Giving Voice to Service User Choice:

Music Therapy as an

Anti-Oppressive Practice

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Music therapy experiences are informed and impacted by one's personal relationship and history with music and dance.

The expert skills of a professional music therapist to build therapeutic relationships using music and train music therapy interns increases healthy responses from residents, families, and staff.

Music therapy fits in well with the resident centered Eden-Care philosophy.
at the German-Canadian Care Home

Although music therapy is valuable it should not be forgotten that the centre is a difficult place to be.

The music therapist respects people’s concerns about music keeping in mind the possible negative effects of music and music therapy.

The music therapist respects people’s concerns about music and possible negative effects of music and music therapy.

The music therapist has encouraged and supported the staff to feel comfortable to use music to more effectively support residents' musical needs at Arbourview Residence.

Music is a valuable resource for all people including people with dual diagnosis developmental delay/mental illness, stimulating memory, helping with socialisation, and improving mood.

Although music therapy is valuable it should not be forgotten that the centre is a difficult place to be and that some residents have high support needs that may be better addressed through experiencing the choice of other therapies.

Clients with dual diagnosis developmental delay/mental illness struggle with a significant lack of support in the community.

The professionals on the team respect and appreciate each other’s quality and competence.

Music therapy is a hassle for some staff and they do not appreciate its value to residents.

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Abstract

Societal structures create and maintain disparities between persons of dominant and non-dominant status affecting all aspects of the community including healthcare service delivery. Music therapists as healthcare providers have a responsibility to explore ways that social justice approaches can address and mitigate discrimination in music therapy education, research, and practice. Anti-oppressive practice (AOP) offers a systematic way to disassemble inequity in practice and to inspire inclusive practices. In order to consider how music therapy can operate as an anti-oppressive practice, this thesis explored the question; What are the experiences of residents and staff in music therapy as an anti-oppressive practice? Interviews were conducted with older adults in a residential setting who were living with complex health conditions including dementia, and with residents who have dual-diagnosis intellectual deficit/mental illness referred to an assessment service for teens and adults. Analysis of the interviews using Constructivist Grounded Theory indicated that music therapy is perceived as valuable in providing a broad spectrum of support including in improving socialization, mood, and communication, but potential negative impacts can occur if music is not provided sensitively. Music therapy was additionally observed to foster positive relations between staff and residents although some staff considered music therapy was a hassle for them. The song-based music therapy service model developed by the author and described by interviewees were contextualized through a reflection on the service development and training experiences of the author. This is provided through historical description and critical autoethnography. The wider literature about music and human experiences was consulted for further context and rationale. The research processes and findings of the interviews and autoethnography revealed that it is the inclusive collaborative expertise of the music therapist which allows the social justice framework of anti-oppressive practice to be evident in her music therapy service and music therapy research.
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Service users and their caregivers volunteered to participate in the research, to share their experiences of music therapy services. Their openness and consideration was invaluable and I credit and thank them for the willingness to give their time and energy to advance service user led music therapy approaches.

My PhD colleagues have also radically shaped my journey. Thank you Triona McCaffrey for initiating my relationship with the University of Limerick and both Triona McCaffrey and Jason Noone for sharing your expertise and enthusiasm for inclusive collaborative service user led music therapy practices, and the synchronicity that brought us together in PhD studies.

To the music therapy friends and colleagues who offer continued support and critique for my research and publications, encouraging me to develop service user led music therapy practice, thank you. Also, to my music friends and colleagues who inspire and challenge me artistically, my gratitude.
Without the support of my family and friends, my doctoral research would have been so much more difficult. Thank you to my partner Steve Cottrill for your endless patience and support and for being my rock these three years and always. Thank you to my sons, Zack and Raffi Baines-Mallel for your encouragement and care and my parents, sisters, brother and extended family, your words of support have been so appreciated. Thank you friends for the hugs, words of support, and good luck gifts. You are all vital to the completion of this research.

Like being the soloist with a music ensemble, the service users, their caregivers, and my family, friends and colleagues have provided grounding and inspiration throughout my doctoral journey. The musical truths of creation, pulse, rhythm, tempo, dynamics, melody, harmony, phrase, and form have informed and guided my research. This thesis is dedicated to music and all of music’s metaphors.
List of Presentations and Publications Arising From the Thesis


Ireland to the International Association for Music and Medicine 4th Annual
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Chapter One

Introduction

The Vision

Anti-oppressive practice (AOP) is an approach to human services in which social justice is the central operating principle (Potts & Brown, 2005; Larson, 2008). Music therapy as a human services profession requires a social justice framework to increase ethical conduct and good practices, with the concurrent acknowledgement that music and songs exist within a sociopolitical context. Anti-oppressive research practices seek to incorporate services user’s voice to develop practical solutions to service development through respectful processes of inquiry (Potts & Brown, 2005; Larson, 2008). Working in partnership with service users and their relatives and carers to create and develop health services is increasingly accepted as necessary within the AOP framework (Hopton & Nolan, 2003).

To explore the topic of this thesis, a study was developed to incorporate and amplify service user’s voices by inviting them to describe their experiences of music therapy services. Carers were also invited to share their perspectives. The goal of this process was firstly to learn how to enhance music therapy practice for these research participants/service users and secondly, to better understand music therapy practice and music therapy research as an anti-oppressive practice. As presented later in the thesis the
guiding question developed for the project was, *What are the experiences of residents and staff in music therapy as an anti-oppressive practice?*

In keeping with an AOP sensibility, to understand better the experience of people who are observing or participating in music therapy sessions, they were consulted directly, upholding AOP values of inclusion and consultation with stakeholders. Participants included service users, staff, and carers at two sites where music therapy services have been developed and where I have worked for over six years. One site provides long-term residential care for older adults with complex care needs including dementia diagnoses. The other site provides an assessment and planning service for adults and teens with dual-diagnoses mental health and intellectual disability in short-term psychiatric locked residential treatment.

The development of music therapy as an anti-oppressive practice has occurred organically through a reflective integrative process of over two decades of music therapy practice and social activism. To contextualize this understanding, related themes of my prior training are presented and discussed as well as personal information linked to my relationship with and understanding of music.

This research study used the qualitative interpretivist approach of Constructivist Grounded Theory (CGT), which has been described as a structured yet flexible methodology (Charmaz, 2006). CGT was chosen for its capacity to incorporate, reflect, and engage an anti-oppressive practice framework. Interviews were undertaken with fourteen people across the two healthcare sites and transcribed. The transcriptions were then systematically analyzed employing a method of thematic analysis where feedback and participatory commentary from research participants was described. These
descriptions or codes were analyzed, categorized, presented, and reflected upon and have been discussed further in the final section of the thesis.

Additionally, an autoethnographic research process was engaged from the outset of the thesis. This honoured reflexive tradition within qualitative research, where the researcher’s thoughts, history, and experiences contribute to the analysis of the data, as well as to the framing and presentation of the findings. The autoethnographic work allowed exploration of themes of power, in particular the role of music and music therapy within healthcare systems where power dynamics can be hidden within a public or outward rhetoric of care and concern that can mask unremarked habits of coercion and control.

The structure of the thesis

The first part of the thesis reflects on the models of practice that underpin the development of music therapy as an anti-oppressive practice. The second part is a critical review of literature of the uses of song for the development and maintenance of human health, locating and substantiating service users’ preferred song-based music therapy approach. Subsequently, the research is located historically. This is followed by a review of Constructivist Grounded Theory and Autoethnography research methods. The results section including interview data, analysis, and autoethnography follows concluding with a discussion in which music therapy as an anti-oppressive practice is further conceptualized and critiqued.

Consistent with a number of post-modern research methodologies, biographical details and reflections are presented as part of the research process (England, 1994;
Norum, 2000; Mosselson, 2010; Edwards, 2012; O’Callaghan, 2012). These details provide a rich description of the educational, cultural, and social experiences that influenced and shaped the ontology and epistemology of the research undertaken and are woven throughout the thesis for further contextualization.

Background to the Research

Thompson and Pascal (2011), writing about critical reflection explained that, “However far we develop our understanding, there will still be much further to go. This is entirely consistent with the idea of reflective practice,” (p. 24). The core of my approach to research is critical reflection and has taken many forms over the years. On a personal level, this has included things such piano improvisation, journaling, professional supervision, and feminist/anti-oppressive analysis. On a social level, reflection has taken the form of collaborative research with clients to explore their understanding and awareness of the impact of music therapy in their lives. To further this social reflection, this work was submitted to international scrutiny through publication in peer reviewed journals (Baines, S., 2000/03; Baines & Danko, 2010) and presentation at national and international conferences.

Critical reflection has also shaped my understanding of music therapy service delivery. Different models and approaches to music therapy and healthcare service delivery influenced key elements of the way I practice music therapy and have impacted the development of music therapy as an anti-oppressive practice. Themes of
collaboration, inclusivity, and empowerment are threaded throughout my journey with these foundations.

Music is the most foundational truth of my existence. Much of what I know and understand about life is through experiences and metaphors of music: patterns, sequences, dynamics, harmonies, forms, expression, co-creation, lyrics, feelings, memories, and more. One of my earliest clearest memories is of standing, reaching above my head, and plinking the notes on the piano, listening, as I stood as tall as I could, under the keyboard. The longer I live, the deeper my connection with music has become.

I was raised in a family where I was expected to work hard, encouraged to question authority, and ultimately, to make a contribution to society, participating in social action from a young age: first through church-based programs, then peace marches, and then later in university student action. Ultimately I trace my current employment in health and my ongoing work for social justice from these values I learned in my family of origin. My on-going social action consists of increasing consciousness of anti-oppressive practice in music therapy and music therapy education, increasing global peace consciousness through working for Music Therapists for Peace, www.musictherapistsforpeace.org, and developing inclusive large group approaches to music therapy practice that are effective with a broad spectrum of clinical diagnoses.

I came to the field of music therapy because, throughout my life, when I was not feeling good, music made me feel better. To feel better, I simply needed to find the motivation to play or listen to the music I needed to hear, and my feelings would improve. When motivation for music failed when dealing with life stress through late teens and early adulthood, I tried the conventional approach to feeling better which was
verbal psychotherapy. I inevitably left my sessions feeling worse; acutely aware of what was not working in my life and did not feel I was making progress. I tried changing my diet and implemented an exercise program but experienced little positive result from these holistic interventions either. These experiences inspired me to learn more about the mechanics of my musical feeling better experience and ultimately desired to share it with others who were not feeling good through the study and practice of music therapy.

Music has always played an important role in my life. There was usually music sounding in my childhood home: classical music, Irish tenors, musicals, and church music from mom and dad who also enjoyed country, jazz, pop, and folk. Formal instruction in music began with piano lessons at age six. I sang weekly in the church congregation where I experienced the bliss of group singing accompanied by the organ. I regularly attended symphonic concerts with my mother watching in childish joy as the orchestral members expressed their music through their co-joined bow strokes, each moving slightly differently and yet all similarly. I loved to watch the audience responding to the music, leaning forward, or back, nodding in time to the pulse, often closing their eyes with their faces softening in response to their listening.

At the age of twelve, I joined the school concert band to play French horn. I loved the different timbres of the wind ensemble creating melody and harmony together. When it went well, we experienced that wonderful group high of co-creating with intention. At fourteen, I got my first job, playing piano for ballet classes. Here, I observed how I could assist people to move by the manner in which I expressed myself on the piano. That year, I purchased a guitar and a harmonica and had fun singing and playing music with my friends at campfires and parties. I joined a world-class marching band, learning to
perform first on French horn and then on euphonium while I marched in international parades and shows. I worked in a record store where I observed and assisted people to choose music recordings to buy for personal use while I continued studying music in private piano lessons and group music training through the high school and community marching band.

Subsequently, I studied music at the bachelor’s level at the University of Calgary completing courses in each of the music divisions; education, composition, and accompaniment, supplementing my music studies with courses in English, psychology, sociology, anthropology, and women’s studies. I sang in the women’s and jazz choirs and played piano in the university wind ensemble. To support myself, I improvised piano music for university ballet and modern dance classes, taught piano, and accompanied fellow music students for their recitals and juries (examinations). Following this, I initiated my Bachelor of Music Therapy at Wilfrid Laurier University. I continued to study and perform classical music on piano, sang with the mixed choir, and initiated a vocal jazz choir. To support myself, I performed, playing pop and light jazz piano in restaurants, lounges, at golf courses and bars, observing people interacting in response to the music I played, learning to play their favourite pieces so that they would continue to support me. These many experiences of working with the public as a professional musician in combination with my music therapy education framed my understanding of my training and informed and deepened my life-long foundational relationship with music.

My formal studies in playing music, early piano lessons, Bachelor of Music, and Bachelor of Music Therapy all had classical music at the foundation. Introductory studies
in music therapy revealed that the pioneers of the music therapy field all had classical music as their background. This Eurocentric music education was unremarked in the field, and I sought to better understood and inform myself through developing a feminist analysis of the history and practices within music therapy.

During my course work first music therapists and models studied were Mary Priestley (1975), Nordoff and Robbins (1971), and Juliette Alvin (1978). Each of these models focused on improvisation derived from classical Western-European musical roots. Composed songs were mentioned but many of these songs originated in the Western classical music tradition. As a post-modern Canadian woman with understanding of cultural imperialism, a woman that participated in many styles and forms of music finding therapeutic merit there, I was concerned that much contemporary or popular music and more importantly, personally culturally relevant music, was neglected in the aforementioned foundational theoretical perspectives and practices of music therapy. As my personal perceptions and experiences of health and wellness were shaped by post-modernism and integrated humanistic, existential, feminist, cognitive-behavioural, and rehabilitative therapeutic concepts in addition to psychoanalytic understandings this lack of musical inclusiveness did not sit well with me. Historical Eurocentric foundations that are essential to locate approaches to music in music therapy did not fit well with my worldview.

Next, Gertrude Orff (1974) and Florence Tyson (1981) were presented; two practically based music therapy approaches that were more congruent with my music-based way of being. Tyson’s (1981) work in particular resonated with my own experiences: that people desired music experiences typical of their cultural origins as part
of their health maintenance. These models of music therapy employed a broader spectrum of musics in their practice including popular forms from clients’ cultures. In practicum courses, we addressed clinical goals using familiar songs with older adults in long-term residential care and familiar song structures such as the blues form with teens with conduct disorders. For my final practicum, I had the privilege of supervision from Fran Herman (Herman & Smith, 1988), one of Canada’s pre-eminent music therapy pioneers. Music therapy experiences were improvised in the context of familiar song.

My next developmental stage was music therapy internship in Manhattan, New York, at Terence Cardinal Cooke Health Care Center with Helen Mandel Grob. Grob was a Paraverbal Therapist trained by Evelyn Heimlich (1980; 1987). Grob integrated this learning with her deep understanding of music and developed a music-based approach called Music Therapy Using Paraverbal Techniques (Bruscia, 1987). Subsequently, I worked for two years at a non-profit service agency in Manhattan, New York with children and adults with dual diagnosis developmental delay/mental illness.

In this job, I modified music therapy using paraverbal techniques to include a feminist analysis. Among the many elements I assessed for was the clients’ deepest connection with music by offering a variety of music therapy experiences and clinically observing responses. Then a specific music therapy program that worked to resource clients through that connection was developed.

The first clients I worked with were school-aged children with visual impairment and dual-diagnosis developmental delay/mental health in a specialized school. In individual music therapy sessions, I sometimes employed my improvisational skills creating musical dialogues with children with multiple needs but primarily used songs as
the foundation of my practice. Songs helped the children create structure in their otherwise often confusing environments. Songs helped them sequence tasks. In group music therapy, songs helped group members support each other in social skill development, story telling, increase short term memory skills, and a myriad of other skills that assisted the children in increased control over, functioning, and agency.

Following a year working in the school, I moved to the Adult Day Treatment Program and the Adult Continuing Treatment Programs. These were programs that served adults with visual impairment with dual diagnosis developmental delay/mental health and mental health/developmental delay respectively. Again, I found that the use of song was vastly preferred over any other music therapy technique. Clients independently used songs to motivate themselves, to relax themselves, to focus, to pass the time, and more. A group of clients requested a music therapy group based on do-whap music and experienced joy and community as they sang together in harmony, happily discussing the songs and performers. With their superior knowledge of the music that resourced them, my role was to support healthy group dynamics. Their songs and singing their songs clearly had many important meanings and offered therapeutic opportunities.

Although it would be difficult to argue that a unilateral Eurocentric position exists, there are many contributing histories and experiences that allow theorists and other researchers to reveal Eurocentrism. For over a hundred years European values, ideas, and concepts have served as a foundational ideology of Western social sciences (Gheverghese, Reddy, & Searle-Chatterjee, 1990). This has had a powerful influence in the development of therapeutic practice (Naidoo, 1996; Walls, 2004; Hays, Chang, & Dean, 2004; Sonn & Green, 2006; Wilcoxen, Magnuson, & Norem, 2008; Ryba &
Schinke, 2009; Van Herk, Smith & Andrew, 2010; Hall & Brelan-Noble, 2011; Pilgrim, 2014). As Eurocentrism can be hidden and unremarked, it is essential that analysis be undertaken that confronts, challenges, and reveals this influence, ultimately empowering service users and service providers to dismantle the dominative and assimilative results of colonialism (De Lissovoy, 2010). I felt that music therapy would benefit from a framework by which to explore Eurocentrism and colonialism in practice and research and that led me to further research study.

I completed my Master’s degree at New York University while working in the programs described above. The focus of this education was Music Psychotherapy. Requirements of the program included study of the improvisational model of music therapy as well as introductory Guided Imagery and Music and introductory Vocal Psychotherapy. These advanced studies informed my daily music therapy practice philosophically, theoretically, and practically. Philosophically, I became more conscious of the European and American psychodynamic and humanistic models of psychology throughout all aspects of the music therapy program where I yearned for feminist critique. Theoretically, I became clearer on my political roots and how that affected my critical analysis of academics. Practically, my academic learning offered valuable information on how to work with persons in alternative states of consciousness due to participation in therapeutic music-based experiences. However, unlike the aforementioned models I was studying, in my employment, I continued to be song-based, grounded in my clients’ preferences.

This paradox was explored in my Master’s thesis, “The Sociocultural and Political Context of Music Therapy: A Question of Ethics,” (Baines, S., 1992). In this work I
researched the prominent music therapy models of that time, Activity Music Therapy, Improvisational Music Therapy, and Guided Imagery and Music, in terms of their historical roots and sociocultural perspectives. My research illuminated that historically, each of these models was Eurocentric, founded in psychological theory and music developed in England, Germany, or the United States. Practitioner preference or training background directed the model of music therapy used and the musical methods employed. Professional Music Therapists trained and then offered their specific model of music therapy to prospective clients and clients then worked within that model irrespective of the client’s psychotherapeutic preference, musical preferences, or cultural background. Gonzalez’s (2011) research explored this phenomenon finding that music therapists were drawn toward approaches and interventions similar to dynamics they were familiar with in their music cultures.

Working from a feminist analysis, it seemed to me that to function in a truly client-centered manner, music therapy practitioners should broaden their therapeutic paradigms to include client as expert. Practitioners needed to respond to the clients’ right to participate in personally meaningful musical experiences. Ultimately, this was described as an ethical imperative: to offer culturally and personally meaningful music therapy experiences as requested and co-created with the client. A journal article presented a portion of this research (Baines, S., 1994). After completing this education, I then employed a feminist analysis in work across a broad spectrum of music therapy settings and populations grounding my academics in real-life music therapy experiences to study the results of applying this theoretical position practically.
In 1993, I returned to Toronto, Canada to build a music therapy practice. Canada is a one-party payment health care system although over the past few decades, a two-tier system is emerging. The first tier provides health care for the vast majority of Canadians. Music therapy is rarely supported in the public tier of practice. The second tier is the much smaller upper socio-economic class who can afford to pay for music therapy privately. Occasionally, non-profits groups or other payers support music therapy programs, particularly for clients with increased complex care needs. Because music therapy is rarely supported in the mainstream health care system in Canada, it has become a therapy available primarily for the wealthy/elite. The on-going lack of financial support for music therapy services in this system is an issue illuminated through the anti-oppressive practice lens.

In this environment of fiscal restraint, I worked to develop music therapy practice. A few hours were spent weekly at a complex care facility. When I shared my newly learned academic models of care, the older adults had different plans. In opposition to the methods of music therapy I had been taught, they requested that they be able to sing their favorite songs while playing percussion instruments. A few more hours each week were logged at four group homes for adults with multiple disabling conditions. Here, favorite songs were preferred as well. The clients exhibited minimal to no response until they were engaged in song-based experiences with their preferred songs. In addition, I worked with two young men who had experienced traumatic brain injury. For each of these men, singing their favorite songs was the backbone of their therapeutic process. In addition, one of these men found it helpful to express himself through writing songs, using the structure of the song to help express difficult feelings with difficult to access words.
The following year, I moved to Vancouver where music therapy was more established and more work was available. In the complex care facilities where I was employed two days per week the on-going request of the residents was for song-based work. This refined and honed my interest and knowledge regarding the developing song-based approach. I was also working in community mental health settings with adults with severe, chronic and persistent mental illness. Again, despite exposure to improvisational and imagistic methods of music therapy provided in sessions, clients indicated that listening to and/or singing songs was preferred. Similarly in my work in youth corrections and with males who have ASD songs were the most successful way to engage in sessions. By the late nineteen-nineties, I decided to study and publish about this service user preferred approach to music therapy (Baines, S., 2000/03) that appeared to be very beneficial in all domains of functioning: physical, communicative, emotional, social, and spiritual supporting intra-psychic as well as inter-psychic development. According to the results of the research, resourcing clients through programming their favorite songs into their lives in a predictable manner was often rehabilitative and offered clients an on-going sense of empowerment and wellbeing, (Baines, S., 2000/03). This research was replicated and expanded in 2010 (Baines & Danko, 2010) to include staff and management survey data as well as in-depth interviews with service users. Similar results were found to support song-based sessions as meaningful and helpful for clients from a range of service contexts.

This overview of my personal journey provides the background to the research presented in this thesis. My narrative reveals consistent interest in the service user voice, and the client perspective in the development of treatment methods and services.
Therefore the research reported here has strong and extended roots from my vision of client centeredness and client informed practice in music therapy.
Chapter Two

**Literature Review of Influential Theoretical Perspectives and Models of Practice**

*Introduction*

This literature review follows the conventions of CGT in focusing on materials pertinent to the research (Charmaz, 2006). Reflection on the origins of my approach to music therapy reveal that I am drawn to ways of practicing, evaluating, and researching that have at their centre a concern for the goal of empowerment informed from feminist theory and feminist therapy, music therapy using paraverbal techniques, group theory and music therapy, psychosocial rehabilitation, and community health and health promotion, psychological considerations, the role of music in music therapy, and anti-oppressive practice. This chapter will explore the influence of these theoretical perspectives and models of practice followed by a review of applicable psychological considerations. To conclude, the role of music in music therapy practice will be reviewed.

*Feminist Philosophy and Therapy*

My maternal grandfather’s mother was a suffragist and worked for women in Canada and in the province of Ontario vote. Her son, my grandfather was a pacifist who went to World War I to do his duty but refused to carry a gun, opting to be a stretcher-bearer instead. I was raised to believe that I was the equal of all other persons. However,
once I was out in the world my experience in the broader community did not match with this family philosophy. In the community, I was expected to act and dress in certain ways based on cultural norms in that setting rather than being myself. This social dissonance was foundational in the development of my feminist consciousness. The phrase, “the personal is political” (Hanisch, 2006) a fundamental tenet of feminist philosophy, eloquently described this experience; that personal experience is shaped by political truth. “Each woman’s [person’s] personal experience and situation is a reflection of the position of women [those people] generally in our society” (Cammaert & Larson, 1988, p. 15).

The words in [ ] are my addition to update and use inclusive language in the quote. In other words, ones privilege in life is dependent upon the privilege and power structure that one was born into. In my life, I had the privilege of being born in Canada in 1962 to white middle class parents who valued advanced education and who empowered me. I had the disadvantage of being born female in a gendered sexist culture.

Feminist theory is committed to dreaming of and working towards a better future (Haran, 2010, p. 393). My feminist analysis developed through independent studies in feminist theory, university Bachelor’s level women’s studies courses, and through consciousness raising activities such as social activism in the women’s, peace and student movements. This perspective was applied to my other courses. A Master’s women’s studies course on women and mental health that was particularly critical critiqued medical/psychiatric and psychological theory and practice from a feminist perspective. The required reading on feminist psychotherapy (Dutton-Douglas & Walker, 1988) structured my patchwork feminist analysis into a workable therapeutic framework and personal process. Reflective processes taught that the feminist therapist should engage in
a continuous process of consciousness raising through internalizing what is learned from therapeutic encounters while providing knowledge and skills to clients (Cammaert & Larsen, 1988). Knowledge is power and feminist knowledge is a powerful tool for developing efficacious ethical socially just practice.

Feminism contends that the accumulation of knowledge has been controlled by a privileged male hierarchy and the shaping of knowledge has occurred in accordance with male criteria of achievement and performance (Ballou & Gabalac, 1985, p. 23). Baines, D. (1992) stated that,

Like feminist ethics, feminist knowledge is an evolutionary and on-going process. However, it is one that is essential to the development of non-biased ethical practice. Feminist theory is a process and is in process. Its continued development is guaranteed by its tenets of continued consciousness raising and knowledge evolution … ensuring ethical and authentic interactions (p. 48).

Through reflective feminist practice, disparities and inequities can be addressed rather than ignoring negative influences, which can creep into practice in unacknowledged ways. For example, acknowledging the high rates of physical, emotional, and sexual abuse and offering support to all those who exhibit those symptoms can be realized. Acknowledging the historical oppression of people excluded from privilege because of the colour of their skin including in the field of feminism and working to dismantle these social barriers can be addressed. And in particular,
empowering the voice of marginalized service users through developing co-creative, efficacious, respectful music therapy practice and research processes can occur.

*Paraverbal Therapy and Music Therapy Using Paraverbal Techniques*

The model of music therapy practice during my internship was Music Therapy Using Paraverbal Techniques. Paraverbal Therapy was developed in response to a need created by deinstitutionalization in New York State in the nineteen-seventies for children with disabilities moving into the community who did not respond to typical visual and verbal models of care (Heimlich, 1980). Using a psychiatric framework, Heimlich generated a multi-sensory approach she called paraverbal therapy (Grob, 1998). Paraverbal means alongside of verbal (Heimlich, 1980, p. 16) and “Paraverbal therapy is a method of observation, diagnosis, and treatment whose primary goal is the purposeful attenuation of the disorganizing effects aroused … by conventional verbal therapy” (Heimlich, 1987, p. 299). Paraverbal techniques involved the flexible use of alternate, pleasurable channels for communication with a minimum of verbal communication (Heimlich, 1980; Bruscia, 1987).

Helen Grob, CPvT, expanded Heimlich’s psychiatric framework to include a neurological and developmental framework with a focus on communication. Music was not used primarily for its aesthetic qualities but rather, the individual and combined components and characteristics of live music were used in diagnostic assessment to develop goals, objectives, and treatment protocols and to serve as a possible vehicle to address them. Clients were observed, noting all non-verbal cues exhibited in terms of
aspects of rhythm, tempo, pitch, pulse, accent, and dynamics. Rhythmic, cyclic sensory input (visual, kinesthetic, tactile, auditory, vestibular, and proprioceptive) provided the structure for clients to participate in socially relevant experiences in a non-confrontational environment, thereby increasing functioning in multiple domains simultaneously (Grob, 1998, p. 38). Grob preferred live music so the therapist could musically respond to behavioural cues in the moment often stating that the therapist need not be a musical virtuoso but required education in behavioural sciences, psychotherapeutic approaches, human development, and related pathologies. Developmental tasks were conducted primarily through the structure of specifically composed songs. Intermittently, projective songs were created in the moment with verbal clients to assess their perceptions of various situations and conditions in their lives. Heimlich emphasized the value of working with more than one child at a time, how the energy of one child could stimulate increased targeted participation in another (Heimlich, 1980; Heimlich, 1987). “Peer groups are used when peer models are needed and when one client can influence another in areas when a therapist … is less effective“ (Heimlich, 1965, p. 16). Grob utilized this model in individual, dyadic, and group music therapy sessions, including parents, surrogates, and other family members when appropriate (Bruscia, 1987, p. 275).

I completed the internship requirements of my accreditation at three different sites for a period of ten months: in the Developmental Delay Clinic and the Skilled Nursing Facility that served people suffering from Huntington’s disease in a Specialty Hospital and off-site in Spanish Harlem at a Therapeutic Nursery for high-risk mothers with their high-risk toddlers. Grob skillfully connected with persons of all ages with complex
diagnoses and enhanced their overall wellbeing through her model of practice, which was admired and respected by the multi-disciplinary team in the hospital.

*Group Theory and Music Therapy*

Both individual and group music therapy have been demonstrated to have great merit, each offering unique developmental opportunities. There are some people for whom group music therapy is counter-indicated due to specific histories and needs; music therapy group process is not appropriate for every client with every diagnosis. But where there is readiness, group music therapy can provide additional values of meeting the needs of more than one service user simultaneously, empowering group members to support each other, challenging the immense health concern of isolation through shared experience, ultimately offering both increased efficacy and fiscal accountability. In light of the aforementioned reasons together with decades of cutbacks and ongoing underfunding in the healthcare sector, I have focused on group music therapy throughout my training and professional practice. The following literature review of group therapy and group music therapy will inform and contextualize the service user preferred song-based approach to music therapy as an anti-oppressive practice.

Group and community therapies emerged in the late nineteenth and early twentieth centuries as a response to the, “death of communities and the rise of individualism,” (Kemp, 2010, p. 292). Group therapy is efficient, offering different points of view and resources (Jacobs, Massons, & Harvill, 2002; Plach, 1996; Posthuma, 2002) and the success of group therapy included feelings of commonality, belonging, feedback,
vicarious experience, approximation of real-life, and the pressure to maintain commitments (Jacobs, Massons, & Harvill, 2002). In group therapy, membership in the group typically arose from needs as well as availability, much like real-life social experience (Posthuma, 2002). Recent literature addressing the value of group work is available in many areas of practice: from the ineffectiveness of group therapy interventions with Turkish migrants women with recurrent depression (Renner & Berry, 2011), or the value of group therapy for social skill training in groups for persons with traumatic brain injury (Braden, et al, 2010). Group interventions are both cost-effective and therapeutically effective (Peterson, et al, 2008).

Baines’ (Baines, S., 2000/03; Baines & Danko, 2010) open group music therapy model of practice, the clinical precursor to music therapy as an anti-oppressive practice, most closely resembles a self-help group with an expert facilitator. Traditional self-help groups grew out of the mutual support model exemplified by Alcoholics Anonymous. The power of the self-help model is revealed in the estimate that the number of persons in self-help groups rivals the numbers in both individual and group professional therapy combined (Yalom, 1995). Disenfranchisement and frustration with available services because of increased sophistication of service users plus decreased traditional support systems may account for the growth in the self-help movement (Posthuma, 2002). Self-help groups offer a sense of belonging, mutuality and universality (Posthuma, 2002), characteristics that can be analogously applied to the open group music therapy process that I have developed. Empowering of the service user to choose self-help, music therapy, and other non-traditional approaches to health maintenance is in keeping with anti-oppressive practice.
To describe the music therapy research model, the role of the group leader must be explored. The field of self-help psychology can again provide some helpful parameters. Between seventy and eighty percent of self-help groups employ expert facilitators, exemplified by groups such as cancer survivors and persons living with HIV/AIDS (Yalom, 1995). Yalom (1995) reported that qualities of a good leader include the ability to provide emotional support and stimulation and manage the group’s energy. Effective leaders are present, comfortable in themselves including judicious self-disclosure and develop their roles in response to the needs of the group members (Yalom, 1995; Banks et al, 1997; Jacobs et al, 2002; Posthuma, 2002). Contemporary models of practice including feminist therapy and anti-oppressive practices report examples of the benefit of these leadership approaches (Ballou & Gabalar, 1985; Baines, D., 2011).

Literature on group music therapy has its roots in foundational music therapy publications. In the landmark text, “Music in Therapy,” Gaston (1968) heralded the importance of group music therapy practice stating that music’s greatest potency is in the group. Sears (1968) presented highlighted the effectiveness of group music therapy in his classification systems of the underlying constructs and processes of music therapy. An overview of subsequent chapters revealed the majority of the authors enlisting the use of song with various clinical populations, both in individual, but particularly, in group music therapy contexts. Related publications explored the health value of group music experiences (Plach, 1996; Watson & Vickers 2002), the ease of group cohesion in music therapy groups (de l’Etoile, 2002), and the structural value of songs (Carter & Oldfield, 2002). Songs have a clear beginning and end, which can be reassuring for clients. Song-based group formats can meet the needs of groups of varying sizes, from a dyad to a
group of many, and uses musical materials readily available to the general public as a resource for on-going support. These processes are in keeping with music therapy as an anti-oppressive practice.

In accordance with a critical feminist analysis, the foundational model of practice for music therapy as an anti-oppressive practice was developed in response to requests of the persons served while also informed by my experience as a therapy client. In agreement with Curtis (2011), I feel that all therapists should participate in both individual and group therapy to personally understand the dynamics of support and change. In my case, my less than successful experiences in individual verbal therapy informed by my numerous positive group music experiences foundationally motivated me to combine these understandings in my therapeutic practice. However, to have therapeutic integrity, my real-life therapy experiences required critical reflection as to why the verbal approach was unsatisfactory along with academic and practical music therapy research to structure and frame these experiences into points of reference.

*Psychosocial Rehabilitation and Music Therapy*

Another model of practice that deeply influenced the development of music therapy as an anti-oppressive practice is Psychosocial Rehabilitation (PSR). Approximately forty years ago, there was a worldwide move to transfer patients with chronic and severe mental illness from large institutional care into community care settings (Psychosocial Rehabilitation Canada, 2009). The psychosocial rehabilitation model of care resulted from the need to provide community mental health services that
developed patients’ skills for success in the community and based on a collaborative client-centered approach. PSR has expanded internationally and now, published research of the approach can be found in many countries including clinically significant effectiveness of PSR in an inpatient program for persons with Severe Mental Illness in rural New South Wales (Murugesan, et al, 2007) with residents with SMI in a halfway house in India (Chowdur, et al, 2011) in an outpatient programs to address social functioning and well-being for older people in Finland (Routasalo, et al, 2008; Savikko, et al, 2010) and to meet the needs Australian veterans and their families (Hanley, et al, 2011).

The principles of PSR readily adapted for use in group music therapy; the clients had ownership and agency in their own program, designing the sessions from set up to closure. Research about the value of this program indicated that clients found it a suitable asset in their quest to support and maintain their mental health. PSR concepts have been explored in music therapy by Chhina (2004) who described psychosocial rehabilitation music therapy with mental health service users as person-centered, Vander Kooij (2009) who used song-writing in recovery for adults living with serious mental illness, and McCaffrey, et al, (2011) in the recovery approach to mental health, which highlighted integrating the service user voice to develop shared consciousness of the therapeutic relationship creating possibilities for change. The integration and enhancement of the service user voice in psychosocial rehabilitation broadened my awareness of strategies to increase client agency and empowerment in music therapy practice providing another foundational influence for the development of music therapy as an anti-oppressive practice.
Anti-oppressive practice is a social justice approach developed to address inequity embedded in sociocultural structures. For the fragile populations whose experiences of music therapy are addressed in this research, decreased privilege is ongoing and highly deleterious. Community health and health promotion within fragile populations are serious concerns that need addressing. For the purposes of this research, key concepts of community health and how to promote community health with fragile populations will be examined. Next, these concepts will be applied to the music therapy as an anti-oppressive practice.

Health promotion is a highly diverse, multidisciplinary field of practice and research that employs behavioral and social science theory to improve public health (DiClemente, et al, 2002). Community health initiatives are grounded in social justice and empowerment achieved through participatory, community development processes that in partnership with community members address broad determinants of health (Baisch, 2009; Trickett, et al, 2011; Wallerstein, et al, 2011; Weyers, 2011; and Ogden, et al, 2012). New initiatives in community health and health promotion are making ground in areas of health care where in the past much of the process had become custodial and remedial in nature. Inclusive community health care planning focuses health care funding in areas where they are needed most as identified by the community in question such as involving frail elderly living in the community in planning for chronic health condition
management combined with adapting meaningful activities to maintain functioning (Daniels, et al, 2011).

Community Music Therapy represents a community health promotion approach in music therapy (Bunt, 1994; Ruud, 1998; Baines, S., 2000/03; Baines & Danko, 2010; Kenny & Stige, 2002; Ansdell, 2002; Pavlichevic & Ansdell, 2004; Stige, 2002). This approach endeavours to de-clinicalize the music therapy process by working in an inclusive, collaborative, capacity enhancing way to address service user needs. To differentiate from clinical music therapy practice, in previous publications and presentations, I used the term community to describe my music therapy approach. Continued research led me to inevitably problematize the term, community as inadequate. For example, in social work, three community paradigms, traditional, collaborative, and radical, each with very different goals, have been described (Thomas, O’Connor, & Netting, 2011). A search for increased precision in describing my work subsequently led me to the descriptor anti-oppressive practice.

Psychological Considerations

The field and clinical profession of psychology while it has been an essential root branch of the development of music therapy requires an anti-oppressive analysis to address systemic oppression embedded in traditional models. Specific psychological literature applicable to the development of music therapy as an anti-oppressive practice will be presented here to further contextualize the research.
Clinical psychology historically concerned itself with remediation and occasionally, with prevention of psychological problems which resulted in a myopic view of human nature (Peterson, 2009). The field of psychology has narrowed with the focus on psychodynamic or psychoanalytic theory with the result that interventions designed for one social or cultural setting are used across cultures having colonizing effect (Bowden, 2010). Negating that Indigenous people are entitled to their own culturally based understanding of human health (Proudlock & Wellman, 2011) is an example.

In contrast, non-traditional sectors of the psychology field have addressed important elements of anti-oppressive practice including asset-based approaches for community development (Kramer, et al, 2011), integrating social justice into counseling pedagogy (Brubaker, et al, 2010), and acknowledging the typically abysmal treatment of disabled and forensic clients worldwide, demanding professionals pursue international human rights standards for these forgotten clients (Perlin, 2010). Music therapy needs to stay current and grounded in anti-oppressive theories of psychology and demand that oppressive psychological theoretical perspectives are critically analyzed in educational and clinical practice. Rather than taking on traditional approaches carte blanche because of their traditional stature, music therapists need to apply an anti-oppressive analysis to their understanding and use of psychological theory and concepts to further individual and community health.

The Role of Music in Music Therapy
Depending on one's theoretical positioning and the setting where one practices, music can assume different roles in the practice of music therapy and this role is a political statement. When one examines the teams that music therapists typically work with, in healthcare, education, and corrections settings, it is clear that all other practitioners, with the exception of rare individuals, rely almost exclusively on verbal communication for therapeutic process. This is one reason that as a music therapist on the team, I prefer to focus on the use of the music to address therapeutic goals and put music at the core of my music therapy practice while simultaneously systematically decreasing the use of verbal process. This is a political choice. Furthermore, my anti-oppressive practice consciousness has led me to employ the service user’s preferred music (usually popular song) to address the service user’s goals.

An equally important reason that music is fundamental to my practice is that music is foundational to my existence. I believe that without music, it is possible that I would not be here. It has been my experience that I need live music in my life, if not every day, almost every day, to keep myself healthy and well. Based on my observations of many different kinds of people in my work as a musician, music educator, and music therapist, I am convinced that many people have a similar deep foundational relationship with music.

When training in the Bonny Method of Guided Imagery and Music in the Master in Music Therapy program at New York University, 1991/2, Madeleine Ventre (2002) educated students to observe the entire session, and in particular, the client through a musical lens. This was in keeping with my learning during my internship with Helen Grob where I was taught to notice the observable musical characteristics of clients such
as rhythm, pulse, harmony, dynamics, tempo, and more and develop music therapy goals based on these observations. The Master’s in Music Therapy program at New York University supported this concept; we should observe and understand ourselves and our processes through the perspective of music and musical improvisation. In this way we could integrate broad understanding of and affinity for music into therapeutic intent.

Music is used pervasively by people in ordinary and often mundane circumstances, where music listening is not the primary activity as well as in settings where the music is the focus to provide emotional support (Juslin & Laukka, 2004). Everyday listeners experience peak music experiences and although there are cultural differences, Eastern and Western populations benefit from peak experiences of music (Rana, Tanveer, & North, 2009).

Creative Music Therapy, one of the foundational music therapy models, is based on the philosophy that everyone can respond to music (Nordoff & Robbins, 1971; 1985). To address specific therapeutic needs, Creative Music Therapy relied on improvised music based on European music traditions, pre-composed European music from previous centuries, or compositions written by Nordoff in a classical neo-Romantic style (Nordoff & Robbins, 1971; 1985). Analytic Music Therapy (Priestley, 1975) used improvised music based on European music traditions as did Alvin (1965; 1966; 1978) in her work with autistic children. The Guided Imagery and Music (Bonny, 1975; Bonny & Savary, 1973) model of music therapy employed pre-composed European music from previous centuries. These four models provide the historical foundation of all subsequent music therapy theory. They have a common theme of using either improvised music based on European music traditions or pre-composed, mostly pre-twentieth century European
music. However, music sales indicate that this style of music is not popular within the
general public and requires significant training to play pleasaingly. With the reliance on
these approaches on European music traditions, an unfortunate result is that the vast
majority of clients are not able to support themselves musically when away from their
music therapist.

Live and recorded popular music is readily accessible in the culture, to be
accessed when desired and needed. Client-preferred songs are culturally and personally
relevant, stabilizing and enhancing identity and social authenticities. Aigen (2008) has
cautioned music therapists to acknowledge their aesthetic values and those of their
clients, to be conscious of the ways that they interact and to address how traditional
aesthetic standards can be elitist and disempowering for the average person. In my case, it
could be presumed that my love of songs may have influenced my use of preferred songs
with clients. However, I love large classical forms as well but my clients have not
preferred this style. I love improvised music and love to improvise music but again, this
approach to musicking has not been preferred by my clients and is pursued outside of the
music therapy field. Instead, service users’ personally meaningful songs have been the
on-going request. Their requests sometimes have included songs and forms that I do not
prefer but as I share these songs with clients, my preference has shifted and with my
client, I then find pleasure in what I had previously not preferred. Through my clients’
sharing their valuing of their songs and experiencing the therapeutic results of
incorporating preferred song into music therapy practice, my love of and respect for
songs has continued to increase.
Songs are expressive of who we are, how we feel, and they bring us closer to others. Songs keep us company, express our beliefs, values, joys, sorrows and secrets. Songs mark the progress of our lives, expressing hopes, disappointments, fears, and triumphs, a sort of musical diary of our life stories (Bruscia, 1998). A number of music therapy models have advocated and integrated the use of pre-composed popular music including Community Music Therapy (Ansdell, 2002; Baines & Danko, 2010; Baines, S., 2000/03; Kenny & Stige, 2002; Pavlicevic & Ansdell, 2004; Stige & Aaro, 2012; Stige, 2002), Resource-Oriented Music Therapy (Rolvsjord, 2004a; 2004b; 2006; 2010; Rolvsjord, et al, 2005), and Performance Based Music Therapy (Naess & Ruud, 2007; Soshensky, 2011). It has been my experience that the use of pre-composed popular music offers a full range of therapeutic possibilities.

**Anti-Oppressive Practice**

A review of literature researching anti-oppressive practice completes this chapter. Anti-oppressive practice is “a heterodox, umbrella term [that] borrows bits and pieces from various theories…. Marxist, Feminist, Anti-Imperialism, Anti-Racist, critical post-modernism, post-structuralism …” (Baines, D., 2010, p. 13). Anti-oppressive practice is an emancipatory approach to social work that emphasizes social justice and social change (Collins & Wilkie, 2010; Hines, 2012). Anti-oppressive organizations’ philosophies and practices can be described supporting local development, social development, active participation, structural definition and analysis of the situation, consciousness raising and social action (Karabanow, 2004). AOP asserts that power imbalances are based on age,
class, ethnicity, gender identity, geographic location, health, ability, race, sexual identity and income and “are embedded in the profit-model of patriarchal, racialized, homophobic, colonial capitalism” (Baines, D., 2010, p. 19). Personal troubles are seen as inextricably linked to these oppressive structures embedded in the culture. Characteristics of anti-oppressive practice include, “critical consciousness raising, solidarity and balancing the voice of clients with social justice, and linking with social movements and unions” (Baines, D., 2010, p. 86). These practices are employed to amplify the voice of the service user.

Anti-oppressive practice articulates that humanity is characterized by diversity, multiplicity, pluralism, and conflict, not by sameness, unity, monism and consensus (Mullaly, 2010). Post-modernists believe that no group should define the reality, needs, interests or experiences of another group. The welfare state and social work practice have often overlooked differences and diversity and, instead, forwarded policies and practices of “homogenization, exclusion, bureaucratic control and surveillance, hierarchical decision-making and professional expertise” (Mullaly, 2010, p. 307). Post-modernists criticize modernism for its use of dominant discourse reflective of class, gender, race, and other forms of dominant-subordinate relationships and are concerned for language and discourse that addresses pathological, diagnostic and professional vocabularies that exclude and disempower service users (Mullaly, 2010). People in society considered to different and diverse are often subject to discrimination and exclusion by people and institutions with increased privilege. Harmful treatment can negatively impact self-confidence, fear, anxiety, the ability to trust, and life opportunities (Lago, 2011).
Oppressive structures that systematically block and penalize marginalized people must be combated, disrupted, subverted, and undone (Kannen, 2008).

Anti-oppressive practice and research are being explored across human services professions. Nurses noticed that older adults with dementia living in care increased empowering interactions that were maintained over time once an anti-oppressive model was introduced (Martin & Younger, 2000) and anti-oppressive practice was effective with chronic pain sufferers (MacDonald, 2008). Anti-oppressive social work services are being developed for Traveller children and their families in England (Cemlyn, 1999) and to address stereotypes of disability benefit recipients in Northern Ireland (Heenan, 2005). Anti-oppressive education strategies have been outlined to increasing teacher’s awareness of the disability injustices (Jones, 2011) and have been broadly applied to concepts of culture and identify to promote cultural values that contribute to social justice (Parrott, 2009). Doctors, in clinical contexts, are developing strategies to counteract dehumanizing oppressive behaviour and enhance patient empowerment (Thesen, 2005).

Beyond the typical characterizations of oppression such as racism, ageism, etc., new research is addressing how these oppressions can interact and must be addressed in combination, for example, older adults from racialized minorities (Gunaratnam, 2008) and older adults with intellectual deficits (Gilbert, et al, 2007). Anti-oppressive practice encourages us to resist practices that suppress difference and dissent, defending and developing ways to give voice to the voiceless and bring the needs of marginalized clients and communities to the attention of those who make decisions (Baines, D., 2008).

Summary
This chapter reviewed the theoretical perspectives and models of practice that have informed the development of my approach to music therapy by first integrating my feminist roots with paraverbal therapy and PSR practices. The impact of Group Theory and Music Therapy and Community Health and Health Promotion then revised these views closing with the influence of psychology in music therapy and a reflection on the role of music in music therapy practice locating the current research. To complete this chapter, anti-oppressive practice was explored developing the framework for the subsequent discussion.
Chapter Three

Locating Service User Preferred Songs in a Healthcare Context

Introduction

Integrating the service user voice in music therapy session design has revealed that preferred songs are the predominant choice to inform the music therapy approach used (Baines, S., 2000/03; Baines & Danko, 2010). To substantiate the use of service user preferred pre-composed song, research on the value of song for therapeutic practice to maintain and increase human health will be presented. Music therapy research on the use of song will initiate this review.

Music Therapy Research on Songs

Music is a part of human life from the beginning. Early music interactions between family members and infants in an Intensive Care Unit were studied where the value of music to foster reciprocal interactions between caregivers and infants was noted and located with attachment and systems theory (O’Gorman, 2007). Case reports demonstrated with slightly older children the ways in which the strengthening of the parent infant relationship can be achieved through joint music play (Edwards, 2011).
Recent publications in music therapy provide clinical examples from many different setting and populations on the value of song in music therapy practice. For example, live music including the use of familiar song facilitated by a music therapist is effective in calming children undergoing EEG testing (Loewy 2006). Familiar song was recommended in children’s hospice care with preadolescent boys with profound developmental delays (McFerran & Shanahan, 2011) and for the process of life review in hospice care (Sato, 2011). Culturally specific music and song are employed in palliative care with children supporting ethnicity and identity (Forrest, 2001). Popular music is prevalent and influential in identity formation in the lives of adolescents (Clements-Cortes, 2010; McFerran, 2010) such that young people believe that music will help them feel better (McFerran, 2010). Using songs from ESL learners’ culture or music from the culture in which they live or a combination of both is successful (Schwantes, 2009). Case material from children, adolescents, and adults with behavioral disorders due to brain injury described the multi-dimensional importance of songs to the therapeutic process (Magee, et al 2011). Songs are used by groups as a way to develop their identities and build relationships between members and because of the variety of taste, group member grow in acceptance of each other’s differences (Noone, 2008). Using preferred song is culturally supportive, strengthening identity and self-awareness. The role of fellow musician, comparable to the role of fellow travelers as described by Yalom (2002) changes the focus from interventions and techniques allowing the interpersonal and intermusical relationship to become a more natural resource for therapeutic change (Solli, 2008).
Songs in music therapy can be used to explore unresolved feelings and to increase connectedness. The interpretive and subjective nature of lyrics has been discussed by a number of authors (for example, McFerran, et al, 2011) with agreement that the interpretive aspect of lyrics can complicate the use of pre-composed songs therapeutically. Familiar songs can function as a projective tool for clients to express complex feelings in a safe way (Hinman, 2010), “lyric analysis [allowing] group members to explore various themes,” (Noone, 2008) but some music therapists (for example Elwafi 2011) have described feeling conflicted about lyric content of some client requests. The importance of the client’s connection to and motivation for their preferred music because of their deeply personal relationship with their preferred songs, can render these preferred songs powerful ways to explore feelings and emotional states. The role of the therapist is to present the song as authentically as possible, to monitor and support any responses of the client, and to facilitate any deeper understandings that may be brought forward by reflection on the song materials. Client choices can raise concerns about suitability of content, especially around abusive lyric material but an anti-oppressive lens can reveal that if music reflects the state of the individual in their social context where violence may be an everyday occurrence, then violent fantasies can operate as a way to exercise personal control over uncontrollable events. Lyrics of preferred songs must be addressed in a thoughtful, therapeutic, and anti-oppressive manner to harness the full potential of preferred songs.

Supporting the music therapy research on the use of pre-composed songs are publications exploring music therapy, singing, and performance. Female inmates perceived wellbeing improved from participation in choral singing, particularly from
performance outside the corrections facility (Cohen, 2009). Singing and using the voice provided a unique creative, meaningful and productive experience for men who are homeless and mentally ill (Iliya, 2011), results echoed in research with adults with chronic, persistent, and severe mental health conditions (Baines, S., 2000/03; Baines & Danko, 2010).

The broader health community has studied the health implications for music including the use of singing for health. It is from this human health and development literature that the next part of this review is derived, further substantiating and contextualizing the service user preferred use of pre-composed song as a music therapy resource.

Singing and Songs: Developmental Perspectives

Research indicates that singing is a naturally occurring human capacity and emerges precociously and spontaneously from early infancy without the need for training (Dalla Bella, et al, 2007; 2009). Singing appears to be as natural as speaking offering evidence that, even people who rarely sing can sing proficiently in tune and in time and that this ability is normally distributed in the general population (Berkowska & Dalla Bella, 2009).

The parent infant relationship is strengthened through joint music play (Addessi, 2009) and music is important in homes for children under five years of age such that parents should integrate music experiences as a daily practice for their young children (de Vries, 2009). The expressive importance of song for children is evidenced by untrained
young singers’ transcultural ability to transmit emotional content through song (Adachi, et al, 2004; Adachi & Trehub, 2011).

Older research revealed the value of songs to teach emotional development in young children (Hartwell-Walker & Frieden, 1982), to motivate children to rehearse information to retain selected knowledge (Wolfe & Hom, 1993), and for speech and language development through vocalising and singing (Sutton, 1993) supported by the rhythmic structure in song and music (Cohen, 1994). Songs have been found to be valuable in developing phonemic discrimination necessary for early literacy and language development, (Standley & Hughes, 1997; Cheong-Clinch, 1999) and music can teach children about sounds, music, and cultural diversity, important elements of learning (Nicols & Honig, 1997).

More recent research is broadening the link between music and learning. For example, cognitive skills valued in Zimbabwean Shona culture are translated through traditional children’s games and play songs, creating indigenous ways of knowing (Nyota & Mapara, 2008). Individual agency was revealed as the informing philosophy of Shona children’s songs with songs providing a vehicle for studying the development of children’s abilities (Muwati & Mutusa, 2008) and teaching cultural standards, (Makina, 2009) true of children’s songs in our culture.

Music is essential in the educational of all children (Wetzel, 2007) and can be particularly important for children with special needs. Music therapists have provided a range of studies evidencing that writing situation specific songs can promote independence in young children with autism (Kern, et al, 2007), songs can improve speech production in children with autism spectrum disorder (Lim, 2009), singing can
enhance the ability of children with cochlear implants to understand emotional content in communication (Hopyan, et al, 2011), and hand-clapping songs can be used for both development assessment and remediation (Brodsky & Sulkin, 2011). Humphrey (2009), a musician nurse working with persons with learning disabilities some of which were considered severe created a range of songs to communicate understanding of sexual health, personal hygiene, and bullying, finding the creative approach a valuable mode of communication.

The value of music for learning continues into adolescence where in an older study, songs and chants were shown to increase attentive behaviour in adolescents in educational settings (Robb, 1996). When music was used to engage youth in learning, results of increased self-esteem, self-expression, building peer relationships, language skills, and learning skills were reported (Cheong-Clinch, 2009). Musical preferences of adolescents offer insight into developmental issues and personality style (Schwartz, 2004) and teens increased positive perceptions of teens from other groups when they believed those teens shared those musical preferences (Bakagiannis & Tarrant, 2006). Service user preference for songs shared in music therapy group practice is reflected in these studies.

Songs as a learning partner continues with university age students across a variety of disciplines. Student ratings supported the use popular song lyrics to teach abnormal psychology concepts (Potkay, 1982) and popular song was shown to be helpful to take the mystery and complexity out of personality theory by showing students examples of personality theories in everyday life via popular music (Leck, 2006). Music videos were suggested as a tool to teach empathy in training counselors (Ohrt, et al, 2009) and to
increase empathy at a College of Pharmacy by providing musical examples of pharmacological experiences (Vance, 2006). Songs were used to engage Chinese learners in further understanding of their Chinese heritage beliefs (Harbon, 2008) and rap and hip-hop music were employed to help students learn science (Emdin, 2010). McCree-Hale, et al. (2010) realized the effectiveness of using downloadable songs from Apple iTunes as an incentive for college students on a web-based follow-up survey. Preferred songs served both as more motivating and a more cost-effective motivator than money. Elmer’s (2011) thorough review of the literature on the subject of human singing gathered together the elements of a developmental theory. Her multi-level conclusions provided a clear foundation for the use of singing to enhance developmental potential, the basis for the use of preferred song in music therapy practice supported by these findings.

Singing for Health

Using preferred songs in music therapy practices involves singing. The experience of singing is accessible to the vast majority of the population (Dalla Bella, et al., 2007; Dalla Bella & Berkowska, 2009; Berkowska & Dalla Bella, 2009). A range of further research that indicates the value of singing to increase health is presented in the next part of the thesis.

Female prisoners and university students singing in a mixed choir found that participation in the choir increased development and functioning in both personal and relational skills (Silber, 2005). Kokotsaki and Hallam (2007) researched the perceived benefits of active music making in groups by asking undergraduate and graduate music
students in two English universities to describe the impact of making music in ensembles. Their results yielded the largest effects in relation to the improvement of social skills such as development of friendships, increased ability to co-operate and to function as part of a team. Being in the ensemble made students feel important and useful, particularly in small groups. Students reported an increased sense of communal achievement, mutuality, and achievement of high standards. Some reported increased leadership skills; others experienced how the challenge of group work encouraged them to achieve more and improved their self-confidence. Students appreciated the range of music skills that developed and consolidated through their group music making. These group music-making responses can be similarly applied to group singing. Compared to listening to music, participants in group singing reported increases in immune response (Kreutz, et al, 2004). The trauma healing potential of singing has been reported (Overland, 2005) as have the health benefits of group singing for adults with cancer (Young, 2009). Songs supported patients with cancer as they identified with the situations described in the songs and this helped create a healthier identity (Ahmadi, 2011).

Since 2009, a Canadian initiative has been drawing together researchers from related disciplines in a seven-year international collaboration for the AIRS project, Advancing Interdisciplinary Research in Singing, (www.airsplace.ca). The goal of this group is to uncover influences on singing as well as the influence of singing through interdisciplinary research initiatives. To date, AIRS has developed a broad range of studies supporting the use of singing to enhance health.

*Use of Songs in Therapeutic Contexts Outside of Music Therapy*
Outside of the field of music therapy there is developing research supporting the use of familiar songs for therapeutic practice, which contributes to the foundation of the use of preferred songs in music therapy practice. Short musical fragments were shown to cue both general and specific memories (Janata, et al 2007); music served as an auditory and physiological backdrop to life, delineating past events reminding clients of past hopes and dreams (Duffy, et al, 2011). For those that enjoy music, lyrics can be supportive, revealing and expressing emotions, universalizing experiences and offering choices (Gladding, et al, 2008) and listening to prosocial songs could increase prosocial behavior (Greitemeyer, 2009). Songs can be used in counseling including asking the client to compile a list of significant meaningful songs and listening to and discussing these songs, listening to songs and discussing the imagery invoked, or using songs with groups to support a group theme (Bradley, et al, 2008).

Using song in counseling with specific service user groups has yielded positive results. Singing familiar songs with elder residents promoted empowerment (Zingman, et al, 2002) and live music increased engagement and well being for people with moderate to severe dementia (Sherratt, et al, 2004). Music used with young children enhanced the development of the therapeutic relationship in that music offered the children a healthy expressive medium (Lefevre, 2004). Similarly, the use of music with traumatized adolescents was recommended to establish the therapeutic relationship, facilitate interaction, self-awareness, and personal change (Keen, 2004). Addicts have been taught to change their music-listening habits, learn to face their dangerous music, and begin to incorporate music into their lives as a source of enjoyment and enrichment (Horesh,
The value of listening to Classical, New Age, and Modern Rock to alleviate dysfunctional attitudes in needy and self-critical individuals and develop more adaptive beliefs offered promising results (Mongrain & Trambakoulos, 2007) and the effectiveness of music listening to classical and popular music to support pregnant women experiencing stress, anxiety, and depression was shown to be effective (Chang, et al, 2008). Women who listened to their preferred music post-cesarean section surgery required reduced analgesics improving their recovery rate and earlier contact with their children. Researchers wondered if there would be increased positive results if a music therapist provided live music (Ebneshahidi & Mohseni, 2008). Popular song was used in school counseling to enhance trust and support the development of the therapeutic relationship (Kimbel and Protivnak, 2010) as well as in nursing, (Mirow, 2010) and with persons with dementia (Harrison, et al, 2010). Working with familiar song increased relational competencies helping clients to connect with their inner world and express (Mössler, et al 2011; 2012).

Concurrent with this research are studies examining the negative potential of some popular song forms. Results concluded that typically, college and high school students rarely attend to song lyrics and often did not understand the lyrics they attended to; aggressive music, aggressive lyrics, or both do not increase hostility. Songs with violent lyrics are often fast, have driving beats and are loud, rendering the words almost impossible to hear (Wanamaker & Reznikoff, 2001) supporting the argument against censorship. Other research disagreed reporting that music and lyrics with violent content increased aggressive thoughts and feelings in participants although this increase was short-lived when music with positive lyrics and content was played. Further study was
recommended to research participants’ responses to repeated exposure to negative content (Anderson, Carnagey, & Eubanks, 2003). Correlative links between music preference and mental health status in young people reported that music preference could be indicative of emotional vulnerability (Baker & Bor, 2008). Suicidal lyrics in rock music were studied discussing that the knowledge that someone had died by suicide combined with specific personality characteristics predicted the lingering impact on some listeners whereas other listeners responded with pro-social, altruistic thoughts of helping people in distress (Peterson, et al, 2008). Recently, evidence for a link between exposure to heavy metal lyrics and aggressive behavior was found (Mast & McAndrew, 2011). The critical analysis of the results of these studies informs the use of pre-composed service user preferred songs in music therapy practice.

Rap music has experienced similar negative stereotypes in the community as heavy metal music but has been employed successfully in therapeutic practice. *Rap Therapy* is a culturally sensitive approach, which employed the lyrics of respected rap artists to enhance therapeutic relationships with young African American men (Elligan, 2001). Songs were selected and used for different purposes (Ridder, 2005): to catch the attention of the participant, to regulate arousal level, and to enhance communication and dialogue (Ridder, et al, 2009). *Rap Therapy* is a viable model for work with at-risk youth (Gonzalez & Hayes, 2009) in that the songs can be used as a projective technique and are valuable to facilitate connection (Evans, 2010).

A psychodynamic music psychotherapy model that used songs selected by the therapist to stimulate discussion reported that in order to harness the full potential of the approach and to reduce the risk for harm, the therapist needed to be aware not only of the
lyrics but also the rhythmic, tonal, expressive, and formal elements of the music and, particularly, the relationship between textual and musical elements (Gardstrom & Hiller, 2010). This is good advice for all practitioners who use song in their practice. 

Songs offer a viable vehicle for therapeutic and developmental support as demonstrated by research from multiple disciplines. Yet songs have the power to harm as well, again, a well-researched domain. It is my contention that by maintaining a focus on the relationship between the personal and the political, we can offer the best support for our service users, particularly when we use service user preferred songs to support health. The subsequent research on songs will speak to this politicization.

Sociocultural and Political Potential of Songs

In addition to their psychological content, songs have been attributed to communicating such constructs as cultural identity, moral development, and community cohesion and esteem. Listening to music engages cultural background knowledge along with decoding of different parameters of the musical structure (Zacharpoulou & Kyriakidou, 2009). The instance of music in religion provides an excellent example where music functions to reinforce identity, increase collectivity, express theology, and focus and stimulate religious experience (Lynch, 2006; Mathis, 2007).

Other studies examined the undeniable links between cultural transmission and song a representation of which will be presented here. Official anthems of amateur soccer clubs in Rio de Janeiro help establish healthy identities for locals (Tubino, et al, 2009) and music has central importance for the development and transference of cultural
identity of the people of central Appalachia (Baummer, 2010). The performance of race in the United States (Schroeder, 2010), the complex social practice of popular song of Kinois music both in the Congo and in the diaspora (Trapido, 2010), and protest songs during the civil right movement in the United States (Trigg, 2010) offer additional examples of cultural transmission through song. The interpretation of song lyrics by different political groups, in particular, rightwing cultures, has been studied (Spencer, 2010) as has the rise of Soca music in Trinidad (Guilbault 2010) and the different roles musicians have taken in response to the 2006 war in Lebanon (Burkhalter, 2011). Gilboa, et al, (2009) discussed the effectiveness of music for promoting cultural exchange reporting that listening to each other’s music helps in discovering commonalities.

Song is a valued vehicle for cultural transmission in many countries and cultural contexts across the globe. In Europe, Baker’s, (2008), research of the Eurovision contest reported that the commercial practices of reaching viewers in over 40 countries in and outside of Europe has created simplified, well-known images of countries or regions leading to televisual constructions of each nation rather than reflecting the complexity of the nation itself. Mitrovic, (2010), agreed in her study of the sociocultural transition of members of the old eastern block into European status, in particular examining the case of Serbia. She noted that national identities were both constructed and recycled in this process.

There is research about the role and influence of music in sub-cultural politics in some parts of Asia. Music in post-1997 Hong Kong was studied (Ma, 2002) including the important role of Chinese popular songs in social change and nationalism over the course of the twentieth century (Ho, 2006). Rivalry as well as collaboration between artists from
Taiwan and South Korea revealed the emerging popular culture (Shin & Ho, 2009). The empowering aspects of local popular music genres in Hong Kong (Chew’s, 2009) contributed to musical innovation, local audience empowerment and sociocultural critique (Chew, 2011) with a vital political role played by alternative Chinese pop music production.

Music has been shown to have an important role in war (Rikard, 2004), for example, the phenomenon of singing in the ranks of the Canadian military during the Great War. The group activity of singing brought the soldiers together, forged bonds of comradeship, reinforced belonging in the group, and helped address the strain of unending combat and service (Cook, 2009). Songs have provided an important vehicle for cultural resistance in Iraq, because of accessibility due to the impossibility of banning song listening (Zangana, 2009). Song and song texts have been used in propaganda, for example, Chinese songs from the Korean War era evidence imagery applied to American military personal that had previously been applied to Japanese soldiers during the second world war, evoking past traumas, (Cathcart, 2010). Expression of ideology through the text of French political songs provides another example (Crozet, 2010). Music’s intrinsic cultural and political value can be used as a means of emancipation from but also as a tool for domination (Dankoff, 2011). For example, the intersection of the influence of the music, lyrics, and musician’s persona can function as a political force and a potential threat to national security (Cote, 2011). When working with service user preferred song, the sociopolitical context of song must be acknowledged and addressed so that this music can be harnessed for therapeutic development. Marsh (2010) summed up the process
reporting that popular music can provide an arena for people to engage in meaningful public dialogue about political issues.

Popular song forms can develop in response to political stress and oppression. Originating from clear political roots of marginalization, in addition to unsurpassed growth in the United States, rap and hip-hop music have experienced rapid expansion and become a worldwide phenomenon inspiring studies from right-wing lyrics in mainstream German hip-hop (Putnam and Littlejohn, 2007), to rap music as a form of expression for Slovak youth (Barrer, 2009), to the images of violence in Rap music lyrics, youth violence and the changing commercial practices within the music industry (Herd, 2009). According to Emden (2010), hip-hop enthusiasts and rappers can be found all over the world where urban youth are marginalized, active hip-hop communities come together bonded in their exclusion from the mainstream culture.

Along with valuable cultural transmission, the medium of song can also transmit oppressive information, the case of gender cultural information offering an example for review. In Malawi and Southern Africa, research exploring men’s appropriation of female music concluded that initiatives by women and gender activists to exploit female music for female empowerment are needed (Lwanda, 2003) a situation mirrored in Swazi (Mduli, 2007, 2009). In Zimbabwe, women must transgress traditional roles to be able to perform music (Jones, 2008). Increased negative representations of women in male-produced urban grooves have been blamed on Western popular music standards and postulated to contribute to the erosion of women’s equality (Chari, 2008), results echoed when examining images of women in selected songs by Thomas Mapfumo (Naidoo, 2010). In similar song and gender studies outside of Africa, the gender gap between men
and women’s legitimization in popular music has been identified (Schmutz & Faupel, 2010) with the socialization process of youth masculinity and singing being complicit and unwittingly perpetuating patriarchal hegemony (Ashley, 2011). In the field of orchestra music, during school and university education, girls do much better than boys but are outnumbered by boys in professional orchestras at a rate of four to one as reported in 1997 which is blamed on patriarchal values (Davidson & Edgar, 2003). Jazz reported similar gender inequality (Wehr-Flowers, 2006) as did the fiddle contest circuit in Canada (Johnson, 2000).

In the field of popular Western music, female success is well below the media hype in that female success does not evidence the staying power of male success and may be as precarious as the next big hit (Wells, 2001). Country music has continued to reinforce limited ideas of peace and security promoting traditional views of gender hierarchy where the masculine is valued at the expense of the feminine and aggression at the expense of nonviolence (Pruitt, 2007). Traditional Irish Pub music continues this trend where the residual effect of women’s historical exclusion from public music making in Ireland has manifested in the unequal representation and status of women musicians constraining their presence and their behaviour with the emphasis placed on women musicians as sexual objects, having lesser authority and power, and subject to harassment and relegation to less privileged positions (O’Shea, 2006). Gender disparity has been identified in the lyrics of American pop music celebrity Bruce Springsteen where American ideals are described in male terms and women are relegated to being part of that story (Moss, 2011).
Perhaps because of its fast rise to prominence in many disenfranchised populations worldwide, the sociocultural elements of Hip-hop music have been studied extensively including issues of gender inequity. Hip-hop femininities and masculinities have been described as being subject to socioeconomic concerns of white supremacist, patriarchal, multinational, corporate capitalism (Miller-Young, 2008). Misogynistic discourse and the images in rap music affects the representations of black women through mass-mediated sources so that black women’s experience is overshadowed by the representations of black women in popular culture (Reid-Brinkley, 2008). That notwithstanding writers have been identified who articulate feminist politics and challenge popular representations of women of color (Clay, 2008). Music is a gendered discourse in which the meanings of musical acts and lyrics differ according to whether the musician is male or female. Anti-oppressive practice acknowledges this disparity and works to mitigate discrimination when using service user preferred songs.

Popular song has an important history of use as a means to transmit information of all kinds; social, political, and health related. For example, the history of the HIV/AIDS epidemic in Africa can be studied through popular songs. Music accompanies African people from birth to death imparting social values, entertainment, consoling the bereaved and cementing relationships. The transition from songs describing threats to wellbeing, to songs of panic and stigmatization, followed by messages of hope and calls to care for people living with HIV evidences the importance of popular song as a channel for cultural communication (Chitando, 2008; Bastien, 2009).

The above international multidisciplinary review has discussed that along with therapeutic and educational value, song is a strong purveyor of sociocultural and political
information. When using service user preferred songs in music therapy, understanding the political roots of the music is essential for ethical practice. As service users express their preferences, inference can be drawn regarding their therapeutic needs based on the political nature of the music they prefer offering insight into their worldview. Anti-oppressive practice asks us to notice the political nature of personal experience and incorporate that understanding for ethical practice to decrease the risk for harm. Clearly the use of service user preferred songs poses potential for harm because of the aforementioned socially discriminatory practices within the music field. As well, the political nature of popular music poses the potential for benefit. Music therapy as an anti-oppressive practice supports service user preferences while acknowledging risk for harm within those preferences and working to mediate these risks while developing potential benefits.

_Economic Realities and Possibilities of Using Pre-Composed Song for Health_

Over time, with increasing longevity of the human population, there are increasing pressures on healthcare and social services that the current system is ill-prepared to deal with (Gilbert, et al, 2008; Arney, et al, 2011). To address this situation, ethical, large group, fiscally accountable models health management need to be researched and developed. According to the aforementioned review of research pertaining to the positive use of pre-composed song and singing for health, pre-composed song can a valuable resource. However, as previously reviewed, concerns regarding appropriateness of lyric content are valid as are concerns regarding gender disparities. As
previously reported, with attention, controversial lyrics can be utilized to support
therapeutic progress (Elligan, 2001; Wanamaker & Reznikoff, 2001; Anderson,
Greitemeyer, 2009; Ridder, et al, 2009; Gonzalez & Hayes, 2009; Evans, 2010; Elwafi,
2011).

Semantic habits are created through radio and song revealing the possibility for a
promising future supported by songs (Cook & Krupar, 2010). However, based on the
business models currently in use, this appears highly unlikely (Baines, S., 2013b). In
related research, popular music and its relationship to the culture of peace in Nigeria
were examined concluding that popular songs could be potential agents of the culture of
peace (Emielu, 2010). The need for censorship of songwriters to negate the capitalist
driven culture of conflict was discussed and songwriters were encouraged to align
cultural constructions to promote a peace agenda in Nigeria and elsewhere in the world.
However, a standard of censorship is politically unsustainable within most communities
concerned about the suppression of free speech. Rather than censorship of songwriters,
the value of using pre-composed song to support health and social justice can be
safeguarded through employing anti-oppressive practices such as analyzing music genre,
style and lyrics for discrimination and then using that awareness to promote therapeutic
progress.

Summary
Song and singing are an essential part of human experience from birth to grave. Literature exploring the broad array of worldwide cultural singing practices indicated that singing can be used to support positive outcomes in many areas of human development and health. However, within the experience of song and singing, there is potential for negative effects to be because of hierarchical discriminatory structure in culture expressed in music discourse. Utilizing anti-oppressive practices provides a framework for realizing the positive potential of song while decreasing possible adverse consequences. Music therapy as an anti-oppressive practice is informed by research using song to promote health and wellbeing.
Chapter Four

Locating the Research in Context

Introduction

This chapter will locate the current research by presenting and positioning the work with regard to the epistemology and method chosen with reference to prior research I have conducted.

All discourse, whether universalistic and/or particularistic, must be subject to contestation, so that we are held accountable for the thinking that we articulate in our writings, and so that we do not reinforce much of the taken for granted assumptions about the world (Sewpaul, 2007, p. 398).

Research is a political process embedded within the culture in which it occurs, (Barton, 2005). It involves the distribution of power between individuals and social structures, an AOP sensibility requiring that models of research are critiqued within the relevant political context.

Ellis, et al, (2011) reported that postmodernism inspired a crisis in confidence in the 1980s creating new opportunities to reform the social sciences and reconceive the objectives and forms of social science inquiry. Scholars began to recognize the various
assumptions held by different traditions especially noting that many conventional research approaches were narrow, limiting, and parochial. Researchers were therefore encouraged to use their reflexivity in the each of the stages of research including evaluating the design, data collection and data analysis processes to consider the research process and effects that the research may potentially have in a counter-colonial context, (Nicholls, 2009).

Reflexivity is the process of observing and analyzing ones process from multiple viewpoints. Within an AOP ethos practitioners and researchers value reflection on the contexts of oppression and consideration of the ways in which collusion with oppression occurs (Anderson, 2004). The White, masculine, heterosexual, middle/upper-classed, Christian, able-bodied perspective that implies that other ways of knowing are unsatisfactory and invalid requires reflexive practice to inform researchers of deeper layers of political context and open possibilities for radical change (Ellis, et al, 2011). By employing CGT methodology informed by anti-oppressive practices to study music therapy experiences, I can research, other ways of knowing enhancing the voices of research participants silenced through multiple processes of systemic oppression.

Two Prior Research Studies

In the spring of 2000, I conducted and published the results of research surveying the participants of open group mental health music therapy programs at six different community mental health sites (Baines, S., 2000/03), which was followed up with a further survey and interviews in 2010 (Baines & Danko, 2010). The survey instrument
was developed in consultation with the service users and their staff who recommended no more than a one page form that offered answers that could be checked off as well as room for narrative responses. The survey was voluntary and was administered when the various programs had been running from one and a half to two years.

One goal of the survey was to offer the participants opportunity for anonymous/written input into the direction of program development. Another goal was to assist participants to describe and understand what the program meant to them as well as how it worked for them. As well, it was hoped that the survey would provide the music therapist, staff, and management, clearer understanding as to how and why participants found the program valuable. An additional goal was to publish the work in a peer reviewed journal in order to both to submit the process to international scrutiny and to describe a model for consumer initiated, partnered, and directed music therapy program development. The questions were proposed by service users and staff and subsequently, five questions were chosen in consultation with the service users.

The structure and process of these groups, based on the specific requests and input of the service users, consisted primarily of group singing of preferred popular pre-composed songs with percussion instrumental accompaniment. Attendance and participation was voluntary and unusual for mental health services, the groups were often well attended. Some group members chose and sang preferred/requested songs while some played small percussion instruments such as maracas, tambourines, and hand drums. Sometimes there were participants who played guitar, bass, and drum kit. Sometimes songwriters shared their work. Some participants preferred to listen and observe. Some danced. Some participants sat on the periphery of the program or in
another room than the program but considered themselves part of the music therapy program and wanted to fill in the survey. Clients with severe social inhibitions interacted with others. People diagnosed with severe depression left the program with a “bounce in [their] step,” (remark from participant). At all six sites, there was a strong positive response to the survey, again, a relatively unknown experience in voluntary research with mental health service users.

The largest number of respondents stated that they came to the program for relaxation. This number was echoed when respondents were asked how they independently used music in their lives, answering most frequently, relaxation. However, the presented programs were rarely relaxing, often full of active music making played in time to up-tempo songs. The next three most prevalent reasons to come to the music therapy program were because people like to sing, followed by fun and socializing. These preferences were followed by a sense of belonging, leisure, creativity, skill development, and support and these noted preferences were echoed in the comments. It is surmised that this fun, social atmosphere that provided a sense of belonging could be the reason for the sense of relaxation both sought and experienced by group participants as their number one reason for attendance.

The principal thing that participants desired to change about the program was the frequency, requesting increased music therapy services across the board. However, services were never increased and with on-going budgetary constraints, one by one, these programs were all eventually cut. It is of consequence that not only was there strong participation in the survey, the reasons for participation in the music therapy group of relaxation, fun, and socializing, are all central resources for persons with chronic and
persistent mental health conditions. Also of importance is the result that participants came to music therapy group because they liked to sing.

The voluntary participant survey was repeated some years later with similar findings including that the main reason for participation remained to support relaxation (Baines & Danko, 2010). The findings overall revealed the rich relationship that participants shared with their favoured songs as well as their willingness to understand and support other service users’ song choices in the group.


The research undertaken for this thesis is with persons who have advanced dementia living in long-term care and persons with dual diagnosis developmental delay and mental health in short term psychiatric treatment. The area of Disability Studies is therefore relevant to a framing of the research processes in this thesis.

Disability is socially constructed (Mercieca & Mercieca, 2010). Historically disability was understood to be caused by impairments in the body within medical model of diseases and disorders, whereas a more contemporary perspective within a social model considers that disability results from social and environmental factors (Ardha & Woodhams, 2005). Disability is currently measured in terms of how far it is from ability and how severe in relation to social structures, in terms of power and oppression (Mercieca & Mercieca, 2010). Stevenson (2010) argued for the epistemological assumption that all people, “including people with impairments, are complete people, of
equal value as human beings, and have Human Rights” (p. 39), grounding disability studies in anti-oppressive practices.

A pejorative view of persons with disability has often been furthered by disability research, which traditionally was conducted by non-disabled people using primarily a positivistic methodology based on the medical model. Non-disabled experts produced knowledge unrelated to disabled people’s experience and hierarchical power relationships between researcher and respondent served to reproduce wider social inequalities between disabled and non-disabled people (Daniele & Woodhams, 2005). Even inclusive research rarely gave descriptions of how persons with disabilities were involved in the research, their roles, contributions, any challenges encountered or support that was provided (Bigby & Frawley, 2010). Emancipatory disability research has also been critiqued in that it may be restricting the understanding of disability rather than be emancipating in nature (Mercieca & Mercieca, 2010). Employing the understanding of disability studies enhances the social critique of music therapy services and music therapy research with marginalized service users increasing potential for research results that are applicable to real-life experiences.

Music Therapy as an Anti-Oppressive Practice

The term, anti-oppressive practice is new to music therapy (Baines, S., 2013a) although the early roots of the contemporary view can be located in a number of areas in music therapy (Baines, S., 2013a). For example, Kenny’s (1982, 1985, 1989, 2002) early writings offered an inclusive ecological paradigm, the roots of Indigenous Theory.
Gardner (2008) furthered this work exploring the links between Indigenous Theory and aesthetics. Boxill’s (1988) writings in peace studies introduced a social justice perspective to music therapy, work that has been continued by Vinander (2008), Vaillancourt (2009, 2011, 2012), and Baines, S. (2013a). Ruud’s (1988) constructivist writings contributed, as did family systems theory presented by Bruscia (1984) and Maranto and Bruscia (1987, 1988). Other roots can be found in music therapy models and theories that used elements of critical theory. This group includes Resource-Oriented Music Therapy (Rolvsjold, 2006, 2010), Music-Centered Music Therapy (Aigen, 2005; Brandalise, 2009), Culture-Centered Music Therapy (Stige, 2002) and especially Community Music Therapy, which has experienced surge in interest in the latter part of the twentieth century. This has resulted in significant publication and dialogue to define the territory (Ansdell, 2002; Baines, S., 2000/03; Baines & Danko, 2010; Bunt, 1994; Gaston, 1968; Kenny & Stige, 2002; Pavlichevic & Ansdell, 2004; Ruud, 1998; Stige & Aaro, 2012; Stige, 2002). These precursors of music therapy as an anti-oppressive practice have broadened and deepened music therapy theory and possibilities, challenging and reforming traditional Eurocentric perspectives.

In particular, music therapy as an anti-oppressive practice has resonances with feminist theories (Baines, S., 2013a). Music therapists have explored the relevance of feminist theory to the practice of music therapy starting with a few key research papers in the nineteen-nineties (Baines, 1992; Curtis, 1990; 1996) to a more active and robust community of research and practitioner perspectives reported through the past decade. Hadley's (2006) landmark edited text provided an overview of a range of feminist perspectives drawing together a group of writers from different backgrounds in various
stages of feminist analysis to address the role of feminism in the field of music therapy. This work explored practice, research, and theory described in detail in a paper at the time (Edwards & Hadley, 2007). Recent contributions include feminist music therapy pedagogy (Hahna, 2011; 2013) and feminist analysis of music therapy practice and research promoting a social justice approach (Curtis, 2012a, 2012b; Hadley, 2013).

Other social justice partners in music therapy as an anti-oppressive practice include Post-Colonialism (Kigunda, 2003; Pavlicevic, 2004; Nzewi, 2002, 2006; Akombo, 2009; Elwafi, 2008; Miyake, 2008). This group of researchers has addressed the oppressive structures inherited from colonial history studying the value of employing culturally specific respectful approaches to health through music. Critical Race Theory tackles the vestiges of colonialism, schooling practitioners to explore how race manifests in their practice and to address issues of white privilege in music therapy practice and research (Hadley, 2012; Veltre & Hadley, 2012). Queer Theory explores the systematic oppression of person’s with non-dominant sexual orientation, challenging essentialist notions of sexuality postulating that sexual identities are complex, fluid and socially constructed (Hadley, 2013). Sexuality Studies theorists explore the concept of sexuality and how it relates to social justice (Hadley, 2013) illuminating further potential areas of oppression in music therapy practice and research. Music therapists need to examine their personal experiences within a political context in order to further inclusivity and understanding. The respectful recognition of these theories provides further foundations for music therapy as an anti-oppressive practice.

Music Therapy Research as an Anti-Oppressive Practice
The role of researcher is always present for an anti-oppressive practitioner. This role is taken in trust with service users. Without a research framework, practice cannot function in an ethical manner. Ongoing anti-oppressive analysis is a process of inquiry that can further clarify and enhance ethicality. Anti-oppressive practices when applied to music therapy research offers the opportunity to co-create understanding of human complexities with the service users and offer genuine individual and community support toward a more socially just future. Participatory arts agendas can be a radicalizing process, transforming, emancipating, and encouraging “resistance, democracy and citizenship” (Clements, 2011, p. 19), processes that can be applied to anti-oppressive research practices.

Potts and Brown (2005) proposed three tenets of anti-oppressive research: “Anti-oppressive research is social justice and resistance in process and outcome” (p. 260), “Anti-oppressive research recognizes that all knowledge is socially constructed and political” (p. 261), and “The anti-oppressive research process is all about power and relationships” (p. 262) cautioning researchers to constantly reflect on how one is being constructed and how one is constructing ones world. Larson (2008) further developed principles of anti-oppressive social work practice with mental health service users that readily translate into research principles. These principles included inviting service users to be full participants in all aspects of the service; using language and discourse that is respectful, egalitarian, and empowering; actively deconstructing the medical model with service users and their families and encouraging alternative healing perspectives and strategies; establishing just working relationships; promoting education; embracing
cultural diversity and strengths; and promoting principles of social justice. Although reflexivity is not included in this list, it is an essential part of engaging the self in research. Critical reflection is about reframing situations and stories, challenging and changing dominant power relations and structures, and operationalizing progressive social change (Morley, 2008). Critical reflection provides for understanding how the personal is political (Hanisch, 2006) and for development of strategies to address oppression.

Music therapy has begun to consider and address issues of social justice and anti-oppressive practices. These analytical and emancipatory positions have been applied to music therapy, informing and expanding theoretical awareness and approach to practice, contributing to the anti-oppressive dialogue. The aim of anti-oppressive practice in music therapy research is to expose and dismantle oppression and to increase the relevance and practice of social justice within all systems and programs of music therapy. Employing an anti-oppressive practices approach to music therapy research and practice ensures the highest ethical standard can be the measure of future results. As Strier (2007) wrote,

to liberate … research from oppression is based on the assumption that any intervention or research project, regardless of the benevolent and progressive nature of its goals and intentions may replicate the structural conditions that generate oppression (p. 859).

Although it has been challenging, an AOP sensibility has required that this research study involve deep and critical reflection on each procedure and step in the research.
Anti-oppressive analysis applied to major stakeholders of music in Western culture, from early music pedagogical experiences (Jacques, 2000; Bartel & Cameron, 2004; Gould, 2004; Whidden, 2008; MacArthur, 2011) on through to experiences interacting with the music profession (Johnson, 2000; Davidson & Edgar, 2003; Wehr-Flowers, 2006) and the music business (Wells, 2001; Lwanda, 2003; Pruitt, 2007; Chari, 2008; Clay, 2008; Jones, 2008; Miller-Young, 2008; O’Shea, 2008; Reid-Brinkley, 2008; Springer, 2008; Moss, 2011), reveals that abusive and oppressive experiences are widespread and structurally embedded (Baines, S., 2013b).

Summary

Program development and published research using participatory paradigms have provided the foundations for music therapy as an anti-oppressive practice in healthcare contexts. Previous research evidenced strong autonomous participation with the results indicating that guaranteed relaxation, fun, socializing, by singing preferred songs in groups are important resources for people with chronic mental health conditions. Music therapy as an anti-oppressive practice provides clear parameters for thinking about research toward developing practices that are emancipatory both to service users and to the culture as a whole. This doctoral research seeks to further elaborate the previously described music therapy process using an anti-oppressive practice approach with services users with a range of needs including communication concerns. Specific research methodology and protocols to enhance access to these marginalized service users’ voices were necessary.
Chapter Five

Methodology

Introduction

The research employed two methods to collect data: Constructivist Grounded Theory (Charmaz, 2006, 2011; Mills, et al, 2006; Allen, 2011; O’Callaghan, 2012; Higgenbottom and Lauridsen, 2013) and Autoethnography (Anderson, 2006; Uotinen, 2010; Ellis, 2011). The qualitative interpretivist approach, Constructivist Grounded Theory (CGT) was used for the analysis of the interviews across two sites. Interviews were undertaken with fourteen people across two healthcare sites. Face-to-face semi-structured interviews were conducted with music therapy participants as well as with members of the multi-disciplinary health care team including front-line care staff, specialists, managers, and administrators at two sites. These interviews provided a vehicle to explore perspectives of the contribution of music therapy in a long-term care facility and in a locked psychiatric ninety-day residential treatment centre for adults and teens with dual-diagnosis of developmental delays and mental health issues. The interviews were transcribed and analyzed. The analysis of the interviews is presented in the chapter six.

An autoethnography (Anderson, 2006; Uotinen, 2010; Ellis, 2011) that explores my practice and the research undertaken for this thesis was created. This work offers
narratives of my music therapy practice, which are then reflected on and critiqued. This research appears in chapter seven.

*Constructivist Grounded Theory*

“Grounded theory methods consist of systematic, yet flexible guidelines for collecting and analyzing qualitative data to construct theories *grounded* in the data themselves,” (Charmaz, 2006, p. 2). In CGT, the data is the starting and referential position for theory development, from which concepts are generated and constructed. According to Higgenbottom and Lauridsen (2013) through using the lens of constructivism, Charmaz developed her approach through reflecting on what is now called Classical Grounded Theory, (Glaser & Strauss, 1967; Starks & Trinidad, 2007). As Mills, et al, (2006) report, constructivist grounded theory can be tracked through the work of Strauss (1987) and Strauss and Corbin (1990, 1994, 1998) in their relativist positioning that the researcher constructs theory through interpretation of participant’s stories.

Charmaz employed a relativist epistemology adopting the stance that researchers cannot separate themselves from the research (Mills, et, al, 2006; Allen, 2011; Higgenbottom & Lauridsen, 2013), an epistemology shared by anti-oppressive practice. O’Callaghan (2012) described constructivist grounded theory in the music therapy literature with the following assumptions:

(a) there are multiple realities, (b) the researcher’s background inevitably affects findings, (c) data are constructed through the interactive collection process, (d)
data analysis is subjective, and, (e) findings are interpretive, can only be partially
generalized, and are contextually bound, (p. 238).

In CGT, theory is generated from and verified by the data through a process of
inductive analysis (O’Callaghan, 2012). This is a process of discovery where themes and
issues are explored as they arise from the research process. Grounded Theory was created
to study social processes rendering it a applicable methodology to explore music therapy
practices.

The relativist epistemology employed in CGT is in keeping with anti-oppressive
practice. The topic of this thesis required a flexible methodology with which to explore
the complex social processes encompassed in the research process and in the analysis and
interpretation of the data and findings. Constructivist grounded theory methodology
provided this flexibility within a structured reputable methodology.

Autoethnography

In autoethnography the researcher is the participant (Smith, 2005) and is the
starting point for all aspects of the research process (Foster, et al, 2006). A reflexive
orientation illuminates the beliefs and values of the researcher and shapes interpretations
of the data. Uotinen (2010) described how autoethnography has the qualities of being
personal, research-like, evocative, analytic, descriptive, theoretical, and artistic,
producing change in the world and people. This emancipatory characteristic reflects an
anti-oppressive practice ethos.
Autoethnography combines characteristics of autobiography and ethnography (Ellis, et al, 2011). There are countless ways that personal experience can affect the research process, who, what, when, where, and how to research. These decisions are necessarily tied to institutional requirements such as Institutional Review Boards, resources, for example scholarship funding, and personal circumstances, for example a researcher studying oppression because of personal experience with oppression. In autoethnographic research personal experience is used to illustrate features of cultural experience that make characteristics of a culture familiar for insiders and outsiders.

The term *analytic autoethnography* refers to research in which the researcher is a full member in the research group or the context of the research; evident as such a member in published texts, and; committed to developing theoretical understandings of broader social phenomena (Anderson, 2006). This type of autoethnography is contrasted with what Anderson (2006) described as *evocative* autoethnography where the researcher shares their emotional experience by reflecting on ethnographic observations but does not engage the criticality of the other. In this research, I am leading and have published widely in the topic of the research while continually seeking to develop my understanding of music therapy practice in relation to the broader social context in keeping with *analytic autoethnography*.

Autoethnographic research has been described as rigorous, theoretical, analytical, emotional, therapeutic, and inclusive of personal and social phenomena to produce thick descriptions capable of reaching wider more diverse mass audiences (Ellis, et al, 2011). The narrator’s credibility and validity are referred to as offering *reliability* meaning that the work induces in readers a sense that the experience described is lifelike, believable,
and possible; ultimately readers determine if a story describes their experience or the experience of others they know (Ellis, et al, 2011).

**Contextualizing the Methodology**

A review of disability studies and music therapy research as an anti-oppressive practice explored and informed commitment to social justice research practices. The aforementioned significant barriers affecting the participants of this study including fragility of health, access, and communication concerns, epistemologically indicated constructivist grounded theory methodology, which was subsequently described. In keeping with the advice of O’Callaghan (2012), the inspiration for my research has been already been described and I will continue to further clarify my ontology in an ongoing manner. In accordance with a constructivist paradigm, to describe my methodology I have modified the following topics generated by O’Callaghan (2012). Data analysis in grounded theory is primarily inductive, using a comparative approach to explore statements made by research participants (O’Callaghan, 2012). In this process, the researcher is the author of the co-created experience and meaning. In addition, the researcher can later use deductive analysis to notice comparable themes and topics across the data.

**Framing the Research Question**
O’Callaghan (2012) encouraged the use of broad research questions about unsatisfactorily understood phenomena. My research question is, *What are the experiences of residents and staff in music therapy as an anti-oppressive practice?* AOP seeks to understand and address social structures that oppress those of non-dominant status in our culture. Service users with increased communication concerns and fragile health in residential care certainly fall into this non-dominant status group. This question asks about music therapy practices as well as music therapy research practice offering a broad scope to the inquiry.

*Sampling*

Sampling in constructivist grounded theory occurs in a manner to research multi-layered dimensions of social processes. To initiate the research, administration at the two sites were provided the program information document prepared for ethical review that can be found in Appendix A. Sampling took place within a time limit of three months from posting the recruitment poster to completing the final interview as per the ethical review agreement. Sampling for participants for the interviews was completed using a recruitment poster asking for volunteers, which can be found in Appendix B. Research participants were self-selected or volunteered by their legal guardians. Examples of consent forms can be found in Appendix C. Four residents and four staff volunteered at the German-Canadian Care Home. One resident and five staff volunteered at Arbourview.
Data

Data analyzed in this research were elicited through two sources, semi-structured interviews and autoethnography. A research log and reflexive journal were maintained to provide a reflective record of the process of the research. The log was a record of the processes engaged, and the journal provided my reflections on the data and results. Interview data was elicited with the statement “Tell me about music therapy at …”

Interviews were recorded and transcribed. Based on the requirements of ethical review in the centres they were required to be between fifteen and forty-five minutes in length. In interviews with participants with typical communication skills, when they experienced a loss of focus, the statement, “Tell me about music therapy at …,” was reintroduced. In interviews with participants with increased communication concerns, when they experienced a loss of focus, familiar musical cues were used to stimulate further responses. I then transcribed the interviews verbatim in preparation for my analysis through coding and categorizing as recommended by Charmaz (2006) and O’Callaghan (2012) as a way to ensure that all of the subtleties of the interaction were included.

Data Analysis

An on-going literature was written to continually ground the study in current peer-reviewed research. The autoethnography was regularly expanded and updated to ground the research in my historical and current practices and the reflexive journal was
maintained to explore my interpretation of the participants’ experiences. Interviews were conducted, transcribed, and coded based on their chronological occurrence over the one and a half year course of the research process.

**Coding**

After transcribing the interviews, I coded them line-by-line. O’Callaghan (2012) explained that initial coding is used to gain perceptions of research participants’ actions and views from their perspective. Each of the coded interviews were then colour coded in preparation for comparative coding as a way to maintain the integrity of the interview while exploring relationships between the participants’ responses. Codes were then revisited and reviewed in response to reflexive journaling and on-going interviewing and coding experiences. As per constructivist grounded theory, categories were subsequently developed to reflect the themes of the codes.

**Saturation**

It is arguable whether all elements of this research reached saturation. Codes and categories were analyzed and reflected on in terms of anti-oppressive practice and my practice until satisfaction and a sense of results was obtained. With the autoethnography, the narratives were reviewed and reflected on similarly in an on-going manner until final editing of the thesis.
Developing Theory

The process of theory development took place throughout the research process and will be described in the final section of the thesis.

Confidentiality

Due to the vulnerable nature of the service user participants, all research data was stored under pseudonyms in my password protected laptop computer. When not locked in my home, my computer has either been on my person or in secure locked storage at my employment sites. Signed consent forms are kept in a locked cabinet in my home. An example of these forms can be found in Appendix B.

Summary

The elements of Constructivist Grounded Theory were used to describe the progression of the research including exploring the research question, outlining the sampling process, and describing how the data was collected and would be analyzed. A description of the coding process followed. The parameters of saturation were defined and the course for developing theory. Details of confidentiality concluded the chapter.
Chapter Six

Results of Data Analysis

Introduction

This chapter presents the findings of the research resulting from the interviews. The categories generated from the codes devised for each interview are presented and discussed. These materials are then further reflected on from the point of view of the research based on my extensive experience and expertise in this work.

German-Canadian Care Home

Based on the legislation governing this site, The Personal Information Protection Act/PIPAwww.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/00_03063_01, it is an option for this research report to include the facility name. This is included with the permission of the German-Canadian Care Home. Music therapy has been provided at this centre for at least the past twenty-five years. The music therapy programme is offered two days per week with the stated goal of delivering high quality participatory therapy services to vulnerable residents.

The German-Canadian Care Home (GCCH) is a long-term care facility that offers three levels of care with one hundred and thirty-seven licensed complex care beds.
Special Care is for residents who require a smaller unit to be settled, who have behaviours that require increased staffing, and/or who if they exited the facility would become lost. The GCCH has two special care units. Extended care is for residents who require mechanized lifts to help them out of bed and into their wheelchair or into the bath. These residents are either not ambulatory or use a wheelchair with rudimentary ambulation. These residents share dining services and recreation programming with the largest number of residents who live in an open unit designated complex care. This group includes residents with a range of life challenges, the youngest of which is fifty-nine. The main needs that prompt admission are dementia, major mental illness, neurological disorders, and physical and medical conditions, often experienced in combination with diminished social supports. Research participants included residents from special care and complex care, staff, and administration.

The categories generated through the research process are presented below where elements of the interviews are described and reflected upon with reference to my practice and to music therapy as an anti-oppressive practice. All quoted material is taken directly from the interviews. Any general references made to what was said only refer to statements within the interviews.

Music therapy experiences are informed and impacted by ones personal relationship and history with music and dance.

The impact of the histories of experience of staff and residents on the processes of music therapy are diverse and relevant to the development and practice of music therapy.
Music therapy service users come to music therapy with their personal histories with music and dance informing their relationship with the music that they experience in music therapy. Familiar songs trigger memories and re-experiencing of personal history including history of family music making. A resident with advanced dementia, born in another country and struggling now to speak English, described her personal history in music, which was reflected in a quote from her interview, “We [the family] had anything, and music, you know, not played out … as a concert, or so on, no, it was, music [at home].” The respondent did not think about music as only personal but rather as experienced within a family dynamic and context; a family that made music and danced together.

Creating a safe, structured therapeutic environment where residents can explore their personal histories with music in familiar and creative ways requires particular attention to histories of individuals, but also collective histories, for example when working with groups who are survivors of genocide. Reminiscing about music experiences offered a glimpse into the reminiscing process of music therapy participants. When relating her experience singing in the church choir, a resident remarked, “I did it at one time, years ago at Church but I was with a group of ladies in the choir.” A staff person remembered, “I remember when my parents came over from [country] in the fifties, in the late fifties, and my uncle, they came in fifty-two and my uncle came in fifty-six, my mother and he would sit on the porch and sing for hours.” Another resident remembered that, “He [father] would sing and then I learned the songs.”

Service users’ request their preferred songs as part of music therapy sessions. One residents explained this as follows, “Oh, I like the songs we choose, um hm, I like the
songs we choose,” and a resident with dementia offered, “It’s just … gosh, I have never really heard … I hear it but then it is somewhere else that I hear it but never saw anybody playing it but you play it so … so … like nothing and it, it is just beautiful.” Song requests require special attention as familiar songs trigger memories and re-experiencing of personal history.

One staff member reflected the important role of music in her life, as a child, then as a parent, and grandparent as well as throughout her personal and working life reflecting a well-established personal relationship with music. She stated, “My grandfather was a conductor – he had an orchestra – my father played instruments, my mother played the piano, all my sisters would sing.” Similar historical references to music and dance were shared.

Music has an important role in participants’ lives. Narratives of musical memories were recalled with detail, respondents’ faces reflecting a sense of comfort and pleasure. One resident told me about her mother, “My mother had a beautiful voice though, she was very good at singing,” and another about her father “So, he [father] did play the piano and I would stand there.” Dance also featured in musical memories. For example one resident described how, “…he [step-father] played that [melodeon] and then he would do the Highland Fling at different times,” and another described her family, “Yah, ah, but, they didn’t have to teach me dancing, when I heard the music, then I just,” at which point the resident rose to her feet and started waltzing.

Relationships with music began when they were children and fed them throughout their lives, “We used to sing in the family,” “I grew up with music so maybe that’s why,”
and “My grandchildren love piano and guitar.” Relationships with dance supported lifelong pleasure as revealed by a resident:

“But, but ah, I knew how difficult it was for me to have the opportunity to go to a dance. Boy, they turned hands down at that but eventually, I got there and I ended up at the Ballroom on Main Street and it was beautiful and there was the most beautiful orchestra there, can’t think of the name of them now, and um, and I thought, oh, this is absolute heaven. It was, it was. And the floor! Well, my husband said there was another floor that was even better than the Ballroom but it was good anyway. And oh, it was just delightful. It really was. And the first few times, it was hard because I had to be home before the dance was finished … they get the joy out of the music and it’s wonderful and you know you just hear that music and you’ve got to, and the same with my husband, I mean, I met him at the Ballroom and ah, course he was used to … he came from nine years old from [country] and the family landed in [province], that’s where they had the farm and of course, there were farm dances and barn dances. I’ve been to them to, in [town], [province]. Well, that’s lots of fun,” and, “And [a recreation worker] is very good helping me there, because I … she’ll swing me around.”

Live music was preferred including playing music, dancing, singing in church, and listening to music. Happy memories of sharing music with family and friends including at the German-Canadian Care Home dominated the category.
Music therapy as an anti-oppressive practice is informed by cultures from all over the world with particular attention to the service users’ and staffs’, each teaching the other about different ways to relate to music and ways to relate to different musics. Music therapy as an anti-oppressive practice is a multi-level analysis that explores residents’ histories to support a healthier future. Music therapy as an anti-oppressive practice operates with understanding that music is important to different people in different ways, incorporating the service user’s voice to create inclusive approaches to practice that enhance the use of music as a resource. Music therapy as an anti-oppressive practice incorporates multicultural understandings of music and dance enhancing services’ well-established relationship with music and dance as a resource. Music therapy as an anti-oppressive practice involves honouring the service user’s personal relationship and history with music and dance and seeks to enhance the existing relationship that service users have with music into a reliable resource: to feel connected to others from the past through memories and in the present through validation of their experiences and joys. Music is important to the service users, their visitors, and the staff.

The expert skills of a professional music therapist to build therapeutic relationships using music and train music therapy interns increases healthy responses from residents, families, and staff.

The multiple roles of the music therapist at the German-Canadian Care Home, which have been developed to address the needs of residents, visitors, and staff and administration, were noted. The expertise of the music therapist to use music to develop
therapeutic relationships and to train music therapy interns is valued as is extensive song repertoire and the enjoyment that music therapy programs brings to the respondents.

The extensive repertoire of the music therapist addresses the needs of the multicultural population at the German-Canadian Care Home. A staff person remarked, “You can pull from your repertoire music, without anything. I don’t know,” ”You know, my background, being [nationality], I obviously, my ears are twirking and picking up, when I hear a tune that I’m familiar with,” “[you] just lapse into a polka or lapse into some [ethnic] tune.”

A resident said, “Oh, I like the songs we choose, um hm, I like the songs we choose,” and another resident with advanced dementia exclaimed happily, “I heard it so many times.” A resident that preferred dance described her enjoyment of the music saying, ”The beautiful rhythms in the songs that, the music that she plays.”

Healthy socialization increased during music therapy programs including smiling, conversing, dancing, tapping hands, and other forms of healthy touching. Music can be a support for relationship building for example, “… the resident might say to the staff who is younger, I remember that song when I was your age,” “Like I said, when you are there with your music they are less shy.” A staff said that, “I might even find an excuse to go and watch you play you know, I might have a dish here or something, oh let’s take it back to the kitchen, to see what’s happening, to see their expressions.” Other healthy responses such as, “for people with um, immobility, you know the music kind of gets their arms moving” and “you know music has a lot of impact for memory, you know, and ah, for some people who maybe their cognition isn’t there” were noted.
Music therapy as an anti-oppressive practice defines health broadly, incorporating the cultural perceptions of both the service user and the system to better support the service user to develop increased healthy responses. Music Therapy as an anti-oppressive practice intentionally utilizes the natural phenomenon of music to initiate joyful, healthy experiences and facilitate service users, their visitors, and staff to connect during music therapy.

*Music therapy fits in well with the resident centered Eden-Care philosophy at the German-Canadian Care Home*

The philosophy of the approach to care at the German-Canadian Care Home is resident centered. Recently, the home decided to adopt the Eden-Care model, which readily interfaced with the model of care already in place but offered a well-documented structure by which to expand the concept of resident-centeredness into all aspects of life at the facility where there is an overall high quality of care including music therapy. Codes generated from these interviews were varied but related so that this category refers to the shared philosophy of Eden-Care and music therapy as an anti-oppressive practice.

The roots of Eden-Care originated in the nineteen-fifties in Regina, a central Canadian city in a Lutheran long-term care facility. The Eden-Care philosophy is to create an environment that has the qualities of the Garden of Eden: compassion, creativity, freedom, openness, safety, beauty, and benevolence. Since that time, the Eden Alternative, or Eden-Care has been spreading into other long-term care facilities across Canada and internationally. In Eden-Care, employees are encouraged to embrace their
humanistic and spiritual qualities, in essence, bring their personalities and values into the workplace. Staff at the German-Canadian Care Home are encouraged to treat residents as they would someone in their own family who needed care. Although healthy boundaries are expected, as part of the mission staff members are also asked to be personally present to their work and offer emotional, social, and spiritual as well as physical care. Eden-Care is a whole person approach that aims to address resident needs in a multi-level manner and readily interfaces with music therapy as an anti-oppressive practice, which aspires to address these philosophical perspectives as well.

In line with Eden-Care, there is an observably strong work ethic tempered with a deep caring attitude at the German-Canadian Care Home and consequently residents are provided with excellent care. Both staff and administration goes above and beyond to support residents working hard and addressing the needs of residents on multiple levels. As a resident described, “But you know, I need to … I’m trying hard but you took it last night, I mean, ah, the nurse took it last night, she went to fix something on it, to help me,” explaining that a nurse had taken home a rug the resident was hooking but had made some mistakes and the nurse returned it repaired so that the resident could continue working on her craft.

The residents appreciate the care ethos. One respondent said “Everyone is kind and they do their best for you.” Another resident described feeling empowered in Resident’s Council, “We have meeting once a month and that’s good because you can find out what’s going on in the home here, you know, what they’re doing and stuff like that, and Food Services Director and Food Services Manager are there and they are the dieticians about the menu and that so I told them that I wanted baked potatoes and they
gave me baked potatoes.” Programs facilitated by the music therapist were also commended, in particular, a program that involves two volunteers who play accordion. Resident remarks included, “The accordion players, yes, they’re very very good, and one of the gentlemen in this group has a beautiful voice,” and “Well, it inspires me that they are as old as they are and they are still learning, …”

In keeping with Eden-Care and music therapy as an anti-oppressive practice, professionals from a variety of disciplines are encouraged, in consultation with the music therapist, to offer music-based supports. A staff member described, “I know the dietician plays for the … she just played (piano) … for the residents,” and a recreation staff member empowered to use music in her work explained how with one resident, “… occasionally I would tap her hand and we would just sing lullabies together.” An administrator recalled interacting with a resident, “And I don’t even know, I’m just humming to her whatever she is singing.”

Music therapy as an anti-oppressive practice can thrive where employees are invited and supported to go above and beyond their job descriptions while maintaining appropriate professional ethics and boundaries. Music therapy as an anti-oppressive practice supports staff to express themselves musically with residents, broadening, deepening, and enhancing their relationships, reflecting the philosophy of Eden-Care. In addition to supporting residents physical, emotional, social, and spiritual needs, music therapy as an anti-oppressive practice also requires that politics to be considered. Music therapy as an anti-oppressive practice incorporates the humanistic and spiritual elements of Eden-Care but adds a socio-political analysis to address residents’ needs in a more systemic manner.
Although music therapy is valuable it should not be forgotten that the centre is a difficult place to be

Long-term care facilities are difficult places to live. Need is expressed minute-by-minute, hour-by-hour, day and night. Most residents in the building have cognizance of their circumstances on some level, as reflected in the remark of a resident, “But, you know, and then my mind was a lot better then.” Some residents are preparing for the end of their lives and others are in deep denial. Residents frequently call out, in confusion, in pain, in frustration. Call bells ring, carts rattle as they roll by, there are strong smells and you can hear voices speaking in many languages. The environment can be difficult for everyone, from residents to visitors to staff.

One resident stated, “But you know, there’s only so much help,” and another resident remarked, “Um hm, yah, It’s pretty boring in here.” Staff offered further comment, “I can’t imagine, you know, sitting there knowing that, the time’s coming,” and from another staff person, “And then you just have so much loss, what are you left with?” And from another, “Everybody seems to be, rush, rush, rush.” Remarkning on music therapy’s contribution to the environment, “It’s better than call bells and people screaming down the hall, STAT this or, you know, …”

Living in long-term care means living in a difficult environment. Not only is the physical environment of living with unpredictable noises, people who are strangers, and having a serious reduction of agency difficult, people living in long-term care suffer from seriously compromised health and live with that constant oppressive fear, “You come
here and you deal with so much loss, I mean that’s got to take a toll on a person: loss of
friendships, loss of loved ones, loss of role.”

Residents notice that others need help and often desire to help one another but
they can lack the capacity in that, “they are not able to participate as much as they like,”
“they don’t know how to do this, they just know how to do this,” and “now they are not
able any more.”

Music therapy as an anti-oppressive practice acknowledges the true circumstances
of service users and addresses them with that respectful knowledge while working to
mediate those oppressive circumstances. Music therapy as an anti-oppressive practice
explores the personal and systemic reasons that residents are waiting to die and provides
quality of life enhancing programming to enrich the lives of those living in long-term
care. Concurrently, music therapy provides supportive closure experiences to prepare for
death. In the long-term care setting, the role of music therapy as an anti-oppressive
practice is to include the service user’s voice to develop programs and protocols that
serve to support end of life practice. Music therapy as an anti-oppressive practice
acknowledges the desperately difficult reality of being a resident in a long-term care
facility while working to enhance opportunities to experience wellness.

The music therapist respects people’s concerns about music keeping in mind the possible
negative effects of music and music therapy

Various concerns regarding possible harmful effect of music and music therapy
that were voiced will be explored and reflected on. It is important that participants felt
comfortable to voice these concerns to the music therapist researcher indicating their understanding that the research valued all responses.

Both residents and staff expressed feeling intimidated at times about participation in music experiences, fearing criticism and because of a sense of musical inadequacy. One worker stated, “Yes, it’s intimidating because I can’t play an instrument.” She continued, “I said, I can’t sing.” Hearing a compliment that she had a nice voice a resident responded, “I didn’t think I did.” This concern reaches into other areas of practice. For example, a resident worried about how the audience received the bell choir performance, “But it sounds, it always seems to me, it sounds like kindergarten stuff.”

Memories of having insufficient money to pay for music in the past can make participation in music therapy programs stressful for some. A resident with advanced dementia became worried at different times, “I don’t a have - well I never really have had money,” “Oh yah, it’s all right but I can’t afford it, I can’t,” “Oh not always because I haven’t got the money to do it all,” reflecting her worry of not being able to pay the person making music.

Music can and does stimulate memory and although many of these memories will be positive, some may not be. This concern was raised by a worker when describing reminiscing to familiar music, “It is probably something maybe too, too hurtful for them to remember.” A resident’s narrative exemplifies the link between music and hurtful memories, “I was mad at my mom because she wanted me to take piano and I wanted to take accordion and she wouldn’t get me an accordion so I got mad and I wouldn’t come to my lessons on piano so, you know, I hurt myself, I hurt myself by doing that, I hurt
myself.” At this point in her interview, she was offered support to process this difficult memory.

Residents expressed negativity toward other residents, “but you know, they just sit there like dumb-bells and they don’t budge,” from one resident and from another, “they get frustrated and they say, oh I can’t do this.”

Music therapy as an anti-oppressive practice employs a political analysis to address issues of potential harm in practice. Music therapy as an anti-oppressive practice integrates the understanding that music stimulates both positive and negative memories that require facilitation to be valuable to residents. Music therapy as an anti-oppressive practice addresses the pervasiveness of feelings of musical inadequacy and works to restore music to its appropriate resourcing role in people’s lives. Music therapy as an anti-oppressive research practice asks us to be open to not knowing and learning through integrating the voice of the service user.
The Arbourview Residence (pseudonym)

The Arbourview Residence (pseudonym) is protected under the privacy legislation FIPA, (The Freedom of Information and Protection of Privacy Act/FIPA: www.bclaws.ca/EPLibraries/bclaws_new/document/ID/freeside/96165_00), and therefore cannot be named.

Transcriptions of interviews with service users and staff were coded and the codes were then grouped according to their similarity to each other. Categories were developed to describe and reflect the essence of these groups of codes. The categories are presented below in italics. It was not permitted to use any transcript material verbatim for this site due to the designation of the site under FIPA privacy legislation so the usual practice of quoting from interviews was not possible. Instead, the codes are referenced since they reflect what was stated in the interview. Although these codes are not quotes, they are represented in quotation marks within the descriptive text below for clarity of reading. Each category is reflected on with regard to what is revealed about the anti-oppressive music therapy practice at Arbourview Residence.

Arbourview Residence is a locked psychiatric residence that serves persons in crisis who are fifteen years and older who have a dual-diagnosis that includes developmental delay and major mental illness. A mental health team completes a ninety-day assessment process, which includes community planning for discharge. Psychiatrists, psychiatric nurses, community nurses, general practitioners, developmental specialists, mental health workers, occupational therapists, psychometry, an art therapist, and a music therapist comprise the team. The model of care in place is The Mandt System,
www.mandtsystem.com, which is based on developing healthy relationships between all the stakeholders in the environment to create safety and promote healthy development. The service users’ voice is vital and integrated into all aspects of the treatment plan. This model interfaces positively with anti-oppressive practice, and within this model an inclusive and service user led music therapy practice has been developed.

*The multidimensional contribution music therapy makes to the residents' developmental potential and wellbeing is valued.*

The ability of music therapy to support residents’ current status as well as inspire residents to achieve increased functioning was noted. Music therapy offered opportunity for residents to develop personal and social skills supportive of their wellbeing. “Music therapy helps residents feel they can do something.”

It is pleasurable and gratifying to see residents and staff relaxing and enjoying music therapy experiences together. “[They] learn about how residents share from observing them in music therapy group,” “Staff and clients participating together in music therapy group strengthens their relationships.” “When staff and clients participate together in music therapy group, clients can feel safer bringing their issues to staff.” “Music therapy translates into a better working alliance with residents,” and, “Music therapy helps clients and staff connect at a higher level.”

“In music therapy, residents can explore their musical potential.” In particular, there is value in providing specific music therapy strategies that are supportive of residents, which can be observed and adapted by caregivers and other members of the
resident’s home community. “The community appreciates concrete music therapy strategies for clients” like “residents can use music therapy music to transition.” “The community can implement music support easily,” “Clients can transfer co-creative music making from the music therapy program to caregivers,” and, “Music therapy strategies for clients can be transferred to the community.” “Sometimes when residents are discharged, music therapy services are continued in their home community.”

Each service user has a preferred music support strategy. The manner in which they prefer to access music is honoured, perhaps listening independently, making music in groups, choir, dancing, or strumming a guitar. “Most residents will play an instrument during music therapy group, many residents enjoy playing the drum during music therapy group.”

For some residents, it is acknowledgement through playing a favourite song that makes them feel special and safe in sessions. “Residents forget their troubles when they participate in music therapy.” Some residents like to listen alone, but others prefer groups. “Music therapy brings moments to client’s lives that probably wouldn’t have happened without music therapy.”

Music therapy as an anti-oppressive practice focuses on service user preferences to develop on-going resources that function as a support system while creating opportunities for residents and staff to relate to each in musically familiar ways. Music therapy as an anti-oppressive practice creates opportunities for residents and staff to build relationship by experiencing themselves and others as musical beings. Music therapy as an anti-oppressive practice offers service users on-going support by providing the home
community concrete music therapy strategies to empower service users to continue to address developmental potential, health, and wellbeing.

*Music therapy documentation provides the team with valuable and unique information as to the residents’ social and affective states*

Working within a team approach, each discipline’s assessment is needed to provide a piece of the clinical puzzle that characterizes the residents’ wellness. Professionals from different disciplines on the team find that music therapy documentation can inform their practice. “Music therapy updates provide a good picture of residents.” “Music therapy reports help me understand our clients.” “Music therapy weekly updates are great.”

Required music therapy documentation consists of interim and discharge reports, which provide an overview of residents’ overall functioning, impressions, and recommendations for community planning within the parameters of the discipline of music therapy.

The weekly music therapy update, instituted to describe progress during the weekly, weekend music therapy group, and individual sessions is useful for staff to read if they were not present. “Music therapy updates inform me of residents affective state on the weekends.” “Music therapy weekend updates are reassuring.” “Music therapy updates provide a good picture of residents.”

The team is composed of unit, medical, and therapeutic staff all of who were represented in the research participants and who offered remarks about music therapy
documentation. “Music therapy updates inform me how residents are socializing.”

“Music therapy updates inform me how residents interact.”

Music therapy as anti-oppressive practice develops documentation that provides a full picture of residents’ physical, communicative, emotional, social, and cognitive progress through unique music therapy information. Music therapy as an anti-oppressive practice develops unique documentation such as weekly updates to support residents’ needs.

*The music therapist provides expert programming that addresses clients' needs.*

“[The music therapist has] expertise in disabling conditions.” “[She] create[s] accommodations for residents' disabling conditions.” “[She] create opportunities for residents to participate in a way that makes them feel comfortable.” “[Her] knowledge of music is a huge benefit to clients.”

“Through [her] influence music has been integrated into all aspects of our program.” “Through [her] influence, clients now have full access to their music.” “When [she] inform[s] staff of preferred auditory information for residents it is beneficial for residents.” “Before [she] worked here, it was not so apparent to staff how important music is in a lot of our client's lives.”

Staff noticed the value of music for many of the residents during the weekly music therapy group. Subsequently, they were more supportive of residents listening to personal music players and using the computer to access music in a much more frequent
and consistent manner. Overall, workers revealed a developing appreciation of the value of music therapy for this population.

Music therapy as an anti-oppressive practice works to integrate service user’s preferred music into all appropriate aspects of the treatment plan. Music therapy as an anti-oppressive practice integrates service user’s music needs and preferences in a collaborative manner honouring the personal nature of ones relationship with music.

*The music therapist respects people’s concerns about music and possible negative effects of music and music therapy*

Music can do harm, music having the potential to hurt as much as it has the potential to help. For example, “Music can be too stimulating.” “Songs can trigger clients to cry.” “How is music experienced by clients in a state of crisis?”

“Specific styles of music can be repulsive for some people, specific music of specific bands can be repulsive for some people.” “Sometimes residents’ listening is too loud.” “Some of the messages in music are not good.” “The content of some songs isn't appropriate for everyone in music therapy group.” “The community can struggle with clients who prefer heavy metal, the community can struggle with clients who prefer punk.” “The community often stereotypes intense music with negative behaviour.” “It is a challenge to play music that will resonate with everyone.”

“Sometimes new residents state that they can't sing, sometimes new residents state they are not good at music.” “Some residents say that they won't sing.” “Residents repeat negative self-statements about music learned from others.” “Residents may have
had their music expressions laughed at.” As well, staff expressed concerns about their own musicality and their ability to support residents musically.

Music therapy as an anti-oppressive practice recognizes music’s potential to do harm and works to identify and mitigate negativity. Music therapy as an anti-oppressive practice respects that staff has concerns about music’s potential to do harm and consults with staff to create increased safety.

_The music therapist has encouraged and supported the staff to feel comfortable to use music to more effectively support residents’ musical needs at Arbourview Residence_.

Staff are encouraged by the music therapist to use music in their practice and can feel comfortable that the music therapist fully supports them to integrate music into their work.

“Staff can sing with residents,” and “Residents sing seasonal songs with staff.” “Singing a resident's preferred song helped her deal with frustration in the course of the day.” “When residents do not want to go to bed, [staff] sing to them.”

“Residents need more musical support to sustain their development.” “Residents want to try musically but need more staff support.” “Staff can support residents experiencing music more frequently.” “Staff can support residents having time to play instruments in the music room weekly.” “When residents need time off the unit staff can take them to the music room.” “Staff can take residents to the music room to play drums independently.” “Residents can play instruments in the music room independently.” “It is
exciting to see residents take their minds off their worries with music, it is exciting to see residents take their minds off their worries by playing music.”

“At this centre, we are becoming more sophisticated in our use of music with residents.” “Staff are becoming more familiar to supporting clients using music technology.” “[Staff] would like [the music therapist] to continue to prescribe staff supported music experiences for residents.” “It can be easy for [staff] to support music therapy goals with residents.” As one staff exclaimed, “We can use music to make our client's lives better.”

Applying a philosophy of collaboration and inclusivity, music therapy as an anti-oppressive practice works to build a strong team to expand the scope of music therapy support through empowering staff to support residents with music by incorporating the service user’s voice, the service user’s desire for more music therapy, and decreasing barriers to service through inclusion of staff in the music therapy plan. Music therapy as an anti-oppressive practice educates and empowers other healthcare professionals to use music in a sophisticated manner in their respective practices to support healthy development. Music therapy as an anti-oppressive practice seeks to empower healthcare practitioners to use music in their practices in a way that enhances the goals of the Arbourview program.

*Music is a valuable resource for all people including people with dual diagnosis developmental delay/mental illness, stimulating memory, helping with socialisation, and improving mood*
Music can be a valuable resource for evoking memories, supporting socialisation, and enhancing mood stabilization. Residents often have a well-established positive personal relationship with music when they come to Arbourview. At Arbourview, residents are supported to use music therapeutically to support their developmental potential.

As one staff remarked, “I've been a nurse for a long time and I've been aware of the importance of music for persons with developmental delays.” “Music is supportive.” “Music provides an expressive outlet.” “Music changes your mood.” “Music brings people together.” “Participating in music creates social inclusion.” “Music is important from a social development perspective.” “Music promotes boundaries.”

“Residents gain benefit from familiar music.” “Lyrics have meaning to clients.” “Music stirs memories,” and “memories are accessed through music.”

In terms of anti-oppressive practice, providing socially inclusive group and individual music therapy experiences for service users who are routinely discriminated against in the community is a direct intervention that works to support healthy self-esteem and identity. Music Therapy as an anti-oppressive practice follows an ethic of acceptance and valuing, working to dismantle ethics and structures of oppression whenever and wherever they are encountered, and particularly to dismantle the routine discrimination that is experienced by persons with disabilities. Music therapy as an anti-oppressive practice offers service users opportunity for typical social skill development in a safe, supportive, creative environment while educating caregivers to understand and support service users’ musical preferences.
Although music therapy is valuable it should not be forgotten that the centre is a difficult place to be and that some residents have high support needs that may be better addressed through experiencing the choice of other therapies.

The environment at Arbourview is difficult. “Residents are in a locked unit.” “The centre is not a realistic place.” “The centre is not life.” “The centre is not home.” “The centre is a place with rules and regulations.” “Music therapy can provide a welcome escape from a difficult reality.”

“When residents arrive, they are over-whelmed.” “At this centre, not all residents have privileges to go out.” As a resident recalled, “I remember that when I first came to the centre, I did not go on outings.”

Residents are offered a range of experiences during their assessment. “We never know what residents will connect to.” Some residents prefer art to music, some residents prefer visual art to music, some residents prefer written arts to music, some residents prefer verbal arts to music.” “Residents get to experience art therapy.” “Residents get to look inside themselves.”

Anti-oppressive practice asks us to understand the restrictions experienced by residents in the community and at Arbourview, essential to developing strategies to increase agency, health, and wellbeing in the community. Respecting service user’s preferences is central including respecting when service users refuse service. Music therapy as an anti-oppressive practice acknowledges that music therapy can be counter-indicated for some service users. Music therapy, as an anti-oppressive practice, values
and respects uniqueness and continually works to dismantle the sociopolitical structures, which seek to oppress uniqueness.

Clients with dual diagnosis developmental delay/mental illness struggle with a significant lack of support in the community

“The community often does not know how to support our clients.” “When residents break down in the community, they lose community experiences.” “Residents who are breaking down in the community cannot go out to group events anymore.” “The lives of residents who are breaking become smaller and smaller.”

“Clients don't always experience social inclusion on a day-to-day basis.” “Clients with limited communication struggle with social inclusion.” “Some clients who come to the site have strained relationships with their caregivers.”

“Some in society have unrealistic expectations of clients with developmental delays.” “Sharing time with our clients is a lot different than to social experiences outside of work.” “Some caregivers feel the need to try to keep our clients busy.”

Music therapy as an anti-oppressive practice advocates for service user’s rights in the community addressing discrimination on all levels. Music therapy as an anti-oppressive practice works in the community to decrease stigmatization of people with developmental delays and mental illness acknowledging the socio-political roots of discrimination against people with developmental delays and mental illness. Offering the community information and support on how to best support persons with developmental delays is a piece of music therapy as an anti-oppressive practice. Music therapy as an
anti-oppressive practice works with other anti-oppressive practioners to dismantle oppressive social structures working collaboratively to create inclusivity through social justice.

*The professionals on the team respect and appreciate each other’s quality and competence*

Research participants described other disciplines and practioners with respect during their interviews. “We have a multidisciplinary team.” “We have a strong team of therapies here.” “We work as a unit to support residents.” “We work with a great team.”

“Medical and therapeutic aspects create a team.” “Our expertise informs medication choices.” “This medical team wants to hear therapeutic aspects.” “The medical team cares about humanistic aspects of our clients.” “It is amazing to work with a medical team that cares about the humanistic aspects of our clients.”

“Music therapy is an integral part of this program.” “Music therapy is one important piece of the team approach to help residents get better.” “Music therapy is part of the team approach to help residents get better.” “Music therapy is a valuable part of the team.” “Music therapy is one important piece of the multidisciplinary approach.”

“Staff learn a lot about what clients are going through in music therapy group.” “Staff are interested in which clients participate in music therapy group.” “Staff are interested in which clients are not participating in music therapy group.” “Staff are interested if clients attending music therapy group are attending staff's groups.” “Staff are
interested to know why and why not clients attend music therapy group and other groups.”

Music therapy as an anti-oppressive practices works to develop healthy team relationships to increase client services. A well-functioning experienced team provides proficient support for residents with complex developmental needs. Integrating non-traditional therapeutic approaches that are service user preferred to enhance health is an anti-oppressive practice. Supporting staff to integrate music in their professional practices is an anti-oppressive practice. Music therapy as an anti-oppressive practice is grounded in these standards of inclusivity and cooperation.

*Music therapy is a hassle for some staff and they do not appreciate its value to residents*

Although there were numerous positive remarks in interviews the candour of a staff member who raised negative perceptions and opinions was appreciated. It was noted that, “Some staff do not appreciate your work,” and that, “Some staff do not appreciate music therapy.” As well, it was reported that “Some staff think the music therapy group is a hassle.”

Anti-oppressive practice asks that we listen and offer respect to all voices that have a stake in the service. This includes voices of dissent. By listening deeply, we can improve our service. Music therapy as an anti-oppressive practice must remain open to all voices including dissenting voices to remain grounded in collaborative inclusive practice. Music therapy as an anti-oppressive practice seeks to elicit the voice of music therapy dissenters to address concerns and strengthen practice. Anti-oppressive practice suggests
we link with like-minded people and offer excellent service so that we can develop integrated practice but it also requires that dissent be honoured.

Summary

This chapter presented the results from interviews across two sites that were analyzed with methods and techniques of Constructivist Grounded Theory. The analysis consisted of generating categories from coding of the interview transcripts. Both sites were analyzed separately because two forms of analysis were needed due to different privacy legislation governing the two sites. The results from the German-Canadian Care Home were analyzed in the traditional manner working with quotations from the interviews. These analyses presented that residents and staff appreciated the expertise of the music therapist to provide a broad spectrum of music therapy services to older adults and that music therapy is a valuable asset to support residents, their visitors, and staff both personally and in a manner that develops their community. Due to the more stringent privacy legislation for Arbourview, the results were analyzed using a modified process where codes reflected interview material were employed for analysis rather than direct quote. These analyses revealed that staff and residents appreciated that the music therapist has expertise in music therapy with adults and teens with developmental delay/mental illness and value that the music therapist has empowered residents and staff to integrate music into residents’ daily lives in a structured and reliable manner. Analyses revealed that music therapy provides unique support and opportunity to maintain and increase the wellness of residents while at the centre and in their home communities.
Results from both sites indicated that sometimes music therapy is not appreciated, and that the sites are difficult places to reside. These results are further elaborated and critiqued with reference to music therapy as an anti-oppressive practice in chapter eight, after the autoethnography which is presented in the next chapter.
Chapter Seven

Reflections on Music Therapy as an Anti-Oppressive Practice

Introduction

The following autoethnography describes music therapy program development, process, and research framed within an anti-oppressive practice ethos. Although I wrote this piece as part of my doctoral research I can now see that I have carried an autoethnographic sensibility with me throughout much of my journey as a music therapy practitioner. I have continually reflected on my work and written about the need for social justice principles to ground professional practice. From my perspective, music therapy practice occurs as social action in a multi-level framework: from the atomistic to the global. Practices that obscure or ignore the social power dimensions of music therapy are not consistent with emancipatory goals for therapists, services and most importantly service users.

I am appreciative of the opportunity to engage in autoethnography particularly since it offers a way to reflect on personal experience, while critically appraising power relations in context. Anderson (2006) proposed the term analytic autoethnography to refer to research in which the researcher is; a full member in the research group or the context of the research; visible as such a member in published texts, and; committed to developing theoretical understandings of broader social phenomena. He contrasted this type of autoethnography with what he described as evocative autoethnography where the
researcher reflects on their ethnographic observations but does not engage the criticality of the other, rather draws the reader into the emotional experience of the author only. I fit the Anderson criteria as I am leading this research, I have published widely in the topic of the research and I continually seek to develop my understanding of music therapy practice in relation to the wider social milieu. At the same time autoethnography should not be a straightjacket. Creative breath and life is needed to bring its revelatory capacities to bear on the topic of oneself in context.

*I am music*

The neuroscientific perspective indicates we are biospecified for music (Phillips-Silver (2009). That is, our brains became engaged and more organized when we are participating in music. In my own life, as I entered adolescence, I struggled with my mood, struggles that continued into adulthood. In my late teens, I worked with a therapist who specialized in psycho-education but this verbal approach was unsuccessful. My mood issues had increased into frequent debilitating headaches. I worked with a biofeedback psychologist, which helped with the headaches briefly but did nothing to address my very real struggle to manage my moods. I continued to access a variety of verbal psychotherapeutic services over the next decade with continued limited results. However, throughout this rocky period of my life, I noticed that when I was actively engaged in music, my moods felt more stable. It was an exceptional day when I first encountered the field of music therapy: a real *aha* moment, when I decided to pursue the profession.
When I am with my music, I feel good. Music creates a bubble of wellness. In my research and program evaluation I have been able to show how music can create a bubble for social connections (for example, Baines, S., 2000/03; Baines & Danko, 2010). When music is sounding, humans know what to do: walk away, walk closer, dance, listen, sing along, conduct, play instruments, daydream. All of these behaviours enhance the healing opportunity of agency and knowing how to be in the world.

Program Development Using an Anti-Oppressive Analysis

In the beginning of my music therapy practice I followed what is described as a client-centered approach, recommended by the professional association to which I belong, the Canadian Association for Music Therapy. For me, client centered meant noticing the full spectrum of the client’s experience, integrating my political consciousness of how and what power was afforded to clients including when and by whom. Through this focus, I noticed that the process preferred by my clients, irrespective of the setting or diagnoses, and required my focus, creativity, and study, for over twenty years, was a song-based music therapy approach. This approach was not the way I was educated nor trained to practice but rather was co-created and researched with the service users I supported.

Over the course of my professional employment as a music therapist, the primary reason I have developed programs has been due to financial need on my part, a difficult ethical position from which to begin. However, I have negotiated this ethical dilemma by using feminist analysis to address issues of oppression. Here in my doctoral research, my
feminist analysis is expanding under the umbrella of anti-oppressive analysis. An AOP perspective helps me to find ways to integrate and balance my financial needs with the needs of the persons to whom I offer service. To earn my living practicing professional music therapy, I need to find or create viable ethical music therapy programs. As a professional music therapist in Canada, I have signed and adhere to an ethical code that critically analyses and directs my professional behaviour.

While addressing many aspects of Anti-Oppressive Practice, unlike the previous manifestation which I helped create when I was Ethics Chair of the Board, the current manifestation of the Canadian Association for Music Therapy (CAMT) Code of Ethics [www.musictherapy.ca/members-documents/codeofethics99.pdf](http://www.musictherapy.ca/members-documents/codeofethics99.pdf) does not require members to participate in social action. To me, as a member in good standing for over twenty-years, this is an appalling oversight. While some healthcare professions in Canada such as social work have been integrating social justice into training and practice for decades, social justice was removed from the Code of Ethics of the CAMT in the most recent document. The document was revised by a music therapist with a doctorate in clinical psychology, a field where social justice aspects are less developed. Including social justice in the Code of Ethics elevates our work from the specifics of the treatment room into the needs of the greater community. Traditional clinical models are no longer the norm as more music therapists expand their work to address client needs systemically. A social justice critique offers forays into community practice substance and structure, an provides a framework to describe and address client needs in a multi-dimensional manner that supports the development of a more socially just future for all of us.
My second reason for music therapy program development is derived via an anti-oppressive analysis turned to social action: a desire to pioneer music therapy services for persons who are not well served by the current health care system. I have co-created new programs with persons with chronic and persistent major mental illness in under-resourced community care settings. I have also co-created music therapy programs with children with special needs living in the community, and I continue to develop music therapy anti-oppressive practices with persons living in long-term care and persons with developmental delays in short-term residential psychiatric care.

My third reason for music therapy program development has been because of personal concerns that I have turned into social action. For example, one morning, after listening to the news, I became distressed by a reported rise in youth crime. I called a local youth corrections facility and spoke to the director of programs who agreed to look over a proposal. Soon, I was working weekly at two sites. That particular contract lasted for three years until massive government cuts of all programs. Another example is that I continually incorporate my awareness of physical, emotional, and sexual abuse rates into the way I practice music therapy, offering me increased understanding of hyper-vigilant, dissociative, and other typical symptomatic responses to trauma to music therapy participants of all ages and stages.

I develop my music therapy process through peer review through regular presentations at professional conferences, publications in professional peer-reviewed journals, and networking with like-minded music therapists. In particular, I support the group Music Therapists for Peace www.musictherapistsforpeace.org, knowing that teaching peace is one antidote to violence. I advocate for this group through social media,
encouraging like-minded people to engage in social action, offering examples of my own work. I host regular events to share music and peace and write a regular column in the Music Therapy Association for British Columbia Newsletter, *The Drumbeat*, for Music Therapists for Peace.

*Thinking About My Approach to Research*

My approach to research has been to study active functioning music therapy programs I lead rather than study a group conscripted or created for the purposes of the research inquiry. When the group is functioning, the participants are working with me and with each other. These parameters of interconnection are important to me. All of the persons I support require increased time to establish any kind of relationship due to cognitive, communicative, and physiological issues. By studying functioning music therapy programs where therapeutic relationships are in good order, these participants can have their voice heard in research, a voice that has often been silent or silenced in the past.

I work at the two agencies that are the venues for this research. The first is a long-term care facility. Persons living there struggle with communication due to cognitive, psychological, and physiological causes often complicated with language barriers. The second agency is a ninety-day psychiatric residential program that serves persons in crisis who have been diagnosed with Intellectual Deficits/Mental Health. In this group of clients, some are non-verbal, some use gestural communication, some sign language, and most of those who are verbal use language in atypical ways and like in long term care,
within this population, some of the clients have English as a second, third or fourth language.

The model of practice being studied is founded on music therapy using paraverbal techniques, the roots of which are psychiatry, neurology and developmental psychology and psychosocial rehabilitation, which incorporates the service users’ voice in all aspects of healthcare delivery. The work is informed by anti-oppressive practices, a social justice approach, both foundational and essential because of the multiple oppressions experienced by persons’ seeking health services and in particular, persons who employ alternative modes of communication and are deemed disabled by the culture. The goal of this approach is to assess and support individual communication in order to enhance that individual’s voice, increasing their agency in and ownership of their therapeutic process.

What is “voice”?

Voice is many things. Voice is the sound that we make when we express sound from our mouths. Voice is also the way that sound is expressed: loud, soft, gentle, or harsh. Voice is the choice of words or no words, the choice of gestures, facial expressions, and body language, even choice of attire and personal grooming choices. Voice is the choice of specific words, used typically or atypically. Voice is culture. Voice is spirit. Voice is the music child. When ones voice is heard and reciprocated, ones voice increases. Anti-oppressive practices assess and increase voice. Music therapy assesses and increases voice. Paraverbal techniques assess and increase voice.
When people live in residential care, their voice is decreased. In a new and unfamiliar environment, their sense of self is less clearly defined and supported. They experience loss of agency in that they are told when to get up, eat, wash, and go to bed. If they have unusual and unique ways of communicating, dressing, eating, moving, and being, these are scrutinized by staff and other residents, often with negative consequences decreasing typical performance of self, of voice. Residential care, although offering life-giving support, can also remove the life-enhancing aspects that feed individuality, agency, and empowerment necessary to maintain self and voice. Music therapy as an anti-oppressive practice acknowledges the consequences of living in residential care and supports residents’ voice in all aspects of life at the residence.

The Social Phenomenon of Music in Music Therapy

I value music therapy groups because during group music therapy, I can harness the culturally typical resourcing features of group music for therapeutic intention: the social aspect of music is present and functioning to promote wellness. I can involve participants in group music therapy experiences to resource them socially with music.

Pavlicevic (1997) has written eloquently regarding the social phenomenon of developing a therapeutic relationship, where an etiquette is negotiated between the therapist and client: when and what will take place during music therapy. The client and the therapist appraise each other as the relationship is negotiated (p. 46). In an anti-oppressive framework, the client’s voice, personal and political, is primary, with focused and appropriate attention being offered to other stakeholders such as the institutional
needs, or family concerns, integrating the political with the personal to advance client’s potential and development.

For example, sometimes residents at Arbourview prefer music that is generated in subcultures considered anti-social by the general population as represented by the resident’s families, caregivers, and community. These music prejudices against genres such as Heavy Metal, Gangsta Rap, and Punk can be escalated in smaller and rural communities where the culture is more homogeneous including music norms. As previously reported, resident preferred music offers significant therapeutic opportunity. In keeping with anti-oppressive practice, Arbourview staff have been educated regarding the value of these so called negative musical forms for expressing the full range of feelings of residents who are oppressed by not only the personal consequences of the manifestation of their diagnoses but also by the communities where they live. Further to this training, Arbourview community liaison staff subsequently educate resident’s immediate community on how to support residents musically with their preferred music.

*Leadership*

My approach to leadership is informed by feminism, psychosocial rehabilitation, and music. Feminism uses leadership to empower on a personal level and to dismantle oppression in the community. Psychosocial rehabilitation suggests that workers lead by being a good *rehab model* exemplifying the attributes we hope to inspire. The musical role of the conductor and the accompanist also inform the way I lead, the conductor facilitating and managing all the metaphors of music, the accompanist supporting the
service user with musical metaphoric expertise. When functioning as a good rehab model, using my metaphoric musical skills by enhancing my awareness of the elements of music in all aspects of practice to accompany my clients on their personal journeys, and conducting the music therapy with attention and attunement, my sense of leadership is realized.

*Multiculturalism in Music Therapy: Stories of Practice*

I live in a highly culturally diverse city with all socioeconomic classes expressed by locals and immigrants from all populated areas of the globe. This multi-cultural truth is reflected in the manner in which I teach and practice music therapy.

A few years ago, I was asked to teach a class of students who were studying to be personal care assistants about music therapy. The class was comprised of students from Western European backgrounds, second, third and fourth generation Canadians as well as first generation Canadians from Asian and Indo-Asian backgrounds. In addition, there were students new to Canada from Africa, diaspora India, and the Philippines. First we talked about our personal relationship with music, with special songs, and with active musical experiences. Next, students chose percussion instruments and we began to improvise freely. I noticed that the students with non-Indian backgrounds established a steady beat; the students with Indian roots maintained polyrhythms; African students joined in playing both types of rhythmic patterns. When verbally debriefing after the improvisation, two students with Western European roots commented on how “bad” the students of Indian ethnicity were rhythmically, misunderstanding the cultural context of
rhythm. I provided space for students to demonstrate rhythms from their cultural backgrounds and a deeper multicultural understanding was achieved.

It is essential that music therapists open their horizons and hearts to all styles of music to augment and enhance best practice. Although inclusivity has always been a tenet of my practice, the aforementioned experience shaped how I respond to anyone who begins to express themselves musically in the vicinity of music therapy programs – I incorporate their expressions and explain them to the rest of the group. This is done musically and often also verbally.

Multi-cultural practice is a reality in most parts of Canada, particularly in urban settings, and in many other regions, worldwide. When including service users from many cultures, the following approaches that have been effective. For morning programs, I try to incorporate music with a wide variety of styles and rhythms from the participant’s country of origin. As much as possible, I offer culturally appropriate rhythm instruments so that everyone can be involved. For evening programs, the following format has proven to be very effective. The other night, in the special care unit, we had residents from Ireland, Germany, Japan, Hungary, Canada, India, the Ukraine, and Croatia, staff from the Philippines, Canada, Korea, India, and Slovenia. I played the piano, songs familiar in Canada in the forties, fifties, and sixties, songs with gentle rhythms and slow steady tempos. One by one, the residents settled into chairs, sometimes closing their eyes, some humming, others conducting with their hands, some holding hands. The staff speaking voices became quieter, more melodic. Some staff listened, some sang, some gently danced with the residents. We all settled together and joined in the connection of shared live piano music played with therapeutic intent. This reflects how I understand the power
of music in my own life and in my practice. Peak music experiences in choir and wind ensemble during high school and university taught me that music played with intention, particularly in groups, initiates powerful healthy experiences. Even when the music creating did not produce peak experiences, the results were a sense of wellbeing and community. Listening to and playing piano in performance settings taught me that piano music, played with intention, can help people settle. These experiences are true of people living in long term with chronic health conditions.

**Music Therapy Program Development in Long Term Care**

I have been practicing music therapy in long-term care for over twenty years. I have always enjoyed working with older adults. I love their stories, their music and songs, and I love that I can ease their pain and concerns and inspire them with my music and my caring. I cannot imagine what it would be like to wake up in a facility every day. Having been hospitalized three times over the course of life thus far, I can only imagine that knowing I would not be going home would be tremendously difficult. When I intentionally use my music to shift the tenor of the experience from one of confusion and fear to one of belonging, familiarity, and comfort, I experience a sense of meaning and value, which is very satisfying to me.

The beneficial effects of music interventions for people with dementia have been reported in numerous studies (Brotons, et al, 1997; Brotons & Pickett-Cooper, 1996; Kroger, et al, 1999; Gerdner, 2000; Gerdner & Swanson, 1993; Clair, 1996; Clair, et al, 1995; Claire & Bernstein, 1994). Sherratt, et al, (2004) reported that music, specifically
live music, increases levels of engagement and wellbeing for people with dementia. My work with persons with dementia has indicated the validity of these findings. My first contract working with this population was in Toronto in 1993 when I was building a mixed music therapy practice, freshly graduated from my internship studying Music Therapy Using Paraverbal Techniques and my Master’s of Arts in Music Psychotherapy from New York University. While I harbored my own concerns about traditional approaches to music therapy, I was determined to integrate the theoretical models and practices of my bachelors, internship, and Master’s studies into my practical music therapy work.

I remember that on my first day of work with older adults, I entered the complex care facility with some trepidation. I had no relevant experience with the elder population other than church youth group singing and my first music therapy practicum in my bachelor’s degree. My internship experiences had been with high-risk mothers and toddlers, patients with Huntington’s disease, and clients with complex developmental concerns. My Master’s education in music psychotherapy, and my first job music therapy experiences were with children, teens, and adults with developmental delays, mental health, and visual impairment. As I initiated the contract, I was reminded of Kenny’s (1989) work describing the field of play, positioning my consciousness in a place of open readiness.

I prepared by buying a songbook with preferred songs for older adults and putting together a box of hand percussion instruments. When I came to the room where the music therapy session was to take place, a few of the more verbal/vocal group members told me that I should hand out the instruments and to play some of their favourite songs. In
response to this service user request, I did and we began developing a relationship based on me responding to their spoken and unspoken needs through music and personal connection. As I attempted to integrate elements of my Master’s training, particularly, clinical improvisation, some residents responded with total resistance by walking away or by talking loudly, offering negative comments and not responding to redirection. In observation of the participants during *sing-along, rhythm band*, they became increasingly fully engaged whereas during even a brief period of improvisational playing, they quickly appeared to become unfocussed, unrelated to me and to each other, and agitated. The songs evoked shared stories. Residents interacted with me and with each other in positive exchanges. The environment increased in health overall. Next I attempted to integrate focused listening and imagery work into my eldercare. Again, the residents, most of who had been born in the time of World War One, met these techniques with strong resistance again, by leaving the room or making loud negative comments. The live music making employing preferred songs was easily observed as the most appreciated and most readily engaging approach. The familiarity of the experience and the music appeared to foster the therapeutic liaison and response. My training had indicated that song singing in groups was not a foundational or valued method. Yet I meet music therapy goals utilizing this service user preferred approach. Well-educated and creative, it was my job to address service user goals and in a client-centered framework, these goals could be pursued within the model of music expression that was service user preferred.

This experience of clients preferring a song-based model has been replicated for over twenty years throughout the many populations and institutions I have worked. I believe that in responding to participants’ musical preferences, I meet my clients in a
respectful space. This space is negotiated despite the possibilities of verbal, oral, and aural processing disorders as well as having best spoken languages outside of English. Shared songs provide shared experience concurrent with individual resourcing. Shared songs provide a way for us to be together in a social way. Shared songs structure the time of the program, each with a beginning, a middle, and an end. Turn taking of choosing shared songs provides a broader structure of the duration of the program and enhances social interaction as residents support each other in taking their turn.

I assess how best to support participants utilizing the keen observational model I learned in my music therapy internship with Helen Grob, Music Therapy Using Paraverbal Techniques. By employing this approach over the years, I came to understand the value of using different instruments and music for different situations, for example, the accordion and singing in the morning and playing focused grounding piano in the evening.

*Negotiating the Space with the Team*

Over the years, there have been times when I started music therapy practice in settings where the care staff did not want the program. This would be evident by various forms of negative behaviour when I was facilitating music therapy. For example, years ago at another facility, I planned to play the piano for music therapy programs, as it was the instrument I had the greatest experience and facility on and as per my approach that incorporates the service user’s voice, it had been preferred by service users with similar backgrounds. The set-up of the room was wrong for the program to succeed: the piano
was placed too close to the nurse’s desk and the music would interfere with the nurse’s duties. I asked management for the piano to be moved but this request was denied. And so, I began my practice under these circumstances. Of course, the nurse did not appreciate the interruption. However, over time, after observing the residents respond in positive and healthy ways, she began to soften her attitude. Soon, she planned her work so that she did not use the phone during the music therapy program. She trusted the music therapist with the residents and left the unit to make deliveries to other parts of the building during music therapy. She became supportive of the music therapy program. It has been my experience that by offering excellent programming, over time, even the most negative staff either become more supportive of music therapy or they choose to be absent during music therapy. This experience reminds me of the anti-oppressive tenet encouraging practitioners offer excellence and to link with like-minded workers (Baines, D., 2007). Not all co-workers will be like-minded but excellent service can provide the common ground needed to increase the functioning of the team.

When the unit functions better because I am creating a music therapy program to address current and on-going concerns, I am satisfied. I feel the value of my contribution to the health of all persons on the unit, residents, staff, and visitors alike. When a resident is overwhelmed and struggling and my musical intervention brings focus and a relating to here and now, I am gratified. When the staff improves in their state and demeanor due to proximity to a well-facilitated music therapy group, I feel pleased and fulfilled. I love what I do.

I love going to work. I love saying hello to the people that I have not had the pleasure of greeting for a few days. I love reporting to them that we will be doing music,
the immediate shift in the attitude of many people in proximity of the program. I love initiating the program and feeling the dynamics in the room move into a more co-creative flow, sharing the process of supporting the resourcing of the residents.

Music and Memories Special Care Morning Music Therapy Program

The energy of the special care unit in the morning is mixed. Some residents seem to be painfully dragging themselves into precarious consciousness while others greeted the day with enthusiasm hours earlier. Others have been awake and agitated all night. My role is to use music to assist some in integration, others in vitalization, and still others in focus and grounding. I play accordion in the morning because residents have told me that hearing it is a stimulating, life affirming experience. As well, I sing in morning programs. The human voice has stimulating, invigorating virtues as well as focusing grounding qualities which I employ to support the residents. I sing their names, I sing their favourite songs, I invite them so sing with me as I sing directly to them. The program is built on the use of familiar songs: songs that provide comfort, fun, familiarity, creativity, and more. Residents participate based on their own health, mood, interest, and comfort. Some sit far from the group, others readily join the circle. Some prefer to dance, some listen, some sing, some play small percussion instruments such as maracas, small tambourines, and bongo drums. Bits of conversation are stimulated and used to provide an integrative experience through related song and social experience. Staff sometimes participates, singing or dancing briefly with residents while the complete their morning responsibilities. The program is timed to the needs of the unit: after breakfast is mostly
off the table and before the mid-morning snack or just after the mid-morning snack and before lunch. This way, the residents are supported in a continuous ebb and flow of activity through the morning rather than being asked to start music while they are the midst of a care routine. The program is designed to meet the current needs of the current residents, a milieu that is constantly changing. Who will be up today? Who will be in the mood to do music? What music will they prefer? Will meeting the needs of one address the needs of another? Are counter indicated preferences occurring? Mitigating these needs is my job. Can I address the needs of one of my dancers while supporting the needs of one of my late-painful risers? Familiar song is the container for the experience. Songs that remind, songs that support, motivate, and comfort, songs that inspire, songs that initiate them into the day in a way that supports their needs. These songs are delivered and woven together with intent addressing mixed needs on a lively and unpredictable unit.

*Music and Memories Special Care Evening Music Therapy Program*

On one warm summer evening, I went up the to the special care unit. The residents were restless, some agitated. Wandering, asking to leave, to find the family members, calling out, occasionally striking out at the air, or at each other. I sat down at the well-tuned old upright piano and began playing, *Walking My Baby Back Home*. Residents began to gather and sit independently or upon invitation. They began to hum the lines and sing the refrain, *Walking My Baby Back Home*. I continued with gentle swing tunes, slow waltzes, and a relaxed tango. More of the multi-cultural group of
residents sat in the chairs around the piano of their own volition mostly, some upon invitation and assistance from staff. Some closed their eyes; others began to minimally conduct the music. Some hummed, some sang, some listened, some held hands. A tired care staff spoke to me with gratitude: They are all so relaxed now. The instrumental piano music provided a familiar social context for settling and grounding and listening in community. I felt it; I trust we all did. And I trust that this can be replicated on future occasions.

Music and Memories Extended Care Music Therapy Program

The extended care music and memories program occurs right after lunch. Due to extensive complex care needs, these residents require increased support to participate. I play the accordion and sing for this program. I have trialed using the piano and guitar but have been encouraged by the residents in this program to use the accordion. As reported by one participant, “I love the piano, I love the guitar, but I love the accordion best,” to which I replied, “why?” She responded, “because it keeps me awake.” The stimulative, vibrant, dynamic, sustaining properties of the reeds of the accordion combined with singing familiar preferred songs with intention provide the backdrop for social interaction and emotional support. Because of severe health conditions, many of the residents simply listen to the music. Some play small instruments; some conduct the music dancing their hands in time to the rhythm, others sing, some tap their toes, and some participate in brief social conversation. Sometimes staff take time to participate with their residents, interacting with them in the music, a welcome change from care routines. Sometimes a
volunteer joins the program, dancing and interacting with the residents, smiling and singing the words to the music. The program is conducted in the large open lounge with the Geri chairs and wheelchairs circled to provide increased social contact. More able-bodied residents from the Complex Care Unit participate from the sidelines, offering their voices, rhythms, dances, and choices in support of their extended care family. The program can be tender or raucous and anything in between depending upon the current needs of the current residents. Songs might be sung in many different languages while residents are encouraged to participate to their fullest abilities. Staff appreciate observing the residents participating in the program for example, as one unpredictable and easily agitated resident held my hand and sang, *Let Me Call You Sweetheart*, to me while I chorded on the accordion, his regular care staff said with smiling wonder, “I didn’t know he knew how to be nice.”

*Sing-Along in a Complex Care Music Therapy Program*

When I initiated the music therapy service at the German-Canadian Care Home over six years ago, there was a large group weekly sing-along established for many years that was led by two volunteers who both played accordion while one sang. Although they offered their best effort, the music could be quite uneven and they frequently spent time talking to each other during the program while the residents became increasingly unfocussed, confused, and anxious. Slowly, I integrated myself into their program: first on piano and guitar, and then later on accordion. Over time, we picked up the energy of the music through playing steady tempos enriched by increased musical intention through
my phrasing and dynamics. Since that time, the program has grown larger with increased staff support. Residents are brought from the Special Care Unit to be involved in the larger facility community. The program has become both more entertaining as well as more therapeutic. Music from many cultures is offered along with some basic sing-along repertoire that everyone knows and can participate in. Residents can be observed singing, clapping hands, tapping toes, dancing with staff, volunteers, and each other, and socially conversing all supported by the music environment being created.

AOP is a collaborative inclusive approach that while therapeutically intervening with the service user addresses the broader needs of the community. In using service user preferred songs to structure the program, a familiar music-making ethos is evoked such that although long-term care is an artificially created grouping, residents, staff, volunteers, and visitors can interact in familiar quality of life enhancing ways. In this manner, barriers to social connection are decreased for all participants who are included at their own discretion. This approach to music therapy practice makes sense within AOP as it addresses social inequities while increasing health and quality of life.

*Hand Chime Choir Music Therapy Program*

As the health of residents living in long-term complex care has declined over time, my role in the hand chime choir has increased as described in Theurer (2003). Supportive community care initiatives such as home care, respite care, and assisted living long term care have taken out the cohort of more able residents leaving those with higher and more complex needs to move into this type of facility. An example of this is that over
time, the hand chime choir has determined that they prefer to have me sing while I conduct them to accompany me with chordal harmonies rather than conducting them to play melodies which requires increased concentration and independent follow-through.

When they are in the program, over time, as their functional health decreases, residents require increased support to remember how to make the chime sound and when to sound it. Simultaneously, I have observed increased negativity towards each other’s mishaps as well as their own potential failings. To keep the program therapeutic, it must be well planned with a large component of fun. Otherwise, the participants often appear to become anxious about doing things the right or wrong way.

The residents request this program and appear to appreciate working together to create a concert. With support, they choose the repertoire and rehearsals begin. At the Hand Chime Concert, residents are brought from all over the building to share in the facility-wide event. The performers are often more anxious and sometimes more negative during performances, yet they state a desire to perform. Facilitating the performance requires organizing the music, the chimes, and the players while maintaining their sense of focus and support and offering a sense of success.

Within the general community, some of the population participate in performance groups. Community performance groups have been found to offer an increased sense of communal achievement, mutuality, and achievement of high standards (Kreutz, et al, 2004). My own music therapy research with marginalized populations mirror these results as does the work of Cohen, (2009) and Iliya (2011). Framed by Kreutz’s work, the benefits to residents of the mutual effort experienced when participating in the group
practices offer rewards to the participants. The process of communal achievement of high standards occurs through the rehearsal process and the performance.

The entire community is cognizant of the hand chime choir’s progress because the choir practices in the small open dining room and the sound travels. Often other residents gather near to listen and to observe the practices offering comments as to the progress of the group. On the day of the performance, family and friends are invited and the residents who are not in the choir are arranged to be the audience.

This process described is both inclusive and collaborative, tenets of AOP. It empowers residents to participate as fully as their mood and health permits. It engages the related community to experience these residents as musical and capable dispelling prejudicial myths of aging.

Music Appreciation Program

The Music Appreciation Program is a large group program for residents in complex and extended care. When I started working at the facility, this program consisted of the music therapist choosing classical music CD’s, talking about the music, turning on the music on the player, and serving coffee, tea, cheese, and crackers. After I offered a few sessions like this, the residents informed me that they did not want coffee, tea, cheese, and crackers as they had just had their teatime before the initiation of the program so I cut the “treats” element. I began to play CD’s with music from a variety of styles and found that the residents appreciated the broader selection of experience. After a few more sessions, I realized that because of the structure of the programs that were offered in the
building, the residents who attended the Music Appreciation Program had not heard me play the piano so at the next session, I offered a Music Appreciation Program based on me playing piano and singing their preferred songs. Residents stated that this format was much preferred and the program has continued as a live music process since that time. When possible, I bring in other musicians to supplement the timbres and tones being experienced. Other times, interns offer increased dueting opportunities. But usually, the program consists of me, sometimes at the piano, sometimes on the guitar, sometimes on accordion socializing with the residents and playing their favourite songs.

While the music is sounding, some residents listen, some sing along, some conduct, tap, clap, stand and dance or dance in their chairs, engaging physically with the music. Many of the residents, due to progressing dementia, can no longer make requests. For them, I offer choices. For example: “Mary, would you prefer a lively tune or a slow tune?” or “Bob, do you want to hear a tango, march, waltz, polka, country song, etc.?” Some will ask me to play their favourite song, a song that I can recall but that they no longer can. Some residents are able to make requests and these requests provide increased variety in the program. These particular residents, due to their increased cognition, are often isolated from their more demented fellow residents and need increased stimulation and support. Their contributions of contemporary choices brighten up the routine of more commonly played older musical resources and while enhancing these residents’ sense of agency and self-worth. Between songs, we often engage in social discussion, sharing stories and experiences. By the close of every program, a strong sense of camaraderie has developed enhancing our sense of connection and wellbeing. We genuinely thank each other for sharing time and music together.
Facility Wide Special Event Program Support: Community Development

Celebration of Life Music Therapy Program

When I was offered my music therapy position at the facility, I was asked if I would be able to facilitate the Celebration of Life program, a monthly memorial for residents in our community who had passed away. Although I had no experience facilitating this type of program, I felt that I would be capable. At my first celebration, I decorated a table with a white cotton tablecloth covered by a lace tablecloth. On it, I placed a wooden cross because the vast majority of our residents are Christian. When residents are from other faiths, I share prayers of peace from those religions as we celebrate their lives. I placed white artificial flowers and green vines prettily arranged, turned on small battery candles, and placed framed pictures of our deceased residents tastefully for viewing. I gathered historical information about each resident with which to share a story for them. In addition, I gathered quotations that described peaceful supportive images of the passage from this life to whatever is beyond this life and I brought out hymnbooks.

I began the program with a greeting and then asked those present to choose a hymn to initiate our celebration. Alternating hymns, quotations, and personal stories, the residents and I worked together to create the program. That day, we chose to always close these programs with the song, Amazing Grace, a typical closing song for memorials. Once that song was completed, I thanked those present for coming and helping me create
our celebration and asked them to turn to their neighbour and thank them for coming.
This process was again, very connecting and has been continued each subsequent memorial.

Over time, residents have come to me and told me what they would like me to do for their celebration. One asked for the song, *My Blue Heaven*. Another asked if I would be sure to play a polka to celebrate his passing. Sometimes staff attends although it is usually fellow residents and myself, and sometimes family of the persons who have passed.

Although the name of the program is *Celebration of Life*, the mood of the residents and family members is often sad as they mourn their losses. When it is just the residents and myself, the program often takes on the aspect of an *end of life* group, focusing on what matters at the end of life and how they would like the end of their lives to go. When family members join us, more often, the program becomes a *grief* group. Family members usually cry as they tell stories of their relative who has died. We talk about specific memories of experiences at GCCH and share feelings about the person who has passed. Often, residents grieve other important deaths. No matter who is present or who’s life we are celebrating, the program is always supportive, caring, completing, and full of a strong sense of community expressing the music therapy goals in place.

*Western Barbeque in Special Care*

Each summer, the facility provides a Western Barbeque or similar thematic party for Special Care residents and their families. Staff don their Western duds, checkered
tablecloths are put out, and burgers are barbequed. The party combines the two Special Care Units and requires those residents from the one unit be transferred to the larger unit with the patio. With the high energy created by having all the residents and many of the family members in one space waiting for barbeque, the room can become quite chaotic which is disruptive for residents. The Director of Recreation, my supervisor, asked what I could do to support this program.

I strapped on my guitar, made a list of the cowboy, country and western songs that I know to support the theme of the event and went to work. I identified residents who were becoming restless and moved discretely to their space. I spoke their names, looked into their eyes and sang their preferred thematic songs. Almost immediately, these residents became engaged in the music. Those peripheral to the restless group receiving music began to settle simultaneously. As another table of residents appeared to be need support, I moved again to address that group. Using my voice and guitar to engage most directly with the restless group at the table while sharing my music in a more ambient way with the rest of the room, I was able to focus the excited energy into a fun party atmosphere.

Large group music therapy process like this is exceptional for community development. Staff smile more, residents relax and enjoy themselves, families are integrated into a social scene during which they can share time and experiences with their loved ones in care. This is an important role for the music therapist. As staff and families observe the transformation of residents from chaotic to focused within the music therapy milieu, understanding of the role of music in the lives of residents and the role of music therapy increases. Staff increases their understanding of how they can use music to
enhance their work with residents. Families learn how through music, they can readily have positive contact with their loved ones. Empowering residents to have increased access to music through empowering staff and families to share music with residents is part of music therapy as an anti-oppressive practice.

*Christmas Bazaar*

Each year, the largest fund-raiser for the German-Canadian Care Home is a Christmas Bazaar, which is held in mid-November. Artists and craftspeople in the community are invited to purchase table space to sell their wares. Residents create items to sell on a crafts table. Raffles, door prizes, and a large silent auction raise more funds while exquisite baked goods as well as a meal accompanied by beer or wine are for sale. The Director of Recreation asked how I could help.

At the bazaar, I dress in holiday colours, strap on my accordion as well as two strips of jingle bells, which I connect around my ankles, and I play seasonal music. In the early part of the event, I spend most of my time as a traffic director encouraging attendees to shop at the craft tables or to purchase a meal. Later in the day, I go from room to room playing and singing, dancing with children and residents, encouraging attendees and vendors to sing and to dance with each other and to spend their money supporting our centre. Comments indicate that this addition is now an essential part of the event, something that regulars look forward to each year. This is another important role of a music therapist: to increase connection within the home and with the immediate community creativity through music while supporting the team effort of fund-raising.
Christmas Dinners

Each year during the Christmas season, the German-Canadian Care Home provides a full turkey dinner complete with hors d’oeuvres, dessert, and coffee for residents and their families. Due to the large number of attendees, these dinners take place over the course of three evenings. Recreation staff decorates the room and tables with white tablecloths, red accent runners, with seasonal placements and centerpieces. Care staff assists residents in dressing in something special. Management assists in serving beverages and food while care staff support residents who need more help to eat. Before I began working at the facility, CD’s provided music before dinner and entertainers after dinner. The Director of Recreation asked what I could do to support this program.

Just as residents and their families began arriving, I started playing seasonal music on the piano. The backdrop of solo piano music seemed to enhance an atmosphere of specialness that has been remarked on many times since. Conversation seemed to flow more easily, participants settled comfortably into their chairs. Occasionally, people danced. I continued to play throughout the dinner, providing background support for a sense of connection and community. During coffee and dessert, I led the group in seasonal music, a time-honoured favourite with many people during the holidays.

In my role of music therapist, I am able to read the room quickly and support the intended response. When there are only a few attendees at the beginning of the event, I go to their tables and ask for their preferred songs connecting them directly and personally to
the experience. Once the room is full, I facilitate an ambiance of pleasant social connection with intentional piano music. When leading the seasonal music after dinner, I include residents preferences interspersed with their visitors’ choices to increase the sense of personal connection and shared experience. Facilitating these events with music supports residents in a multi-dimensional manner, in keep with music therapy as an anti-oppressive practice.

*Individual Music Therapy in Long Term Care*

Because of the large number of residents who would benefit from music therapy services and the limited number of music therapy hours, the vast majority of my time is spent offering group music therapy programs. However, there are some residents for whom individual music therapy services are essential. Although housed with residents with similar needs, these residents require increased services beyond those offered to other residents. This is often because of decreased dementia in comparison to the majority of the residents and/or increased mental health needs best met by individual music therapy. Another focus group of residents for individual music therapy is residents who are in the final stage of life. Sessions are usually brief with an emphasis on the here and now, accessing for opportunities to increase quality of life through such things as increased creativity and autonomy, life review, and comfort measures such as relaxation and distraction.

Residents with increased mental health concerns are encouraged to approach the music therapist when they need some individual music therapy attention and are often
offered regular individual music therapy services through music therapy interns. As well, this group of residents is continually assessed by the music therapist in terms of the intensity of their mental health symptoms such as isolation, hygiene, anxiety, and overall coping rather than relying on self-referral alone for individual music therapy service. Sessions focus on positive identity and empowerment through music. Residents are encouraged to identify their musical dreams such as playing the piano or guitar or writing a song, and offered encouragement and support to realize these dreams. When appropriate, these residents are offered the opportunity to showcase their work for the other residents in a concert format. Other residents create a life review project or learn to use music for self-care to support their quality of life. Individual music therapy experiences often bridge these residents into group music therapy experiences.

Those residents with increased dementia are referred to music therapy by the team, as are palliative residents. Recreation staff have been offered consultation and are empowered to use music with palliative residents. Although I am only at the centre two days a week, palliative residents receive comfort music services more frequently this way.

Those residents with increased dementia requiring individual music therapy receive brief sessions as well, mostly due to time constraints. These are usually residents who are agitated and whose behaviour is agitating other residents on the unit. Agitated residents are individually taken to a quiet space and settled using music, offering both them and the residents remaining on the unit respite. Often, once these over-stimulated residents have been settled with music, they remain settled for an extended period and
can be returned to their unit. With these residents, preferred music usually performed live and is employed to stimulate connection and comfort.

Music Therapy Program Development for Adults and Teens in Crisis with Dual-Diagnosis Intellectual Deficit/Mental Health

My first music therapy experience with adults, teens, and children with dual-diagnosis ID/MH was during my internship in a clinic in New York that specialized in assessment and treatment planning for this group of people. My supervisor, Helen Grob, schooled me in Paraverbal Techniques, teaching me to observe using a musical lens and to respond to cues to enhance communication and healthy functioning. Reflective language was employed, when appropriate, to stabilize perception. This approach was extremely effective, professionalizing the role of music therapy in the multi-disciplinary team. In addition to working in the Developmental Delay Clinic in my internship, music therapy using Paraverbal Techniques was modified for use in a therapeutic nursery with high-risk mothers and toddlers as well as with adults with Huntington’s disease.

Over twenty years later, I again found myself working with adults and teens with ID/MH. However, today, this work is with persons in crisis who are in a locked psychiatric residential facility for ninety days. My job in this facility is to assess the residents’ music-based resources and develop a music therapy protocol for post-discharge. With these clients, like clients from previous settings, I have found the quickest way to establish contact is through a shared song. Psychoanalytic theory would call this a, “transitional object,” (Winnicott, 1953). When I know their song, it creates a
connection, it pleases them. When I can resource them to experience their song in a way that enhances health, it creates opportunity for development that can be on-going. When the other residents know and sing their song, it supports a sense of belonging, understanding, and shared truth. Clients preferred music accompanies them and supports them. Because many of these residents return to communities where there are no available music therapy services or there is no specific funding for music therapy services, discharge planning can include such things as attending and participating in coffee house, dance lessons at the community centre, community choir, and other community music-based programming.

Group Music Therapy with Teens and Adults with DD/MH

Group Music Therapy takes place weekly and residents participate based on their health and mood. Because of the uniqueness of the population and their status of staying for ninety days, often there are residents on the unit who, because of behavioural concerns, are unable to go off unit to the music therapy room. However, because of the time limited stay of ninety days, it seemed inappropriate to exclude them from music therapy group. Therefore, the music therapy group sometimes takes place in the music therapy room but often, the program occurs on the unit.

After I had been working at the facility for approximately two months and staff had been observing and participating in music therapy group and individual music therapy, they were consulted regarding program development. At that time, senior staff with increased experience at Arbourview and with residents with ID/MH emphasized that
an essential element of the music therapy programming needed to be the group and that
the group needed to be a weekly event. Their reported observations indicated that the
music therapy group created a setting where the residents expressed themselves in
positive individual as well as social ways offering staff a unique perspective on the
residents needs, interests, skills, and abilities.

Music Therapy Group is initiated with a “hello” song, greeting each resident in
turn. Often, the group members choose to greet the “new” resident first, or the resident
who would be next to graduate is first. When the clients in residence are unable to choose
who is first, group members are greeted from left to right, typical to Western culture.
Then, the residents take turns requesting their favourite songs and these are shared with
the group. Residents are offered a variety of percussion instruments as well as singing to
express themselves during the rendering of preferred songs. Typically, residents
evidenced acute awareness as to who had already had a turn, whose turn it was, and who
still needed to have a turn evidencing social understanding and integration. For those
residents who had difficulty choosing a preferred song, other residents often offered
suggestions and support. Other times, I offered choices of a fast or a slow song, a song
from a preferred style, band, or singer. Typically those residents who when first in the
program exhibited difficulty choosing, in time found ways to indicate their song choices.
Occasionally, the group chose to improvise as part of their group process although this
usually happened when there was a particularly empowered client base, often when most
and/or all the clients were verbal, and in the context of a preferred song.

Sometimes group members prefer to dance as their primary connection to music. I
encourage residents to dance by dancing while I sing and play guitar. Other times, staff
dance with the residents. For those residents who require a wheelchair, staff move the chair rhythmically in response to the music, dancing in this manner.

Sometimes during music therapy, residents present a song that they have composed or improvise a song. When sharing these songs, residents share a part of themselves unique to music therapy. Other residents observe this and sometimes request to compose or improvise a song in a similar manner, expanding their repertoire of music-based support.

The music therapy group provides an opportunity for residents to experience themselves creatively in a supportive structured environment. Residents can learn from each other as well as from staff enhancing their developmental opportunities. Staff can learn how to support residents with music, increasing residents’ access to what for some, is an essential resource and enhancing their quality of life.

*Individual Music Therapy with Teens and Adults with DD/MH*

For a more thorough assessment, residents are also offered individual music therapy. The timing of individual music therapy assessments happens in consultation with the team. Assessment consisted of a specifically designed individual music therapy session to assess and support the needs and abilities of the resident. Music therapy assessments could include improvisation on drums, other percussion instruments, guitar, piano, and/or vocally; skill building on instruments; song writing; song singing without and with piano, guitar, and/or percussion improvisation, and dancing. Residents are assessed for readiness through consultation with the team.
Residents may have, at their foundation, a relationship with music that is profound and a vital resource. The music therapist may have access to parts of the resident’s presentation not observable in other settings and this is highly valuable in the assessment process. If residents evidence a foundational relationship with music that is fostered in music therapy, then on-going services are often recommended in their home communities. Where music therapy is not available due to a lack of availability of professional practitioners, residents are recommended into community and/or church choirs, dance programs, drum circles, and local support staff is educated on how to support residents musically.

_Initiating The Research Project: German-Canadian Care Home_

The German-Canadian Care Home is a long-term care facility in multi-cultural metropolitan area servicing persons with complex healthcare needs and in particular, persons with dementia. When the CEO was approached regarding the research study, she advised me to complete their protocol and submit it as soon as possible so that the project could work its way through the ethical review committee and ultimately for approval by the Board. Once informed of my intention to conduct research, the German-Canadian Care Home immediately provided standardized documents that described the protocol for ethical review. This step was readily completed due to the streamlined research protocol already in effect with ethical approval coming within three months of the proposal being presented. The ethical review committee offered their approval in June 2012. However, Board approval took longer due to decreased meeting time through the summer months,
ultimately only occurring in early September 2012. While I was waiting for this approval, the CEO advised me to get fully prepared to start the study as she believed in the project and felt Board approval would readily be achieved.

In keeping with Anti-Oppressive Practices, the study was designed to work with participants who volunteered rather than being assigned. Recruitment of participants was initiated through a poster. The recruitment poster was successful in that it did recruit eight respondents. However, the problems with the recruitment poster were revealed through the responses of residents. Although the wording appeared “straight-forward” to me, numerous residents, staff, and family members asked questions stimulated by the poster that had nothing to do with the research clearly indicating that the poster was not effective in communicating clearly. Questions such as, “When are you moving to Ireland?” and “Are you quitting your job?” indicated that although readers understood the gist of the poster, that I was completing my doctoral research and that my home university was the University of Limerick, the details were not presented clearly enough so that they understood I would continue working and that the research would be conducted at the German-Canadian Care Home. I remain concerned that this may have decreased the number of potential participants.

Another issue with the recruitment poster was that the placement of the poster was problematic for persons in wheelchairs. As required by facility protocol, each of the required placements was in a frame that is too high on the wall for persons in wheelchairs to read. This was frustrating in terms of the AOP ethos because it denied service users easy access to information needed to volunteer for the research, decreasing their voice in the research.
The German-Canadian Care Home is committed to client-centered services but is housed in a building with numerous challenges including a small elevator, a long hallway ramp, narrow hallways, and narrow doorways. The home has fund-raised and planned a new facility based on Eden-Care and is awaiting government approval. As the home changes over to the Eden-Care model it is expected that these impediments will be redesigned or removed to increase residents’ quality of life. Until then, administration is only incorporating a small number of cosmetic changes.

It can be difficult working at places that have such strict protocols that are more to do with rules and regulations than to addressing client immediate needs. Over the years I have followed the adage offered by my mother, “Choose your battles.” In this circumstance, a change in posting policies was declined due to the limited time frame of the research posting. All other postings in the frame on the elevator are posted elsewhere in multiple places where people in wheelchairs can read them and/or are given to each resident, for example, the recreation calendar and the weekly menu.

*The Arbourview Residence Research Project*

It is unusual to have to report that Arbourview did not have an ethical review process for research at the time I first approached them to be included in the research. I received the response that they were interested in developing one. From the beginning, this site indicated that it would be difficult to create the protocols to participate in research but that they were willing to try.
For over a year, I met regularly with the director and then the program director, developing proposals, discussing with my supervisor, and ultimately creating a document to be reviewed by the University of Limerick Research Ethical Review Committee. This proposal was approved on first review, and it was rewarding after all of the pre-requisite work to receive feedback from the Ethics Committee Chair that the materials submitted were commended as excellent. Next, the proposal was submitted to the Director of Arbourview for review. Upon her approval, the Quality Assurance Director for the parent organization of the agency reviewed it. A Privacy Impact document was created and presented for review by that director. Each of these steps took from up to a few weeks to a few months to complete.

Around this same time, I participated in my doctoral confirmation at the University of Limerick, IR. Feedback from Professor Susanne Metzner heightened my consciousness regarding the polarity of the oppressive lens and the anti-oppressive. That is, if there is something called anti-oppressive practice, there must also be oppressive practice, but how should this be understood and defined? Following this meeting, I wrote a journal article on Anti-Oppressive Practices in Music Therapy Research, which I continue to edit and plan to submit upon completion of my doctoral research. I found this writing task helped me further my critical theoretical consciousness, deepening my awareness of the roots of Anti-Oppressive Practices in music therapy and how AOP functions in music therapy research. In particular, feminist music therapy research (Baines, 1992; Curtis, 1990; 1996; 2012a; 2012b; Hadley, 2006; 2013; Edwards & Hadley, 2007; Hahna, 2011; 2013) and critical race theory music therapy research (Hadley, 2012; Veltre & Hadley, 2012) strengthened my commitment to applying social
justice frameworks to music therapy with marginalized service users. While writing this paper, Arbourview received ethical approval and the research project was initiated on November 18, 2013.

This approval was met with excitement by the centre. The members of the professional team are aware that it is a unique setting and were pleased that the road for further research had been negotiated successfully, paving the way for future projects. Shortly after recruitment posters were posted, guardians were approached for consent, and participants began to volunteer.

Early in the research process, the consent process with residents needed addressing. The model of care at the site is one of relationship building so it seemed appropriate to create a relationship-building consenting process. Because the music therapist approaching with a staff observer to initiate an individual interview/music therapy experience and not on the typical time and day for music therapy, it would be expected that residents who are in the unit because they are in crisis, would probably refuse which was the case the first time. Again, because of the relationship-building aspect of the program, it was hoped that residents would be more amenable after a second or third request but it was decided that only three requests would be made, each on a different day, to contain this part of the consenting process. Using this process one resident consented and one refused.

Common Results
Because participation in this research was voluntary, it might be assumed that those who volunteered to participate have a positive relationship with music, music therapy and with the music therapist. This reality potentially results in decreasing responses about concerns with the music therapist and the music therapy program. Although some concerns were expressed during interviews, it is expected that other concerns that were not named exist and need to be assessed for in a consistent manner through reflexive process in keeping with Anti-Oppressive Practices.

*Initial Results From German-Canadian Care Home*

Conducting the research was exciting and interesting. As residents and staff shared their impressions of music therapy, my mind leapt from thoughts of changes I wanted to make in my practice, to awarenesses of the support and understanding music therapy receives at the German-Canadian Care Home, to the difficult plight of residents, to the role that anti-oppressive practice takes in my music therapy practice and research. After transcribing the first three interviews, I learned more about how to interview, making sure that I listened more and said less. This knowledge was immediately applied back into my practice, research, and teaching, to listen more and to talk less.

Transcribing these interviews was humbling. When re-listening and processing the interviews via transcription, residents’ reliance on music therapy to enhance their quality of life became very apparent. Staff echoed this awareness, remarking how music therapy supported residents on all levels.
I continued the journey of learning how to do Constructivist Grounded Theory. I initiated a Reflexive Journal to explore my experience of the research. The interviews were coded and then re-coded as I deepened my understanding through supervision and reflection of how to accomplish this process. These codes were then coloured to maintain my contact with which codes belonged to which interview as I categorized them. With categorization, the codes began to tell their stories about music therapy as an anti-oppressive practice at the German-Canadian Care Home.

Initial Results From Arbourview

The research process at Arbourview resembled the experience at the German-Canadian Care Centre with some specific differences. Because the music therapy program takes place on Saturday morning, not all of the staff participants had observed or experienced it but rather, based their understanding of the service on verbal reports heard in rounds and written documentation. Other staff participants had experienced music therapy with the former music therapist and/or with the music therapy intern on a weekday shaping their experience and perceptions of music therapy.

The interviews were interesting and enlightening. Because I had not experienced music therapy with three of the staff participants, I was interested and excited to hear what they had to say. These participants offered deep insight into music therapy with these service users beyond my expectations. Their support for the program was based on clearly articulated understanding of the value of music therapy for the residents at Arbourview. Additionally, they spoke about music therapy initiatives and strategies that I
have introduced such as increasing residents’ access to their preferred music, personal music players, and instruments, contrasting music therapy from the past with the current service.

Two of the research participants were unit staff who have worked with me during music therapy on many occasions. These participants spoke more directly to me about my work with residents, reminiscing about specific experiences that occurred during music therapy sessions. As well, they remarked on how valuable and important the new music therapy initiatives and strategies that I have introduced since being hired are for residents’ developmental support and quality of life.

One resident was consented by family but refused participation in the research interview, which was respected. Another resident required to be asked to participate on two different occasions, agreeing on the second time. His interview highlighted the residents’ experience of music therapy offering valuable information that would be otherwise unavailable.

Like for the research at the German-Canadian Care Home, transcribing the interviews deepened the experience of hearing about music therapy services, clarifying my understanding through transcription. The coding process was carefully completed with the knowledge that because of the privacy legislation, FIPA, these codes would serve in the results for data analysis rather than the traditional employment of quotes for this purpose. With careful reflection, categories emerged to further describe music therapy services at Arbourview and music therapy as an anti-oppressive practice.

*Writing the Thesis*
I have been writing almost since day one of my candidacy at the University of Limerick, IR. The thesis has had many elements in the past that are no longer there, first included to explore this work and then removed as I refined my understanding of the work. Now I am working hard toward completion, contextualizing my previous ideas into understandable researched results. I am excited and scared. I am so happy to be growing and learning. I am finding supervision very constructive and helpful, clarifying the track of my thinking. I am working hard not to oppress myself as per my ideology but I do feel time pressured. I am fearful of how my thoughts will be received. This is all part of the process in typical PhD learning and I take comfort in that.

As I near my submission date, I can see the big picture of my thesis and it is exciting. Many of these ideas and plans have been part of my process for a long time and I feel a deep sense of gratitude with my excitement that I have worked my way through the research experience thus far. I am very enthusiastic about sharing this work with the community through publications and presentations.

Creating this thesis has been like composing a complex piece of music. Often when I wake up, I have deeper awareness of what I heard in my inner listening the day before and how to incorporate it into the thesis, thickening the descriptions. It is like first hearing the basic harmony of a composition and then simultaneously hearing and knowing the simplicities and complexities of creativity that are possible.
Chapter Eight

Discussion

Introduction

This research elaborates the incorporation of an anti-oppressive practice philosophy in music therapy practice and research. Anti-oppressive practice is a framework that politicizes work in healthcare, requiring extensive critical analysis, reflection, and activism; this research encompasses all three. Using constructivist grounded methodology (Charmaz, 2006; O’Callaghan, 2012), music therapy as an anti-oppressive practice was studied at two sites providing music therapy to service users who are marginalized by cognitive and communication disorders and their caregivers. Interviews and transcripts from residents, and also from staff who came from job roles as diverse as requiring basic office skills to advanced education were elaborated, analyzed, and reflected upon. A critical autoethnography (Anderson, 2006) was created to further critique and contextualize the work. Discussion will explore the links and differences between the results of the research sites and reflect on the role of anti-oppressive practice in the music therapy.

Positivity of Results
Music therapy has long and strong service records at both sites. The resident and worker respondents offered highly positive narratives of music therapy, the music therapist, and the anti-oppressive practice framework in use at both sites as was expected. A reason for the enthusiasm for music therapy expressed during interviews and revealed in the results could be due to participants needing to speak directly to the music therapist in the interview and perhaps being uncomfortable to express negative views about my conduct and service directly to me, observing the social norm of politeness. Also, all of the interviewees other than residents who no longer live at either residence will continue to work with me after the research perhaps increasing their cheerleading during the interviews. This will be taken into consideration when exploring the results.

Negativity About Music Therapy

Concurrently, it was expected that if there were negative perceptions of the program, they may have been suppressed partially due to the possibility that it was more likely that respondents who preferred music would volunteer to participate. To include the service user voice, service users and their caregivers need to feel safe to voice concerns/dissent. When voices of concern are empowered and heard, inclusivity is occurring. Once one voice sounds, another may feel safer to sound, and listening in an open and non-judgemental way ensures that every voice is important. Participants voicing their concerns is indicative the trust that exists between the research participants and the researcher.
As reported in the interview and autoethnographic results, over the years there have been staff who have been negative about music therapy. It is understandable that not all staff members are supportive of music therapy staff or would fully endorse the field of music therapy and/or my approach. Depending upon ones personal philosophy and background, the field of music therapy may not be an easy fit. Not everyone understands and values music therapy, some seeing it as an unnecessary extra. Groups are usually conducted on the unit so that residents who are restricted to the unit can participate. At times, the sound might be disruptive to staff completing tasks. At Arbourview, during music therapy group, at least one staff member is required to observe the group and staff take turns as they cycle through their breaks. Perhaps one reason for a negative view is envy; music therapists have skills in using music and excel at using music to support health.

To make real progress, music therapy needs to address dissenters to create increased understanding. By listening to voices of dissent, we can learn where our work is not translating, where there is more work to be done. This is an inclusive and collaborative process. We can learn where we need to develop new strategies for communication so that music therapy can be better understood, integrated into the team more fully, and ensure efficacy. Music therapy dissenters teach us where we need to work harder and how that work needs to be accomplished, and can offer us an opportunity to see if there are some hidden aspects of music therapy that practitioners may not feel comfortable acknowledging.

In my experience, through offering excellent service, staff observe the value that music therapy has to support residents’ health and wellbeing, and over time, dissent
decreases. Documentation, so that the team can have a clearer picture of role of music therapy in relationship to the rest of the team and the goals for the resident, offers another opportunity for integration. Music therapy as an anti-oppressive practice works to link with members of the team listening for all voices to build inclusive collaborative practice.

**Eden-Care and Mandt**

Music therapy fits in well with the aesthetic *resident centered* Eden-Care philosophy at the German-Canadian Care Home and the *safety and development through respectful relationships* mind-set of the Mandt System used at Arbourview. These models of care seek to mitigate the impact of intolerance and inequity. Residents are accepted and valued.

Eden-Care and Mandt have many commonalities with music therapy as an anti-oppressive practice with one important distinction: AOP engages a social justice critique. Engaging the philosophy of the centre and reflecting on the relevance of this philosophy to anti-oppressive practice creates goodwill towards music therapy but also places music therapy in a position where the practices and ethos of the service can influence the centre’s approach to residents in a mutually beneficial collaborative manner. Engaging in anti-oppressive practice integrates the political ramifications of music therapy services expanding the scope of practice to include using music as a partner in social action within the institution as well as interfacing with the immediate community.

**Eliciting the Service User’s Voice**
Music therapy processes are valuable to discern a resident’s preferred music support strategy and each service user has a preferred music support strategy. It is important to discern residents’ preferred music support strategy, developing this personal response into a structured music therapy strategy so that caregivers can offer on-going support to residents and continue to include the service user’s voice in their health strategies. Service users often know what will work best for them and anti-oppressive practice workers incorporate this self-knowledge into their recommendations and music-based supports. By supporting the service user’s sense of their own resources, service users are afforded increased agency. Preferred music provides increased reliable support. Service users who increase in understanding of the value of their preferred music are further empowered toward independence.

Staff remarked on the complexity of exploring what experiences residents will be comfortable with, understanding that residents are unique individuals and that uniqueness is respected and valued. Some residents respond best to plans that focus on physical needs including walks, time in the gym, stretching, and relaxation skills. Some respond best to visual expressive arts, others to crafting or writing. Each individual is unique and deserves a unique treatment plan based on developing their strengths and abilities. The residences offer a wide array of experiences both to assess preferences and to offer residents opportunities for personal agency in relation to their daily lives.

Sometimes residents have difficulty expressing their needs and staff work together as a team observing and consulting to determine residents’ needs and preferences. Residents are encouraged to explore their likes and dislikes, broadening their
repertoire of responses. By employing residents’ preferences to address their needs, a positive relationship is created where residents can explore and become accustomed to increased health.

All service users respondents struggled with communication yet each offered profound expressions regarding their experience of music and music therapy. One resident at GCCH with advanced dementia as well as a first language that is not English provides an example. To focus her attention, a preferred waltz was played on the accordion. She began humming from the second note and then as she was singing the words of the chorus she smiled and said, “Heart-warming … you live in it, you don’t think it, it’s in here, beautiful … yah, it’s just beautiful.” She clasped her hands to her chest and patted her heart as she spoke. And in another statement she said, “I feel warm and remembering you know, it’s a warm, personal, from your personal life, you know, you can make, the nice warm musical not flat,” at which point she stood and waltzed alone, smiling, her eyes glowing. Her commentary reveal a deep personal relationship with music, especially music that is familiar to her, that continues to resource her in her late ‘90’s despite her diminishing cognitive capacity.

Both during and after the song presentation in the interviews, these participants would resume speaking about music and music therapy experiences. Those with cognitive disorders require increased support to complete many tasks. Nevertheless, these service users and others who are marginalized have the right to have their voices included in research. However, the support needed to participate must be acknowledged and supplied. Hearing their preferred music appeared to increase a sense of agency and sense
of identity. By providing this familiar experience, respondents could extend their focus and their voices could be included.

Eliciting the service user voice can be complex when that person struggles with communication and cognitive issues. Music therapy as an anti-oppressive practice embraces collaborative inclusive models of research. Music therapy research as an anti-oppressive practice works to develop respectful practices that lead to ethical results supporting participants in a manner that increases the usability of the data. At the same time it is essential within this approach to acknowledge that the participant’s reason for entering the research and the researcher’s need for clarity and reference to the point of topic of the research must not generate conflict.

Loss of focus

Both resident and worker research participants lost focus at times over the course of their interviews. Tangential statements, for example when discussing her love of Elvis music, a respondent commented that she wants to go to Graceland, were listened to and then the participants were redirected in a respectful manner back to the research statement. Participants with typical cognition were refocused by the reiteration of the phrase, “Tell me about music therapy at …” Those with cognitive and communication disorders were provided musical cues to help them refocus in a manner typical to music therapy sessions. Participants were offered the opportunity to request a song, or if their cognition precluded this task, a song specifically familiar too them was chosen for them as per a typical music therapy sessions to increase their orientation and participation.
Inclusive collaborative practice requires a philosophy of deep respect. Rather than the cultural misunderstanding resulting in disrespectful behaviour of some care aid students reported in the autoethnography, inclusive practice accommodates difference collaboratively through working to understand and empathize with the experience of the service user. Respect is a term with cultural nuance. Music therapy practice is embedded in the culture in which the music therapist practices, (Ruud, 1998; Stige 2002). This becomes progressively more complex within increasingly multi-cultural settings. Music therapists must educate themselves broadly and extensively in the music and cultural practices of the service users. Music therapists must explore, analyze, and incorporate the culture of the settings in which they work. Music therapists must reflect on their personal sense of culture and how they express their culture of music therapy. Respectful practice is created from courteous competence framed by cultural sensitivity and awareness.

In the interview results, research participants’ comments that were tangential to the research were coded and categorized but ultimately not included in the results section due to their lack of applicability to the research statement. However, including them in the coding and categorizing led to reflection on what kinds of memories and thoughts are connected to music and music therapy offering a glimpse into the reminiscence process and experience of music therapy participants.

*Personal Histories of Music and Dance Matter*

The research results showed that resident preferences, reflective of their personal histories with music and dance, informed their relationship with music therapy and were
incorporated into music therapy program design. Music can hold a central role in people’s lives as one of their closest personal relationships and an essential resource. Preferred songs remind them of happier times, help them feel safe, and focus their sense of identity. At Arbourview, some residents prefer children’s songs, particularly when they are in crisis and seem to feel safer when they share these songs with staff. At the German-Canadian Care Home, people in the vicinity of the music therapy program often dance. Residents particularly enjoy when the staff dance a few steps across the area in response to the music.

In the six years that I have worked for the German-Canadian Care Home, residents have regularly related memories of music and dance experiences that have been triggered by the music therapy program. Many staff from cleaning to kitchen staff, care aids, nurses, management, and administration, have taken me aside to share with me the important role of music and dance in their lives. As discussed in the thesis, in my numerous roles making music in the community, from accompanying dance classes, working as a professional musician both solo and in bands, to my music therapy work, I have experienced first hand the impact of music and dance on individuals and in groups.

Music and often dance are present in some degree in every human culture on the planet and in some cultures, mark the passage of every day. These experiences inform service users’ understanding of and participation in music therapy. Not all music and dance histories are positive and experiencing feelings of musical inadequacy can be a potential harmful effect of music. The widespread wounding of the musical self appears to span across ages, backgrounds, and diagnoses. Some residents and some staff who regularly participate in music therapy programs revealed a deep sense of inadequacy
regarding music expression and fear to accept a new way of addressing music experiences through music therapy. The breakdown of one's relationship with music as a resource was reported as painful and hurtful. Using music therapy to resource residents and staff with music and dance can mediate these painful experiences and return participants to a state of healthy connection and creativity.

Music Therapy as a Health Resource

The research outcomes revealed that music therapy is inclusive, collaborative, and valuable offering comfort, support, stimulating memory, helping with socialization, improving mood, and increasing healthy responses from residents, families, and staff. Participating in group music therapy offers opportunity for social inclusion and creates social inclusion. In group music therapy, residents are accepted and encouraged to express themselves in their own idiosyncratic ways and these expressions are accepted and employed to support development. As residents' expressions are accepted and valued, residents feel valued, enhancing their self-esteem and positive sense of identity.

Participants remarked that individual music therapy experiences offer the same opportunities for self-esteem and positive identity building through a sense of inclusion inspired by co-creative music therapy experiences with the music therapist although the group experience of peer and staff acceptance is more significant. In particular, some staff at Arbourview noted the increased value of music for non-verbal residents or for some residents with autism where music was used as an expressive and communicative outlet.
Participants expressed strong appreciation for my music therapy skills: musical expression abilities, providing preferred repertoire, developing therapeutic relationships, training music therapy interns, and providing expert programming that addresses clients' specific needs. During the music therapy programs, the musicality of residents and staff is assessed and optimised by the music therapy facilitator while providing opportunities to connect and relate. Individually, participants are provided with choices and validation with the intention of stabilizing identity and enhancing potential. Observing each gaining increased music skills is inspiring. All participants in the music therapy group are encouraged to expand their musical repertoire of choices.

The music therapy is focused on the service user. In addition, anyone visiting the service user can also experience the health enhancing value of music therapy. As reported by staff at German-Canadian Care Home, visitors experience the positive effect of observing the person that they are visiting participate in the health enhancing benefits of music therapy.

In the music therapy group, front line and therapeutic staff often function as participant/observers, supporting residents’ music making. Staff participating in music therapy by singing, playing percussion, and dancing with residents is pleasurable and gratifying as both residents and staff relax and enjoy music therapy experiences together. When workers observe the residents making music, they often smile in enjoyment, similar to residents’ reactions when they observe staff making music. Residents and staff experience each other differently within musical parameters. There is a process of the balancing of the power differential between staff and residents, this inclusive collaborative process contributing to the therapeutic alliance. Residents have the
opportunity to experience staff as musical beings rather than experiencing them only
performing nursing, mental health, occupational therapy, psychiatric duties. Staff
experience residents as musical beings rather than only as a recipient of their help.

Staff remarked on their own positive responses to the music therapy program such
as listening, singing, dancing, and observing residents participate. When staff engages
their musical selves on the job, they are more fully present, bringing their creative self to
work. When they connect with residents using music, it can enhance their therapeutic
alliance. When we process together in the music therapy, we build our relationships.
When staff and residents develop a strong working alliance, residents have increased
opportunity to develop skills for self-regulation and social skills. When staff participate
in music therapy with the residents, their understanding and valuing of music therapy
initiatives is increased.

It was highlighted that residents are now receiving support from music in all
facets of their treatment plan. Staff at Arbourview reported feeling unsure as to the best
way to support residents’ musical needs but are aware that supporting residents’ musical
needs is beneficial to residents. Staff requested music therapy prescriptions, clear
directives, on how to therapeutically support residents’ musical needs in an on-going
manner so that music therapy initiatives can be expanded. They reported feeling relieved
that they have been offered specific strategies to support residents with music. The music
therapist has provided specific music therapy initiatives considered effective in
supporting residents’ needs including encouraging resident to bring their personal music
players and structuring listening to preferred music into residents’ daily schedules such as
singing and dancing with residents and listening to their preferred music together.
When residents listen to their preferred music or watch preferred music videos together or with staff, their relationships are supported. Other music therapy prescriptions such as taking residents to the music room so that they could practice piano, guitar, or drums, or simply to discuss the instruments and music were described. Supporting residents by listening to their musical compositions was discussed.

Support from the music therapist for members of the team to use music in their practices is a collaborative process that relies on good communication. Working in a co-creative inclusive manner has increased the overall understanding of the therapeutic use of music at Arbourview Residence. Increasing frequent accessible documentation has further informed staff on the value of music therapy to support health development. One worker had not observed music therapy but based on service user reports, verbal reports in rounds, and music therapy documentation, conveyed thoughtful remarks describing how the music therapy service functions, the value of music therapy for residents, and how music therapy informs his practice. Another Arbourview professional who rarely participated in music therapy described how she had integrated music therapy initiatives into her program planning and implementation such that goals for music therapy are supported by her interventions and vice versa. Staff can feel comfortable that the music therapist fully supports them to integrate music into their work.

Research participants offered positive commentary of the anti-oppressive practice approach to music therapy in use although they did not define it as such. Anti-oppressive aspects such incorporating the service users’ voice by noting and integrating service users’ preferences in all aspects of music therapy service delivery, staff empowerment to integrate music therapy strategies and initiatives, and the inclusive collaborative nature of
the service were described. Increasing familiarity by integrating music preferences into music therapy in a meaningful manner increased trust in the process and expanded the potential benefits. Residents are supported to develop agency through validating their personal histories through their song interests and other musical choices. However, this process has cultural implications.

Health always has a cultural overlay; different cultures have different perceptions, expectations, and assumptions about health as well as the role of healthcare practitioners and the healthcare system as reflected in the interviews. In order to elicit increased healthy responses, music therapists need to understand both the service user and the system’s perception of health and assist with any needed negotiations. Typical observable healthy responses such as smiling, singing, moving physically to the music, and interacting in positive social ways seem to be relevant to all cultures as represented in the interview and autoethnographic results.

When residents are invited to participate in music therapy, most chose participate, but some refuse. For some, their relationship with music is so personal that they do not incorporate other people and music. Others require increased time with the music therapist to develop a therapeutic relationship, time that is unavailable within the constraints of the music therapy contract. Some are not comfortable in a group setting. Some prefer to listen to music independently. Refusing service is an individual action of agency and is respected.

Part of the Team
Staff participants discussed respecting and appreciating each other’s quality and competence. The team’s ability to work well together to support residents was highlighted, the integration of disciplines being central to the support provided to enhance residents’ health and wellbeing. Music therapy was valued on the team.

In particular, staff at Arbourview discussed the team, how data derived from one discipline supported the practice of another. The strength, range and scope of the multidisciplinary team to support people with developmental delays who are in crisis to stabilize and return to their home communities were highlighted. In her interview, one nurse described how therapeutic expertise informed medication choices. Another nurse shared that the team works as a unit to support residents. A therapeutic practitioner expressed pleasure that she worked with a medical staff that appreciated therapeutic aspects and that staff learned a lot from participating in music therapy group with the residents. Medical personnel described valuing the team approach to helping residents get better, that the team works as a unit to support residents.

Music therapy was described as a respected member of the team by both medical and therapeutic staff. A doctor remarked in a number of ways that music therapy was a valuable part of the team and a therapeutic staff remarked on the importance of music therapy group for promoting healthy relationships between residents and staff. Additional similar remarks are indicative of the highly regarded role of music therapy at Arbourview and German-Canadian Care Home.

Working with a strong, committed, involved team is gratifying. Each of the team has demonstrated the willingness to work together for the good of the residents. Music therapy as an anti-oppressive practice fits well into this environment. At Arbourview,
both at rounds and in response to documentation, members of the team integrate music therapy knowledge plus the information shared by all the professionals in a manner that is good for the residents. Psychiatric nurses have reported greater ease in drawing blood samples, bathing routines, and sleep hygiene when they sing with residents. The psychiatrist reported using a preferred song as a point of contact to develop the therapeutic relationship. The occupational therapist uses music in her programs, as does the expressive arts therapist. The behavioural support psychiatric nurse watches resident preferred YouTube videos to help build a working alliance. Music has an integral position in the lives of most residents and staff. By utilizing this commonality, staff can enhance therapeutic interactions.

Members of the team work with the community team to upgrade home environments and community supports to build on-going developmental support. When residents work well in music therapy and would benefit from on-going service and when there is a music therapist in their geographic area who is taking referrals, specific music therapy recommendations are made. However, many residents come from geographic areas that do not have music therapists, or the music therapists are not taking referrals, not all residents are candidates for music therapy, but many of these residents would benefit from on-going music-based experiences. Community music-based specific music therapy strategies have included purchasing a guitar or a drum, dance classes, choir, drum circles, karaoke, and listening to live music free of charge in safe environments. Outreach staff has reported the success of some of these plans adding another voice to the team.
Whether at Arbourview or at the German-Canadian Care Home, the strength of the practitioners on the multidisciplinary team combined with an ethos of integration creates a support system that is effective.

**Documentation**

Staff participants remarked that music therapy reporting often provides unique information, sometimes exceptional to the music therapy setting, including preferred music, preferred instrument, preferred manner to access music, preferred manner of participation in music, musical and social history, and specific social and emotional responses. Knowing a resident’s preferred song provides for that song to be used when there was an incident or stress for the resident supporting the resident to settle and become more cooperative increasing their ability to participate in their lives in a purposeful manner. Music therapy preferences were described as functioning as an alternative to pharmacological and environmental interventions.

Documentation has supported staff to offer residents increased music opportunities. Workers reported using the information provided to support residents musically with greater specificity, empowering residents to integrate their preferred music experiences into their daily lives. The music therapist offered expert consultation and documentation and developed music therapy initiatives and strategies to create ongoing music-based supports for residents.

Because of government guidelines, written documentation holds a more important role in music therapy practice at Arbourview than at the German-Canadian Care Home.
where more limited documentation and direct verbal consultation are the channels for communication. This is reflected in the results regarding documentation that were conveyed by Arbourview staff. Staff from GCCH focused primarily on verbal reporting whereas the remarks from staff at Arbourview discussed both verbal and written reports. Administrators, nurses, recreation therapists, occupational therapists, psychiatrists, and support workers reported that they were using more music in their work. These participants indicated a clear understanding of how and why they were using music.

Residents are encouraged to bring their personal music players and are offered increased or unlimited access over the course of the day. Residents are offered access to computer time where many watch YouTube videos as part of their daily structured plan. Residents who are learning piano or other music skills are supported by staff to practice during the week. At Arbourview, one worker expressed understanding of offering residents choice when interacting with music. Other Arbourview narratives included singing to residents at bedtime to help them settle, listening to the songs residents were writing in music therapy, taking residents shopping to purchase a preferred instrument, using music to foster relaxation, motivation, and creative expression, to foster self-regulation and positive identity, and assist with transitioning.

At Arbourview, music therapy is the only therapeutic program on the weekend. The music therapy updates were created to broaden the awareness of music therapy strategies and initiatives to members of the team who are at Arbourview during the workweek. Three participants who never work on the weekend remarked on these reports as being used for both medical reasons, such things as prescribing medications, and therapeutic planning, such as assessing residents’ comfort in group settings. Specifically,
the music therapy update added a humanistic layer to the medical report of bodily functions, behaviours, and medications, providing a social and emotional picture of the resident. Interim and discharge reports from the music therapist were used for community planning including contracting music therapy services in residents’ home community, purchasing instruments and music players, singing and dancing with residents in their homes and/or enrolling residents in community music-based programs.

Music is not the sole purview of music therapists. Music is a human right. If music is only employed when the music therapist is present, residents are deprived of music being present in their lives in an appropriate manner. Inclusive and collaborative practice provides for residents to support themselves with their preferred music in a timely, reliable, and structured way. Negotiating the use of music in the healthcare setting must be done in a respectful manner. The music therapist has the most education, knowledge, and experience using music to support goals of rehabilitation and consults with the other members of the team to support residents with music. When non-music therapy professionals integrate music into their practices, residents have increased support from music in a reliable on-going manner increasing their benefits of a resourcing relationship with music.

Difficult Environment

Both service users and staff remarked on the complex and difficult nature of living in these residences. Service users expressed concern and frustration with their peers, as well as confusion and anxiety regarding their day-to-day experience. For
example, a resident participant from the German-Canadian Care Home reported multiple negative concerns, from criticizing other residents for not becoming more involved in music therapy programs to criticizing the quality of bell choir performances to concerns about her care and more. These statements are reflective of her mood, health, and circumstances and provide an insight into the experience of residents in long term care.

There is so much need in a long-term care facility. Residents require more help than they would ever have imagined and this is excruciatingly difficult. Many residents with dementia are sure that they are going home and every day, they wait for family to pick them up. At Arbourview, residents live in a locked unit for ninety days. Some residents will be completing their residency while others will have just arrived and are in full crisis. When they arrive, residents’ lives have been increasingly restricted in the community because of health and safety reasons. For safety concerns upon arrival they experience restrictions at the site. Remarks from both sites highlighted the chaotic auditory environment of the residences, as well as awareness of the many losses and fear of the future.

Although living in residential care is difficult, music therapy can offer resources to address such struggles. Music therapy practiced in open spaces helps mitigate the confusing and distressing auditory environment. Music structures the time and the space providing a healthy distraction from the ever-present needs. During music programs, it seems that the ever-present need becomes more manageable, that many residents are contented and supported providing more resources for those who still need more care. Music therapy is one of the services that directly address service users’ needs mediating the environment for a time to provide a momentary break from these concerns, a valuable
distraction and diversion from this reality but the same time the music therapist must be aware of the losses and difficulties that residents face. Music therapy may lift mood but it is not delivered as a pick-me-up but rather a way to use music in all it facets to support people in what they are feeling and experiencing during sessions.

Music therapy as an anti-oppressive practice acknowledges the difficult nature of residential care supporting residents in a multidimensional manner while advocating for good services. The remarks regarding the music therapy service revealed that service users require increased reassurance to address on-going multi-layered concerns: from their health, to their circumstances, to their sense of musical competence.

Potential for Harm

Music can do harm. Music can be highly emotive, a memory trigger, and stimulating and consequently, has the potential to do harm. The risk for harm increases as the participants’ vulnerability increases. Many residents have experienced traumatic events in their lives that have impacted their ability to function and cope. All are in crisis when they arrive in residential care. It is essential to be aware of the ways in which music can do harm when people are in a state of vulnerability.

Most residents at the German-Canadian Care Home have dementia with other health complications. Their executive thinking is impaired, decreasing their ability to abstract, conceptualize, to remember, and to process unpleasant memories. Although dementia is rare, because of equally impairing cognitive disorders, concerns regarding negative reactions to memories are also true of residents at Arbourview.
It is obvious that residents lose focus at times during music therapy. This could possibly be because of a memory of a painful subject or time of life. When residents appear uncomfortable with internal stimuli, I intervene. For those with higher cognition, time is taken to explore the nature of their concerns and to therapeutically work for resolution. Therapeutically, unpleasant memories raised by music can offer opportunity to work through negative feelings and processes and explore a consciousness of resolution. However, this degree of therapeutic depth is not always possible with service users with decreased cognition. For residents with less cognitive functioning, support and distraction are used to elicit a more comfortable state. For residents who are not ambulatory and cannot leave the program, careful observation is employed to offer concern and consideration for all their memories.

Residents deserve the right to explore their memories and music therapy supports that work. Residents often live in a state of confusion and anxiety exacerbated by this confusion. Overall, research participants’ remarks indicated support for the perspective that experiencing memories can be precious, that reminiscing is usually a positive experience. In the residents’ interviews, their pleasure at remembering songs, words to songs, and memories stimulated by songs was observed. Residents come to program and remain in program, which would indicate that participation in the music therapy session is valued, more than potential hurtful memories are disruptive. Professional music therapy skills are required to mediate reminiscing experiences to harness memories in ways that can enhance wellness.

Residents at both sites are similarly highly sensitive to over and under-stimulation. One professional noticed how certain sounds were difficult for some
residents. Others described that different residents can have negative reactions to certain styles of music, particular songs, and/or specific performers. Timbres and dynamics were described as uncomfortable for some. Like the managing of difficult memory material, music therapy expert clinical observation of reactions and responses followed by specific therapeutic interventions serves to address and mitigate such situations as they arise.

Experiencing feelings of musical inadequacy was raised as another potential for causing harm. Some residents might be afraid to try in music and afraid of making a mistake. Others may have been bullied with regard to their musical choices and expressions. A number of research participants indicated early wounding from music experiences. One of the roles of a music therapist is to assess and evaluate clients’ relationship with music and mitigate any wounding to redevelop a healthy resourcing relationship. Otherwise, the tendency is to avoid participating in music as reported by research participants.

Musicality is liberally distributed in the human family and it is only very rare people who truly struggle to be musical. And yet, teachers and family members tell young people not to sing, or to sing quietly, harming their sense of agency with music. Many young students who desire to play music are systematically taught to dislike music and to fear their teachers. Experiences like these create wounds where experiences of resourcing should be happening and once a person believes that they are not musical, it is very difficult to change that self-statement. These wounds seem to go very deep, can carry on throughout life, and require increased support to challenge.

Some residents’ musical preferences can lead to harm. At Arbourview, this is reflected in what staff referred to as intense music, specifically, Heavy Metal and Gangsta
Rap. For staff these styles are stereotypically associated with anti-social behaviour.

Resident preferences can lead to negative reactions in the community. A previous resident came from a rural area and preferred Gangsta Rap. Staff were concerned that his home community mistrusted him, partly because of his musical choices. Another resident preferred heavy metal including adopting a typical hairstyle and make-up nonconforming with local culture and was bullied. Residents sometimes experience negative reactions when they express their musical preferences to their caregivers in their home community. Caregivers need support to know how to support residents’ musical choices such as listening without judgment and offering praise.

Music therapy programs are inclusive. Musical preferences reinforce a sense of identity, a sense of continuity, and a sense of security. Clients are encouraged to share their preferred music and this music is included in the session. Clients are supported to offer regard to each other’s music and music skills, fostering inclusivity and positive identity. At both residences, all musical interests are included, from country to religious to heavy metal to rap. All musical gestures and nuances are included and supported, from tapping toes to gentle rocking to subtle changes in breath. When service users become familiar with routines of the sessions they learn to trust that their preferences and memories will be validated and their emotional states regulated, even when the memories might be difficult for them to recall and the associated emotions complex.

Music therapists study the potential effects of music in all areas of human functioning and learn how to mitigate the potential of music to do harm. In therapeutic settings, music should only be used judiciously and under the advisement of the team. Sometimes residents use music in a harmful way such as listening to headphones on too
loud a volume. When this happens, it is documented and verbally reported so that the unit staff can offer on-going support. Staff are encouraged to report harmful use of music to the team and especially to the music therapist so that the harmful choices can be addressed and the resident’s healthy relationship with music can be restored. Staff are aware that they can bring concerns about the potential of music to do harm to the music therapist for consultation. When other healthcare professionals use music in their practices, with their decreased understanding of music’s potentials, it is incumbent on the music therapist to consult with the intent of decreasing the potential for harm.

*Lack of support in the community*

People with non-dominant status are silenced by oppressive structures in our cultures leading to a serious state of under resourcing, which is the case for both the service user research groups. Arbourview residents, people with visible intellectual disabilities, are routinely subjected to discrimination in the community. There is a general ignorance of dual-diagnosis developmental delay/mental illness and in communities with decreased understanding of disabilities this discrimination increases.

Arbourview staff that liaise with the community described the challenges faced by residents. Residents’ idiosyncrasies and unpredictability were offered as typical sources of misunderstanding leading to discrimination. Residents were described as sometimes difficult to manage and to understand, unpredictable, and struggling to self-regulate.

After completing their residency, Arbourview residents return to their home communities, and most do not have access to a music therapist. However, for most of
them, music therapy experiences were a part of their improvement in functioning. Often, caregivers in the community are unaware how helpful music support can be. Specifically designed music therapy experiences that have been supportive during the assessment can be replicated in the community to maintain and increase developmental potential. Residents’ preferred efficacious music experiences can be programmed into their lives in reliable and rehabilitative ways, decreasing reliance on a paid music therapist.

Community support work from Arbourview consists helping caregivers design healthy environments for the residents to live in plus health maintenance strategies. Further support offers counselling and parenting strategies for families. But within the broader communities that residents call home, narratives of residents continue to struggle for acceptance continue.

Older adults suffer multi-level discrimination including decreased access to resources as well. There needs to be on-going community education to reduce discrimination against older adults and people with developmental delays and mental illness including educating the community about the nature of aging and of developmental delays and how to be supportive. Initiatives are needed to increase appropriate housing and employment opportunities enhancing awareness of their positive attributes and political rights. Service users need support to understand and advocate for themselves against the ignorance in the community. Although in recent decades, there have been many positive initiatives in the community, there is still vast misunderstanding. Healthcare workers need to work harder to explain the concerns of older adults and people with developmental delays and mental health to the public to decrease this widespread oppressive stance. Recent initiatives are making strides but
there is still significant work to be done to create acceptance within an inclusive community.

In terms of anti-oppressive practice, supporting people who suffer extreme discrimination is foundational. The structures in culture that maintain discrimination must be addressed in a systematic manner to create a more socially just future for all of us.

*Anti-Oppressive Practices in Music Therapy*

Music therapy, as an anti-oppressive practice, works to amplify the service user’s voice to express and address health concerns through developing respectful research practices. In this research, the music therapist’s anti-oppressive practices approach was revealed to achieve real-life results. Participants described inclusive, collaborative features of the music therapy service as well as how music therapy and the music therapist function as advocates for service users. The AOP approach to documentation and community planning was highlighted. In particular, music therapy initiatives and recommendations for on-going music-based supports were appreciated.

To function as an anti-oppressive practitioner, empathy with and respect for the service user is foundational. What may be considered respectful in one culture can be seen as disrespectful in another such that respect is a term that has deep cultural nuance. Music therapy practice is co-created with the culture in which the music therapist practices. Ruud, (1988), and Stige, (2002), have described music therapy as a cultural practice. To practice in increasingly complex multi-cultural settings, music therapists must educate themselves broadly and extensively in the music and cultural practices of
the service users. Music therapists must explore, analyze, and incorporate the culture of the settings in which they work and reflect on their personal sense of culture and how they express their culture of music therapy. Respectful practice is created from courteous competence framed by cultural sensitivity.

Anti-oppressive analysis asks us to examine the social and political circumstances of our clients, to open our consciousness to the layers of oppression many face in their personal existence. Rather than focusing on attempting to remedy personal concerns in isolation, anti-oppressive practitioners examine the social and political structures that trap and hold service users in harmful conditions.

To offer deep respect to service users, music therapy as an anti-oppressive practice uses a full critical analysis to illuminate detrimental social and political conditions that interfere with access to health and wellbeing. The ethical review process for Arbourview is a case in point. When the research was initiated at Arbourview, there was no ethical review process in place but a willingness to create one. This situation existed because of the uniqueness of the site and the fact that the site has been in existence less than ten years. All aspects of care have been in a continual process of development due to the complex nature of the residents and the conceptual framework of ninety-day residential treatment.

When this research was proposed, the team was supportive, particularly because once the ethical review process was in place, they could initiate their own research. This research proposal was collaborative, inclusive, and non-invasive, and it was felt that it would be a good project to develop the research protocol at the site. Because of various setbacks, which are described in the autoethnography, this review process took more than
a year and a half to complete but ultimately was successful, despite the complicated process. The University of Limerick Research Ethical Review Committee approved the proposal ‘with excellence’ on first review. Subsequently, the proposal was submitted to the director of Arbourview for review. Next, the Quality Assurance Director for the parent organization of the agency reviewed it. Then, a Privacy Impact document was created and presented for review by that director. Each of these steps took from up to a few weeks to a few months. By creating this research ethical review protocol, as is their right, service users at this site now have a voice in future research conducted at the site, more fully integrating their care.

Anti-oppressive practice readily informs and integrates with music therapy practice framing our work with an ethos of social justice toward supporting service user led processes.

**Contributions and Limitations of the Methods**

Constructivist Grounded Theory (Charmaz, 2006; O’Callaghan, 2012) and Autoethnography (Anderson, 2006) offered reputable flexible methodological grounding for this research. Within these methodologies, anti-oppressive practices informed research design and implementation such that service users marginalized by cognitive and communicative disorders were empowered to contribute to research studying their services.

For the CGT study, in keeping with an anti-oppressive practice framework, research participation was voluntary. Similarly, interviewing techniques were modified
when needed to support service user inclusion and participation. The CGT methodology furthered my understanding music therapy as an anti-oppressive practice than participatory approaches used previously, expanding the depth, breadth, and clarity of responses offered by residents and their caregivers, more fully enhancing the understanding of the music therapy practices within an anti-oppressive practice framework.

Autoethnographic methodology (Anderson, 2006; Uotinen, 2010; Ellis, 2011) generated a complex, detailed, reflective record of my doctoral research experience of studying music therapy as an anti-oppressive practice. This methodology offered a place for stories of practice that explore and represent music therapy as an anti-oppressive practice, thick descriptions discussing both how and why music therapy has value and impact. Concurrently, autoethnography contextualized the process of music therapy as an anti-oppressive practice, revealing how and why an anti-oppressive practice framework enhances ethical music therapy research and practice.

Limitations of the CGT method included the time constraint created by the deadlines for the PhD resulting in a specific time conclusion for data collection rather than optimal saturation. However, it was possible to show that meaningful data collection was possible within this time frame.

*Issues*

The first issue identified in the research involved the lengthy ethical review process at Arbourview. Service users have the right to have their services researched to
develop good practices. Not only was there no ethical review process in place, the
development of the process was arduous and lengthy. This degree of complexity resulted
in previous studies being abandoned before they were initiated limiting service users
access to voice. The establishing of an ethical review process was undertaken with the
consciousness that the review process needed to be created to support good practices at
Arbourview, that the lengthy process had nothing to do with the need for the process, and
that completing the process was an action of anti-oppressive practice.

A second issue involved the use of a poster for participant recruitment. At the
German-Canadian Care Home, many potential research participants were born outside of
Canada learned English when they immigrated, sometimes as one of several languages
they spoke. The language on the recruitment poster was Canadian English. Although the
poster used very few carefully chosen words, potential participants asked the researcher
many unrelated questions indicating misunderstanding. These questions included who
could and would participate and where the research was taking place. As well, at
German-Canadian Care Home, management decision posted the information too high for
people in wheelchairs to read potentially excluding these participants. I say potentially
because one participant was a wheelchair user requested that someone who could see the
poster read it to her after which she volunteered to participate in the research.

At Arbourview, the recruitment poster led to issues as well. People who either
lived or worked at Arbourview could see the poster. However, guardians of potential
service user participants who did not visit the site were not exposed to the posted request
for research volunteers. To remedy this, the on-site social worker provided contact
information and these potential participants were contacted directly by telephone and
then emailed a copy of the poster. This lack of personal contact between the researcher and guardians of these potential participants may have reduced the pool of service users in the study.

I being the researcher that researches my practice affects all aspects of the research posing the greatest issue. Social politeness combined with the situation of ongoing work relationships have implications for the highly positive nature of interview remarks. Employing rigorous methodology including reflective practice and critical analysis served to address and mediate this concern.

Summary

The discussion explored the specific and the broader implications of the results revealing the value of music therapy for these services users particularly when framed by anti-oppressive practices. Reflection on concerns that were raised about the potential harm for music, and the way in which some staff were not appreciate of music therapy, as well as the enthusiastic nature of many remarks contributed a rich narrative of the value of music therapy in these settings. Similarly, other discussion reviewed what is particularly important about the way that I work and gave me a perspective of where I need to develop on a personal and professional level. Developing further the theoretical and practical applications of music as a resource for clients within an AOP ethos emerged as a potential focus for future research endeavours, which will form part of the recommendations presented in the next chapter.
Chapter Nine

Conclusion and Recommendations

Conclusion

The research for this PhD is grounded in my extensive experience as a practitioner, my prior research work for my Master’s degree, other research evaluations of my practice, and my long term commitment to social justice and peace initiatives both within music therapy and more widely. During my Master’s research work I provided a critique of current prevalent music therapy models of practice using a sociocultural and political framework (Baines, S., 1992). The resultant analysis provided a conceptual framing in which the service user’s voice is privileged in the process of music therapy program development. At the time my lack of clinical practice provided minimal framing from experience. To address this, post-Master’s, I developed a way of working with service user perspectives in many different settings with persons in different ages and stages of life with a broad spectrum of diagnoses. I worked practically, developing the application of this conceptual position through a process of observation and reflection. In time, I initiated participatory research with adults with chronic and persistent mental illness that integrated the service user’s voice to explore both the music therapy service and the music therapy research process. The results indicated that service user led practices in music therapy offer a framework for including service user preferences in a
manner that increases successful self-management through participation in music experiences.

My doctoral research moves this earlier research forward incorporating the voice of service users marginalized by cognitive and communicative disorders to explore their music therapy service experiences. The framework of anti-oppressive practice was expanded to include music therapy with an invitation to the field of music therapy to include anti-oppressive practices.

Music therapy is a practical human services field that requires a social justice analysis to enhance ethical good practice. Anti-oppressive practice has been described as, “a heterodox, umbrella term [that] borrows bits and pieces from various theories,” (Baines, D., 2010, p. 13), which applies to AOP’s roots in music therapy, elaborated in the literature review. Music therapy as an anti-oppressive practice links the work of music therapy with philosophies that seek to address oppression in all aspects of practice and research. Anti-oppressive practitioners incorporate service user preferences into all aspects of program design and development. The music therapy programs have been developed using this approach creating a practice that is based on service user preferences. The research supported this concept when staff remarked that music was now present in a structured manner in resident’s lives evidencing their awareness of music therapy service user preferences. Anti-oppressive practitioners exemplify and articulate a broad-based political awareness, acknowledging the challenges that persons designated non-dominant status experience and advocating for an inclusive socially just future.
Remarks from research participants revealed that songs support us, motivate us, relax us, and help us feel safe, that singing is fun and group singing is easier than singing alone, choosing a preferred song is meaningful, a group singing a preferred song is meaningful, the structure of a song, the beginning, middle, and end is predictable and comforting, and increased musical ability increases personal and community esteem. Music therapy as an anti-oppressive practice honours the personally relevant nature of ones relationship with music through integrating service user’s requests into program development and process. Music therapy, as an anti-oppressive practice, seeks to understand and integrate service user’s primary positive connection with music to foster increased trust and agency. Music therapy as an anti-oppressive practice incorporates service user preferences in a collaborative manner for program design and implementation. Music therapy as an anti-oppressive practice works to support service users to develop their use of their preferred music as a resource, empowering service users to independently support themselves with music in an on-going manner. By resourcing people through their primary positive connection with music, over time, service users are inspired to use music independently to maintain and increase their personal agency in relation to healthcare choices.

Music therapy as an anti-oppressive practice involves discerning the health impact of the social and political status of service users, advocating for service users, and working to mediate oppressive social and political structures that negatively impact health. Anti-oppressive analysis asks us to examine the social and political circumstances of our clients, to open our consciousness to the layers of oppression many face in their personal existence. Both residents and their caregivers discussed these tenets of AOP in
their interviews when they articulated the lack of support in the community for persons marginalized by cognitive and communicative disorders. Rather than focusing on attempting to remedy personal concerns in isolation, anti-oppressive practitioners examine the social and political structures that trap and hold service users in conditions harmful to their health and wellbeing. To offer deep respect to service users, music therapy as an anti-oppressive practice uses a full critical analysis to illuminate harmful social and political conditions that oppress access to health and wellbeing. Participants reported that music therapy initiatives have been integrated into the program and in the community indicating a multi-level inclusive collaborative social justice approach. Through including and collaborating with service users to develop services, music therapy as an anti-oppressive practice seeks to make the role of the music therapist over time redundant in the service user’s life. Music therapy as an anti-oppressive practice offers practitioners and researchers a way of analyzing their philosophies, theories, approaches, and interventions to address matters of discrimination as they arise. As revealed in the research findings, informed by anti-oppressive practice, music therapy can be an anti-oppressive practice.

Recommendations for Further Research

Future exploration is needed to discover ways to further include marginalized service users’ voice in music therapy practice and research. More exploration is also required to explore more fully the relationship of anti-oppressive practices with music therapy research and practice. To further this agenda of personal resourcing through
music, the links between music pedagogy and abuse require investigation, including music therapy pedagogy. With the powerful relationship between service users and their music revealed here, research exploring the value and mechanics of a daily music quotient is promising.

Anti-oppressive practice asks practitioners to participate in social action to create meaningful change. The completion of this research as part of doctoral studies at the University of Limerick substantiates the work and shares it with a critical audience. The outcomes of this research published and will be shared at in-services at both research sites. At the German-Canadian Care Home, the board has requested a presentation. I am exploring sharing the work with the service users in summary.
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Appendix A

Project Information

Date: May 29, 2012

Project Title: Giving Voice to Client Choice: Developing Anti-Oppressive Practices in Music Therapy Field Work

Investigator: Sue Baines
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INVITATION

This project will study music therapy programs for residents living in a complex care facility. You are invited to participate in this study. If you are the legal guardian for a family member for one of our residents, I invite you to endorse their participation in this study.

WHAT’S INVOLVED?

The researcher will record a 15 to 45 minutes interview with residents, residents’ family members, care staff, housekeeping, dining staff, management, and administration who will be invited to share their views and opinions about music therapy.

For staff, although it is intended these interviews take place during work hours of the interviewees, outside of work hours or by telephone can be arranged.

POTENTIAL BENEFITS AND RISKS

Benefits of participation are having your views and opinions of music therapy make an important contribution to music therapy at the German-Canadian Care Home and to the field of music therapy and therapeutic practice in general.

There are no known or anticipated risks associated with participation in this study.
CONFIDENTIALITY

Throughout this study, you and/or the senior resident will remain anonymous. In written documents, persons will be identified by their initials only (e.g. Senior Mary Brown = Sr. MS, Care Aid John Smith = CA. JS). Any depiction in photographs and/or video material, faces will be obscured, unless specific permission has been obtained.

Data collected during this study will be stored in electronic format and hard-copy by Sue Baines, the music therapist. Data will be kept until the finalization of the last research paper related to this effort, after which time all personal data (including contact information) will be deleted/shredded. Access to this data will be restricted to persons

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to participate in any component of the study. Further, you may decide to withdraw from this study at any time, or to request withdrawal of your data (prior to data analysis), and you may do so.

PUBLICATION OF RESULTS

It is intended that results of this study will be published in reports, professional and scholarly journals, students theses, and/or presentations to conferences and colloquia. In any publication, data will be presented in aggregate forms. Quotations from interviews or surveys will not be attributed to you without your permission. Images of you will not be published without your permission.

Feedback about this study will be available from Sue Baines. You will have access to the final reports via the Recreation Department.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact the Student Investigator or the Faculty Supervisor (where applicable) using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Committee at the Care Home. If you have any comments or concerns, please contact the CEO.
Music Therapy Research: Would you like to participate?

What: Sue Baines, our music therapist, is enrolled in PhD studies in Music Therapy through the University of Limerick, Ireland and will be conducting part of her research here at the German Canadian Care Home. Participation will involve a 15-45 minutes recorded interview about your opinions of Music Therapy here, at the German Canadian Care Home.

Who: Residents, family members and caregivers, staff, management, and administration

Where: Here at the German Canadian Care Home or wherever you prefer off-site

When: By appointment, at your convenience – please contact Sue through the Recreation Department to arrange your interview

Why: To develop improved music therapy services
FACULTY OF ARTS, HUMANITIES AND SOCIAL SCIENCES
RESEARCH ETHICS COMMITTEE
CONSENT FORM

Consent Section:
I, the undersigned, declare that I am willing to take part in research for the project entitled “Giving Voice to Client Choice: Music Therapy as an Anti-Oppressive Practice”.

• I declare that I have been fully briefed on the nature of this study and my role in it and have been given the opportunity to ask questions before agreeing to participate.
• The nature of my participation has been explained to me and I have full knowledge of how the information collected will be used.
• I am also aware that my participation in this study will be recorded (audio) and I agree to this. However, should I feel uncomfortable at any time I can request that the recording equipment be switched off. I am entitled to copies of all recordings made and am fully informed as to what will happen to these recordings once the study is completed.
• I fully understand that there is no obligation on me to participate in this study.
• I fully understand that I am free to withdraw my participation at any time without having to explain or give a reason.
• I am also entitled to full confidentiality in terms of my participation and personal details. Nobody apart from the researcher and some members of staff will be able to find out whether or not I participated in the research study.

________________________________________________________________________

_____________  _______________
Consent Section:

I, the undersigned, declare that I am willing to take part in research for the project entitled “Giving Voice to Client Choice: Music Therapy as an Anti-Oppressive Practice”.

- I declare that I have been fully briefed on the nature of this study and my role in it and have been given the opportunity to ask questions before agreeing to participate.
- The nature of my participation has been explained to me and I have full knowledge of how the information collected will be used.
- I am also aware that my participation in this study may be recorded (video/audio) and I agree to this. However, should I feel uncomfortable at any time I can request that the recording equipment be switched off. I am entitled to copies of all recordings made and am fully informed as to what will happen to these recordings once the study is completed.
- I fully understand that there is no obligation on me to participate in this study.
- I fully understand that I am free to withdraw my participation at any time without having to explain or give a reason.
- I am also entitled to full confidentiality in terms of my participation and personal details. Nobody apart from the researcher and some members of staff will be able to find out whether or not I participated in the research study.
Resident’s Name _________________________________________________________

Resident’s Signature ____________________________________________________

Date ______________________  

OR

CONSENT PROVISION Approval/Consent of Representative or Legal Guardian.  
Resident's Name _________________________________________________________

Name of Representative/Legal Guardian____________________________________

Signature of Representative/Legal Guardian________________________________

Date________________________

Witness Name___________________________________ Date: ____________

Signature: _____________________________________________________________