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AJMT Volume 28 marks the first 12 months of AJMT online, and is a tribute to the legacy set up by our previous Editor, Dr Helen Shoemark. Both analytic data and anecdotal feedback suggest that AJMT is widely read and enjoyed throughout the world, and that readers value the new, freely online format. This year’s edition promises more informative and inspiring reading with 5 articles covering diverse and topical issues within contemporary music therapy practice.

The introduction of the National Disability Insurance Scheme (NDIS) in Australia has had challenging ramifications for music therapists. Helen Cameron, an experienced clinician, reflects on the limitations of this funding scheme for people with intellectual disabilities. Drawing on case studies, Cameron argues that the current NDIS model, recommending initial short-term therapy with follow up care from assistants, does not support people with profound and multiple disabilities who benefit from expert long-term music therapy.

Felicity Baker also adds to the topical discussion by offering a theoretical framework and group songwriting protocol for caregivers of people living with dementia. With rising numbers of community-dwelling people living with dementia, it is important to identify mechanisms that support informal family carers. Baker illustrates her protocol with a case study to explain how the songwriting process supports the realization of coping strategies. This article builds on Baker’s pivotal publication, *Therapeutic Songwriting: Developments in Theory, methods and Practice* (Baker, 2015).

Two recent music therapy graduates, Alice Cotton and Brooke Medcalf, present their
Masters research projects. Using a phenomenological approach, Medcalf examines the use of mindfulness informed techniques by music therapists. Cotton uses thematic analysis to explore arts workers’ experiences of working in partnership with music therapists. Finally, Winifred Beaver and Meg Morris report their analyses of tango music used to support dance classes for people living with Parkinson’s disease.

This year was my first as AJMT Editor, and I am fortunate to be surrounded by an efficient and enthusiastic team. Thank you to Kate Williams - AJMT Associate Editor, Liz Mclean - our inaugural Copy Editor, and the 2017 reviewers. We hope our readers enjoy Volume 28.

*Imogen Clark*

**Reference**

Long term music therapy for people with intellectual disabilities and the National Disability Insurance Scheme (NDIS)

Cameron, H. J.


In plain language:

People with disabilities across Australia now have access to services to help them in their daily lives and to reach their goals through the National Disability Insurance Scheme (NDIS). People who wish to have music therapy need to include it in their plans. Here we talk about the issues which may be experienced by people with severe and profound intellectual disabilities, especially the issue of receiving long term therapy. The NDIS does not support long term therapy and recommends that assistants be trained to provide the service. Why this is a concern and the benefits of working with a registered music therapist are discussed. Examples of how music therapy over the long term may help people with severe and profound intellectual disabilities are given.
Position paper

Long term music therapy for people with intellectual disabilities and the National Disability Insurance Scheme (NDIS)

Helen J. Cameron
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Abstract
The needs of people with disabilities have recently been under the spotlight with the advent of the National Disability Insurance Scheme in Australia. The ability of people with disabilities to be self-determining and access services which reflect their needs is becoming a reality. Service providers are examining the impact of the National Disability Insurance Scheme (NDIS) on their businesses and assessing the effects on their current and future clients. This paper will explore how people with severe and profound intellectual disabilities are being served under this scheme with particular reference to music therapy services. Long term involvement in music therapy is highlighted and the benefits explored, addressing concerns regarding the inclusion of ongoing therapy in participants’ NDIS plans. Case vignettes highlight the value of long term music therapy.

Keywords: music therapy, NDIS, severe and profound intellectual disability, long term therapy

Introduction

Long term music therapy for people with intellectual disabilities and the NDIS
As the National Disability Insurance Scheme (NDIS) fully rolls out across Australia, participants will be able to choose the providers of all their services. Upon entering the scheme, participants may use a NDIS planner who can provide advice regarding the range of services which may be accessed. Music therapy has a long history of working with people with intellectual disabilities (Alvin, 1965; Nordoff & Robbins, 1971) and is provided for under the support category of Capacity Building for Improved Daily Living in the NDIS Price Guide (Australian Department of Human Services (DHS), 2016).

To date the inclusion of music therapy in a participant’s NDIS plan has been ad hoc with some participants gaining approval for music therapy services and others not. To address these issues a White Paper was recently prepared for the Australian Music Therapy Association (AMTA) discussing the inclusion of music therapy in NDIS plans (McFerran, Tamplin, Thompson, Lee, Murphy & Teggelove, 2016). AMTA also produced short animations and information on music therapy and its applications (www.rmtschangelives.com.au) and the symposium “Music, Health and
Wellbeing, and the NDIS” was hosted by the University of Melbourne in September 2016 to explore how music services, including music therapy, would continue under the NDIS. These initiatives have disseminated information in accessible formats to the wider community regarding music therapy and the NDIS. Despite this, it appears that the ability of adults with severe and profound intellectual disabilities to continue to access music therapy through NDIS plans remains unclear and ad hoc (McFerran, 2016). This is particularly the case where participants may benefit from long term therapy. The ability of participants to exercise choice and control, principles stated in the NDIS Operational Guidelines (Australian Department of Human Services; DHS, 2016) are tempered by the limitations on access to therapy. There is a dichotomous relationship within the guidelines whereby the social model of disability, as the overarching philosophy, is overlaid with the medical model in the delivery of therapy services. This impacts services to people with intellectual disabilities, specifically those with severe and profound intellectual disabilities.

Here I argue that long term therapy is an important service for people with severe and profound intellectual disabilities and should be supported by the NDIS.

Music therapy for people with intellectual disabilities

Music therapists have worked with people with intellectual disabilities since the earliest days of the profession (Alvin, 1965; Nordoff and Robbins, 1971). Music therapy benefits have been reported for people with intellectual and developmental disabilities in the areas of communication, cognition, physical development and emotional development (Hooper, Wigram, and Carson & Lindsay 2008). McFerran, Steele, Lee, and Bialocerkowski (2009) found in a descriptive review of the literature, that for people with severe and profound disabilities, music therapy can address communication and physical goals. Development is typically at the pre-intentional level, (Hughes, Redley and Ring, 2011) and therefore music is particularly important as an avenue of social contact and nonverbal self-expression (Johnels, Johnels and Rådemark, 2016). Mood matching, attunement, scaffolding and improvising on the musical output of the person with a disability, thereby validating and extending their communicative possibilities, are some of the skills a music therapist can offer to the participant (Bruscia, 1987).

Key influences which have shaped current approaches to music therapy practice in this field are Nordoff and Robbins’ creative music therapy (1977) and Community Music Therapy (CoMT). Creative music therapy aligns with strength based approaches. This approach, described as gentle empiricism by Ansdell and Pavlicevic (2010), is humanistic in orientation. The observation of people in situ and “allowing the emergent phenomena (of people- in- music, therapy – in- music, music-in- health) to show themselves” (Aigen 2005, quoted in Ansdell & Pavlicevic, 2010, p. 134), is a key feature of the ‘gentle empiricism’. Creative music therapy promotes the development of the ‘music child’, whereby the musical output of the person and their engagement in the musicking is of primary concern. Musical interactions are analysed with the extensive use of video which informs the direction of the work with each participant and the development of the “music child” within. Nordoff and Robbin’s ascribed no pre-existing theoretical model to their work however
Aigen (2005) describes Creative music therapy as “music-centred theory”.

Community music therapy (CoMT) dates from 2002 with a key article written by Gary Ansdell (Ansdell, 2002a). While resisting definition (Steele, 2016), CoMT is closely aligned to the social model of disability. The PREPARE acronym meaning ‘participatory, resource-oriented, ecological, performative, activist, reflective, ethics driven’ describes the key elements of CoMT (Stige and Aaro, 2011). The use of music is “to enhance connectedness and support communities, through both individual and group work” (Steele, 2016, p 4). CoMT is considered a move away from the ‘consensus model’ of music therapy practice which was influenced historically by the medical model and a move towards more ecological and social models of practice, to promote health through musicking with individuals or groups across multiple contexts (Ansdell, 2002a).

Many people with severe and multiple disabilities are often socially isolated and have reduced access to recreation, community engagement and development of relationships outside the home or workplace/day placement (Walker, Crawford, Leonard, 2014; Wiesel & Bigby, 2016). Creative music therapy and CoMT approaches can facilitate engagement in the community and the development of relationships by allowing the space, time and opportunity for connections to be made and developed within a music therapy milieu. Group music therapy can provide a valuable service in assisting people to connect and communicate with others, to develop relationships and participate in the community.

**Competing philosophies of the NDIS**

The provisions in the NDIS Price Guide and the Operational Guideline (DHS, 2016) can be challenging to understand. The philosophy of the NDIS is based on a social model of disability, and yet a medical model of disability is employed for therapeutic support. The Operational Guideline states that the objects of the NDIS Act, section 4 are to promote choice and control for people with disabilities and to adopt a strength based approach to help the participants with their goal setting in relation to their NDIS plan. Similarly, for therapy services, the NDIS Price Guide (DHS, 2016) states “the aim of therapeutic supports provided for participants with an established disability…is to participate in the broader community” (p. 42). This reflects the social model of disability whereby the impact of a person’s disability is mediated by the social conditions in the environment and the accommodation of the impairment. Factors such as physical access to buildings via ramps, existence of accessible toilets, availability of braille and large print type and so on ameliorate the effects of a person’s impairment (Oliver, 1983). People with disabilities are seen as the experts on themselves and are fit to make decisions regarding the services they require (Oliver, 1990, quoted in Gallagher, Connor, Ferri, 2013). Hence supporting an NDIS participant to identify and pursue their goals is congruent with the social model of disability.

In music therapy, current thinking is aligned with the social model of disability. The philosophies underpinning Nordoff Robbins creative music therapy (1977) and Community Music Therapy (Pavlicevic & Ansdell, 2004) align with the capacity building and strengths based approaches reflected in the NDIS operational guidelines.

In contrast to the social model of disability, the medical model of disability considers that impairment and the consequences of the impairment are the
responsibility of the individual. Elimination or reduction of the disability is considered to be facilitated by professionals (Gallagher et al, 2013), and places the onus on the professional to facilitate participant improvement within a restricted time frame. Under the NDIS Price Guide support category 3.15, which addresses therapy services, it states “Ongoing funding for therapy is subject to a detailed plan with expected further progress or change” (DHS, 2016, p.42). In an attempt to address this, the NDIS Price Guide states “family or trained assistants will be engaged to deliver ongoing maintenance therapy” (DHS, 2016, p.42). For most participants, this reflects a move away from the reliance on an expert to deliver a program prescribed by a therapist. Physiotherapists, for instance, frequently employ the services of an assistant to deliver a set of exercises for a client. Certainly, a reduction in the involvement of a professional can be regarded as consistent with the social model of disability. However, requiring programs which are ongoing or which provide maintenance therapy, to be delivered by carers may not be the most cost effective or preferred outcome for the participant. Indeed, without the music therapist’s involvement there may be no service at all as the ability of untrained assistants or family members to facilitate music-based interventions without considerable support is improbable. Music therapy requires the therapist to possess a high degree of musical skill and training in the clinical application of music in therapy. It is not a matter of facilitating a set of exercises. Music therapy with this population is an intense interactional exchange through the medium of music, requiring flexibility in presentation to respond to the participant moment by moment.

In comparing music programs delivered to people with intellectual disabilities by community musicians and music therapists, McFerran (2008) found that for people with severe and profound intellectual disabilities, music therapy was considered to be more appropriate for meeting the individual needs of the participants. The focus for the music therapist is the interpersonal interactions and development of relationships (Lee, Davidson & McFerran 2016). In contrast, people with mild to moderate intellectual disabilities may have their needs more appropriately met by the community musician as they focus on the enlivenment of the participants, allowing participants to leave a session in a stimulated state (McFerran 2008).

A typical music therapy group session with people with intellectual disabilities has a bell curve with greeting songs, instrumental activities, songs and relaxation incorporated with a winding down activity and farewell at the end. There is consideration of mood regulation and levels of stimulation and a flexibility of approach to respond to the needs of the participants in the moment. Music therapists seek to meet each participant’s needs and to engage at their level of communication and ability. Musical elements may be modified or a particular music therapy method may be employed such as improvisation or spontaneous song creation in order to respond to a participant in the moment.

The ability of therapy assistants to deliver such a music therapy program would require them to have extensive music skills and therapeutic knowledge to respond appropriately. This is not to say that these therapeutic skills cannot be transferred to carers or to family members and it is beneficial that funding has been included to facilitate training of assistants.
and informal and funded carers. Generalisation of skills is extremely important. However, from extensive personal experience, few carers and non-musicians have the confidence or skill set to undertake such work. The transference of these skills, gained over years of training and experience, to an assistant or carer would require extensive training and supervision. Community musicians, who may have the requisite musical skills, focus on using music to activate and stimulate. This may be effective in meeting the needs of people with mild or moderately intellectually disability, as reported by McFerran (2008). However, this approach may not adequately address the needs of people with severe and profound intellectual disabilities who may find such an environment overstimulating. A more nuanced approach to meeting their sensory and communication needs with in a musical relationship is provided within a music therapy milieu. Many already have reduced access to social contact and the community and the training and expertise of a music therapist can provide the opportunity for social contact, community engagement and an expressive communication experience through the music therapy process.

Of further concern is the requirement in the NDIS Price Guide (DHS, 2016) that therapists report further progress and change. Music therapists working with people with severe and profound intellectual disabilities are skilled at recognising, responding, nurturing and reporting on the incremental nature of progress and change. Pavlicevic, O'Neil, Powell, Jones, & Sampathianaki (2014) identified that change can be slow and incremental. The Diagnostic and Statistical Manual for Mental Disorders 5 (DSM-5) also identifies that change and development are slow for people with severe and profound intellectual disabilities and their needs can best be met through services over an extended period (American Psychiatric Association, 2013).

Given that ongoing therapy and maintenance therapy is specifically not provided for by the NDIS, the achievement of progress and change will be further limited for people with severe and profound intellectual disabilities. The Price Guide (DHS, 2016) states:

For participants where such treatment can only be met through skilled rather than non-skilled care, this treatment is to be funded through medical funds, not NDIS. Ongoing funding for therapy is subject to a detailed plan with expected further progress or change. Providers develop this plan with the participant and it should clearly state the expected therapy outcomes and demonstrate a link to the participant’s goals, objectives and aspirations. (p.42)

Of concern is that progress and change will be time limited with reduced potential for achievement of goals and may be delivered by under-skilled personnel. In this way, the ability to choose and access therapy services which meet the needs of people with severe and profound disabilities has been inadequately provided for and is at odds with the Operational guidelines (DHS, 2016) and the DSM-5(2013).

The Operational guidelines state that the objects of the NDIS Act are to: “Enable people with disability to exercise choice and control in the pursuit of their goals and the planning and delivery of their supports” (para 4.41, DHS, 2016). However, it mandates the level of choice and control by the participant through the Price Guide limitations and requires therapists to report
on progress and change. This implies that the disability will progress and change and it is the responsibility of the professional and the participant to deliver that change within a restricted time frame. Therein lays the conundrum of the competing models of social and medical models of disability.

**Long term music therapy**

A music therapy program I provide has been servicing the disability community for 18 years. Some of the participants have attended for the entire duration. The program promotes community access and participation within a semi-segregated setting and addresses the capacity building tenets of the NDIS, such as choice and control, development of relationships, lifelong learning and health and well-being (DHS, 2016). It is exclusively for people with disabilities, and offers a group program in a community venue where people can participate in a preferred activity. I wanted to create an opportunity for people to mix and meet other people outside their family or work place, with a view to creating new friendships. This is a key measure of social inclusion according to Weisel and Bigby (2016). For people with severe and profound disabilities their needs can be easily and frequently assumed or dismissed. This is a program whereby their needs and preferences are given priority. There is often a desire for repetition of music, modification of tempo, matching of mood through dynamic and style of playing and extemporisation to facilitate or prolong a musical interaction. This responsiveness is required to fully engage, stimulate or provide regulation of stimulus for the group members.

Providing a therapeutic encounter requires careful consideration of the needs of the person who communicates without spoken or conventional language. It requires sensitive reading of the mood of the group, adjustments to tempo, dynamics and style of playing in order to meet, in the moment, the needs of these members who have severe or profound intellectual disabilities.

Meeting an individual’s needs within a music therapy group or in individual therapy for social contact and through attunement with the person’s communication style may be the impetus for continuing to access a service for an extended period of time. Discussion regarding duration of therapy has been largely absent in the music therapy literature. Pavlicevic et al (2014) recently discussed the value of long term music therapy and found that rather than leading to developmental change, the value of long term therapy was the ongoing opportunity to experience social connections, and self-confidence. In other research, references to the period of time clients with intellectual disabilities have received music therapy are made but without discussion surrounding the reasons for the length of therapy (Lee, 2014; Rika, 2013; Warner, 2007; Agrotou, 1994). Working with people with severe or profound intellectual disabilities can require a long period of assessment and development of rapport and trust within the therapeutic relationship. Understanding and responding to people with severe and profound intellectual disabilities requires a sophisticated level of skill as well as time in order to develop trust, and enable change.

**Benefits of long term participation**

Long term participation in music therapy has clear therapeutic benefits for the participant with severe or profound intellectual disabilities. Pavlicevic (2014) identified social connections and self-
confidence. Warner (2007) considered challenging behaviours to be communication attempts. She states that “working with very small changes over time may lead to a dramatic reduction in challenging behaviour” (p.57). Lee (2014) considered the need for longitudinal studies to “trace the process and benefits of individual as well as group sessions as building meaningful interactions and relationships with adults with PIMD takes a long time, over several years” (p.260). McFerran and Shoemark (2013) studied the musical engagement of a young man with a profound intellectual disability and identified 4 key principles of music engagement, the fourth being that the “Relationship is built over time”. Here I contend that alongside these benefits development and change may take place as well as ameliorating the deterioration of skills. Also, the opportunity for a person with profound intellectual disabilities to experience choice and control on a regular basis provides the experience of personal agency in a life where these opportunities rarely exist. Here I will detail these benefits and illustrate them through case vignettes.

Communication and self-expression.

Bill is a 41-year-old man who acquired a brain injury at age 3 after falling under a train. Bill has attended my group programs from their inception in 1998. He is severely physically disabled although he can walk with support and communicates through gesture, picture representations and vocalisation. When I first met Bill, I found it a challenge to understand how to effectively communicate with him. He would accept a choice of instrument I had offered (most often the tambourine) then after a short period would carefully place it beside his wheelchair. I continued to offer other small percussion choices and they would be similarly treated. I interpreted this to mean that he had a limited attention span. However, when I finally offered him the snare drum Bill demonstrated to me that he was communicating a preference and this was not a reflection of his attention span, as he was able to sustain playing throughout the entire session on this instrument. Bill and I have been able to explore his cognitive skills over the years to the delight of many who have seen his playing through the use of the snare drum and the guitar. Through arrangements of various songs, Bill plays different rhythmic riffs and demonstrates his understanding of the form of music by playing the drum or guitar on cue. The assisted playing of guitar through strumming has given me as many insights into Bill’s abilities as well as his mood. Bill prefers to take my arm to strum the guitar although he is capable of playing with his own hand. He is most accurate in conveying his mood and energy levels in this way as he will strum vigorously and hold my arm firmly when feeling well and upbeat. He can also accurately strum the strings depending on the chord, finding just the lower 4 strings for a D chord. When he is less energised and feeling poorly his playing is reflected by slower playing and weaker hand grip.

The ability to fully understand idiosyncratic communication styles and to develop ways of interacting takes time. Communication and self-expression can be supported in an ongoing way and the development of interactional skills and rapport with the therapist can develop.

Choice and control.

Joel is a 25-year-old man who has attended individual music therapy for 11 years. He has a profound intellectual disability, spastic hemiplegic cerebral palsy and uses a wheelchair. Additionally, he has retinal displacement, is legally blind, has
renal failure and is tactile defensive.

When I first began working with Joel I wanted to encourage him to interact with me through tapping instruments. Initially I encouraged him to touch the piano keys hoping that he would indicate for the music to continue through a key touch and perhaps also interact with me musically on the keys. After persisting with this approach over several sessions I realised the full extent of his tactile defensiveness and abandoned this approach. Joel vocalises frequently so I follow his lead and document his responses including the type and timing of vocalisations in the music I play for him. He makes a variety of sounds including ‘Mmm’, ‘Ahh’, ‘blurts’ and high vocals. Joel also recognises the choruses of certain songs and will vocalise on cue. His most favoured music is ABBA but he responds well to a variety of other music and styles. Through noting his preferences and responses and incorporating improvisation extensively into the music I am able to respond to the minute changes in Joel’s breathing and vocal output to meet, match or discontinue a song. At times, he will take a breath, hold it and throw his head back with his mouth open, so I time the music to correspond with the breath expiration and we continue the song. Over the time I have been working with Joel I have been able to gauge Joel’s preferences from his responses. For example, Joel will continue to sing if he wants more and we repeat the song. During the last year or so Joel has developed a small nod which I reinforce with a verbal confirmation “Yes, you want more”.

Through personal planning meetings with the other service providers involved with Joel, this skill is being supported and generalised to other environments. Joel’s parents have supported him over the years to attend music therapy because his mother states that it is the one time in his daily life that Joel gets to have choice and control over the activity and his interactions are fully supported in a musical conversation.

Participation in music therapy may be the one situation where choice and control is enabled. Over a longer period of time opportunities to experience choice and control is enabled and consolidated. These are important elements of a good quality of life and enable the person to be self-determining and empowered. (Kostikj-Ivanovikj and Chichevska – Jovanova, 2016).

**Social contact and ameliorating deterioration.**

Scott has attended my group program since 1999. A man in his 50’s, he has Down syndrome and is verbal, although electively mute. Set in his ways, Scott has always sat close by me at the keyboard. In 1999 Scott demonstrated his ability to read as he quoted for me without prompt, the establishment date and name of the hall we were in, read spontaneously from a wall plaque! This incident reminded me not to take for granted the skills which Scott possesses although he may not choose to display them. His comprehension is good and he typically varies his responses depending on his mood and energy level.

Scott’s participation is somewhat ritualised but always incorporates choice. He likes to choose whether he strums the guitar or not and will often go to the song card to select the same cards each week, with his favourite being ‘Better be home soon”. When the microphone is handed around he considers whether he will sing into it, motivated more if his turn is ‘forgotten’. Recently another member, who enjoys assisting with the microphone, forgot to offer Scott a turn to sing a verse of ‘Big Yellow Taxi’ and he took the opportunity to get the microphone for him-
self to sing a verse. While Scott has the ability to verbally communicate, his elective mutism has masked the deterioration of his verbal skills, which therefore has not been easy to track. Hence, he now sings with poor articulation and frequently mumbles the words. A preliminary diagnosis of dementia has also been given. Despite this, music continues to be effective in encouraging him to use his communication skills. I was recently able to interpret Scott’s desire to have ‘Better be home’ sung twice in a session. He held up the song card at the start and I confirmed that he wanted me to sing it at the start. “Yes” he confirmed with a slight nod. So, I played the song with strong rhythms at a moderate pace and with a moderately loud volume, appropriate for the start of the session. Later, he held the card up to his chest again, indicating the desire for a reprise and I played it with soft arpeggiated chords for the final song of the night. Music therapy has been able to maintain communication skills for Scott and to provide him with an ongoing avenue of social contact.

Maintaining social contact and communication avenues which are idiosyncratic are possible through music and therapeutic attunement. Additionally, maintenance of skills and ameliorating deterioration are valid goals in therapy.

**Development of skills.**

Zac is a man of 37 who also has attended my group program since inception in 1998. He has a profound intellectual disability and autism. He laughs at times when happy and conveys his mood through his facial affect and body language. He displays limited awareness of others, giving no eye-contact and moving into another’s space without recognition. In the groups, Zac has always participated with an assistant’s support. He shows preference for different songs by vocalising occasionally and giggling. His favoured mode of participation is to tap the tambourine with a strong beat. Over the years he has not modified his beating to match the tempo of the music or stopped when the music stopped unless the assistant intervened.

This year, after 18 years of involvement Zac has begun to show an awareness of the music by spontaneously stopping with a pause in the music and looking towards me. This awareness of me and my playing is a new development and I respond by resuming my playing and then pausing again, encouraging a back and forth interaction. He seems to acknowledge this by looking at me with a direct side long look, which demonstrates another new development, of seeking my attention.

Learning and development as result of a participant’s severe or profound intellectual impairment requires long term teaching and support according to DSM-5 (APA, 2013 p. 36). Therefore, enabling change and meeting of goals takes time.

In summary, communication and self-expression, choice and control, social contact through participation and interaction, maintenance and development of skills, ameliorating deterioration and enabling development are valuable and important goals for people with severe and profound intellectual disabilities. Achievement of these goals requires a considerable amount of time and skill.

**Limitations of long term therapy**

The limitations of long term participation in therapy may include a reduced ability to create new connections. Watson (2007) suggested that long term therapy may “prevent the development of new relationships in the future” (p.32) whereby dependence on one environment to provide social interaction may reduce
access to new experiences. Hudgins (2013) noted that in community mental health, closure can help empower a client through reducing dependency on the therapist, signaling a new phase of independence and positive change. However, people who access a music therapy program over a long time may do so because this is their “community”. From a social role valorisation perspective (Wolfensberger, 2000) whereby social conditions set by mainstream society are to be emulated for people with intellectual disabilities, people who are non-disabled may also have a limited number of friends and friendship groups and do not always seek to gain new friends or leave a group. Long term participation is generally valued in society. Therefore, long term participation in a music therapy program may not necessarily lead to the exclusion of other social connections being developed.

Of concern is that many people with profound disabilities do have few or no friends outside paid carers or family (McVilly, Stancliffe, Parmenter and Burton-Smith, 2006). In a systematic review Verdonschot, de Witte, Reichrath, Buntinx, and Curfs (2009) found that people with intellectual disabilities were less likely to be involved in community activities, more often engaged in passive leisure activities and had 3.1 people in their social network including paid workers. Social participation has been shown to increase wellbeing (Wilson, Cordier, Parsons, Vaz, and Buchanan, 2016) and may be protective of mental health problems. Participation in music therapy over the long term, delivered by a registered music therapist may be an important avenue for ongoing social connection, creating opportunities for developing relationships, community participation and improved mental health for people with severe and profound intellectual disabilities.

**Conclusion**

The NDIS represents a unique opportunity for people with disabilities to access funding for services they require to live an “ordinary life” (Operational guideline 4.1, DHS, 2016). For people with severe and profound disabilities the need for maintenance or longer-term therapy may be a reasonable and necessary support. The requirements of further progress or change is a conundrum as development, and therefore change and progress, occurs very slowly and incrementally and usually over an extended period of time. Of more relevance for these participants is the opportunity to have ongoing experiences of social connectedness and personal agency (Pavlicevic et al, 2014). As described here, there are benefits to be derived from long term involvement in music therapy in the areas of communication, self-expression, choice and control, social contact and developmental change through accessing music therapy over the long term.

For the people who currently access music therapy and who have attended programs for an extended period, it is important that they are able to continue to access such services. The current NDIS Price Guide (DHS, 2016) is unclear in its treatment of people seeking to include their long-term access to services in their plans. Success in gaining funding from NDIS is dependent upon the knowledge of music therapy by the NDIS planners. Anecdotally, some people who have a NDIS plan implemented report that the current services an individual receives are being maintained. While this is encouraging, it is still an ad hoc approach. It is incumbent upon the NDIS to clearly articulate this and continue to fund support services if this is the NDIS participant’s...
preference. Additionally, the opportunity to access the services that the participant requests in order to live an “ordinary life” (NDIS Operational guideline 4.1) should be reflected not restricted. The provision of a tailored plan, which acknowledges that reasonable and necessary supports may include long term therapy by a registered professional, needs to be reflected clearly in the guidelines and not be dependent upon the knowledge or discretion of an NDIS planner.

It appears that the NDIS has financial restrictions to consider (Bonyhady, 2016) and the current rate for individual therapy may well cause strain within the system. Consultation and negotiation could address these issues. The use of community musicians and music therapy assistants to deliver ongoing maintenance therapy may serve to reduce dependence on specialised services and deliver a cost saving to the NDIS. However, in the long term, these personnel will require extensive supervision to meet the complex needs of this group of people and therefore will incur an added financial cost. Participation in music therapy for people with severe and profound disabilities over the long term with a registered music therapist has clear benefits and should be included in participants’ NDIS plans if this is their preference. As evidenced by the participants who continue to attend the author’s JAM music therapy group and individual therapy over 18 years, there is a demonstrated need for long term therapy due to the unique benefits of music with a registered music therapist.

Note. All names have been changed to protect their identity.

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References


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A theoretical framework and group therapeutic songwriting protocol designed to address burden of care, coping, identity, and wellbeing in caregivers of people living with dementia

Baker, F. A.


In plain language:
This article describes the theory and methods underpinning a 12-session intervention protocol for family caregivers of people living with dementia. It describes a process whereby family carers co-create 3 songs that focus on the positives and challenges of caregiving with a view to helping them cope with their caregiving role, exploring their changing role as a carer, and grieving the loss of a potentially different future life path. The article offers an example from a pilot study to show how the intervention is applied in practice and its potential beneficial effects.
A theoretical framework and group therapeutic songwriting protocol designed to address burden of care, coping, identity, and wellbeing in caregivers of people living with dementia

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Abstract

Family caregivers of people living with dementia provide an enormous service to the community. However, it is recognized that the emotional, physical, and social burden they experience can increase the risk of caregiver burnout and lead to complex health issues. Any threat to carer wellbeing increases the chances they will no longer be able to care for themselves or the person living with dementia. Problem focused/behavioural approaches and emotion focused/cognitive approaches to coping have been shown to reduce the sense of burden experienced by family caregivers of people living with dementia. In this paper, the author describes a group songwriting protocol for family caregivers of people living with dementia that focuses on activating coping strategies. Over 12 music therapy sessions, groups of caregivers come together to create three songs that focus on expression of emotions, explore the caregiver identity, and identify helpful coping mechanisms. This paper outlines the theoretical foundations for the use of group songwriting as a medium to support family caregivers and presents a short case illustration of its use in practice.

Keywords: songwriting, family carers, identity, caregiver burden, coping, dementia

Introduction

With dementia now affecting more than 50 million people worldwide, and approximately 7.7 million new cases diagnosed annually, addressing the long-term care needs of people living with dementia (PWD) has become a global challenge (Prince, Albanese, Guerchet, & Prina, 2014). Dementia not only effects the person who has the disease but also has a significant impact on the lives of informal caregivers who make enormous personal sacrifices to care for a spouse, parent, parent-in-law, sibling, friend etc. who is living with the disease. Coping with caring for a PWD is difficult because the progressive nature of dementia leads to ever-changing, unpredictable and incomprehensible changes in behaviour (Steeman, Dierckx de Casterlé Godderis, & Grypdonck, 2005). It is the
behavioural problems associated with the progression of dementia that render caregiving a stressful and difficult task. It may be difficult for the caregiver to engage in social activities previously enjoyed due to the demands of caregiving (Van Bruggen, Gussekloo, Bode, et al., 2016).

As a consequence of the challenges family caregivers face on a daily basis, it is unsurprising that numerous studies report significant mental and physical consequences for the caregiver (for example Clark & Diamond, 2010; Ornstein & Gaugler, 2012). More specifically, family caregivers of PWD display higher rates of mental illness and lower subjective wellbeing when compared with the general population (O’Dwyer, Moyle, & van Wyk, 2013; Sörensen, Duberstein, Gill, & Pinquart, 2006). Burden, stress and distress are more than four times higher in family carers of PWD than the general population (Thommessen, Aarsland, & Braekhus, 2002).

**Models of coping and quality of life for family caregivers**

While several models of coping with the caregiver role have been proposed, perhaps the most widely accepted and used are Lazarus and Folkman’s (1984) Transactional Stress Theory (Crelilin, Orrell, McDermott, & Charlesworth, 2014; Del-Pino-Casado, Frias-Fri´As-Osuna, Palomino-Moral, & Pancorbo-Hidalgo, 2011) and the Pearlin Stress Process Model (Pearlin, Mullan, Semple, & Skaff, 1990). Lazarus and Folkman proposed that caregivers who experience stress undergo a two-stage appraisal process before responding to the stressor. During the initial encounter of the stressor, the caregiver first appraises the perceived threat, and considers whether they have the required internal (physical and psychological abilities) and/or external (social, professional support) resources available to respond to the stressor, and therefore whether they are able to cope with the challenge presented to them (Figure 1, see [1]). Building on this model, Pearlin et al. (1990) add that there are five factors that impact caregivers’ ability to manage this process: 1) the background of the caregiver, the person being cared for, and the context of caregiving; 2) objective primary stressors (the care needed and demanded); 3) subjective primary stressors (role overload and relational deprivation); 4) secondary stressors (role strains and intrapsychic strains); and 5) mediators (social support and other coping strategies) (as cited in Del-Pino-Casado et al., 2011, p. 2312) (Figure 1, see [2]).

**Coping strategies for caregivers**

Coping has been defined as “constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that were appraised as taxing or exceeding the resources of the person” (Lazarus & Folkman, 1984, p. 141). Kramer and Vitaliano’s (1994) review of coping frameworks for caregivers of PWD suggested that the most commonly adopted adaptive approaches to coping were problem focused/behavioural approach coping (Figure 1, see [3a]) and emotion-focused/cognitive approach coping (Figure 1, see [3b]) (Del-Pino-Casado et al., 2011; Lazarus & Folkman, 1984). These have been described as:

- problem-focused/behavioural approaches: approaches where the caregiver actively tries to solve or modify the challenging problem (Lazarus & Folkman, 1984; Moos et al. 1990).
Figure 1. Theoretical Framework of Stress, Coping and Wellbeing for Family Caregivers, incorporating Pearlin’s Stress Process model (Pearlin et al., 1990) and the Transactional Model of Stress (Lazarus & Folkman, 1984).

- emotion-focused approaches/cognitive approaches: coping strategies utilised to manage the emotional response to the stressor (Lazarus & Folkman, 1984; Moos et al. 1990).

When utilizing these problem-focused/behavioural approaches to coping, family caregivers may draw on their own resources, or caregivers may access external support services to ease their burden. Del-Pino-Casado et al.’s (2011) review of coping strategies, concluded that people cope with the caregiving role by:

1) developing skills and strategies to manage the care of PWD (Figure 1, see [4a])

2) identifying, developing, and routinely engaging in activities that support their own wellbeing (Figure 1, see [4b])

3) seeking professional assistance and/or assistance from their own social support network (Figure 1, see [4c])

4) acquiring knowledge about and having expectations for the disease progression (Figure 1, see [4d])

While emotion-focused/cognitive approaches to coping have been viewed as relating to negative outcomes (e.g. Papastavrou, Tsangari, & Karayiannis, 2011), more recent research suggests that they are not as maladaptive as initially suggested (Khalaila & Cohen, 2016). Cognitive reframing (Figure 1, see [4e]) is one strategy that can assist carers to emotionally cope with the challenges they face by encouraging carers to have a shift in thinking (Figueiredo, Gabriel, Jacome, & Marques, 2014). More specifically, this involves guiding the carer to identify maladaptive, self-defeating or distressing cognitions about the PWD’s behaviour and
their own competency as a caregiver, and reframing these into more constructive and positive thoughts (Vernooij-Dassen, Draskovic, McCleery, & Downs, 2011). A Cochrane Review (Vernooij-Dassen et al., 2011) exploring the impact of cognitive reframing on family carers of PWD found that it was effective in reducing anxiety and subjective stress but not sufficiently effective to be used as the sole coping approach.

Mastery (Figure 1, see [4f]), another emotion-focused approach relevant to caregivers of PWD (Pearlin et al., 1990), is generally understood as the “sense of being in control of forces impacting one’s life” (Khalaaila & Cohen, 2016, p.909); an internal resource that is important in mediating the negative effects of caregiving (Pearlin et al., 1990). Cairney and Krause (2008) suggest that increased stress impacts people’s capacity to solve problems, to utilize pre-existing reasoning skills, and leaves them feeling overwhelmed and helpless. These stressors in turn, reduce family carers of PWD’s sense of mastery and thereby perpetuate the cycle of stress (Mausbach, Roepke, Chattillion et al., 2012). Therefore, any approach that enhances a sense of mastery and being in control, may directly impact carers’ coping capacities.

A sense of personal identity (Figure 1, see [4g]) is integral to sustaining health and wellbeing and is often challenged during major life changes, including the assumption of a carer role (Burke, 2005). Through changes in roles and responsibilities, carers are called on to relinquish other roles deemed not as urgent which may impact their sense of who they are. They may experience internal conflict which threatens their sense of self-continuity; the frame through which they problem-solve and make decisions about their lives (Berzonsky, Cieciuch, Duriez, & Soenens, 2011). In a systematic review, Eifert, Adams, Dudley, and Perko (2015) found several role-related issues emerge as people assume a caregiver role. Carers reported experiencing role engulfment and a sense of losing their sense of self. They struggle with accepting what they had to give up as a carer; “the activities that once defined” (p.363) their sense of self. They also reported a strong desire to maintain the pre-existing relationship and life they had shared with the care-recipient before needing to take on this role. Furthermore, studies reviewed reported that carers talked of a loss of shared identity, particularly in spousal carer relationships where their role within the relationship had changed; for example, moving from a wife and lover to a mother or constant provider. Given these struggles with carer identity, any intervention that allows for caregivers to explore caregiver identity, while also allowing carers to reconnect with other aspects of the self, is likely to lead to a healthy sense of self.

Rationale for therapeutic songwriting

Therapeutic songwriting, a theoretically grounded (Baker, 2015a) and widely applicable therapeutic method of practice (Baker, Wigram, Stott, & McFerran, 2008, 2009), is emerging as a creative and uniquely beneficial alternative to counseling approaches to address personal issues (for example, Burns, Robb, & Haase, 2009; O’Callaghan, 1997; O’Callaghan, O’Brien, Magill, & Ballinger, 2009; Tamplin, Baker, Macdonald, Roddy, & Rickard, 2015). There are several reasons why songwriting may be an appropriate tool to assist people who are caregivers of PWD. Firstly, songwriting is a creative and versatile means to exploring and expressing emotions. Through identifying and naming key issues and expressing emotions in
lyrics, songwriters can address varying needs for experiencing mastery, self-esteem, life review (Baker et al., 2008), as well as reappraise and reframe their perspectives on caregiving (Baker, 2015a; O’Brien, 2005). As carers project their emotions onto the lyrics and music, they may experience an emotional release and feeling of relief; a catharsis that can potentially be re-experienced each time the recorded song is played (Baker, 2015a). Indeed, the act of creating lyrics offers people an opportunity to voice their feelings and feel acknowledged and heard by others (O’Callaghan, 1997).

One of the advantages of songwriting over talking therapies (e.g. counseling or support groups) is that the creation of a song is not instantaneous; it takes time and therefore calls for those creating the song to have prolonged engagement with the issues being explored (Baker, 2015a). Through the shaping and refining of lyrics and music over a number of sessions, people may engage in “processing and reprocessing” of complex and sometimes painful issues (Baker, 2015a, p.19). By sitting with their feelings and experiences during this time, the lyric creation process creates possibilities for reappraising and reframing their perspectives and feelings towards themselves, the PWD, and their caregiving role.

From a cultural perspective, songs are generally accepted as vehicles for expressing poignant issues and therefore have value when used within a therapeutic frame. As completing a song demands focus, it is difficult for those creating the songs to steer the focus of therapeutic discussions towards a different issue as part of an avoidance strategy or defense mechanism). If a carer begins to digress, the therapist has the means to refocus the carer by redirecting him or her to the task of creating a song on the identified issue. Although this can also be achieved within a verbally-based therapy, redirection may be easier when the focus is on creating a song - it is task-oriented. During songwriting, the therapist can encourage the caregivers to keep returning to the focus of the song and not to avoid reviewing difficult emotions (Baker, 2015a).

Ambiguity and ambivalence are common feelings caregivers may experience as they come to terms with a situation that is challenging. Songs are a perfect medium for expressing complexity, ambivalence, and ambiguity. For example, the lyrics can portray one emotion while the music can portray a conflicting emotion (Baker, 2015b). Further, songs provide the perfect structure to tell a complex story – verses, a chorus, and a bridge. In verse 1, the problem is introduced, in verse 2, the lyrics explore specific issues of concern and through verse 3, the issues are further explored and/or a resolution to the problem is found. The chorus functions to express the feelings associated with the issue, and the bridge (if included) offers an alternative perspective or solution to reflect complexities.

Therapeutic songwriting has an established history of addressing issues of identity in the clinical and non-clinical contexts (Baker & MacDonald, 2017). Songs may be autobiographical in nature (Pennebaker, Mayne, & Francis, 1997) and can tell stories of people’s past, present, and anticipated future (Tamplin et al., 2015). The process offers the opportunity for people to reflect upon their journeys, step outside themselves and their contexts, and try to view themselves from a new angle and construct new meaning (Baker, 2015a, p.21). It also offers opportunities to address issues of identity by building micro-narratives, which ultimately contribute to the building of a macro-narrative
(Tamplin et al., 2015). For carers of PWD, this is particularly important as they try to find meaning in, and incorporate the new caregiver role while also struggling to keep alive other domains of their identity (Quinn, Claire, & Woods, 2010).

Working on creating songs in the context of a group provides people with unique opportunities to engage in teamwork and share life’s experiences and challenges with others (Baker, 2013a; Grocke, Bloch & Castle, 2009; Schwantes, Wigram, McKinney, Lipscomb, & Richards, 2011). The group songwriting experience mimics other therapeutic group processes such as support groups but with the added advantage of having a clear focus and group goal – the creation of a song. The process fosters “trust, letting others in, and respecting others’ experiences and perspectives” (Baker, 2015a, p. 22). In Baker’s (2013a) study of group songwriting processes, she found that the safer, more intimate, and more trusting the group is, the more people were willing to open up authentically (p.141) and create a song that synthesizes the therapy process (Baker, 2013b).

One important strength of the songwriting process is that the artifact becomes a permanent record of the therapeutic songwriting process (Baker, 2013b). This is in contrast to verbal therapies, which happen in the moment and cannot be revisited unless audio recorded and played back. Therefore, the songwriting process and song product offers possibilities to revisit the issues discussed, thereby deepening people’s understanding of the issues affecting them, or assisting them to reframe and reappraise their context and response to the stressor. For carers, playing the song created can help bring clarity and deepen the connection with and meaning of the material expressed in the song.

Three models of songwriting

Three models of songwriting form the basis of the protocol: 1) insight-oriented songwriting, 2) narrative songwriting, and 3) psychoeducational songwriting. Insight-oriented songwriting (Baker, 2015a; Health & Lings, 2012; O’Callaghan, 1997) enables people to explore their feelings and behaviours within their current context, develop insight, and reconcile conflicting feelings about their situation. The process involves creating lyrics and music that direct people to “rethink, re-know, re-feel, or re-experience” (O’Callaghan 2005, p.125) thoughts and feelings and ultimately revise and reframe their thinking and feeling on issues that have been barriers to coping and wellbeing. In other words, the songwriting process allows experiences of physical and emotional stress associated with caregiving to be expressed and in doing so, increases carers’ insight into the source and impact of the stress.

Narrative songwriting (Baker, 2015a) is an approach that draws on the story-telling potential of songs to help people reconstruct their life narratives. Through the creation of songs that synthesise the narrative explorations of past, present, and future, people are able to construct meaning (Feinstein & Krippner, 2008) and address issues of changed roles and carer identity conflict. Within the narrative songwriting process, the therapist assists people to tell and retell their stories and in doing so, supports them through rephrasing their verbal contributions (to check for understanding), challenging them to view the issues from different perspectives, and helping them reframe negative thinking. Evidence suggests
that through the repeated retelling of stories, there is a long-term integration of identity (Obodaru, 2012).

Psychoeducational songwriting (Baker, 2015a) originally developed by Silverman (2011; 2014), aims to educate the group of carers on a topic relevant to their stressor context. During the process, the therapist stimulates discussions about alternative ways of thinking and behaving, and then the group collaboratively co-constructs strategies to deal with their day-to-day stressors. The song created from the material raised in discussions becomes a record (and subsequently a future reminder) of what the carers can actively do to cope in life. For carers of PWD, psychoeducational approaches have been found to be effective in reducing symptoms of depression (Mittelman, Roth, Coon, & Haley, 2004; Pinquart & Sorensen, 2006), improving carer wellbeing, and reducing caregiver burden (Marriot, Donaldson, Tarruerm & Burns, 2000).

The songwriting protocol for family caregivers of people living with dementia

This protocol is designed to be implemented by a music therapist and involves the co-creation of three group composed songs, each of which have a specific focus on one aspect of caregiver wellbeing. The three songs would enable caregivers to:

1) express and reframe negative caregiving experiences and celebrate positive experiences by creating a song about the caregiver journey (insight-oriented songwriting, Figure 2, song 1)
2) explore their changed role and reconcile caregiver identity conflicts by creating a song about caregiver identity (Figure 2, song 2)
3) identify healthy coping strategies by creating a song that focuses on coping skills and strategies (Figure 3, song 3)

Figure 2. Emotion focused and cognitive approaches to coping (Song 1 and 2).
During the creation of Song 1 (sessions 1-4), the carers have an opportunity to voice their struggles and celebrate their triumphs with other carers. Through this collaborative process, and supported by a trained music therapist, the carers create a song that contains lyrics that reflect their collective caregiving experiences. The carers are invited to express in words, some of the social, emotional, cognitive, and physical challenges they experience as a caregiver. For example, a carer may express how the constant repeated questioning by the PWD of “what day is it?” or “what is the time?” can test the carer’s tolerance. The therapist then validates this contribution by stimulating a broader dialogue with the group about what behaviours challenge their tolerance. When negative comments arise such as “I’m not doing a good enough job because he gets so angry with me”, the therapist can reflect this comment back to the carer by asking them to provide “evidence” of how she knows she is not doing a “good enough” job. This creates opportunities for the carer to develop insight into how this thinking is self-defeating and may have no factual basis. The therapist can respond and reframe thinking: “Yes he can get angry but this might be because he is no longer able to make sense of his world and may have no other way of expressing his confusion but to get angry. This might not have anything to do with what you have said or done.”

Once the group has voiced a range of struggles and challenges faced, the therapist seeks to balance these by facilitating a discussion about the rewarding aspects of caregiving. Sometimes the challenges of day-to-day caring become overwhelming for carers and they do not take time to reflect on the joys, accomplishments, and rewards associated with their roles. The therapist’s
role here is to “summarise” carers’ extensive explanations by using key words or short phrases such as “unpredictable, daily grind, confusion”, and wherever possible, uses the carers’ own words verbatim.

The list of thoughts and feelings generated through the brainstorming activities are then read out and the therapist guides a brief group discussion to help carers identify the core message or feeling to be expressed in the song. The words or phrases relevant to the core message are then identified and shaped into lyrics. At this point, the therapist may guide a discussion about what genre or style their song should be. During sessions 2–4, the remainder of the song is created using the same process with a final chorus, verses, and sometimes a bridge being constructed and then recorded.

Song 2 (sessions 5–8) explores carer identity and the internal conflicts they may be experiencing about this role. Based on Fitts and Warren’s (1996) domains of the self-concept; academic self, social self, personal self, family self, physical self, and moral/spiritual self, the songwriting process encourages the group members to think of all aspects of themselves as they begin to describe how their role as a carer impacts their other life roles. Therefore, this songwriting protocol has a distinct emphasis on ensuring that the pre-carer identity is not lost or forgotten. Again, the music therapist’s role is to ensure carers explore their sense of self, and to help them reconcile any negative perspectives of their carer identity. As per song 1, the carers’ verbal contributions are shaped into song lyrics and music created to support the lyrics (see Baker, 2015a, p.146).

Song 3 (sessions 9–12) shifts the focus from emotion-focused approaches of coping, to problem-focused approaches, utilising psychoeducational models of songwriting. Beginning with a brainstorming session, the therapist facilitates a discussion to assist carers to identify a concrete “problem” or series of problems that if resolved or minimized (Silverman, 2014), would enhance caregiver coping and wellbeing. The therapist then asks the carers to offer potential solutions or strategies for coping with these stressors or problems. If no ideas arise, then the therapist can prompt reflections by offering possible coping strategies. These possibilities were derived from Folkman and Lazarus’ “Ways of Coping” questionnaire (1988):

1) confrontive coping (e.g. taking a risk, initiating an action considered unlikely to work)
2) distancing (viewing events as fate, ignoring the event, making light of the situation)
3) self-controlling (efforts to regulate feelings, not acting too hastily but thinking things through)
4) seeking social support (seeking information and professional help, talking to others about feelings)
5) accepting responsibility (apologising, making promises to do act differently, acknowledging one’s role)
6) escape-avoidance (wishful thinking, efforts to avoid problems, hoping for a miracle, fantasizing about things being different, avoiding people)
7) planful problem-solving (making a plan and following through, thinking through potential solutions to a problem)
8) positive reappraisal (rediscovering what is important in life, inspired to do something creative, changing something about myself)
9) other actions (exercise, mindfulness, visiting a friend, reading a book, listening to music, eating well, taking a vacation, respite, accepting help when others offer it)
Once a list of possible solutions has been generated, the pros and cons of these are then debated and the group eventually arrives with a list of commonly agreed strategies. These then become the focus of the song’s content. Once the song has been created, the song becomes a source of support and a reminder of their agreed strategies and coping tools.

Case illustration and discussion

This case illustration is drawn from a larger study about the use of songwriting for people living with dementia and their family caregivers (Baker & Stretton-Smith, 2017; Baker & Yeates, 2017), which trialled the delivery of song 1 only. The study received ethical approval from The University of Melbourne, approval number 1545742.1 and all participants gave written informed consent to participate in the study. Each participant was assigned a pseudonym for the purposes of reporting.

The four carers of PWD described in this case illustration were recruited by the manager of Caladenia Dementia Care in Melbourne and comprised one male spousal carer (Byron), one female spousal carer (Nyssa), one female daughter carer (Natalie), and one male son carer (Sean). Two music therapists co-facilitated the songwriting process that explored the four carers’ experiences and feelings associated with caregiving. During session 1, the carers were encouraged to share their stories and express positive and negative feelings towards themselves, the care recipient, and their role. One therapist acted as scribe, noting down all the ideas on a whiteboard, and when necessary, summarising long descriptions of stories into key concepts. One carer (Natalie) was clearly quite stressed in her current situation and dominated much of the first half of the session. The therapists drew other carers into the discussion by directly inviting comments from them. Towards the end of the session, the lists of ideas on the whiteboard were read out, and the carers commented on how many of the ideas were negative. There was consensus that they wanted to ensure that positive experiences were also represented in the song. Through a process of democratic decision making, rephrasing, and reframing, the lyrics to what became the chorus were created: Lyric 1. “I see a beam of light shining through the haze” (referring to moments where the PWD had clarity); Lyric 2. “Sensing your true spirit in different ways” (referring to their experience that the core of the PWD remains despite cognitive decline); Lyric 3. “Sharing paths of love gives us reason for the now” (shared loved gives meaning to the tasks of caring); and Lyric 4. “Memories of our past give us strength to smile again” (refers to how memories of the past shared together fuels them during periods of stress).

During sessions 2 and 3, the three verses were composed and the whole structure of the song including melody and harmonic framework developed. The carers utilised metaphor and imagery to express their feelings, this being less confronting than more explicit and less abstract descriptions. Comments such as “not being on the same wavelength”, “daily grind”, “enjoying the present moment”, and “seeing the core of the person” were transformed into powerful lyrics. As they shaped their ideas into lyrics, they gained insight into their challenges, frustrations, and positive feelings. During this time, emotion focused/cognitive approaches (Figueiredo et al., 2014; Papastavrou et al., 2011) were utilised, with the therapist needing to ensure opportunities for expressing painful and difficult moments were balanced with positive ones. During
session 3, carers talked about their frustrations around not having the skills to manage extreme behaviours. These feelings were reflected in verse 3 where the lyrics expressed frustration about how the roles held by the carer and PWD were changing and no training had been provided to deal with that.

Session 4 involved bringing the whole song together and creating a pre-chorus to link the verses with the chorus. The group were clear that they wanted to express how they witnessed short periods where the PWD was not “present” but somewhere else; disconnected from reality for just moments. The imagery of not being on the same wavelength was used here “Moments of absence, I wonder what you see, is it this wavelength that’s unknown to me”. The third time the pre-chorus appeared, the carers decided to modify the words to “Moments of absence, I wonder where you are, I feel so sad that you’ve drifted this far” to express their sadness of not being able to connect. The final version of the song lyrics is detailed in Figure 4.

The carers commented that the song enabled them to voice their opinions and create a song with “like-minded people” (Natalie, carer of her mother) and without being judged. Sean (carer of his mother) commented that it was different to the carer support groups where everyone goes around and has their opportunity to speak. This approach is more collaborative (Baker & Yeates, 2017).

<table>
<thead>
<tr>
<th>Verse 1: Our lives are intertwined</th>
</tr>
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<tbody>
<tr>
<td>We know not for how long</td>
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<tr>
<td>So much sorrow, so much joy</td>
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<td>Does it break us or keep us strong?</td>
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<tr>
<th>Pre-chorus:</th>
<th>Moments of absence, I wonder what you see</th>
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<td>Is it this wavelength that’s unknown to me?</td>
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<th>Chorus:</th>
<th>I see a beam of light shining through the haze</th>
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<td></td>
<td>Sensing your true spirit in different ways</td>
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<td>Sharing paths of love gives us reason for the now</td>
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<td></td>
<td>Memories of our past give us strength to smile again</td>
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<tr>
<th>Verse 2:</th>
<th>What day is it? What is the time?</th>
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<td></td>
<td>This is our daily grind</td>
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<tr>
<td></td>
<td>Living in your changing world</td>
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<td>With such a confused mind</td>
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Repeat Pre-chorus
Repeat Chorus

<table>
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<tr>
<th>Verse 3:</th>
<th>Roles are changing, It’s frustrating</th>
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<tbody>
<tr>
<td></td>
<td>For both you and I</td>
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<td></td>
<td>It’s so draining, There’s no training</td>
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<td>To this we’re resigned</td>
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<tr>
<th>Pre-chorus 2:</th>
<th>Bridge moments of absence, I wonder where you are</th>
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<tr>
<td></td>
<td>I feel so sad that you’ve drifted this far</td>
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Repeat Chorus

Figure 4. Song Lyrics of True Spirit.

This songwriting process has drawn on insight-oriented approaches to activate emotion-focused and cognitive approaches to coping with the caregiver role. By encouraging carers to reconceptualise their problems, they transformed their views of problems as being insurmountable, to “uncover the positive aspects of a situation” and reframe them as an “opportunity for further growth” (Figueiredo et al., 2014, p. 217). Their whole mindset changed when
they acknowledged and accepted that they are not to blame and that they can benefit from searching for and highlighting the positive aspects of their circumstances. Therefore, this intervention is helpful because it aims to enable carers to accept what cannot be changed and embrace opportunities for positive experiences.

Music therapists wanting to support caregivers of PWD can utilize one, two or all three of these songwriting protocols. Each one has its own aim and does not need to be used in conjunction with the other approaches. That said, there are some challenges that clinicians need to consider when implementing such a protocol. Firstly, some carers have experienced a stronger need than others to debrief about their experiences and have a tendency to dominate the session. In these cases, careful containment is needed. The clinician may need to be quite assertive in winding up lengthy personal accounts in order to keep the whole group moving along and connected. Here, the clinician needs to balance the need to give carers space to debrief and share but also ensure all carers have an opportunity to recount their own experiences.

Another consideration of the group songwriting process is the composition of the group. Spousal carers of PWD share quite different experiences to those of adult children or other family carers. In the small number of groups who have participated in this protocol thus far, spouses tended to display more distress and greater difficulty reconciling role changes compared with adult children. More examination of this issue is needed before any conclusions can be drawn. However, it does beg the question as to whether homogenous or heterogeneous groups are of most benefit to family carers.

Finally, although carers of PWD have inherently different challenges to other types of carers (carers of people with mental illness, disabilities etc.), it is likely that some categories of carer challenges will be somewhat similar irrespective of the diagnosis of the care recipient. Therefore, this protocol may be relevant for other caregiving contexts. Further exploration of carer-focused music therapy protocols are needed to assist carers to manage their own health and wellbeing.

**Conclusion**

The songwriting protocol developed here is grounded in theories of stress, and coping emotion and problem focused coping strategies. In song 1, there is a particular emphasis on expressing negative feelings and reframing maladaptive thinking about caregiving experiences and abilities. This is to enable the carers to vent negative emotions and reframe their thinking to being more positive and less self-defeating. Song 2 focuses specifically on exploring the identity as a carer to ensure carers feel comfortable in their role and are not harboring resentment and ill-feelings about their role as a carer. Song 3 focuses on identifying healthy coping strategies that will enable the carers to cope during periods where their coping capacities are tested and there is a risk they may not cope with demands expected of them. This theory-informed protocol outlines the creative and therapeutic processes involved in creating a song with a focus on self-expression and insight, identity, and focused coping strategies that may help carers of PWD to transition into and manage the caregiver role. Further research is recommended to test the effectiveness of this protocol on wellbeing outcomes such as
anxiety, depression, burden, coping, and resilience.

References


Baker. *Songwriting protocol for caregivers* 30


O’Brien, E. Songwriting with adult patients in oncology and clinical haematology. In F. A. Baker, & T. Wigram (Eds.), Song writing methods, techniques and clinical applications for music therapy clinicians, educators and


Ornstein, K., & Gaugler, J. E. (2012). The problem with “problem behaviours”: a systematic review of the association between individual patient behavioral and psychological symptoms and caregiver depression and burden within the dementia patient–caregiver dyad. International Psychogeriatrics, 24(10). 1536–1552. doi.10.1017/S1041610212000737


Baker. Songwriting protocol for caregivers 32

*Australian journal of music therapy, 22*, 2-23.


In plain language:

Some music therapists are partnering with arts workers to promote participation in the arts for people with a disability. However, there is little research into the perspectives of arts workers or on the role of music therapists during these partnerships. This research aims to address this, by asking: “What roles do arts workers identify music therapists as playing during inclusive arts partnerships?”

Interviews were held with two arts workers who had partnered with a music therapist on a project that made the arts more inclusive of audience members with a disability. Arts workers identified that the music therapist: (1) helped arts workers cater to audience members’ needs, (2) helped audience members manage the arts experience, and (3) provided project coordination. This research demonstrates that music therapists have a role in strengthening the connection between arts workers and audience members with a disability.
Introduction

Inclusion and participation are central to disability rights (Disability Act 2006 (Vic); United Nations, 2007), and access to the arts is seen as particularly important (Office for Disability, 2010). Informed by Community Music Therapy theory, some music therapists are partnering with arts workers to promote access to the arts for people with a disability (Rickson, 2014; Shiloh & Lagasse, 2014; Stige & Aarø, 2012). Working in this framework often means adopting roles outside of traditional music therapy practice (Stige & Aarø, 2012), yet there is little literature describing what these roles might be. Furthermore, there is no literature at all who have partnered with a music therapist.

Arts workers’ perspectives on a music therapist’s role during an inclusive arts partnership

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Abstract

Inclusive arts are central to achieving disability rights. Some music therapists are working to promote participation in the arts for people with a disability by partnering with arts workers. However, the perspectives of arts workers involved in such partnerships have not been documented, and the roles that music therapists play are unclear. This research aims to address this gap in the literature, led by the question: “What roles do arts workers identify music therapists as playing during inclusive arts partnerships?” Interpretivist interviews were conducted with two arts workers who had partnered with a music therapist on a project that made the arts more inclusive of audience members with a disability. Thematic analysis of interview transcripts found three themes. Arts workers identified that during the partnership, the music therapist: (1) helped arts workers cater to arts patrons’ needs, (2) helped patrons manage the arts experience, and (3) provided project coordination. This research demonstrates that music therapists have a role in strengthening the connection between arts workers and arts patrons with a disability. Arts workers identified that the music therapist helped to remove barriers to participation for patrons, however this involved adopting roles outside of traditional music therapy work.

Keywords: inclusion, disability, inclusive arts, accessible arts, community music therapy (CoMT)
This leaves a limited understanding of how music therapists support arts workers to practice inclusively, and no understanding of music therapists’ roles from the perspective of the systems they engage in. This study aims to address these gaps in the literature, by documenting arts workers’ perspectives on the role of a music therapist during an inclusive arts partnership.

**Literature Review**

**Disability.**

The social model of disability states that disability is experienced when people with impairments face barriers to participation in the community (Oliver, 1990; United Nations, 2007). This represents a shift away from the medical model of disability as impairment, and instead places emphasis on social and cultural factors. Subsequently, promoting inclusion through removing barriers to participation is a key objective of disability rights advocates and government policy (Disability Act 2006, (Vic); Office for Disability, 2010).

The language used to describe people with a disability is important. Some people prefer person-first language, while others argue identity-first language is affirming and positive (Office for Disability, 2010). The word “inclusion” has also been criticised for embedding a sense of otherness and a need for assimilation (Austin & Brophy, 2015). In order to reflect the language used in current policy (Cultural Ministers Council, 2009; Office for Disability, 2010), the terms “inclusion” and “person with a disability” will be used in this report.

**Contemporary Music Therapy Practice.**

The development of Community Music Therapy (CoMT) as a theoretical framework has highlighted the value of music therapists working to promote community participation (Stige & Aarø, 2012). CoMT theory considers music therapy participants in relation to their community, exploring the connection between individuals and the systems they interact with (Stige & Aarø, 2012). As Stige and Aarø (2012) argue, music therapists need to engage in changing the system around participants, as well as continuing to provide individual support where needed (Stige & Aarø, 2012). Practicing in this framework often means that music therapists adopt roles outside of traditional music therapy work (Stige & Aarø, 2012). However, Pavlicevic and Ansdell (2004) argue that defining a music therapist’s role is less important than simply looking at what can be done to address need.

**Inclusive Arts.**

Inclusive arts is defined as arts that is participatory and inclusive of audience members, artists, or arts workers with a disability (Austin & Brophy, 2015). Inclusive arts are called for by both disability advocates and policy makers as the arts are an important part of cultural life, yet many people with a disability remain excluded from participation (Austin & Brophy, 2015; Office for Disability, 2010). The arts also provide a meaningful platform for advocating for disability rights (Office for Disability, 2010), and as Austin and Brophy (2015) state, art can disrupt public conception of disability. For these reasons, inclusive arts projects are a government priority in Australia (Cultural Ministers Council, 2009), with academic research and staff training listed as two strategies for overcoming barriers to participation (Office for Disability, 2010).

Informed by CoMT framework, a number of music therapists are now becoming involved in inclusive arts projects (Rickson,
2014; Shiloh & Lagasse, 2014; Soshensky, 2011; Stige & Aarø, 2012). Stige’s seminal case study demonstrated how music therapy promoted arts participation for a young person with Down syndrome (Stige & Aarø, 2012). Rickson (2014) and Shiloh and Lagasse (2014) qualitatively supported these findings, reporting that developing the inclusive practice of musicians provided new opportunities for people with a disability to participate in live music. Similarly, Soshensky (2011) found that inclusive arts helped to break down oppressive attitudes towards people with a disability, although these findings are limited as Soshensky’s (2011) methodology is unclear.

Of the inclusive arts literature, three music therapy studies describe a partnership with a person employed in the arts industry, otherwise known as an arts worker (Rickson, 2014; Shiloh & Lagasse, 2014; Stige & Aarø, 2012). Two of these studies detail the music therapist’s role during the partnership, although this was not the focus of the research (Rickson, 2014; Shiloh & Lagasse, 2014). Rickson (2014) philosophically stated that the music therapist had a political role during the partnership, supporting marginalised people to participate in a forum not usually available to them. Shiloh and Lagasse (2014) provided more concrete examples of the music therapist’s role which included providing access to supports and encouraging musical engagement. However, both of these articles presented this information informally and as separate to the research findings, reducing the robustness of the arguments presented. Soshensky (2011) does not describe the music therapist’s role at all, limiting the applicability of the research for therapists seeking to practice in inclusive arts.

Despite the importance of these partnerships in promoting inclusion, the perspective of arts workers has not been explored in the literature to date. Rickson (2014) and Shiloh and Lagasse (2014) explored the perspective of audience members of an inclusive performance, but did not document the perspectives of the musicians they partnered with. Arts workers are important, for as Stige and Aarø (2012) state, they have some power in the arts community and the values it upholds.

Research Question and Correspondence to Research Design

From the above literature, it is evident that more research is needed on the perspectives of arts workers involved in inclusive arts partnerships. Inclusive arts has been prioritised by disability advocates and in government policy (Austin & Brophy, 2015; Cultural Ministers Council, 2009), and supports a CoMT approach to practice (Stige & Aarø, 2012). Contemporary disability and music therapy theory emphasises the importance of engaging in cultural systems (Oliver, 1990; Stige & Aarø, 2012), yet arts workers’ perspectives have not been explored to date. Furthermore, it is acknowledged that music therapists need to adopt non-traditional roles when working in this framework, yet there is a lack of information into what these roles could be. Given this literature gap, as well as the current policy emphasis on academic research into inclusive arts (Office for Disability, 2010), there is a strong case for research that captures both the arts workers’ perspective, and explores music therapists’ roles in inclusive arts.

This research aimed to address in part the lack of literature documenting the perspectives of arts workers who have partnered with a music therapist. Specifically, the research aimed to understand what roles arts workers identified music therapists as
playing, so that music therapists can better understand how to support arts workers to be inclusive. The research was guided by the question: What roles do arts workers identify music therapists as playing during inclusive arts partnerships?

The research approach is informed by interpretivist epistemology, based on the belief that knowledge is constructed when experiences are individually interpreted (Hiller, 2016). In this project, the researcher was concerned with understanding arts workers’ perspectives of music therapists’ roles, and acknowledges that this understanding is embodied in context (Hiller, 2016). The research methodology aligned with an interpretivist epistemology and involved interview data collection with two participants and a thematic approach to analysis. As Hoskyn (2016) states, thematic analysis is not tied to a specific methodology, however a constructivist paradigm was adopted for this project. The research was approved through The University of Melbourne’s Human Research Ethics Department processes for student research with all relevant ethical guidelines adhered to.

**Methods**

**Research participants.**

Two arts workers participated in the study. Participant 1 worked for a metropolitan arts venue, and participant 2 worked for a large performing arts company. Both participants had worked with the same Registered Music Therapist (RMT) on an eight-month project that culminated in an autism-friendly performance of a professional music theatre show. The RMT involved worked at a special school, and collaborated with arts workers to enable the school students to attend the performance. In the three-way partnership, the arts workers and RMT each acted as a representative of their respective organisations. Participant 1 collaborated on behalf of the venue, Participant 2 represented the performers, and the RMT represented the school and students.

Throughout the article, the word ‘patron’ is used to describe the students forming the audience members for the autism-friendly performance. This is to reflect their primary role as audience members rather than as music therapy participants.

**Inclusion and exclusion criteria.**

Arts workers were defined as a person employed in the arts industry. Participants were required to be at least 18 years of age, speak English, and give informed consent, before being included in the research. Eligible participants needed to have partnered with an RMT on a project that aimed to make the arts more inclusive of people with a disability. Arts workers who had partnered with a music therapist more than five years prior to the interview were excluded.

**Sampling procedures.**

The participants were recruited through snowball sampling. The initial participant was identified through the researcher’s professional networks, and this participant then referred the second participant. Volunteer sampling was also used, in which the researcher placed an advertisement in the Australian Music Therapy Association weekly bulletin. However, no eligible participants responded. A timeline of the recruitment, data collection, and analysis is detailed in Table 1.
Data Collection.

In-depth, semi-structured interviews were conducted with participants, an approach recommended by O’Leary (2010) for under-researched topics. Small scale, in-depth approaches were preferred given the interpretivist design. During the interview, participants discussed their involvement in the inclusive arts partnership. Participants were asked what roles the music therapist had played during the partnership that contributed to building an inclusive arts community.

Pre-determined questions and probes were used during the interviews, although the order of questions was flexible. As stated by Minichiello, Aroni, and Hays (2008), use of these interview techniques ensures complexity and clarity of information during in-depth, semi-structured interviews. Interview recordings were transcribed by the researcher and formed the data for analysis, alongside reflections by the researcher.

Data Analysis.

Thematic analysis was used to analyse data, in which repeated patterns of meaning were searched for across the entire data set. This method is appropriate for constructivist and interpretivist paradigms, and it provides a straightforward method of analysis for first-time researchers (Braun & Clarke, 2006; Hoskyn, 2016). The analysis was inductive and aimed to give a rich overall description of the data set. This approach is recommended by Braun and Clarke (2006) when working in a new area of research. The analysis was at a latent level, in that the development of themes involved interpretative work by the researcher (Braun & Clarke, 2006).

The thematic analysis was informed by Braun and Clarke’s (2006) six-stage process, and performed using MAXQDA software. In Stage One, the researcher transcribed the interviews and recorded initial reflections of the data. Stage Two involved systematically assigning initial codes to participants’ responses across the entire data set and collating coded data in table form. During Stage Three, codes were collated into potential themes, with the accompanying data arranged alongside potential themes in table form. In Stage Four the researcher reviewed themes in relation to the entire data set, before naming and defining themes in detail during Stage Five. Stage Six involved compiling the analysis, further refinements to themes, and writing up results. Analysis was largely based on the interview transcripts, although voice tone and the researcher’s reflections also informed the analytic process.
Results
Three themes related to the role of the music therapist as identified by arts workers were found:

1. The music therapist helped the arts workers cater to patrons’ needs, by providing specialised knowledge on music and disability

2. The music therapist helped patrons manage the demands of the arts experience, by creating a sense of familiarity

3. The music therapist provided project coordination.

Table 2 provides examples of coded data associated with each theme.

Table 2
Examples of coded data for the three themes.

<table>
<thead>
<tr>
<th>Theme</th>
<th>Examples of coded data</th>
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| 1. The music therapist helped the arts workers cater to patrons’ needs, by providing specialised knowledge on music and disability | • “She was schooled in how they’re conditioned and how their disability would basically make them react to certain sounds” (Participant 2)  
• “They guided us on basically all the needs of the [patrons]” (Participant 1)  
• “She knew how to tweak and design what we played and showed them” (Participant 2) |
| 2. The music therapist helped patrons manage the demands of the arts experience, by creating a sense of familiarity | • “[Music therapists] are the key regulators” (Participant 1)  
• “[Music therapists] make it a very predictable environment” (Participant 1) |
| 3. The music therapist provided project coordination | • “Just really getting a sense of logistics and getting a whole kind of community in and out” (Participant 1)  
• “[The music therapist] really led the communication with the project partners, internal communications with her executive, with the [special school], with the [families] and so on” (Participant 2) |
Theme 1: The Music Therapist Helped Arts Workers Cater to Patrons’ Needs

The music therapist brought specialised knowledge of music and disability, which helped arts workers cater to the needs of patrons with a disability. Both participants identified that because of her training, the therapist understood how a patron with a disability might experience the performance. As participant 2 stated: “She was schooled in how they’re conditioned and how their disability would basically make them react to certain sounds, certain environmental factors... that was her specific knowledge in this partnership”. Both arts workers valued this understanding of the interaction between music and disability, and participant 2 emphasised that “it was really important that she had that music background”. Arts workers also described how this specialised knowledge resourced them with information on disability that they otherwise wouldn’t have had. As participant 1 explained: “[The music therapist] guided us on basically all the needs of the [patrons]...you know, I work here and...I’ve got a background in working with people with disabilities but I don’t understand the needs of [patrons] with autism”. Both arts workers continually identified that the music therapist enabled them to tailor the event to patrons’ needs, through sharing specific and specialised music therapy knowledge.

The music therapist also helped arts workers cater to patrons’ needs by guiding modifications to the venue and performance. Participant 1 stated that the music therapist provided clear instructions on changing the venue, including ticketing system adaptions, creating a chill-out space, and providing sensory items. As participant 2 described, the music therapist also instructed changes to the performance content, guiding the tempo and volume of music, the lighting, and the inclusion of greeting songs. Participant 1 described the therapist’s role in determining the musical genre presented, stating “they can guide us in saying, actually that show is going to be too narrative driven, [whereas] something like musical theatre is really good...something else is just too much sensory overload”. Similarly, participant 2 identified that the therapist instructed on ensemble size, advising “a larger orchestra would obviously be more disturbing than it would be enjoyable”. Both statements demonstrate how the therapist led the modifications to the arts experience, and that this helped the arts workers better cater to patrons’ needs.

In helping arts workers cater to patrons’ needs, the music therapist increased the disability awareness of both arts workers and venue staff. This was partly through training, in which the therapist met with venue staff prior to the performance and provided information on potential needs of people with autism. As part of this training, the therapist provided cues and strategies for staff and demonstrated helpful ways to interact with patrons. The following excerpt illustrates this role:

“[The therapist] explained how the [patrons] would be moving through the front of house, and the area’s leading into the theatre...and, you know what could happen and what could possibly be a strange situation for people who had not necessarily dealt with [patrons] with disabilities before. [She] gave them examples of situations, just to give them some tools on how to handle certain situations”. (Participant 2)

The therapist also raised staff’s disability awareness informally. As participant 1 stated,
“part of working with music therapists, is also getting to know the kind of ways that they use”. Here, participant 1 comments on the disability awareness gained by observing how the music therapist interacted with patrons in preparation for and during the event. Through observing the music therapist, participant 1 became familiar with some of the therapist’s methods and approaches of engaging with people with autism. Both arts workers identified that through observing the music therapist work, they better understood patrons’ needs.

Finally, participants identified the therapist’s role in promoting patrons’ wellbeing outcomes, underlying the changes to the performance and venue. Participant 1 described the therapist as playing a “risk assessment” role, while participant 2 stated the therapist promoted “wellbeing and feeling good ... the physical kind of experience of joy”. Both arts workers related this wellbeing-promotion role to the therapist’s specialised knowledge, with participant 2 stating “not any kind of [worker] could have provided the [patrons] with a profound experience like she did”. Interestingly, participant 2 suggested the patrons’ disability helped them respond positively to the music, when the content was modified appropriately. This is shown in the following statement:

“[Patrons] with autism in particular, [the therapist] explained that they like repetitive patterns, clapping for example, that would calm them down... she knew how to tweak and design what we played and showed them, around hopefully those best outcomes, emotionally and physically”. (Participant 2)

These excerpts demonstrate how the music therapist’s specialised knowledge helped arts workers to provide a meaningful and positive experience of the arts for patrons, by better catering to their needs.

**Theme 2: The Music Therapist Helped Patrons Manage the Demands of The Arts Experience**

The music therapist helped patrons to manage the arts experience by creating a sense of familiarity. Participants described the music therapist’s role as “setting the scene” (Participant 1), making patrons “feel welcome and at home” (Participant 2). The music therapist created this sense of familiarity through both her use of music, and her pre-existing relationship with the patrons. Both arts workers identified how the music therapist used familiar greeting songs at the event, and had played music from the performance to patrons in the months prior to the event. Patrons were also supported during the event by their pre-existing relationship with the therapist. As participant 2 explained, patrons “identified [the] experience with her and her person”. In this statement, Participant 2 reflects on how patrons were able to identify the arts experience with the music therapist’s physical presence and style of interacting. Participant 2 also commented that the music therapist “gave the whole event a frame in a way, through her person and her music, that the [patrons] would feel very comfortable with”. These quotes illustrate how the music therapist’s familiar music and presence helped patrons manage the novel experience of the arts event.

Key to this familiarity was the music therapist’s role in preparing patrons for the arts experience. Participant 1 and 2 explained that the music therapist led the preparation, and that this role began many months prior to the inclusive arts event. Participant 1 described how the therapist prepared patrons...
for the venue, by creating visual forewarning resources and bringing patrons to the theatre prior to the event in a “meet your seat excursion”. Similarly, participant 2 described how the therapist musically prepared patrons by adapting the performance music to voice and guitar. The following excerpt illustrates this musical preparation:

“What [the music therapist] did a lot was the singing, singing the tunes, singing some very simple lyrics, singing them over and over again... so the [patrons] have that kind of enjoyment of “Oh, I know this song!”, kind of recognition factor, and that worked really well” (Participant 2).

This quote illustrates how the music therapist’s role in preparing patrons for the event was central to their sense of familiarity during the arts experience.

Each arts worker also identified that the music therapist enabled patrons to manage the arts experience by helping patrons regulate. Arts workers described the therapist’s role as “pacifying” (Participant 2), and that she helped “minimise the anxiety” (Participant 1) for patrons. By supporting regulation, the music therapist enabled patrons to negotiate challenging aspects of the arts experience. This role is illustrated in the following excerpt:

“[Music therapists] are the key regulators if you like, in my experience, on what is a very busy performing arts centre with lots of anxieties and lots of sensory overloads... they provide that sort of calming, regulating, preparing role, which I think is really, key”. (Participant 1)

Both participants also described how the music therapist helped patrons manage the experience, by creating a familiar and controlled environment. As participant 1 stated, “by doing the strategies like the welcome song...they make it a very predictable environment, and I think it’s mainly from their practical way of being with the students”. This familiar, structured environment helped patrons regulate and enabled them to manage challenges presented by the arts experience.

Unlike the arts workers, the music therapist had a long-term relationship with the patrons through her work at the special school. As the music therapist was the key person engaging patrons in the performance preparation, patrons were able to identify the performance experience with the music therapist. The music therapist’s familiar music, physical presence, and style of interacting allowed patrons to draw on the pre-existing relationship to assist with regulation during the novel performance experience.

Theme 3: The Music Therapist Provided Project Coordination

Each arts worker identified that the music therapist played a coordinator role, overseeing the entire process of the project. This role began with pre-event preparation, and continued through to post-event debriefing and evaluation. Participants described the music therapist’s role as “spokesperson” (Participant 2) and providing the “liaison” (Participant 1) between the venue and the patrons’ needs. Participant 2 described this liaison role in detail, stating that the music therapist led the “communication with the project partners, internal communications with her executive, with the [special school], with the [families] and so on”. Participant 1 and 2 also identified how the music therapist organised transport for patrons, and managed the logistical aspects of project execution.
Participant 1 described this role as: “Just really getting a sense of logistics and getting a whole kind of community in and out… getting around the venues, space and safety, they really took the key role in all of that, just logistics wise”. This quote illustrates how arts workers identified the music therapist as leading practical aspects of project execution. Finally, both arts workers noted that the music therapist played an evaluation role, contributing to post-project debriefing, and conducting informal evaluative discussions with patrons’ family members. In contributing to evaluation, organising project logistics, and leading communication, the music therapist adopted a coordinator role during the partnership.

**Discussion**

Based on the findings, it could be proposed that the primary role of the music therapist was to support the connection between arts workers and patrons. Arts workers identified that the music therapist’s role was as much about changing their arts practice, as it was about supporting patrons with a disability. This focus on the relationship between patrons and arts workers aligns with CoMT theory, in that the music therapist examined patrons’ needs in relation to the system they interacted with. The music therapist’s role in changing systems while supporting individual need also reflects CoMT theory. As Stige and Aarø (2012) state, music therapists may need to continue providing individual care in order to facilitate community-oriented goals. Interestingly, arts workers identified that in order to perform this role, the music therapist required specialised music therapy knowledge and a pre-existing relationship with patrons. This suggests that music therapists may have something unique to offer in inclusive arts, particularly with regard to enabling access for audience members with a disability.

The findings are significant in relation to the social model of disability and recent literature on inclusive arts. Arts workers identified that part of the music therapist’s role was to remove or minimise barriers to participation for patrons, supporting a fundamental ethos of the social model of disability. These findings are also similar to those of Rickson (2014) and Shiloh and Lagasse (2014), who reported that developing arts workers’ inclusive practices enabled greater participation for people with a disability.

Interestingly, arts workers identified that the removal of barriers involved providing appropriate supports such as sensory items and a chill-out space. This mirrors Shiloh and Lagasse’s (2014) statement that a role of the music therapist during inclusive partnerships is to ensure access to supports for audience members with a disability. Arts workers also identified that minimising barriers to participation involved training staff, and raising staff’s disability awareness. This is one of the key strategies recommended by the Office for Disability (2010) for enabling access to the arts for people with a disability. These findings have practical implications, in that music therapists could offer to provide supports when considering a partnership with an arts worker. Furthermore, music therapists could potentially adopt staff training and disability awareness roles during partnerships, aligning with government policy for developing inclusive arts practices.

Importantly, arts workers identified a number of roles that fall outside of traditional music therapy practice. This supports CoMT theory (Stige & Aarø, 2012), and reflects sentiments expressed by Soshensky (2011) that moving into a broader social context can
extend the roles of music therapists. The role described in Theme 1 (helping arts workers cater to patrons’ needs) was outside of typical music therapy work, and the role in Theme 3 (project coordination) had little to do with direct delivery of music therapy clinical services at all. However, both roles were important for promoting participation and inclusion, implying to practitioners that all professional skills are potentially therapeutic. Music therapists may need to be willing to adopt non-traditional roles, and invest in general managerial skills, in order to achieve participation goals. This support’s Pavlicevic and Ansdell’s (2004) proposal that defining the music therapist’s role may be less important than simply looking at what can be done to meet needs at a particular point in time.

Limitations and Recommendations for Future Research

A number of limitations are apparent in the current study. First, this study does not capture the voices of the patrons themselves. In this way, the study may be contributing to patrons’ continued marginalisation, and potentially limiting the relevance of such music therapy roles to their priorities and interests. While patrons’ exclusion from participation was due to the ethics guidelines for student research, it is nonetheless problematic. More research is needed into the perspectives of patrons, including what roles patrons identified the music therapist as playing that supported their interests and access to the arts.

Second, while the findings presented here are useful to music therapists working with audience members with a disability, it is unknown to what extent they can be applied to music therapists promoting the inclusion of artists or arts workers with a disability. More research is needed that explores music therapists’ roles in other areas, such as promoting equitable access for musicians and arts workers with a disability.

Conclusion

Inclusive arts are central to promoting disability rights, yet there is limited literature documenting the role of music therapists in inclusive arts partnerships and the perspectives of arts workers involved. Consequently, there is little information on how music therapists can engage with arts workers in their community to promote the inclusion of people with a disability, and what roles arts workers identify as helpful to developing an inclusive arts practice. This report aimed to address this gap, by asking “what roles do arts workers identify music therapists as playing during inclusive arts partnerships?” The findings show that the music therapist helped arts workers cater to patrons’ needs, supported patrons to manage the arts experience, and provided project coordination. These findings have practical implications, providing insight into roles that music therapists can adopt in their clinical work that achieve increased access to the arts for people with a disability. Performing these roles aligns with contemporary music therapy theory, current government policy, and a social model of disability approach to practice. The results may allow music therapists to better understand how to support arts workers to practice inclusivity, and suggest that music therapists have a role to play in supporting the connection between music therapy participants and arts workers in their community.
References


Exploring the music therapist’s use of mindfulness informed techniques in practice

Medcalf, B.


In plain language:
Despite the extensive research that demonstrates the efficacy of a mindfulness-based approach when working therapeutically, there is limited literature that investigates its integration into music therapy. This study explores the experience of four music therapists who describe the use of mindfulness-informed techniques in practice. Data was collected via interviews and analysed using the systematic method of phenomenological microanalysis, which captured the fundamental elements of the participants’ experience. Results reveal the participant’s aspirations for employing this method, its concurrent enhancement of their professional and personal experience as well as its capacity to engender client empowerment and other positive outcomes. It is also acknowledged that in some cases, its use can be contra-indicated and the benefit of formal training in the facilitation of mindfulness-based programs is highlighted.
Original research

Exploring the music therapist’s use of mindfulness informed techniques in practice

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Abstract
Despite the extensive research that demonstrates the efficacy of a mindful approach when working therapeutically, to date, there is limited literature that investigates its integration into music therapy. The purpose of this phenomenological study was to explore the experience of four music therapists who incorporate techniques informed by mindfulness into their music therapy practice. Data was collected via one-on-one Skype interviews with each participant. These interviews were analysed using the method of phenomenological microanalysis from which, five global meaning units emerged capturing the fundamental elements of the participants’ experience. These included (1) the integration of music and mindfulness, (2) client empowerment, (3) the benefits of the practitioners’ personal relationship with mindfulness, (4) positive client outcomes and (5) the parameters of a mindful approach. These findings illuminate how mindfulness-informed techniques might be applied in music therapy, as well as potential benefits to the client and practitioner alike. Furthermore, they highlight the importance of maintaining an awareness of the technique’s limitations with relation to the client’s unique circumstance. Additionally, formal training regarding the facilitation of mindfulness in a clinical setting is advocated so that music therapists may be best positioned to communicate a mindful approach, develop therapeutic skills and enhance the therapeutic encounter.

Keywords: music therapy, mindfulness, phenomenology, empowerment

Introduction
The word ‘mindfulness’ is commonly associated with Buddhism and its teachings regarding the human experience of suffering. Buddhist psychology teaches that suffering emerges from our natural tendency to resist or react to experiences in our daily life (Shapiro & Carlson, 2009).

In an effort to diminish suffering, mindfulness is cultivated as a means through which one can observe the mind’s patterns of resistance and reaction, to relate to them in an accepting manner and respond with discernment and clarity (Shapiro & Carlson, 2009; Siegel, Germer & Olendzki, 2009). Removed from the explicit context of Buddhist tradition and applied to the Western psychological and psychotherapeutic domain, the meaning of mindfulness has been defined more specifically as: the conscious act of bringing
attention into the experience of the present moment, and attending to thoughts, feelings and physical sensations with a non-judgmental awareness, acceptance and compassion (Bishop et al., 2004; Kabat-Zinn, 2003; Siegel et al., 2009). It is proposed that by harnessing these qualities, clients can increase awareness of unhelpful thought patterns and behaviours, and learn to respond more effectively to improve emotional and psychological functioning, health and well-being (Kabat-Zinn, 2013).

In their book, *The Art and Science of Mindfulness*, Shapiro and Carlson (2009) state, “through mindfulness practice, re-perceiving occurs, facilitating a shift in perspective. This shift, we suggest, is at the heart of the change and transformation affected by mindfulness practice.” (p.103). They propose a theory for the function of mindfulness in fostering change, change toward the way we perceive our thoughts and ultimately how we respond to them.

In 1979, Dr Jon Kabat-Zinn pioneered the Mindfulness-Based Stress Reduction program (MBSR), the original mindfulness-based intervention that began as a program offering those experiencing chronic illness a ‘self-regulatory coping strategy’ (Kabat-Zinn, 1982, p.33). This program runs for a period of eight-weeks and involves participants coming together once weekly for 3 hours to receive intensive training in mindfulness meditation and exercises. Additionally, in between sessions, participants are instructed to practice on a daily basis for at least 45 minutes, as the principle of MBSR is encouraging mindfulness as a way of life (Kabat-Zinn, 2013; 2017). Over the eight-week period, the premise is that individuals will begin to become more aware of the onset of symptoms of stress and pain associated with their condition. Instead of reacting to these cues, it is intended that they will respond more reflexively, with a sense of acceptance and non-judgment, reducing the severity of symptoms and cultivating a sense of control and resilience (Kabat-Zinn, 1982; 2013). In an article regarding the origins of MBSR, Kabat-Zinn (2011) describes how one of the main motivations behind designing this program and introducing mindfulness into mainstream society was to cultivate a deeper level of compassion, wisdom and “understanding of the mind/body connection via new dimensions of scientific investigation” (p.286).

Since this time, interventions that employ mindfulness as a key component of treatment have flourished, offering a variety of well-documented and evidence-based approaches such as Mindfulness-Based Cognitive Therapy (MBCT); (Segal & Williams, 2012), Mindfulness-Based Relapse Prevention (MBRP); (Bowen, Chawla & Marlatt, 2014) and Mindfulness-Based Eating Awareness Training (MB-EAT); (Kristeller & Wolever, 2011). This continually growing body of research provides us with evidence of the effectiveness of these mindfulness-based programs (MBP) on positive health and well-being outcomes. Various outcomes include a decrease in the experience of anxiety and depression (Khoury et al., 2013; Strauss, Cavanagh, Oliver & Pettman, 2014), increased abilities in emotional and behavioural regulation (Gu, Strauss, Bond, & Cavanagh, 2015; Keng, Smoski & Robins, 2011), a reduction in substance craving (Witkiewitz, Bowen, Douglas, & Hsu, 2013), reduction in chronic pain (la Cour & Petersen, 2015) and improved quality of life (Samhkanian, Mahdavi, Mohamadpour &
Rahmani, 2015). Music therapy literature also demonstrates the efficacy of music therapy methods in supporting populations experiencing depression and anxiety (Gutiérrez & Camarena, 2015; Klainin-Yobas, Oo, Suzanne Yew, & Lau, 2015), substance related disorders (Bruscia, 2012; Silverman, 2014), chronic pain (Bradt, Dileo, Grocke & Magill, 2011) and enhanced skills in emotional regulation (Foran, 2009; Moore, 2013).

Despite the demonstrated outcomes for both approaches, there appears to be limited literature that investigates the explicit connection between music and mindfulness and how they might function when applied simultaneously in the context of music therapy. For the author, a desire to understand more about this connection developed when, as a music therapy student, she observed an 8-week music therapy program that applied mindfulness as a fundamental aspect of the therapeutic process. As a result, this research paper was originally formulated and submitted as a minor thesis for her post-graduate qualification in Music Therapy in 2015. It is important to note that despite bringing mindfulness into daily life experiences and engaging in a regular mindful yoga practice, the author does not profess to have a time-honoured or disciplined meditative practice, and has not yet undertaken clinical training in mindfulness.

An article published in the *Journal of Creativity in Mental Health*, by Eckhardt and Dinsmore (2012) proposes an intervention that combines mindfulness with music listening as a treatment for depression. The described approach employs music as an emotional stimulus; a “springboard” (p. 177) into verbal discussion around the experience of certain emotions and a mindful awareness as a way of acknowledging, exploring and ultimately developing insight into these emotions. The potential benefits of listening to music mindfully have also been described by Graham (2010) who posits that by providing music or sound as an attentional target, clients can practice shifting awareness between external stimuli and inner thoughts and emotions. It is his belief that by training one’s attentional capacity through exercises that encourage focused listening, people can strengthen awareness and tolerance of unhelpful, ruminative thoughts.

The function of mindfulness within the practice of music therapy has been considered by Fidelibus (2004), whose doctoral dissertation explores the music therapist’s relationship with mindfulness during clinical improvisation. He illuminates the potential of improvisation to bring the therapist into the moment, to expand his/her capacity to observe and respond non-judgmentally, and to limit engagement with habitual or overly analytical thinking (p.219). Furthermore, there is music therapy literature that describes the application of mindfulness in conjunction with receptive music therapy methods such as relaxation in palliative care (p.115-117, Grocke & Wigram, 2007) and imagery exploration in drug and alcohol rehabilitation (Van Dort & Grocke, 2013). In sharing their rationale behind the use of music to enhance a mindfulness activity, Van Dort & Grocke (2013) state:

> Music provides a focus for the experience of the client, in that melody and rhythm draw the person’s attention inward, and changes in harmony, instrumentation, and dynamics...
maintain the listener’s interest …The music provides a listening experience within which the client can become aware of feelings and other perceptions in a manner that promotes understanding and insight (p.117).

Whilst the literature underpinning the usefulness of music in combination with mindfulness is far from abundant, it enables us to reflect upon its potentialities. In recent years, a quantitative pilot study by Lesiuk (2015) aimed to investigate the effect of what is described as “Mindfulness-Based Music Therapy” on improving mood and attention in women receiving chemotherapy for breast cancer. Each participant received four, weekly individual one-hour sessions and each week a new mindfulness theme was introduced in combination with a different music experience. Results showed a significant increase in attention, positive mood state and in particular, a decrease in the participants experience of fatigue. However, in notable contrast to other evidence based methodologies such as MBSR and MBCT, there is no mention of any form of mindful meditation being included in the sessions, nor had the facilitators undertaken formal training in mindfulness.

In order to support the integrity of MBP during a time of exponential growth and interest, Crane et al., (2016) recently developed a framework elucidating the essential elements of MBP. According to this framework, MBP “engages the participant in a sustained intensive training in mindfulness meditation practice, in an experiential inquiry-based learning process and in exercises to develop insight and understanding” (p. 994). It is also essential that the MBP teacher “has engaged in appropriate training and commits to ongoing good practice” (p. 995). Whilst this study proposes an exploration of programs, which were non-invasive, time efficient and clearly beneficial to the participants, it is unclear as to whether these outcomes could be attributed to strengthened skills in mindfulness, the music therapy intervention, or a combination of the two. With respect to the framework outlined by Crane et al., (2016), further investigation into what could be considered a Mindfulness-Based Music Therapy program would be of value.

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In order to become an instructor of methodologies such as MBSR and MBCT one must undertake extensive training, personal practice and supervision to ensure consistency and integrity are maintained (Crane et al., 2016; Mindfulness Training Institute Australasia, 2017; Woods, 2009). The credence that mindfulness cannot be communicated authentically without a dedicated commitment to practice is firmly reflected in the literature (Kabat-Zinn, 2003; 2017; Shapiro & Carlson, 2009, pp. 15-29). As elaborated by Crane et al., (2016) MBP teacher training not only develops sound theoretical knowledge, but the understanding that at the heart of facilitating is the embodiment of mindful qualities that consequently nurtures the client’s experiential understanding (Kabat-Zinn., 2017).

This study acknowledges the current gap in the literature and endeavours to contribute to further reflection by drawing upon the experience of four Registered Music Therapists (RMTs) who described their own inclusion of mindfulness into practice, creating an opportunity to reflect, share and ultimately
contribute their knowledge informing their practice. To holistically understand their experience, the qualitative research approach of phenomenological inquiry was chosen (Finlay, 2013). More specifically, McFerran & Grocke’s (2007) developed method of Phenomenological Microanalysis was adopted. Phenomenology recognises that the human experience is complex and cannot be generalised, valuing the unique perception of the individual. Applying a phenomenological approach to research involves exploring the individual ‘lifeworld’, with regard to the phenomena under investigation (Finlay, 2013, 2014; Forinash & Grocke, 2005), capturing the fundamental meaning behind the described experience and illuminating essential features common to all (McFerran & Grocke, 2007, p.269). Furthermore, such as with the practice of mindfulness, while receiving and reflecting upon participant descriptions, phenomenological research advocates that the author be wholly present, with an attitude of openness, receptivity and curiosity (Finlay, 2014, p.123). Therefore, investigating the music therapists’ experience in this manner paid respect to the phenomenon of mindfulness itself.

Method

Participants.

Information regarding the research topic was distributed through the Australian Music Therapy Association weekly bulletin and potential participants were invited to contact the author via email. One personal contact was also invited via email. The University of Melbourne Human Research Ethics Committee approved both methods of recruitment. A consent form and plain language statement were sent via email and participants affirmed participation and permission to audio record their interview by signing and returning necessary forms to the author.

Participants were eligible if they were RMTs who had used or were currently using mindfulness in practice. There was however, no prerequisite for inclusion regarding formal or comprehensive training in mindfulness-based programs such as MBSR or MBCT. As diversity among participants is recommended when undertaking Phenomenological Microanalysis (McFerran & Grocke, 2007), there were no restrictions placed upon age, gender, or long or short-term experience using mindfulness. There were also no prerequisites as to what population/s or demographic a participant might engage with when using these techniques. Pseudonyms have been used in the interest of confidentiality.

Data collection.

In order to gather rich descriptions of the participants’ experience, one-on-one, in-depth interviews were carried out via Skype. A semi-structured interview style was chosen (Forinash & Grocke, 2005; Kvale & Brinkmann, 2009), which required a list of questions to be generated. Since the author possessed no previous experience carrying out phenomenological research interviews, having these pre-articulated questions enabled the focus to be maintained on gathering information with specific reference to the question and redirect any tangential discussion (Kvale, & Brinkmann, 2009; McFerran & Grocke,
Each interview was audio recorded and transcribed verbatim.

**Data analysis.**

In an effort to maintain authenticity before the interview process, the author engaged in an integral part of qualitative research known as ‘self-inquiry’ (Bruscia, 2005) or ‘epoche’ process (Moustakas, 1994). This process required assumptions, beliefs and expectations to be identified and assisted the author to remain aware of how preconceptions might influence interpretations during data analysis (McFerran & Grocke, 2007, p.271). Again, drawing parallels between phenomenology and mindfulness, this process required the author to draw upon the qualities of acceptance, curiosity and non-judgement to go beyond preconceptions and remain open to the unfolding of meaning in the data.

Phenomenological Microanalysis is a systematic seven-step process requiring iterative contemplation of the different layers of meaning in each experience (McFerran & Grocke, 2007), which is reached through a deep “dwelling” and recursive re-ordering of the data (Finlay, 2015, p.1). The collective, significant and individual themes that developed from the process were categorised into Global Meaning Units (GMU), which collectively constitute the end product of analysis, the Final Distilled Essence, representing the essential features of the participants’ experience. The final result was then sent to each interviewee to verify its authenticity and affirmed or adjusted accordingly.

**Results**

Three participants contacted the author of their own volition and the personal contact accepted their email invitation making the total number of participants four (1 male and 3 females). Each participant worked in a different area of practice, offering further diversity. Table 1 outlines relevant information regarding each participant below.

<table>
<thead>
<tr>
<th>Participant</th>
<th>Area of practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tracey</td>
<td>Palliative care</td>
</tr>
<tr>
<td>Alex</td>
<td>Dual diagnosis (Mental health challenges and substance abuse)</td>
</tr>
<tr>
<td>Jill</td>
<td>Children with intellectual disabilities &amp; self-care for ‘helping professionals’</td>
</tr>
<tr>
<td>Louise</td>
<td>Young people (14-24 years) receiving current or post cancer treatment</td>
</tr>
</tbody>
</table>

As outlined in Table 2, five GMU and their corresponding themes emerged as a final result of the aforementioned process of analysis.
Table 2
*Global Meaning Units* 1-5

<table>
<thead>
<tr>
<th>Global Meaning Units</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The integration of music and mindfulness</strong></td>
<td>Music is effective as a means to facilitate and sustain engagement in mindful practice. Using the clients’ preferred music is an effective way to motivate interest in mindful practice. Active music making can enable the individual to bring their attention into the present moment and offers opportunities to practice mindful skills.</td>
</tr>
<tr>
<td><strong>Client empowerment</strong></td>
<td>Mindfulness is employed because of a desire to provide a method that could enable empowerment of the individual.</td>
</tr>
<tr>
<td><strong>Benefits of practitioners’ personal relationship with mindfulness</strong></td>
<td>As a practitioner, personal knowledge and experience with the benefits of mindful practice can enable a deeper client-therapist connection. Mindful qualities stimulated through practitioners’ own personal engagement in mindful practice can positively impact their own lives. Aligning with an approach that is congruent with the practitioners’ belief system can enhance therapeutic presence.</td>
</tr>
<tr>
<td><strong>Positive client outcomes</strong></td>
<td>Mindfulness training can enable the individual to become more objective about their experience and to enhance their ability to make positive changes. Various positive client outcomes are attributed to engagement in mindfulness training. Mindful interventions combined with musical interventions provide positive outcomes.</td>
</tr>
<tr>
<td><strong>The parameters of a mindful approach</strong></td>
<td>It’s important for the practitioner to be aware of the client’s physical, emotional or mental circumstance and acknowledge that a mindfulness-based intervention may not be the appropriate choice. Each context and client is unique and it’s important to observe, reflect and adapt your intention to suit. Mindfulness is an intervention best applied and developed over time.</td>
</tr>
</tbody>
</table>

**Final distilled essence.**

Each of the four RMTs who participated in this study expressed a strong desire to incorporate mindfulness into their practice as they believed in its ability to engender a sense of empowerment in the individual. In addition, music was regarded as a versatile tool that can be used to encourage engagement in mindful practice, sustain attention and facilitate mindful skills. Furthermore, the practitioner’s own personal relationship with mindfulness was seen as a valuable means to understanding the client’s experience with developing mindfulness, concurrently deepening the empathetic connection and enhancing
therapeutic presence. Participants also described a variety of positive client outcomes that they attributed to engagement in mindful practice. However, it was acknowledged that a mindful approach is not always appropriate and an awareness of its parameters with regard to each individual circumstance is important.

Discussion

One intention for embarking upon this research was to contribute further insight into the application of mindfulness within music therapy. For this reason, each participant was asked the question: “How do you describe your incorporation of mindfulness techniques into your music therapy practice?” While it is recognised that each person’s approach was exclusive to their context and experience, there were significant similarities that emerged, which are discussed in the following 3 themes relating to GMU 1. It is important to note that the described techniques are not prescriptive but rather insights into how mindfulness-based theory has informed, enriched and been uniquely incorporated into each participant’s practice of music therapy.

GMU 1 - The Integration of Music and Mindfulness

Theme 1.
The effectiveness of music as a means to encourage and sustain engagement in mindful practice was the most common theme to emerge from the data. Each participant acknowledged that an individual was more likely to engage in a mindfulness task (such as guided meditation, setting intention or increasing body awareness through yoga postures) when music was available as a purposeful source for which attention could be directed. Alex states: “I find that the people I work with are much more able to do a mindfulness exercise with music ...Their attention span and capacity is sustained by at least 3-fold compared to the same exercise without music.” For Alex, music is an unmistakable assistance to engagement with mindful exercises and is a means through which the individual can maintain and shift awareness to, whilst acknowledging thoughts. Tracey also describes choosing music to enable the individual to “feel held in the space, but not distracted”, while for Jill, “music was used as an adjunct when setting intention and drawing attention to the breath or during guided meditations”. Further to this, participants discussed the importance of the type of recorded music they chose or how they played their instrument in order to maintain this engagement.

Through their training in music therapy, RMTs learn and develop understanding of how the elements of music can affect a person’s state of being (Grocke & Wigram, 2007, pp.45-60) and how to apply active and receptive musical experiences to reach therapeutic outcomes (Baker & Wigram, 2005; Wheeler, 2014; Wigram, 2004). The participants in this study offered insight into how this pre-understanding influenced their choices. For example, Louise emphasises the importance for her to find and work with music that is calm yet has enough interest to gain a client’s attention:

“When I first began choosing music for practicing mindfulness I took a little bit from relaxation ideas, but the purpose is not to be relaxed. So, there had to be things in the music that they could pay attention to and notice but it couldn’t be too busy, as
I wanted to allow space for thoughts to bubble up.” Similarly, Tracey describes her purposeful consideration of musical elements to create a holding space that doesn’t distract but rather deepen the client’s focus, creating an environment to encourage the development of mindfulness:

“I’ve got a few tracks that I would use that generally have a sense of long phrasing, so that the breath is encouraged to deepen. Ah, they’re repetitive so that we’re not catching melodies or anything like that. Nothing too volume-wise, it’s not going too loud or soft, nothing too dynamic.”

Similar to the rationale of Van Dort & Grocke (2013), participants shared how they thoroughly consider a number of elements when choosing music. That is, both the music’s ability to provide a point of focus to stimulate awareness but not consume attention and music that is not so demanding that it takes away from the process of observing thoughts.

By cultivating sustained attention through mindful practice, it has been suggested that the individual is better positioned to enhance his/her awareness, enabling a more effective response to changes in the environment (Jha, Krompinger & Baime, 2007). As proposed by Graham (2010) and demonstrated by Lesiuk (2015), focused music listening has the potential to promote a person’s attentional capacity. The experience of the participants in this study could be seen to demonstrate this conclusion, as their described use of appropriate music was to engage and sustain the individual’s focus on a mindful task. However, further study into whether a mindfulness-based approach in music therapy assists in the long-term development of mindful skills such as increased affect tolerance, decreased ruminative thinking and a greater sense of non-judgmental awareness would be desirable.

**Theme 2.**

Using the clients’ preferred music was seen as an effective way to motivate interest in mindful practice by both Jill and Louise, with Louise discussing her use of individuals’ preferred music as “the hook for the practice”. In Louise’s experience, “the most appropriate music to use for encouraging engagement is the person’s choice” thus providing “a point of interest to motivate their engagement”. Jill also encourages the individual to choose short songs they favour to demonstrate the relative ease with which one can introduce the practice into their lives; “It’s not so daunting... sitting down with a song that you’re already familiar with... its only three and a half or four minutes.”

However, in notable contrast to this is Tracey’s preference to use unfamiliar music. “I should be clear too, I try to use music that’s not familiar. I also try to do that on purpose so they don’t have any attachment prior to the music.” In her experience working in palliative care, a lot of the individuals she works with are filled with anxiety brought on by a busy, ruminating mind. She believes that for some, “mindfulness offers a productive way of channelling that energy of the mind into an awareness rather than a rumination.” By using unfamiliar music, it is her intention to create a holding space that supports the development of mindful qualities, such as awareness, understanding
and acceptance of the individual experience.

As discussed, Jill and Louise describe how familiar music is a way to spark interest in the practice of mindfulness and how demonstrating its incorporation into already established rituals, such as listening to music, might cultivate curiosity and potentially begin the development of a long-term relationship with the practice. Although firm conclusions can’t be drawn, perhaps this could be seen to echo Eckhardt and Dinsmore’s (2012) proposal for mindful music listening and their belief that music is an effective “springboard” into the practice of mindfulness (p. 182).

Conversely however, it is worth considering that a familiar song can evoke unexpected emotions or carry an attached meaning for the client (Jusiln & Vastfjall, 2008). As in Tracey’s context of palliative care, in some circumstances, evocation of unexpected emotions or associations has the potential to steer an individual back toward the ruminative state that she may be endeavouring to move them away from. Though, when working on developing skills in mindfulness, she discussed how such an occurrence can generate the perfect opportunity for developing affect tolerance by practicing awareness, non-judgment and acceptance of such associations.

**Theme 3.**

Both Jill and Alex emphasised how making music actively can bring us in to the present moment. Jill states that “music making is one of the most mindful things we can do, it’s when we’re really immersed and we come to that single point of focus.” Alex describes how key components of mindful practice such as awareness, non-judgment and acceptance, are promoted through the act of improvisational music making:

“I look at improvisation for instance, and non-judgement is quite important …It’s all about acceptance, that you can accept things as they are and in the moment as they unfold, so music does all that. You may want it [the music] to be different but then if you have a mindful attitude you can go yeah, ‘I recognise that I want it to be different but it’s ok’ and you keep going … So, in that sense, the actual act of making music is almost like a mindfulness act”.

When engaging clients in improvisation, whether with drums, voice or percussion, Alex promotes awareness of the body and mind, and non-attachment to thoughts regarding how clients might want their music to sound. As the individual moves from engaging with the habitual mind and simply inhabits the music in the moment, the power of music as a tool, not only to access a state of mindfulness but also to embody its intentions, is illuminated. This is done in the hope that the individual can access and develop feelings of non-judgement and acceptance of their actions in other aspects of their lives outside of the therapy room.

**GMU 2 - Client Empowerment**

During the process of exploring parallels amongst experiences, the participants’ dedication to engender a sense of empowerment within clients was undeniably evident. When divulging experiences of client empowerment, these RMT’s appeared energised by having shared in the occurrence, as if something of
great value had been attained. For example, Jill ardently shared that when she was working with children with challenging behaviour, she was driven by her desire to shift away from what she referred to as “a teacher-dominated culture around managing behaviour” and focus more on the self-directed regulation of behaviour and emotion through heightened self-awareness:

“I think these kids a lot of the time weren’t seen as having the capacity to be able to have that insight and a lot of them really were, and they did develop their skills. So, it’s really about their independence and in a true sense of not relying on an external adult telling them what to do but to an extent, advocating for themselves”.

Furthermore, through the incorporation of music and mindfulness activities, Jill offered the opportunity for her students to develop increased awareness of bodily and emotional sensations during moments of vexation: “So I would be encouraging kids for example, when they’re having a meltdown, to be drawing attention to their breath and their thought patterns and becoming aware of their body”. She also encouraged autonomy in identifying weekly learning objectives by having them draw attention to their goals whilst listening to music.

Music listening in the classroom can help children regulate their emotions and improve learning (Foran, 2009), while mindfulness training has been found to have a positive influence on impulsivity, attention problems and social attunement in young people with externalising disorders (Bögels, Hoogstad, van Dun, de Schutter & Restifo, 2008). As supported in the literature, it appeared that Jill’s intention was to engender skills of self-regulation, self-assertion and increased control over learning, not only in the classroom but other environments also (Broderick, 2013; Meiklejohn et al., 2012; Schonert-Reichl, et al., 2015).

Participants also discussed how the inclusion of mindfulness could serve to take the emphasis away from being an ‘expert’ practitioner, as it cultivates a skill to be accessed in the absence of a therapist. For instance, Louise advocates mindful listening to pre-recorded songs, equipping her clients with a self-regulatory resource, accessible at any time in support of the various challenges faced during cancer treatment. This enhances the individual’s capacity to independently engage with mindfulness, which existing MBP studies have found to be significantly effective with this population (Dobos et al., 2015; Fish et al., 2014; Ledesma & Kumano, 2009). In the palliative care setting, Tracey values the practice of mindfulness in a similar manner as reflected in her sharing of the following experience:

“A man I was working with recently, he went through some amazing processes during mindfulness, which were addressing his post-traumatic stress and unpacking things ... He was able to actually take thoughts in a safe place and compartmentalise them. Once he was mindful and once he could actually know that he was in control of his thoughts, unpacking that stuff and putting it away was, um, he couldn’t believe that it took such little effort and he’d been carrying it around his whole life ... He was practicing on his own then,
to just overcome lots of issues, existential issues in nature”.

The outcomes described here such as being “in control of” and “compartmentalising” thoughts are perhaps not synonymous with mindfulness, which encourages the ability to relate openly and acceptingly to challenging thoughts (Segal & Williams, 2012; Shapiro & Carlson, 2009). However, this example could serve to demonstrate how introducing an approach such as mindfulness, which encourages the individual to explore and attempt to relate differently to challenges, might create opportunities for the client to consider a different perspective.

While discussing this experience, Tracey poignantly expressed her sense of reward in being able to highlight the power that her client had over his own emotional and spiritual territory: “I’ve just sat here and given you the method, you’ve done the work, you have the power. The best thing about it is, I don’t have to be here to do it with you”. Similarly, Alex shares his decision to incorporate mindfulness into his work: “It’s not a power over, it’s really a power with... you plant a seed so to speak and if the people water it, it will grow, and that’s something that you eventually don’t need a therapist for anymore. You can do that yourself, which I think is the ultimate aim.”

As existing literature suggests, the development of self-awareness and acceptance that is nourished through mindful practice has been found to generate a sense of empowerment (Cairns & Murray, 2015). In Tracey’s case, empowerment was engendered by relinquishing any perception of control she had over her client’s developing wisdom, while Alex sees himself in mutual collaboration with the client. This sense of equality in the relationship is a unique feature of mindfulness intervention that has been echoed in other qualitative studies (Aalderen, Breukers, Reuzel, & Speckens, 2014). Therapists seeking to cultivate a sense of collaboration, to facilitate empowerment of the self or encourage skills in self-regulation might consider discovering more about mindfulness and its benefits to practice and to reflect upon the ultimate potential for growth and trust that can blossom through a mindful therapeutic alliance (Shapiro & Carlson, 2009).

**GMU 3 - Benefits of Practitioners’ Personal Relationship with Mindfulness**

This GMU embodies evidence regarding how the participants’ experience with mindfulness has enhanced their personal and professional lives. To Alex, when working therapeutically, a mindful approach is “holistic and respectful of the individual”. It nurtures empowerment and equality and deeply resounds with his worldview. Moreover, by engaging in mindfulness as self-care, Alex takes the time to better understand himself, thus expanding the value of his therapeutic presence. Jill also believes that engagement in mindful practice is of great benefit to her personal and professional life as it helps to calm her mind, develop her creativity and enables her to feel more receptive in her interactions with others. Furthermore, Louise and Tracey both shared that their personal experience with mindfulness offers a lived experience of its benefits and enables them to cultivate a deeper client-therapist connection.

As highlighted by the previously discussed article by Crane et al., (2016) it is integral that practitioners implementing
MBP engage in their own personal practice of mindfulness and meditation, as the embodiment of mindful qualities nurture experiential understanding and motivation in practice (Aalderen et al., 2014; Crane et al., 2016). Furthermore, as these findings suggest, the therapist is also nurtured by their own relationship with mindfulness. As reflected in the existing literature, its cultivation can enhance the therapeutic encounter by strengthening present mindedness and an attitude of openness and compassion (Hick & Bien, 2008) and support non-judgmental reflection and regulation of reactions precipitated by counter-transference (Shapiro & Carlson, 2009). It also has the potential to deepen therapeutic presence, strengthen emotional attunement and embolden the client-therapist alliance (Geller & Greenberg, 2012; Schomaker & Ricard, 2015).

**GMU 4 - Positive Client Outcomes**

This GMU developed from the participants’ descriptions of positive outcomes unique to the individual’s personal challenges, which they attributed to engagement in mindfulness training. Described outcomes included resilience (Meiklejohn et al., 2012), sustained attention (Jha et al., 2007), increased emotional and behavioural regulation (Keng et al., 2011), decreased rumination (Hawley et al., 2013) and non-medicated respite from symptoms (Eisendrath et al., 2014). All positive outcomes that are also strongly supported by the current literature regarding the employment of mindful strategies in psychotherapeutic practice. However, the combination of mindful and musical interventions and their explicit influence over positive outcomes has not been explored in great depth. Alex touched on this point when he stated: “It’s hard to say whether these mindful outcomes are stimulated by the intentional way I use music or because I use a mindfulness framework. I think it’s probably coupled together.” He also suggested that common factors such as his personality may contribute to the manifestation of positive outcomes (Zimmerman & Bambling, 2012), though in his experience, positive change appears to be largely attributed to the combination of mindfulness and music therapy methodologies. To the author’s knowledge, there is limited literature that supports this conclusion. Improved understanding regarding how this combination might positively impact patient outcomes is worth further investigation.

**GMU 5 - The Parameters of a Mindful Approach**

Despite acknowledgment of the positive outcomes that can manifest from using a mindful approach, participants also asserted the importance of maintaining an awareness of its parameters, given that it is not appropriate for all circumstances. Research informs us that self-focused attention can often intensify the experience of distress and exacerbate symptoms associated with illness (Brockmeyer et al., 2015; Mor et al., 2010), therefore in some cases, bringing awareness into the body or mind may be contra-indicated.

Assessment and evaluation are integral parts of the music therapy treatment process (Gfeller & Davis, 2008). RMTs are trained to consider the effect of music upon emotion and how to facilitate discussion around this, and these skills are consistently strengthened through continuing
professional development (Graham, 2010; Wheeler, 2014). In light of this, it could be argued that undertaking specialised training in MBP would similarly strengthen the practitioner’s ability to discern the suitability of a mindful approach, support confident and authentic responses and most effectively guide any potential ill-effects brought about by its use (Kabat-Zinn, 2003, 2017; Woods, 2009).

While this study has provided insight into how mindfulness-based theory has informed and enriched each participant’s practice of music therapy, it is recognised that this is a topic with extensive considerations. Both mindfulness-based methodologies and music therapy are well established approaches to improving health and well-being and this study was limited in its ability to deeply contemplate a number of important factors, as highlighted in the previous discussion.

Conclusion

The insights gained from this phenomenological study are drawn from the experience of four music therapists who incorporate techniques informed by mindfulness theory into their music therapy practice, a subject that has been relatively unexplored in the literature. These findings reveal the music therapist’s aspirations for employing this method, its concurrent enhancement of their experience as well as its capacity to engender client empowerment. While positive client outcomes have been outlined, it has also been acknowledged that in some cases its use can be contra-indicated and the benefit of further training in the facilitation of MBP is discussed. It is hoped that this study provides impetus for further exploration into how mindfulness and music therapy might support or complement one another in practice.

References


A structural analysis of music in tango dance classes for Parkinson's disease

Beevers, W. & Morris, M.E.


In plain language:
This study examined the music used in tango dancing classes for people with Parkinson’s disease. The main aim was to determine if there were musical features common to the most beneficial pieces. Specialised software (MATLAB) was used to analyse the music’s tempo, beat clarity, key signature and brightness or energy levels. This was combined with data from the teacher and clinicians involved, they named the pieces or musical features they considered most successful. Results found the most successful music was in duple time with tempo range of 105 and 125 beats per minute. It had a clear, steady and always audible beat, an interesting melody and a musically cued ending.
A structural analysis of music in tango dance classes for Parkinson's disease

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² Healthscope, Australia

Abstract
This study examines the music used in therapeutic Argentine tango dancing classes for people with idiopathic Parkinson’s disease (PD). Evidence is accumulating that selecting appropriate music can improve movement performance and health related quality of life for people with PD. The main aim of this project was to determine if there were musical features common to the pieces used in dance classes. Data were evaluated from computer software analysis of the music, an interview with the dance teacher, and a questionnaire completed by four physiotherapists involved in the tango classes. These professionals selected the most beneficial pieces of music based on participant responses. The classes were directed by a tango teacher, with support from physiotherapists. The teacher chose 15 pieces, all in mp3 format. The music was analysed three ways: (i) quantitative computer analysis using MATLAB software; (ii) detailed physiotherapist appraisals; and (iii) a dance teacher interview. Results from both the analysis of music using computer software and qualitative questionnaire with physiotherapists showed the most successful music to range in tempo between 105-125 bpm, in simple duple time, with a clear downbeat, moderate pulse clarity and minimal key modulations. The physiotherapists prioritised a clear beat, appropriate tempo, then melodic interest. The dance teacher selected music according to rhythm, tempo and melodic interest. The computer software identified the optimal tempo, pulse clarity, brightness, tonality and modulations of the pieces. The findings provide insights showing that rhythmical music with a clear down beat and tempo matched to exercise requirements may optimise therapy outcomes in people with chronic diseases.

Keywords: music analysis, dancing, Parkinson’s disease, exercise

Introduction
Parkinson’s disease (PD) is associated with movement disorders and cognitive impairment, especially in people over the age of 65 years (Kalia & Lang, 2015; Nutt, 2016). It is a progressive, degenerative, neurological condition that primarily affects the basal ganglia deep within the brain (Nutt, 2016). The loss of dopamine producing cells in the basal ganglia leads to debilitating motor and non-motor impairments and loss
of function in affected individuals (Kalia & Lang, 2015; Malek et al., 2016; Morris, Iansek, McGinley, Matyas, & Huxham, 2005). PD is characterised by movement disorders such as, hypokinesia, bradykinesia, dystonia, tremor, rigidity and postural instability (Hou & Lai, 2008; Jankovic, 2008; Macphee & Stewart, 2012). Therapeutic dancing is receiving increased attention worldwide (Shanahan et al., 2016). It appears to be beneficial for health and wellbeing because it combines therapeutic and sustained exercise with social interaction and enjoyable music.

There are a range of physical treatments as well as pharmacological therapies to help people with PD to move more easily. Exercise, physical activities and physiotherapy programs aimed at improving movement, gait and balance are important to the management of the symptoms of PD (Morris, Martin, & Schenkman, 2010). Exercise is argued to play a neuroprotective role, especially in the early stages of the disease (Fisher et al., 2008). Dancing is a sociable and enjoyable form of exercise and is sometimes recommended as an adjunct to traditional physiotherapy or gym training (Westheimer et al., 2015). It has greater adherence rates for PD participants compared to routine exercises (Twyerould, 2016). Dancing is increasingly used as an exercise intervention (de Dreu, van der Wilk, Poppe, Kwakkel, & van Wegen, 2012). It incorporates the elements suggested by the European Physiotherapy Guidelines (Keus et al., 2014). The guidelines describe components that should be included in movement strategy training; 1) cueing strategies to improve gait; and 2) complex motor sequences to improve functional mobility. The main pharmaceutical treatment for PD is dopamine replacement therapy (Nutt, 2016; Trail, Protas, & Lai, 2008). Levodopa is the most effective and commonly prescribed anti-PD medication, yet the benefits begin to decline after five to eight years of continued use (Fahn, Marsden, Calne, & Goldstein, 1987).

Several different dance genres have been investigated for supporting movement for people with PD. The most frequently used are: Irish set dancing (Shanahan et al., 2014; Volpe, Signorini, Marchetto, Lynch, & Morris, 2013; Volpe et al., 2012), modern dance (Batson, 2010; Marchant, Sylvester, & Earhart, 2010) and tango dance (Hackney, 2009; Hackney & Bennett, 2014; Hackney & Earhart, 2009a, 2009b, 2010a, 2010b; Hackney, Kantorovich, & Earhart, 2007; Hackney, Kantorovich, Levin, & Earhart, 2007; Hackney & McKee, 2014; McKee & Hackney, 2013).

Duncan and Earhart (2012) compared the outcomes of one hour long, twice weekly, PD tango dancing classes to a PD control group with no intervention. The tango group improved for all of the physical measures in comparisons with the control group, which showed little change (Duncan & Earhart, 2012). Argentine tango is thought to facilitate movement because the music is engaging to listen to, and the rhythmic patterns employed facilitate the listener to move automatically then actively. The music for Argentinian tango is most commonly in duple time and less frequently in triple time (Collier & Haas, 1995). The music is typically performed by an ensemble of piano, violins and double bass, bandoneon and a male baritone singer (Halfyard, 2011). More contemporary compositions may feature female singers, usually those with a low pitched voice (Collier & Haas, 1995). The lyrics are generally about love or romance,
and can be solemn in nature (Taylor, 1987). They may be sung with humour (Collier & Haas, 1995).

The current study was part of a larger project on dancing involving nine participants with mild to moderate disability, or stages one to three using the Hoehn & Yahr (1967) classification system. They were recruited from metropolitan Melbourne through community based physiotherapists, PD support groups, doctors and movement disorders clinics. The larger project examined the safety, feasibility and effects on mobility, of weekly dancing classes over eight weeks (Aguiar et al., 2016).

Results from Aguiar et al.’s study showed that regular participation in music cued dancing and exercises enabled people with PD to move more easily. Although Aguiar and colleagues demonstrated favourable results, their study did not clarify the extent to which therapy benefits were associated with the exercises, dance steps or music. Further, to our knowledge, analysis of the music used in PD dance classes is limited, despite the powerful effect that music can have on motor control (Blandy, Beevers, Fitzmaurice, & Morris, 2015), engagement (McNeely, Duncan, & Earhart, 2015) and social interactions (Hackney & Bennett, 2014). Therefore, the current study aimed to examine the music used in therapeutic Argentine tango dancing classes for people with idiopathic PD for commonly occurring features. We also examined whether particular pieces were considered to be more successful by physiotherapists and teachers.

Methods

Participants.

The participants in the current project were one Argentine tango dance teacher, three registered physiotherapists and a registered music therapist (the researcher) who facilitated the dance classes for Aguiar et al (2016) study. Ethics approval was gained from La Trobe University, and all participants gave their informed consent. The tango corpus used in the current study is detailed below in Table 1.

Data analysis.

In this study, we conducted a computer based music analysis of the music recordings, and a qualitative analysis of the music by the physiotherapists and dance teacher.

The computer based analysis of the music was conducted using MATLAB® software. Computer-based evaluations of music recordings, also known as digital analysis, has been used in music analysis for over a decade (Knox, Beveridge, Mitchell, & MacDonald, 2011). MATLAB® software with the addition of the MIDI and MIR toolboxes (Lartillot, Eerola, Toiviainen, & Fornari, 2008; Lartillot & Toiviainen, 2007) was chosen for our research. MATLAB® has a large number of additional toolboxes that expand its’ computational applications (Mathworks, 2010). The MATLAB® signal processing toolbox enables analysis of sounds for their acoustic features. This includes their frequency, roll-off, distortion levels, presence of wow and flutter, amplitude and volume ratios. Our analysis examined the music in terms of tonality and modality, tempo, rhythm and pulse, and note distribution. This method is in line with the approaches published in several studies (Mathews, Clair, & Kosloski, 2001; Priest, Karageorghis, & Sharp, 2004). One of the variables was brightness. Brightness is a measure of how much energy is given to individual sound
events (Long, Ma, Wan, & Zhou, 2010). A short sound event with little or no roll-off has a higher brightness result (Long et al., 2010). Examples of these are plucked (pizzicato) strings, a drum tap or a staccato chord on the piano. A lower number indicates a low brightness or a more blurred sound. The pulse clarity results are higher for pieces where the downbeat is very clear and there is minimal roll off or sound decay between notes. Tonality was also of interest because an examination of the harmonic structure of music is integral to music analysis. There is minimal published information on the effect of different modalities on people, or the effect of many modulations on human movement. Cancela (2014) conducted preliminary work on preferences for chord progressions in short melodies, created to cue movement in people with PD. Komeilipoor et al (2015) showed that consonant harmonies and sounds could lead to more consistent movements than disharmonious sounds (Komeilipoor, Rodger, Craig, & Cesari, 2015).

To further examine the music, we conducted qualitative analysis of

Table 1. 

<table>
<thead>
<tr>
<th>Piece</th>
<th>Lyricist</th>
<th>Composer</th>
<th>Performers</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alma</td>
<td>Sarcione</td>
<td>Scorticati</td>
<td>Carabelli</td>
<td>Partial score</td>
</tr>
<tr>
<td>Amor Y Vals</td>
<td>Bahr</td>
<td>Biagi</td>
<td>Biagi-Lago</td>
<td>No score</td>
</tr>
<tr>
<td>Con Alma Y Vida</td>
<td>Marco</td>
<td>Di Sarli</td>
<td>Oscar Serpa</td>
<td>No score</td>
</tr>
<tr>
<td>El Abrojo</td>
<td>No lyrics</td>
<td>Bardi</td>
<td>Di Sarli</td>
<td>No score</td>
</tr>
<tr>
<td>El Cabure</td>
<td>No lyrics</td>
<td>De Bassi</td>
<td>Carabelli</td>
<td>No score</td>
</tr>
<tr>
<td>Felicia</td>
<td>Pacheco</td>
<td>Saborido</td>
<td>Carabelli</td>
<td>Partial score</td>
</tr>
<tr>
<td>La Guinada</td>
<td>No lyrics</td>
<td>Bardi</td>
<td>Carabelli</td>
<td>No score</td>
</tr>
<tr>
<td>La Melodia De Corazon</td>
<td>Santiago</td>
<td>Di Cicco &amp; Artola</td>
<td>Donata orchestra</td>
<td>No score</td>
</tr>
<tr>
<td>Milonga De Mis Amores</td>
<td>de Contursi</td>
<td>Laurenz</td>
<td>Canaro</td>
<td>Partial score</td>
</tr>
<tr>
<td>Nada Mas Que Un Corazon</td>
<td>Bahr</td>
<td>Sucher</td>
<td>Osvaldo Pugliese (Chanel)</td>
<td>No score</td>
</tr>
<tr>
<td>Pedacito De Cielo</td>
<td>Exposito</td>
<td>Francini &amp; Stamponi</td>
<td>Calo42 - Podesta</td>
<td>Partial score</td>
</tr>
<tr>
<td>Peligro</td>
<td>Gotan Project Tango 3.0 (Japan ed)</td>
<td>Gotan Project Tango 3.0 (Japan ed)</td>
<td>Gotan Project Tango 3.0 (Japan ed)</td>
<td>Partial score</td>
</tr>
<tr>
<td>Silueta Porteña</td>
<td>Daniel &amp; Noli</td>
<td>Cucaro</td>
<td>Roberto Maida &amp; Canaro</td>
<td>Partial score</td>
</tr>
<tr>
<td>Soñando de Juventud</td>
<td>Discepolo</td>
<td>Discepolo</td>
<td>Rodolfo Biagi</td>
<td>Partial score</td>
</tr>
<tr>
<td>Vida Mia</td>
<td>E. Fresedo</td>
<td>O. Fresedo</td>
<td>Fresedo orchestra</td>
<td>Partial score</td>
</tr>
</tbody>
</table>
interviews with the dance teacher who chose the music and led the intervention, and a questionnaire answered by the four physiotherapists who were involved in the therapeutic dancing classes. An in-depth, semi-structured interview was conducted with the dance teacher. This interview involved open-ended questions to generate discussion and a detailed response from the participant, informed by Minichiello and colleagues writings (2008). A questionnaire (see Appendix) was also devised and administered to the physiotherapists to gather their perspectives on the music.

The purpose of the qualitative analyses was to understand which music was deemed to be particularly helpful; which elements of the music optimised outcomes; and to develop a greater understanding of the selection of music to facilitate therapeutic movement. A secondary thematic analysis was conducted of the teacher interview and physiotherapy questionnaires, influenced by a Grounded Theory approach (Glaser & Strauss, 1967).

Results
The results for pulse clarity, brightness, tonality, and modulations are shown below in Table 2. We shall present both quantitative and qualitative data for each musical element. MATLAB® gives a result between zero and one for brightness. The greater the number, the brighter the music. The pieces were grouped by their time signature for the tempo results.

**Pulse clarity and beat.**
Table 3 shows the pulse clarity results for each of the tango pieces. The pulse clarity results for the tango intervention range from 0.82 for *Peligro* to 0.09 for *Sueno De Juventud*. The average was 0.32, indicating a moderately strong pulse clarity.

Table 3. Pulse clarity results

<table>
<thead>
<tr>
<th>Piece name</th>
<th>Pulse clarity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alma</td>
<td>0.14</td>
</tr>
<tr>
<td>Amor Y Vals</td>
<td>0.32</td>
</tr>
<tr>
<td>Con Alma Y Vida</td>
<td>0.13</td>
</tr>
<tr>
<td>El Abrojo</td>
<td>0.42</td>
</tr>
<tr>
<td>El Cabure</td>
<td>0.56</td>
</tr>
<tr>
<td>Felicia</td>
<td>0.51</td>
</tr>
<tr>
<td>La Guinada</td>
<td>0.19</td>
</tr>
<tr>
<td>La Melodia De Corazon</td>
<td>0.21</td>
</tr>
<tr>
<td>Milonga De Mis Amores</td>
<td>0.38</td>
</tr>
<tr>
<td>Nada Mas Que Un Corazon</td>
<td>0.35</td>
</tr>
<tr>
<td>Pedacito De Cielo</td>
<td>0.23</td>
</tr>
<tr>
<td>Peligro</td>
<td>0.82</td>
</tr>
<tr>
<td>Silueta Porteña</td>
<td>0.27</td>
</tr>
<tr>
<td>Sueno De Juventud</td>
<td>0.09</td>
</tr>
<tr>
<td>Vida Mia</td>
<td>0.14</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td><strong>0.32</strong></td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td><strong>0.82</strong></td>
</tr>
<tr>
<td><strong>Minimum</strong></td>
<td><strong>0.09</strong></td>
</tr>
</tbody>
</table>
Table 2.
MATLAB® analysis of the tango corpus

<table>
<thead>
<tr>
<th>Piece name</th>
<th>Pulse clarity</th>
<th>Brightness clarity</th>
<th>Piece length</th>
<th>Key signature</th>
<th>Mode strength</th>
<th>Modulations</th>
<th>Lyrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alma</td>
<td>0.14</td>
<td>0.37</td>
<td>3:01</td>
<td>D major</td>
<td>0.06</td>
<td>A major, D minor, A minor</td>
<td>From 1:05</td>
</tr>
<tr>
<td>Amor Y Vals</td>
<td>0.32</td>
<td>0.35</td>
<td>2:45</td>
<td>B flat major</td>
<td>0.12</td>
<td>B flat major, E flat major</td>
<td>From 1:57</td>
</tr>
<tr>
<td>Con Alma Y Vida</td>
<td>0.13</td>
<td>0.42</td>
<td>2:21</td>
<td>C minor</td>
<td>-0.08</td>
<td>C minor, A flat major, F minor</td>
<td>From 1:26</td>
</tr>
<tr>
<td>El Abrojo</td>
<td>0.42</td>
<td>0.46</td>
<td>2:48</td>
<td>A major</td>
<td>0.2</td>
<td>A major, D major, F# minor, E minor</td>
<td>None</td>
</tr>
<tr>
<td>El Cabure</td>
<td>0.56</td>
<td>0.37</td>
<td>2:30</td>
<td>F major</td>
<td>0.05</td>
<td>F major, A minor</td>
<td>None</td>
</tr>
<tr>
<td>Felicia</td>
<td>0.51</td>
<td>0.38</td>
<td>2:38</td>
<td>D minor</td>
<td>-0.23</td>
<td>D minor</td>
<td>None</td>
</tr>
<tr>
<td>La Guinada</td>
<td>0.19</td>
<td>0.38</td>
<td>2:41</td>
<td>D major</td>
<td>0.11</td>
<td>D major, D minor, A major, A minor</td>
<td>None</td>
</tr>
<tr>
<td>La Melodia De Corazon</td>
<td>0.21</td>
<td>0.37</td>
<td>3:18</td>
<td>C# minor</td>
<td>0</td>
<td>C# minor, E major, A major, A minor</td>
<td>From 1:29</td>
</tr>
<tr>
<td>Milonga De Mis Amores</td>
<td>0.38</td>
<td>0.41</td>
<td>2:58</td>
<td>A flat major</td>
<td>0</td>
<td>A flat major, A flat minor, E flat major</td>
<td>None</td>
</tr>
<tr>
<td>Nada Mas Que Un Corazon</td>
<td>0.35</td>
<td>0.28</td>
<td>2:51</td>
<td>G major</td>
<td>0.05</td>
<td>G major, E minor, B minor</td>
<td>From 1:11</td>
</tr>
<tr>
<td>Pedacito De Cielo</td>
<td>0.23</td>
<td>0.36</td>
<td>2:20</td>
<td>A flat major</td>
<td>0.07</td>
<td>A flat major, A flat minor, D flat major, D flat minor</td>
<td>From 0:53</td>
</tr>
<tr>
<td>Peligro</td>
<td>0.82</td>
<td>0.49</td>
<td>3:57</td>
<td>D minor</td>
<td>-0.24</td>
<td>D minor, A minor, F# minor, E minor, D major</td>
<td>From 0:19</td>
</tr>
<tr>
<td>Silueta Porteña</td>
<td>0.27</td>
<td>0.31</td>
<td>2:53</td>
<td>E flat minor</td>
<td>-0.19</td>
<td>E flat minor, B major</td>
<td>From 1:08</td>
</tr>
<tr>
<td>Sueno De Juventud</td>
<td>0.09</td>
<td>0.38</td>
<td>2:44</td>
<td>C major</td>
<td>0.08</td>
<td>C major, A minor</td>
<td>From 0:54</td>
</tr>
<tr>
<td>Vida Mia</td>
<td>0.14</td>
<td>0.32</td>
<td>3:25</td>
<td>C minor</td>
<td>-0.28</td>
<td>C minor, C major, E flat major, F major, F minor</td>
<td>From 1:57</td>
</tr>
<tr>
<td>Average</td>
<td>0.32</td>
<td>0.38</td>
<td>2:52</td>
<td></td>
<td>0.12</td>
<td>3.2 modulations</td>
<td></td>
</tr>
<tr>
<td>Maximum</td>
<td>0.82</td>
<td>0.49</td>
<td>3:57</td>
<td></td>
<td>0.28</td>
<td>5 modulations</td>
<td></td>
</tr>
<tr>
<td>Minimum</td>
<td>0.09</td>
<td>0.28</td>
<td>2:20</td>
<td></td>
<td>0</td>
<td>1 modulation</td>
<td></td>
</tr>
</tbody>
</table>
The pieces nominated by the physiotherapists as being the most helpful are listed in Table 4.

Table 4.  
Physiotherapist’s most helpful pieces

<table>
<thead>
<tr>
<th>Physiotherapist 1</th>
<th>Alma</th>
<th>La Guinada</th>
<th>Nada mas que on Corazon</th>
<th>Sueno de Juventud</th>
<th>Vida Mia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physiotherapist 2</td>
<td>Alma</td>
<td>Amor Y Vals</td>
<td>La Melodia De Corazon</td>
<td>Silueta Porteña</td>
<td>Vida Mia</td>
</tr>
<tr>
<td>Physiotherapist 3</td>
<td>“The violin segments, when the beats were fast and there was no singing.”</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One reason for these pieces being the most successful was that “those with a louder and stronger beat were easier to follow and to synchronise the dance steps to” (physiotherapist 1). Also, they were an “auditory cue to trigger dance movements” (physiotherapist 2).

The strength or clarity of the beat was important to the teacher. She selected music that had a stronger, more identifiable and distinct beat. Examples included La Melodia and El Abrojo.

**Brightness.**

The results for pulse clarity and brightness are presented in the following table.

Table 5.  
Comparison of pulse clarity and brightness

<table>
<thead>
<tr>
<th>Piece name</th>
<th>Pulse</th>
<th>Brightness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amor Y Vals</td>
<td>0.32</td>
<td>0.35</td>
</tr>
<tr>
<td>El Abrojo</td>
<td>0.42</td>
<td>0.46</td>
</tr>
<tr>
<td>El Cabure</td>
<td>0.56</td>
<td>0.37</td>
</tr>
<tr>
<td>Felicia</td>
<td>0.51</td>
<td>0.38</td>
</tr>
<tr>
<td>La Melodia De Corazon</td>
<td>0.21</td>
<td>0.37</td>
</tr>
<tr>
<td>Milonga De Mis Amores</td>
<td>0.38</td>
<td>0.41</td>
</tr>
<tr>
<td>Nada Mas que Ur. Corazon</td>
<td>0.35</td>
<td>0.28</td>
</tr>
<tr>
<td>Pedacito De Cielo</td>
<td>0.23</td>
<td>0.36</td>
</tr>
<tr>
<td>Silueta Porteña</td>
<td>0.27</td>
<td>0.31</td>
</tr>
</tbody>
</table>

Brightness result is greater than the pulse clarity result

<table>
<thead>
<tr>
<th>Piece name</th>
<th>Pulse</th>
<th>Brightness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alma</td>
<td>0.14</td>
<td>0.37</td>
</tr>
<tr>
<td>Con Alma Y Vida</td>
<td>0.13</td>
<td>0.42</td>
</tr>
<tr>
<td>La Guinada</td>
<td>0.19</td>
<td>0.38</td>
</tr>
<tr>
<td>Sueno De Juventud</td>
<td>0.09</td>
<td>0.38</td>
</tr>
<tr>
<td>Vida Mia</td>
<td>0.14</td>
<td>0.32</td>
</tr>
</tbody>
</table>

Brightness result is lower than the pulse clarity result

<table>
<thead>
<tr>
<th>Piece name</th>
<th>Pulse</th>
<th>Brightness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peligro</td>
<td>0.82</td>
<td>0.49</td>
</tr>
</tbody>
</table>

Of the 15 pieces, nine had similar brightness and pulse clarity. This included four of the pieces that the physiotherapists found to be most effective: Amor Y Vals, La Melodia De Corazon, Nada mas que on Corazon and Silueta Porteña. The physiotherapists also preferred Alma, La Guinada, Sueno de Juventud and Vida Mia. These pieces had brightness results that were greater than their pulse clarity result. The average brightness result for the pieces preferred by the physiotherapists was 0.34.
Tonality.
The key signature, mode strength, modulations and note distribution from MATLAB® showed the tonality for each piece as displayed in Table 2. Physiotherapist 2 advised that the harmonies were “pleasant to the ear, harmonious, enjoyable” for El Abrojo; and “lovely to listen to, gentle, uplifting and melodic” for La Melodia De Corazon. Physiotherapist 3 was not aware of the harmonies. The physiotherapists were also asked open ended questions about what they would select and avoid when choosing music. None of them mentioned harmony or tonality. Their focus was primarily on the beat and tempo of the music, which were thought to trigger movement in people with PD (Thaut, 2013).

Lyrics.
Physiotherapist 1 had a partial understanding of the lyrics. The teacher and the remaining physiotherapists did not understand the lyrics due to their unfamiliarity with Argentine Spanish. Similarly, the researcher did not understand the lyrics. Physiotherapist 2 commented: “the singer made me and the patients feel good”. The voice arguably humanised the music. The teacher commented: “The singing is also really beautiful”.

Musical form.
The musical form was not mentioned by either the teacher or the physiotherapists. Nevertheless, both the teacher and physiotherapist 2 volunteered that the ending of the music was important. The teacher commented: “some endings in the tango music are quite tricky... it wasn’t clear, or it was too drawn out or ending very abruptly”. Physiotherapist 2 said she would ask potential dance exercise participants to listen to and use “the beginnings and end of musical phrases, to help guide their movements”.

Tempo.
When selecting the music for the dance classes, the dance teacher did not have a beats per minute (bpm) figure in mind or a range of values for the most suitable tempo. She selected the pieces based on the “feel” of the music. That is, she advised that she selected music that was “not too fast, not too slow, somewhere in the middle”.

The physiotherapists did not mention the bpm for the music. They had varied opinions about which of the music pieces were too fast, too slow or appropriate in tempo. Physiotherapist 3 commented that the range of tempos for the entire musical selection was good, “going from slow to fast and vice-versa”. Physiotherapist 2 nominated three pieces as having a good or appropriate tempos: Alma - 124 bpm, La Melodia De Corazon - 128 bpm, and Vida Mia - 124 bpm. The average tempo for these three pieces was 125.2 bpm. Physiotherapist 2 assessed Silueta Porteña - 169 bpm, and Milonga De Mis Amores - 168 bpm, as being too fast, given that people walk at between 100-120 steps per minute.

Duple time pieces.
As seen in Table 6, the tempo range for the duple time pieces was 106-186 bpm, with an average of 135 bpm. The teacher and the physiotherapists described four simple duple time pieces as either ‘most effective’ or having an appropriate tempo for PD dance classes.
or less clear (Scholes & Nagley, 2011). MATLAB® gave a tempo for each downbeat in Amor Y Vals and Pedacito. The participants were instructed to step to this downbeat. MATLAB® gave Sueno De Juventud a bpm for each beat in the bar as represented in Table 8.

**Table 8.**

<table>
<thead>
<tr>
<th>Piece name</th>
<th>Tempo (bpm)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Average</td>
<td>132.3</td>
</tr>
<tr>
<td>Maximum</td>
<td>160.0</td>
</tr>
<tr>
<td>Minimum</td>
<td>79.0</td>
</tr>
</tbody>
</table>

**Discussion**

The focus of this research was to study the music heard and experienced by the dance participants. An analysis of the structural elements of the musical pieces used in the PD dance classes showed that movement was enhanced by a mix of triple time and duple time pieces; a range of keys and modulations within each piece; tempos that ranged from 79-186 bpm; and moderate pulse clarity and brightness levels. The importance of a clear beat was a recurring theme in the responses from all the physiotherapists and the teacher. In the pieces that were perceived to be successful, the predominant reason given was that the beat was strong, predictable and clear. When the downbeat was very strong and clear, individuals could respond by synchronizing or attenuating their movements to the beat (Thaut, 2013; Wittwer, Webster, & Hill, 2013). A clearly marked upbeat prepares the listener for the downbeat, possibly leading to greater confidence and success in matching
the movements to the beat (Chen, Penhune, & Zatorre, 2007). In contrast, a weak musical beat makes it difficult for the participant to know when to place their foot, as they cannot find or feel the beat easily (Phillips-Silver, 2009).

For the current study, the researcher wanted to determine if the harmonies and harmonic structure of the music was noticed by either the teacher or the physiotherapists, and if it had any impact on participants’ movement and dancing. The teacher did not specifically mention tonality, key or modulations. The physiotherapists were asked directly about harmonies in the questionnaire. The word ‘harmonies’ was chosen as the most likely to elicit a response from the physiotherapists when their level of music education was unknown. The presence of lyrics was also of interest as it could create a dual task interference issue for PD participants (Brown, de Bruin, Doan, Suchowersky, & Hu, 2009). In other words, listening to the lyrics may have distracted participants from dancing or moving. There are conflicting opinions on the effects of multiple stimuli for Parkinson’s patients (van Wegen et al., 2006). In addition, there is little agreement as to which stimuli are most distracting and for how long (Nieuwboer et al., 2007). Some distraction can cause freezing and loss of balance (Rochester et al., 2004). The presence of lyrics did not appear to facilitate or hinder movement in this sample of people with PD.

Two musical elements of interest are tonality and musical form. The tango is written in several different keys, and modulates from those keys freely. While this may be of interest to music therapists, it was not noticed or commented on by either the physiotherapists or the dance teacher. The tempo, time signature, pulse clarity and brightness levels were all perceived to be important elements for optimising dancing performance in people with PD. The musical elements that were most successful at supporting the participants in dancing the tango were duple time signature, moderate pulse clarity, moderate brightness and a tempo range 121-124 bpm.

The teacher and physiotherapists had differing opinions as to which pieces were the most beneficial, however all wanted the music to have a clear beat that was audible throughout the music. The preferred pieces had a pulse clarity range of 0.09-0.32, with an average of 0.19. These findings are in agreement with several recent studies (Leow, Parrott, & Grahn, 2014), showing that a clearly heard and felt beat is pivotal to the success of dancing for people with PD. Furthermore, the rhythm also has to be steady. Leow et al (2014) found that music where the beat was very clear (high groove music), elicited greater synchronization of steps to the music, longer stride lengths and faster stepping in people with PD.

Music that was too fast was thought to exacerbate some movement disorders in PD, such as freezing of gait and postural instability, particularly when combined with multiple stimuli such as a teacher giving instructions and managing a partner (Pelosin et al., 2010; Rochester et al., 2004; Shanahan, Bhrain, Morris, Volpe, & Clifford, 2016). In contrast, music that is of suitable tempo may well enhance movement in people with PD (Shanahan et al., 2015). For example, Rochester (2010) recorded the preferred walking cadence in steps per minute of people with PD prior to testing their ability in dual-tasking while walking. Their results ranged from 98-106 bpm, measured while the people
with PD had no auditory cues. They tested their walking with all or one of the following cues: visual, auditory, or somatosensory cues (Rochester et al., 2010). They found that walking speed and stride length improved with all forms of cueing, with dual task cueing having a significant improvement. The bpm range post intervention was reduced to 101.8-103.43. The tango dancing participants in this current research had the music as an auditory cue and their co-participants dancing could be regarded as a visual cue. Additional cues came from the teacher who cued the participants by clapping, counting out loud and demonstrating with her body. Some of the music was not perceived to be optimal. For example, Amor Y Vals, a triple time piece, had the lowest tempo mark for this group of pieces at 79 bpm given for each downbeat. From the perspective of the physiotherapists and teacher, this piece had a very fast feel, in part because the music is very busy. It could be argued that stepping at 79 bpm is too slow, and that concentrating on walking slowly was difficult and had the potential to affect balance. Stepping to each beat, at 237 bpm, would be too fast, as shown by the research on gait in PD by Morris et al (Morris et al., 2010). Another example was Pedacito De Cielo. This music employed a lot of rubato for artistic effect and had a weak pulse clarity. This led to physiotherapist 1 listing it as one of the least effective pieces, commenting that it was “too difficult to count because of the variety of music instruments and the beat was not clear enough”. Sueno De Juventud had a tempo score of 158 bpm, making it one of the fastest pieces in the tango suite. As for Amor Y Vals, stepping for each bar at 52 bpm was too slow according to the locomotor research by Morris et al (Morris et al., 2010). In terms of stepping to each beat in a waltz pattern, 158 bpm is too fast. People cannot easily synchronise their steps to such a fast stepping rate. In people with PD, a too slow or too fast stepping rate could lead to stumbling and falls. The teacher noted that the PD participants enjoyed the change in rhythm from duple time to triple time.

There were some limitations to this study. Firstly, we did not control for PD medication, with all the participants performing the dancing classes in the on-phase of their medication cycle. Whether or not their responses to music would be different when off their Levodopa awaits confirmation in future trials. The study was also limited by a small amount of data from three clinicians and one dance teacher. To optimise the generalizability of findings it would be helpful to extend this line of enquiry to larger numbers of participants from a variety of professional and dance backgrounds.

To conclude, this trial provides preliminary evidence to suggest that well-chosen music can facilitate movement to music in some people with progressive disorders such as PD. That is, music with a clear, steady and always audible beat, in duple time, with minimal key modulations and within the 105-125 bpm tempo range appears to facilitate dancing. Further trials with larger samples and a greater range of musical choices are needed, to understand more fully which music best enables movement in people with Parkinson’s.
References


Appendix: The physiotherapist questionnaire

Instructions and questions for the registered physiotherapists in the Tango Dance intervention

Please listen to the music you received via the Dropbox account. As you listen, remember taking part in the tango classes and how you felt as a participant and as a physiotherapist considering tango music for exercise therapy groups.

Section one has general questions about all the music. Section two refers to two specific songs – El Abrojo and La Melodia de Corazon. Section three asks what you would do if selecting music for exercise interventions. Most of these questions need a Yes or No response. Some ask for a detailed answer.

Please enter your responses into the form, save, and return via email.

Section One – General questions

1. Did you enjoy the music used in the tango dance intervention?
2. Describe why you did, or did not enjoy the music.
3. What were you most aware of, in the music, while doing the tango classes?
4. Did the music support you in doing the exercises?
5. Were there some pieces that you felt were most effective?
6. Which ones were they?
7. What was it about the music that was helpful?
8. Did any of the pieces of music distract you from participating in the exercises?
9. Why? Was the music too interesting/boring/unclear?
10. Were there some pieces that you felt were least effective?
11. Which were they?
12. What was it about them that was not helpful?
13. Did the music support the Parkinson’s’ participants in doing the exercises?
14. In what way?

Section Two - Questions about “El Abrojo” and “La Melodia de Corazon”

1. Please can you listen to these two pieces before answering the questions
2. Think about the rhythm for each piece. Was it conducive to the exercise?
3. Did the music have a clear and steady beat?
4. Was it predictable?
5. Was it easy to follow?
6. Did you have a clear sense of when the next downbeat would occur?
7. Were you able to match your movements to it?
8. Think about the tempo of each piece. That is, how fast it felt to you, did it feel appropriate?
9. If it was too slow, what was the effect on you and your participation in the exercise?
10. If it was too fast, how did that affect you?
11. Was the effect of the rhythms and tempi on you any different to their effect on the participants?
12. Were the melodies repetitious and boring?
13. If not, what made the music not boring despite having heard it many times?
14. Were you aware of the harmonies?
15. If yes, what was notable about the harmonies?
16. Were you aware of the various instruments in the music?
17. Were the instruments familiar to you?
18. Which ones?
19. Were you aware of the singers in the music?
20. Could you understand the singers?
21. Did you know what the lyrics were about?
22. Did your level of awareness of the singers and the lyrics have an impact on your capacity to participate in the exercises?

Section 3 - What would you do?

1. If you were choosing music for an exercise intervention, what would you want from the music?
2. What would you prioritise in choosing music – melody, rhythm, tempo, musical tastes of your participants?
3. How important is it that you enjoy the music too?
4. What musical features would you avoid?
5. What would you ask your participants to listen to, and use in the music, to aid their completion of the exercises?
6. Is there anything else you would like to add?

Thank you for taking part
The third edition of *Music Therapy Research* is a comprehensive volume, superseding the previous two editions through a significant expansion of content and by showcasing the increasing diversity in research within the music therapy profession. Barbara Wheeler and Kathleen Murphy have succeeded in producing a current, relevant and useful resource for researchers, students, educators and clinicians. It is clear to see how this text complements undergraduate and graduate research coursework, and assists the clinician in thinking about the relationship of research to practice.

The structure of content has been laid out in a logical sequence for the researcher undertaking a project, including considerations for each stage of the research journey. Sixty-eight chapters in total (increased from forty-one in the previous edition) are organised under nine units. Unit one offers an updated overview of music therapy research by Wheeler and Bruscia, and an historical portrait by Merrill describing the growth of music therapy research over time. These chapters give a good introduction to the scope of and significance of music therapy research. These are followed by two chapters reflecting on the relationship between research and practice, and research and theory. Unit two contains chapters on the mechanics of crafting a research project, including the development of a topic, reviewing the literature, ethical thinking, multicultural considerations, working with other disciplines and the securing of funding. These provide the backdrop for the researcher in making sure their work is feasible, well-informed, ethical and sensitive to participants and audiences alike. Unit three delves into the epistemological foundations of objectivist and interpretivist research, and then addresses the issues of each paradigm in separate chapters. From here, the paths diverge, with unit four covering methodological concerns in objectivist research, and unit five focusing on interpretivist research. These units describe some of the criticisms of each type of research, including issues of measurement in objectivist research, and the collection and interpretation of data in interpretivist research.

The following three units form the majority of the content with no less than forty-one research designs included. Objectivist designs are grouped under single
subject and small \( n \) research, descriptive research, pre-experimental designs, quasi-experimental designs and experimental designs. Interpretivist designs are grouped under natural setting approaches, phenomenology, meaning-focused approaches, language-focused approaches, theoretical approaches and case approaches. Other types of research described include microanalysis, mixed method designs, systematic review, meta-analysis and synthesis, historical research and philosophical inquiry. Finally, unit nine offers concluding chapters on recommendations for evaluating objectivist and interpretivist research, and the process of writing up and preparing research for publication.

There have been some changes in this latest edition aside from the content layout. Most notably, the shift to grouping chapters into objectivist and interpretivist research, rather than qualitative and quantitative, as in the second edition. Wheeler writes that by using these terms, she hopes this will encourage “music therapy researchers to think beyond a specific research methodology and to consider the complex nature of music and the full range of human experience when developing their research questions” (p. 45). I found this a refreshing perspective, encouraging greater clarity in linking ontology, epistemology and research design when shaping a starting idea into a research study.

As a new researcher, I found this book to be very helpful, and was appreciative of the large quantity of information made available in one place. After becoming familiar with the content, it was the reference that I would return to repeatedly during the course of my research, particularly in looking for reading signposts in the reference lists of the relevant chapters. Seeing descriptions brought to life through the frequent use of illustrative research examples was also very useful. Even when the examples did not match the description exactly, the points of difference in approach were also clarified. I particularly found the chapters on epistemological foundations and methodology to be explained well, clearly enough for someone thinking through these concepts for the first time, but in plenty of depth to consider how to relate the information to my own study. I also found the chapters on reading and evaluating literature to be valuable and applicable to my workplace for staff professional development, not just for music therapists. As a clinician, I look to implement the findings of research into my practice. However, I believe that a refresher on how to critically evaluate research findings is of great relevance at any stage of one’s career. For the clinician currently not engaged in research, moving the chapters on evaluating research to the introductory section may make for a section of great relevance to this specific audience.

This volume includes contributions from 71 authors from 12 different countries, representing a rich spectrum of international culture, education and experience. The expanded section on interpretivist research design reflects the growing number of studies in music therapy being conducted in this style, and the expansion of content illustrates the growth of music therapy research around the world. At over 5kg, the hardback edition is definitely an ‘on the desk’ volume, not for frequent carrying around or shipping.
Wheeler and Murphy have made a huge contribution to the music therapy profession through compiling a thorough, updated manual on reading, writing and understanding quality music therapy research and gathering the collective knowledge and wisdom of a generous group of international experts in the field. *Music Therapy Research* is an essential text for university libraries, and for anyone educating researchers, conducting research or music therapy clinicians wishing to remain well informed on the current state of research in their profession and its relationship to practice.
In this most recent edition, An Introduction to Music Therapy Research presents a comprehensive overview of the world of music therapy research. Designed to be used by novice researchers, this book is an abridged version of the recently published Music Therapy Research, Third Edition (Wheeler & Murphy, 2016). Seventeen of the original 68 chapters feature in this edition, while an additional three chapters have been created to condense the remainder into more manageable content for beginning student researchers.

The book begins with two preliminary chapters that introduce important concepts in music therapy research, and explore research trends, both modern and in an historical context. The basics of beginning a research project are then explored through chapters 3-9, from practical advice on how to develop a topic and review extant literature (chapters 3 and 4 respectively), to deeper philosophical issues such as ethics, cultural considerations and epistemological principles in research. Each chapter provides a detailed overview of concepts and frameworks related to each topic, many of which are supplemented by relevant examples from existing literature.

Chapters 10-13 deliver summaries of various methodologies specific to objectivist and interpretivist research, and provide a comprehensive list of related terminology and potential problems that might be encountered in research design and implementation. The three newly created chapters (14-16) attempt to synthesise several chapters from the parent edition by providing brief descriptions of several different types of research design for each epistemological approach. Although these descriptions lack the detail to adequately capture the complexities of research design, the concise summaries do allow for the key features of each topic to be easily identified and compared to others. The final four chapters are again excerpts from the parent edition, and feature practical advice on how to prepare, execute and evaluate research projects.

The selection of chapters, original and new, successfully delivers the most salient information from the original text. The diverse range of authors bring experienced voices to many different perspectives of research, while the inclusion of examples from the extant literature help to contextualise many of the theoretical concepts that are introduced. There are minor editing inconsistencies, such as the occasional reference to chapters not present in this abridged version, however the inclusion of chapter titles in the text ensure that the vigilant

**Wheeler, B.L. and Murphy, K. (2016). An introduction to music therapy research: Third edition. Dallas, TX: Barcelona Publishers.**


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St John of God Accord, Melbourne, Australia
reader will still be able to locate the correct information within this edition.

A particular highlight of this book is the way in which authors frequently prompt the reader to reflect on their own beliefs about knowledge. This is particularly evident in chapters 8 and 9, which introduce the principles of objectivist and interpretivist research respectively. Educators will find this a helpful inclusion to initiate discussions on personal values and biases in research. As only brief overviews of research designs are included in this edition, it is perhaps not ideal for those who wish to pursue research at a higher level; in this instance, the parent edition may be better suited. However, as a recent graduate of the Master of Music Therapy course, I feel that the information presented in this edition is more than sufficient to assist students in deciding on and developing their first research project.

AU $79.95, 792 pages (hard copy)

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_Peters’ music therapy: An introduction_ is the third edition in a series of texts dedicated to providing a general introduction to music therapy, specifically outlining the scope of practice in the United States. This is the first edition written by Lathom-Radocy and the title acknowledges Jacqueline Schmid Peters who authored the first two editions (1987, 2000). Lathom-Radocy identifies her aims in writing this edition as updating the literature to include research and understandings developed since the second edition, as well as updating terminology to reflect the _Diagnostic and Statistical Manual of Mental Disorders, 5th edition_ (2013). The book is directed toward people with limited existing knowledge of the field, including students in introductory music therapy courses, professionals in related disciplines, people contemplating becoming music therapists, and the general public. As music therapy is taught at a Masters level in Australia, it could be used in the first six to twelve months of the course but may also be useful for students or current registered music therapists who are seeking a starting point to review or explore clinical practice in areas they have not worked before.

_Peters’ music therapy_ is divided into three key sections – part I and II are brief, while part III makes up the majority of the text. Part I offers a definition of music therapy and an overview of the education and training of music therapists in the United States. Part II moves from a historical overview of the use of music to promote health in different cultures, into the development of music therapy as an organised profession, again predominantly situated in the United States. Part III solidifies focus on the clinical practice of music therapy with an ‘applied’ rather than theoretical understanding of the field. It begins by providing fundamental background knowledge regarding principles and processes that guide music therapy practice, but is predominantly dedicated to describing music therapy with specific client populations. The first two chapters of part III outline a range of theoretical understandings as to why music is useful as a treatment modality and how music is used in therapy before taking the readers step-by-step through a treatment plan. These chapters may be useful for revision, or serve as a reference point for music therapy students when developing clinical positions and conducting educational in-services. This information is then specifically applied in the following
fourteen chapters to different client groups, covering definitions, terminology and causes, as well as settings and the use of music in therapy. The book finishes by providing an overview of selected approaches, and highlighting the importance of research for music therapy clinicians.

The structure and clarity of previous editions is maintained in this latest edition of *Peters’ music therapy*. Organisational and learning tools are used to enhance clarity and break up the information. Most useful are the ‘questions for thought and discussion’ concluding each chapter. Usually used as a teaching tool, these deepen engagement with the text and the field more broadly, and help the reader to reflect on the information and processes explored. The use of headings and sub-headings enhance the practicality and accessibility of the book, lending itself to individualised readings. However, there are no visual components to this long 665-page book. Visual components may have been useful as an additional learning tool to engage readers and divide and demonstrate particular components of the text.

Another strength of this book is its exploration of the use of music for health and healing from a multitude of angles and perspectives. *Peters’ music therapy* is underpinned by the philosophy that introductions to music therapy should accentuate the use of music as core to the treatment process in order to differentiate music therapy as a therapeutic field and profession. Lathom-Radocy offers various sociocultural and academic perspectives on the use of music, including understandings from indigenous and ancient cultures, scientific and educative fields, and of course, from music therapy research. However, inevitably, there are core aspects of this text that are specific to American music therapy or influenced by the United States’ traditional, medical and behavioural theoretical lineage. For example, the definition of music therapy central to this text focuses on music-based experiences as “planned, goal-directed [and] specifically prescribed [to] influence positive changes in an individual’s condition, skills, thoughts, feelings or behaviours” (p. 5). This varies from the Australian Music Therapy Association’s definition, which is centred around the use of music to “actively support”, rather than influence, people as “they strive to improve their health, functioning and wellbeing” (AMTA, 2012). Despite this, the research of many key Australian music therapists is referenced throughout the text.

The scope of music therapy research and practice has expanded significantly since the turn of the century. As well as this, the core understandings, notions and language associated with many contexts and fields that music therapy exists within are ever evolving. One limitation of this text is the lower than expected percentages of referenced or suggested readings published since the year 2000. The suggestions for further reading at the end of each chapter are a useful resource that seek to enable readers to expand their knowledge in a specific area if they desire to do so. However, Lathom-Radocy only ‘hand-search’ two journals to update literature for this edition; the *Journal of Music Therapy* and *Music Therapy Perspectives*. The author acknowledges this limitation, justifying the length of the text as a confining factor. While it is important to acknowledge previous research (and there remain core concepts that are still relevant), this text may have benefitted from excluding some older literature so that literature reflecting more current thinking could have dominance in the reference list.
Peters’ music therapy is a well-written and useful text for people both within and outside of the music therapy field. Although it is based on more traditional models and approaches, these models are often used as a starting point or ‘introduction’ to music therapy practice. It is outside the scope of this book to explore community, resource-oriented, feminist or other contemporary approaches to music therapy, despite their growing relevance in research and practice. Despite its length, the structure and clarity of this book makes it easily accessible, with music therapy emphasised as a unique and valuable therapeutic practice.