How did I use Music Therapy to foster connections between residents, and between residents and others, in a rest home and hospital environment?

by

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Abstract

This study is submitted in part fulfilment of a Master of Music Therapy degree through Victoria University of Wellington (VUW). Group and individual music therapy sessions were undertaken within a rest home and hospital environment in response to the rest home managers request to bring residents out of isolation and increase socialisation. Facility notes, plans and observations, meeting notes, and reflective and reflexive journaling were written during a six-month period from February to July 2019. This clinical data was then used, with informed consent, to investigate how music therapy was used to foster connections between residents, and between residents and others within the rest home and hospital environment. Findings from Secondary Analysis of the data showed the overarching category of rapport led to the interplay of four main themes: interdisciplinary collaboration and teamwork, therapeutic approaches, physical and musical resources, and environmental conditions. The Community Music Therapy (CoMT) ethos supported the flexible work within the context to achieve the manager's goals resulting in increased connection between residents, and residents and others. The use of reflexivity enabled the development of richer therapeutic relationships and helped align the researcher's community musician skills to those of a community music therapist. Further studies which focus on rapport, connection and relationships, in music therapy with older people, are needed.

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Ethics Statement

This project has been reviewed and approved by the New Zealand School of Music Postgraduate Committee. The Victoria University of Wellington Human Ethics Committee has given generic approval for music therapy students to conduct low risk studies of this type; (ref: #22131, 2019) and consequently this work has not been separately reviewed by any Human Ethics Committees. Informed consent was sought from a participant's guardian for a required case vignette and written consent was given by the facility for the data gathered during placement to be used as Secondary Analysis research. See Appendix C for an example.

Introduction

The following research stems from my work in a rest home and hospital setting as part requirement towards a Master of Music Therapy degree. It looks to answer the question: How did I use music therapy to foster connections between residents, and between residents and others in a rest home and hospital environment?

The rest home and hospital has not been identified and the names of participants have been changed to protect their identities.

The Setting

I undertook 750 hours of work practice at a residential rest home and hospital for older adults. I worked predominantly in the hospital setting. My time at the facility was spent in group work, individual sessions and what could be described as 'hallway-conversations' and musicking [1]. Key words on artwork around the facility were: Trust, loyalty, sharing, fun, happiness, hugs, laughter and love. Key value words were: Passionate, caring, open, authentic, accountable, courageous and extraordinary.

The manager of the home emphasised they were trying to create and maintain a family atmosphere and asked me to encourage residents out of their rooms to decrease their isolation. Following breakfast residents were to be brought to the hospital lounge area where I would provide music therapy for the group. This was an opportunity for me to develop a programme based around the concepts of Community Music Therapy, which would encourage participants to connect, socialise and build relationships. I was particularly interested to uncover the strategies necessary to foster socialisation in a population which experienced a wide range of health-related concerns and varying abilities. For example, residents were managing a range of symptoms related to Parkinson's disease, stroke, Alzheimer's Disease, undiagnosed degenerative conditions, and various cancers; and some were in the hospital for respite and end of life care. The mix of abilities would potentially make managing group work challenging.

Some relationships were less than ideal, with varying degrees of interpersonal difficulties between residents, between residents and staff, and even between residents and their family members. Prior to coming into the rest home and hospital environment, many residents had been living on their own, with a spouse or with family members. Residents

[1] *Anyone taking part in and contributing to a musical performance, including back room staff (Small, 1998).*

were now in a new home environment surrounded by people they did not know and had not chosen to be with. These people were of diverse cultures with different values and were helping them with everyday personal care. Based on former experiences they had varying ways of undertaking tasks. Everything was different for the residents and they found themselves in the position of starting new relationships in their advanced years, with declining health states and with reduced levels of tolerance, perhaps due to ill health. It was important therefore to support them to feel safe, comfortable, valued and positively connected to others.

In collaboration with the activities co-ordinator of the facility, the regular morning group became established. The main aim of the group was to use music to foster positive connections that might lead to ongoing relationships between residents, between residents, caregivers and staff, or between residents, their family and visitors.

My Background

My music therapy approach aligns to person-centred and humanistic philosophies where: the client is seen as a fellow human being; empathy, creativity, and authentic contact and communication are shared with people on equal and realistic terms. Feelings, intuition, spontaneity, and playfulness are considered signs of healthy interactions, and accepting our vulnerabilities and faults are welcomed as strengths. These basic human elements help create community which relieves stress and anxiety (Kitwood, 1997; Rogers, 1951). I observed that in the rest home context where I was working some residents stayed in their rooms for long periods of time and staff-resident relationships were sometimes strained. I worked to engage with staff as well as residents to get them singing and participating in music in the hope that it would bring about a shift in the rest home cultural environment. Thus I was influenced by Community Music Therapy (CoMT) which advocates for being open and flexible in

situations, viewing each context and population as its own unique entity, and encouraging peoples' active participation in music alongside others to create inclusive communities which promotes wellness.

In the New Zealand context my approach has developed with the awareness of and respect to Durie's (1994) Te Whare Tapa Wha model. This indigenous Maori model emphasises the connectedness and balancing of the four pillars or cornerstones of health: te taha tinana (physical), te taha whanau (social), te taha hinekaro (emotion) and te taha wairua (spiritual). A person is in balance when all walls or pillars are equal which did not seem to be the case in a rest home hospital environment.

I have also been influenced by Carolyn Kenny's (2015) Field of Play model where her indigenous American Indian culture informs her music therapy work. Her model embraces the following ideas where: a person's presence and energy contribute to the space created for clients; clients are viewed as beauty; the space worked in nurtures safety which supports play leading to creativity; this then informs clients' self-power and growing confidence through their expressive creativity; and where "We are the music. And the music brings us into relationship with others" (Kenny, 2015, p.10). The music I shared with others within the facility invited connection through building commonality and familiarity.

To feel comfortable using the indigenous models of others I looked at my own culture, heritage, whakapapa (genealogy). I reflected on the culture-incorporated creativity and dexterity that I inherited from the lace makers of England; the music, handed down through at least four generations; the strong, resilient spirit of my early settler ancestors from the United Kingdom, Norway, and Europe who undertook perilous journeys to come to New Zealand to carve out a new life from very little but sheer determination, adapting, making do, inventing where needs must, improvising and learning as they went. I bring with me the

culture of being a community musician: singing from a young age to older adults at socials, being part of music competitions, performing at rest homes and in music theatre, performing at festivals and being a music tutor. I bring improvisation developed through my undergraduate jazz study and thinking on my feet from a career in radio broadcasting.

Another aspect of my culture, which I consider important for this context, is that I bring personal experiences of loving deeply and knowing at my core being the feeling of losing things a person holds most dear, such as people, security and health. These feelings heighten my awareness and empathy towards the people I worked with so that I understood at some level the range of emotions they may be feeling and that they shared with me. My experiences have led me to a deeper understanding, appreciation and knowledge of the positive benefits music can bring to a person's life.

Literature Review

The Aging Population

The United Nations Department of Economic and Social Affairs (2017) points out that in countries and areas around the world, populations aged over 60 are outgrowing younger generations due to decreased fertility along with increasing longevity. The World Health Organisation (WHO, (2011)) predicts the population of older adults, identified as those aged 65 years and over, will increase to around 1.5 billion by 2050, up from around 525 million in 2010. Ridder and Wheeler (2015) equate this to a ratio of 1 in 5 people over 60 years old. Knight, LaGasse and Clair (2018) suggest the category of older adults begins between 60 and 65 years, indicating that 20% of the population in America will be over 65 by 2050. Thus, the care and wellbeing of older people is a critical concern in today's societies. The WHO (2011) reports that "policies and programmes that promote mental health and social connections are as important as those that improve physical health status".

Older People Living in Care

The functioning ability of older adults may decrease. They may become more isolated due to the death of friends and spouses (Ridder & Wheeler, 2015). They may also develop new psychological challenges due to the loss of work networks after retirement, which can lead to loneliness. Knight et al., (2018) describe the loss of relationships as well as a change in work status as significant life transitions, that, along with other losses such as hearing, mobility and independence, may increase social isolation.

Older people living in care have unique psycho-social and psychological needs. While having basic needs met is important and necessary for residents in care, more is needed if they are to enjoy full and satisfying lives (Eliopoulos, 2015). Other needs include

interconnection with the community. For example, 'home', mentioned earlier, for many people is defined by the relationships they have with family and significant others within a particular environment (Eliopoulos, 2015). Choice within a person's own home is also a major factor for a balanced life (M. Brooks et al., 1992). 'Home' is a wholesome, healing term, and homesickness can be thought of as being heartsick for human affection and warmth (Campbell, 2000). Yet people who are in long-term care, especially those who are hospitalised, may experience physical, psycho-social and environmental barriers to building and maintaining interpersonal relationships. Eliopoulos (2015) states "quality of relationships influences quality of life" (2015, p. 46). Care staff can develop meaningful relationships with residents and their significant others, which can lead to very satisfying and rewarding outcomes (Eliopoulos, 2015).

Relationships

A search of literature using the parameters of - music therapy, relationships, older adults – resulted in a limited number of books and articles specifically on the topic within music therapy. However, Brooks and O'Rourke (1992), share how music offers opportunities for non-verbal expressions of loss and helplessness, and can alleviate isolation and loneliness while encouraging communication.

Brooks and O'Rourke (1992) also say that working with individuals and building a relationship with them before beginning group work helps them to feel comfortable joining in because at least they know another person. Group music has been found to positively influence relationships between staff and residents in communities and rest homes (Melhuish et al., 2017). Strange, Odell-Miller and Richards (2017) look at the roles and relationships non-music therapist assistants bring to music therapy groups in different therapeutic settings. Literature on this topic is still growing but this collection of writings supports the idea that

including non-music therapists such as care staff and professionals from other disciplines within a group music therapy session, increases their appreciation of the stories, choices and abilities of the people in their care. This leads to better connections and relationships between residents and caregivers. O'Callaghan and Magill (2009) found that the by-product of patient-centred oncologic music therapy sessions, was reduced stress levels on staff and carers, an improved work atmosphere and staff's perceived improvement of patient care. O'Callaghan et al., (2018) also note that pastoral workers observed that music therapy appeared to have a beneficial effect on oncologic staff wellbeing.

Meaningful and positive interactions can come about through music therapy over time, thereby developing healthy relationships (Pasiali, 2013). Bibbs and McFerran (2018) discuss that even though a patient's relationship toward a particular song may bring back negative associations, with the support of a group situation and in the presence of a music therapist individuals recovering from mental illness can learn to once again engage positively with those songs.

Knight et al., (2018) note that music therapists can build rapport with older adults to bring about increased stability to emotions, connection of feelings and social support, enhanced sense of self-identity, and improved social connection, well-being, intellectual stimulation and physical functions. Brooks et al., (2017) discuss the way information shared with individuals contributes to building relationships and trust.

Reflecting on how relationships potentially develop after a common connection has been established, led me to broaden the search parameters to include 'connection'. Community Music Therapy (CoMT) could be used to foster connections leading to relationships (Ruud, 2004).

Community Music Therapy

Ansdell and Stige (2015) suggest CoMT has been "an inspiration for broader and more flexible practice, …a critique of traditional theory, …a platform for exploring fresh interdisciplinary theory, and …an instigator of inter-professional dialogue" (2015, p. 595). CoMT moves away from the medical model of looking for what is wrong with the individual and trying to fix it (Ansdell & Stige, 2015), towards the ecological model which observes the interaction between the person and the environment, thereby linking "health with social, cultural, and political factors" (Bronfenbrenner, 1979; Ansdell & Stige, 2015, p. 607). CoMT could therefore be seen as "a striving for human musical connectedness, in the service of human flourishing" (Ansdell & Stige, 2015, p. 610).

In a randomised controlled study Coulton et al., (2015) conclude that community group singing has beneficial effects for the mental health of older people. Chan (2014) notes that music is cross-cultural and can transcend hierarchic boundaries while also increasing cultural understanding and supporting a person's identity and self-esteem to grow connections in a community. Wheeler (2015) states that "CoMT can contribute to the freedom and well-being of groups and individuals" (2015, p. 238).

These writings exemplify the potential benefits of CoMT in an aged care facility, such as improved mental health, self-esteem and agency. Ruud (2004) discusses the 'ripple effect' (Wood et al., 2004, p. 61) comparing CoMT to the ripples which occur when a stone is dropped into water; waves naturally radiate out across the water. But Ruud (2004) notes that CoMT can be thought of as more than that with sound not only moving outwards from the source or person toward the community but also bringing the community in. Rather than being a theory, framework, model or even a practical intuitive approach, Ansdell and Stige (2015) propose CoMT is an international movement focused on the rethinking and reviewing of the practice of music therapy which values empowerment and participation. They suggest CoMT can be health-promoting and socially active; it is more than building community in the

traditional de-institutionally responsive way; it can be thought of as working flexibly on a line continuum - from an individual through to community basis; it is collaborative rather than competitive between professions and lay people. Ansdell and Stige (2015) discuss a repositioning of music therapy from under the medical umbrella. Instead they suggest music therapists keep a "creative interplay" between their performing musical skills and those of a health worker (2015, p. 614). Davidson (2013) explored how his skills as a music specialist of many years and his training as a music therapy student interweaved with the use of CoMT in a school setting. He suggested social and cultural perspectives and musicking together could bring about a more cohesive school community for better learning outcomes.

In this research I will focus on how I, a music therapy student with many years of musical performance and practice, can use music within the context of a rest home and hospital to foster the connections, which may lead to building relationships between residents, and between residents and others, thereby enhancing the quality, wellness and family-feel of that community.

My Research Question

How did I use music therapy to foster connections between residents, and between residents and others, in a rest home and hospital environment?

Methodology

Method

I engaged in qualitative research, also referred to as interpretivist research (Wheeler & Murphy, 2016). Wheeler and Murphy (2016) cite Denzin and Lincoln (2011) who suggest this type of research studies natural settings with the researcher interpreting phenomena and the meanings they may bring.

Secondary Analysis

I used Secondary Analysis of data. Secondary Analysis is "a research strategy which makes use of pre-existing quantitative or qualitative research data for the purposes of investigating new questions or verifying previous studies" (Heaton, 2004). In this instance the pre-existing data was generated for work practice rather than research purposes.

Data Sources

The pre-existing data sources used to answer the research question were: my session plans and observational notes; meeting notes; and my reflective and reflexive journaling. I gathered these plans and notes between February and July 2019 during my practice at a rest home and hospital facility. There were no direct research participants in this study. I gained informed consent from the facility to use my data for research purposes. I also created a vignette, which included existing data. Because the vignette focuses directly on a particular music therapy participant, I asked for informed consent from the medical staff and the participant's guardians for the use of these data.

Thematic Analysis of Data

The descriptive data were subjected to Thematic Analysis (TA). Thematic Analysis is a theoretically flexible and useful method, which identifies, organises and reports on patterns or themes from within the data (Braun & Clarke, 2006; Clarke & Braun, 2017). "TA is essentially a method for identifying and analysing patterns in qualitative data" (Clarke & Braun, 2013, p. 120). Hoskyns (2016) evaluates Thematic Analysis as having the capacity to "accommodate highly diverse data sets" (2016 p. 568) within the practice of music therapy. The six steps outlined by Clarke and Braun (2013) include: becoming familiar with the data; coding raw data with quick labels to establish themes; checking the codes fully describe the themes and allocating short titles to them; writing up the findings and discussing their meanings and what has been previously written about this in the literature.

The coding procedure was undertaken in Word Excel. Columns were allocated to show the date that data were written on and the originating source. The raw data was selected and entered. Memos were added to enhance any quickly outlined data from the day. I closely examined each chunk of data for meaning and gave it a code. After many iterations, coded data were sorted into categories, moved and/or renamed as needed as themes were recognised. The categories were sorted, and colour coded, and examined again to identify major and minor themes. The facility and participants names were changed to protect their privacy. Examples of the coding process have been included in Appendix A (p. 76)

Budget

There were no budget implications as existing data from my music therapy practice was utilised.

Findings and Discussion

The findings and discussion sections have been combined to help the reader understand the ways I interpreted my findings.

My research looked to answer the question: How did I use music therapy to foster connections between residents, and between residents and others, in a rest home and hospital environment?

I found that I was able to foster connections between residents, and between residents and others, by engaging in interdisciplinary collaboration; utilising therapy skills such as being open and flexible; talking and having conversations and engaging in playful interactions; mediating when interpersonal relating was hard; drawing on physical and musical resources; and creating optimal environmental conditions for socialising. This could only happen after I had already established rapport with each of the parties.

My raw data revealed a continual interplay between the four main themes. For example, *collaborating* with staff to reposition the residents within the *environment* allowed for easier use of *therapeutic approaches* leading to use of *resources*. Likewise, a *therapeutic approach* was enhanced by *resources* which led to *collaboration* and altered the *environment* aesthetic. The synergy between the separate themes and their sub-themes led to an enhanced therapeutic response from those present. The following, *Figure 1*, illustrates this phenomenon, showing the blurring and overlapping which occurs between the themes around the central category of rapport, which then leads to connection.

Themes Diagram

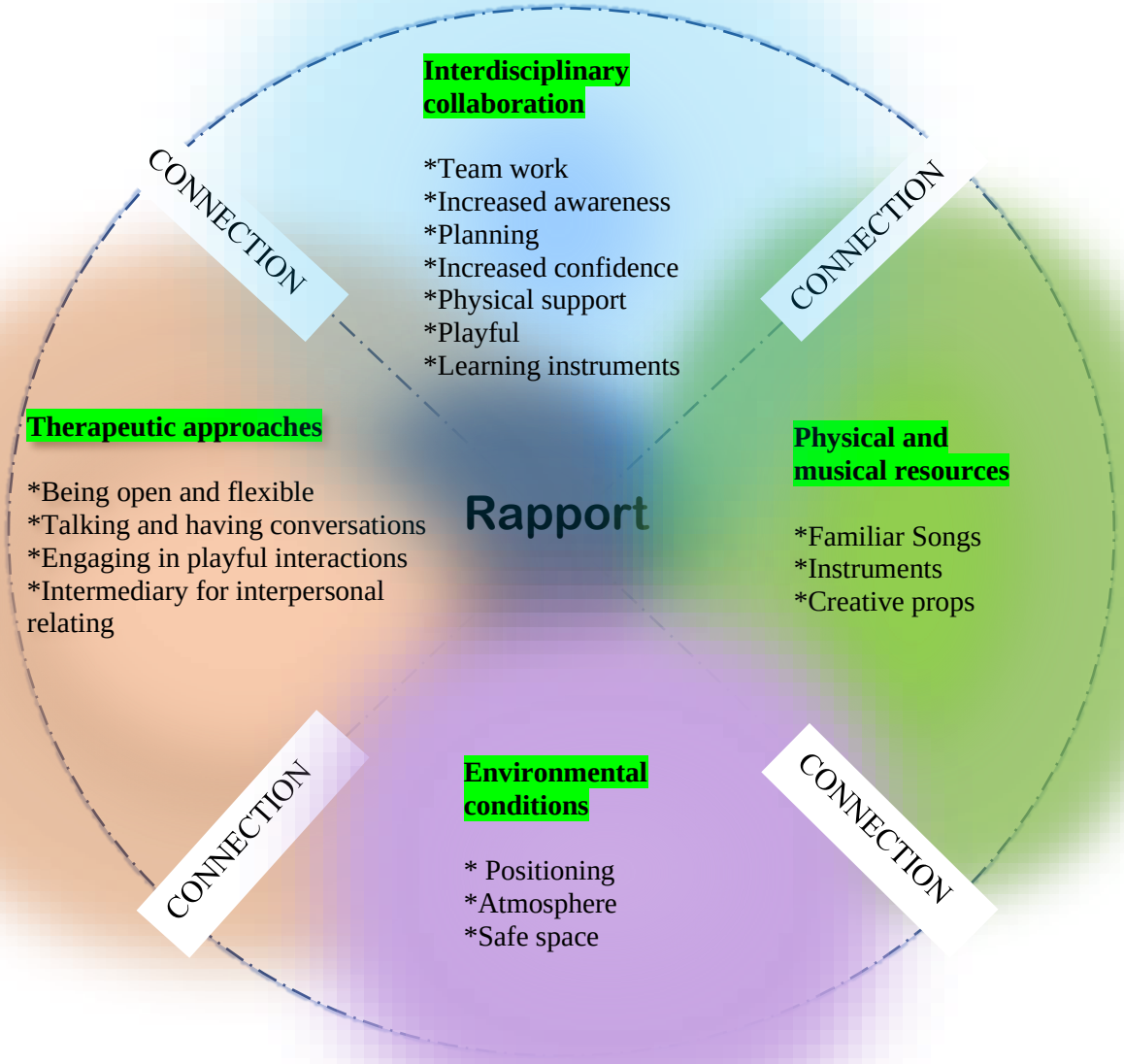

Figure 1: Category of rapport leading to themes and sub-themes, blending and intermingling with each other

Rapport

It began with rapport. The major overarching category in my findings was that I built rapport with people; therefore, it precedes the themes which became apparent during analysis. I built rapport by finding commonality and similarity with people. Hampton et al. (2019), found that similarity was considered attractive in people and linked it to the certainty of being liked, which led to fun and enjoyment after the initial interaction. When I first met people, I asked about their musical preferences, and songs they liked or that had special meaning for them. I followed up on their responses in a positive manner which often led to connecting through shared singing, thereby building commonality, trust and empathy. Miller (2016) suggests that rapport develops when a communicator picks up on the points or suggestions that another person has made. This may lead to people becoming "more at ease" (2016, p. 41), and sharing more openly about themselves. This could contribute to creating a non-judgmental environment between the people present. Price (2017) says rapport is the starting point for building trust which "requires effective communication, honesty, respect and commitment" (2017, p. 54), and observes that mutual rapport and trust from all participants is needed to build a therapeutic relationship. This process can be difficult when working with people who have dementia, although Sanders and Swails (2011) note that social workers did indeed develop reciprocal interactive relationships with end of life dementia patients when music was used.

Connection

Rapport led to connection. The definition of connection is "to become joined, to have or establish rapport, to establish communication" (*Merriam-Webster Dictionary*, 2020). Brown (2015), in her study about shame and vulnerability, suggests that we are "hardwired to connect with others, it's what gives purpose and meaning to our lives, and without it there is

suffering" (2015, p. 8). Kitwood (1997) indicates that real and deeper contact with people in care situations occurs when feelings are expressed and experienced. I supported those I was working with by meeting them as equals in their vulnerability – which reflects both my humanistic and person-centred frameworks. I did this by connecting with my own vulnerable side. I showed empathy, understanding how lives can quickly change and how it takes courage to keep going. Through listening to people's stories, singing their favourite songs, being playful and creative with them, and seeing their unique beauty (Kenny, 2015) I showed I could identify with them and had respect for them. I worked to understand them as much as I could, spending time with them, nurturing them, supporting them and their needs through music just as I would hope someone would do for me.

Group work

The open structure used in group work meant people with a wide variety of ages and health diagnoses were present at any one time. Participants were brought in or taken away during a session for cares, medication or treatments. Change was constant. I found it important to be flexible and to alter what was happening within the session quickly and professionally, while also providing a sense of continuity. Therefore, rapport and connection were constantly being renewed and revisited through welcoming the newcomers. Some residents remembered each other from previous sessions while others were challenged by their declining cognitive function. By encouraging participation through singing, which is considered to be physiologically and psychologically beneficial (Shultis & Gallagher, 2015), rapport and connection were built through common sharing. Some residents were daunted by the thought of coming to group sessions, either because they did not know anyone in the group or for psychological reasons. I used the idea outlined by Brooks and O'Rourke (1992)

and visited residents individually to build rapport. I observed some of them then started coming to group sessions. Connection.

I will now address each of the themes and sub-theme findings individually.

Theme 1. Interdisciplinary Collaboration and Teamwork

Interdisciplinary collaboration and teamwork ensured that connections were made and maintained between me and the residents, between me and the staff, and between residents.

Collaboration

The first major theme was collaboration. My support network within the facility fluctuated, therefore connecting with other allied health professionals became important for support. The home's staff informed my practice on matters of residents' information and knowledge, teamwork in handling residents, and team building. Knowledge gained collaboratively from other professionals, individuals, or group sessions, helped inform my work within the wider setting of the home to contain and regulate residents' behaviour. I was also aware of collaboration between staff and residents. Melhuish (2017) found collaboration helped staff become more aware of residents' feelings and skills; change their way of working with residents; and connect with residents. In the context I was working in, this became apparent when I began to see staff bringing more residents to music therapy group and an increase of musical interactions between staff and residents in and out of music session time. Gold et al. (2019) found that staff presence during music therapy sessions resulted in a perceived reduction in burden and sick leave.

Collaboration led to mutual increases in awareness regarding residents' strengths and needs.

> *Music therapy group. The new activities coordinator, Samara, came and helped, which was great. I had put the small hand-held percussion bag open on the trolley. She picked up a couple of shakers. She gave one to Quinten. He shook it throughout the session and really engaged with it. Samara was aware and indicated by looking at me and gesturing toward the resident, of Eva tapping her hand and Nina smiling and toe tapping. Nelly stayed still with her eyes closed most of the session. Samara and Quinten exchanged shaker duals - very excellent. (Reflexive journal: 9 April).*

Collaboration also enabled me to generate more relevant aims for residents and increase my confidence in leading groups. When other team members were participating in group sessions, they were able to support me by positioning residents physically to maximise socialisation and model responses to residents. At times the energy levels within the group increased and sessions were more fun, and it was possible for me to give more focus and have greater contact with individuals within the group. Similarly, incorporating music into existing activities resulted in creative, playful and imaginative warmups prior to group music therapy sessions.

> *Morning group – prior to the morning group session beginning, the activities coordinator Samara was playing balloon tennis with residents. I started doing strums and finger style picking on the guitar to mirror and match the movements between Samara and the residents. I followed the balloon up by strumming low strings to high, then picked two or three strings while the resident positioned to touch it. If they hit it hard I would do a strong strum in support. A soft tap back would be matched with a gentler two or three string strum. We kept this going for about 5 minutes. MEMO: The residents played 'tennis' by hitting the balloon when it was tapped toward them then watching and waiting for their next turn. (Group clinical notes: 2 July)*

Also, encouraging staff to follow up on learning to play instruments increased their awareness of the benefits of musical participation through personal experience.

Planning and increased awareness

Working alongside team members enabled us to discuss resident's needs more fully, share knowledge of residents, and plan and set more relevant goals and aims, which resulted in more benefits for residents. For example, I needed guidance and support from staff regarding safety issues when working in residents' rooms, such as the management of room alarms.

> *Sally was the Registered Nurse (RN) on today. I asked her to show me how to disconnect and reconnect the residents' safety pressure mats when I go into rooms for individual sessions. As she showed me we also talked about resident's who may benefit from music therapy. Later at 2 pm, I went to visit with Tamie, as per Sally's suggestion. Tamie was expecting her daughter although she kept calling her, Mother. She didn't have time for music she said. I was going to leave but saw her 'Map of Life' framed on her bedroom wall. We ended up chatting for half an hour about her life events. She engaged with stories of her OE, doing things in the 60's and 70's - the Flower Power era; driving fast cars. I connected her stories to small snippets of songs from the era as we talked. She joined in singing and smiled. (Reflexive journal: 6 March)*

Being warm and welcoming to staff and others led to them staying and joining in group sessions. It was important for team members to understand what music therapy could offer people, because they referred residents to me who they thought might benefit from music therapy. Being with staff allowed us to discuss resident's needs more fully as we shared varied aspects of care.

Increased confidence

Spending time with team members discussing and outlining my aims of music therapy for the facility helped increase cohesion between us while working with residents.

Facilitating groups alongside a colleague also motivated me to stand and move around. For example, the colleague's presence and energy gave me confidence by having someone to bounce ideas off which contributed to the development of my leadership skills. Prior to this I had been quietly sitting, singing, playing instruments and feeling very self-conscious. By standing I was able to get physically closer to group participants which helped foster connections.

Physical support

Working collaboratively alongside colleagues in group sessions freed one of us up and allowed for greater one-to-one focus, which residents would respond to through increased levels of interaction. For example, residents would actively shake percussion instruments or sing a few words or song phrases where they may have otherwise sat quietly. Team members assisted with the physical positioning of residents providing opportunities to develop and foster acquaintances. For example, while arranging residents for a concert a colleague suggested we could help residents who had recently met during music group to sit together, and this potentially enabled their relationship to develop.

> *I saw Albertine this afternoon at the Wednesday 2:30pm concert. Barry, the entertainer, was playing country songs and she was singing along - sitting next to Donna by the door. It gave me a good feeling. The activities coordinator, Samara, had placed Albertine in her position and suggested I place Donna next to her. This continued the connection they had made in the morning. They were no longer*

> *strangers but were developing their acquaintance with each other. Donna was singing along too. (Reflective journal: 17 April)*

Staff helped to move distressed residents into the music group circle. This supported the work I was doing and showed they trusted music may provide a calming influence. For example, when a distressed resident, who had requested to stay at the other end of the room, made negative comments, I asked staff to bring her closer to the main group instead of taking her back to her room. She became quiet as I changed instruments and played a song she had previously asked for.

> *Carolyn called out from down the other end of the room and said she was feeling sick. I tried to help. She swore at me and spoke negatively to me. Staff were going to take her back to her room. I got them to bring her into the circle. She had been negative about the sound of my guitar, so I switched to my keyboard and sang 'Now is the hour' - a song she had sung last week and as a result I had added it to the group song list. She became quiet and relaxed. (Group clinical notes: 28 May)*

Collaborating with staff was also helpful when trying to find solutions to regulate distressed individual residents outside of music therapy sessions.

Playfulness

I inspired playful musical interactions focused on having fun, being creative, encouraging imagination and being humorous. This led to shared laughter, socialising and the humanising of connections between residents, residents and staff, and residents and others. I encouraged fun, playful and humorous connections through music by altering song lyrics to include staff names and duties, support resident self-expression through choice, and encourage their

curiosity and musical interests. Residents quickly, creatively and imaginatively responded by coming up with their own song lyrics leading to fun and playful interactions with staff.

I gauged when it was appropriate to be playful and humorous, and observed residents relax whether in group or individual sessions, or in casual conversations. When playfulness and humour were present, I observed an increase of imagination, creativity, and skill awareness of participants. This brought a humane and family feeling to interactions within the environment.

Wheeler (2015) notes that play and playfulness are signs of greater well-being and human agency. Amir (2005) suggests that humour and music together "created in the here-and-now" can release tension resulting in a sense of freedom (2005, p. 19). When humour is used appropriately by the therapist and understood by the client, it can quickly lead to deeper therapeutic work, i.e. humour is a sign of good mental health (Amir, 2005). Therapists and clients could "tap into their sense of humour, to use their imagination, to feel freer, and to be spontaneous, funny, playful and creative" (Amir, 2005, p. 19). Sometimes I observed or residents said they did not feel playful. I respected their feelings and would adjust my delivery accordingly.

Collaborating with team members through sharing light-hearted moments, singing playful songs, being creative and imaginative during group sessions, also led to residents being creative, imaginative and having fun. For example, residents would join in making doggy bark sounds in a well-known song (How Much is the Doggy in the Window). This led to residents then suggesting other animal songs and creatively coming up with non-traditional animals and making their possible noises. Adding music to pre-session games was an opportunity to work and connect with colleagues and residents and provided a link into music group sessions. Staff members connected with residents by modelling movements to songs.

> *(The activities coordinator) Samara was clapping hands. I took up the cue and started playing clapping songs. Celine joined in. Nelly joined in and clapped her hand - the back of her hand to her palm. She watched Samara and ended up clapping palm to palm. (Group facility notes: 14 May)*

Learning instruments

When staff showed an interest in learning to play an instrument or engage as individuals with music, I worked with them to support their queries and enthusiasm and increased their skill levels as I was able. This built rapport and supported their first-hand understanding and experience of music as a therapy and tool for change. It was also an opportunity for me to blend my community musician / tutor skills with my developing music therapist skills which supports the Community Music Therapy movement ethos.

Theme 2. Therapeutic Approaches

The second major theme of therapeutic approaches includes four subgroups: being open and flexible; talking and having conversations; engaging in playful interactions; and being an intermediary for interpersonal relating. The subgroups blended verbal and musical approaches which built positive, friendly, open, non-judgemental and non-threatening connections. Residents and others safely shared themselves, had fun, and were playful. Those interactions created a relaxing socialising space that humanised residents, medical and care staff. Participants involved could reveal new aspects of themselves and felt able to express a spectrum of feelings including anger and frustration. Mössler et al. (2019) describe music therapy as a "mutual relational process" (2019, p. 2802) suggesting that when therapist and client are musically and emotionally together, a meaningful communication may develop. That process supports Ansdell and Stige's (2015) description of the CoMT movement and its reframing of the medical model into wellness mentioned in the literature review.

I fostered connections by using the approaches of being open and flexible, talking and having conversations, and engaging in playful interactions. Having an opportunistic attitude and an adaptable approach toward people and situations gave me the confidence to engage in conversations about music. It also fostered connections through song and at times playfulness, fun and humour. I became an intermediary when it was hard for residents to relate with others.

Being open and flexible

I was conscious of being open to making the most of chance informal moments. Openly and flexibly engaging and following residents' thoughts or stories about music, and promoting

their ability to share these with others led to: group cohesion; social interactions with residents and staff; increased awareness of cultures and celebrations; and encouragement of active music making. For example, if I saw residents in the lounge outside of group time, I would start playing songs using my guitar as accompaniment. I would move onto keyboard for a change of pace, then onto finding songs online which residents may have remembered and asked for through hearing other songs. Staff who came in and out of the area undertaking their duties, cares or taking a break, would join in chatting about a singer or ask to play the guitar so they could share songs their parents had taught them as children. I was always open and happy to share my instruments.

I openly welcomed visitors dropping into group sessions. I spoke with them and invited them to stay and join in. For example, if a friend of a resident arrived just as a group session was starting, I would introduce myself and invite them to stay. They would pull up a chair next to the resident and participate in the session. Some visitors began to visit their friend or relative specifically at music time because the music provided opportunities for them to engage in a common shared experience.

Seeing and taking opportunities to spend time being present, and sitting and engaging with residents through music, built rapport and trust, supported their self-expression and well-being, and encouraged autonomy through making choices. Being open to leaving space after songs, connected residents through sharing reminiscences brought up from singing songs and supported skill appreciation. 'In-the-moment' singing connected staff and residents through awareness of others. Being flexible also supported residents to remember past and present experiences, ask for songs and make music together at any given moment.

Some residents, who regularly attended music group and liked to sit together, would get animated and chatty. I facilitated sessions like this with an open, flexible approach. I put my original goals aside and became ready to move wherever the moment took us.

A connected music group with lots of interaction between residents today. Tamie was chatty. She and Bernice (and Donna when she arrived) chatted together most of the session. It was close to being disruptive, but it was what I was also trying to achieve so I couldn't get grumpy about it. I used it and capitalised on anything I could turn into a song - replaced lyrics to the song either being sung or about to be sung. It worked well. We had some light-hearted moments together. (Facility notes: 23 April)

Being open and flexible to anything that may happen in the space freed me up to have fun over what may, from a community perspective, be seen as potentially embarrassing situations. By creatively altering my perception and reaction to events, I tapped into my playful fun side and used exaggeration which created moments of humorous connection within the group. This was different from my formal classical performance training which looked for perfection in everything. It did however reference my jazz improvisation training and the well-worn adage of 'if you make a mistake, make it twice so nobody knows it's a mistake'. It was even different from the 'entertainer' role in that I felt myself put my ego to one side. I was not looking for applause, accolades or to be the clown. I was being my authentic playful, creative, happy self. I was enjoying a moment of connection and humanity with the people I was with.

Morning group - Near the end of the session my music stand fell over. I made a game out of it by throwing more books up in the air. Charles, Carolyn, Philip and Zack all laughed. (Facility notes: 16 July)

Birthday celebrations were an opportunity to be flexible and share familiar songs with residents' families, along with caregivers and group participants who were present. When residents had their birthday, I would take the opportunity to invite everyone to join in the celebration by singing 'Happy Birthday'. I worked to include everyone, especially if family members had recently arrived to visit.

I took the opportunity to turn passive music situations into active music-making occasions. For example, when I was approached to 'entertain' the residents in the main rest home lounge as part of a Nurses' Day celebration, I began the session with what they were used to: seeing someone at the front of the room playing and singing songs. This soon led to them asking for other songs I was unfamiliar with on the guitar, so I sang them acapella and residents joined in. To encourage an active therapeutic session, I handed out percussion instruments and residents engaged by playing them while singing, moving, and discussing rhythms and other songs. I worked in-the-moment encouraging them to also be open and share their thoughts, feelings and music memories, which they did.

When I saw residents on their own, I would sensitively engage with them by asking if I could join them. If they agreed, I would steer the conversation towards music. This would lead to them choosing songs they would like to hear. We would sing them together and they would comment on the lyrics that had touched them. I was aware that I may be modelling a social approach for others. Spending time with residents in a communal setting and outside of group time, provided support and opened them to engaging with others who came into the room.

> *Following a meeting I went back to the hospital lounge area. Donna was sitting alone in the dining room with her unfinished lunch. I sat with her while I had a cuppa tea. I got her a lime juice at her request. I asked if she'd like a song. She said, "yes*

please". She chose the Bob Dylan song 'Blowing in the wind'. She commented at the end that it was a lovely song. Words that meant most to her were 'the answer is blowing in the wind'. I then sang 'Skye boat' and 'Cupid'. When Ted, a day resident, came into the area I introduced him to Donna. The three of us chatted together for a few minutes. (Facility notes: 19 February)

Interactions which were informal, impromptu and in-the-moment were based around the topic of music and often changed the atmosphere within the space. For example, a day resident was sitting in the reception area waiting to be collected. He was anxious because his ride was late. When I saw him there, I joined him, and we chatted about music. The conversation turned to Scottish culture and singers as he was Scottish. A staff member in a nearby office called out names of Scottish musicians and we all sang portions of songs from the artists. This led to the reception area of the home being full of song and laughter. The gentleman's ride arrived, and he happily waved goodbye. Another example of being open to chance conversations led to a resident and her friend, also from the home, interacting with their caregivers and choosing to participate in an afternoon music session.

Talking and having conversations

Spending time talking with staff helped to build rapport and supported residents to gain confidence to participate in group sessions. Positive therapeutic relationships were built over short periods of time through conversation and shared music. I visited residents in their room when they were unable to attend group music. This initiated and maintained contact and consequently they were more motivated to come to music group and to sit and socialise with others, when they felt well enough.

In group sessions I modelled and encouraged conversation between participants. This led to music sharing and spoken social interactions energising participants who commented that time passed quickly. Staff supported and conversed with residents who chose to participate in music group.

Introducing residents verbally to each other during group time potentially reduced their isolation. It occurred to me that in self-help groups participants introduce themselves, likewise at workshops or conferences there are often name tags available to help people network together. With that in mind, and as my groups had varying diagnoses, to support them out of isolation within the group I created awareness between participants by changing lyrics to a familiar 'Hello' song introducing them individually to each other in a formal way. The result was that residents acknowledged and responded to each other in a social way by looking towards another person, trying to shake hands, and enquiring about the other person's life. I also introduced new participants to the group through song.

> *Morning group - I stopped playing the guitar and introduced people next to each other by singing acapella in a formal one-to-one style. Quinten looked at Belle, Quinten and Keith connected by touching each other's closest hand - Quinten's left to Keith's right. CeCe opened her eyes and Keith looked toward CeCe. Philip looked at CeCe. Donna and Philip acknowledged each other. Donna kept commenting to Philip regarding his name and how to correctly pronounce it. (Group facility notes: 11 June)*

Residents expressed themselves through conversations about current events. Conversation led to shared singing, connection and appreciation of other cultures, team building, and family members sharing knowledge of residents' personal music tastes. For

example, a resident's daughter was able to tell me her dad loved country music especially Kenny Rogers and Johnny Cash.

Participation in music group gave residents a regular socialising space for conversations and interactions with each other. It brought them out of isolation. They often commented that time passed quickly.

> *During group: Tamie, who is new to group today, talked with Bernice. Normally Tamie stays in her room. She joined in playing a percussion instrument. She commented time passed fast. Bernice talked to the group about memories stirred from the songs we were singing. She talked about her family and sharing music. Olive stayed for the whole session - first time that's happened. She asked for 'Mood for love', played the shaker instrument, sang 'We'll meet again', and told Nelly to ''wake up''. After the session, the group participants chatted amongst themselves. There was a calm feeling in the room. (Facility notes: 12 March)*

The opportunity to join music group sessions presented staff with a reason to talk to residents, something to talk about, as they asked them if they would like to participate.

> *I'm becoming known as 'the music lady'. The caregivers say to the residents "The music lady is here. Do you want to stay for the music?". Some residents don't respond, others do either verbally or with a nod or there's recognition through their eyes. (Facility notes: 20 April)*

When visually impaired residents joined the group, they appreciated being introduced to others already there. For example, it was important for me to help a sight-impaired

resident be aware of who else was in the room and provide auditory cues about where people were sitting. The residents would say "hello" to the newcomer.

When residents showed interest in other people's cultures, I encouraged conversation around heritage. For example, a resident wanted to sing Irish songs and asked if anyone was from Ireland. One resident was from Scotland and started singing Scottish songs instead. I mentioned that other residents and staff were from the Pacific Islands.

In conversation with the home's manager I was invited to join staff meetings and cultural blessings. It was an opportunity for me to be present which helped to build team rapport with staff members, and awareness of the importance of self-care.

> *A kaumatua [Maori elder] came in to bless the staff and facility as there had been a lot of illness and five deaths in the last two weeks. He told staff to look after each other and themselves, especially our wairua [spirit]. Our attitudes and what is happening in our lives affects the balance in the facility. We all gave each other hugs at the end of the blessing. It was very lovely. Ka pai. All good. (Facility notes: 9 April)*

I reflected on this session and Te Whare Tapa Wha and how my personal life may have been influencing my practice. I expand on this later in the Vignette Discussion section (p. 59).

Engaging in playful interactions

Singing humorous songs requested by residents and changing lyrics in light-hearted ways supported the expression of a range of emotions within songs. It socialised and connected residents and others adding fun into musical games and activities. Playful interactions

inspired residents to lead the group. They creatively changed action lyrics which then engaged other group members and created playful sessions where time passed quickly.

Residents also playfully changed song lyrics as a way of supporting fellow residents to stay seated. For example, when a resident was trying to stand during music group but was at risk of falling, other group participants picked up on my lead of changing the lyrics to support the resident to remain seated; they quickly came up with their own fun lyric suggestions. This connected the group while staff members assisted the resident. I also parodied the lyrics of a familiar movement song modelling to residents that they could express deeper emotions and feelings of dissatisfaction through songs.

> *During morning group work: I played 'If you're happy and you know it' but lyric-parodied and sang 'If you're grumpy and you know it stamp your feet'. CeCe, Marie, Keith, Claude and Ivy all stamped or moved their feet to their various levels of ability. I felt the residents all enjoyed being allowed and encouraged to express their frustrations. It felt cathartic. (Group facility notes: 22 May)*

Lyric parody reflected residents' self-expression and supported movement and interactions between staff and residents. For example, a caregiver asked for a familiar song while helping a resident with his breakfast. The resident started chair-dancing and they smiled and connected. When residents asked for songs they knew from their childhood, they joined in singing and became playful. For example, a resident asked for the song 'Wheels on the bus'. Other group participants agreed they would like to sing it. Near the end of the song a 96-year-old resident arrived. She suggested "The horn on the bus goes" and proceeded to made horn sounds. The group joined her in laughter.

Encouraging residents to choose which movement they would like to do in familiar songs led to shared laughter and fun. For example, I playfully muddled my left and right feet in 'Hoki Toki' asking, "Which left foot?". As senior staff members went about their duties they joined in and residents responded positively.

Introducing creative props encouraged residents' musical imagination, while novelty resources supported playful humanising interactions between residents, family members and staff. For example, when a resident and a staff member saw an unusual roll-up keyboard, they both wanted to get their hands on it and find out what it sounded like.

Supporting playfulness through leaving space in songs, encouraging silly sounds and humour, mirroring and modelling creative expression, having fun conversations and including staff members who were present, all led to connection through imaginative playfulness as did staff knowledge and humorous rapport with residents. For example, a resident appeared to be in a playful cheeky mood and was hiding music session props under his blanket. I joined his playfulness with a song which supported a colleague to retrieve the props in a playful manner. In another example, while playing with fabric props, a resident wanted me to wear on my head a 2-metre pink lace fabric we had been musicking with. I followed her suggestion draping it completely over me. As it was then tickling my nose and making me hot, I made a game of blowing the fabric off my face. The residents joined in laughing. Playfulness also engaged visitors in fun sessions. For example, offering a visitor a squeaky duck which she then 'squeaked' during the 'Birdy song' led to the resident she was visiting also squeaking the duck and laughing.

Playfully practicing the ending of familiar songs created in-the-moment musical games which resulted in fun, laughter and social interaction. For example, making a game out of the end of the song 'Kiss me, Honey'.

I slowed the tempo right down to allow for those who wanted to participate. The group sang "But honey, honey", I sang; "Ah hah?", we practiced singing together; "Don't stop!" They smiled, laughed and commented to each other that they had nearly got the words rhythmically in the correct place. Everyone seemed to enjoy it. (Facility group notes: 14 May)

Providing residents with time and space for musical play within a group session, to make funny noises and experiment musically with rhythms, phrasing and scales and to mirror those playful antics, led to moments of fun interactions and socialisation. For example, residents connected rhythmically with each other which then led to imaginative vocalisations, inspiring other residents to join in the fun, humorous moment.

Morning music group (semi-circle) - I handed a small hand drum to Zack; Zack was hesitant to play it. I encouraged him to tap anywhere on it and modelled this for him. I gave a covered tambourine to Philip. He started shaking and tapping it. Zack started playing and tapping the rhythm of 'Old black Joe'. Philip started playing the same rhythm and tempo as Zack. Philip started singing ascending arpeggios. He sang up one octave. I played with his idea by joining him vocally and took it further and went higher. Claude, Carolyn and Zack all laughed and chuckled. Carolyn playfully started singing arpeggios too. (Group facility notes: 16 July)

Making playful, fun and humorous noises also led to fun conversations which engaged residents' creativity and imagination. For example, a conversation resulting from a music session activity led to residents humorously interacting together:

> *Afternoon music group in rest home lounge: Someone said, "Make a siren sound". I did. There was discussion as to what siren it was - police, fire or ambulance and that my sound was more like a screeching cat. I encouraged residents to come up with their own siren sounds. Some didn't know how to make any noise, so I encouraged and modelled for them how to make 'pop' sounds. That caused some laughter too. (Group facility notes: 26 June)*

Staff rapport with residents helped when a person became disorientated and confused. For example, when a resident heard me singing 'Happy birthday', she indicated it was her birthday the next day. I was singing her the song when a caregiver gently but humorously commented that it had been the resident's birthday the previous week.

Intermediary for interpersonal relating

I became aware of residents' intolerance towards others within the home. Residents with different diagnoses confided in me their frustrations resulting from other people's loud disruptive behaviour; their own personal financial matters; and apparent lack of consideration by caregivers while undertaking residents' daily cares. I saw these moments as opportunities to engage the residents in conversation and music which may support their psychosocial state. At times resolution was only found when I became an intermediary between the parties concerned. The main contributors of intolerance in this study were those with neurologic disorders which include dementia and stroke (Tomaino, 1999). Montgomery et al., (2009) note that following a stroke a person may develop anxiety showing frustration about financial matters and other psychosocial factors, one of which includes intolerance towards the 'busyness of life' (2009, p. 29). Gilboa (2016) says music and dialogue can acknowledge people, and present opportunities to learn about cooperating, social variance and conflict.

Talking was residents' initial response to events happening around them. They would voice their disapproval of someone else's behaviour, becoming frustrated and verbally intolerant toward others. When that happened mediation helped them to understand the feelings of other residents. For example, a regular verbally dominant group participant yelled at another resident who was asking for songs. After I quietly said "It's okay" and explained his song choice was important too, she calmed down and her shaking lessened.

In another example, when a resident's visitor shared her story with the group and another resident became impatient with the time it was taking, I sensitively diverted the focus onto the dog the visitor had with her and engaged the group in singing 'How much is that doggy in the window' encouraging playful barking and other silly sounds. The distressed resident had enjoyed this song in previous sessions. Residents then started singing 'Old MacDonald' with group members choosing which animal was on the farm. We all made the noise of that animal. For example, a snake, a rabbit and other non-traditional animals.

Theme 3. Physical and Musical Resources

Musical and instrumental resources were my tools-of-trade for engaging and connecting through musical means. I observed residents relax when they heard a song they knew, liked or that held significance for them: they either joined in singing or humming; acknowledged by nodding, smiling or hand gestures; sat back in their chairs, closed their eyes then chose to open or keep them closed after the song or tune had ended. The use of familiar song created group commonality and provided a means for developing and creating a sense of community through "The common groove" (Pavlicevic, 2003, p. 118). Pavlicevic (2003) discusses how humans are synchronous, and when there is an absence of this it can be an indicator of health issues. Being rhythmically in time with another person therefore indicates an element of

wellness and a settled calm environment. Hand percussion instruments connected people as they initiated conversation about the instrument, that is, colour, shape, sound; how to play them: and people's skill and rhythms produced through using them. Creative props also initiated conversation about how they were made, vocalisation of sounds and fun, creative and interactive moments which supported self-expression.

Collaborating musically with people utilising resources, empowers and enables them culturally and socially. Performing music together actively, by playing, listening or musicking, promotes health and human development, and supports the ecology of the person and the environment (Ansdell & Stige, 2015).

Familiar songs, tuned, and percussion instruments, and creative and novel props helped foster connections between residents; between residents, staff and others; and between me, residents and others.

Familiar songs

Familiar songs encouraged reminiscence and engaged residents so they stayed in the group longer, leading to greater sustained interaction and socialisation. I varied the tempo of songs to re-energise or match group energy levels, and I played songs staff and residents could 'dance' to together. I organised songs that were relevant to special events and considered how songs from various cultures, and songs that were familiar to residents, could help them express and discuss their identity. I encouraged residents to request songs. I sang about things that were happening in and outside the room, often by adapting a song in-the-moment to help people become more aware of themselves and others.

I enabled residents to choose their own instruments and play these as they wished. When residents were able to participate and express themselves freely, they developed knowledge and appreciation for what they and others could do.

a) Staying with the group

Residents would ask for songs and join in singing them while staff were doing duties in the area. Staff became aware of residents' participation and commented on it. For example, I supported two residents who were known to find the pre-dinner hours difficult. When one of them asked for music I was happy to share songs she had previously indicated she liked. I identified the need to keep both residents emotionally calm as noise happening in the area had been known to agitate them, for instance, the sound of tables being set and the clinking of cutlery. I sat near them playing at a tempo matching their resting states. I chose familiar songs which they had enjoyed in past group sessions. I engaged in conversation with staff in the area to include everyone and invite a safe sharing environment. Staff in turn commented on residents' participation.

Staff would also request their favourite songs while attending to residents. For example, a nurse asked for a very popular song while with a resident, then sang the song with the group. To see the nurse as a person who would join them supported individuals.

Residents also participated for longer through engaging in familiar songs. For example, a resident who was normally restless, stayed and actively engaged for an hour-long group music session singing songs she knew. The familiar songs and music combined with social interaction appeared to help anchor her and hold her. It helped reorientate and calm her.

b) Interacting

Singing familiar songs created moments of interaction between residents and created awareness of the physical presence of others. The residents could see and hear each other which led them to mirror other residents' sounds. For example, one participant was

motivated to lean towards and reached out to touch another resident's arm during a song. The two residents looked at each other. Another participant coughed, causing a resident on the other side of the group to open her eyes and look toward where the sound had come from. She then coughed as if in reply.

Sometimes it was appropriate for me to begin singing songs through from start to finish, as people were used to hearing them. This prompted conversation between residents and others, which led me to adapt my delivery of the song. For example, to support a conversation which started during a song, but also to support others in the group still showing enjoyment, I continued playing, moving from medium-volume strumming and singing to softer fingerpicking. I then began to gently hum the melody while cycling through the verse and chorus again. The conversation and appreciation of the song continued afterwards which kept everyone connected for longer.

c) Unfamiliar songs

Introducing new songs that may be unfamiliar to the group created interaction through conversation. For example, when I played the Gerry Goffin, Carol King song 'Loco-Motion', the group participants discussed the song amongst themselves.

With regular use new songs became familiar to the residents. For example, the short 'Hello' song I had written was regularly used to open sessions. Group participants and staff grew to know it and would participate in singing residents' names and acknowledging each other through the song.

d) Reminiscence

Familiar songs reminded residents of events and times in their lives. Residents would choose to share their stories with the group. For example, one resident recounted memories of her family sharing music together as the children grew up.

e) Energy levels

I matched residents' tempos and energy levels. I would adjust my original tempo of a song to the pace of participating residents when I saw them singing or tapping to the rhythm. For example, I went from one song straight into a group favourite. I slowed the song down to meet the pace and lower exertion level being shown by a resident who had joined in.

I also used familiar songs to re-energise the group which connected staff and residents in chair-dancing together. Chair-dancing is where residents remain in their chair and either move a little as if dancing, or have their hands held by another person standing and dancing with them. I also modelled movements of Rock-n-Roll songs which supported residents to move and appreciate each other.

> *In a bracket of Rock-n-Roll songs one resident followed my lead by shaking his legs like Elvis Presley. I added the song 'Blue beat' and improvised around beating and tapping toes. Donna commented Karter was tapping his toes and Albertine was too. Donna (who very rarely moves) even tapped her right foot with my encouragement. (Group facility notes: 24 April)*

Residents expressed themselves and interacted with others through song. They also expressed their deeper thoughts and feelings through discussing song lyrics. For example, singing the song 'My favourite things' from *The Sound of Music*, a song that may usually be

thought of as positive and uplifting, led to a resident becoming thoughtful about the things she could no longer do, such as travel, spending time walking out in nature, and using her computer. Another resident shared why he liked the sad lyrics of his favourite song because it reminded him that his life was coming to an end. I was respectful of the residents' shared feelings of loss and sadness. The group connected with them through shared empathy.

I played a simple instrumental two-chord patterned rhythmic vamp. It provided space, and modelled giving people time for self-expression, imagination and creative playful interaction leading to group members and staff appreciating the skills and imaginations of others.

> *During morning tea, I doodled on the keyboard. It gave residents space to listen to the sounds. It felt unusual for me to begin with. Then Philip started to tap his cup and plate to the rhythm of the two-chord vamp I was playing. He followed me. Then I increased the tempo. He followed and we laughed together as we realised we were listening to each other. He started doing smaller quaver-type rhythms. I followed him. He looked at me. I was aware other residents were listening. Zack said "He's playing the beat". Nelly nodded her head as if to agree. She was listening too. Samara started to take Philip's cup, plate and tray away but I indicated to let him keep them as he was beating out the rhythm - almost as if he was using a Pacific Island Pate drum, but the moment had passed. Later Zack started to sing 'Lili Marlene' over the two-chord sequence. Donna recognised the song and said "He's singing Lili Marlene". (Facility notes: 2 July)*
>
> *Later again Zack started singing another song. Nelly joined in singing the same song with him. She wasn't quite in sync with Zack - about 2 bars behind. (Group facility notes; 2 July)*

Residents also explored their deeper feelings through writing their own lyrics to familiar melodies. For example, a resident expressed herself in group time about her current situation of being dependent on others for her daily living activities and asked how much longer it would go on. Afterwards we started having individual therapy sessions. She talked about her frustrations and asked for my help to craft her lyrics into a song over a known melody. The song was then sung for her family.

Including everyone in the room and their activities in song, energised the group and created awareness of each resident's individual identity within the larger community.

f) Cultures

Residents became aware of other group participants' cultures by asking for familiar songs from those cultures. For example, singing Celtic songs fostered the connection between two residents from different cultures. Likewise, including greetings in Pacific languages in songs fostered the connection between staff and residents. For example, Arihi is Samoan and I would greet her singing "Talofa to Arihi", and she would reply in Samoan.

Cultural songs may also include those sung for special occasions. For example, I sang a familiar celebration song which residents individually responded to, creating a shared experience.

When group members had passed away residents agreed it was appropriate to sing the person's favourite song or songs in remembrance. This supported residents to say their goodbyes. For example, one of the group's regular participants had died overnight. Talking about it and singing songs connected to that participant helped others process the passing.

Familiar songs also supported residents and their family through their final hours together. For example, a resident's family was gathered by her bedside and asked me to sing her favourite songs they said held deep meanings for her.

Instruments

Residents expressed themselves on percussion instruments of their choice leading to increased appreciation of their skill by other residents. For example, a resident chose to play the bells for most of a session. Another resident in the group was motivated to compliment him on his playing. Exploring percussion instruments, their sounds and how to play them, led to residents gaining confidence in themselves. For example, a staff member offered a resident a squeezy hammer-type music instrument. The resident was shown how to shake it back and forth. When a sound was produced he started smiling and kept shaking it.

Percussion instruments supported interaction and socialisation between residents and visitors leading to connection. Unfamiliar instruments also resulted in interaction and socialisation between visitors and residents. For example, I handed out orchestral triangles. Residents commented on the instruments and a regular visitor to the group walked around playing one of the triangles and engaging with the residents.

Residents became aware of others in groups sessions through the sound of different percussion instruments. For example, when shaking percussion bells one resident commented that another participant's bell was bigger and had a deeper sound than hers. Residents were more receptive to different instruments at different times. For example, changing from guitar to keyboard supported an unsettled resident to continue participating in music sessions.

Residents also connected with staff by commenting on the volume percussion instruments were played at. For instance, a staff member was told “Turn down the noise”, when she played a shaker in front of a resident.

Lightweight portable instruments were helpful in connecting with residents in their room, when they were unable to come to group sessions or were still becoming aware of the availability of music group. For example, I introduced myself to a new resident as I passed her room. She was interested in knowing about the music group. I had my portable keyboard with me, so we shared some songs she liked from the 60s and 70s. Later when she did come to group, we revisited some of those songs.

I offered residents the choice of hand percussion instruments. Through playing these instruments, residents were supported in being actively involved in music sessions. Not only did percussion instruments provide a tool for residents to contribute to a song’s rhythm, they also provided a means of building confidence, an outlet for self-expression and imagination, as well as a very important audible way to connect to others in the group. For example, a resident overcame his initial hesitancy with an instrument and tapped out the rhythm of his favourite song. Another resident joined in and started playing the same rhythm and tempo. This was then followed by a vocal improvisation which I matched, creating laughter within the group and inspiring yet another resident to start vocalising.

Creative props

I introduced a colourful, creative visual and tactile sensory prop of long scarves. I had searched out and bought them from recycling shops, then knotted them all together. I arranged them so they fanned out from a central point which gave up to nine participants in their big chairs a scarf end to hold. It stimulated the residents’ imaginations. For example, one resident said it looked like a colourful spider’s web. Another commented that when

everyone held the end of a scarf, they were all connected. These were both thoughts I had considered while putting the prop together. I combined the prop with familiar songs and humorous vocalisations which led to residents expressing themselves imaginatively.

Individual larger pieces of fabric also stimulated conversation amongst residents and led to singing songs connected to the discussion. For example, the introduction of light, floaty, lacy fabric created conversation around memories of sewing and fabric textures, which led to singing a familiar song about sewing.

Theme 4. Environmental Conditions

I altered the physical placement of residents within the environment to foster connection. Residents were placed into a semi-circle instead of rows. This made access easier for staff, allowed closer individual work within group sessions, and improved lines of sight for participants thereby increasing socialisation and reducing isolation. These factors support the ecological components of CoMT outlined in the literature review (Ansdell & Stige, 2015).

One of Kenny's (2006) primary fields in her Field of Play model is the musical space which she describes as "home base": a sacred, safe, nurturing place (2006, p. 100), where growth and change can happen. Therapist and client enter this space when they acknowledge each other's aesthetic beauty and have an intention to engage. Engaging leads to the next primary field: The field of play. This space includes experimentation, imitation of sounds, modelling and communicating emotions, and only happens once trust has formed in the musical space field. For me this resonates with the building of rapport with individuals and the group, and the importance of supporting the person's internal environmental space through the therapeutic relationship: helping them to feel safe. I did this by incorporating songs people knew and had indicated they liked. This built trust through predictability of knowing the song which deepened rapport. It led to imaginative creativity, thereby building stronger connections in the group, and between individuals and me. All of this was supported by the environment.

Introducing unfamiliar songs created opportunity for external and internal environmental change through conversation. This led to people expressing their opinions. In other words, it supported personhood (Kitwood, 1997).

Positioning

I planned carefully and ensured that people were physically positioned in ways that would create a welcoming, safe atmosphere to foster connections. I placed chairs in a way that would balance the need for openness with the need for participants to have physical proximity and visual access to each other and the wider environment. This maximised opportunities for interaction and socialisation.

As indicated earlier under the heading *Therapeutic Approaches - Talking and having conversations* which also impacts on environment, I created a safe and comfortable psychological atmosphere by using well-known predictable songs. I welcomed everyone including new residents, staff and visitors through song and individually introducing group participants to each other. This fostered friendly atmospheres where residents acknowledged each other and continued connections following group sessions; where staff members felt safe to burst into impromptu song; and where visitors regularly spent time.

As the number of residents attending music group sessions grew, I collaborated with staff to increase the area to work in. For example, I talked with a senior caregiver about how we could make better use of the space available in the room. She moved the tables in the dining room into a 'restaurant-style' arrangement, that is, into either single or double table groups. This allowed us to extend the music group into the dining area which gave us easier access to participants. Rearranging the room and the residents within it supported more visual access between residents and led to greater group interactions. For example, residents were able to see and watch each other participate in the group. They then responded to a participant changing the actions to a popular movement song. When residents were relaxing with their eyes closed or watching quietly without movement, I stood close to them which included them in the group session. For example, when I crouched and sang next to a resident who had his eyes closed, he joined in singing the song with me. Another participant

commented “He’s singing in his sleep”. She then started singing the song which prompted yet another resident to applaud her. The group atmosphere was positively enhanced when residents would ask to sit together.

Atmosphere

Staff members commented on the positive feeling in the room while they went about their duties. They joined in singing the familiar predictable songs and interacted with group participants. For example, a staff member commented that the room had a lovely gentle atmosphere, and she would like to come and be part of music group every day. She had been washing the inside windows in the dining and lounge area throughout most of the session and joined in singing songs from across the room. I included her in the session by singing about what she was doing and by following up on song suggestions she or residents offered. One resident asked for 'Sadie the cleaning lady' so we all sang as much as we could remember. The staff member laughed and joined in.

I supported new residents to the home in their decision to observe music sessions before they actively participated. For example, a new resident came to the lounge during group time. He declined a percussion instrument and instead chose to observe from further back in the room. By the end of the session he joined in humming ‘Carnival is over’ which another resident had started to sing.

Singing familiar songs that were appropriate to the context, created environments suitable for staff to show their respect to unwell residents. For example, I offered to relieve the manager who was sitting with a resident in a darkened room. I sang quiet acapella songs of comfort from a list I had recently seen in a music therapy book (Hanser, 2016). This created a relaxed and respectful atmosphere, which then supported staff and carers who came to show their affection to the resident.

Safe spaces

I introduced residents to each other during songs. This supported increased socialising and interaction leading to friendlier environments due to people knowing who else was present in the group.

Creating supportive safe environments led to staff members spontaneously singing songs, and to residents acknowledging others within the group. For example, I joined in with a staff member who started singing a familiar song, which resulted in an interaction between the staff member and a resident.

Providing music group at a set day and time offered an opportunity for residents and their friends to regularly engage and interact in a calm, stress-free environment. The environment created by music group also supported opportunities for continued interaction and socialisation between residents following sessions.

Vignette

I now share the following vignette as an example of how (1) I linked my prior experience and knowledge of a resident with my musical theatre community musician skills, with (2) a lesson from my supervisor on leaving space, and (3) my interpretation of how this potentially connects to CoMT as the vignette concludes with a performance, as such, in a communal area, and the appreciation of the performer shown by another resident.

4 April 2019: Lesson on prior knowledge, leaving space and Community Music Therapy

> *The afternoon peace in the rest home was suddenly shattered by Nelly's piercing scream. A scream that resonated in my solar plexus.*[2] *I had heard it the day before while in session with another resident and it had me asking "How can I help?"*

[2] *I will reflexively expand on this in the Vignette Discussion section*

Today I got my portable keyboard and made my way to Nelly's room, one of many opening onto a long corridor. She was sitting in her big movable soft chair at the foot of her bed. I knocked on the open door and asked if I could enter. She stopped just long enough to nod. As there were no chairs I asked if I could sit on her bed. Again, she agreed by nodding. Nelly had been coming to music circle group since it started in February. She had begun to recognise me. As I sat, I decided to choose the soothing sounds of the 'surf'. I selected it on the keyboard and played each note to recreate lapping waves on a beach, matching the rhythm and intensity to her breath and anxiety level. She stopped screaming, paused and seemed to listen. I started slowing the tempo speaking quietly as I did. I asked if she liked going to the beach. She nodded. I suggested we imagine walking barefoot on the warm sand and feel it between our toes. She nodded. I slowed the tempo of the waves to follow her breathing and relaxing. She was quiet for a few moments then began moaning. Thinking in the moment, I asked if she liked musicals. She nodded. "Which ones?" "Oh", she paused and showed frustration as she tried to find the words, and continued "all of them" as she waved her hand dismissively at me. I suggested 'My Fair Lady'. She smiled. I started singing the first couple of words unaccompanied of 'I could have danced all night'. She joined in singing strongly and confidently. I followed her tempo and lead. In the final phrase of the song she held up her arms in an end-of-song flourish. I mirrored her. We laughed. At that moment her caregiver came in and said it was time to take her to the dining room for tea. Nelly nodded and indicated she was happy to go.

A few weeks later during a morning group session, conversation turned to show tunes. To engage Nelly, I used my prior knowledge and started to sing 'I could have danced all night'. She joined in with her beautiful soprano voice, singing loud and strong. I could clearly make out her words. As soon as she finished, I was about to launch into another song when my supervisor, who was visiting that day, indicated to me to pause and wait. After what felt like a long time another resident pointed toward Nelly and said, "Oh, she was good!"

Vignette discussion

I now expand on my footnote in the vignette, "A scream that resonated in my solar plexus" (p. 57). The scream instantly touched me. At the time it happened I was going through a lot of personal emotional pain. I was dealing daily with my own feelings of being overwhelmed not only with postgraduate study but also with the hurt, tension and confusions of a difficult marriage breakup, and of needing help and support for which I was getting counselling. When I heard Nelly's primal scream it touched my heart and deeper knowing and being. In that moment she had verbalised my pain and I felt connected to hers, whatever may be causing it. My instinct was to nurture and help her.

All my prior knowledge, skills, training and life experience intuitively kicked in: the singer who got on stage even after an argument; the Outward Bound lessons that taught me to keep digging deeper and deeper to get out of physically and mentally challenging situations – you not only need your first wind but your second and third winds too; my many hours behind a control desk on high-pressure national and international live radio where you 'do and think' simultaneously and have to put yourself aside to keep focused on the next few minutes ahead – the listener does not need to know the possible mayhem going on behind the scenes; overcoming physical pain; the self-help group ethos of 'one day at a time', or sometimes 'one moment at a time' and 'just keep going'; the institutional religious upbringing of putting others first; the music theatre training of 'the show must go on'; the determination of not letting anything derail my dream of becoming a music therapist; my training as a Reiki Master; and the young woman who was taught to 'ground' by feeling warm sand under her feet.

These are some of the experiences that have contributed to building my reserves, stamina, inner strength, and resilience. I was also working on letting go, forgiving, and had recently had the word 'hope' tattooed on my wrist. Rogers (1951) summarises that by letting

go of “control” a person gains it (1951, pp. 39–40). When Nelly screamed, I felt it. I took a breath, grounded myself, put my professional hat on and went to be with her. In a subsequent session she confided that she screamed and cried out because she wanted company. She did not like being alone. Consulting her clinical records later, indicated she had been at the home for many years.

My first aim when I got to Nelly’s room was to build rapport, as I did not want to get turned away. I did this by showing respect for her space, by knocking on her door and asking permission to enter and sit. I assessed the situation in the context of how she was presenting in that moment. I reflected and quickly responded by matching Nelly’s mood with improvised sea sounds. Dileo and Bradt (1999) describe this technique as “entrainment”, which is the interconnection of several principles, where music matches and then alters a person’s mood (1999, p. 183).

Carroll and Lefebvre (2013) outline various improvisational techniques, some of which can be seen in the vignette session, that is, to “establish contact, elicit responses, guide towards greater freedom and expression” (2013, pp. 12–13). Having a conversation with Nelly was necessary for me to obtain information. In a recent study Nelligan and McCaffrey (2020) identify that both verbal and musical skills support the therapy process. In the vignette my primary therapeutic tool was “music *as* therapy” (Bruscia, 1998, p. 39), although I did asked questions to elicit information.

Tomaino (1999) lists various neurological disorders of which Nelly displayed some possible similarities. She says that the therapist must be aware of interpreting a patient’s subtle cues, and that the therapeutic relationship contributes to the session’s outcome. Dileo and Bradt (1999) conclude that pain in life is not wasted and that as therapists we can access this to show empathy towards a client. They also say that “music entrainment” is a “powerful tool” and should only be used by those trained to do so (1999, p. 187).

I believe the vignette illustrates CoMT. By using music when working "*with"* Nelly (Pavlicevic & Ansdell, 2004, p. 26) the atmosphere in the rest home changed and became calmer once her screaming stopped. The individual session could be viewed as a traditionally "inside" or "closed" session (Pavlicevic, 2004, p. 41) but our singing would have been heard down the corridor – the ripple effect (Wood et al., 2004). My time with Nelly increased my knowledge of her song preferences, singing skills and physical self-expression. When I thought it was ethically appropriate, I transferred that knowledge to the group session or "outside" (Pavlicevic, 2004, p. 41) in what could be considered for this resident a community performance situation with the group.

The vignette demonstrates how identifying a resident's musical preference can be helpful in reducing negative affect. According to Shultis and Gallagher (2015) this helps the client avoid unnecessary distress of cultural, religious or negative attachments to the music. They indicate previous studies have shown that if a person likes the music there are positive therapeutic gains from it.

Further reflections

My research question begins with "How did I …", making this a personal research project about how I applied music therapy techniques to different scenarios to foster connections. It also presented opportunities for intense personal and professional growth within the spectrum of 'musician / performer / entertainer' and 'music therapist'.

Community Music Therapy or not?

Stige and Aarø (2012) comment that modern CoMT practice focuses on wellness, is interdisciplinary, and values human connectedness. It makes space for people's stories and voices to be heard within their community, opening "a space for visions of a better world", that is, social change (2012, p. 5). They outline that participating in music, being socially inclusive, giving access to resources, and collaborating for wellbeing and health, define CoMT. By including the word 'connection' in my thesis question, this research positions itself alongside CoMT, and the resultant themes and sub themes reveal my data support those outlined by Stige and Aarø (2012).

My findings align with Ruud's (2004) supposition that the ripple effect not only radiates outwards but also inwards. The sound of music, singing and laughter did spread out from sessions to other areas in the facility – like the ripples of a stone falling into water. People then gravitated towards the sound – a reversed ripple effect. Caregivers, staff and visitors came to investigate and join in, if only for a quick dance or to sing a line or two. They would then carry on with their business or duties, often still humming and dancing as they went. Residents enjoyed seeing staff participating and connecting as humans. Cunha (2017) indicates CoMT can bring about social change within a context and help create new

relational narratives (Cunha, 2017). I believe there were data to support this happening in the facility I was in.

Within the context I "listened" to the people (Pavlicevic, 2004, p. 46), to how they were and how I perceived they wanted to be. I constantly asked: "What do they need? What could I offer the facility? Who am I in this context?" Hence the Kenny (2006, 2015) connection and my interpretation of turning my thinking to "They are the beauty aesthetic, I bring the music, I am the music, let us grow and connect through music". Stige and Aarø (2012) outline the qualities of CoMT in the acronym P.R.E.P.A.R.E. (2012, p. 6), these being: participatory, resource orientated, ecological, performative, activist, reflective, and ethics driven. Previously Ansdell (2002, cited in Ansdell & Stige's 2015, p. 599) had outlined the questions Community Music Therapists may critically consider in relation to their work: "Their identity and roles; sites and boundaries; aims and means; assumptions and attitudes" (Ansdell & Stige, 2015, p. 6). Pavlicevic (2004) argues that the context where the music therapy work is taking place defines how it is thought about.

> *To practise as Community Music Therapists, we first need to understand ourselves as part of the mental, social, physical and musical context in which we work; we need to know directly its meanings and values to do with music and life, and need to re-frame and possibl[ly] re-shape our skills in response to the immediate reality of the moment* (Pavlicevic, 2004, pp. 45–46).

I learnt to constantly reshape and build my skills throughout my time at the facility.

Importance of journaling

My reflexive journaling was a necessary part of my qualitative interpretive methodology (Bruscia, 1998). Important parts of processing my placement included: writing down my

casual hallway conversations and other informal encounters; deeply pondering aspects of my life and practice; and questioning what was influencing me. These writings were then available as raw data for my Secondary Analysis and complimented my practice facility notes. Pavlicevic (2004) provides an inspiring example of reflexivity relating to her presence within a South African workshop. Melhuish et al., (2017) suggest keeping a reflective diary can provide a useful perspective of a therapist's experience. Kitwood (1997) also discusses the use of reflection as necessary in person-centred work.

I spent considerable time reflecting on the concept of CoMT as it related to my work, which I believed began the moment I drove through the gate and walked through the doors. My presence advocated for music. My journals supported this. I then queried what was the best way to collect notes within the CoMT approach, from: sung and spoken casual hallway encounters; group sessions; individual sessions where staff would come and go, and music that rippled and filtered down the corridors. Perhaps I would be best to think of them as field notes within a research journal, as Brown (2015) does. But what format would be best to capture all components. I am still deliberating. But in the current study I carried a small A5 notebook with me and made sketched notes as soon as I could after any encounter.

Importance of space and time

It was important for me to learn to take my time in sessions and relax. There was no need to rush. Once I mastered this, my stress levels reduced and sessions flowed more easily, which benefitted both residents and me. This also created more space in sessions which was important as it supported residents to express themselves. Rather than moving straight from one activity or song into another, providing space gave residents time to cognitively process or finish songs. This either sparked new memories or allowed other participants to appreciate a resident's talent or skill mastery, which led to connection as can be seen in the vignette

presented earlier. Abad (2003) observes that mastery empowers and gives an "increased sense of control" to a person (2003, p. 30).

In-the-moment

I have used the term in-the-moment to describe my work. For me this means to work with what I had in front of me at any given time. Kenny's (2006) *creative process* subfield says moments hold the past and future, and that each moment is all there is. Others (Melhuish et al., 2017; Warja, 2015, p. 254; Wigram, 2004) use the word spontaneity which implies 'unplanned'. Although this is accurate to a point, my approach was to be ready, as best I could be, for opportunities which may connect within the context, be it conversational, musical, playful or creative. Perhaps the term 'improvisation' could also be used as this implies creativity.

Leading groups; vulnerability; group dynamics and energy levels

Leading groups required a different perspective from that of performing. Rather than merely standing at the front singing songs and getting lost in the music, music therapy work requires a constant cycle of observing, assessing, evaluating, strategising, responding, delivering and being fully present while working in-the-moment. To get to this place I had to face my own vulnerabilities (Brown, 2015), find my own authentic self, be open to making mistakes, take off my 'perfectionist performance, entertainer hat' and learn to follow the lead of residents and others. They became the group leaders. This personal and professional growth allowed me to be more open and flexible and find confidence to: open my mouth and sing without being embarrassed; be okay with comments about my voice; try not to hide my voice; and reflect compliments back so we could feel connected together. All this was necessary in supporting me to grow my confidence to stand up, be seen and lead the group. Boyatzis

(2005) states that by being aware of ourselves holistically, and by engaging fully with people, community and environment, we are more likely to get better results and be in balance.

I learnt to read the group mood and dynamics. I adjusted my delivery to either contain or energise the group, and to engage with verbal participants while also noticing the small movements of the less verbal and immobile. I began to rethink leadership as facilitation to encourage engagement, interaction and socialisation. Gardstrom (2007) says novice leaders sometimes feel awkward moving; learning that their presence close to participants can be supportive and reinforcing is important. Her chapters on leadership are headed as "Facilitation skills" (2007, pp. 85–116), and she comments it depends on the goal of the session as to whether the person is a leader or facilitator. In the context of this study I reflected that those two terms were interchangeable within sessions.

Musician / performer / entertainer transition

An overwhelmingly challenging aspect of my placement was the transition from performance major in jazz vocals to music therapist. I was questioned by others and myself repeatedly about how to manage this as people would often only want to listen to me sing. Ansdell and Stige (2015) discuss how the flexibility of the CoMT movement has given music therapists the remit to still engage in their professional skills within their music therapy work, calling it "creative interplay" (2015, p. 614). By incorporating this into how I viewed myself in the context I felt I could share myself more openly, honestly and authentically.

Limitations and future recommendations

There were many challenges for me working within the aged care population. It took time getting used to the smell of relatively large numbers of people cohabitating together; seeing the wide range of physical and cognitive health diagnoses; noticing how busy staff were

managing residents' cares; and feeling emotionally and physically drained at the end of a day. The work inspired me to keep looking for the beauty in the people I met, to nurture their wellness and to share their personality through music.

The results of this study are limited due to the way and time frame in which the data were collected. Data were subjected to Secondary Analysis which is only as good as the notes written while undertaking practice hours. Future research could be based on Action Research which may be more appropriate to the setting. This could then be analysed, and actions altered throughout the allotted time frame.

The Findings are only relative to this particular context and generalisation may not be appropriate for other settings. However, they highlighted that interactions outside of a music group session enhanced healthcare knowledge which led to greater connections. Future study could also be enhanced by researchers tagging their work with the words relationship, connection, rapport and trust. This would significantly improve search engine capabilities and facilitate easier access to greater bodies of work in this subject area.

Summary / Conclusion

My thesis question was: How did I use music therapy to foster connections between residents, and residents and others in a hospital environment? Analysis of the study data revealed the use of rapport led to connection through the blending and synergy of four main themes and their sub themes. I engaged collaboratively with other allied professionals; developed my therapeutic approaches; used physical and musical resources; and became aware of the environmental conditions necessary to create a safe space for a trusting authentic client-therapist relationship to develop thereby bringing about change in a client's well-being.

I also became aware of the importance of reflexive work and how this nurtured my personal and professional growth and helped me blend my community musician hat with my developing community music therapist skills. I also moved from 'intellectually knowing' to 'physically experiencing' music therapy. Throughout my placement at the facility I saw and felt the outcomes in action. I found my authentic self, acknowledged my vulnerabilities and what I brought to the context. I learnt I had to have all sides of my Te Whare Tapa Wha strong and nurture my own aesthetic before I could really be 'with' the people in the context. This increased my understanding and empathy toward them. My learning included discovering and understanding how I was building trusting therapeutic relationships and their importance. All these aspects added to my appreciation and enjoyment of the people I engaged with in the facility and gave my work heart, love and hope.

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Appendices

Appendix A

Example of data analysis

Example of analysis of raw data							
Colour coded resultant themes - names changed to protect residents' identity							
Date	Data Source	Raw Data	Interpretation of raw data	Rapport	Code - brought together to make category	Pre-theme	Interpretation
29-May	group facility notes	Morning group session - ***Samara [DT] joined me up the front of the group. We were singing 'How much is that doggie'. We both made dog sounds in the appropriate place - then changed to cat sounds. Donna kept the animal theme going by asking for 'Old MacDonald'. Donna, Samara and I were all laughing during 'Doggie' and 'Old MacDonald' songs. Marie was watching and smiling and appeared to be enjoying the stupidity of the moment.*** MEMO: Group members chose which animal was on Old Mac's farm and we all made the noise of that animal e.g. a snake etc. and other non-traditional suggested animals.	Singing playful songs and being creative and imaginative led to residents also being creative and imaginative.	rapport	Interdisciplinary collaboration - resources (familiar song) / impromptu / interaction / humour / fun	fun	Inviting the input of another team member to group sessions, sometimes resulted in an increased element of fun.

2-Jul	Facility notes	Morning group - Later, ***in between songs, Zack started singing an old song I didn't know. After a couple of lines Nelly started singing the song too. She was about half a line behind Zack but it was the same song***	I allowed quiet space between songs giving residents the opportunity to process and remember other songs and share them if they wanted. This led to musical interaction with other group participants.	rapport	Therapeutic approaches - being open and flexible	space	Leaving space after songs provided opportunities for residents to connect through familiar remember songs.

1-May	group facility notes	Afternoon: ***Claude's daughter arrived and told me he loves country and western music, e.g. Kenny Rogers and Johnny Cash.***	A resident's relative was able to tell me more about his personal musical preferences	rapport	Therapeutic approaches - conversation	song	Conversations with visiting family members enabled more knowledge about residents' personal musical tastes which led to more connection with residents when those songs were shared.
16-Apr	group facility notes	***Bee asked for 'Galloop went the little green frog'. I sang 'Galloop'. Keith came back to the group with his visitor. His visitor sang along to 'Galloop'.***	The chance to play and have fun with music	rapport	Therapeutic approaches - playful interaction	song	Residents requests for humorous songs led to socialising and connecting with others.
28-May	group facility notes	***I dedicated 'Love's like a butterfly' in memory of Bernice. The residents including Donna said that was a nice idea.*** Bernice passed away last Thursday and that song had been one of her favourites requested by her family.	I sang a familiar favourite song to the memory of a recently deceased resident allowing space for other residents to reflect and respond.	rapport	Physical and musical resources	resource (song)	The playing of recently deceased residents favourite songs provided space and supported group members in remembering them.

2-Jul	Facility notes	Morning group - Later ***Zack started to sing Lili Marlene over a two chord sequence I was playing*** on the keyboard. Donna recognised the song; ***"He's singing Lili Marlene".***	I played a simple two chord musical progression which sparked a resident's creative imagination and he started singing a familiar song which was then recognised by another resident.	rapport	Physical and musical resources	creativ ty	Creating space through improvised music led to residents connecting through imaginative interaction.

Appendix B

Example of informed consent form

MUSIC THERAPY PROGRAMME (MMusTher)

Case Vignette – Information and Consent Form

Hello. I am …….., the music therapy student currently working at …….

As part of the requirements for my music therapy clinical placement I am required to complete an exegesis, illustrated by a vignette from my clinical work. I am writing to ask if I can describe the work I have done with ……. in my exegesis.

The exegesis including the case vignette will be sent for examination. The examiners will be both internal and external to the New Zealand School of Music, Victoria University of Wellington. The exegesis will also be published in the Victoria University of Wellington library, in hard copy and as an online resource.

If you agree, the case vignette is likely to include background information about …….
. Anonymity will be protected whenever possible, with all information that might identify ……., and/or the name of the facility being removed. I will use a pseudonym when describing……. I will not use photographs, audio, or video material in my case vignette.

Please take time to think about this, and ask any questions you might have. When you are sure you agree that I can write about …….in my case vignette, please sign both copies of this letter, keep one, and give one back to me. If you would like a copy of the case vignette and/or exegesis, it will be provided for you after the work has been completed and examined, following the conclusion of my placement.

I ……..give consent for information about…….to be included in the case vignette described above.

Name:……..Signature:……..Date:……..
Parent/guardian or representative

Name:……..Signature:……..Date:……..
Facility representative

This consent expires on (date) and may be withdrawn at any time by contacting the Music Therapy Programme Director at 64 4 4635233 x35807

Appendix C

Example of facility written consent form

Master of Music Therapy Research Project

How did I use music therapy to foster connections between residents, and between residents and others in a rest home and hospital environment?

CONSENT FORM

- I have read the information sheet and have obtained sufficient information about the study.
- I understand that from the review of clinical notes residents' real names and details will not be used in any publication or presentation arising from this research.
- I understand that informed consent will be sought from families should a particular case example be used to illustrate the findings.
- I understand that research data will be kept for ten years and will be stored securely at the New Zealand School of Music and/or on a password-protected computer or password-protected USB memory stick.
- I understand that I can withdraw information from the research up until the end of October 2019.
- I acknowledge that the study will be published in the library of Victoria University and may be presented at conference and/or in published papers.
- I understand that I can contact the researcher or research supervisors [supervisor] if I have any concerns or questions relating to the research.
- I also understand that I can contact the Victoria University of Wellington Human Ethics Convenor if I have any other concerns about this research.

I therefore consent to Colette Jansen reviewing clinical notes and records that are kept during her placement at [facility name] for her research.

Signed:_____Date:_____

Print name:_____