

ADULTS WITH NEURO-DISABLING CONDITIONS: EXPLORING THE
WAYS MUSIC THERAPY CAN SUPPORT RESIDENTS IN A LONG TERM
CARE FACILITY

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Abstract

This exegesis presents findings which emerged from secondary review of clinical practice data collected during a music therapy placement. The setting for this research is a long-term residential care facility for people with a variety of physical and neurological conditions, including cerebral palsy, traumatic brain injury, stroke and multiple sclerosis, aged 18 to 65. The aim of the facility is to maximise the quality of life for people with physical disabilities and those with terminal illnesses. The research aim was to develop theory about how music therapy can provide support to people with long term neurological conditions. Thematic analysis was employed to develop core themes about the support that music therapy has provided. These findings are presented under the following six themes: building relationships, collaborative practices, fostering community, acknowledging diversity, emotional support and musical engagement. These themes all focus on relatedness, and the quality of life of individuals, groups and the community. They also indicate the value of a flexible community-centred approach for delivering music therapy. A vignette from clinical practice is included to illustrate important points made in the exegesis. The study complements other music therapy research situated within a health-care perspective and could offer particular significance for new music therapy practitioners looking to understand and work with people with neuro-disabilities in long term care facilities.

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Introduction

The purpose of this research was to explore my experience of involving adults with neuro-disabilities in the music therapy process at a residential facility, and to present my own theoretical perspective with regard to this practice. The research was carried out over a period of ten months of a student music therapy placement. The broad reflective question for the study was:

‘How can music therapy support adults with neuro-disabling conditions in a long-term care facility?’

Hundreds of millions of people worldwide are affected by neurological disorders.

Approximately 6.2 million people are life-limited because of stroke each year (World Health Organisation, 2014). In New Zealand, the most common cause of disability for adults is disease or illness (42 percent), and 53 percent of all disabled people have more than one type of impairment (N.Z. Statistics New Zealand, 2014). The Ministry of Health (N.Z. Ministry of Health, 2015) summarises neuro-disabilities as including: brain/head injuries, encephalitis, meningitis, unspecified neurological disorders/disabilities and other brain/nervous system disorders.

It is difficult to describe long-term care for people with neuro-disabilities in clear ways as statistics cross a number of care providers and diagnostic areas. Nevertheless, it is clear from a number of websites, including Statistics New Zealand and The World Health Organisation, that there is a need for provision of quality of life in residential facilities. The majority of the research appears to focus on acute care, palliative care and dementia care.

Neuro-disability

‘Neuro-disability’ is an umbrella term for a wide range of disabilities stemming from long-term neurological conditions which cause damage to the brain and nervous system (Magee, 2005). Neurological conditions are complex and account for a high number of years lived with disability (Wilson and Aubeeluck, 2014). Neuro-disabilities affect motor, communication and cognitive abilities and most result in profound changes to many aspects of an individual’s life. Where patients have an acquired condition such as traumatic brain injury, multiple sclerosis, or cerebro-vascular accident (stroke), this can cause ‘multiple and complex disabilities because the brain damage is often global’ (Nayak, Wheeler, Shiflet &

Agostinelli, 2000, p. 116). The emotional sequelae that frequently follow acquired brain injury can interfere with a person's re-entry into the community.

The research and the research facility

The research took place in a long-term care facility catering for adults aged 18 to 65, experiencing physical and neurological impairments. Residents were experiencing both congenital conditions such as cerebral palsy, and moderate to progressive conditions such as multiple sclerosis. Other residents had previously suffered events such as cerebro-vascular accidents (stroke), or sustained traumatic brain injury from motor vehicle accidents and other traumatic events.

The environment was spacious with a large lounge that doubled as a meeting room, and there was a space at the back of the lounge, not immediately visible to everyone, that catered eventually for many sessions of music therapy. There were up to 35 people residing at the facility at any one time. The term 'resident' will be used to describe the people living and receiving care at the facility.

The facility already provided for some rehabilitation and therapy through gymnasium sessions for mobility, seated aerobics for rhythm-assisted movement, a varied activities programme encompassing art and music activities, games and meditation, among other nourishing and interactive pastimes.

One of the overall aims of the care facility was to provide health-care services that promote life to the full by enhancing the physical, intellectual, social and spiritual dimensions of being human, while maximising the quality of life and well-being of its residents. Values paramount and integral to care were Manaakitanga (Hospitality), Aroha (Compassion), Whakaute (Respect), Tika (Justice) and Hiranga (Excellence).

Music therapy was introduced at the facility to provide another vehicle for participation, emotional expression and general opportunities to develop well-being for this population. Both individuals and groups received music therapy with full assessment taking place prior to therapeutic goals being formulated.

The policies of the facility state that carers, management and the residents are valued as people. The atmosphere on arrival seemed open and welcoming, the hallways occupied by carers, management staff and residents all coexisting together with the feeling that the

environment belongs to everyone and everyone is accepted and valued. The facility encourages collaboration with other service providers, and a life and work balance is respected.

Personal position

My background is as a trained teacher in New Zealand and overseas, and I have come to music therapy at the ‘twilight’ of my working life. I am excited by this pioneering profession in New Zealand, and the possibility of combining my passion for music with the opportunity to develop therapeutic relationships with people. I see this as being an immense privilege.

I was attracted to a qualitative approach during my research as it feels closely aligned with how I might work in clinical practice. I am still developing my personal approach to music therapy but my overall philosophy is humanistic and person-centred. I would like to work with adults with neuro-disabilities among other populations.

As a singer-songwriter I have a special interest in creating songs with people in therapy, knowing that this can be a freeing and powerful experience. It is a vehicle favoured in this study as a way to support people’s emotional well-being.

Structure of the exegesis

The study begins by defining the main topics under discussion in this paper, then provides a review of relevant literature. The research methods are then presented. An overview of my clinical practice demonstrates how the practice took shape at the facility and changed and consolidated over ten months, and a clinical vignette presents a descriptive and reflective account of a particular aspect of the work. The theoretical perspective developed is then stated, followed by the findings, presented under six main categories or themes, each supported by excerpts from the data. The final discussion contains any literature relevant to the findings.

Literature Review

The review covers a necessarily broad field because of the range of client groups found in long-term care environments. Further literature will be introduced as it informs the research. The setting for the research is long-term residential care for people who have experienced neurological illness or trauma and who have since been medically stabilised, therefore this review will focus on longer term support. There has been a lengthy tradition of music therapy in long-term care but the many and varied conditions that people present with in these types of contexts can contribute to a quite complex environment. While there is considerable literature on acute hospital care and intense interest in ‘Neurologic Music therapy’ (NMT), I will only refer to this area if it informs long-term support. The keywords for searching the literature have been music therapy, neuro-disability, neuro-rehabilitation, psychosocial emotional approaches, collaboration and long-term care. The databases searched have been the Massey University Library’s integrated search tool ‘Discover’, which multi-searches Ebsco, Scopus, Medlink, NAMT, Psych Info and Eric. Google Scholar has been reviewed as well, for information about the citing of seminal works. The broad scope of literature informing the practice has meant that articles within the last ten years have been prioritised.

Long-term care

Residential-styled environments for physically challenged people with neuro-disabilities are rapidly replacing the standard institutional skilled nursing home (Regnier & Denton, 2009). The literature indicates that there is little evidence of the types of support needed for people living in long-term residential care with neurological conditions, internationally (Wilson & Aubeeluck, 2014), but that there is considerable material in the related fields of neuro-palliative care and dementia settings.

An ethos of personalised and tailored care is seen as important in long-term care settings as are patient-led care and goal setting (Daveson, 2007). There are many frameworks for developing music therapy that link to the values of quality of life and well-being in a community of care environment, consistent with philosophies of care in long-term facilities, for example holistic care, the care of the whole person. The Ministry of Health supports this premise discussing the relationship between holistic care and its contribution to quality of life and well-being. Holistic approaches address cognitive, social, emotional, and functional aspects of brain injury together (Wilson, 2002). This idea is complemented by Bunt’s view

(1994, p. 3) that ‘music therapy is best delivered in a humanistic framework where the emphasis is on growth rather than treatment’.

In a related study for dementia patients, twenty-eight reviews were carried out supporting psychosocial interventions emphasising the importance of consideration of the individual’s life context. The authors concluded that the most promising interventions, including music therapy were those that were individually tailored and behaviour-oriented (Vernooij-Dassen, Vasse, Zuidema, Cohen-Mansfield, & Moyle, 2010).

Group music therapy in a long-term care setting can allow clients to continue to use their music in an ongoing way to maximise their health and well-being, and groups can promote a sense of belonging (O’Grady & McFerran, 2007). These authors stress that both individuals and groups feature in long-term care and music therapy can have a wide-reaching support in both of these contexts.

Another trend favoured in the literature for residents in long-term care environments generally is independent living, as much as this is possible. Examples of this could encompass increased levels of exercise for clients with neuro-disabling conditions, and access to activities in the community to enhance independence.

Community music therapy is an approach to working musically with people in context. (Stige, 2002b). While a community can be a geographical place it can also be a temporary collection of people whose circumstantial community is a hospital or residential place (Stige et al., 2010). Stige’s (2002a) discussion of practice, theory and research in CoMT proposes that ‘two main notions of community music therapy exist: a) music therapy *in* a community context and b) music therapy for change *in* a community. Both notions require that the therapist be sensitive to social and cultural contexts. The community becomes a context not only for work but also a context to be worked with. Both variants of community music therapy suggest the relevance of project-oriented approaches in which sometimes the therapy process of several groups or individuals may belong to the same community music project. Community music therapy is necessarily ecological, since individuals, groups, and communities function in and as systems’ (p. 328).

Mercedes Pavlicevic (2004) uses a metaphor to describe community music therapy: ‘music naturally radiates, like dropping a pebble in a pond and ...the waves of energy spread out in concentric circles (p.16). Other authors agree that the basic premise of CoMT is that its

therapeutic effect can reach beyond the ‘closed doors’ of individual clients’ spaces, to the whole of the institution and their broader communities, i.e. it becomes an ‘open door’ approach. This can be designed to suit clients’ needs according to their health and well-being, countering isolation that can arise with clients with restricted independence (Dennis & Rickson, 2014; O’Grady & McFerran, 2007 ; Wood, Verney & Atkinson, 2004;). CoMT thus differs from the traditional closed door approach in music therapy, where the therapist works solely with an individual client, particularly where clients are not mobile.

Music therapy and neuro-disability

The therapeutic use of music is widely documented as being valuable in the field of neuro-disability and having a significant role to play (Baker & Tamplin, 2006; Bradt, Magee, Dileo, Wheeler, & McGillivray, 2010; Magee & Davidson, 2002; Weller & Baker, 2011). A definition that closely aligns itself with the philosophy of long-term care environments comes from the World Federation of Music Therapy: ‘Music therapy is the professional use of music and its elements as an intervention in medical, educational and everyday environments with individuals, groups, families, or communities who seek to optimise their quality of life and improve their social, communicative, emotional, intellectual, and spiritual health and well-being’ (World Federation of Music Therapy, 2011).

Historically music therapy in this field has tended to focus more on functional and communication issues than psychosocial issues, where ‘the tasks of emotional coping and the role these skills play in treatment are often overlooked’ (Wong, 2004, p. xi), but this is beginning to change, as supported in the literature by a number of authors (Baker & Tamplin, 2006; Durham, 2002; Magee & Andrews, 2007; O’Kelly & Magee, 2013).

Tamplin (2006) regards dealing with emotional issues as particularly important with people with long-term neurological illnesses as unresolved negative emotions or social behaviours can impact on a person’s ability to participate in the overall context of their rehabilitation.

Although agreeing with the therapeutic potential of music therapy in rehabilitation, Paul and Ramsey (2000) concluded from their study that full potential of client participation is rarely observed. Maranto (1993) previously ascribed this to such factors as pain, fear, anxiety or lack of motivation.

In a rationale for conducting music therapy with people with neuro-disabilities, Magee (2005) states the growing evidence that music assists with neuroplasticity, enabling connections in

the brain to be made between healthy and damaged centres of the brain. Magee emphasises that music is an innate ability in all human beings, citing the vocalisations of infants long before they learn language, as part of this rationale. Furthermore, the idea that music provides an organisational framework and elicits emotional response gives more veracity for the inclusion of music therapy in such programmes.

After reviewing the literature, it is clear that a number of authors are in agreement about the efficacy of music therapy in settings with adults with neuro-disabilities, but mixed results are highlighted by more than one author (Paul & Ramsey, 2000; Weller & Baker, 2011).

Weller and Baker (2011) conducted a systematic literature review of the role of music therapy in rehabilitation and found that although studies showed that music can be employed to connect the physiological, psychological, cognitive and emotional components of rehabilitation, further research would be needed to explore all of these components in this setting. The authors in the review agreed that music therapy can encourage motivation, stimulate long term memory, and provide a space for cognitive, emotional and social functioning while also incorporating physical functioning exercises. However they are cautious about the music therapist working in physical and neurological settings because 'Music therapists do not have the training to complete neurological assessments' (p. 60).

Music is perceived as sound and is processed in both left and right hemispheres of the brain. (Altenmuller, 2004). Baker and Tamplin (2006) state that singing and talking share neural pathways and activate similar regions in the brain. More importantly, the authors stress that when speech regions in the brain are damaged, singing songs can assist in recovering speech function.

Johansson (2011) in a later review of literature supporting music therapy and neuro-disability, found that music listening activates many brain structures and has the effects of improving attention, verbal memory, and emotional adjustment in stroke patients.

Early references in the field (1980's and 1990's) suggest that music therapy can be key to the recovery of former capabilities, often referred to as restorative care, and that this can improve the quality of life for those with progressive long term neuro-disabling conditions (Aldridge, 1991; Jones, 1990; Magee, 1995).

Tamplin (2006) argues that people with brain injuries sometimes have limited ability to explore emotional responses using verbal means, so music can help in enabling the

expression of loss, grief adjustment and anxiety. Durham's case vignettes also support these observations, describing how reminiscence work and singing familiar songs with patients with short term memory difficulties can help access long-term memory (Durham, 2002).

Magee & Andrews (2007) write about the value of music therapy in patients with acquired brain injury resulting from cerebro-vascular accident or stroke. They assert that it can stimulate the brain functions linked to speech, with melodic intonation being the most studied intervention programme in this area. Thaut (2007) indicated that rhythmic auditory stimulation can synchronise motor movement and improve motor function in stroke patients. Clair, Pasiali & LaGasse (2008) suggested using music accompaniments to provide rhythmic structure for movement. They also recommended choosing musical instruments for their therapeutic potential to maximise physical movement such as range of motion, strength, finger dexterity, and coordination.

Baker and Tamplin (2006) state that singing and talking share structured patterns of sound and neural-physical pathways for sound production. In speech recovery music therapists can use melody to improve pitch variation; rhythm to improve stress and phonation; and singing to promote comprehension. Neurologist Oliver Sacks (1998) agrees that strategies like singing songs about tasks and instructions can help embed sequence in brain-damaged clients. He also supports the idea that familiar music can help recall emotion, long-term memory and identity.

Music therapy in neuro-rehabilitation

Since the 1990's there has been an expansion of the clinical applications of music therapy in this area, (Aldridge, 2005; Baker & Tamplin, 2006; O'Kelly & Magee, 2013) and there are indications that music therapy can help to address meaningful, functional skills such as independence and emotional adjustment in the treatment of the whole person (Baker & Tamplin, 2006).

A pilot study looking at the effects of music on mood states of people with acquired and complex neuro-disabilities, (Magee & Davidson, 2002), found a significant difference in mood states in people between pre- and post-music therapy interventions in a positive direction. The scale used was 'The Profile of Mood States' with the method being a single-subject design. Recognising that music therapy was quite new in neurological rehabilitation, the authors concluded however, that the findings warranted further investigation to find out what qualitative data might emerge, given that clients with neuro-disabling conditions

generally are at risk from fluctuating mood states. The limitations of the study were that only two sessions of music therapy were used and the authors agreed that replication of the study would be needed to confirm these findings.

The research and practice of music therapy in neuro-rehabilitation internationally is relatively new, and its provision differs broadly around the world (Magee & Andrews, 2007). Tamplin (2006) notes it has been practiced in the UK and USA for the past 20 and 30 years respectively. In Australia, Felicity Baker established the first music therapy programme in neurological rehabilitation in 1992 (Tamplin, 2006). Tamplin describes working in this setting as a still-emerging area of practice and provides a brief rationale for the place of music therapy in clinical rehabilitation services in her study at the Royal Talbot Rehabilitation Centre in Melbourne, Australia. One of the goals in that setting was to enhance the hospital's interdisciplinary rehabilitation approach towards the achievement of patient rehabilitation goals. Results included increased staff knowledge about music therapy and collaborative work. The programme provided qualitative and quantitative data demonstrating the positive effects of music therapy in the rehabilitative process. For example, it was found that music therapy offered a non-verbal means for externalising and working through the social and emotional issues that may arise as a result of hospitalisation and adjustment to trauma. For some patients with recent brain injury, music therapy was provided when no other therapy was possible because of the incapacity of the patient's condition (Tamplin, 2006).

Other areas addressed through music therapy in Tamplin's 2006 study included relaxation, pain management, and sensory stimulation, alongside the meeting of various physical, functional and communication goals. The establishment of this programme in a large public rehabilitation facility is a testament to the ongoing development of Australian music therapy practice in terms of both research and clinical practice. However, the author emphasises that there is a lack of understanding of the part music therapy can play in neuro-rehabilitation generally and that there needs to be more rigorous research in the field.

In the UK, the primary role of music therapy in neurological settings appears to be rehabilitation of communication skills, physical rehabilitation, with social and emotional health being cited as secondary reasons (Magee & Andrews, 2007). Magee (2005) found that for non-verbal patients, music therapy provided a supportive intervention for the exploration of feeling states, and improvisation allowed patients to respond in a spontaneous way.

Models for rehabilitation and recovery

Rehabilitative music therapy has been described as ‘the use of musical experiences and the relationships that develop through them as a means of helping clients who have been debilitated by illness, injury or trauma to regain previous levels of functioning or adjustment to the extent possible’ (Bruscia, 1989, p. 98).

For rehabilitation in neuro-disability, a multi-disciplinary approach has been recommended by many authors (Baker, Tamplin & Kennelly, 2006; Magee, 2005, 2008; McNab, 2010; Wilson & Aubeeluck, 2014), with supportive care needs being interwoven into more physiological needs. This approach recognises that those with progressive long-term conditions have complex needs that require psychological and social factors to be taken into account as features that enhance quality of life (Magee & Andrews, 2007). The need for adaptable models of music therapy in care within the fields of neuro-disability and neuro-rehabilitation, alongside the need to demonstrate outcomes has also been identified in the literature by these authors.

Different models for the inclusion of music therapy in clinical settings, and psychosocial approaches and their importance have been highlighted by many authors in this field, (Daveson, 2007; Magee & Davidson, 2002; Nayak et al., 2000). Psychosocial approaches in music therapy, according to the British Association of Music Therapy (2012), use music to enable emotional expression, engagement in social interaction, and adjustment to disability.

A three-pronged meta-model for music therapy, known as MIND (music therapy in neuro-disability) provides an adaptable model within neuro-disability and neuro-rehabilitation. Daveson (2008) describes the three approaches of this meta-model as restorative, compensatory, and psycho-social-emotional, and illustrates these by using case vignettes of work with those with brain injury and neuro-degenerative disease. The rationale for the meta-model is that it allows a multi-focused approach for patients with brain injury and neuro-degenerative disease who can present with various types of needs at one point in time. It is a patient-centred and patient-led practice model, and uses a standard approach to goal setting, the SMART goal, ‘Specific, measurable, attainable, relevant and time related’ (Maidment & Merry, 2002, as cited in Daveson, 2008, p. 71), although a drawback with this patient-led care approach may be that not all patients are able to give consent. Interesting discussion/controversy was indicated by Gilbertson and Aldridge (2008), who argued the limitations of the meta-model were: the danger of using the approach prescriptively, in other

words pre-determining a course of treatment; and compromising the creative processes involved in music therapy practice. They concede, however, that the meta-model highlights the importance of the way research evidence is communicated and incorporated into clinical practice, and that the meta-model also attempts to address the basic demand for contemporary literature in music therapy.

Collaborative interdisciplinary practice

Those with progressive long-term neurological conditions have complex needs and in the community this care requires a multi-disciplinary approach (Magee & Andrews, 2007). There are indications in the literature that professional collaboration is important in the field of neuro-disability and neuro-rehabilitation when working as a music therapist: working in a team can provide opportunities to share the divergent skills, knowledge and experience which individuals can bring together (Magee & Andrews, 2007; O'Hagan, Allen, Bennett, Bregman, Lumsden & Wallace, 2004; Paul & Ramsey 2000). Collaboration with other professions while working with people living with neuro-disability, also offers music therapists the opportunity to acquire essential skills and theoretical and clinical knowledge specific to a clinical area which they may not have acquired in training (Magee & Andrews, 2007). In exploring perceptions of music therapy in rehabilitation settings, the authors above assert that where music therapy is integrated into a team it is perceived as having a particular role in rehabilitating both communication and health needs, and that this approach ensures optimal outcomes from referrals, and a broader application of music therapy. In these interdisciplinary settings, clients' potential is maximised; for example, an occupational therapist might work with a patient on communication needs and the music therapist, in collaboration, might work with the acoustic environment improvising a musical exchange to relax the client and decrease discomfort.

Alternatively, some members of the multi-disciplinary team may work with clients on functional recovery while, music therapists help integrate tactile, auditory and visual senses of clients and help them express themselves verbally or musically. (Tamplin, 2006).

O'Hagan et al. (2004), in their description of collaborative working, highlight 'interdisciplinary collaboration' which may best suit the context of this research, as it is where clients' needs are paramount and therapeutic agendas are put aside to work collectively as a team. The authors say that working this way is important for music therapists specifically in New Zealand. This is because in comparison to other music therapy communities in the

world, music therapy has a small professional body which can result in professional isolation, and consulting with other similar professions is important.

Twyford and Watson (2008) found that collaborative approaches are an essential part of music therapy and that these need to be acknowledged and recognised within training courses in music therapy. Anecdotal studies of practice show that multi-disciplinary work can be valuable for people with neuro-disabilities. Durham (2002) discusses an example of this collaboration where an occupational therapist working with a music therapist resulted in a therapeutic intervention synchronising music with breathing for the patient.

Magee, Brumfitt, Freeman and Davidson (2006) support an inter-disciplinary approach to address functional communication in complex neural communication disorders, for example a collaboration between an occupational therapist and a music therapist might mean working on function and expression respectively.

Magee (2005) asserts that music therapy can offer something unique to a multi-disciplinary team working in a rehabilitation setting. The music therapist could, for example, provide specific information about how the patient is experiencing the acoustic environment and make suggestions about how musical sounds can be manipulated in terms of pitch and volume to aid the overall therapeutic experience. Magee reflects, however, that an apparent lack of understanding of the role music therapy plays in therapeutic outcomes, seems to be a barrier to its implementation in a multi-disciplinary team. Tamplin (2006, pp. 44–45) found that while working with other allied health professionals, ‘therapists can be more empathetic and effective in their own work’.

Music therapy methods and techniques

A range of music therapy techniques including song-writing, improvisation to encourage musical dialogue, listening to and discussing songs, and music-assisted relaxation, were described in the literature as useful in assisting people with neuro-disabling conditions to express themselves verbally or musically, and to develop listening skills, information recall, concentration and abstract thinking (Tamplin, 2006). The positive effects of group singing have also been identified as being important for mood, health and well-being for non-clinical populations (Clift & Hancox, 2010).

Tamplin (2006) also describes a rehabilitative music therapy programme where patients interact with percussion instruments as being effective for developing various types of attention skills, for example, sustained selective attention. Song-writing as a therapeutic intervention was brought to increased attention in 2005 when Baker and Wigram revealed that many music therapists had developed unique ways of using song-writing with different clinical populations (Baker & Wigram, 2005). Baker and Tamplin (2006) then completed a survey using songs in therapy as a first in the area of neuro-rehabilitation, highlighting the sharing of songs and stories for use in generating lyrics for original song writing. The predominant themes were of adjustment to disability and developing a sense of identity.

The study into the practice of song-writing over clinical populations around the globe carried out by Baker, Wigram, Stott and McFerran (2008) involved 477 professional music therapists across 29 countries, its purpose being to find out how prevalent song-writing was in clinical practices internationally. The goals of the interventions focused mainly on adjustment issues, externalisation of thoughts, fantasies and emotions, and developing a sense of self. The study states that song-writing can be regarded as an important intervention within neuro-rehabilitation, as indicated by the substantial number of respondents, and the authors urge further investigation and discussion of this method in music therapy.

Paul and Ramsey (2000) describe the use of specially adapted musical devices such as midi devices that aid fun and musical experiences. Midi can convert muscle movements into sound to provide a musical experience thus providing fun alongside a musical experience, as well as working on impaired muscles. This idea is endorsed by Bruscia (1998) when he reflects that when people can create sounds that are powerful they feel that they have more control over their environment.

Summary

Several approaches have been found to be effective in the field of long-term care of neuro-disabling conditions, such as person-centred holistic care, lifestyle plans, community music therapy, and independent living in as much as this is possible. The therapeutic use of music is widely documented as being valuable in the field of neuro-disability and has a significant role to play as one component of holistic care. This has been endorsed by many authors in this review. The shortage of positions in this field might suggest a lack of understanding, however, about potential for working in neuro-rehabilitation, and several authors have commented on the lack of rigorous research in music therapy in long-term care. Collaborative

approaches are seen as important for the sharing of skills and knowledge in a rehabilitation environment. There seems to be scope for further investigation of therapy in long-term care settings; for example, the literature suggests that more psychosocial approaches might be important so that patients' emotional needs are met. Many authors agree that this approach is as important as meeting physiological needs in music therapy, asserting that if emotional needs are met, then recovery models focusing on restorative/compensatory functions and communication will be more effective because patients will be relaxed and able to deal with more rigorous therapy.

Research Methodology and Methods

The focus of the research was to describe the ways in which music therapy can best support adults with neuro-disabilities in a long-term care residential environment. I took a qualitative approach, critically reflecting on my clinical data to provide my own interpretation of the value of music therapy in this setting and developing a theoretical perspective regarding my research question. This methodology, relies on naturalistic methods of interpreting, observing and analysing to ensure an adequate dialogue between myself as researcher and the people I interact with. Lincoln and Guba (1985, p. 71) stress the importance of this collaboration ‘The construction of realities must depend on some form of consensual language’.

The research approach is constructivist, reflecting the belief that there can be no absolute shared truth, as knowledge is constructed by individuals’ backgrounds and contexts (Guba & Lincoln, 2005).

The chosen design was secondary analysis of data from clinical documentation. Secondary analysis is best known as a methodology for doing research using pre-existing statistical data (Heaton, 2004). It means to look again, observing patterns, drawing knowledge and making interpretations from the data.

Data collection

Data was collected as part of my clinical practice and detailed notes were kept of the various therapeutic experiences offered at the facility. Data sources included supervision notes from meetings with my visiting registered music therapist, reflective diary notes, notes from meetings with the rehabilitation and therapy team at the facility, and a series of data sets from six sources of data to ensure a broad representation of data (three individuals and three groups).

Data analysis

Drawing closely on analysis of data and existing literature, the method of data used in the study is thematic analysis. Dey (1993) describes this as a process of coding, sorting and organising data. Braun and Clarke (2006) state that ‘thematic analysis offers an accessible and theoretically flexible approach to analysing qualitative data’. An inductive approach to thematic analysis allows themes to emerge from the data, rather than searching for predefined themes or categories. The result is a rich and detailed yet complex amount of data.

Coding was used for all six data sources, where themes were highlighted and grouped to form categories. When conducting thematic analysis, analytic memos were written in a reflective journal to link my thoughts with the original data sources, where relevance to other literature, critical questioning and suggestions in response to the data were noted. Taking each theme separately and re-examining the original data for information relating to that theme was a vital stage in the analytic process to ensure the relevance of the data.

I also used peer review, an evaluation of professional performance or products by other professionals (Denzin & Lincoln, 2011). The process meant consulting with another music therapy student to look at the data and propose themes with regard to addressing the research question appropriately. Peer review helped to ensure that the categories fitted into the themes appropriately.

At this point in the research process, Braun and Clarke (2006) suggested further refining the themes in a hierarchical manner along with sub-themes and codes or 'nodes' to capture the 'essence' of what they are about. Organising the themes in this hierarchical manner really helped clarify the whole process. Appendix 1 sets out these themes and sub-themes in a thematic map.

Overview of my process

(see samples of analysis in Appendices 2 and 3)

1. Entered data into Excel documents
2. Open coding, by naming emerging patterns or themes
3. Finding/critically analysing codes
4. Combining codes into categories and sub-categories
5. Re-assessing until no new categories were identified
6. Writing analytic memos throughout the process or later when reflecting
7. Carrying out close analysis of data with existing literature in mind.

Although I began working inductively there was some deductive analysis employed to reaffirm themes towards the end of my analytical process.

I took into account the concept of reflexivity described by Tolich and Davidson: 'Reflexivity is the idea that social researchers always remain part of the social world they are studying' (2011, p. 39). Working in this way required reflecting upon and questioning my own values

and any assumptions I made during the research. I looked carefully at my own work to eliminate any biases caused by my own values impinging on the research.

Ethical Considerations

I abided by the Code of Ethics for the Practice of Music therapy in New Zealand (New Zealand Society for Music Therapy, 2006), and the Massey University Code of Ethical Conduct for Research, Teaching and Evaluations using Human Participants. I worked from the ethics template approved for music therapy students undertaking the thesis paper NZSM Casework and Research.

I received regular supervision from supervisors at the New Zealand School of Music campus, and with a visiting music therapist to discuss any issues, challenges or queries that arose during the ten months of the placement period.

I gained informed consent from the facility in which I worked for clinical data gathered as part of my practice to be used for research purposes (Appendix 4: Request for Permission Letter to Facility), and consent from a resident to use our clinical work together for a vignette to illustrate the broad findings of the work (Appendix 5: Consent Form for Vignette). I also obtained permission to use supervision and meeting notes (Appendix 6). Secondary analysis was undertaken at my place of study where data was de-identified and kept in a secure location.

I spoke to some residents about the nature of my study and all the usual precautions were taken with regard to health and safety issues. While consultation with Māori was not a formal part of the building of the research, conversations were held with appropriate people at the facility and at Massey University throughout the study to ensure that any research outcomes would contribute as much as possible to the ‘tangata whenua’ (see Glossary of Māori Terms, p. 50) of New Zealand.

The results will be communicated to Massey University and may be published in a music therapy journal within New Zealand or further afield.

Clinical Practice

The shape of the practice changed throughout the ten month placement, with my role initially being one of observation and learning about adults with neuro-disabilities. I outline how the role changed to accommodate the needs of the residents as I became more informed about the practice. The context for the work was to provide an environment where people supported each other and made meaningful connections.

During the first three months, I worked alongside individuals, building relationships with them and exploring their interests, capabilities and musical choices. Goal-setting with people about what they would like to achieve during their music time was a feature also. The next step was familiarising myself with the profiles of the residents, their care needs, lifestyle plans and goals as part of my assessment process. Discussions with the rehabilitation and therapy team were valuable here also, with referrals made to me on the basis of who might benefit from music therapy interventions.

A clinical liaison was assigned to provide coordination of the student placement and to provide opportunities for facilitating music therapy sessions. This was a valuable relationship where I could raise issues when and as needed and gain useful ideas about how music therapy could complement other programmes operating in the facility.

The initial sessions took place in people's rooms, but by the start of March with the forming of the music making group, we needed a bigger space and moved to the piano room at the back of the main lounge. This was important as music therapy, and myself as a therapist, could now be visible and more accessible for larger numbers of people.

It became clear that part of my role was *supporting people to participate* in musical engagement in some shape or form best suited to their diverse needs and interests. People could decide whether to join sessions of their own volition, and also come and go as required. When appropriate or requested, closed-door therapy was provided to individuals for privacy, safety and other reasons.

Informal therapy, group improvisation, and spontaneous in-the-moment therapy started to shape the practice as I began to work more flexibly, with people communicating with me about how best to support them. This was really rewarding and not as labour intensive as facilitating groups in non-communal places where much organisation and time was required

in setting up. More time was spent in the presence of music and this developed a real sense of community of which I became an integral part. Over the last two months this became the main way of delivering music therapy and for supporting people in a social, rehabilitative and health-related way. The placement became less about clinical practice and more about an ecological framework with features of community music therapy (see Discussion section of exegesis). The following table summarises the whole range of music therapy experiences provided to each client group during the placement. For my analysis, I chose three of the individual clients and the first three groups in the table, as my data sources (see Data analysis section).

Overview of music therapy experiences offered over whole practice

Individual therapy 1/2/3/4/5/6	Active music making group	Women's group (Residents with progressive conditions)	Large group – collaboration with activities staff	Large group/community get-togethers
Singing and conversation to facilitate engagement and motivation	Support to build repertoire and make music together	Music assisted relaxation and mutual enjoyment	1. Seated aerobics – rhythm assisting with movement coordination	Support to participate and make choices
Mastery and song writing	Support to achieve independence	Making choices	2. Vocal groups eg. duets and acapella groups	Build resources and tools for large group engagement
Speech production for client with dysarthria	Support to create original compositions	Comradeship and reducing isolation	3. Theme nights – support residents to participate eg. Spanish theme	Celebrations
Percussion activities to develop attention and listening skills.	Providing tools and resources for group to manage themselves	Making connections with others		Show -casing of individual or small group performance items
Song writing to explore emotional adjustment and a sense of identity.	Support others to provide appropriate percussion for group	Exploring loss Of independence		Incorporating community group in with other functions
Collaboration PT and MT – early training for cause and effect and pre verbal communication (CS)	Support to learn new skills/enhance other skills	Exploring coping strategies eg. sense of self		Involving family , visitors and staff
Walk in/spontaneous therapy depending on daily needs		Goal setting with the group		Facilitating shared concerts

Findings

The research question for this exegesis is: *'How can music therapy support adults with neuro-disabling conditions in a long term care facility?* My findings have demonstrated that music therapy can support adults with neuro-disabilities through the gradual development of therapeutic and collaborative relationships, and the simultaneous facilitation of musical engagement and provision of emotional support, which in turn fosters a sense of community. The acknowledgement of diversity is central to the work.

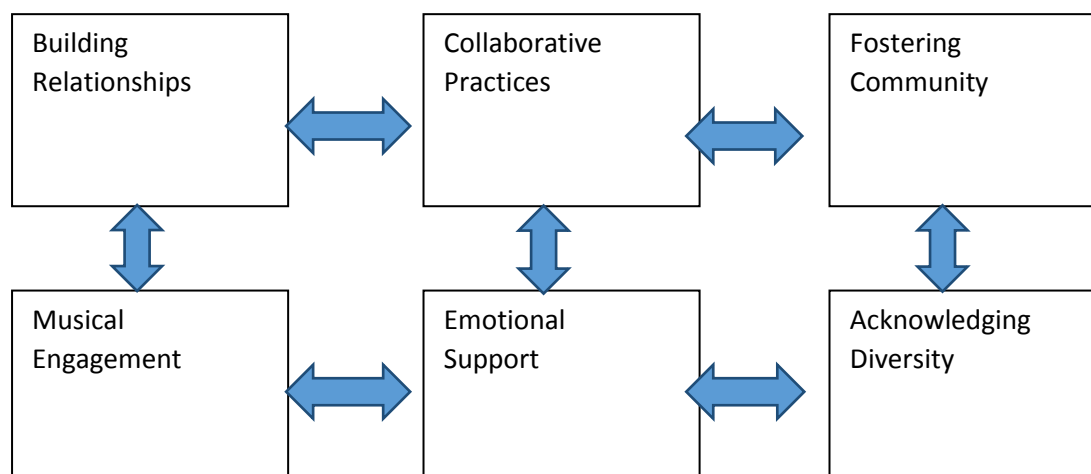
In this section, the development of my theoretical perspective is described, followed by the in-depth clinical vignette. The analysis of my research is then presented in the subsequent sections, organised under the six themes, with descriptions and critical reflections and includes excerpts from the data to provide supporting evidence. Related literature can be found in the Discussion section, following the Findings.

Theoretical perspective

Over the course of the study, I developed my theoretical perspective regarding the validity of support that music therapy can offer, by identifying six key areas of support. These are illustrated in the diagram below. I found that within a long-term care facility across groups and individual work there was a consistent following through of these six themes. Obviously these findings relate specifically to one setting but could help inform other long-term care facilities about how music therapy can best support adult residents with neuro-disabilities.

I discovered when analysing the data, that at times it was difficult to confine identified codes to just one theme. There were many overlaps as codes were considered important in more than one context; for example 'support to participate' and 'song-writing and lyric substitution' can be found over more than one theme. The six themes, important in my evolving practice, are connected in various ways; their inter-relatedness is illustrated in the following diagram.

Music therapy supports residents in long term care facilities in the following ways



To maintain confidentiality, people are de-identified and the following abbreviations will be adhered to in the findings. Residents will be referred to as R, clinical notes - CN, reflective diary notes - RD, supervision notes - SN, and meeting notes - MN.

The findings are first ‘brought to life’ (illustrated) with a short extract of practice that I was engaged with during the placement. The music therapy described below illuminates a number of the themes identified in my analysis and was a case which interested me and was quite typical of the individual work that I undertook.

Vignette of Music Therapy Practice

‘Connecting with the music therapy process to create an original composition’

Sophie

Sophie¹ is a woman in her fifties who has suffered a right-sided stroke (or cerebrovascular accident) at age 43 and has been living in supported care for 13 years. I began talking to Sophie in an open gym session I was observing. I noted that I had not seen her around the facility before and learned that she preferred to stay in her room and take her meals there. I noted in my reflective diary that music therapy might be good initially to help decrease isolation for her. Sophie’s communication skills were extremely well developed and she was able to hold clear intelligent conversations during music therapy sessions. She had been a librarian and had home schooled her five children prior to suffering a stroke. During the

¹ My participant’s name has been changed to protect her identity in this research

initial sessions of building trust and rapport with Sophie, I found out that although wheelchair-bound at present, her goal is to walk again and regain her independence. Our first few sessions revealed Sophie's somewhat fluctuating motivation, and a dry wit!

'That's a nine inch nail song'. (Johnny Cash 'Hurt') We both laughed. CN 22/2

Music has been a large part of Sophie's life and she shared with me that she enjoys varied styles from folk to opera and that she draws immense pleasure from listening to music and appreciating it.

'I identify with opera, I like story and song'. CN 6/3

'Musical conversations would start with one artist and develop into natural discussion about several artistic styles and artists'. CN 16/4

Sophie and I made a connection straight away, through our love of 60s and 70s music, and from there we negotiated how to spend our session times. Thus, sharing songs, exploring lyrics and discussing artists and musical styles became the shape of the earlier sessions, with Sophie conversing knowledgably. I challenged myself to see how I could support her musically but also how music might help with increased social engagement in the facility for her. Sophie opened up about her loss of independence and some repressed feelings from her childhood as the relationship between us developed. She had reservations about being able to sing but relaxed enough to try, and surprised herself.

'Sophie explained that she has breathing difficulties which would prevent her joining me to sing. However after two or three sessions she started to accompany my singing of folk songs in a descant voice with some understanding of harmony'. CN 16/4

In the fourth session Sophie, a poet, began to voice her aspirations:

'I feel like I'm opening up to possibilities'. CN 16/4

'I've always wanted to create music'. CN 16/4

During the session, illustrated in the table below, we began to do some brainstorming for lyric writing. Sophie used some phrases from her poetry to identify ideas and lyrical phrases she would like to use in her main theme of overcoming past hurts and having hope for the future.

Brainstorming for lyrical phrases: CN 6/5

<i>Themes</i>	<i>Lyrical phrases</i>
<i>Rebirth/Second chances</i>	<i>'I emerge restored, inspired' (phoenix metaphor, coming through the fire)</i>
<i>Affirmations/Hope for the future</i>	<i>'I found a life to live'</i>
<i>Overcoming grief and hurts</i>	<i>'I grow stronger'</i>
<i>Articulating beliefs</i>	<i>'I am' '(God) keeps me secure'</i>
<i>Realisation of falseness of prior beliefs</i>	<i>'There is no game/there is no wall'</i>

Through our discussion that day (6/5), we agreed that the aim of our collaboration was to create a song that told Sophie's personal story. It was quite a powerful session with Sophie disclosing information from her childhood and explaining the metaphor of coming through the fire to see hope for the future. Sophie remained strong throughout the process and became animated when we started to frame the song. The song writing process followed O'Brien's guided song writing outline 1) brainstorming, 2) reframing (chorus and verses), 3) determining style and key of the song, and 4) setting the melody and accompaniment (O'Brien, 2004)². I played several styles (eg. light rock, blues) for Sophie on the guitar varying tempo and dynamics, until she indicated a ballad style as her preference by raising her hand. I played different rhythms until Sophie gave me a smile and nodded her head when I was picking the guitar gently in a melancholy way in a 4/4 timing. 'That's the one I want. I can hear my song!' she said. Sophie asked for some picking up of the pace, and strumming, to add power behind the lyric in the choruses. She noted the meaning for her in the session by saying:

'This is more than just a song to me' CN 12/5

Our collaborative song. (See Appendix 7 for music).

'Heartbeat of Hope'

Sometimes I feel just like a fool.....don't know the game, don't know the rules

That's when I hit the wall, lose my way and then.....I fall

² 'Guided song writing' demands a high level of interaction through non-musical language and verbal and non-verbal indications between patient and therapist to achieve the goal of creating an original song' (O'Brien, 2004, p. 2).

Something that someone said.....a thought that's in my head

that's when I walk away..... can't lose if I don't play

Chorus 1

I am that child again

There's that hurt and pain again

I feel the flames and then...

I burn

'I AM' keeps me secure..... I'm not alone you hold my hand

There is no wall, there is no game.....I can grow, come through the flame

For a child must always grow.....choose a path that she can go

I found a life to live... ..With all the love.....you give

Chorus 2

I fell you saved me

You pulled me through..... the phoenix fire

I emerge.....restored.....Inspired

Outro.....I'm his, he's mine, I'm his, he's mine'

The song collaboration appeared to help in meeting some of Sophie's personal, spiritual and emotional needs as she came to terms with a difficult past. Some of her musical goals have been addressed also as she has realised her aspirations of creating music. As a music therapy student I was able to support Sophie in an empathetic way through the music therapy process by first building a therapeutic relationship together, gaining rapport and trust, and then offering the pathway of song-writing as a possibility. Therapist and resident became strongly connected prior to the song writing process as common interests were identified musically and in other ways, which gave Sophie the confidence to share very sensitive repressed

feelings, but also hope for the future evidenced in the title ‘Heartbeat of Hope’. Sophie has expressed the wish to keep her first music composition to herself as it is very close to her heart, saying ‘*It’s private for me*’. However she has shared her sense of accomplishment with me.

Sophie has purchased her own keyboard and is now exploring its sounds and some possible melodies for other compositions. This has led to more social engagement for her with the keyboard being a focal point in her room for caregivers and visitors. Sophie recently started individual physiotherapy which may give her increased motivation for striving for the goal of gaining more independence for herself. Sophie is showing responsibility for her goals, independence and self-supported living. In our evaluation of our work I consider that the building of song-writing and our reflections about her experience have helped significantly to support her, employing a number of the following themes: building a therapeutic relationship, making connections, engaging musically and creating a song collaboratively.

Specific outcomes for Sophie relating to the themes in the study were that she found support for her well-being by being engaged firstly in *relationship building* and later in the *collaborative* process of defining themes and the song-writing process. Outcomes for *emotional growth* were evidenced in Sophie’s significant shifts for example from social and physical isolation, without creative outlet, to increased self-esteem and empowerment, emotional healing, and skill development. The outcome of *musical engagement* was evidenced by Sophie achieving her personal music goals; being supported to express her repressed feelings and harness these into creative song-writing; having her music transcribed and composed, which she can now play at her leisure; and being inspired to obtain a keyboard to continue her music on her own. While she viewed her music as private to her, she now also has the potential to engage with her *community* through sharing her new found skills, when she is ready.

The Six Themes

The following section sets out and discusses the findings under the six themes. The bold statements at the beginning of each section express the key learnings for each theme and sub-theme identified in the study.

1. Building relationships

Relationships grew gradually, changed, and consolidated over many months.

1.1 Being alongside

Taking the time to be alongside and listen to residents tell their personal stories led to a foundation of trust upon which the practice was built.

Relationships formed gradually in this setting as people needed time to develop trust in a new person and I needed to learn to be alongside them quietly, listening and interacting in a non-threatening way. Being a presence for people in a humanistic, empathetic way became the platform upon which the practice was built. Listening to residents allowed time for observation and learning about people living in the presence of neuro-disabilities that required them to be in supported care. People started to open up and articulate their feelings and thoughts and after some time trusted me with their personal stories, and in particular thoughts about their loss of independence. As a student music therapist I was afforded the time to nurture and cement friendly contact and think about possibilities for engaging people in therapy. If a person seemed to need to express grief and loss I would arrange an individual closed-door session with that person. At first I felt out of my depth when residents expressed losses and difficult memories, sometimes quite emotionally, but after a while I could only reflect on how courageous and strong they were as they talked about coming to terms with their conditions and making the most of their living situations. On the very first day of my placement, one of the residents welcomed me in a very positive way wishing me great success for my time at the facility. This was very heartening and positive. I tended to get overwhelmed in the first few months thinking that I would like to bring happiness to people but reminded myself that I was not here to ‘fix things for people’ but to challenge them to grow.

R: ‘This is just the place I live, some caregivers are respectful and we get along with dignity’. CN 27/5

R: ‘With you I know you’re going to follow up on what you say’. CN 16/4

‘I value my time talking to people each day. I feel like I am another person they can relate to, talk about their aspirations with and how they are coping day to day’. RD 28/3

'Resident and I talked about her independence, times she might have a seizure and difficulties with her eyesight'. CN 5/3

R: 'I'll be happy in my old age; I'll be a great old lady'. CN 27/5

R: 'With you I know you're going to follow up on what you say'. CN 16/4

1.2 Providing support in a therapeutic relationship

The ways in which I might support people therapeutically took on more clarity as relationships consolidated.

As relationships developed and rapport was established, the ways in which I might intuitively offer therapeutic interventions started to become possibilities. Building on residents' interests and early musical influences led the way to providing appropriate sessions with them, and making global assessments helped in forming goals for supporting people as well. I offered opportunities to decrease isolation for people by inviting them to a group or an individual session. Times were formulated to meet with people mainly in their rooms at this point for privacy and safety, as well as the fact that no place had been designated for music therapy at that point. I provided support for people who were not attending many other activities at the facility, and made sure they were given a voice about how they would like to spend their music time so they had some input. I encouraged openness and communication by continually asking for feedback. I felt nervous making promises to people in case I couldn't fulfil these but at some point I had to develop the practice and go with a programme and start to implement it to the best of my ability. Residents had other commitments so music therapy was put on a timetable along with other activities for the purpose of internal organisation and planning ahead. I developed a set of closure questions to round things off and to create reflection and connection for the following week.

(Questions for session closures) 'How did you enjoy the session?' 'What did you like about it?' 'What would you like to do next time?' CN 22/3

'I feel happy that there appears to be a purpose in being together, finding companionship and common ground, and bringing some joy and happiness for the women in the group'. RD 22/7

'R showed that he was happy to 'dance' with the music. I took his hands and jived with him'. CN 18/2

As the placement developed, relationships changed from those of ‘getting to know’ and ‘being alongside’ to therapeutic relationships where I could challenge people to grow through musical experiences. I trusted in my emerging ideas to offer meaningful music experiences for a variety of people. Joy seemed to be a natural outcome for many people as they expressed themselves freely, and I was very touched at how quickly people opened up, entering into musical dialogue, identifying and comparing their familiar, preferred music with others, and engaging in techniques such as turn taking, and call and response. A person-centred approach allowed for people’s interests to be factored in, as this is an approach that respects the individual as a whole person. I built my own ideas for interventions but also used the feedback from residents themselves to construct deeper experiences for them, listening to them telling me their wishes about how to support them in this environment; for example people might say ‘I would like to sing and play in a group’. This might have been the desire to see what certain percussion instruments sounded like when played, or the wish to join a group and share familiar songs. To work therapeutically meant being mindful of providing medical safety and being conversant with any conditions that contraindicated participation in therapy. Recognition of the physical atmosphere and positioning of resident and therapist, and addressing communication needs (eg. whether residents were verbal or non-verbal) was also important, as there might be a need for communication aids. Emotional safety and supporting people with commitment and motivation became important, and some residents starting mastery on instruments asked for some help with this.

At times during the placement I felt I would have liked to see more people and facilitate more groups, and yet it took time to set up sessions, write notes and generally organise the resources required daily. Supporting *some* people well, seemed to be more important than rushing around making myself so busy that I would risk burnout. I noted in my reflective diary that I needed to be mindful of confidentiality and personal and professional boundaries, and if people wanted to disclose sensitive information to me I would then encourage them to talk to the pastoral care staff after a music therapy session. At times I felt I got too close to people and they would confide in me, leaving me then feeling powerless when I could not make things specifically better for them. I brought these issues to supervision, (see Supervision 2.5), and I explored with my supervisor ways of being able to step back, and manage intense communication, while at the same time acknowledging people’s feelings.

2. Collaborative practices

To collaborate is defined by the Oxford dictionary (“Collaborate”, 2014) as working in conjunction with another or others, to cooperate.

2.1 Rehabilitation and therapy team

Being part of a team allowed for many collaborative opportunities that strengthened my role as a student music therapist.

The context of the placement was explained to me as a ‘long-term care facility with *some* rehabilitation’ and my role in that context would be expected to be clarified as I shaped the practice. I would be the only therapist working regularly on site in the facility, and would work in isolation initially. Although the manager of rehabilitation and therapy was a physiotherapist she was afforded little time to do this alongside managerial duties, apart from facilitating open gym sessions, and working with one or two individuals with high needs per week. Other allied health professionals would visit as needed including occupational therapists, community/contracted physiotherapists, speech therapists, and mental health workers. Communicating and collaborating with other members of the team was important for a sense of working together towards common goals as we were a small team supporting up to 35 residents. I assisted the Activities team with seated aerobics (1 hour per week) and activities staff music sessions for residents (1.5 hrs per week) as part of the initial placement observation time and continued with these collaborations for the duration of the practice. Getting to know the staff in other settings was valuable perhaps to raise awareness of each other’s main roles and the need to work together. This was reinforced at monthly meetings where support, advice and feedback was offered. My clinical liaison provided a valuable professional contact where I could raise issues when and as needed and gain useful ideas about where music therapy might complement programmes already existing in the facility. Opportunities were created through this relationship for a wide range of experiences and observation opportunities allowing me to gain a broad view of people living with neuro-disabilities. Music therapy was considered a valuable addition, where appropriate, to a resident’s ‘lifestyle plan’ and this meant session attendances were recorded and goals monitored for all staff to see. Health and safety policies were important to be aware of and these were expected to be observed, for example learning to use wheelchairs which were customised was paramount for residents’ safety.

‘Try to work with people who don’t have much else in their day at first’. MN 29/4

‘Each resident has a lifestyle plan or care plan that is tailored to their individual needs and so a goal or objective for music therapy could be developed for those plans’. MN 29/4

‘Wheeling R’s backwards and forwards will require me to know how to operate each wheelchair. This was important for safety and to ensure getting to therapy was not a barrier to involvement for the R’s’. RD, 21/2

2.2 With residents

Collaborations with residents empowered them and led to feelings of belonging and pride in achieving something together.

Involving residents in the planning of celebrations and concerts was a chance to empower people by giving them a role and a part to play in the planning of music therapy events. This is consistent with patient led care models mentioned on the literature review. I noted in my reflective notes that residents were communicating with me about how to support them also. I really appreciated that and saw it as affirmation of my role. Collaboration in a group meant that residents could help set goals together by collective agreement and take part more fully in the music therapy process. For example, the members of the women’s group decided what was important to them for their group time by indicating their choices, and this included voting to make a book of their favourite music for sharing weekly. Song-writing and lyric substitution was a regular feature of collaborative work and many compositions were shared and later shown and enjoyed by larger groups of people for example at concerts and get-togethers.

‘The resident was a great MC at the concert and it gave him a role but also something to build his confidence and self-esteem’. CN 4/7.

During a seated aerobics exercise, the ‘R guided me, giving me cues during the pelvic arch, so we could work together’. CN 21/2

R: ‘We want to have fun and laugh when we meet weekly as a group’. CN 10/6

‘It started with one (R) and I playing two chord blues on our guitars and grew into something bigger as people started to come over and join in’. Soon we were writing a song called ‘Feel good mama!’ CN 11/7

Sometimes collaborations did not work out and this became frustrating as a therapist. This was due to many factors such as failed communication, fatigue, mood change, attendance at outings, and medical appointments, and it became clear that I would have to work in a more flexible way after two to three months at the facility. Adopting this next approach would eventually support more people more effectively than a programme that was too rigid, and group improvisation in the mornings in communal areas began to become a regular feature of the programme from about mid-year.

2.3 With staff and caregivers

Collaborating with staff led to music therapy being valued and supported and other activities being complemented.

Caregivers helped people access their music therapy times in the first few months when there was a loose timetable in place. This was appreciated and seemed to add to the value placed on having additional therapy available at the facility. Staff coming to concerts and arriving informally at sessions strengthened feelings of collaboration at the facility. Special events were well supported also, and advertised in advance. Staff presence helped provide atmosphere. The head of pastoral care assisted with my learning to use the screen and projector which allowed more accessibility to song lyrics for residents at large group and concert sessions. Collaborations with the activities team were valued and enjoyed by residents and these gained momentum as the placement ensued.

Staff member: 'You take the female parts for the duets and lead the women and I'll take the male parts'. CN 7/7

'I believe in interaction. There should be no line between us and more people need to get involved'. (Caregiver who participated in a music making group session). CN 24/3

Staff member: 'I've tried to get (R) up for you in time for his music therapy several times but he's adamant. So you might need to go to him'. CN 1/4.

'It was really good to see so many people at the concert. The Managers came in from time to time and some of the caregivers and activities staff danced beside residents and helped them play an instrument. Support was essential for safety and to be able to meet the needs of the group. The R's enjoyed seeing their staff and were smiling and laughing with them'. RD 4/7

2.4 Interdisciplinary work

Interdisciplinary work allowed for utilising each other's area of expertise and setting goals collaboratively.

This collaboration was different to the collaboration with the team as it involved only two other specialists and myself. It started on a trial basis between two physiotherapists and myself as a student music therapist to explore possibilities for assisting each other in mobilising and increasing communication for a resident who had suffered a subarachnoid haemorrhage previously. My brief was to 'direct attention (through music) to move in ways that improved physical rehabilitation' (eg. posture), and to encourage communication by providing sensory experiences through music. This was achieved mainly through singing instruction and observation of the resident's attention, facial gestures, emotional responses and vocalisations. I played and sang music varying expressive elements, while the other therapists carried out passive and functional movement with the resident. This was a valuable experience for me learning how other allied health therapies work first-hand. The feedback I got from the sessions enabled me to grow as a professional and gain confidence. At first I was anxious about my role but later learned to relax and take responsibility for the acoustic environment and observe responses from the resident, letting this guide the process. The interdisciplinary work provided an opportunity for myself as a student music therapist to provide the human aspect to treatment whereas the physiotherapy provided the physical and medical focus. This is consistent with the humanistic model outlined in the literature review which helped inform the practice.

PT to MT: 'You can give singing instruction to help with R's function eg. 'Look at me', as you move and sing from each side of the tilt table. This will be good for extending his neck muscles as he tracks you from side to side.' MN 22/7

MT encourages R: 'Put your other hand over the instrument and we will turn it together and see what sounds it makes' CN 12/8

PT to MT: 'You will be able to distract (R) from pain and discomfort while we are working to improve muscle function' CN 29/7

2.5 Supervision

Supervision was a collaborative journey that helped me to develop as a professional.

Throughout this equal partnership of supervisor and supervisee participating and interacting with each other, I was able to build my professional identity, gain confidence, and develop awareness of things that came up for me personally from what residents had shared. My supervisor reframed problems to allow me to solve them by looking at them in a different way, encouraging self-examination. After a few months the issues of self-care and mindfulness came up as I struggled to maintain motivation at times, and we problem-solved through these issues. One of the unique things about the process was thinking about new ways of working that fitted my personality, things that I had not thought of. Both positive and challenging issues were discussed and I was encouraged to notice my strengths. Supervision was valuable in bridging theory and practice, recognising boundaries and generally developing as a professional. Some of the questions/statements that challenged me most in the partnership are listed below.

How would you do that differently next time?

How do you value what you do?

‘Try to take a supportive role with some things instead of being in charge of what happens with everything’

‘Try again if a client withdraws, don’t dismiss the client as not being responsive’

‘Develop more vocal improvisations with clients, trust you will be able to work in an intuitive way, see where it goes’

3. Fostering community

Community has been described as ‘a group of people living together and practicing common ownership’ (“Community” 2014). ***The presence of music regularly, especially live music, appeared to strengthen the community.***

3.1 Making connections

This sub-category involved the development of a fluid network of connections through music between therapist and residents, and among residents.

People were invited into the music and responded in various ways and at various levels. Sometimes as therapist I prompted the exchanges but participants also offered exchanges,

through musical and non-musical gestures, and in verbal and non-verbal ways. This was evidenced by physical contact and support, a sharing of jokes and humour or just by a resident being alongside another resident as an offer of companionship. Making connections contributed toward a sense of community over time. Spontaneous music-making appeared to enable people to make meaningful connections perhaps because of its freedom and naturalness. In the latter stages of being a student in residence at the facility I gained a sense of being integral to the community, beginning with my place in the rehabilitation and therapy team and spreading out into all the sub-groups and social and cultural contexts present in the community. I recognised that my role my started to take on some of the features of Community Music Therapy as introduced in the literature review. Once I got to know people, their strengths, their diverse needs, and capabilities, I could build on these things by forging a connection or a meaningful moment within a large group or get-together. This became second-nature in many settings. When we were planning to attend an urban marae (see glossary, p. 50), I was asked to go along with the group and lead a waiata. One of the residents had a role as well answering a speech then signalling for me to begin. I felt that this brought the residents and myself closer as a unique group connected by our involvement in a cultural exchange. The residents adapted to my being part of activities outside the facility. I attended a funeral with the residents after I had been at the facility only a few months, and felt and showed genuine empathy for the resident's loss of a friend and fellow resident. I made myself available to listen and be alongside people after the funeral and asked people if they wanted to talk or have a particular piece of music played to acknowledge how they were feeling about their loss and what it may have evoked for them. For myself I felt sadness that I was due to start individual therapy the following month with the resident who died. Being aware of the connectedness among the residents overall outside of music therapy enabled me to respond and facilitate music therapy experiences that were sympathetic to the needs and contexts of the community.

'The residents got used to my being part of activities outside the facility and I think this may have in part encouraged their support of the activities I initiated' RD 17/6

'(R took another resident's hand and swayed to the music with him.' CN 14/5

'(R) passed another person an instrument as they came into the group to make them feel welcome'. CN 18/4 Good Friday.

'I was really touched when (R) went over to (R) and offered her hand during the group session. It appeared to be an offer of friendship and comfort'. CN 2/4

'We connected through our love of 60's and 70's music'. CN 25/3

3.2 Participation and belonging

Music enabled and created lively and inviting opportunities for people to participate.

There were many potential barriers to participation for residents, so as a student music therapist I had to be mindful of practical access issues, and work to remove barriers, for example assisting people to attend activities both musical and non-musical and in effect 'supporting to participate'. Participation and belonging have been grouped together as a sub-category as on many levels the philosophy at the facility worked towards overall well-being for its residents and these two features can be essential contributors to quality of life. Group music at various levels encouraged feelings of belonging to various sub groups or the facility itself, and brought people together through a musical platform. Eventually, even reluctant participants were present at group music, encouraged by their friends and also myself, and immersing themselves more and more in a group experience. I felt people needed to be reminded that they weren't facing an uncertain future alone and felt that facilitating a sense of belonging was helping with this. By taking part in monthly celebrations such as theme dinners, I developed my own sense of belonging to the facility and at these types of functions my own role overlapped and merged with those of the caregivers and other staff. There was the task of feeding the residents which everyone pitched in to do at these events happily. Musically, theme dinners provided an opportunity for the facility's own music group, the 'Hi Notes' to provide some appropriate music to support the theme, and I helped facilitate this, however it was nice not to have to be the organiser for these events, but just have a part to play.

'It gives me something to do and I don't have to listen to my music alone' (Member of Women's group). CN 17/6

'(R) enjoys participating, listening, and interacts well in musical environment, hums and mouths words often and smiles and laughs with others'. CN 10/6

A response from a reluctant participant: 'That'll do, whatever!' (to my suggestion of the song 'Stupid Cupid'). I said 'You'll be a rock n roll man'. He smiled. CN 3/7

‘The impending concert has given everyone a talking point and involvement as residents select a song for the group to sing and share on Friday, reflecting their choice of genre and music, and perhaps helping them to reminisce about a time they were well and independent’. RD 2/7

3.3 Social interaction and humour

The musical platform encouraged social interaction and spontaneous fun and humour.

A group of people in the presence of music led by a music therapist seems to be an experience that gives people permission to have fun and relax and communicate with each other. Large group get-togethers became a regular feature the residents conveyed they wanted often. These invited social interaction, fun and humour and often residents saw each other in a different, more playful, light hearted way. I felt that some people surprised themselves by how much motivation and enjoyment they could derive from get-togethers in communal settings, and it seemed to be affirming for people as a group. Celebrations such as theme dinners encouraged social interaction also and enabled the residents to be able to thank their staff through songs such as the ‘Residents song’ revealed in July amid much hilarity and written by the residents at a lively song writing workshop. The song referred to various staff in light-hearted way, mentioning their contributions to the facility. This helped give the group a sense of identity as well.

(R): ‘The music makes me want to dance’. (Manager): ‘We have to make do with the bits that work’ (this drew a lot of laughter of a supportive nature). CN 21/2

‘The large group listened to the solos with respect’. CN 4/7

One resident to another: ‘You sang that nicely!’ CN 4/7

Resident’s song: ‘We get service with a smile’; ‘There’s a gourmet in the kitchen’, ‘there’s a crisis on the way’. (To the tune ‘Bad Moon Rising’ by Creedence Clearwater Revival.

4. Acknowledging diversity

'The state of being diverse' ("Diversity", 2014).

4.1 The need to work in a flexible way to support diverse needs

There was a need to work in diverse ways to meet a range of needs, and this required flexibility as time progressed in the practice.

It became evident quite early on that there was a diverse range of needs among the residents and that this might require me to work with some flexibility. People experienced conditions that meant they presented quite differently in terms of their communication, cognitive and functional abilities. There were quite able people cognitively and physically and some quite disabled people in terms of their ability to participate and engage in music. I realised that there was not going to be a 'one size fits all' approach that would meet everyone's needs. A collaborative approach went some way towards meeting these needs and also the closed-door approach for people who could not get around very easily.

Towards the end of the practice, flexible programming meant being able to work better with diverse needs, more than a strict timetable would have allowed. For example, improvised group sessions in communal areas where everyone was catered for in a different way became a model of practice. In this setting some people felt comfortable watching and listening, and indicated their wishes. Others engaged in the music therapy process as much or as little as they desired, and again others were wheeled in by caregivers for the stimulation and nourishment of being near others. People also could come and go throughout, and were empowered in their decision making. So quite a lot of people were deriving something quite useful from the presence of daily music opportunities in the facility. I worked with openness and acceptance of people being present as much as they wished and I think this informal way of working actually drew more people into communal areas on these mornings. On asking for feedback people often told me they enjoyed these sessions the most; they could relax, but yet had something to do. Having the time to respond to in-the-moment requests to provide comfort for people in distress or to work with individuals to lift mood was valuable too, and could happen with flexible programming.

A bedside therapy group (gathering in the room of one of the residents) was started in June to support women with progressive illnesses. To ensure that there were no barriers to attending for a person on bed rest, it was decided to have the therapy in the resident's room. I

encouraged the women to make choices and decisions about what they would like to do in their weekly time together. As a student music therapist I enjoyed the opportunity to work with people with diverse needs and to enable something worthwhile for everyone through flexible ways of working.

4.2 Restrictions experienced

Some people experienced restrictions to engaging in music because of the symptoms of their progressive conditions and their impact on function and communication.

Some people with progressive illnesses had restrictions that had to be factored in when planning music therapy sessions as this meant they might experience challenges communicating, with movement, fatigue, or sometimes restrictions with functioning, such as spasticity. Instruments were quite often refused as trying to hold them was difficult for people with spasticity. I noted in my reflective notes that trying to hold instruments possibly made people more aware of their disabilities.

‘Some can talk and some can see better than others, some can hold instruments’ .CN 18/6

‘(R) communicates by writing on her pad on her wheelchair’ CN 24/6

‘No instruments thanks’. I offered to tie wristbands with bells on. Again ‘No thanks’. CN 22/7

“For some people it is an effort to communicate I think and even have eye contact is difficult with progressive multiple sclerosis. I encourage ‘I’ statements and feeling statements’. RD 18/6

‘The women enjoyed sensory work despite their challenges for example spasticity, and liked me to take their limbs and dance with them’. CN 29/7

4.3 Techniques to meet diverse needs

Observing people in their environment and learning about neuro-disability was important to be able to adopt appropriate techniques.

Among the techniques used to support people with diverse needs were the use of space, timing and silence to allow time for people to process things in sessions. Matching, turn-taking and call and response techniques were all used regularly with success with this

population. My use of prompts and feeling statements as therapist (encouraging residents to describe their feelings) was also important for people experiencing deficits in function and communication.

‘Learning the sensory, fatigue and neurological parameters of the residents was important in work sensitively with people’. SN 13/6

‘She came in screaming in a high-pitched voice. I went over and matched her pitch, she quietened down and we picked up the song from there’. CN 22/7

5. Emotional support

Emotions have been described as strong feelings derived from one’s circumstances, mood or relationships with others (“Emotions”, 2014).

5.1 Supporting people to manage and express emotions

Supporting people emotionally with long term neuro-disabilities became a critical factor in maintaining overall well-being.

The expressive elements of music served as a vehicle for residents to externalise various emotions from loss, to feeling blessed, to reminiscing about times they were well and independent, to anger and both negative and positive self-reflection, among others. Part of my role became clarified quite early on as one in which I would most likely support people emotionally because music therapy seemed to work quite powerfully towards this outcome. In the presence of music, people took risks too and vocalised their aspirations and hope for the future, talking about acceptance of their conditions openly at times, and also about a day when they might walk again and regain some of the things they have lost.

It was important to work empathetically and sensitively with people showing a lot of vulnerability and one of the challenges was keeping them in the present as some individuals tended to relive the past and at times ‘get stuck there’. It was very humbling that people trusted me with their precious memories and heartening that there were a lot of positive things expressed as well as sadder things. Residents talked about upcoming social outings and what was happening around the facility, and some people expressed a decrease of communication with loved ones now that they were in care. People also demonstrated ways that they were coping with their illnesses by trying to ‘see the bright side’. Emotional safety was an important consideration in a group always as was confidentiality. Sometimes it was

necessary to contain the group emotionally before a session started so that people felt safe and protected before sharing things that were close to them.

'It's all I can do now (smile) and I'm happy I still have that'. CN 10/6

'That was beautiful. I'm transported somewhere else when I hear that song'. CN 3/6

R: 'I want to talk about losing my wife, she died' MTS: 'We can talk about that and if you like we can then share some music that you might have enjoyed together?' CN 20/3

R: 'I need help with my emotions and I love to sing'. (Resident self refers). CN1/5

R: 'I'm not ready for another relationship yet'. CN 11/7

5.2 Supporting residents through song-writing and lyric substitution

Song-writing was used as a vehicle for externalising emotions and telling personal stories.

People liked having something for which they could have ownership.

Song-writing and lyric substitution was used as a way of recording personal stories with many individuals and groups over ten months, with some choosing to share their songs with others. People felt empowered with such a tangible piece of 'themselves'. Lyric substitution was also enjoyable for groups of people who could take a song they liked and quickly change some lyrics, amid fun and hilarity at times, to make the song personal for themselves. This technique of creating new lyrics for popular songs was quite freeing for people. Making choices was important for self-esteem and confidence and positive feelings overall.

R: 'I want to play the guitar so I can remember my friend, walk in his footsteps'. CN 16/8

'We're the In-crowd, the In-crowd, wearing flowers in our hair, we're going somewhere' (to the tune Royals). CN 22/7 (Women's group lyric sub.)

R: 'I want to be walking and talking with you X.....you could push my chair X '. CN (Individual) 18/3

'You'd find it hard to have a relationship here'. CN 11/7

'I'm not ready for another relationship yet'. CN 11/7

I wrote in an analytic memo that some people seemed to have fewer places in the outside community that they could visualise themselves going to as they worked on their songs. The idea of freedom was a recurring theme, as was the sea and imagining being driven there. Shared stories and personal journeys were made into songs and people often worked towards a sense of identity and adjustment to disability through this approach. Emotions were sometimes strongly evoked in song-writing and it was a way to release grief and pain for some people. Loss of independence, intimacy, self-reflection, affirmations about the past and a yearning for the way things could be, were also themes.

Example of some relevant lyrics (to a two chord blues pattern)

Em 7

'Hey baby you better slow down

A7

hey baby you better slow down

Em7

At the same time gotta keep the motor running

A7

Gotta use it or you'll lose it yeh,

Em7

A7

Em7

Hey baby you better slow down'. CN 11/7

6. Musical Engagement

The music therapy sessions helped people to achieve many musical outcomes: mastery, independence, group skills and enjoyment; creativity, and the building of tools to be able to support their own music without a music therapist.

6.1 Mastery and independence

Some individuals worked towards learning an instrument and others formed a music-making group 'Hi Notes'.

A small music-making group began to meet early March, initially with four people who played instruments and were keen to make music with others, and goals were set together for developing musical skills, making choices and enjoying participation as a group. Some improvisation happened during instrumental breaks, but mostly people liked the security of a definite structure overall. Performance opportunities were sought by the group as time went on and a repertoire was added to each week. Other people were welcome to join in with the nucleus of players and we met in a communal area at the back of the lounge where the piano was, (this had become known as the key area for music therapy), to encourage this. Sometimes friends and family arrived and joined in the sessions and on one occasion a caregiver interacted with the group, playing percussion. At times we would invite a special guest from the wider community to perform for us. I was amazed at how skilled the group became towards the end of the placement and I realised my expectations had been too low generally as to what could be achieved over ten months with the group and the development of skills. Harmonies by the participants when singing was a real strength. Two of the residents had sung with church choirs but found a real outlet in the opportunity to play instruments as well as sing during these group sessions. We varied our instruments in response to song genres and although I was able to give clearer introductions using guitar, the group liked strong rhythmic tunes to be accompanied by piano, eg. Johnny Cash's 'Walk the Line'. The policies at the facility stated that 'residents should learn instruments for a varied music programme' so I tried to encourage this. Individuals were involved in mastery sessions and two people bought their own instruments while I was on placement, a keyboard and a guitar.

R: 'When I can play some chords on the guitar can I join the Hi Notes?' RD 20/6

‘The Hi-Notes are happy to share their music with everyone in large groups but enjoy their own sessions when they can work on the structure of their songs, make choices for repertoire and extend themselves musically’. RD 2/7

6.2 Creativity and originality

People found new ways of playing by experimenting and being curious

By inviting people to make choices and try new things in their music time, people began to explore new ways of playing and gained satisfaction from this. This attracted the attention of others who then became interested in experimenting as well. I emphasised that there were no rules and this appealed to people as it was quite freeing from expectations. Some instruments had to be adapted for people to be able to access them, eg. using a drum on a stand, and using wrist bracelets with bells on, to note two examples. Sometimes the more able people assisted the others.

R: played his tambourine by placing it upright in his chair on his right side and rolling the steel circles with his left hand. He said he was trying to find new sounds’.
CN 12/5

R: ‘I like learning the notes of each chord as it gives me more choice of what to play’.
(Resident playing the glockenspiel) CN 18/6

‘They responded and interacted and sang familiar songs with harmony so well, far in excess of everything I had predicted for a music making group’. RD 17/4

6.3 Group skills through musical engagement

The group skills of cooperation, commitment and negotiation were important in the music-making group.

Power sharing was difficult for the residents as everyone wanted a song to sound a particular way and as facilitator of the group I had to make sure everyone had an equal voice in the decision-making. I was aware of not influencing the group too much, but had an equal share in the decision-making as well as the tasks of accompanying and facilitating. There were parallels with my teaching history and it was difficult at times to stand back and let the group evolve in a natural manner. The process of negotiating was frustrating for me sometimes as well as I felt it took away from valuable time ‘making music’. Cooperation was difficult at times for the group and there was a tendency to allow the most outspoken people to have

more say. However the group felt empowered when they negotiated too, and solved problems together, and this was one way the individuals grew through their music. During reflection time, after the session people, expressed their thoughts about their group, their music, upcoming performances, and were usually pleased with the overall progress made. Each person would usually compliment someone else at the end of the session with genuine pleasure. Friendships developed within the group and individuals supported each other with encouragement, both verbally and non-verbally. Sometimes people would not turn up and this was frustrating for everyone.

R: 'I really would like people to make a weekly commitment to be here if possible, then we can learn a song properly together'. CN 17/3

R: 'I want to play a standing drum'. This led to problem- solving as a group about how this could be achieved. Eventually we were loaned a cymbal on a stand which led to the realisation of a dream for the resident. CN 17/3

R: 'You played that nicely today'. 'You're getting really good with that drum'. CN 16/4

6.4 Resource-oriented therapy

Resources were built for a time when a music therapist might not be available to facilitate the group.

Resources were developed over time and a repertoire created and built up by many members of the group including music for ukulele, guitar, piano, and glockenspiel. A 'wish list' was created for suitable percussion instruments at the facility. Eventually I talked to the group about a time in the future when they might want to use their skills to carry on their group without a facilitator such as a music therapist, and suggested that possibly the activities team could assist with this as well. Everyone agreed that they would like to continue the 'Hi-Notes' and have some items ready for a Christmas concert, either on their own or with support.

MTS: 'One of you could lead the sessions when I'm not here as you're getting really good at negotiating what to play and how to play'. CN 22/7.

Discussion

The key findings are discussed and interpreted in this section and include excerpts from the literature to support particular ideas. In standing back to try and construct a picture of “the key findings, I am firstly struck by the commonalities between many of my chosen themes and how they overlap and intertwine. Many themes have ‘relatedness’ in common. *‘Relatedness’ suggests a reciprocity of factors like trust and empathy between two or more individuals* (“Relatedness”, 2014). This is not surprising, however, as the study was carried out in a care environment and not a medical environment, where it may have been more difficult to nurture therapeutic relationships, build collaborative practices, make connections, and foster community. This clinical practice therefore was informed by humanistic theories introduced in the literature review. The findings also support the idea of a flexible approach to enable fuller participation of people with neuro-disabilities, by acknowledging and catering to diverse needs. Lastly the study reflected a community-oriented approach which seems to be in keeping with recent developments worldwide in community music therapy. Quality of life and well-being are essential components of long-term care environments. Music therapy needs to support this, and, in so doing, it will make an effective contribution.

Relationships, relatedness and community perspectives

The theme of building relationships reflects Ruud’s idea of being alongside people and being a presence for them in a humanistic way (Ruud, 2010; Wigram, Pedersen, & Bonde, 2002), showing ‘unconditional positive regard’ for the person. This was borne out in my practice. Music therapy training in New Zealand has a strong humanistic focus and this has been written about in pioneering music therapy literature: *‘The work of many music therapists seems to fall within a humanistic framework’* (Bunt, 1994, p. 43). At some point over the initial few months I recognised that there was a shift from the emphasis on the relationship to the importance of the music itself and I tried to use this as the pivotal tool to build therapeutic relationships from this point onwards.

A sense of belonging and the idea of ‘relatedness’ has been highlighted as an overarching idea in the findings of the research, both from the sense of MTS showing empathy and trust when building relationships and belonging to the community she was situated in, and the residents gaining a stronger sense of belonging to their own community. This idea is endorsed by Stige and Aarø (2012), as being essential in meeting people’s needs: *‘Belonging*

and relatedness have been suggested as being basic psychological or social needs that if not met can have harmful consequences for a person's health and well-being'.

The core of my relationships at the placement was firmly grounded in music but there were other roles that developed and extended beyond the role of music facilitation, and this led to my role becoming situated in the social context of the facility. *'Music can be a tool for encouraging participation, networking, opening doors, and empowerment'* (Ruud, 1998, p.3). The developing of a sense of community meant making connections, facilitating participation, and encouraging social interaction. I found my practice reflected a lot of the goals of a community music therapy approach, as introduced in the literature review. This revelation linked to my emerging identity as a music therapist. The research outcomes show ideas consistent with community music therapy in that human connectedness, relationships, collaboration, participation and exploring health-promoting connections are some of the underpinning values that inform this approach (Stige and Aarø, 2012). Viewing the facility as a community and learning how music could work in partnership with individuals and the community became key to establishing the role and I was afforded time to do this as a student on an extended placement.

I also observed that interacting and collaborating with team members, learning from them and also providing and accepting support, was key to establishing my role at the facility. My experience fits with Twyford and Watson's (2008, p. 13) comments on collaboration: *'Collaboration is effective in professional, political and personal ways and the success of a team is dependent on the type and characteristics of each team member where each team member brings a variety of professional knowledge, expertise, skills and personal characteristics to a team'*. The vignette I described in my practice, on p. 21, shows the importance of working collaboratively to achieve therapeutic outcomes, on a one to one level as well. Forinash (2001) stressed the value of supervision as being a journey in which the two participants are likely to grow and be transformed in some way as a result.

The idea of working in an ecological context, introduced in the literature review, was borne out in the findings. Bruscia illustrates this premise with his comment *"The ecological area of practice includes all applications of music in music therapy where the primary focus is on promoting health within and between various players of the socio-cultural community and/or physical environment, (Bruscia 1998, p. 229)*. While the therapist may work to facilitate changes in the individual, the basic premise that change will ultimately lead to changes in the

community. Thus helping an individual to become healthier, is not viewed separately from the context in which the individual lives. This ripple effect (see page 6) seemed to be present in the facility whenever music was initiated with residents, with everyone benefiting in some way.

Flexible therapeutic approach

A flexible approach allowed for diverse needs to be acknowledged and used to shape music therapy programmes. This approach was very important to this study and was arrived at through the process of building relationships and making connections, and trialling different ways of being with people in their environment. Addressing diverse needs involved a person-centred music approach with positive inclusion, while balancing health-related and music-related goals and aiming at the overall enjoyment of the group as a whole.

Not limiting my role to pre-arranged sessions became important in that many people could immerse themselves in music spontaneously, and become empowered about making their own choices. The negotiation of relationships and the emerging role of the music therapist took time but the culture of the facility was one that encouraged and supported spontaneous, in-the-moment and informal interactions between residents and the music therapist, and quite often with staff and caregivers as well. It was important to be able to respond to in-the-moment requests from the Clinical Manager, for example, *'Is there any music happening now? The resident's session of independent living has been cancelled'*.

Quality of life and well-being

Quality of life refers to *people's emotional, social and physical well-being and their ability to function in daily life* ("Quality of life", 2014), and well-being has been defined as 'the state of feeling healthy and happy' ("Well-being", 2014). Music therapists can be significant contributors to both quality of life and well-being in long-term care environments. The music therapy programme can be shaped to reflect the philosophy of the facility, and support the values of the community itself. My sustained interaction with the community at this particular facility allowed for increased contact and availability in which to spend time nurturing relationships and establishing programmes that fitted with the philosophy of the facility. The underlying premise is holistic care, which is the care of the whole person, and giving attention to all community members. These ideas have resonated throughout the study.

Displaying a sense of humour was key to maintaining the interest of members of the community, for the reason Freud describes: *'Humour has been described as a periodic release from the obligation to be rational and logical all the time'* (Freud 1967, cited in Haire & Oldfield 2009, p. 29).

The music therapy placement made me reflect that music therapy can bring about positive outcomes for a great range of people in long-term care, and that if people are feeling supported in their emotional well-being, and showing indications of change and positive growth, then music therapy can really make a difference. This idea is supported by a number of experts in the field. (Baker et al, 2008; Magee & Baker, 2009; Tamplin, 2006). Wigram et al. added to this notion noting that *'Various elements of music making can be used to help people externalise their emotions'* (Wigram et al, 2002, p. 69). Song-writing was one vehicle that was recommended by many authors in the study overall as a way to support well-being (Baker et al., 2008; Baker & Tamplin, 2006; Baker & Wigram, 2005; O'Brien, 2004). Reflecting on the need for support of all community members in music therapy sessions reminded me that over the practice I learned to stay with and manage difficult interactions and this was one of my growth areas. At first there was a tendency to create musical dialogue with more able people but I went on to balance this with people with higher needs throughout the year, encouraged by both my supervisor and clinical liaison.

Strengths and limitations

This study complements other research that addresses music therapy within a health-care perspective. It could hold particular significance for newly-qualified music therapy practitioners looking to understand and work with people with neuro-disabilities in long-term care facilities.

My experience in research using a qualitative approach has helped deepen my understanding of choices and actions in my clinical practice and assisted me to develop a framework for working with adults. (see Findings p. 20). Interpreting and questioning my own practice was an important skill to develop and my experience may be useful for others to reflect on.

From my observations I realise that I may have been looking for positive signs of people making connections as I was excited about it, and may have not represented more challenging things to the same extent. My special interest and belief in the power of song-writing may have influenced some of the techniques chosen in this study.

The chosen methodology may have had an impact on this study as it involved secondary analysis of data which involves looking again at clinical documentation. I wrote most of the data myself so it is clear that the results are strongly influenced by my perspective. Had the data been gathered specifically for the purpose of research, I may have sought to investigate other aspects of practice, or capture other people's views, through different data collection methods. However the data was collected as part of my clinical practice and included rich descriptions, personal reflections and clinical observations within which the residents' views were represented.

The findings of this study are not representative of all residents in long-term care facilities. They are based on the experiences of one student music therapist at one residential care facility. Therefore a different music therapist asking the same research question could have a different interpretation of events and findings. However, the findings and theoretical perspective developed from this study could be applied to other residential facilities and future studies could seek to capture the subjective experiences of residents involved in the music therapy process to better inform the practice.

A music therapy process that values meeting and balancing the diverse needs of people with neuro-disabilities in long-term care can strengthen individual relationships and foster a sense of community amongst people in an ecological way.

Future implications

The participatory nature of action research may allow for an enquiry that would more fully represent perceptions of the value of music therapy at a long-term care facility such as the one in this study. It might more fully represent the voices of the residents and staff instead of this study which contained data that I selected on their behalf. Further exploration of community music therapy practice in long-term care might provide valuable information for music therapy processes and practices that improve the quality of life for people in long-term care facilities.

Conclusion

This exegesis explored the involvement of adults with neuro-disabling conditions in music therapy in a long-term care facility, and developed a theory about this area of practice. The thematic analysis revealed six broad areas of support offered by music therapy to residents in

a particular residential facility. These themes centred on aspects of relating between residents themselves, and between staff and residents in the community. The core themes identified regarding the kind of support music therapy offered included:

- Building relationships
- Collaborative practices
- Fostering community
- Acknowledging diversity
- Emotional support
- Musical engagement

As I reflect on the question of how best to support people in long-term care and attempt to summarise these themes, it seems that music therapy resourced the residents, who were willing participants and sometimes quite vociferous about their music time, to develop their personal strengths. The residents felt most comfortable and natural taking part in large group, informal improvisation in a community music-making context. In this way people found new ways of being with each other, connecting with others about the music they were passionate about, sharing and offering opinions and having fun.

I finish this exegesis with the sentiments of community members (staff member, resident, and myself as music therapist) which seem to me to characterise the findings in more personal terms.

‘The music therapy student immersed herself fully into the life of the facility and worked with both residents and staff to create a musically enriched environment for all’. Manager, Rehabilitation and Therapy Team. 12/11.

‘People are interacting more, opening up and smiling, and this is really good for them’. Resident 18/6.

‘A popular song at the placement was ‘You raise me up’ (Josh Groban) which could be viewed as a metaphor for music and its continuing significance at the facility.’ Music Therapy Student’s R.D. 18/7.

Glossary of Māori Terms

Marae – a Māori meeting house

Waiata – a song or chant

Kaumatua – An elderly person of status

Tangata whenua – the indigenous people of the land

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Appendices

Appendix 1. Thematic Map

Category	Sub categories	Codes from the data
BUILDING RELATIONSHIPS	1.1 Being alongside	<ul style="list-style-type: none"> • Sharing personal stories • Listening • Rapport and trust • Articulating difficult memories • Articulating hope for the future • Exchanging confidences • Loss of independence • Reminiscing • Disclosures
	1.2 Providing support in a therapeutic relationship	<ul style="list-style-type: none"> • Support to participate • Decreasing isolation • Person centred • Medical conditions • Therapist confidence • Setting musical and non- musical goals
COLLABORATIVE PRACTICES	2.1 Rehab and therapy team	<ul style="list-style-type: none"> • Context of placement /clarifying role • Support, advice and feedback • Lifestyle plans • Awareness of safety issues
	2.2 With Residents	<ul style="list-style-type: none"> • Setting musical and non- musical goals • Song writing and lyric substitution • Support for movement • Planning concerts and special events
	2.3 With staff	<ul style="list-style-type: none"> • Support for people to attend therapy • Attendance at events for support and safety
	2.4 Inter-disciplinary team	<ul style="list-style-type: none"> • Working towards a common goal • Growing as a professional
	2.5 Supervision	<ul style="list-style-type: none"> • Equal partnership • Developing as a professional through self-examination and critical reflection
3 FOSTERING COMMUNITY	3.1 Making connections	<ul style="list-style-type: none"> • In a large group/community • Between residents • Between therapist and residents
	3.2 Participation and belonging	<ul style="list-style-type: none"> • Support to participate • Encouraging reluctant participants
	3.3 Social interaction	<ul style="list-style-type: none"> • Fun and humour • Celebrations • Theme dinners • Affirmations
ACKNOWLEDGING	4.1 the need to work flexibly to cater for	<ul style="list-style-type: none"> • Group improvised therapy

DIVERSITY	diverse needs)	<ul style="list-style-type: none"> • In the moment therapy • Individual • Spontaneous high needs therapy • Therapist enjoyment of working in diverse ways
	4.2 Restrictions experienced	<ul style="list-style-type: none"> • Different ways to communicate • Challenges for people
	4.3 techniques that supported flexible ways of working	<ul style="list-style-type: none"> • Observation • Valuing people • Prompts • Invitation to respond • Leaving time • Space in the music • Call and response • Matching • Turn taking • Invitation to make choices
5 EMOTIONAL SUPPORT	5.1 Support to manage and express emotions	<ul style="list-style-type: none"> • Expressing loss and grief • Loss of independence • Expression of positive feelings • Self -reflection and affirmations • Vulnerability • Mood changes • Empathy from therapist • Self- referral • Building of self -esteem and confidence
	5.3 Song writing and lyric sub	<ul style="list-style-type: none"> • Expression of hard emotions • Exploring personal stories • Visualisations • Developing a sense of self
6 MUSICAL ENGAGEMENT	6.1 Mastery	<ul style="list-style-type: none"> • New skills • Empowerment • independence
	6.2 creativity and originality	<ul style="list-style-type: none"> • New ways of playing • curiosity
	6.3 Developing group music skills	<ul style="list-style-type: none"> • Negotiation • Cooperation • Commitment
	6.4 Resource oriented therapy	<ul style="list-style-type: none"> • Leaving tools for groups to run themselves • Repertoire building

Appendix 2. Analysis of Data 1 Sample: Women's Group Session 24/6

Raw data	Description	Possible category	Analytic memo
All women have multiple sclerosis except one	Most have MS	Acknowledging diversity	I'm wondering what coping mechanisms the women will show eg. are they aware and accepting of their illnesses? 24/6 What is their sense of self? (Steele)
How's your week? Most said ok. For some people it is an effort to communicate I think and even have eye contact is difficult with progressive Ms. So I have to encourage feeling statements and eye statements.	Therapist prompts	Different ways to communicate. Challenges in a group Restrictions experienced	I feel guilty that I have my independence and that I raised my children to adults. 3/7
Plenty of pauses, time to respond.	techniques	Time to respond	
T communicates with pen and paper, but gives thumbs up. I was aware to include R. She was non-verbal and happy to write in her notebook to communicate where she used her note writing for communication.	Including non-verbal member in group	Diversity – restrictions experienced	Need to read about ms and get ideas for techniques 24/6
I've bought my itunes along. We can listen to 'Nature's Best' 1 and 2	Varied media	Techniques	Live/recorded music, a balance seems to work well here
Listened to Crowded house, Lorde, Bic Runga, Dave Dobbyn. Nature (voted NZs most popular song). Also listened to some unfamiliar recent contemporary music, Adele and Jessie j- contrast.	History of nz music, and new unfamiliar music	Listening to music for relaxation. Listening to a range of music	Was quite contrasting to listen to NZ music from 70s and 80s then contemporary pop
Mts: if you like a song and think you might want it in our booklet you can indicate your choices by putting up your hand or thumbs up.	Invitation to respond	Making choices	The women have severe spasticity so we will need book stands 26/6
Discussion – are there good things about our sharing session? All said yes.	Invites responses	Agreement in group Therapist prompts	
'feel alive and good' 'music you can float off to' 'makes me feel complete'	Describes feelings	Expressing positive emotions	I was overjoyed at these responses 26/6

Appendix 3. Analysis of Data 2 Sample

Sub categories	Codes from data	Concrete examples
Being alongside	Therapist listens	‘My husband is not communicating with me. We need to go somewhere nice, swim in the sea if it’s warm , then share a nice meal’ CN 3/10 ‘ I live in my head a lot these days’ CN 16/4
	Disclosures	‘ I felt guilty all those years, whereas I was the victim’ CN, 12/5
	Sharing personal stories	‘ I didn’t survive my childhood perfectly intact. , but now there’s a chance to grow again CN, 16/4
	Articulating hope for the future	‘I’m going to be great when I’m an older lady’ CN, 6/5
	Loss of independence	‘It’s all I can do now (smile) and I’m happy I still have that’ CN 10/6 ‘When I can walk again I will go to the tangi ‘ CN, 11/7
	Rapport and trust	‘With you I know you’re going to follow through with what you say’ CN, 18/4
	Exchanging confidences	‘What I don’t want to lose is the consciousness of who I am. Lose my memory’ CN, 12/5 ‘This is just the place I live, Caregivers come and go, some I like, some I don’t. Some are respectful and we can get along with dignity.’ CN, 11/4
Providing support	Decreasing isolation	‘ I enjoy the company of the others in the group’ CN, 10/6
	Motivation	‘I could make you a contract for playing daily’ CN 22/6

Appendix 4. Request for Permission Letter to Facility



Music Therapy Dept., New Zealand School of Music, PO Box 2332, Wellington, NZ

Tel: 04 463-5233 ext: 35807/35808

Dear [REDACTED]

Request to undertake Masters' research in music therapy at [REDACTED]

As you know I am a second year Master of Music Therapy student completing my clinical placement at [REDACTED]. As part of my training I am required to research an aspect of my practice, by looking back at the records I have kept about my work here in this setting. I am writing to you to ask for formal permission to undertake my research here as this is a requirement of ethical approval for this research from Massey University Human Ethics committee.

My research title is: *Adults with neuro-disabling conditions: Exploring the ways in which music therapy can best support residents in a long term care facility.*

My role so far has been to work with individuals and groups, building relationships, exploring musical choices, fostering a sense of community, and setting goals with people about what they would like to achieve during sessions.

The purpose of the research is to improve my learning and inform other music therapy students, practitioners, and carers of the outcomes of my work in this setting. There will be no client participants in this research and the methodology used is called 'secondary analysis' of practice data collected as part of normal music therapy work. It acts as a kind of 'audit' of my clinical work. Therefore there is minimal risk to residents at [REDACTED], and music therapy continues normally throughout the process.

I attach a copy of my proposal and a copy of the ethical approval letter issued by Massey Human Ethics Committee and the Ethics' Decision Tree, which records ethical process. Please do contact me or my supervisor if you have any questions about it. I will be seeking informed written consent for use of a clinical vignette in the thesis and there are a number of options for client involvement. No residents will be under pressure to be involved. If possible could you confirm to me in writing that this project can be undertaken, by Monday 14th July 2014.

With thanks and kind regards,

Liz Bolwell (Ms)

Appendix 5. Consent Form for Vignette



Music Therapy Dept., New Zealand School of Music, PO Box 2332, Wellington, NZ

Tel: 04 463-5233 ext: 35807/35808

Information and Consent Sheet for Permission to use a Vignette of Music Therapy Practice in a Music Therapy Research Project.

Researcher : Liz Bolwell

Supervisor: Dr. Sarah Hoskyns

I, [REDACTED] give consent for information about myself to be used in the research project to fulfil the requirements of the Master of Music Therapy at the New Zealand School of Music. I have been informed about the purpose of the research, which is focussed on how music therapy can support adults with neuro-disabilities in long term care. I understand that my personal and musical journey will be represented in a confidential sensitive manner with a pseudonym used to protect my identity. I have had time to consider whether I want to give consent for clinical notes from music therapy to be used and I have been able to ask any questions I wish of the researcher and her clinical liaison. I also understand that I will receive a copy of the vignette in due course.

Signed: [REDACTED]

Date: 14/7/2014

Appendix 6. Permission letter to use supervision and meeting notes



**Music Therapy Dept., New Zealand School of Music, PO Box 2332, Wellington, NZ
Tel: 04 463-5233 ext: 35807/35808**

Information and Consent Sheet to use Meeting and Supervision notes in a Music Therapy Research Project.

Researcher: Liz Bolwell
Hoskyns

Supervisor: Sarah

10 September 2014

Dear [REDACTED]

I am writing to ask formally whether I can use the notes from our supervision meetings for my research project. I am looking back at my data to make meaning of it and in order to be able to answer my research question 'How can music therapy support adults with neuro-disabling conditions in a long term care environment?'

The purpose of the research is to improve my learning and inform other music therapy students, practitioners, and carers of any issues arising from the work. The notes we developed could help in the processes I need to work through to be able to achieve this.

Yours sincerely

Liz Bolwell

Appendix 7 Song Composition

