Building bridges in team centred care

Keynote Address
Australian Music Therapy Association National Conference
Brisbane, August 2000

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(sung)
The river is flowing, flowing and flowing.
The river is flowing, down to the sea.
Oh mother carry me, a child I will always be.
Oh mother carry me, a child I will always be.

Hey loka, ho loka hey, ya ya.
Hey loka, ho loaka, hey ya ya. (Sufi Chant).
Give me the beat boys to free my soul.

I want to get lost in your rock and roll and drift away (Doobie Brothers)
Them that's got shall get.
Them that's not shall lose.

So the bible says, and it still is news.
Your mamma may have, and your papa may have.
But God bless the child, that's got his own, that's got his own... (Billie Holiday)

Music therapy is the child that's 'got its own.' At the same time, it is a part of everything and has the unique capacity to tie together. I encourage patients to sing and I tell them that singing is the one instrument that is inside the body. When we sing, the vibrations integrate all of our physiological systems at one time. The breath enhances the tone that stimulates the organs creating homeostasis in the body. And when we breathe and tone, we can drift. We can go places we have never been. Music therapy can stimulate the mind and relax the body all at one time. Music therapy treatment ties our mind and body together in ways we are only beginning to understand.

Music therapists can also tie teams together. Interweaving aspects of music for patients and staff in order to create community within the work setting helps us build an environment of trust and safety. Setting space aside each week for team time may be the single most effective way we can promote our services and win understanding. Music therapy is indeed the child that 'got its own.'

In having its own, we have also paid our dues. The number of times I have been on the elevator in the hospital with a cart of instruments and hear a social worker, visitor or once a team of surgeons laugh and giggle, "Hey, looky here, the bands comin' alright!!" Or, in the early days, to bite my lip at a team meeting when a nurse might have asked me to "go cheer Amy up before a spinal tap." It has taken years of practice and clinical security to not only appreciate these comments for what they are, but to also extend myself and the service music therapy can provide beyond a place of insult and into a mechanism of teaching. 'These folks don't know what music therapy is,' I think to myself. I have 50 seconds in rounds or the time it takes the elevator to move 3 floors to educate and promote. What a great challenge.

At rounds, I might say to the nurse, "Ya know nurse, Amy is really tired of being cheery and her mom is so busy trying to hold her up. She really needs to cry and release. Thanks, I'm gonna go play for her. She may want to let it out before the procedure. She loves the chimes and maybe playing them will help contain her during the tap. That's a great referral.

To the surgeons I might say: "Hi I'm Dr Loewy (handshake), the music therapist. We were
down in the Operating Room last week. There was a boy having a splenectomy. They couldn’t
give him anesthetic because his blood pressure was too high. We used this rain stick and some
chanting to slow it down. It worked within moments. We go right into the Operating Room and
use the music therapy to ease a patient’s transition from wake to sleep state. Think of paging us if
you see the need (Give business card). Nice to meet you..."

To have our own means we have to explain and show rather than roll our eyes, hide or become
introverted. We are all young and since we are musicians, words might not always suffice
or feel as masterful to us as music does. But it is our words, our writing, our research, training and
presentation that will enable us to build communities and bridge into new territory through team
efforts. This is the message that I will present to you today. Building a program takes efforts
vertically and horizontally. In order for the work to flourish, I think we need to be stimulated and
excited about what we are doing in a music therapy realm. How are we nurturing ourselves as
music therapists? Burnout is a syndrome in any field, but especially in ‘helping’ fields and music
therapists are not excluded from this. If we are going in and doing it ‘for them’, our spirits and
energy will be dry and void by the days end. But if we know what our own needs are and make
time to replenish and use the deepest part of ourselves in the work, then we will stay vibrant and
relish in the depth of the work and the part of our selves that will go through new ventures and
experiences.

Music therapy involves work with human beings that are ever changing and creatively
evolving. Science is often that way too. In the Neonatal Intensive Care Unit last week, the
attending physician was showing a team of residents an image of a head scan, indicating specific
areas in a 30 week premature infant, where cysts were formed. Another doctor came in and
disagreed, showing that the region of the brain had possible fluid, but not cysts. The attending
physician said, “these pictures are interpreted in different ways depending on who is reading
them.” Any of us who have had an illness may be prone to think of medicine as an art. Certainly
not all x-rays or scans are Rorschachs, but there are different ways to treat illness based on trials
and interpretation. In music therapy, the orientation and training both psychologically and culturally, will offer a vast variety of possibilities for the clinician. Although the goals may be related and the course of treatment may involve similar principles in terms of
emotional and physical need, the means of addressing the need will vary greatly from one music
therapist to the next. As our field continues to grow, we need to respect our differences and leave space for a variety of methods to be explored. In this way, our schools of
practice will continue to expand.

To nurture ourselves means that we honor the music inside us. We need to play and
improvise. At the same time, I think we need to honor our journey and make conscious
connections that musically contextualize what it is we do and why we are doing it. An Australian
music therapist I have met, Barbara Davison, is inspiring to me in this way. She dances from her
music into new clinical territory which expands her professional vision, leading her back to the
music. She enriches and nurtures her own growth by using music for herself. From birth to
themes and new variations, our musical soliloquies have wonderful power. Music therapy
experiences for ourselves, with our peers, in supervision, or within our own music therapy
sessions, highlight the essence of who we are and what we are doing. The years I spent in my own
individual music therapy provided focus and crystallized the development of my true
musical self, which is connected to everything I am and will be.

Instituting programs has been the most important part of my work for the past several years.
At this point, I think it has been the way I have contributed to the field. In a sense, it has been a
calling. It is something that comes naturally to me and it serves a definite purpose. Although there
are plenty of therapists working in institutions and universities, as clinicians and professors or
teachers, there are not a great many program builders. Perhaps this is because institutions or
individual music therapists have neither the budget nor the navigational skills to direct such a
venture. So many music therapists that I have supervised or hosted as interns from America and
other countries (Germany, Israel, Spain, Switzerland, Brazil, Korea and South Africa), have remarked that their programs do not offer courses in grant writing or program building. I truly believe that this is an international need.

What is vital about instituting a firm music therapy program is that it can enhance central aspects of growth for the field. In my opinion, the five core components that ensure solidity in building bridges in Team Centre Care are: Training, Presenting, Writing, Developing Referral/Assessment Protocols and Researching.

1. Training

Music therapy students learn on many levels. For example, a music therapy student in preparing for an in-service on the pulmonarv unit may collect articles on asthma and may also video tape a session to create clips that will be shown to the team as an example of music therapy in asthma care. The student is learning on many levels and at the same time, she is building the music therapy program. She is learning how to present her work as well as a music therapy technique such as a breathing intervention. The student has data and research to provide scientific rationale for what she is doing and the handouts she has prepared (including the referral and assessment) offer the team access to learning how referrals can be made. The session description provides an understanding of how music therapy can be translated into words, providing new ways of addressing medical goals. Additionally, new areas of understanding may be revealed within the music process thereby addressing areas of concern that may not have been uncovered through routine interviews.

Perhaps the most exciting part of the example just given, which covered training, presenting, researching and writing (referral/assessment), is the gift that such work offers a program. The team sees how important the in-service is in the training of music therapy students and the students find jobs because they have learned how to present their work and how to program build. I haven’t heard from any of my former students that they could not find a job – because they have learned how to program build. If the job isn’t listed through our association or in the newspaper, they have called schools and hospitals and started from scratch. They have learned how to ‘get their own.’

The first component of building a bridge starts with an identity. The paradigm in Figure 1 reflects the many levels of learning and activity that occur for music therapists. First, as community holders, in various roles of leadership and gate keeping. Second, the variety of thinking and feeling states we are opened to in our continued training. Third, how we consolidate and validate our findings and fourth, the mechanisms we use to integrate and translate our experiences.

2. Presenting

The second component of building a bridge involves presenting. This can be done on many levels. Perhaps the most prudent presentation exists within the creation of a promotional video. This is a wonderful way to create team cohesion. In creating video during the initial months of program building, I make the key gate keepers of the team my allies. I often work a little with many players of the medical staff, but I strategically choose one for each discipline to help me create an initial promotion video. Few staff members are instantly able to say what music therapy is. Staff allies may need just a bit of coaching and rehearsing (which is really teaching) to state more precisely what music therapy is. Making videos provides a real exercise of learning for the team with regard to what music therapy is or can be in the hospital and it has served as a funding mechanism for many grants that have developed within years of program institutions. Video is a most effective means of presenting in order to team build, program build and mobilise funding. Although being in front of a camera does not provide for the optimal
therapeutic environment, the media performance often helps people understand what we do and helps to illustrate the many different uses of music therapy. If something is not understood in one circumstance, perhaps it can be illustrated in another.

Presentation can also build bridges in terms of experiencing and connecting. Every other week at Beth Israel we have music therapy rounds for the Residents and Attending. This time is for the doctors to learn experientially. Depending on the energy of the group, we do drumming circles to energize, or sing alongs to build intimacy, or sound-scaping to promote relaxation. These rounds have become the most effective means of having the doctors understand music therapy. Often, they have seen it with a patient, or have read something, or heard about it from a colleague participating in it. They feel it for themselves and understand its value. Thus presenting can take many forms.

The last kind of presenting comes from what I call ritual keeping. It enhances community building. An obvious example of this is team building through a Christmas Caroling group comprised of staff, who go to each floor of an institution and sing. Another is getting a concert together for New Year’s day. More subtle ways of connecting teams and building bridges include working with pastoral care and setting time aside for mourning through music and prayer during times of need or loss. Ruth Bright (1986) has written eloquently on this topic of grieving. Music therapists can use music to enhance the expression of needs and connection for staff as well as patients. In this way the community stays fluid and open.

![Diagram of Internship Paradigm](image.png)
3. Writing

Training and presenting are essential aspects of team building and field growth. The third component involves writing. One important element of writing that has been important to me is the use of description. I have been impressed that much of the writing in music therapy has adhered to descriptive methodology. Descriptive narratives involve clinically rich material emphasized through illustrative text. I am in agreement with Kenny (1987), who has stated time and again that our field of music therapy is too young for definitive checklists and charts. We are only just beginning to develop a language of our own. Music therapy in the 1960s and 1970s was limited by therapists who borrowed terms from other schools - particularly behaviorism and music education. We are learning how to use paradigms and frame our learning within psychological schools of thought (Edwards, 1999). The result of our efforts to ground and expand takes us to the point of developing a language that is our own. In this way, we derive meaning from the music therapy process through the assignment of words (Loewy, 1994).

It is the words that become important in the day to day functioning of a clinical situation. The music therapy session itself is dynamic and potent, but it is the words that go in the chart, the legal medical record that usually arrives at a new school or hospital before the patient. We need to make the words as accurate as possible and this is best achieved by description. The writing we do about a patient can paint a unique picture, illuminating strengths or unknowns that other disciplines have no access to.

There are 13 areas of inquiry that form the model of Music Psychotherapy Assessment that developed through qualitative study (Loewy, 2000). This model can be used effectively with a variety of populations because it adheres to areas of psychotherapeutic inquiry that applies to both music and psychology and the means by which each area is assessed. These means are exclusive to the music psychotherapy process.

There is a strong unity that exists between Australian and American music therapy development, with both associations being 'born' in the same year, 1975. The writings that emerged from this point in time have focused on the musical essence of therapy. Indeed, the commitment to descriptive writing seems to have endured. The articles authored by Australians hold music therapy descriptive notation as important. I think that both referral and assessment and the formal documentation of these activities is the fourth essential component to building bridges in team centered care. Referral and assessment provide a strong hold in program institution.

4. Developing Referral/Assessment Protocols

It is important to have documented referral. Referral forms provide a written contract of commitment. Commitment to the patient, commitment to the therapist and commitment to the modality of music therapy. The referral form implemented at Beth Israel Medical Center is a two sided document that not only has a check off of diagnosis and comment space, but a description of what music therapy experiences may be indicated for each clinical area of need on the back (Appendix 1). The referral provides grounds for communication between staff and patient. It also provides an assurance of follow through, as well as data for funding bodies that proves music therapy service is indeed needed.

I conducted a survey of the field of music therapy in America back in the early 80's, consisting of collecting assessments of music therapists working with emotionally disturbed children and teens. It was surprising to learn that 33% of music therapists in the United States did not assess or have an assessment format within their first sessions. It is my strongest belief that first sessions are key. They present an outpour of the themes that will unravel through variation in time. Through music therapy, we have unique access to understanding how the body
affects the mind and how the mind affects the body. For example, a teenager was admitted to the hospital with depression and a suicide attempt. The team attributed it to a recent move and a decline in school performance. What was learned through her initial music therapy assessment was that she was mourning the loss of her father. This unknown information was uncovered when the teenager created a melody, singing about her father’s death for the first time. Descriptive notation in assessment provides a means for us to report what we need to with accuracy. Our assessment form is quite open, but provides space for description. The voice has been under rated as a means for assessing and we have it featured as its own category (Davitz, 1964) on our assessment forms. This condensed format provides the nuts and bolts of what the team needs to know and what the music therapist needs to remember. Each population comes with unique needs. Assessing may be custom tailored to reflect the needs of specific aspects of the patients that are being served. Referral criteria help to establish the kind of assessment that can be useful to employ.

5. Research

The fifth component, research, is an important aspect of team building because in order to set up the parameters that involve study and data collection, approval must be sought and departments must consent. Research is an essential component of team building because it illustrates the effectiveness of music therapy. Research is a way to ensure services are provided and moreover, it sets up the perimeters of how services can be delivered. At Beth Israel Medical Center, three research projects are currently underway. The first is The Effects of Chanting in the sedation of babies and toddlers. In this study we are involved in quantitative and qualitative data collection. There are many debates on what kind of research we can undertake. The studies at Beth Israel involve both. We are measuring which modality, chloral hydrate or chanting, is effective in sedating the infants and toddlers. The variables of time, amount of medication and whether or not the test could be completed are very important. Additionally, parents in our study identified that the lullabies and musical intervals, rhythms and sounds are important. The latter is our qualitative data.

The second project is a veni-puncture pain study, looking at music therapy in comparison with verbal support before during and after venipuncture. From a survey that the Pediatric Pain Team administered hospital wide, we developed a mission statement addressing the barriers that assisted in the development of goals. Our primary goal was: To provide consistent, effective management of pain for infants and children including strategies for assessing, documenting and treating pain utilizing both pharmacologic and non-pharmacologic approaches, alleviating or diminishing pain through helping patients cope with, or creatively release, their pain (Pain CQI, Beth Israel Medical Center, 1997). In this study we defined several populations and the types of procedures and age range of the patients. We had three groups: music, verbal support and a control. We are interested in how these groups responded within these three specific contexts before, during and after a procedure involving a needle.

There is currently a movement in America to recognize infant pain. Indeed, music therapy in the NICU is a growing area. One of the ways we built the program in our NICU, which was very difficult to do, was to demonstrate the need by showing how hazardous the sound environment was and to clinically and medically back that up (American Academy of Pediatrics, 1997). Sometimes program building means dispelling myths, such as babies don’t feel pain (Attia et al., 1987), or are not affected by noise (Schwartz, 1999), or fetuses don’t hear (Hepper & Shahidullah, 1994). The medical literature has shown that the noise of the everyday NICU environment can be harmful when above 55dbs (Benini et al. 1996).

An essential part of researching is called quality improvement study. Some hospitals in the US are implementing an internal CQI (continued quality improvement) as a way to maintain high standards of care. At Beth Israel, we use questionnaires for patients, parents and staff. Research
isn't only to measure what one might think is the effectiveness of an intervention. Another important task of research is to ensure that a service was well received. We must listen to our patients and continue to request and integrate feedback.

The third research project is an asthma study looking at wind playing and its effects on lung volume capacity. Asthma is on the rise in the United States and the world, significantly since the mid-nineties. The data we collect includes vital signs and spirometry before and after wind playing. We are collecting qualitative data as well, to learn about how the music affected the breath.

An important part of our asthma work has involved the use of pictures during the first part of our assessment. In the asthma sessions we provide improvisation entrained to the breath of the patient and to slow down the tempo with relaxing sounds. We ask the patient to go to a favorite place. When they awaken, before going into wind playing, we invite them to draw or color what they visualized. In team centered building, I would be remiss if I did not mention the importance of connecting with our strongest allies: art therapists, dance, drama and poetry therapists.

I see the five components of training, writing, presenting, developing referral assessment protocols, and research as interrelated. Certainly training effects presentation, which can crystallize writing. Assessment and referral are the mechanisms of establishing the need for service while research has aspects which tie together all of these activities - assuring validity and moving the field ahead.

Up to this point, I have presented music therapy as the child that's 'got its own.' I have tried to explicate the aspects of team-centered care that connect us to bridging our work with team members - that which enables us grow. This, coupled with the honoring of our intention and continued play and musical journeying, is how I believe we clinicians continue to develop, personally and professionally. However, there is a final point I think I need to address although it is a more difficult topic to discuss. Nonetheless, I know that there may be a few people in the audience struggling, as pioneers so often do. If this final message can support or offer help in any shape or form, then I am pleased to have voiced the place of unpleasantries and what it means to uphold integrity amidst a bully or toxic environment.

Having our own meant knowing the principles that are of the highest priority to us and keeping such principles alive, not necessarily through what we say, but in the way we work, present and write. Prioritizing means letting go of that which we can work on later and gaining clarity regarding what components of a program are essential - the elements we cannot work without. Having had this challenged directly as well as through supervising other music therapists through the years, I would like to close with several insights.

Perhaps the most obvious but surprisingly often overlooked way of instituting a program is expressing the request through patient need. What are the issues of our patients? What are their needs? Whether requesting a space, an instrument or a higher salary, the rationale can be best demonstrated if we can present how our patients will benefit. At times, we need to pull our ego out of the process and put the music therapy field advocate stance on the back burner. Growth comes swiftly when we can demonstrate how what we do will benefit treatment - this is called advocating.

'Having our own' means knowing where we can grow and flourish and it also means knowing where we cannot. One of the essential components I have mentioned several times which is important in building solid bridges is the recognition of gate keepers within our teams. Equally important are to know who are the antagonists. Having been a consultant to child life specialists, nurses, social workers, doctors and teachers linked to different programs through the years, I have learned that there is not one best department for a music therapist. Some music therapists have their own department, but this does not always provide for the easiest links to team centered care. I have found that it is the philosophy of a department and director that will determine the kind of growth and the ultimate garden that will exist. Another important part of
'having our own' is identifying where we belong, with whom we can grow, keeping our integrity high and holding to our core beliefs.

I am grateful for the opportunity to have shared my ideas about music therapy with you today. Instituting new programs is an area of development that remains dear to my heart. My hope is that we can continue to carefully expand. My hope is that we will continue to build bridges through our own use of the music and investment in developing our unique musical soliloquies; through training, presenting, writing, developing referral and assessment protocols that we invite other team members to use; and through research, setting up parameters to succinctly continue to describe our work and gather findings, for publication and future building.

References


Appendix 1

Music Therapy Referral Form

Patient Name:  
DOB:  
Age:  

MR #:  
Caretaker/s Name/s

Relationship to Patient: parent  
friend  
sibling  
foster parent  
relative

Primary Language of Patient:  
English: yes  
no

Primary Language of Caretaker:  
English: yes  
no

Diagnosis:  
Admit Date:  

Reason for Referral: (definitions on reverse side)

Check areas that apply:

Anxiety / Fear:  
( ) Separation Anxiety  
( ) Pre or post operative anxiety  
( ) General Anxiety

Pain / Stress  
( ) Breathing Difficulties  
( ) In need of tension release

Expressive Difficulties:  
( ) Depression or non-verbal  
( ) Acting out of hyperactive

Ego Strength / Coping:  
( ) Facing the illness  
( ) Self esteem  
( ) Needs to communicate / socialize

Loss of Consciousness:  
( ) Awareness  
( ) Stimulation / Imagery

Coma / ICU

Other Specify:

Comments:

Person Referring:  
Date:  

Ex:  
**Music Therapy Referral Criteria**

1. **Anxiety / Fear:**
   Music therapy soothes, familiarizes and/or activates
   
   A. **Separation Anxiety**
      Chanting, musical holding and collaborative musical experiences create a feeling of safety in the hospital
   
   B. **Pre or post operative Anxiety**
      Making music relaxes and eases the mind and body of tension and fear stimulated by hospital procedures
   
   C. **General Anxiety**
      Musical experiences help children make sense of their fears through a non-threatening medium

2. **Pain / Stress**
   Clinical improvisation provides an alternative, non-verbal means for release for a child in discomfort
   
   A. **Breathing and Vocalising**
      Life rhythms and tonal intervalic synthesis help a patient synchronise and deepen the breathing process. Toning stimulates the connection between the body, breath and feeling states
   
   B. **Tension Release**
      Opening channels of musical creativity stimulates the body's need to release tension

3. **Expressivity**
   Structured and unstructured themes help elicit feelings that may be 'muted' or blocked
   
   A. **Depression, non-verbal / inactivity**
      The implicit structure of music therapy techniques such as African Drumming, song sensation, and instrumental composition offer patients a safe means of channeling their excessive amounts of energy
   
   B. **Acting Out / Hyperactivity**
      Community singing, drumming circles and collaborative free improvisations foster communication between patients and within families

4. **Ego strength / Coping**
   The metaphoric use of music in song selection and composition offer patients a safe way into understanding and adjusting to their illness
   
   A. **Facing the illness**
      Performing and tape creating strengthen a child's feeling of worth during this fragile time
   
   B. **Self Esteem**
      Community singing, drumming circles and collaborative free improvisations foster communication between patients and within families

5. **Loss of Consciousness / Coma / ICU**
   The use of familiar melodies help patients become oriented or tuned into a state of safe, grounded, familiarized awareness
   
   A. **Awareness**
      The use of music and guided imagery stimulates the healing process
   
   B. **Stimulation**
      The use of music and guided imagery stimulates the healing process