**Music Therapy and Dementia Care**

“Music Therapy can make the difference between WITHDRAWL and AWARENESS, between ISOLATION and INTERACTION, between CHRONIC PAIN and COMFORT, between DEMORALIZATION and DIGNITY” – Barbara Crowe, Music Therapist

Earliest attempts to empirically study what best improve quality of life of patients with dementia dates to the 1700s. While some studies focused on understanding pharmacological impact on dementia (Bianchetti et al., 2006), others studied the impact of non-pharmacological methods such as music therapy (Raglio et al., 2008). Earlier studies on music therapy were limited to drawing positive associations on physical health (Dainow, 1977) which were later expanded to include emotions and behaviours of listeners (Hevner 1936; Bradt and Dileo 2009).

Mixed results have emerged highlighting the impact of music therapy on improved quality of life for people with dementia. For instance, a randomised control trail (RCT) conducted on 77 patients with dementia in a residential care concluded that levels of agitation were reduced by up to four hours for patients exposed to music therapy as against the group assigned to recreational activity (Dainow, 1977). Although the study confirmed reduced agitation, the impact was statistically insignificant thereby, suggesting that there may be not significant difference between music therapy and recreational activity. On the other hand, Raglio and colleagues’ RCT undertaken on 59 patients concluded music therapy had significant effect on certain psychological and behavioural symptoms such as delusions, agitation, anxiety, nigh-time disturbances and so on. This significance was particularly true for patients suffering from moderate to severe dementia. More importantly, the study focused on drawing conclusion to long term effects therefore, suggesting to us that music therapy is indeed beneficial in the long run. Despite mixed results especially in the short-run, music therapy assists in improving the quality of life of people with dementia. Music therapy may also be considered more appropriate in comparison to pharmacological interventions since medications generally come with side-effects. This is not to say that people with dementia should ignore medical treatment for dementia but rather to think about music therapy as a complement to such treatments.

Although previously made known of the positive impact of music therapy, music therapy may be considered most effective when a person-centred approach is adopted. Exhaustive research conducted in the UK has concluded that a person-centred approach should become the norm for dementia care and management (Alzheimer’s Society, 2007). In addition, Alzheimer’s Society, has been extensively advocating and setting standards that various stakeholders are advised to adopt while caring for people with dementia. However, Brooker (2003) highlights that what constitutes as ‘person-centred’ is not well-defined and more importantly, not straightforward. To further the argument, Brooker’s (2003) own study highlighted for some, ‘person-centred’ approach meant individualised care while for others, it was more of a technique used to work with people with dementia. Nevertheless, it is critical to ensure that organisations and all those involved in dementia care and management should be articulate on what is meant by a ‘person-centred’ approach and how best to implement it.

Theoretically, Brooker (2003) brings forward a holistic model of the person-centred approach. According to this model, person-centred care (PCC) involves four critical elements, each contributing in its own way and no element overpowers the other. The elements include (1) **V**- valuing people with dementia and those who care for them (2) **I-** treating people as individuals (3) **P**- looking at the world from the perspective of a person with dementia (4) **S**- a positive social environment in which the person living with dementia can experience relative wellbeing.

**PCC (person-centred care) =V+I+P+S**

In addition to identifying elements that theoretically constitute the ‘person-centred’ approach, it is crucial to further establish what each element represents.

The first element ‘V’ lays focus on valuing a person with dementia and their carer. More simply, this element lays emphasis on what Rogers (1961) calls the value attached to being non-judgemental and acceptance of the unique aspects of a person. However, it is crucial to first establish how the term ‘person’ is defined in the ‘person-centred’ approach. One controversial and highly debated definition of the ‘person’ is based purely on ‘someone having mental capacity and comprehension’ (Locke in Larson, 2005). However, such a definition is rather suggesting that a person with dementia doesn’t account for being a person in the 1st place. Nevertheless, more recent thinkers define a ‘person’ as ‘situated embodied agent’ (Hughes, 2001). Hughes (2001) further explains that carers and trainers should aspire to treat people with dementia in a way in which they wished to be treated. Therefore, interactions with people with dementia should be no different from the interaction otherwise had with other members of society.

The element ‘I’ encompasses everything that is directed towards providing individualised treatment (Brooker, 2003). More simply, it involves the challenging task of understanding strengths, weaknesses, interests and vulnerabilities of each person. Interventions are reported to be more effective especially in the case of dementia when action plans and interventions are based on understanding the above-mentioned aspects. More specifically, research suggests that for an effective intervention, it important to move away from boxing people into pre-defined categories but to view them on a case by case basis.

The third element ‘P’ or looking from the perspective of a person with dementia is critical as it is viewed as the starting point for explaining behaviours (Rogers, 1961). Similarly, Validation Theory also argues that understanding and acknowledging the subjective world of people with dementia should be the starting point for intervention (Feil, 1993). Dementia Care Mapping (DCM) is a popular tool used to understand perspectives of people with dementia by using several observational and empathy skills (Kitwood, 1997). Previous studies highlight that is efficacy in DCM as a tool (Brooker and Psychol, 2005). This tool requires trainers/carers to record various behaviours according to certain codes and categories pre-defined by the tool. Although the usage of the tool requires skills and usually long hours of observation and recording, it adds value to the ‘person-centred’ since it allows trainers/carers to really view the world from the perspective of people suffering from dementia.

Lastly, the element ‘S’ or positive social environment embodies all relationships between a person with dementia and those they closely communicate with. Communication should not be limited to verbal but rather, studies highlight more merit in identifying and establishing non-verbal communication between people with dementia and their carers (Rogers, 1961). Establishing such relationship is essential to the ‘person-centred’ approach since the sense of self of self for people with dementia is embedded within these relationships (Brooker, 2003)

Although the theoretical meaning and understanding of the elements are highlighted it pivotal that these elements are neither under nor over emphasized while engaging people with dementia.

The following table is suggestive of the consequences of under or over emphasis of the elements of the person-centred approach.

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| **UNDER-EMPHASIS** | **ELEMENT** | **OVER-EMPHASIS** |
| Discriminating within care organisations and policy agenda against people with dementia and those who care for them | **“V”: Valuing people with dementia and those who care for them** | Care evangelism. Platitudes that people agree with but don’t know how to put into practice |
| Chaotic and inappropriate assessments and care plans of people with complex needs and life histories | **“I”: Treating peoples as individuals** | Lots of paperwork. Care plans are all different from each other but meet individual needs only within a narrow range |
| Care will not meet the priorities of the individual. High levels of challenging behaviour and learned helplessness | **“P”: Looking at the world from the perspective of the person with dementia** | Lots of information collected but never used appropriately |
| Poor communication and lack of dementia-aware interpersonal skills by staff. Organisational emphasis on safety and aesthetics | **“S”: A positive social environment** | Slavish following of techniques. Frequent changes in direction as latest techniques are tried and discarded. |

(Brooker, 2003)

**The Way Forward:**

Evidence suggests that the most effective way to improve quality of life of people with dementia is to ensure that care and management is ‘person-centred’. Therefore, firstly, it is important for the organisation to be mindful of their processes, practices, systems and interactions they have not only with people with dementia but with their primary givers as well. Having been mindful of the above will help to identify to what extent the organisation is ‘person-centric’. Moreover, it would also be effective to seek assistance from external researchers, experts in Dementia Care Mapping (DCM) to assess the extent to which staff adopt the person-centric approach.

Secondly, it is critical that staff are trained with the skills to carry out their own DCM. This is particularly important for two reasons. First and foremost, having the skill to conduct DCM will help staff engage with people with dementia from a more person-centric approach and thereby, better understand feelings, behaviours and issues of dementia patients. Secondly, when the organisation has skilled staff, they can further help train primary carers which, in my opinion may be more important since primary carers spend most amount of time with people with dementia. Although DCM is more of a technical tool, it really helps to view the situation from the perspective of the client which, may result in less frustration and agitation for the carers. Moreover, while providing such training, it may be a useful platform for all stakeholders engaged with care and management to work better and towards a common goal.

Thirdly, more specific to music therapy, it may be useful for trainers of the organisation to engage more with clients and their carers to understand better the element ‘I’ i.e. strengths, weaknesses, interests and vulnerabilities. Interactions need to be extended to focus on life events, important dates, impactful experiences and so on. Furthermore, it is critical to record reactions and emotions of people with dementia during process of music therapy to understand how, what type and why certain types of music impact people with dementia.

Lastly, it may also be important to conduct music therapy with the carers since, there is evidence that music tends to reduce stress. This can be used as an opportunity to not only help carers but also build relationships. Having a positive relationship with carers is as important as engaging with people with dementia since improving quality of lives of people requires all stakeholders to work together towards a similar goal.

Although the list of recommendations is not exhaustive, the most important recommendation would be design and transform current systems and practices towards being more ‘person-centred’.

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