

# Establishing a New Music Therapy Service in an Aged-Care Centre with Multiple Settings: The Journey of a Music Therapy Student

By

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## ABSTRACT

This exegesis describes my journey as a music therapy student navigating a practicum placement with older people, in a facility where there had been no previous music therapy service. My uncertainty about beginning the placement was compounded by the fact that major renovations were taking place at the facility, and low staff numbers meant I was left largely to my own devices. The fact that music therapy is a young profession was clearly going to have an impact on how I went about building my own practice as a music therapy student within the facility. This study was therefore motivated by my desire to explore my process of establishing a new service in a healthcare setting and to share the strategies I developed. Using secondary analysis of data as my research approach I have analysed my meeting notes and a self-reflective journal to explore both the advantages and challenges of building a music therapy program as a student. Seven preliminary themes have emerged including 'Developing relationships with staff and finding support within the institution'; 'Educating people about the role of music therapy'; and 'Coming to terms with institutional constraints'. I needed to 'Develop relationships with participants and family members', 'Develop various music therapy programmes for different settings', and I learned about 'Taking risks' and 'Engaging in self-reflexive practice'. The study supports previous research about the challenges of implementing a new service in a facility, including the requirement for high levels of communication/language skills and the need to fulfil multiple roles. It also confirms research that shows that some of these communication skills go beyond the training undertaken by music therapists. This study suggests that this might be remedied through course-development within tertiary music therapy education programmes, and courses and conferences through professional music therapy organisations.

### **Keywords**

Music therapy, service development, age care setting, collaboration, self-awareness

## CHAPTER ONE: INTRODUCTION

*'Music naturally radiates, like dropping a pebble in a pond  
and seeing the waves of energy spread out in concentric circles.'*

*(Ansdell & Pavlicevic, 2004, p. 16)*

### **My Interest in this topic**

During 2017, I completed a 750-hour music therapy placement over a period of seven and a half months as a music therapy (MT) student at Victoria University of Wellington, which was part of the thesis requirements for the Master of Music Therapy Degree. I felt some uncertainty when starting at this facility because I was aware that it was a new placement for the music therapy master's program. I also became aware that the facility was being impacted by renovation and low staff numbers, which created added pressure for those working there. These issues, along with the fact that music therapy was completely new for most of the staff members, suggested there could be a number of challenges in the process of finding my place within this setting. I found myself explaining MT often, as well as trying to find a gap for MT and to squeeze it into a setting which had never experienced a MT service.

Few staff appeared to be interested in my work, and I needed to find my own way to establish my work in the facility for various reasons which I will explain later. The fact that music therapy is a young profession was clearly going to have an impact on how I went about building my own practice as a music therapy student within



the facility. This study was therefore motivated by my desire to explore my process of evolving a new service in healthcare settings and so expose some effective strategies for doing so. In this exegesis I explore my process of evolving a new service in health care settings, including the challenges and advantages as a student, such as the need to educate others about the role of music therapy. This research, based on my self-reflections as a MT student, will examine and explore my personal development as well.

## **Introducing the Settings**

I was placed on my final year practicum in an aged care facility situated in the centre of a residential area in a New Zealand town. It included two main parts: a Care Centre that provided hospital and palliative care (including dementia care), and a Retirement Village that provided in-home care through serviced apartments.

### **The Care Centre**

The Care Centre housed approximately 50-60 residents. It had three wings - one rest home wing and two hospital/palliative care wings. The rest home wing residents were more independent than individuals in the hospital wings, who needed full time care. The hospital wings were always full and sometimes residents were moved into the rest home wing due to lack of beds in the hospital wing.

### **The Village**

The Village offered space for a home for approximately 150 residents who lived in apartments designed for the appropriate level of support/care they needed. All of the villas were self-contained. There were a number of large spaces provided for different activities, events and meetings as well as the manager's office and residents' kitchen, in which meals were provided if needed. The village was supported by a manager who could access nurse and other assistance for the residents as required.

## **Goals & Philosophy of the Facility**

Most of the residents, in both the Care Centre and the Village, were there long-term. The residents lived with various conditions such as dementia, stroke, cancer and natural deterioration from aging. Most of the adults were over the age of 65, and the facility was their home. The philosophy of the home is to create a homely retirement community that puts the respect for its residents at the heart of everything it does.

## **Note to the reader: Personal Assumption/Statement**

Initially the reader may be confronted with what seems to appear a negative perception of my experiences when starting as a new MT student in a new placement and being confronted with a number of challenges that arose at the beginning. Outlining these were important, however, as they were my first impressions of the placement and how I felt in the beginning, as contained in the journal excerpts. This perception perhaps also had to do with some parts of my personality.

When I first started at this placement I felt that I had high expectations from this placement and also of myself. In my reflections 'I wanted to make everything right', and 'I wanted to give a perfect and positive first impression' as a MT student to people (staff and patients) when they met me and heard about MT for the first time, as I was somehow aware of the importance people associate with first impression. This related to my awareness of MT as a new field and 'how precious it is to me'. Through experiencing this enthusiastic feeling, I wanted to share something I find really valuable and want other people to value as well. Therefore, I felt a high level of responsibility to do it right.

However, having to face a whole lot of unexpected challenges and institutional constraints at the beginning of my time at this place surprised me, and at first, I felt as if I had come down to earth with a bigger bump than anticipated.

I always have been a perfectionist, and, at times, it was not easy for me to accept what I perceived as my own failings and the 'failings of the institution'. At the beginning, it was difficult to accept the limitations of the environment and the reality that I could not change some things. I also struggled to be assertive and directive and make independent decisions. As a student, I realised that I needed to understand those limitations, come to terms with them and let go of some of my expectations.

I came to realise that several of the situations described on the following pages are and will be the reality in numerous institutions. I, therefore, began to learn how to manage these kinds of challenges and shift my focus to the positive outcomes/results/moments of my work and the opportunities to create wonderful relationships with staff and patients. I saw the importance of having the opportunity to 'plant a seed', maintain it throughout this placement, and try to keep it growing with the support of others after I left.

As an MT student, I am still developing, grasping and recognising my own approaches. My reflexive work was influenced by a humanistic-based philosophy and approach in terms of training. This was because I was supporting clients to develop to their full potential, by focusing on their self-awareness and self-growth instead of focusing on 'treatment' (Bunt & Stige, 2014). This meant also letting go of initial plans and ideas and being in the 'here and now' (Bunt & Stige, 2014) which became another important learning process for me.

The humanistic perspective underlines the acceptance of human beings and highlights respect and positive considerations for people, valuing their uniqueness and their differences. This 'wholeness' includes integration of body and mind as well as authenticity and autonomy (Bunt & Stige, 2014).

The thesis outlining my journey as MT practitioner is organised as follows:

- Chapter Two, literature review;
- Chapter Three, methodology;

- Chapter Four, findings;
- Chapter Five, discussion;
- Chapter Six, concluding comments.

## CHAPTER TWO: LITERATURE REVIEW

For my brief literature review I used a number of topics that were relevant to my research:

- Music Therapy (MT) – various definitions
- Community Music Therapy (CoMT)
- Music Therapy with older people – various practices
- Music Therapy as a New Discipline
- The Establishment of New Disciplines more generally

I searched the library using various key words in a research 'string', for example:

(Music Therapy) and (Definition)

(Community Music Therapy) and (older people) OR (elderly)

(Music Therapy) and (Establishing a new service) OR (service development)

### **Music Therapy - various definitions**

Defining Music Therapy (MT) was very important at my placement, and I drew on various different definitions:

*"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 physical, social, communicative, emotional, intellectual, and spiritual health and well-being." (WFMT, 2011).*

Music therapy is an allied health profession which uses and involves music to achieve therapeutic goals in areas such as communication, self-expression, emotional support, physical rehabilitation, and social interaction for people "...with medical, educational, social or psychological needs" (Wigram, 2013, p. 29).

Wigram also states:

*"The use of music in clinical, educational and social situations to treat clients or patients with medical, educational, social or psychological needs."*  
(Wigram, 2000e, cited from Wigram, Nygaard Pedersen and Bonde, 2002, p. 29)

Stige et al. focus on self-expression and communication via music:

*"In music therapy there is an interest in human interaction through music and not just in the organism's reaction to music. Music therapy practice therefore often focuses upon human expression and communication."*  
(Stige, Ansdell, Elefant, Pavlicevic, , 2010, p. 3)

And Bunt and Stige say:

*"Music therapy is the use of sounds and music within an evolving relationship between patient/participant and therapist to support and encourage physical, mental, social, emotional and spiritual well-being."*  
(Bunt & Stige, 2014, p. 18)

The first WFMT definition (2011) is broad and in trying to encompass a range of practices is not especially helpful for people who are trying to understand music therapy practices with a specific population. The second, by Wigram (2002), has a strong 'clinical' or 'medical' focus, which is incongruent with the approach I was

taking. I liked the humanistic aspect of Stige et al.'s (2010) definition and the pragmatic simplicity of Bunt and Stige's (2014) definition.

As suggested above, the definition of MT can also vary depending on the participants' population, the orientation and the perspective of specific groups of practitioners, or diverse cultures (Bruscia, 1998), as well as considering the professions' appearing and emerging in different countries and traditions. The professional background of the practitioner, the need of the client as well as the approach that is used in treatments needs to be thought carefully about (Wigram, 2013).

However, I realised that I needed to be very pragmatic in the way I explained it to people because formal definitions can be long and complicated, not appropriate for everyday use with participants because they include a wide range of practices. So, I needed to find how that would play out in my actual practice. I had to adapt all these definitions and come up with a short definition for different people (staff & patients) in the different settings (Care Centre & Village). I had to find a way to define MT that was easy for staff, patients, and families to understand and that got to the core of MT in this setting.

For example, I used the following description with clients and families in the Village:

"MT can be very different in each place. Here for example it can be... us coming together to socialise, singing, making music and sharing our memories & stories."

Other definitions were offered because they refer to medical intervention for example when I explained to staff members and, at times, patients, in the Care Centre:

“With MT I want to help a patient move their arm.” Or: “With MT I want to support and improve patients' speech.”

It can also refer educational work where I could ask somebody if they wanted to learn the piano.

Talking about MT in this way helped my clients and their families understand it in common language or in a way that related to their world.

### **Community Music Therapy (CoMT)**

In the retirement Village I created 'musical communities' to provide opportunities for people to come together. This is how I understood this way of working with this group of people because I thought this was the most practical way to establish MT for various reasons I will explain. Although people lived close to each other in the Village, few of them had opportunities to get to know each other very well. While the idea creating musical communities might not have been a specific goal initially, it evolved naturally over the course of my practicum.

Osterman (2000) suggests that a community exists when people meet in a group and feel cared for, supported and fulfilled, as well as satisfied by their needs and the group has a feeling of (shared) connection and belonging which can have an effect on both, motivation and behaviour. Considering well-being in cultural and social contexts through music (O'Grady & McFerran, 2007; Pagad, 2014; Pavlicevic, 2004; Stige, 2002), CoMT can be characterised as making music in a collaborative way or giving access to health promoting musical activities for disadvantaged people and giving voice to them (Ghetti, 2016; Stige, 2002; Pagad, 2014), and focusing on the relationships.

CoMT is therefore considered as “a broad perspective exploring relationships between the individual, community, and society in relation to music and health” (Stige, Ansdell, Elefant, & Pavlicevic, 2010, pp. 15-16). MT in a group for creating



community can be useful to enhance group cohesion and therefore prevent social isolation (Steele, 2016).

Stige and Aarø (2012) state:

*"Community music therapy encourages musical participation and social inclusion, equitable access to resources, and collaborative efforts for health and well-being in contemporary societies. It could be characterized as solidarity in practice. In this way community music therapy can be quite different from individual treatment, sometimes closer to practices such as community music, social work, and community work." (p. 5)*

Pavlicevic and Ansdell (2004) say:

*"Music naturally reverberates, permeates, goes through boundaries and walls. And in doing so it calls to others, attracts, gathers, connects people together. It creates community. It can also bring the community in, and can create community within a building. Music therapy includes a socio-cultural agenda for the people and communities it works with, and the places it works in." (p. 16)*

While there is some information about CoMT with older people (for example, Dennis & Rickson, 2014, and Nishimoto & Kimura 2017) I was unable to find publications specifically written about CoMT in Retirement Villages. This study will go some way to fill this gap in the literature.

### **Music Therapy with older people - various practices**

Due to society's increasing aging population (Baker & Ballantyne, 2013; Henderson, Willis & Blackman, 2016) and therefore people requiring rehabilitation, there is a higher demand on social services, which places pressures

on the health care system and social structure (Matthews et al., 2015, Lem A., 2015, Särkämö et al., 2013, Guetin, et al., 2009).

In residential care institutions MT is increasingly known as an alternative, cost-effective, non-pharmacological treatment for people with different conditions (Livingston et al., 2014). In this sort of setting, MT is seen to address multiple needs, such as social needs (Cohen et al., 2006; Fung & Lehmberg, 2016,), physiological needs (Werner, Wosch & Gold, 2015), mental needs and self expression (Eells, 2014) and pain management (Gold & Clare, 2013) through relaxing music, breathing and imagery (Kelley, 1996). MT is a non-invasive therapeutic method, which can be supportive and beneficial in improving wellbeing and quality of life in older communities (Baker & Ballantyne, 2013; Eelss, 2014; Hays & Minichiello, 2005; Lee, 2010; Lem, 2015; Ridder, Stige, Qvale, & Gold, 2013) and overall helping to "... promote authentic happiness and healthy ageing" (Baker & Ballantyne, 2013, p.7). According to Baker (2013) "Music-based activities have long been used to promote positive health and wellbeing in older adults..." (p. 9).

The literature shows that MT has been found to be effective with a variety of conditions common in age-care. For example it has been shown to be useful and a practicable intervention in several ways for people with dementia (Hung Hsu, Flowerdew, Parker, Fachner, Odell-Miller, 2015), anxiety (Eells, K., 2014), Parkinson's disease (Talmage et al., 2015), stroke patients (Jun, Roh & Kim 2012; Lim et al., 2013; Thaut & McIntosh, 2014), or patients with depressive symptoms (Cooke, Moyle, Shum, Harrison & Murfield, 2010). As Wall and Duffy (2010) write:

*'MT is often informally used in residential care units to improve communication, emotional, cognitive and behavioural skills in elderly patients diagnosed with dementia both nationally and internationally.'* (p. 2)

As well Lin, Chu, Yang & Chen (2010) suggest that patients with dementia, showing agitated behaviour, benefit from participating in music interventions.

Similarly, Chen (2018) notes the capacity for music to influence many domains of human experience and the impact on stroke recovery:

*'Music engages multiple facets of the human experience, tapping into sensory, motor, cognitive, and emotional domains, as a few examples. Several literature reviews have provided thorough discussion on the role of these factors in enhancing stroke motor recovery.'* (Chen, 2018, p. 1)

The literature suggests that there can be many different areas of concern which can lead to a resident's referral such as social isolation helping people who are at risk for depression and agitation (Cornish & McNair, 2015).

According to Kimmel (2012),

*"People associate music emotionally with different events in their lives. Indeed studies have shown that music is linked to areas of the brain that control memory, emotions and movement, according to the American Music Therapy Association" (08.04.2012, n. p.).*

Once clients have been referred, or self-refer for MT, the next step is assessing them, which Pinson notes as a "continuing process that allows the music therapist to continually refine his/her technique to better meet the needs of clientele". (Pinson, 2013, n.p.).

### **Music Therapy as a New Discipline**

Music therapy is a new profession (Ferrer, 2017; Twyford & Watson, 2007) particularly in the New Zealand context. Various NZ and international music therapists and researchers have noted the challenges in growing such a young profession (McGann, 2012; Twyford, 2009). Furthermore, Priestley and Eisler

(1993) note that music therapists have to defend and demonstrate the value of their work in relation to the more accepted and established professions and need to be “convincing to earn respect” (p. 1). Literature identifies a great need to build an increasing awareness of MT in a new setting (Konienca, 2009; Purvis, 2010). Moreover, Twyford (2009) observes that “creating a new professional role in an established organisation is both exciting and challenging for an individual” (p. 7).

Music therapists often work in a variety of settings such as pre-schools, schools, psychiatric and medical hospitals, rehabilitative facilities, outpatient clinics, day care treatment centres, agencies serving persons with developmental disabilities, community mental health centres, drug and alcohol programs, senior centres, nursing homes, hospice programs, correctional facilities, halfway houses, and private practice (American Music Therapy Association, 1998-2018). They find themselves “being interdisciplinary music therapists” (Wheeler, 2010) which can create both “opportunities and challenges” (Wheeler, 2010).

McGann (2012), describes overcoming challenges as a MT student setting up a new music therapy service and notes the importance of “collaboration, teamwork and multidisciplinary music therapy work” (p.13). Twyford (2007) and Laahs and Derrington (2016) acknowledge the importance and benefits of collaboration to strengthen the identity of the profession of MT but also barriers, such as lack of effective communication, goals or understanding the different roles of other professionals in a large team (Xyrichis & Lowton, 2008).

Various researchers cite a number of tools that can be used when establishing a new practice, such as referrals, documentation and providing information to other employees (Blichfeldt-Ærø and Leinebo, 2016). In the literature it is acknowledged that educating people is often an important part of establishing a new MT service. This involves helping people understand that MT is different from musical entertainment. For example, Ledger (2013) highlights that MT is a relatively new healthcare profession in which music therapists find themselves introducing MT in settings without any history in MT or contextual frame (Ledger, 2010). Often music

therapists are new members in an already established team of healthcare professionals who have never worked with MT before. This means that MT in many institutions needs to be explained (Chang, 2014), which seems to be “an integral part of being a music therapist” (Bruscia, 1998, p. 1). Also Pearson (2018), describes music therapists' need to play various roles at times; wearing multiple hats: the clinical and the business.

Cornish & McNair (2015) and Pearson (2018) said that Music therapy is often misunderstood. Music therapists need to be able to differentiate between music as entertainment, music that is naturally employed to meet therapeutic or wellbeing goals, and music therapy .

Music therapists complete a degree program and are also clinically trained to approach specific ways of working with the patient such as selecting individual music and interventions which are based on the patient's cultural, emotional, psychological, and background. Music therapists also learn how to make quick and spontaneous judgments and decisions to support the clients in the session.

Pearson remarks that

*“...as music therapists we have an opportunity to position ourselves as experts to care communities that are already excited about music.” (2018, p. 5*

The care community was excited about music and although I did not position myself as an expert it certainly gave me something important to draw on.

There seems to be general agreement that it is important to assess and set particular goals for each client to address individual and group-oriented needs (Cornish & McNair, 2015). While in the Care Centre I anticipated I would focus on sustaining or increasing physical or cognitive functioning (Cornish & McNair, 2015), and in the Village on socialisation and connection through sharing and making music. My emphasis in MT for older people might be improving or maintaining the patients' well-being and quality of life.

Having those arguments was particularly important in my project because the facility already had music entertainers, but no one knew how MT would work.

### **The Establishment of New Disciplines more Generally**

As well as in MT, researchers in other disciplines, such as oncology, describe challenges in setting up a new service of new disciplines and highlight the importance of using tools and strategies such as interdisciplinary collaboration (Schellack, Wium, Ehlert, Aswegen & Gous (2015). Grant, Marthick and Lacey (2018), when integrating and implementing a model of integrative oncology services as complementary therapies, also identified barriers due to “lack of knowledge” and “poor understanding of value” (p. 7) of such a service among team members. Similarly, communication/dialogue between specialists and patients regarding referrals and treatment plans for patients is as important as educating staff members. According to Grant et al., “multidisciplinary integrative and supportive care weekly meetings are key to creating a strong, cohesive team” (p. 7).

The literature review highlights the benefits of MT, and the challenges in introducing a new programme.

### **Summary of Literature Review**

Researchers have identified an increasing need for music therapy in aged-care facilities. As a non-pharmacological intervention which has noted benefits for the growing older population, it will become increasingly important in decades to come. However, music therapists apply a variety of definitions and approaches, depending on the context in which music therapy is practiced. Community Music Therapy provides a promising frame for my work because it focuses on the cultural

and contextual needs of communities such as the aged-care facility I will be entering.

Nevertheless, music therapy is a relatively new discipline. Music therapists, like other professionals, have identified challenges in setting up new services including the need to educate others. I am therefore interested to investigate the processes that are necessary when establishing a new music therapy service in an aged-care centre with multiple settings.

## CHAPTER THREE: METHODOLOGY

Chapter three outlines the Methodology, 'qualitative, secondary analysis of data'.

### **Methodology**

The methodology employed for this study is 'Secondary Analysis of Data' (Heaton, 2004). Heaton suggests that the first principle of secondary analysis of data is that it involves the use of pre-existing data, i.e. data that has already been gathered or compiled in some way. The data has been collected for another purpose (such as clinical data) and is reused for research purposes. In this case, I used clinical notes, meeting notes, and a reflective journal (see below).

### **Data sources**

This research (project), which is Qualitative research, used Secondary Analysis of Data of clinical documentation in order to look at how I developed a new service of music therapy for people in an aged care facility with different needs in different settings as a MT student. Data was gathered in the following ways:

- clinical notes of interactions between MT therapist and patient/music therapy case files
- notes from meetings and discussions with staff members (clinical liaison/manager /diversional therapist) and family members
- notes/advice from visiting music therapist,
- reflective journal (reflecting and working on my MT practice)
- personal journal (recording and working through my personal struggle/self-growth)



## **Data Analysis**

Data was analysed using thematic analysis, which “is a method for identifying, analysing, and reporting pattern (themes) within data” (Braun & Clarke, 2006, p. 79).

First, I used different colours to highlight key terms in my notes. Then I sorted, grouped and reorganised concepts, separating ‘challenges’, for example, into personal, institutional, staff, and patients as well as doing a secondary and third coding. This analysis process helped me identify patterns and themes, as shown in the Appendix.

From my coding I developed categories and identified preliminary themes which will be presented in detail in the following findings chapter.

## **Ethical Approach**

In this project I was both the researcher and the student music therapist who was the provider of the clinical data for the research. I was working towards completing my Master of Music Therapy degree through the New Zealand School of Music, Victoria University of Wellington. I abided by the Music Therapy New Zealand Code of Ethics (2012) and the Human Ethics Policy of Victoria University of Wellington. This research received ethical approval from Victoria University of Wellington, made on behalf of students in the Master of Music Therapy Programme. Application Reference: VUW Approval Number 22131, 15<sup>th</sup> July 2015.

## CHAPTER FOUR: FINDINGS

The findings section aims to provide a detailed illustration of how I established a new service of music therapy in the above-mentioned facility.

From my analysis, seven themes emerged including 'Developing relationships with staff and finding support within the institution'; 'Educating people about the role of music therapy'; and 'Coming to terms with institutional constraints'. I also needed to 'Develop relationships with participants and family members' and 'Develop various music therapy programmes for different settings', and I learnt about 'Taking risks' and 'Engaging in self-reflexive practice'. These findings will be supported by excerpts from my data.

### **Developing relationships with staff and finding support within the institution**

The first vital step in being able to establish a new practice as a music therapy student involved getting to know the institution in which I was working and to find support and people to liaise with within it. This was more difficult than I had thought, and I encountered a number of challenges including identifying staff roles, a Clinical Liaison to facilitate my journey as a student, and which staff I would be working with.

#### Identifying staff roles

Identifying staff roles was initially difficult because the place was so large. The Care Centre employed numerous staff - carers, nurses, cleaners, a doctor, a number of managers and staff who worked in the reception, office, and kitchen. Both the Village and the Care Centre had separate managers. There was a Diversional Therapist (DT) responsible for activities, entertainment, and outings in

the Care Centre (replaced by a carer on the days she was not onsite), and in the Village there was an activities coordinator responsible for in-house activities, games, concerts and other events. Because of the size of this institution and the changing shifts I did not have the opportunity to come in contact with all team members, and it took time to find my place amongst such a large team.

According to the clinical guidelines provided for my placement, the role of the clinical liaison included making “expectations clear to the student regarding their role in observing, assisting and contributing, planning and/or implementing” (New Zealand School of Music Victoria University of Wellington, 2016, p. 4). However, it was not clear who should be my clinical liaison. The manager in the Care Centre only had experience with nursing students and was unable to give me specific information about the well-being of patients as she was responsible for operational matters, not therapeutic ones. The Diversional Therapist was named as the person I should approach if I needed information about the activity programme, or about patients, and carers and nurses would help when I needed to physically assist patients. The Care Centre manager tried to answer my general questions but I needed to save specific questions about music therapy for my Visiting Music Therapist, or course lecturers.

*I wondered how the professional supervision with the CL was meeting my needs*

*Journal Excerpt, Notes Supervision April, 2017*

Being unable to find a single person who could help me as a music therapy student meant I felt uneasy and uncertain about my role for some time.

*I still haven't had time to speak with a nurse to find out who is my CL. She is rarely available. There are still questions which are not answered.*

*(Journal Excerpt March, 2017)*

*The carer who replaces the DT on the day when my group sessions take place (care centre) is often not available to assist me. She needs to continue working as a carer due to low staff numbers.*

*(Journal Excerpt March, 2017)*

I eventually realised I would need to go to different people for different answers: the DT for general questions about activities, and the manager (Care Centre) about operational matters and difficulties. If I had questions about conditions of patients, I needed to ask a nurse, and if I wanted information about well-being of patients on a particular day I had to find the carer who was responsible for that patient. However, the information the nurse gave me was not as accessible to me as the DT, so, on the days she was not there, I had to trust my intuition.

#### Developing Connections in a Busy Environment

During my time on placement I became very aware of how important it is to build effective working relationships with a variety of staff. This involved learning to accept that relationships with various staff members would be different, depending on our personality-fit, their availability to connect with me, their roles and their interest in music or music therapy. I wanted to know that my work was valued, and this was not always easy to determine.

Some staff provided occasional affirmation and acknowledgement. One key staff member, who had a child with special needs and experience with MT, was enthusiastic about me being on placement in the facility. Others mentioned that I did beautiful work with the patients and they could see the impact it had on people. Yet another staff member said she was able to observe a significant difference in a patient with whom I worked and who had been previously socially isolated.

However, it was difficult for me to trust myself without receiving as much affirmation, support, and encouragement as I wanted. As I experienced an overall sense of isolation in the beginning of my placement I tended to interpret the absence of this in a personal way – believing that people did not care about me, or about music therapy:

*It took almost four weeks until the head nurse spoke to the sister of my patient who is in palliative care. I had approached her several times and I felt almost guilty about asking again as she is very busy. Although there is no evidence and it is 'just' a feeling, I feel a strong sense of an attitude from her that she is not interested in my work and does not take time for me. Quick conversations are mainly in the hallway and she talks to me only because her manager expects it but she appears unconvinced about my work. On the other hand: Does she need to be convinced? How can I find a balance between accepting staff's doubts about MT and trying to explain about MT.?*

*(Low staff setting – need to take initiatives; need to be clear about my needs  
(precise, concise)*

*Excerpt Journal May 2017*

I was surprised when some staff, from whom I had not expected a response, approached me at the end of my placement and spoke positively about the effect of MT on patients. Managers of both the Care Centre and the Village expressed strong appreciation. This reminded me that it is not always possible to know what other people are thinking, and that, if I am too attached to receiving affirmation and encouragement, I can misinterpret people.

*Both the manager of the Care Centre as well as the manager of the Village, have expressed several times that I do beautiful work with the patients who are glad to have worked with me.*

*Journal Excerpt June 2017*

Finding support, being open to potential collaborations and developing solutions together.

The final aspect of developing positive relationships involved finding solutions in conjunction with other staff. The Village manager occasionally gave me advice about how to address the needs of Village residents, as did the activities coordinator. For example, she encouraged me to use the community newsletter to invite residents to the MT group, answered questions about the needs of individual residents, and invited me to take part and assist a musical quiz she and the activity manager facilitated for the residents in the village. I was happy to be of assistance but due to timing issues this event never happened.

Some of my groups at the Care Centre involved large numbers of participants, and I wanted support to assist residents and to maximise the potential of the music therapy. The Diversional Therapist recognised that she or the carers would be the best people to help but they were rarely available.

Other potential support for my group sessions emerged when I met two harp players who gave concerts in the Care Centre once a month. After a brief conversation they suggested we might collaborate. While I was initially excited about this, we were unable to find a time when we could work together.

I also invited other team members to my sessions. Carers or nurses would sometimes watch sessions, sing along, or help spontaneously when I was running the group. This was very helpful for large group sessions, especially when I was not able to play the guitar and demonstrate physical exercises at the same time. When this support was not available, I put the guitar aside and sang a capella, spontaneously adjusting activities as necessary.

One staff member helped by finding a way to limit distracting noises in the lounge, and developed a system of finding out when patients were available:

*I informed the staff member about my frustration about not always finding it easy to see the patients on my list. We eventually decided I would send her a list of my patients and she would try to support me finding out who was ready and who was unwell.*

*(Journal Excerpt June, 2017)*

Another example was when the Village manager and I explored how we could establish better patients' access to music by setting up an internet connection in the room where MT was happening. This enabled the participants and me to play recordings via the internet, for example on YouTube.

By asking questions and talking with various staff members, eventually solutions emerged. Other strategies that I developed with staff involved checking in with the head carer before working with individual patients, and setting up a timetable for individual sessions. As a result of developing these strategies together, I began to get to know staff better.

### Dealing with Challenges

The other aspect to developing positive relationships was being able to deal with miscommunication and conflict-resolution. With some staff, I encountered cultural and personal differences that made it difficult for us to understand each other and find a common ground and therefore to connect:

*During a group session I was interrupted several times by a patient who sat at piano and started playing it. One key staff member shouted at me to discuss if the patient can play. This happened in-middle of a singing exercise but I was aware that patients' wishes should be respected as much as possible.*

*Journal Excerpt March, 2017*

This made me feel frustrated and helpless, which I wrote about in my journal and discussed with my MT supervisor, peer-supervisor, and counsellor. Speaking about it helped me let go of my strong feelings, and to interpret the situation as a cultural misunderstanding, rather than a personal one. It also highlighted the need for me to establish clear boundaries around the ways in which others might be able to support my work.

### **Educating people about the role of music therapy**

I quickly learned that few staff had any understanding about my role as a MT student, and they had not been prepared for me joining the team until a few days beforehand. Music Therapy was a foreign concept to almost everyone I met (other than one woman whose daughter had benefited greatly from music therapy).

Educating people about MT and its potential contribution in the facility, therefore, became important – helping staff, hospital patients, Village residents, and family members grasp how MT might support and help them or their loved ones. I had to develop an educational strategy, and I now see what a great opportunity this was that will come in useful numerous settings, given that MT is still such a young profession.

Setting up the music therapy practice required much more than introducing myself and setting up session timetables. Having to explain what music therapy can offer, stimulated many questions for me. How would I do this effectively? How would I successfully involve busy staff members? How could I help family members understand the process?

In trying to answer these questions, the following educational strategies emerged:

1. Using institutional communication systems,
2. Talking to key staff in meetings, workshops, or conferences,



3. Inviting staff to attend MT sessions,
4. Experiential education (my support for staff) - Using music to support STAFF in their work

#### Using institutional information systems

In both the Village and the Care Centre, the information systems became important vehicles for educating staff and residents about music therapy. In the Village, there was a monthly newsletter in which regular upcoming events and activities were mentioned and a weekly newsletter with reminders. I put together a short piece about MT for both these publications. Additionally, there were monthly meetings for residents with the manager and activity coordinator, which were an ideal place for me to introduce myself and my work. In the Care Centre, an activity programme was created by the DT, and my MT programme was included. I also used the staff newsletter to inform staff about an MT drumming group that I decided to offer.

#### Talking to key staff and residents

Speaking with key staff was also important. This mainly happened during meetings, spontaneous conversations, or lunchtimes if I happened to be in the kitchen. In the beginning I was often asked whether I just played music to patients or if there was “more to it”. I did not feel well prepared for this question initially, but eventually found a way to explain in language that could be understood by various groups. This was important because I did not want to sound overly academic. I learned from my teacher that recalling individual cases and providing real-life examples of music therapy were more effective than explaining benefits theoretically. I was also advised that I needed to come up with short explanations that went to the heart of the issue. For example, for the elderly participants, I learned to say that MT could help with things like feeling sad, feeling lonely and depressed, needing an outlet for talking and sharing, helping with movement/physical exercises, and calming and soothing when agitated or anxious.

Inviting and involving staff to attend MT sessions

Another strategy was to invite people to attend my MT sessions. For some, being able to observe the impact of MT was more effective than being given explanations. Whenever I met a new carer or nurse, I used these opportunities to let them know about my group sessions and invited them to pop in to have a look.

Providing Music Therapy for staff

The final way in which I attempted to educate people was by providing music therapy for staff, who were often under a lot of pressure. This came about after a meeting with the manager of the Care Centre, and I suggested the possibility of setting up a MT group for staff. She liked the idea, so we proposed it to the head manager, and together came up with the idea of creating a music/drumming group, because the manager thought the term "therapy for staff" might not be well received (see Appendix 3). The Care Centre manager emphasised the importance of improving well-being for staff as much as for patients. She believed that if the staff were happy, patients were more likely to be happy.. Unfortunately, however, due to timing issues, the drumming group only eventuated as a one-off session.

## **Coming to terms with institutional constraints**

Timetabling

### Care Centre

The Care Centre Manager trusted me to set up the timetable, and to plan the programmes.

The existing activity programme for the residents in the Care Centre was organised a month ahead, and timetables were very full. It was described as cultural, recreational, activity based, and cognitively-focused. All of this was scheduled alongside routine activities such as after lunch naps. My group sessions were therefore initially short (15-30 minutes), interspersed between other

scheduled activities. Eventually though, one of the other activities was moved and I was able to run a group session in the lounge after morning tea.

### Retirement village

Like the Care Centre, there were many daily activities already established in the Village such as sports, art and craft, movies, musical activities (ukulele orchestra and singing groups), games and many other events (concerts, exhibitions and trips). Residents also had more opportunities outside of the Village, as they were more independent.

An activity programme was produced monthly and a newsletter weekly, both organised by the activity coordinator. Although it took several weeks to start the MT sessions due to such a full timetable I eventually managed, with all those residents who were interested, by introducing my work and then, at the next meeting, including them in planning the sessions. Finally, when space for a session became available, we agreed to start group sessions in the afternoon.

### Identifying Which Clinical Meetings to Attend

Various meetings were held regularly but it was hard for me, without direct support, to identify what kind of meetings which would be appropriate for a MT student to attend:

- Quality meeting (manager, head nurse, head carer/once a month),
- Management meeting (all managers including head office manager),
- Hand over meeting (nurse meeting/daily)
- Operational meeting (DT, manager/spontaneous and irregular)

After attending the Quality meeting and the Operational meeting, we agreed that these meetings were not particularly relevant for my work. The Management meetings were not suitable either, so it was decided that the nurses' hand-over meetings would be best. However, these meetings took place when I was not onsite, so I was not able to attend them.

The only meetings that I attended consistently were with the managers in the Care Centre and the Village, which happened every four to six weeks, and were an opportunity to share information.

### Space Limitations

An additional problem involved the lack of space. The manager told me that new centres are now building larger lounges and more space for storing equipment (such as musical instruments). However, the facility in which I worked did not have these spaces and there were a number of occasions when I had nowhere to do group sessions in the Village. For example, the room I originally used for MT groups became unavailable while being refurbished, and I needed to move to another room for two months. This was problematic because the only other space was the large lounge, which was used for other activities and there were occasional complaints from residents that their space was being occupied once a week. Despite these challenges, I was lucky to be able to use the lounge until the original room was finally refurbished and ready to use again. I also knew that I had the back up space and support from the Village manager, so was aware that somehow, we would be able to manage these space issues.

Additionally, however, I had no physical space to write my own MT clinical reports, as there was no desk set up for students. I therefore had to make use of whatever space was available from week to week - sometimes the meeting room, sometimes the kitchen (so long as the nursing students had not got there first), sometimes in one of the conservatories at the end of a wing and sometimes someone's office that was temporarily available.

### Funding Issues and Staff shortages

From the beginning of my placement I felt the rush and hurry of hard-working staff throughout the facility. Additional pressures (such as building renovations) made it

even busier. People sometimes had to work double shifts as there were often not enough carers available, especially when a patient or staff member was ill. The carer who replaced the DT on the day of my group sessions often did both jobs (carer and substitute DT) simultaneously, meaning she was incredibly busy. I often heard comments such as: "We are always very busy here... at the moment it is absolute crazy!" Both managers apologised frequently for being less accessible than they wanted to be (although they always asked how I was doing when they saw me passing by in the hallway).

*The placement I have started working in feels extremely busy and people (staff and patients) are not available probably due to overworked staff.*

*Journal Excerpt February 2017*

*Unfortunately there are not enough staff to ask another staff member to help. The DT said there is often low staffing in this setting which makes it more challenging.*

*Journal Excerpt April 2017*

Lack of funding meant that there were just not enough staff, and those staff already employed had huge workloads, and little space to deal with a student music therapist. I felt frustrated about the injustice of this but I knew that I needed to let go of some of my ideals about how I thought it *should* be.

The Village manager reported that staffing pressures were quite typical. She pointed out that the government pays only a certain amount for residential care. She also thought funding would probably be a barrier to introducing a regular MT programme in the future.

I was aware that it was important to speak about these institutional issues as well as my reactions and personal feelings about them. I had several conversations with

my Visiting MT, counsellor and student peer. I learned not give up and to regain the motivation needed to keep going:

*I feel frustrated and helpless about the injustice in this place. People speak about increasing workloads and responsibilities. I see team members doing double shifts to survive because of low income. I see carers lifting patients by themselves, doing this all day! I'm speaking with my support relationships. I know that I cannot change it and keep repeating to myself: "Welcome to reality!"*

*Journal Excerpt, June 2017*

Discovering my own expectations and ideals about working in aged-care and accepting institutional constraints

Although I had intended to go into a new setting with a fresh, curious, and neutral attitude in which to be open and ready for new experiences, my placement in the residence made me realise that this was much harder to achieve. Whether I liked it or not, I had unconscious expectations about what the environment "should" be like, and when the reality did not match my expectations, which were for example the institution being a little more prepared for a MT student, this was quite confronting and challenging for me. For some time, I felt frustrated. The facility did not seem to be prepared for the introduction of a new therapeutic service and this was disappointing:

*I am finding it hard to work alongside the head nurse who is supposed to be my CL. When this was mentioned she did not react or did not show enthusiasm. She is barely available due to being busy and it is hard to ask her questions as she often refers to "later" but then it doesn't happen. There are moments I feel that she has no interest or such in my work. Although I do not have evidence I sense she is unable (or does not want?) to cooperate with me. She often gives me the feeling that I take her precious time. As this situation feels uncomfortable I tried to find staff/nurses who are happier to help me and who are a little more available.*

I became aware that I was telling myself that I ought to have a 'plan' to develop the therapeutic service, including identifying supporting team members. But I realised that this would take time and was an organic process that grew out of being there every day and interacting with others and learning on the job. Often, I had spontaneous ideas during conversations with team members or ideas came later during the following months. These supportive key staff members were those ones who responded very positively to MT and with whom I established a positive working relationship:

*There is another nurse (not head nurse) who had given me some positive responses about a patient I am working with. She noticed him being more socially integrated since working with me. She also noticed that my music lifted the mood of patients.*

*Journal Excerpt May, 2017*

*The nurse who noticed MT having a positive effect on patients was the one whom I approached sometimes with questions. Although she was as busy as everyone else she always took time for my questions. She appeared to be excited about MT and was able to see the impact of it on patients.*

*Journal Excerpt July, 2017*

These positive responses were encouraging. I was initially disheartened when other staff did not respond so positively, and I thought I must be doing something wrong. However, as I became more familiar with the environment, I realised that the disinterest of some staff was not personal. Rather, it was connected to institutional constraints that were beyond the control of the staff I was working with.

I also became aware that the way I interacted with my environment and the people within it could impact on their ability to respond and, therefore, on my overall experience. In the beginning I was shy and a little insecure. There was a natural anxiety, which perhaps many students have, when starting in a new place. However, I was not aware of the positive effect that being required to work independently onsite could have on me. During the following months I overcame my anxiety, which increased my ability to present myself and my work in a more confident way. The more confident I became, the less I worried about whether staff were interested or not, and I was able to see and appreciate the support I was given by staff who were interested.

It is my nature to be idealistic. I tend to expect a lot from myself and others, so coming to accept the limits of the facility was one of my biggest struggles during the year and took a lot of my energy. Firstly, I had to face up to my unconscious expectations and ideals about what I thought aged care ought to be like, and then I had to find a way to be at peace with that. In order to understand and come to terms with those limitations I needed to take a step back and not interpret problems personally:

*I realised that I need to make a conscious choice to not take things personally when they didn't work out. I now remember the managers telling me that it is not in our power to change things in the facility which have been here for so long, and that if things don't work out as expected we shouldn't see it as a failure.*

*(Journal Excerpt August, 2017)*

Gradually, I began to better understand the many issues impacting upon aged care facilities. The Village manager explained that these issues within age-care settings were generations-old, and include funding issues and staff shortages, lack of physical space for therapies or other activities, and lack of knowledge about MT as a therapeutic option, each of which I have discussed above. As a result, I had to



be proactive and make spontaneous decisions about numerous aspects of my work, including building relationships with staff.

Developing relationships with participants and family members

As well as making connections with key members of staff, it was important for me to build effective relations with MT participants and their families. This was quite a different experience for me in each setting.

### In the Care Centre

In the Care Centre I was able to create positive and effective therapeutic relationships with participants on a number of occasions:

*One of the participants in the care centre was tearful in our last sessions when saying goodbye and held my hand after the session. This participant usually sat in the lounge reading her book and did not appear to be interested in what was going on. When I started the MT group sessions she put her book aside and participated actively. At the end of each session she thanked me and a big smile appeared on her face. She often asked when I would be coming back to make more music.*

*Journal Excerpt October, 2017*

Another example was, one of my clients who was always enthusiastic to see me, often saying "Good to have you here, Silvi." He shared his love of music and his memories about his life with me. This became one of my MT goals for him - to support him as he grieved about his family losses and came to accept the ageing process, and to be in the 'here and now' through self-expression and sharing his music. During the following months we established a positive connection and I received feedback from a staff member that he very much enjoyed our music sharing and also the group sessions.

Working alongside family members was also a part of my Care Centre work. One of my patients, Karl (a great lover of classical music) who was in palliative care,

requested I play his favourite classical pieces for him, and music listening became a central strategy in my therapy sessions with him. We would listen to various pieces that he had requested the previous week. Near the end of his life, he asked if I would play at his funeral. During this time, I got to meet his sister. She very much supported my music therapy work, and we met regularly to talk about Karl and how he was doing. I also got to know the daughter of one of my MT participants, who was a regular visitor. She would discuss her mother's well-being and gave positive feedback about my singing with her. We both noticed that after a singing session her mother would have a smile on her face, and seemed to have improved mood.

### *In the Village*

In the Village I encountered some suspicion and distrust about the MT programme being “therapeutic”, and I had to spend time explaining what this meant. I suspected that this was because many individuals interpreted the notion of therapy as implying that there was “something wrong” with them. I had to find ways to explain that there were different ways music could be therapeutic by simplifying how I spoke about it and making it less complicated. For example, I said that simply listening and singing along to music can help us to feel better and improve our mood. Everyone in the Village would agree and sometimes participants would start to speak about their personal experiences of the impact of music in their lives. Eventually we did not need to focus on therapeutic goals, although the music itself enabled therapeutic opportunities.

On a few occasions, residents commented that it was strange having a therapist half their age with much less life experience. Building a trusting therapeutic relationship therefore required me to listen actively and carefully respond, showing acceptance and understanding about their feelings. It was essential to give them as much space as they needed. Over time I experienced their growing trust.

I learned from working in the Village that older people are treated differently than younger people. Some of them spoke about struggling to cope with the rapid changes in society, as such technical change and social attitudes:

*A staff member pointed out that we need to be careful with elderly people because they have a different way of expressing than people do these days.*

*Journal Excerpt May, 2017*

I wondered how I could support their needs:

*How can I support elderly people to cope with the aging process - transition from independence to care (at least 3 participants are struggling with this)?*

*Journal Excerpt/Notes supervision April, 2017*

Over time, I realised that I needed to include more time for discussion in order for Village participants to express their fears about the aging process and ending up in the Care Centre. It was important to them to be able to acknowledge the difference between themselves and the patients in the Care Centre: "We are all very anxious about ending up like that. Sometimes I wake up at night and I am confronted by these fears and cannot go back to sleep", one participant shared with me. Being able to express their fears in music therapy allowed them to see that others felt similar and also to accept the here and now. .

Slowly during those months I noticed participants becoming more trusting:

*Some of the participants are starting to be a little more open and trusting their creativity in music. We sometimes improvise vocally and, after being hesitant at the beginning, they seem to feel more comfortable and trusting their own ideas. They said that they had never done anything like this and it was interesting to explore new ideas.*

*Journal Excerpt August, 2017*

However, being in a group possibly prevented some participants from opening up. This illustrates the values of individual therapy, which unfortunately did not happen in the Village as much as I would have liked:

*Only one participant from the Village group appeared today. We decided to do the session anyway (as an individual session). For the first time she opened up much more and, when playing and singing a particular song, she became tearful and told 'her story' about overcoming cancer, losing her husband and other dramatic things that had happened in life. I held her hand and listened actively. This felt very special as she never speaks about her personal problems during group sessions. This probably had also to do with her being alone with me and getting to know me better and therefore trusting more and opening up more. I felt very honoured.*

*Journal Excerpt September, 2017*

Although less common than in the Care Centre, I nevertheless had an opportunity to work closely alongside family members:

*I had a few conversations with the daughter of one of my participants (who is suffering from Alzheimer's). Both are regularly taking part in the group sessions in the Village. His daughter gives me feedback from time to time about how she feels her father is doing in the music sessions. Her feedback is very valuable and helps me understand him better as he is verbally impaired and feels insecure about it. Towards the end she said her father not only enjoyed making, sharing music and finding a place socially in this group, but also felt accepted by the group, and not judged (for his speech impairment).*

*Excerpt Journal October 2017*

Developing relationships with Village participants involved understanding common fears facing aging people, respecting their needs for autonomy, and

allowing them to guide the process, and engaging with family members where possible.

## **Developing MT Programmes for the different settings**

During my orientation time my idea was to work in both settings – the Care Centre and the Village – which appeared to be variable work. This excited the Village manager, who told me that this would be the first MT service in a retirement village that she was aware of after 30 years working in age care settings. However, each setting had different populations with different needs. In the Village, people were still living independently, while in the Care Centre they were largely dependent on external support. I therefore had to develop two different programmes. This included gaining referrals, identifying goals for MT in each setting, creating time-tables, and selecting activities.

### Referrals and Caseload

#### In the Care Centre

*How do I find out where people are or will be – patients are all over the place*

*Journal Excerpt/Note/Discussion April 2017*

In the beginning I was not sure where my referrals were going to come from. As I became more confident, I built relationships with people and was able to explain more about what MT involved. Most often, I gained referrals from the person who was most aware of the patients' conditions, such as nursing staff, activities officers, or social workers. Those staff members made recommendations for an assessment. The manager, who received regular information about patients' well-being, also gave me referrals. I looked at the profiles of each patient to see whether there were relevant comments in the well-being section. However, it was important to assess patients myself and find out their individual needs before

starting MT sessions with them. Sometimes this involved speaking with family members, if the patients were cognitively and verbally impaired. Sometimes people would be referred for social isolation or agitation and anxiety. Others were referred just because of their love for music.

I started working with a few patients who were referred to MT by the manager of the Care Centre but it was up to me to decide who I planned to work with and when. Occasionally, MT happened spontaneously with residents, such as with a man who watched my group session in the Care Centre and was tearful afterwards. I held his hand and was there for him while he remembered music of the time when he was young. We started meeting regularly to share music that had been essential in various stages of his life and which appeared to be a musical life review.

### *In the Village*

It took a longer time to establish the MT programme in the Village. The first group session took place after about five weeks. I organised two meetings with the potential participants and then found a time and day in collaboration with the activity manager and the Village manager. This was a very different process from the Care Centre because the residents in the Village wanted to be involved in the discussion about their MT. In the Village, self-referral was the main way in which people became a part of music therapy. Residents approached me in residential meetings, through talking to others in the lounge, seeing my notice in the newsletter, and through sharing at other activities.

Identifying initial MT goals for each setting

### *In the Care Centre*

When setting up programmes it was important for me to be able to differentiate music therapy from other music services that were offered in the Care Centre. As

part of this, it was helpful and important to know what other musical experiences people were exposed to or engaged in:

*I learned that there was another musical/therapeutic service which was described in the programme as 'music therapy'.*

*Journal Excerpt March, 2017*

The Care Centre manager and Diversional Therapist both agreed that it would be helpful for me to meet this musician to discuss his approach. Unfortunately, he was never on site on the days that I was there, and I later learnt that he had stopped coming.

I was able to explain that MT focuses on the specific ways in which music can engage people in active music making to improve their health and wellbeing. In the Care Centre my initial goal was to sustain or increase physical or cognitive functioning. In the Village it was to support socialisation and connection through sharing and making music. Another goal emerged later on from working with the residents, which was to support their autonomous decision-making and self-expression.

### *In the Village*

After initial discussion with the Village manager, and a few requests for individual sessions from residents, it was decided that I would offer group -- and individual -- MT. This was decided because many residents were socially isolated and not taking part in any of the activities offered in the Village. Another therapeutic goal became expression through music. Music facilitated residents to tell their stories and share memories through listening or making familiar music that reminded them of their past lives. I realised that this helped with their anxiety about the future. The process of implementing MT in the Village raised the problem of competing with other activities though, which might have had an impact on the number of participants. Another significant issue was that older people tend to like to keep consistent routines, so implementing something new and gaining their

trust was initially challenging. I achieved this over time by involving them in planning the group session, and choosing activities.

I became aware much later that my arguments in explaining why music therapy would be good to take part in could have been stronger with a higher level of confidence and language skills. Nevertheless, at that time I used an argument like: 'Let's share and make music together. Let's share our memories and stories which the music we share reminds us of', which appeared to be convincing for some residents.

### Selecting MT Activities

Selecting activities for the Care Centre MT programme involved different processes for the individual and group sessions. For individual sessions, I looked at the profile of each patient to assess their individual needs before starting MT sessions with them. Selecting activities for the group session involved using well-known music to engage participants in moving, clapping, patting (physical exercises), and singing.

My choice of MT activities in the Village was also influenced by the choices of the residents, in terms of songs included, and how much singing and music-making and talking we did. The residents made it very clear that they wanted to express their autonomous choices, perhaps because of their awareness that their ability to remain autonomous was gradually decreasing as they were aging.

Because the Village participants wanted to be much more in charge of the sessions, and were more sensitive to everything I contributed, I had to become more aware and careful about what I said and did. For example:

*The Village participants are uncomfortable with the word 'therapy'. When speaking about this with the Village manager she said that the word has a certain/negative stigma for many older people. So we are brainstorming to use a different word. This*



*could also help to encourage more people to join our group. The work with the Village is harder because the people are demanding. They need longer to trust me.*

*Journal Excerpt May, 2017*

At the end, the Village manager and I decided to use the word 'Music appreciation' instead of 'Therapy'. We thought that covered making music, discussions and listening and sharing music as well. I realised that people would gain trust only over time and felt reassured at the end of my placement time.

The main activities I used in the Village included using percussion instruments for drumming and singing. I invited residents to improvise on percussion as self-expression, or to sing well-known pieces which they each suggested. In the Village I wanted to empower the participants to be more in charge of the group session activities by sharing titles of their favourite songs and seeing if I knew them. Sometimes we would listen and watch their music on YouTube as well. Using music for reminiscing created an allowance for shared memories with loved ones by sharing familiar songs, which could lead to conversation and discussions with each other, enhance group cohesion and therefore prevent social isolation. Most of these songs were from earlier decades of their lives, such as 'Don't fence me in', 'Let me call you sweetheart', and 'Forever and ever'.

After establishing the routine of regular MT group sessions and also receiving more trust from the Village participants, I was able to vocally improvise with them, using well known melodies. As within the Care Centre sessions, I took a well-known song, used my own words and encouraged them to use theirs. This was often about each participant's day and was frequently funny and made everybody laugh. They expressed that they had never done anything like that before and felt it was a very interesting musical exploration for them.

My goal to support the autonomy of Village residents also had its challenges. One Village participant was quite assertive. He loved the sessions, but sometimes seemed to want to lead them himself. I supported him to do this because I wanted the participants to be able to take charge if they wanted to try this. However, I also sought to maintain the overall dynamic of the group, so I tried to create a balance between encouraging individual leadership and retaining my role as the overall guide or facilitator.

I did not work as extensively in the Village as in the Care Centre. The group sessions ran regularly but involved fewer individual participants. The Village manager later reflected that she regretted deeply that I had not worked more hours there and wished she had invested more time in setting up the service. But because of lack of time, the very busy year and her not realising what an impact MT could have on older people, this was not possible. She also believed the residents from the Village would have benefited as much from individual MT sessions as they did in the Care Centre, because, although there were many activities for the residents in the Village, many of them isolated themselves from society and refused to leave their apartments.

#### Encouraging ongoing musical service/MT in the future

In the Village, I established a CoMT approach, because I believed it would be useful to encourage the participants to continue their music appreciation group once I had left. As the Village manager pointed out, CoMT is highly valuable in terms of its social benefits for participants. However, this was less viable for the Care Centre because of lack of staff able to lead the groups. The Village residents, on the other hand, had the skills, drive, and collective know-how to continue as a group if they wanted to.

## Taking risks

For the first few months, I was confused about so many aspects of my placement that I felt quite out of my depth. However, the positive thing that came out of being left alone to a large degree was that I was forced to take risks and make decisions myself, which has helped me build confidence and trust in myself as a practitioner.

### Building Confidence and Trusting Myself

In the beginning I regretted that I did not have a placement with an already established music therapist to guide me, as some of my fellow students had. I felt anxious that I would miss out on important and valuable information and learning. I was acutely aware of the responsibility of starting something new and that people would gain their first impression of music therapy from their experience of me, and this (along with my perfectionism and being aware that English was not my first language) caused me some anxiety:

*I feel a responsibility for starting something new because people will get their first impression of MT from me. When I call a company for the first time and speak with the secretary, the secretary represents the company and gives the first impression. I am feeling a certain level of pressure when I think about this. I feel anxious that I might not present MT in the right way. I need to remind myself (and also others!) that I am still learning.*

*(Journal Excerpt May, 2017)*

During the following months I started to appreciate the freedom and trust that I had been given. I was able to work independently and had the opportunity to be creative in establishing the programmes I eventually set up. I was able to explore my own ideas as well as finding solutions on my own, and I was pushed into

making my own choices in situations when others were not available to support me:

*Although I sometimes feel left alone (staff often not available) I can see the benefit of being in a situation where most of the times all is up to me: I can work independently and therefore have the opportunity to be creative. I basically have to find a solution for each tricky situation by myself and trust my own ideas. Although this is challenging I can also benefit from this freedom and trust and this makes me feel that I can prove to myself and others that I can do it and for this I need to trust myself.*

*(Journal Excerpt June, 2017)*

On one occasion when I joined a Care Centre van outing, the staff member in charge tried to encourage me to initiate a song with the residents. However, I was aware that they all were lost in their thoughts and gazing out the windows, and there was a sense of peace in the van. I felt that it was inappropriate to interrupt at that moment, so I did not immediately take up the staff member's suggestion. After a time, however, I slowly started to play something that felt right. This helped me trust that I was strong enough to follow my own intuition, and that I would not be pushed into something that did not feel right for me.

I started to become more creative and proactive in trying to find answers to my questions or solve them by myself and by seeking more advice from people outside the setting (although I always asked the managers for permission for important decisions). This helped to become more independent:

*How do I make decisions about inviting people to join music therapy? How much do I use my 'intuition' alongside knowledge to make professional judgement? (Prioritising people's desire to come to music therapy/my professional judgement) I wonder whether I should persist with people who do not initially want to come because I know they have particular difficulties that might be supported by MT and*

*some people need more than one invitation to say yes to things. Some constantly refuse to do MT, one in particular shows aggressive behaviour and sends me away. How much /how long /how often should I persist? (Involving staff?-- staff say 'you can't force them and need to respect their wishes.') So finding a balance is tricky... I want to encourage without forcing or trying to convince someone.*

*Discussion Notes March 2017*

The other important aspect of building confidence was in relation to my sessions with participants. Although I had doubts that my approach in either the group or individual sessions was “right”, the lack of onsite guidance meant I simply had to try things out. This gradually helped me trust myself more and more. For example, I established a positive therapeutic relationship with one of my patients, Bill, who was in palliative care. After a few months Bill’s health deteriorated rapidly and our sessions changed from him sitting in a chair to him lying in bed. It became difficult to understand him at this time. One day I asked a nurse about his condition and she said he was very agitated and aggressive and advised me not to go into his room. At first, I was not sure whether I ought to accept what the nurse had said or go and make an assessment for myself. After a moment, I decided on the latter, and as soon as I entered his room Bill expressed his happiness to have me there. Following my own intuition was an important part of me learning to trust in my own assessment skills and ability to build positive therapeutic relationships. Interestingly, Bill’s sister later said that he could be assertive and would tell people if he did not wish to see them. She said she thought Bill was very fond of me and always happy to see me and share his knowledge of music with me. This was a significant turning point in my self-confidence.

There were other moments in which I felt I had to trust my feelings when making decisions spontaneously, sometimes against the advice of a nurse or a patient:

*I planned to see a patient who suffers from progressive dementia and appeared very confused and agitated. When I went to see her, she lay in her bed and sent me away saying that war was starting and she was unavailable. In that first moment I felt unsure if I should go in, but I took the risk and asked her if she knew an Irish song (she was Irish) and said I would like to sing it with her. She then got off her bed and started chatting with me and then we sang the song. We spent almost an hour together. When the session was finished she smiled and said thank you. Her entire facial expression had changed during the session.*

*Journal Excerpt August 2017*

Finding a way to trust my intuition and take steps forward to make decisions independently was an important moment in my learning as a MT student. This included self-reflexive practice as well, which I identify as a theme in the following section.

### **Engaging in self-reflexive practice**

A key aspect of my self-reflexive practice was facilitated through music therapy supervision and personal counselling and writing a journal.

Initially, I did not realise that I could seek my supervisor's support whenever I needed it, because she was busy, and it was difficult to find time. During the first months on placement my supervisor was overseas for six weeks and only available via email. I therefore sought other support through peer-supervision with a fellow student with whom I had developed a positive trusting relationship the previous year. Additionally, I attended counselling to address some of my personal issues that were influencing my work. Aside from the natural anxiety of beginning work in a new place, I have always been a perfectionist, and I needed help to see that I was interpreting my experience through the lens of failure rather than the lens of positive learning. I also struggled to be assertive and directive and make independent decisions:

*Both my lecturer and supervisor have pointed out that I could be a little more assertive with my Village group. I wonder how to find a balance between leading and have them being in charge. I noticed that as soon as I am a little more assertive some of them seem uncomfortable. I assume that older participants need a longer time to trust.*

*Journal Excerpt June, 2017*

## Dealing with Anxiety and exhaustion & The Role of Supervision and Counselling

*I'm unsure how much the meetings with my CL help/support me with my supervision or are meeting my needs? I don't know what the balance is... I don't want to unnecessarily use my supervisor's time (because she's very busy) to meet my own needs.*

*Journal Excerpt, Notes supervision April, 2017*

Counselling helped me find ways of dealing with some of these issues. With time, I began to feel more confident in making decisions and more resilient when continually confronted by ongoing institutional limitations. My counsellor and, later, my supervisor, helped me to look after my energy and be more discerning about which situations were worth addressing and which were not. My anxiety and nervousness decreased as a result, and I felt that I was able to make more confident decisions. The importance of supervision and counselling was stressed in my music therapy studies, and this was essential in me being able to grow as a student practitioner:

*I am also feeling more assertive about my needs at this setting. I think I have improved my language and can express myself in a more precise way than before which also supports me to be confident in making space for my work.*

*Journal Excerpt August, 2017*

*During one of my group sessions in the Care Centre there were interrupting noises such as carers preparing lunch and speaking loudly with other carers, visitors or nurses. The doors were open and people were also speaking loudly in the hallway. It was almost impossible to do anything without shouting over the top of the noise. It also felt disturbing for some participants. So, I went and asked them politely if they could speak more quietly or have their conversations somewhere else.*

*Journal Excerpt September, 2017*

Both counselling and supervision helped me to deal with issues that arose in terms of taking risks.

#### My Journal

Using my reflective and personal journal was much more important than I had initially thought. I realised that my critical reflection helped me learn about my practice as a MT student and find solutions for problems and decide when to seek supervision and when to make independent decisions.

After putting things onto paper, my initial, emotional feelings became more rational. It almost felt like therapeutic writing for myself. I can see now how essential reflective journaling is for a practitioner in order to take a step back from a situation and seeing the whole.

### **Summary of findings**

I found that the primary task in establishing a new music therapy service in an aged care centre with multiple settings was to develop relationships with staff and to find support within the institution for music therapy. This in turn involved educating people about the potential role of music therapy, which had to be considered within the constraints of the institutional environment. As well as making connections with key members of staff, it was important for me to build



effective relationships with music therapy participants and their families. Deciding who would come to music therapy, and what the programmes and activities would look like in the different settings was complex. As a self-reflexive practitioner, supported by supervision and counselling, I learned to take risks and to increase my independent decision making, which helped me build confidence and to trust myself as a practitioner.

## CHAPTER FIVE: DISCUSSION

Being thrown into the unknown including feeling a sense of isolation at the beginning of my placement was difficult. Having to learn from my own experience how to set up a new MT service in the above-mentioned facility, may have been helpful though. I believe that the institutional constraints and the initial personal struggle guided my work as a student music therapist. In this study I learned through the challenges I faced and identified.

### **Personal care and growth**

Through the process of self-reflection, I have gained a greater awareness of myself in relation to others, and this in turn has helped me recognise and address some of the personal challenges involved in setting up a new MT practice.

Some of the challenges I faced were internal in nature and involved dealing with my own fears and insecurities. My findings reveal a number of strategies I used to overcome these challenges including the establishment of important personal support systems through supervision, peer supervision and counselling. This helped me deal with my own disappointment, and to become more confident and creative.

My growing self-awareness through reflexive practice was crucial to my learning and development as a therapist. Chang (2014) states that working as a music therapy practitioner can make us professionally and emotionally vulnerable. Others note that it is the therapist's ethical responsibility to manage self-care, self-awareness, and self-exploration (Thayer, 2010), although in some recent and more structured models this is a feature of training, as Haarhoff, Thwaites & Bennett-Levy (2015) suggest. Shapiro and Carlson (2009) say that mindfulness can increase self-care, which is crucial to avoiding feeling overwhelmed and other stress-

related issues. Mindfulness could be another useful strategy to explore in my future work.

Self-reflective practice is also crucial for building relationships with potential clients. For example, Baker highlights the importance of extending self-awareness to understand the 'oneself' as a therapist in relation to the other person. Becoming more self-aware means becoming more in tune with patients and aware of their needs (Camilleri, 2001; Chikhani, 2015). Similarly, Kennelly et al. (2017) write about the value of reflexivity when considering our roles, and the importance of making reflexive notes. Learning to write in a healthy self-reflective way helped me connect my thinking and my emotions together, which helped reduce my nervousness, and be more present in my relationships with clients, staff, and family members.

During the whole of my practicum I found myself wondering about my identity as a student of MT without the experience of other music therapists who have been working for many years. I wondered what my stance was and how I could explain MT to others. This personal inquiry is viewed as essential within the literature. <sup>1</sup>Ansdeell and Stige (2016, n.p.) encourage music therapists to question their practice to be more

- flexible,
- context-sensitive, and
- multiple.

They highlight the following issues that music therapists must investigate in their practice:

- Identities and roles

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1 As taken from Community Music Therapy in The Oxford Handbook of Music Therapy

- Sites and boundaries
- Aims and means
- Assumptions and attitudes

and they urge music therapists to ask the following questions:

- Who am I as a music therapist? What am I expected to do?
- Where do I work as a music therapist?
- Where are the limits to this work? What are the limits on what I do there?
- What am I trying to do as a music therapist, and why?
- How do I go about achieving these aims?
- On what theoretical assumptions do I base all of the above?
- How do these ideas affect my attitude towards both people and music?

Such questions were a continual part of my own reflexive practice. The process I went through constantly required me to be inquiring about myself as a practitioner. Ansdell and Stige (2016) highlight the importance of maintaining this curious and wondering attitude in order to become a self-reflexive practitioner. However, I also realised that I needed to balance my self-inquiry at times, in order to not 'overthink' my stance as a practitioner and simply trust the power of music and its capacity to heal through the music therapy relationship. As Pearson (2018) writes:

*"I would much rather use my role as a music therapist to empower other care providers to embrace the power of music, and elevate the presence of music in all care contexts". (p. 3)*

## Professional supervision and counselling

Professional supervision and personal counselling were extremely useful for me as a student in order to make decisions and develop my professional practice, which the literature confirms (Falender & Shafranske, 2014; Kennelly, Daveson & Baker, 2014; Shafranske & Falender, 2008). According to Falender & Shafranske, (2014), clinical supervision provides an environment for exploring personal reactions and how they impact upon therapy. Bunt and Hoskyns (2002) also acknowledge “supervision as the most valued system of support” (p. 260).

## **Practical challenges**

Other challenges were more external and involved understanding institutional constraints, establishing MT programmes that suited the context, developing trust in relationships with the elderly, finding my place in a multi-disciplinary team with other professionals, and educating people about MT as a relatively new profession in NZ.

## Educating people, defining Music Therapy

Like Pearson (2018), I found myself wearing multiple hats – sometimes feeling like a sales person, sometimes a business person, and sometimes a clinician. Additionally, I experienced the challenge of explaining music therapy in different ways and contexts to different people. This is a common experience for music therapists since music therapy is difficult to define and “defining therapy is as difficult as defining music” (Bruscia, 1998b, p. 9). The explanation of what music therapy is or can be is context dependent (Bruscia 1998a; Pearson, 2018; Wigram, 2013). In the Village in particular, it was hard to explain why music therapy would be helpful, because most residents considered themselves to be well and were resistant to the term 'therapy'.

Pearson (2018) points out that the generalised use of the term music therapy, by people who have not qualified as therapists, may also be a problem. This was the case in the Care Centre where entertainers were considered by some, to be doing 'music therapy'. Pearson goes on to say that music therapists need to take an "interdisciplinary leadership role as health-musicking experts" (p. 6) to deal with these issues and increase awareness of this profession.

Such issues were relevant to my placement. I became aware I would need to use a different language than the one from books and research articles with the people I worked with, including doctors and managers in healthcare settings, other employees, family members and clients themselves. I needed to speak about case examples and the results of the effects of MT - to tell the story of a client - rather than using academic and theoretical evidence.

I also learned that although it was important to introduce MT and educate people, it was better initially to find people who were already excited about MT (Pearson, 2018), and then gradually educate others over time.

#### Building trust among older people

As well as wearing 'different hats', building trust, particularly with the Village group was vital. Davies and Richards (2002) state that there can be particular dynamics in the relationships between elderly clients and the therapist, who is often younger, involving a psychodynamic process of transference and countertransference, which can involve both therapist and client. In my case, older clients possibly regarded me as their child, and as mentioned in the findings, the participants in the Village often exclaimed that I was half their age and with only half their life experience. Additionally, it became clear that older people tend to like consistent routines (Jones, 2016; ANMF, 2018), which made it challenging to introduce a new unfamiliar activity alongside an already established programme with many other activities.

### Staff/funding shortages

Other institutional constraints I encountered, such as high and intense staff workloads and responsibilities as well as personnel and funding shortages, are cited as common in the literature (Cunningham, Baines & Charlesworth, 2014; Ledger, 2010; Nübling et al., 2010; Van den Hombergh et al., 2009). Henderson, Willis, and Blackman (2016) highlight the issue of an increasing aging population in aged-care facilities, which is common both nationally (Cookson, 2016) and internationally (Williams, 2010; Tsang & Ngo, 2012). Meldrum (2006) says that many facilities in NZ experience state funding issues, which is a major concern. Similarly, in Australia the “residential aged care sector has reached crisis point with funding and staffing critical issues, according to an ANMF national survey” (ANMF, 2016). Staffing has fallen to an inappropriate level, meaning care is compromised and staff are overworked (Cookson, 2016; Karantzas, Mellor, McCabe, 2011).

It was a struggle to come to terms with these constraints, adjust my expectations, and work around these challenges. While I think there is an urgent need to raise more awareness of this particular issue, I had to realise I could not do this in my role as a student.

This connects with the next challenge I identified - finding a space for MT in a residential facility with an already established health care service and no existing experience or history in MT.

### Finding space for music therapy

The Village manager expressed, in one of our meetings, that lack of space is common in older facilities, which were not always designed to include therapy rooms. I was confronted by this on several occasions in which there was no space for storing instruments, for writing my reports or for the group sessions in the Village. Goditsch and Stegmann, (2016) acknowledge the importance of providing appropriate and suitable space for music therapy. However, this is a difficult task

as music therapists are often going into different institutions (such as schools, health centres, hospitals, aged care facilities), and, because it is a new profession, it is unlikely that these spaces have been specially designed for MT. Rather, music therapists seem to need to adapt and work with this challenge all the time.

Thus, setting up a new service required a balance between working within a setting where things had been as they were for a long time, and also being creative and stretching the boundaries and using spaces in a different way than had been done before. In this sense I could recognise the challenge as a long-term project. I was able to see the potential of growing the programme over time, and that I was 'planting a seed' that would take time to grow.

#### Working in a Multi-disciplinary Team

A further challenge involved learning, as a part-time practitioner and often the only music therapist in the facility, to be a part of a multi-disciplinary team where music therapists can feel somewhat separate from other team members (Chang, 2014, Ferrer, 2017). Other researchers identify potential issues arising such as power dynamics and confusion in terms of understanding each other's roles, and areas of responsibility and authority (Darsie, 2009; Zwarenstein, 2009). This can create conflicts due to varied approaches to patient care. There can also be competing attitudes among different professionals because the various levels of care provided by the music therapist are not clear. Almoayad and Ledger (2016) report that other professionals have felt intimidated and encroached upon when music therapists try to establish a clinical role. Such issues may have underpinned why a nurse discouraged me from seeing a patient in palliative care on one occasion. This suggests that I could have paid more attention than I did to other professionals' views and perspectives of MT and the role of the music therapist in the team, as Darsie (2009) supports.

This leads to the need for respect for differences in an already established working culture, as well as incorporation of everyone's values and principles. In order to



create a place in the multi-disciplinary team, music therapists need to obtain acceptance (Twyford, 2009) and “be valued, understood and ‘seen to be working’” (Odell-Miller, et al., 1993, p. 24), which again emphasises the importance of the educative role that music therapists have to play (Pearson, 2018).

The findings also illustrate the importance of finding people within the team to consult and collaborate with, which the literature confirms (Darsie, 2009; Laahs & Derrington, 2016; Register, 2002; Twyford, 2007; Twyford & Watson 2008). This seems to be the key to expanding and broadening many professions (Register, 2002). Collaboration also means learning from team members and gaining different perspectives and skills (Laahs & Derrington, 2016; McGann, 2012). This helps us to “understand each other's values” (Bar et al, 2018, p. 36), as well as share “knowledge, expertise and to be aware of one's own skills and limitations” (McGann, 2012, p. 68).

Interaction between disciplines is required to achieve “greater awareness and appreciation of other professionals” (Twyford & Watson, 2008, p. 15). Twyford and Watson (2008) recommend a number of fundamental skills involved being a good team member including “personal commitment, maturity, self-discipline, flexibility, willingness and an ability to learn” (p. 8) along with the ability to communicate. As an inexperienced and foreign MT student (with English as a second language), communication was particularly challenging for me. Odell-Miller and Krueckeberg (2009) note that collaborative communication skills, and skills to educate other professionals about MT are often not part of MT training programmes, meaning inexperienced therapists can have difficulties collaborating. Similarly, Purvis (2010, p. 96), states teaching such skills is not a “required component of education programs”, which suggests that music therapists need to develop skills and knowledge beyond the boundaries that MT training offers.

So, my question is, if experienced music therapists struggle to find their place in institutional settings, how can inexperienced students (like myself) find their place? I believe the music therapy profession would do well to consider how our MT programmes might support students better to deal with the high level of

communication skills required. Given that MT is still a relatively young field, it is likely that numerous MT students or recent graduates will find themselves in the same position as me - having to establish a new service that requires complex negotiation and communication skills and ability to fluidly move between numerous different roles.

This research confirms prior research emphasising the need to build awareness of MT as a profession in a new place. As mentioned in the literature review, there are tools which can be used to establish a new practice such as collaborative work which includes “decision making, problem solving, conflict management, and interpersonal communication among the group members” (Register, 2002, p. 305) besides referrals, documentation and providing information to other employees. MT is a relatively new healthcare practice and many music therapists need to introduce, uphold, grow and develop an introductory MT programme where there is no existing service.

### **Therapeutic relationships**

This study confirms that building therapeutic relationships with clients is vital (Bachelor & Horvath, 2006), and as Asbrand (2012), writes, “Evidence of the power of the therapeutic relationship between client and therapist has been extensively reported” (n. p.). Similarly, Rizvi (2016) argues that, “The therapeutic relationship is one of the most important aspects of any therapy sessions” (p. 1), and describes the therapeutic relationship being a “working alliance between a patient and therapist” which involve “the feelings and attitudes that the people in session have to towards one another and how those sentiments are expressed” (2016, p. 359). Other writers emphasise the importance of being genuine and authentic as a therapist (Gelso, 2011; Kolden, Kleine, Wang & Austin, 2011).

## **Community Music Therapy with Older People**

One interesting issue my study reveals relates to the use of CoMT in aged care facilities. Although my CoMT approach in the Village meant that I eventually was able to create a musical community with the opportunity for residents to continue meeting after I left the institution, it was initially hard for the staff and residents to understand what music therapy was, and how it differed from entertainment. Music therapists also seem to have a dilemma trying to define music therapy, community music therapy, and community music (Ansdell, 2002; O'Grady & McFerran, 2010). For example, Ansdell (2002) describes practitioners not always being sure if their practices, which are so diverse, belong to the disciplinary area of MT and/or where the areas of MT, CoMT and community music overlap.

By the end of the placement, however, the Village manager appeared to understand that what I was doing was quite different from entertainment and could see residents benefiting in other ways. For example, she acknowledged clients being involved in a musical activity and opening up towards each other, after sharing personal memories through music. This came about because I was able to set up a trustful environment/community in which they felt welcomed and accepted. She also reflected that there should have been more time invested to support the establishment of MT in the retirement Village, after noticing the impact it had on people. Unfortunately, time-constraints prevented this from happening, which she expressed regret about. Nevertheless, this suggests that further research into the differences between these above-mentioned approaches could be valuable.

## **Implications for future Music Therapy research**

Positive feedback from the participants in the village, and the village manager, suggests that a community music therapist would have a lot to offer older people living in such communities. However, very little has been written about this work, suggesting opportunities for future work.

Further, I have suggested that music therapy training might have more emphasis on helping students to understand and develop the skills necessary for developing new work opportunities where little is known about music therapy. More research is needed to determine the need for such training, and how it might best be offered.

## CHAPTER SIX: CONCLUDING COMMENTS

This research has focussed on examining what is involved in setting up a new music therapy programme in a multi-purpose age care setting. The findings were drawn from my reflective journal entries, clinical notes and interactions with staff and residents in a Care Centre and Residential Village, over a period of eight months.

My study supports the body of literature that acknowledges the importance of:

- Creating space for MT in institutional environments,
- Fostering self-awareness and reflexive practice,
- Educating people about MT (including staff, participants, and families),
- Developing therapeutic relationships, and
- Building collaborative relationships in an inter-disciplinary team.

The study also confirms that establishing a new MT service in an institution is a highly complex process and shows how difficult collaboration can be. I realised that creating working relationships with team members requires time and patience to grow along with the ability to understand different professional languages and communication styles. A number of writers talk about the high level of communication needed by music therapists because of multiple roles they frequently play (Purvis, 2010; Twyford & Watson, 2008; Zyrichis & Lowton, 2008). Music therapists are often working within multi-disciplinary teams where they must be capable to understand other professional languages and be able to translate their own music therapy language into already established educational and health frameworks. However, these sorts of skills tend not to be taught in MT programmes, meaning music therapists often need to perform skills beyond their training. Ansdell and Stige (2016) talk about the complexity of understanding roles and relationships, and how difficult this process is, even for the experienced

practitioner. This study suggests that addressing multiple roles and dealing with multiple 'audiences' could be an important area of development for music therapy tertiary programmes, training courses, workshops and conferences in the future.

My reflective journey of establishing a new service of MT has been transformative in many ways. Having to learn to 'play it by ear' had a major impact on identity, stimulating much personal growth – eventually, I trusted my ability to improvise not only musically but also in other professional capacities. I believe this will have a positive influence on my future as a practitioner, as well as my personal life.

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## Appendix 1: Table of Codings

Journal Quote	Code	Secondary Code	Theme
After several re-arrangements due to timing issues we have finally found a space for the group sessions in the care centre	Orientation	Timetables	Developing MT programmes to suit the context/ Developing MT programmes for the different settings
The DT is not working on Mondays. On this day she is replaced by a carer who will be assisting if she can. I can have assistance from one staff member (group sessions care centre)  I wondered how the professional supervision with the CL was meeting my needs	Who I will be working with	Staff/Team roles	Developing relationships with staff and finding support within the institution
It is often difficult to get hold of the head nurse as she is very busy	Staff	Lack of	Understanding and Coming to Terms with Institutional Constraints
Staff not very responsive about when to start - I feel as if I am being 'squeezed' in  I am feeling sometimes a little lost in a setting in which/it does not feel that there is space for a MT, everything is up to me	Space/time constraints	Lack of	Understanding and Coming to Terms with Institutional Constraints
Besides journaling I am finding it important to share my experiences in my placement with my peer from last year with whom I worked in my previous placement. This is also because my supervisor is overseas for a time and only available via email. I am realising how important it is to speak about it verbally, also because of my personal thoughts	Self care	Self reflective practice	Self reflective practice
When I asked a nurse for his condition she said that he is very agitated and aggressive at times. She advised not to go into his room. In the first moment I was not sure what to do but then I thought I want to find out myself. When entering his room and saying hello he was happy to have me there. I realised that I had ignored the nurses' advice	Trusting self/intuition Therapeutic relationship	Making decisions/ Building confidence	Taking risks
I am also feeling more assertive about my needs at this setting. I improved my language and therefore am able to express myself in a more precise way than before which also helps to be more confident	Creating expectations	Setting clear boundaries/being assertive	Taking risks
I received positive feedback from some residents including family in the village on my last day who brought a card with a poem and the words that I will be missed	Patients	Developing rapport/ Creating therapeutic relationships	Developing relationships with participants and family members
It feels very busy again this month and the managers both are less available	Challenges	Institutional constraints	Understanding and coming to terms with institutional constraints
The village manager suggested to remind residents from the village about my work in the weekly newsletter and in the monthly program.	Educating others	Educating others	Educating people about MT
Both the manager of the care centre as much as the manager of the village had expressed several times that I do beautiful work with the patients who are glad to work with me	Staff	Developing effective working relationships	Developing relationships with staff and finding support within the institution

## **Appendix 2: Information for the staff newsletter**

From: Silvia Jung

To: Care-Centre Manager

Date: Apr 23, 2017, 3.19pm

Subject: Info newsletter music therapy

Dear [REDACTED],

Please find attached to this email the information about music therapy for the staff newsletter. Apologies for late responding.

Please let me know if you have any more questions or comments.

Many thanks

Best

Silvia

Hi everyone,

My name is Silvia. I am a music therapy student at Victoria University.

From February to October I am undertaking music therapy clinical placement at [REDACTED]. I am also required to do a research which is related to my work to improve my learning.

Music therapists use music creatively to help their clients address social, emotional or physical needs. They do not teach their clients to sing or play an instrument and they are not entertainers either but communicate through music making and a shared musical experience to support well-being and improve quality of life.

Music Therapists can work with clients of all ages and social backgrounds with a range of issues.

If you have any questions or would like more information about my work please feel free to ask/contact me.

### Appendix 3: Email exchange/discussion about the idea of a staff drumming group

From: <[silvi.jung@gmail.com](mailto:silvi.jung@gmail.com)> To: Care-Centre manager and Village manager

Date: Jun 11, 2017, 4:30p.m.

Subject: Drumming group for staff at [REDACTED]?

Hi [REDACTED], hi [REDACTED],

After speaking briefly about this with you in the beginning of my time at Summerset, and, after someone mentioning it again I had some thoughts about the opportunity of a percussion/drumming/music group for staff. This could look like this:

*Music/percussion/drumming group (weekly) for team members/staff at [REDACTED]*

The purpose of this drumming group would be for example:

- Musical outlet/expression
- Release of stress
- Group cohesion among colleagues
- Fun and enjoyment

I am happy to offer two different times so people have an opportunity to attend one depending on their schedule or even attend both if they like.

No one needs to have any musical knowledge!

This is a group in which there is space for free improvisation so everything is allowed! It is also a given space in which everyone has the opportunity to do something entirely different from their hard working job.

The format and purpose of this music/percussion/drumming group follows one similar to that which I experience with other music therapy students during our monthly meetings at the university. It is unlike the music therapy work I do with the patients.

Please let me know if this could be something to offer and if you would be interested in participating.

Many thanks and best wishes

Silvia

From: Village manager To: <[silvi.jung@gmail.com](mailto:silvi.jung@gmail.com)>

Date: Jun 11, 2017, 5:58 p.m.

Sounds great I would love to give it a go Silvia... let's talk some more.

Regards [REDACTED]

From: Care-Centre manager To: <[silvi.jung@gmail.com](mailto:silvi.jung@gmail.com)>

Date: Jun 11, 2017, 6:24 p.m.

I think its a great idea Silvi. I would time target my staff at care centre..we can only offer it and hope that staff would see the benefit for this

[REDACTED]

#### **Appendix 4: Email to the village manager for the village newsletter**

From: Silvia Jung

To: Village manager

On Wed, Feb 22, 2017 at 2:33 PM, Silvi Jung <[silvi.jung@googlemail.com](mailto:silvi.jung@googlemail.com)> wrote:

Subject: Introducing MT at the village / MT group at the village

Dear [REDACTED],

Please find my little introduction about me and my work and the opportunity to join a planning meeting as you suggested.

If you have any comment or anything you would like to correct or other additions that might be useful please let me know.

Excuse any mistakes in writing.

Best wishes

Silvia

Hello, my name is Silvia.

I am a music therapy student and placed at [REDACTED] until October. Beside the care centre I also work with residents from the village. Some residents had expressed their wish to be part of a music therapy group. To introduce you to my work and what could happen in a music therapy group session I would like to offer a planning meeting with all who would be interested to join this group. In this meeting I will explain the benefits of music therapy and what could happen in a group session.

Please see [REDACTED] or [REDACTED] to put your name to the list.

I look forward to meeting you soon.

Best wishes

Silvia

## Appendix 5: Closing song in the Care-Centre which residents sang each week

Home on the range

C	F	Fm
Oh give me a home where the buffalo roam,		
C	D7	G7
Where the deer and the antelope play.		
C	F	Fm
Where seldom is heard a discouraging word,		
C	G7	C
And the skies are not cloudy all day.		

[Chorus]

C	G7	C
Home, home on the range,		
Am	D7	G7
Where the deer and the antelope play.		
C	G	Fm
Where seldom is heard a discouraging word,		
C	C7	C
And the skies are not cloudy all day.		

## **Appendix 6: Comments from residents during my placement time**

Me: *"Can I come in for some music?"* Client (smiling): *"You can always come in. Our music is magic."*

- A client from the care-centre

Me: *"What do you think about our little singing improvisation?"* Client: *"I've never done something like this before and I'm still surprised about how I was able to do this!"*

- A client from the village

Occasionally my client (in a wheelchair) and me would start singing a song while I pushed him to his room. When we passed other rooms, residents would sometimes join our singing until we had passed. We would slow down to sing with them together. My client (chuckling): *"Oh this is so good!"*

*"I think what you do is very important and we should spread the word that it will be beneficial not only for us here but also for many other residents in the village and other residents who are lonely."*

- A group member from the village

*"Thank you for bringing me back to music after so many years!"*

- A group member from the village

*"Thank you for giving me the opportunity to do something with my Dad that I normally don't do and to see a different side of him."*

- The daughter of a group member in the village

*"You and your music will be missed!"*

- A group member from the care-centre