyed themselves. We danced along to "You are my sunshine" + had a great fun singing with each other. (female; 20-44; 1 session)

Staff discussed how music therapy helped them work with patients, as well how they felt it helped the patients and visitors. As mentioned earlier, staff wrote more about the community inspired aspects of music therapy than did patients and visitors, and one of the four themes that their textual responses informed was: Staff found music therapy elicited a range of helpful emotions and self-awarenesses, improving individual and team work life, and the ward environment (informed by 56% of the responses) (O'Callaghan and McDermott, 2004). Their written responses included:

... Alters the environment, it softens and humanizes ... It brings joy, especially when staff become actually involved, singing – playing instruments, laughing. Music can be like a catalyst, or "smooth oil" which helps people work together and "work" with patients. Music selection by a patient may help nurses understand more about the patient ... alters the "hospital bureaucratic environment" (nurse: 3-10 sessions)

I ... have been emotionally moved by its effect on the patients. It seems to ... bring them closer to the patients they share a room with. I have

observed patients say to one another “I’m going to miss you”, during a music therapy session. (nurse: > 10 sessions)

I observed patients happily interacting, choosing their own styles of music, making requests, singing or foot tapping, even reminiscing. Sometimes on their own or with co-patients and staff. I also observed staff becoming involved as they worked, humming tunes played by you as they assisted their patients to also be involved. I felt better ... it gave the ward a happier atmosphere and I think it improved morale for the patients and staff

... We walked in ... just as one of the ladies had begun to sing ... (2 nurses, consultants x 2, resident and registrar), and we stood listening until she had finished. Her singing was very beautiful and also very moving, and I felt that we were all very privileged to have witnessed it. (nurse: > 10 sessions)

Many patients are from non-English speaking backgrounds and while there are language barriers and misunderstandings, there are no barriers with music. The patients smile, their feet and hands move (where possible) – they are at one. (administration: 1 session)

... When it (music therapy) ended ... frank discussion took place between myself, my patient and the two other patients in the Ward. (about) ... ~whether men did wear anything under their kilts! – ... – light laughter followed amongst these mature age ladies ~ patients began to give short renditions of other folk tunes... (allied health: < 4 sessions)

Clinical Reflexive Journal

To examine my own perceptions of the relevance of music therapy at Peter Mac, I conducted a thematic analysis on a journal that I wrote about my memories and reflections about my three months of music therapy practice while the data was being collected from patients, visitors, and staff. The coded journal resulted in 20 categories which informed one theme:

At Peter MacCallum Cancer Institute², during three months, music therapy offered patients who engaged in or overheard sessions, as well as visitors and staff, opportunities to encounter dynamic music spaces enabling altered intra-awareness and transient community participation,

² The Hospital’s name has altered to Peter MacCallum Cancer Centre since the study.

although music therapy was not appropriate for everyone. (O'Callaghan and McDermott, 2004; O'Callaghan, 2005)

Codes labelling text depicting how music therapy could inspire these transient ward communities were grouped into five categories: a) patients being with patients and me, in communities; b) "music circles"; c) staff working with music therapy; d) families and visitors sharing music therapy; and e) encouraging patients to participate in music therapy. Space limitations enable only categories a) and d) to be clarified by statements informed by the clinical journal and its codes.

Category: Patients being with patients and me, in communities

"Give him another clap" he said as he slammed one hand up and down on the tray table, because his other arm was immobile (due to a new brain metastasis). He had just watched the patient diagonally opposite get out of bed and play the keyboard.

Patients' life stories, songs, and opinions were shared and validated with families and staff. Staff members' musically inspired stories, dancing, and songs were also shared as they engaged, even momentarily, in sessions while continuing their work. Sometimes music therapy offered a group milieu wherein patients supported each other through their loss experiences and even made practical suggestions for their response.

After one patient sang her song request, "You Don't Bring Me Flowers," she expressed regret about her unfilled life dreams. The patient beside her asked what she was going to do about it and suggested she write them down, take each one at a time, and then she might discover that they are attainable. The other patient said she might just so this.

When reliving memories patients sometimes discovered items that they had in common. Occasionally they became so immersed in their conversations, I felt redundant.

Two patients were sitting quietly in a room and, at the beginning of the session, described different music tastes and did not seem to have much in common. War song requests prompted their discovery that, after the war, they rode the same motor bikes. Much laughter punctuated memories, as they recalled their antics in these machines, with unusual attachments, including machine gun holsters.

The following patient declined music therapy, and then joined his neighbour's session as he witnessed it in their shared room. Upon closure he said:

It takes your thoughts away from what's on your mind (paused, tears), and it brings people together, the three of us, even though I have different musical tastes to Bob, we could still find something in common and it brought us together (looking at another patient and me).

Some patients seemed to have solitary experiences within the group or a dyad. In one session, a blind patient continually requested his favourite old time songs, alternating with another patient who requested classical pieces in between his vomiting. Occasionally, patients and families asked me to play other peoples' requests, suggested who I should visit, and encouraged others to try music therapy. Patients, however, did not always wish to engage in these transient ward communities. They may have simply observed the others, continued reading or, occasionally, left the room.

Category: Families and visitors sharing music therapy

You will never believe what's happening. Someone is playing the piano for mum and she is singing. (Daughter on the phone to her brother, at her mother's bedside, three days before their mother died.)

Music therapy provided opportunities for the patients to converse with or to share non-verbal communication with their families. Patients and families possibly identified with the lyrics as, for example, when one couple took each others hands just when the lyrics, "and grace will lead me home" were sung during "Amazing Grace". Tears, eye contact, and hand-holding were regularly observed as patients' and spouses' musical requests were played. Some visitors sat with the patient during music therapy, seeming to offer a supportive presence even if not actively participating, while others enthusiastically danced, sang, and shared stories.

Music sometimes transformed a quiet room, where a patient may have been sitting in bed, with a family member quietly beside, into a forum where their memories were shared, laughed or grieved about, and massaging touch emerged, affirming their significance in each others' lives, verbally, nonverbally, and musically. When people share music, a mutual supportive presence may be cast that transcends words. Distress can be shared.

Lyrics may have also conveyed special messages. On my arrival, one patient requested the song, (“I’ll be loving you”) “Eternally”, just as her husband was about to leave. Patients were also able to share significant moments with offspring through the sessions. A young patient was inspired in music therapy to play percussion instruments with her toddler and borrowed them to play in between sessions.

Category: Negative or negligible effects

Aasgaard (1999) suggested that music therapy in open ward environments could disturb. The research on my journal also elicited the category, “negative and ambivalent considerations about what music therapy did”. In my journal, I questioned whether the public music therapy program could reinforce one’s “powerless patient identity”. Hearing about music therapy one patient said, “Aren’t hospitals a place for peace and quiet?” A session was not held in his room. Sessions could also be a forum wherein patients could be denigrated. Someone who had been listening to his classical music requests laughingly stated, “From the sublime to the ridiculous,” when another patient requested country and western music. Once a staff member sang in a mocked operatic voice while I played, which seemed to help her, but not the patient. Also when a staff member asked for “happy music” for a patient who was crying, and patients tried to get another subdued patient to choose a request, I thought how the way music therapy was offered in the open wards contexts could potentially invalidate the way that some people just simply needed to “be”.

Research Conclusion

Transient ward communities were evident at Peter Mac when music therapy enabled a music space, characterised by people creatively experiencing their musical selves, in supportive and enlightening social interactions. Biopsychosocial or spiritual benefits in patients, visitors, and staff were evident. While group sessions may have been pre-planned, they usually evolved in patients’ rooms as patients, visitors and staff became involved for entire, or parts of, sessions, dependent on their personal preferences and treatment requirements. Anonymous feedback from people experiencing music therapy in the cancer hospital, and my personal journal, revealed that music therapy often allowed the human spirit to triumph in a treatment context where the fragility of human mortality was ever present, through these transient ward community interactions.

These findings highlight the profound impact that music therapy could have on staff. The importance of maintaining cohesive team work and reducing stress amongst those who work with patients with life threatening illnesses is often emphasised (Kelso and Turley, 1989; Murrant, Rykov, Amonite and Loynd, 2000; Rezenbrink, 1981; Zollo, 1999). Support sessions, where staff could freely discuss feelings related to their work, was reportedly met with resistance in one hospice because they felt they were being “treated” themselves (Beszterczey, 1977). This research about music therapy, however, illustrates that non-intrusive opportunities for staff support exist though simply providing music therapy on the wards in which they work. This was especially highlighted when a nurse witnessed a very ill cancer patient struggle out of bed to play the piano. With tears she said, “I was thinking about resigning but I don’t think I will now.”

Final Thoughts

While this paper focused on music therapy inspired ward communities amongst patients, visitors, and staff in shared oncology wards, the scope for such similar co-operative and helpful social interactions, enabled by a music therapist’s presence, is evident beyond the four walls of a hospital room. For example, patients and their carers can be helped through their cancer experiences by such interventions as music therapists helping someone to write a song with messages to loved ones, enabling a staff drumming group, and organizing hospital concerts. The question of “What is music therapy?” is inevitable as we consider this potential. A widely held view is that a music therapy relationship is necessary for a music therapy interaction (Suzanne Metzner and Brynjulf Stige, conference paper discussion, 21/9/05). Witnessing the myriad of ways that music therapists can help people through community interactions in oncology (and palliative care), has inspired me to expand my conception of this “relationship”, from one denoting only those directly participating in the music based interaction, to also encompass people who witness sessions and choose to engage independently. Such “vicarious” music therapy encounters are evident, I believe, when someone indicates that they have been helped, such as Joan with her grief process:

Joan had refused music therapy but had watched Mary sing songs from her childhood the previous week. She later found me and asked (concerned), “Did you know that Mary is in Room 6 (single room) and mightn’t last long? (smiling) Wasn’t it wonderful the pleasure she had with the music last week?”

Also, in the aforementioned research, one of the “overhearer” patient respondents had written that overhearing a favourite piece of music reminded her that she had a lot to live for.

As a music therapist working with people with life threatening conditions, and those close to them, I believe that it is my task to use whatever music and communication skills I have, in a professionally informed manner, to help people directly or indirectly encounter their treatment and illness experiences. This may be through long term therapeutic relationships, or through “here and now” moments with people I may never see again, such as in many of the transient ward communities described above. Enabling a music space in clinical settings, responding to people living with life threatening conditions, in which participants may experience and share joy, laughter, messages, support for loss, and the fulfilment of a special wish, is an important part of my work, and the longevity of these positive effects should not matter in this work. Of the 207 patients who agreed to participate in music therapy at Peter Mac during my research, over one quarter (at least 26%) had died within seven months of the end of data collection, and 58% of the 409 patients who were offered music therapy, had advanced or end-stage illness, that is, they required palliative treatment or care. Good quality moments, especially for these people, matter.

Frida saw my guitar as I was walking in the radiotherapy waiting area and introduced herself. Eventually I discovered that she was a guitarist and we immediately played together in the waiting area after receiving permission from nearby patients. On hearing us, one of the patients, Hazel’s, anxiety was immediately reduced, according to radiation staff. They also said that this made it much easier and quicker for them to prepare her for treatment. Hazel ended up joining a makeshift band just before one radiotherapy treatment, which included Frida and a radiation therapist on the guitar. I drew up a chart so that Helen could play metallophone notes to support the chordal framework. This spontaneous “catch the moment” music making might be ignored by other patients on these waiting areas, but sometimes they really get in the groove. While we were playing there, one very breathless outpatient stood up, hunched over, and requested “Dance of the Seven Veils” (the strippers tune) as she started taking her clothes off, only to be met by humorous cries of, “No, No, No!” from complete strangers in the waiting area. When I rang Hazel, two months after treatment, thanking her for sending me a photo which her husband took of our session, and to ask for permission to use this story, she said.

... I was in a real state when I got there. Doing this made me come out of myself. That’s how I really am. Best thing I ever did. I was in a real mess. ... Now I think about those good happy times, ...and I have a laugh. I tell everybody (in her community) about the orchestra and how David

(radiation therapist) called it “Hazel and the Nuts” (laughter). It helped me through it all, made me forget about everything else. John (husband) and I kept laughing about it for weeks.

A pastoral care colleague says how Peter Mac seems like an ocean, where “the human tide of suffering just keeps washing in” (Helen Mugg, personal communication, August 9th, 2005). Hopefully, in our work, we can help some people, on their own or with others, to catch a wave and even swim against the tide.

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CHAPTER TWO

DEVELOPING MUSIC THERAPY PROGRAMS IN MEDICAL PRACTICE AND HEALTHCARE COMMUNITIES

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This chapter will provide an overview of the institution and development of a medical music therapy program, tracking the growth of a service which began twelve years ago on one unit of a medical center, and which has expanded into a hospital-wide service, and most recently into a Center for Music and Medicine at Beth Israel Medical Center in New York City.

In the hospital environment, there is a commitment to aggressive intervention and a consensus amongst hospital specialists that any test, agent or strategy which will affect the possibility for positive change, should be available and readily accessible to patients. Practitioners keep a careful watch on the patient's physiological response to interventions, as well, in order to monitor shifts and changes. Medicine is thought to be the primary restorative influence that will effect influential change in a patient's ability to heal. The inclusion of music therapy, as an integral component of medical treatment challenges historic conventions in the delivery of hospital services.

As music therapy is a unique discipline, and one that can provide unconventional incentive to the promotion of change in physiological and ego states, understanding its impacts, especially within quality of life parameters is key to the growth of our discipline. This knowledge in turn challenges the profession, and most importantly those who may benefit from music therapy services.

Background

The Louis and Lucille Armstrong Music Therapy Program originated in Pediatrics at Beth Israel Medical Center, in 1994 through an initial five year grant commitment from the Louis Armstrong Educational Foundation, which has continued since that time. Additional grants from foundations and pharmaceutical companies have supported the delivery of music therapy services while additional funding has been attained for research and public symposia¹. In 1996, the program expanded to include service to HIV outpatient services for children and families and in 1997, music therapy was initiated in the medical center's pre and post operative areas.

Whereas the initial referrals for music therapy in the early work came directly from the medical center's Pediatric staff, the program gradually began to include adults, particularly family members of Pediatric patients. This reflected the way in which an understanding of music therapy was expanding within the hospital and the department was growing. The music therapy team began to provide in-services on other units and also started accepting referrals from adult units.

This ongoing development has been the result of a number of factors. Our day to day music therapy sessions were integral to the development of the service. We documented the effects of individual and family treatment and provided this feedback to the medical team. As well, our team provided frequent in-servicing for staff, and offered experiential groups to staff, particularly for residents in training. On each of the units serviced, we attended ward rounds which increased our referrals. In addition, our assessment form was instituted with a bar code to secure its permanence in the medical record. The studies undertaken in pain management resulted in an eventual reliance on music therapy's presence in procedures such as; veni-punctures, biopsies and circumcisions. We began pilot research that included measuring the impact of music therapy in sedation for tests, both pre-operative, and post-operative (Loewy, Hallan, Friedman and Martinez, 2005).

Our early attention and tabulation of these specific areas of need led us to identify significant lags of service as well as generalised needs within the medical center. These included 1) noise and stress in the Intensive Care Units (ICUs), 2) asthma-non-compliance, 3) high volumes of patients

¹ 1997 Music Therapy and Pediatric Pain (Sponsored by Astra), 1999 Music Therapy in the NICU (Sponsored by Con Edison), 2002 Music Therapy in Grief and Trauma (Sponsored by AMTA/The Grammy Foundation), 2004 Music Therapy at End of Life (Sponsored by Smithe).