The Influence of Group Music Therapy on Residents with Dementia in a Special Care Unit

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Abstract

Empirical evidence on the influence of music therapy on persons with dementia in residential care homes is fairly limited. Residents often experience a low quality of life due to the prevalent medical model of care that focuses on health-related outcomes, rather than a person-centered approach to support and care for the whole person. This qualitative study explored the influence of group music therapy on quality of life in residents with dementia living in a special care unit. Data were generated through focused, ethnographic observations, interviews, document analysis and a focus group. The data provide a rich and in-depth understanding on the process and outcomes related to group music therapy’s influence on residents’ care home experience. The findings provide substantive insights on the role of music therapy in improving the quality of life for residents with dementia and have practice implications for music therapy programming in residential care facilities.

Keywords: Music therapy; Dementia; Quality of Life; Special Care Unit; Engagement; Social Interaction
Dedication

To Mom, Dad, Ari, Genny and Steve, for your love and support.
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List of Abbreviations

MMSE Mini Mental Status Examination
MT* Music Therapy
MTA Certified Music Therapist
NDB Need-driven, Dementia-compromised Behavior Model
RCF Residential Care Facility

*Please note the acronym MT is an abbreviation for this thesis only and does not mean anything outside of this document.
Chapter 1.

Introduction

Music therapy (MT), although at one time obscure, is becoming an increasingly well-known treatment for older adults with dementia living in residential care facilities (RCFs). This profession is beginning to be recognized for providing far more than entertainment to its clients; however, the effect of MT is still greatly misunderstood by the general public as well as other health care professionals. MT is a relatively young occupation, with a very broad and somewhat disorganized body of research supporting its effectiveness. Although certified music therapists (MTAs) believe in the positive effects on quality of life that this treatment has on their clients, the impact may not be as obvious to health care administrators and policy makers who do not witness this therapy first hand. Therefore, it is crucial to conduct empirical research on the influence of MT and inform policy and RCF decisions regarding increase in the availability of this therapy.

Determining the influence of MT for persons with dementia living in RCFs is especially critical at this time. There is no known cure for dementia and strong evidence indicating the prevalence of this disease is increasing. The Alzheimer Society of Canada (2015a) states that 747,000 Canadians are currently living with dementia. Furthermore, they explain that this number is expected to increase to over 1.4 million by the year 2030. Many people with dementia live in RCFs due to the large amount of care that they require as their condition progresses. Many residents with dementia experience a low quality of life in RCFs (Moyle et al., 2011). This inability to maintain quality of life stems from the fact that long-term care is primarily based on a medical model and focuses on health-related outcomes, rather than a holistic treatment of the whole person (Noelker, 2001). Care homes are typically understaffed and lack the ability to support residents'
psychosocial needs (Cadieux, Garcia & Patrick, 2013), or their need for autonomy (Tuckett, 2007).

MT has much potential as an effective treatment for persons with dementia living in RCFs as it is holistic, non-pharmacological, person-centered, and has no known side effects. MT programs can be implemented without a great expenditure on behalf of the RCF. Several researchers believe MT to be a low-cost alternative to mainstream pharmacological treatment (Chou, 2012; Raglio et al. 2008; Bellili, Raglio & Trabucchi 2012). The following sections in this chapter will describe what MT is, how it is structured, the purpose of the current study and finally, the research question.

1.1 What is Music Therapy (MT)?

MT is the use of specialized musical interventions and techniques by a certified music therapist (MTA) to achieve specific non-musical goals and objectives based on the individual assessment of each client. It is important that MTAs, rather than untrained volunteers or staff, conduct MT sessions. Bruscia (1998) states, "music therapy treatment demands a qualified music therapist and can be defined as the professional use of music experiences and the relationships that develop through them with the aim to promote health" (p.668). In other words, musical activities are only considered MT when a MTA is involved in the process. In Canada, a Bachelor or Graduate Degree in music therapy and a 1000-hour supervised clinical internship is required to become a certified music therapist (MTA).

To determine the influence of MT, it must be clearly differentiated from other musical activities that occur in RCFs. The Canadian Association for Music Therapy (1994) definition of MT will be adopted to distinguish MT from other musical activities and programs not facilitated by MTAs and not considered MT. The Canadian Association for Music Therapy defines MT as

*the skillful use of music and musical elements by an accredited music therapist to promote, maintain, and restore mental, physical, emotional, and spiritual health. Music has nonverbal, creative, structural, and emotional qualities. These are used*
in the therapeutic relationship to facilitate contact, interaction, self-awareness, learning, self-expression, communication, and personal development (p.1).

All studies included in the forthcoming literature review specify the use of MTAs, or the equivalent in other countries, to facilitate the various MT programs and interventions for RCF residents with dementia.

1.2 Structure of MT

MT is a diverse field. There are countless ways in which MTAs use music therapeutically with clients. Typically, MTAs create live music through singing and playing instruments. MT can also include listening to, and playing and singing along with, recorded music. MTAs engage clients in musical improvisation, movement to music, songwriting, and reminiscing. MT can be conducted in a group or individual setting, depending on the goals and needs of the clients. Some of the most common MT goals for people with dementia are increasing engagement, social interaction, attention span, reality orientation and reducing agitation, apathy, disruptive vocalizations and wandering behaviour. Other less common goal areas for people with dementia are improving language, memory, and motor skills (Beard, 2011). A common misconception is that MT is only beneficial to past musicians. Brotons and Pickett-Cooper (1996) found that the decrease in agitation following MT was similar for those who had a background in music and for those who did not. This finding suggests that the benefits of MT are not limited to past musicians and music lovers but can be beneficial for all persons.

The structure, length, and number of participants per MT session vary greatly. These elements depend on many factors, including: 1) the individual MTA’s training, preferences and beliefs; 2) the client’s specific needs, abilities and goals; and 3) the available resources in the RCF and the policies imposed by management. MT researchers must be aware of these structural differences when designing studies in order to accurately measure the effect of MT in a specific context with a certain population.
Researchers generally agree on MT session size, frequency, and length for RCF residents with dementia. Gardiner, Furois, Tansley and Morgan (2000) believe that individual sessions are often better than large group sessions "at least initially, for persons with extreme agitation, pacing, and wandering problems" (p.44). Brotons, Koger, and Pickette-Cooper (1997) agree, stating that the most effective MT sessions for people with dementia are individual or small group sessions with no more than five participants. Very little is mentioned in the literature on the ideal length of MT sessions, but most studies report MT sessions as occurring once or twice weekly, lasting 30-60 minutes, for a minimum of six weeks (Brotons & Koger, 2000; Ceccato et al., 2012; Clair & Berstein, 1990; Hsu, Flowerdew, Parker, Fachner, & Odell-Miller, 2015; Hanson, Gfeller, Woodworth, Swanson & Gerand, 1996; Ledger & Baker, 2006; Lin et al., 2010; Melhuish, Beuzeboc, & Guzman, 2015; Raglio, Bellandi, Baiardi, Gianotti, & Granieri, 2013; Raglio et al., 2015; Raglio et al., 2008; Vink, Zuidersma, Zuidema & Slaets, 2014; Vink et al., 2013).

The choice of MT intervention is important to consider when working with RCF residents with dementia. Brotons et al. (1997) found that "instrument playing and dance/movement seem to be the most preferred live music activities of people with [Alzheimer's Disease and related dementias], as these are the activities they can participate in the most and longest" (p.237). Similarly, Sole, Mercadal-Brotons, Galati, and De Castro (2014) found that RCF residents with dementia participated in MT activities that involved playing instruments and improvisation even as their functioning in other areas declined. Hanson et al. (1996) found that persons with dementia at all stages of functioning participated most purposefully in MT interventions based on movement. Residents in their study participated slightly less in rhythm-based activities and least in singing activities.

The level of demand that a MT activity places on a participant must also be taken into account. Hanson et al. (1996) noticed that participants at all levels of cognitive functioning participated most in movement activities that were higher demand than those that were lower demand. The researchers explain that this finding could be due to motor skills being one of the last areas to decline in persons with dementia and that the facilitator could physically demonstrate these movements rather than having to explain
them verbally. In general, research on MT interventions indicates that as dementia progresses, high demand activities using rhythm, improvisation and movement are most effective at eliciting engagement and participation (Brotons et al., 1997; Hanson et al., 1996; Sole et al., 2014).

Although research shows that certain interventions are more effective at producing positive responses in RCF residents with dementia than others, this information must be used with caution, as every person is unique. Gardiner et al. (2000) stress that MT needs to be personalized, flexible, and sensitive to the individual’s needs, goals, ability, and schedule. These researchers explain that MT is personalized when the therapist creates interventions designed according to the client’s “tastes, cultural background, skill level, cognitive ability and desires” (p.43-44), as well as their musical preferences (Hansen et al., 1996). Personalized MT is important, as the same music and interventions will not be effective with all individuals.

1.3 Study Purpose

Abad (2002) states that “as dementia becomes more prevalent in our society, there will be a greater necessity to provide specialist care which encompass the person’s holistic needs, hence the introduction of treatments that focus on the needs of people with dementia, such as music therapy, must be readily accepted” (p.7). Although there are currently many MTAs working in RCFs with residents with dementia, this is not a standard treatment in care homes in British Columbia; many older adults with dementia residing in RCFs who do not receive this therapy. More research is needed to increase support and widespread use of this treatment.

There is a dearth of qualitative studies on the influence of MT on people with dementia residing in RCFs. Qualitative research is important as it uncovers the individual’s experience and looks at a broad range of interconnected processes or causes and can bring important insights not found in quantitative studies. A search of the literature identified five articles that use a qualitative methodology in their study of MT and dementia (Abad, 2002; Dennis & Rickson, 2014; Gold, 2014; Kydd, 2001; Melhuish, Beuzeboc, & Guzman, 2015), none of which used focused ethnography. The purpose of
This qualitative study is to explore the meaning of group MT and understand its influence on quality of life aspects, such as engagement, well-being, mood, agitation level, amount and quality of social interaction, and communication abilities in residents with dementia.

1.4 Research Question

1) How do group MT sessions influence aspects of quality of life in residents with dementia living on a special care unit?
Chapter 2.

Literature Review

This literature review includes a broad range of quantitative MT studies, as well as a few qualitative studies, examining different areas in which MT influences RCF residents with dementia. Few studies look directly at the influence of MT on the quality of life of residents with dementia. For this reason, studies examining MT and social interaction, cognitive functioning, sensory stimulation, memory, communication, anxiety, agitation and depression are included as these are all areas that are likely to impact quality of life. This literature review will synthesize the existing key findings on the influence of MT on RCF residents with dementia and highlight the knowledge gaps in the literature. Table 1 provides a summary of the studies found in the literature review. This table includes the focus of the studies in regards to MT with RCF residents with dementia, the number of studies with each focus, the methods used and overall findings.

Table 1. Literature Review

<table>
<thead>
<tr>
<th>Study Focus</th>
<th># of Studies</th>
<th>Method</th>
<th>Findings</th>
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<tbody>
<tr>
<td>Quality of Life</td>
<td>2</td>
<td>Quantitative</td>
<td>Insignificant results</td>
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<tr>
<td>Well-being</td>
<td>2</td>
<td>Quantitative</td>
<td>Positive results</td>
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<tr>
<td>Social interaction</td>
<td>5</td>
<td>2 Quantitative, 3 Qualitative</td>
<td>Positive results</td>
</tr>
<tr>
<td>Cognition &amp; Memory</td>
<td>4</td>
<td>3 Quantitative, 1 meta-synthesis</td>
<td>Positive results</td>
</tr>
<tr>
<td>Symptoms of Severe Dementia</td>
<td>6</td>
<td>5 Quantitative, 1 Qualitative</td>
<td>Positive results</td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
<td>Quantitative</td>
<td>Positive results</td>
</tr>
<tr>
<td>Anxiety &amp; Agitation</td>
<td>9</td>
<td>Quantitative</td>
<td>Mixed results</td>
</tr>
<tr>
<td>Depression</td>
<td>4</td>
<td>Quantitative</td>
<td>Positive results</td>
</tr>
<tr>
<td>Medication Use</td>
<td>3</td>
<td>2 Quantitative, 1 Qualitative</td>
<td>Positive results</td>
</tr>
</tbody>
</table>
2.1 MT, Well-being and Social Interaction

No qualitative studies, and only two quantitative studies, explicitly examine the effect of MT on quality of life in persons with dementia. In their study on MT with RCF residents with varying degrees of dementia, Sole et al. (2014) found no significant increases in quality of life scores following MT and attribute these results to methodological limitations. These researchers did, however, observe significant positive changes in the subscale items of emotional well-being and observed high participation levels, especially in instrument playing and improvisation interventions. Similarly, in their study comparing MT to individualized music listening, Raglio et al. (2013) found no statistically significant results, however they did find that quality of life scores generally improved with MT and worsened with music listening. These researchers attribute the inadequacy of the Music Therapy Rating Scale as the reason for obtaining insignificant results.

Although research is lacking regarding the influence of MT on quality of life in RCF residents with dementia, quality of life can be thought of as an amalgamation of many, if not all, of the outcomes of MT being researched. In their systematic review and metasynthesis of qualitative studies on factors that affect quality of life from the perspective of people with dementia, O'Rourke, Duggleby, Fraser and Jerke (2015) found that the presence of social relationships, the feeling of having a purpose in life, perceptions of wellness and a sense of belonging to place were all important factors in increasing quality of life.

Subjective well-being is another important aspect of quality of life. Hsu et al. (2015) found that RCF residents with dementia who participated in MT had higher levels of well-being, as measured through the observational tool Dementia Care Mapping. Similarly, Schall, Haberstroh, and Pantel (2015) found that care home residents with dementia expressed positive emotions more frequently and had higher levels of situational well-being after participation in MT. While well-being is not the same as quality of life, it is one important indicator of quality of life that must not be overlooked.

Another key aspect of quality of life is an individual’s quality and quantity of social interactions. MT may be useful in encouraging social interaction among RCF residents,
with dementia (Wall & Duffy, 2010). In their quantitative study of individuals with Alzheimer's Disease living in a RCF, Pollack, Namazi, Dolan, and Hill (1992) found that all eight participants had increases in social interaction at an average of 24 percent after a MT session. Sole et al. (2014) also saw an increase in social interaction and a decrease in non-social behaviour, such as active sensory and passive behaviour, after MT sessions.

In their qualitative study, Dennis and Rickson (2014) observed that MT fostered a sense of community in a hospital ward for people with dementia and improved relationships between residents and their family members. In the same way, Melhuish, Beuzeboc and Guzman (2015) found that collaboration between MTAs, dance movement therapists and care staff enhanced the relationships between care staff and residents creating a more meaningful care environment for residents with dementia. The researchers hypothesize that these results are due to the care staff learning “certain fundamental elements of the therapists’ approach, such as attending to individual pace, and supporting autonomy and choice, that promote good communication and relationships” (p.10). Finally, in a case study by Abad (2002) MT is shown to reduce isolation in a resident with behaviour challenges by allowing him to interact with peers in meaningful and socially acceptable ways.

The move to a RCF can be a very difficult life event, which research suggests may be made easier for some individuals through participation in MT. Kydd (2001) describes a case study of a resident with Alzheimer's disease and how MT was instrumental in his eventual adjustment to life in a RCF. Initially withdrawn and isolated, the man did not participate in activities or spend time outside his room. After several individual MT sessions, the resident began attending group MT sessions. These sessions led to the individual's eventual attendance in recreation activities, drastically increasing time spent outside of his room. Kydd (2001) suggests, “individual music therapy sessions can help a resident acquire the skills necessary to participate in group sessions, which may expand into new recreation programs as well” (p.107).

There is little research on the effect of MT on depression in RCF residents with dementia. Research shows that the prevalence of depression is three to four times
greater for older adults living in care homes compared to those living in the community (Jongenelis et al., 2004). Furthermore, the Alzheimer Society of Canada (2015b) states that almost half of the people with dementia experience depression at some point, which can aggravate the symptoms of dementia and cause increased forgetfulness, confusion and anxiety. The impact of MT on depression in RCF residents with dementia is an important area for researchers to investigate, as a non-pharmacological treatment may be highly beneficial for these individuals.

Three quantitative studies were found that examine the influence of group MT on depression in RCF residents with dementia. These studies use different MT techniques, all with promising results. In her study on the use of reminiscence MT for people with dementia, Ashida (2000) found a significant decrease in depressive symptoms in participants after receiving five days of group MT sessions. This researcher explains that these sessions “provided participants a safe place to interact socially, to share their memories with other residents, and to improve self-image” (p.180). In their study on MT using preferred music with care home residents with dementia, Ray and Mittelman (2015) found that, when compared to usual care, participation in MT sessions reduced the symptoms of depression over and above medication effects. These results were found after two weeks of MT sessions, with three sessions per week, and were maintained for at least two weeks after the last session. Similarly, in their randomized controlled trial Chu et al. (2014) found that group MT significantly decreased depression in RCF residents with dementia.

2.2 MT, Cognition and Communication

Improving cognition and memory are not common MT goals for RCF residents with dementia due to the degenerative nature of the disease. That being said, researchers who study the influence of MT on memory and cognition have found positive results. For example, in their meta-analysis, Chang et al. (2015) found MT to have a small but statistically significant effect on cognitive functioning. Similarly, in their randomized controlled trial, Chu et al. (2014) found that compared to the control group, those RCF residents who participated in group MT had delayed deterioration of cognitive
functions. Additionally, positive effects on cognition were detected one month after the last MT session, indicting that MT may have long-term effects on cognition.

MT may maintain, or even improve, verbal communication in RCF residents with dementia (Brotons & Koger, 2000; Ledger & Baker, 2006; Raglio et al., 2008; Schall, Haberstroh, & Pantel, 2015; Suzuki et al., 2004). For example, in their study comparing the effects of MT and conversational sessions, Brotons and Koger (2000) found MT to be more effective in improving participants’ speech content and fluency. Similarly, Suzuki et al. (2004) found that residents with dementia had significantly higher scores on the Mini Mental State Exam (MMSE) language subscale after MT sessions. Schall, Haberstroh, and Pantel (2015) also found that MT positively affected communication behaviour in RCF residents with advanced dementia as demonstrated through increased scores on the CODEM instrument, a standardized observational instrument for assessing communication behaviour in people with dementia. A study by Ledger and Baker (2006) found that although care home residents with Alzheimer’s Disease did not improve their communication abilities, most participants in the MT condition remained the same while those in the control group showed a steady decline in language functioning over this same period.

MT may also increase non-verbal communication in persons with dementia. For instance, Pollack at al. (1992) found a 36 percent increase in non-verbal communication in RCF residents with Alzheimer’s disease after MT sessions using individualized music. These researchers hypothesize that this increase could be due to the non-verbal nature of the interaction between the resident and MTA that might help compensate for losses in verbal language abilities. As Raglio et al. (2015) describe, “MT is a preverbal, nonverbal communication technique that has the goal of reactivating and developing the archaic expressive and relational abilities that persist along the whole life-span of each human being” (p.1538).

2.3 MT and Agitation

High agitation levels in residents with dementia cause many problems in RCFs. Behaviours associated with agitation have negative effects on caregivers, leading to
caregiver burnout, and on other residents, causing an increase in their agitation levels (Ridder, Stige, Qvale, & Gold 2013). Currently, antipsychotic drugs are the most common treatment for agitation in RCF residents (Ridder et al., 2013). Reliance on these drugs is problematic, as they are known to have many negative side effects, especially for those with dementia (Rolland et al., 2012). It is imperative that RCFs find better, non-pharmacological methods of reducing agitation to create a healthier environment for both staff and residents.

Research examining the effectiveness of MT in reducing agitation in RCF residents with dementia has mixed results. A meta-analysis of randomised controlled trials by Chang et al. (2015) found that MT had a moderately high effect on reducing disruptive behaviours in RCF residents with dementia. Similarly, a narrative synthesis, systematic review found consistent evidence that MT produced at least short-term improvements in mood and disruptive behaviour in RCF residents (McDermott, Crellin, Ridder, & Orrell, 2012). Moreover, four additional quantitative studies demonstrate reductions in agitation after MT (Lin et al., 2010; Ray & Mittelman, 2015; Ridder et al., 2013; Vink et al., 2014). Conversely, three studies indicate that MT has no advantage in reducing agitation over reading interventions (Gardiner et al., 2000), standard care (Ledger & Baker, 2006) and recreation activities (Vink et al., 2013).

The above contradictory results may be due to many different factors, including methodological differences and shortcomings such as differences in MT interventions, duration, and outcome measurement. For example, although Gardiner et al. (2000) found MT to be no more effective than a reading intervention for reducing disruptive behaviours in RCF residents with dementia, these results should be viewed with scepticism as this study has several limitations. First, this study has a small sample size of only two participants, of which only one has a diagnosis of dementia. Second, interventions were only 10 minutes long, compared to 30-60 minutes in most other studies. Due to these shortcomings, this particular study should not be considered as evidence that MT is less effective than a reading intervention.

As mentioned above, the study by Ledger and Baker (2006) found no significant difference in long-term agitation levels between residents who received weekly MT
sessions and those who received standard care. This study used a longitudinal repeated measures design with an experimental and control group and sample size of 60 RCF residents with dementia. These results indicate that MT may have more pronounced short-term rather than long-term effects on agitation behaviours in those with dementia. The researchers explain that two limitations that may have contributed to these results: low endorsement of CMAI [Cohen-Mansfield Agitation Inventory] behaviours and high inter- and intra-participant variability. More research is needed on the possible long-term effects of MT on agitation.

The above-mentioned randomised controlled study by Vink et al. (2013) found that compared with recreational activities, MT had no additional short-term effects on reducing agitation in RCF residents with severe dementia. These researchers hypothesize that the positive effects of MT shown in other studies may be due to the extra attention that MT provides for these residents. This is a valid point; although Svansdottir and Snaedal (2006), Ridder et al. (2013), Brotons and Pickett-Cooper (1996), and Lin et al. (2010) all found that MT reduces agitation, their studies compare the effectiveness of MT against standard care in the RCF. In other words, these researchers compare MT to no MT, rather than comparing it to another activity that provides a comparable amount of human contact and attention. Because of this potentially faulty comparison, any beneficial effects that the studies found could be due to the extra human contact and attention that MT provides, rather than the intervention itself. Vink et al. (2014) conducted a later study comparing the effects of MT and recreational activities. The results of this study indicated that RCF residents who received MT showed statistically significant reductions in neuropsychiatric symptoms of dementia, such as agitation and anxiety, compared to those engaged in recreation activities. This study indicates that "the effect of music therapy is not from extra attention only" (p.392) but due to the therapeutic effect of MT itself.

One way in which MT may reduce agitation in RCF residents with dementia is by compensating for lost abilities. Ridder et al. (2013) explain, "people with dementia have impairments that influence perception, attention, memory and social engagement, and interactions that involve music could be ways of compensating for, or bypassing, those impairments and thus lead to decreases in agitation" (p.668). In other words, MT allows
residents with dementia to engage meaningfully in musical activities, leading to a sense of competence. This engagement is important as the feeling of competence may be rare for a person with dementia who may find everyday life to be increasingly challenging and chaotic.

To summarise, there is more evidence supporting the use of MT as a means of reducing agitation in RCF residents with dementia than there is evidence against it. More studies in this area are needed, especially those comparing MT to activities providing a comparable amount of attention. Studies comparing MT to other interventions are needed to determine what effects MT produces and what effects are caused by increased human contact and attention.

2.4 MT and Medication Use

The prescription of psychotropic medication, such as antidepressants, hypnotics, antipsychotics and anxiolytics, is very high in RCFs. In a study examining psychotropic drug use in RCF in France, Rolland et al. (2012) found that approximately 70% of residents are prescribed at least one such drug. These researchers found that RCF residents with dementia are twice as likely as those without dementia to be prescribed antipsychotic drugs (24% compared to 12%). Residents with "productive behavioural symptoms, such as agitation, irritability, or sleep disturbance" (p.407.e11) are especially likely to be prescribed these drugs. Bronskill et al. (2009) found similar rates of antipsychotic drug prescription in Canada, with between 11% and 30% of residents in RCFs prescribed antipsychotic drugs.

The heavy reliance on antipsychotic drugs in RCFs may not be beneficial to care home residents with dementia. Rolland et al. (2012) explains that there is only weak support for the effectiveness of these drugs in treating the behavioural and psychological symptoms of dementia. Also, these drugs are known to have harmful side effects including delirium, which may put an older adult at an increased risk of falls. These researchers found that residents living in RCFs with a higher intensity of antipsychotic drug prescription had a significantly higher short-term mortality rate. Rolland et al. (2012) explain that a high rate of antipsychotic drug use is likely "a consequence of inadequate
time, knowledge, and resources for implementing other nonpharmacological interventions for behavioral and psychological symptoms of dementia” (p.407.e11).

As noted, one nonpharmacological treatment that may be useful in the treatment of agitation in RCF residents with dementia is MT. Brotons et al. (1997) explain how MT can be an "effective alternative to medication and physical restraint for managing behaviour" (p.238) in people with dementia. Experts agree that this treatment is superior to pharmacological treatment because it has similar benefits with little to no risks or side effects (Rolland et al., 2012; Svansdottir & Snaedal, 2006). Ray and Mittelman (2015) found that when compared to standard care, MT reduced agitation and depression levels “over and above any medication effects” (p.14), but had no effect on wandering behaviour. In their randomized controlled trial, Ridder et al. (2013) found that while psychototropic drug use remained steady in RCF residents with moderate to severe dementia who participated in MT programming, it increased significantly in the control group who received standard care. Another example of using MT to reduce antipsychotic drug use is in Ridder and Aldridge's (2005) case study of a RCF resident with frontotemporal dementia. These researchers saw a reduction in antipsychotic medication after twenty MT sessions within a one-month period. Although there is only a small amount of research on the topic, the existing research indicates that MT has the potential to be an effective alternative to pharmacological treatment.

2.5 MT and Residents with Late Stage Dementia

The Alzheimer Society of Canada (2015c) explains that Alzheimer’s is a disease that causes progressive deterioration of brain cells. This deterioration causes symptoms to worsen over time. The disease “typically follows certain stages which will bring about changes in the person's and family's lives” (p.1). Generally, those in the late stage of dementia have lost their ability to verbally communicate or look after their basic needs, thus requiring care 24 hours a day. The Alzheimer's Society of Canada (2015c) states, “the goal of care at this stage is to continue to support the person to ensure the highest quality of life possible” (p.1). There are many ways to support a person with later stage dementia, one of which is MT.
As residents' dementia progresses to the severe stage, it becomes more difficult for these individuals to engage in meaningful activities and make connections with others. Clair and Bernstein (1990b) explain how "music therapy makes possible opportunities to interact successfully and appropriately with others and to have a sense of belonging or being with others" (p.310). These researchers found that although MT participants with severe dementia declined in their cognitive, physical and social abilities throughout eleven weeks of observation, they increased or maintained their level of participation in structured group MT interventions. This finding indicates that RCF residents with dementia can participate in MT sessions even as the disease progresses into the later stages (Brotons et al., 1997).

Researchers found that some musical instruments, interventions and techniques are more effective than others when it comes to MT with individuals with severe dementia. Clair and Bernstein (1990a) found that persons with very late stage dementia participated in MT activities to a greater degree when an instrument that provided vibrotactile stimulation was used, such as a hand drum positioned in a person's lap. Interventions using these instruments are especially useful once a person has lost the ability to sing, as rhythmic responses to vibrotactile stimulation "seem to be maintained through the latter stages of dementia" (Clair & Bernstein, 1990a, p.125). Also, Clair (1996) found unaccompanied, live singing to be effective at producing alert responses in RCF residents with severe, late-stage dementia who were unresponsive to most other stimuli. Furthermore, Clair (1996) found that when compared to reading and silence, participants responded strongest to the singing of songs that were familiar to them. This ability to participate in music even in the later stages of cognitive decline could be due to the innate nature of music and the fact that it does not depend on memory or cognitive processes.

MT may help RCF residents with severe dementia gain control over their actions. Brotons and Pickett-Cooper (1996) found that some of the typical signs of agitation associated with dementia, which are commonly perceived as not purposeful and uncontrolled, appeared to be more purposeful during MT. During MT sessions, leg movements and toe and finger tapping often became "more rhythmical, thus
synchronizing with the music. This finding suggests that the [residents] were able to gain some control over these behaviors” (p.15).

MT is shown to have positive effects on mood and behaviour in RCF residents with severe dementia. In his qualitative study, Gold (2014) found that MT had a consistently positive effect on the mood and behaviour of eight out of nine hospital patients with advanced dementia as measured through the analysis of the case notes of nursing and care staff. Similarly, in their controlled trial using standardized criteria to measure behaviour, Raglio et al. (2008) found that MT is effective at decreasing the behavioural and psychological symptoms of dementia in RCF residents with severe dementia. MT may also be effective as sensory stimulation for RCF residents with advanced dementia; Pollack et al. (1992) found a 40 percent decrease in sensory stimulating behaviour in eight RCF residents with dementia after MT sessions. Also, Raglio et al. (2008) believe that MT may be useful for increasing the threshold for tolerating environmental stimuli that may otherwise trigger disturbing behaviour in individuals with dementia living in RCFs.

To summarise, these six studies on the effect of MT on RCF residents with severe dementia found positive results, indicating that MT may be an effective treatment to increase alertness, engagement and mood, provide sensory stimulation and allow residents to better control behaviours.

2.6 Gaps in the Literature

Several key substantive gaps in the extant literature were identified on the influence of MT on quality of life in residents with dementia. Two significant gaps are around the use of MT to improve quality of life and to decrease depression in residents with dementia. Both topics are critically important to older adults with dementia living in RCFs. Researchers noted the dearth of studies on the effect of MT on quality of life in RCF residents with dementia (Beard, 2011 & Sole et al., 2014). Beard (2011) rationalizes the lack of research on quality of life to the fact that many studies focus instead on reducing the behavioural challenges associated with dementia. The lack of MT research on decreasing depression in RCF residents with dementia was not
mentioned in any of the studies reviewed in this paper. Due to the high prevalence of depression in RCF residents with dementia, it is imperative that future research explores the influence of MT on quality of life in residents with dementia living in RCFs, especially those also affected by depression.

2.7 Research Agenda

The two most pressing needs for future research on the topic of MT for RCF residents with dementia are for more rigorous studies and for more qualitative studies. Although many quantitative studies explore the effect of MT on RCF residents with dementia, most of these have extensive limitations. Gutin et al. (2012) explain, "there remains a lack of rigorously controlled studies to enable a clear pronouncement as to the clinical pertinence of MT for people with [Alzheimer's Disease]" (p.630). Furthermore, a recent Cochrane review of the effectiveness of MT for people with dementia, by Vink, Bruinsma and Scholten (2013) states, "there is no substantial evidence to support nor discourage the use of music therapy in the care of older people with dementia" (p.2). The authors explain that these results were likely due to methodological limitations in the studies on MT with persons with dementia and that the individual results of the studies could not be validated and pooled for further analysis. Furthermore, a comparison of outcomes was impossible due to different behavioural, psychological and functional scales used in the various studies. Despite these limitations, all ten studies reviewed found MT to be a beneficial treatment for older adults with dementia. The results of this Cochrane review demonstrate the importance of methodological design.

There is a clear need for qualitative research on the topic of MT with RCF residents with dementia. Only five out of thirty-five studies on the topic of MT and residents with dementia used a qualitative research design. Wall and Duffy (2010) explain that qualitative research will provide "a holistic overview of the experiences of gerontology nurses, music therapists, patients and their families in relation to the effects of music therapy on the behaviour of older people with dementia" (p.112). For this reason, the current study has adopted a rigorous qualitative methodology to explore the influence of MT on quality of life of RCF residents with dementia.
2.7 Conclusion

The research on MT with RCF residents with dementia illustrates the enthusiasm that MTAs and other professionals feel towards this treatment modality. The studies reviewed in this paper show beneficial or neutral effects of MT for people with dementia living in RCFs. Benefits include increased emotional well-being (Sole et al., 2014), increased social interaction (Pollack et al., 1992; Sole et al., 2014; Wall & Duffy, 2010), improved cognitive skills (Brotons et al., 1997), and improved verbal and non-verbal communication (Brotons & Koger, 2000; Ledger & Baker, 2006; Pollack et al., 1992; Raglio et al., 2008). Studies show MT to be effective in reducing agitation (Brotons & Pickett-Cooper, 1996; Raglio et al., 2010; Ridder et al., 2013; Wall & Duffy, 2010) and psychotropic medication use (Brotons et al., 1997; Ridder et al., 2013; Rolland et al., 2012; Svansdottir & Snaedal, 2006) in RCF residents with dementia. There is also evidence on the effectiveness of MT for reducing dementia symptoms among persons in the later stages of dementia (Brotons et al., 1997; Brotons & Pickett-Cooper, 1996; Clair, 1996; Clair & Bernstein, 1990; Gold, 2014; Pollack et al., 1992; Raglio et al., 2008). Each of the positive outcomes shown in these studies improves quality of life in persons with dementia living in RCF.

There is increasing evidence supporting the use of MT with RCF residents with dementia in other literature reviews. In their analysis of quantitative studies, Guetin et al. (2012) found that MT tends to have a positive effect on persons with dementia and "can be perfectly integrated in a multidisciplinary support programme for people with [Alzheimer's disease]" (p.630). In their review of 30 clinical empirical studies on the effects of MT on persons with dementia conducted between 1985 and 1996, Brotons et al. (1997) found sufficient evidence that MT is effective in enhancing group participation, building social and emotional skills, as well as decreasing problem behaviour. These researchers found that MT was also effective in stimulating language skills in persons with dementia. Similarly, in their meta-analytic review of the literature on MT for persons with dementia, Koger, Chapin, and Brotons (1999) found "a significant effect of music therapy on the amelioration of symptoms of dementia" (p.5). Although more research is needed, it appears that when the current body of research is integrated MT shows positive effects on the quality of life of RCF residents with dementia.
Chapter 3.

Conceptual Considerations

3.1 Conceptual Considerations

Few studies examining the influence of MT on residents with dementia are influenced by or draw from a conceptual framework. The exceptions are Ray and Mittelman’s (2015) study that uses the need-driven, dementia-compromised behavior model (NDB) and Ridder et al.’s (2013) study that uses Kitwood’s framework of person-centered care. Both studies utilize these frameworks as a way to understand the cause of agitation in residents with dementia.

Kitwood (1997) describes personhood as “a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust” (p.8). He explains that within the framework of person-centered care, agitation is understood as an individual’s reaction to unmet psychosocial needs and their attempt to communicate these needs. The five overlapping needs, that when met support personhood for people with dementia, are comfort, inclusion, identity, occupation and attachment (Kitwood, 1997). Kitwood (1990) also describes a number of processes and interactions that tend to undermine personhood in those with dementia; these elements are labeled as Malignant Social Psychology. Kitwood’s (1990) original list contained ten aspects of malignancy: treachery, disempowerment, infantilization, intimidation, labelling, stigmatisation, outpacing, invalidation, banishment, and objectification. Kitwood (1997) subsequently updated this list to include seven more elements: ignoring, imposition, withholding, accusation, disruption, mockery and disparagement.
Similar to Kitwood’s (1997) framework of person-centered care, the NDB model posits that problematic behaviours expressed by those with dementia indicate unmet needs. This model differs from Kitwood’s framework in that it places more emphasis on various risk factors that interact in persons with dementia, such as cognitive and physical losses, as well as the properties of the physical and social environments. Ray and Mittelman (2015) state that once the needs of an individual are known, interventions can be tested to measure their impact on the needs-driven dementia-compromised behaviours. Both the NDB and Kitwood’s framework of person-centered care are useful when examining the influence of MT in residents with dementia.

Due to the small number of conceptual frameworks used in the literature on the effects of MT on RCF residents with dementia, I have developed a collection of conceptual considerations drawing from several aspects of MT described in the literature, Kitwood’s Model of Person-centered Care, and the NDB model. These considerations attempt to break down the key components of MT and describe the MT process.

The considerations (see Figure 1) are divided into three areas: the MTA’s assessment, the MT sessions, and the resulting quality of life outcomes. Box one, the MTA’s assessment, include: knowing the residents’ preferences, interests, desires, background, culture, skills, abilities, deficits, and schedule. The MTA takes all of these areas into account before the onset of therapy in order to tailor sessions to each individual resident and their specific needs. This information will advise the MTA in their choice of individual or group MT sessions for the resident. This knowledge will also inform the therapist of the type of MT intervention, the difficulty of the intervention and the genre of music to use with the resident. As previously mentioned, several researchers believe individual and small group sessions are more effective than larger group sessions for RCF residents with dementia (Brotons et al., 1997; Gardiner et al., 2000), but this varies depending on the individual and their level of dementia.

The second box outlines what happens during the MT sessions. Most important is the therapeutic relationship, which is built upon rapport and trust. Therapeutic interventions are tools used to produce positive change in the client and must be person-
centered, individualized and appropriate to the client's level of cognitive functioning, physical abilities and preferences. Interventions are where the music enters the therapy in the way of singing, instrument playing, movement activities, improvisation, songwriting, reminiscing and listening to music. As mentioned previously, researchers have found that some interventions are more effective at engaging RCF residents with dementia than others. Residents with dementia participate most in instrument playing (Brotons et al., 1997; Sole et al., 2014) dance/movement (Brotons et al., 1997; Hanson et al., 1996) and improvisation (Sole et al., 2014).

The final box in the diagram shows the quality of life outcomes found in the literature on MT with residents with dementia in RCFs. The outcomes are divided into those that increase positive aspects of quality of life and those that decrease negative aspects that detract from quality of life. The positive aspects include, but are not limited to, improved: mood, cognition, memory, engagement, social interactions, sense of belonging, communication, relaxation, sensory stimulation, emotional expression and adjustment to the RCF. The areas that are decreased with MT to improve quality of life include: anxiety, depression, agitation, and need for psychotropic medication. When the three blocks are examined together the sequence of events is shown: starting from before therapy begins, moving through the therapeutic process, and ending with quality of life outcomes.
Figure 1. Conceptual Considerations on the Influence of Music Therapy on Residents with Dementia in Residential Care Facilities
Chapter 4.

Methods

This chapter presents the research methods used to explore the influence of group MT on quality of life for people with dementia living in a special care unit in a RCF. This study utilized a qualitative approach, specifically focused ethnography, to gain a thick description and in-depth understanding of the research area.

4.1 Research Design

A qualitative research approach was utilized to study the meaning and role of group MT for people with dementia. This research design was chosen because, as Wheeler and Kenny (2005) point out, studying MT sessions as they occur allows the research to be applicable “to what music therapists actually do” (p.64). Similarly, Aigen (1991, 1993, as cited in Wheeler & Kenny, 2005) states that qualitative inquiry is especially suited to MT research due to its strong emphasis on process: “The qualitative researcher’s awareness of the changing dynamics and the process in the research does, indeed, reflect awareness of the same dynamics in the music therapy session” (p.65).

4.1.1. Focused Ethnography

The primary data collection method in this study was focused ethnography using systematic in-depth observations, formal interviews and a focus group. This method was chosen due to its emphasis on the realities created by individuals’ subjective experience that cannot necessarily be objectively quantified. The high-quality observations associated with ethnography have many strengths, ten of which are described by Patton (2015): 1) rich description, 2) contextual sensitivity, 3) being open to what emerges, 4) seeing the unseen, 5) testing old assumptions and generating new insights, 6) opening
up new areas of inquiry, 7) delving into sensitive issues, 8) getting beyond selective perceptions of others, 9) getting beyond one’s own selective perceptions, and 10) experiencing empathy (p.335). A research design using ethnography allowed for a rich and multidimensional description of the meaning and role of group MT in the lives of care home residents with dementia.

Focused ethnography differs from conventional ethnography is several ways. Cruz and Higginbottom (2013) explain that in focused ethnography the subject of inquiry is more focused, time spent in the field is often shorter and more intense, and the researcher’s role is more often that of observer than participant. Focused ethnography is designed to target more narrowly defined cultures, a specific topic or shared experience, small elements of society or small groups of people living within a bigger society. As a result, this method was ideal for studying the subgroup of RCF residents with dementia living in a special care unit. Focused ethnography was an appropriate method of inquiry in this study as it allowed myself, the researcher, to gain “a better understanding of the experience of specific aspects of people’s ways of life and being” (Cruz & Higginbottom, 2013, p.38). Because I aimed to explore the meaning and impact of a specific activity, MT, on a specific group of people, those with dementia living in a special care unit, this more focused approach to ethnography was ideal.

4.1.2. Study Site

A RCF in Vancouver, BC, Sunrise Care Home (pseudonym), was purposively selected as a study site because it has a special care unit for residents with dementia and employs two MTAs to regularly conduct group MT programs on the unit. Sunrise Care Home is a campus of care model residence providing independent housing, assisted living and residential care services. This care home is situated in Metro Vancouver in close proximity to restaurants, entertainment and shopping. The residential care portion of the centre has 154 beds, 33 of which are on the special care unit Emerald Lane (pseudonym). Emerald Lane is a secure and self-contained unit with private bedrooms, a large dining and recreation room, a smaller activity room and an outdoor patio area with a garden. The two MTAs currently employed at Sunrise Care
Home both agreed to participate in the research through interviews and allowing observations of their MT groups.

I was employed as a MTA at Sunrise Care Home in the past, thus I am acquainted with many of the residents living on Emerald Lane. I also know the staff and other MTAs working on the unit. This intimate knowledge of MT, the residents, and the MTAs undoubtedly produced biases. In order to combat these biases, I: 1) engaged in in-depth self-reflection through a reflexive journal, and 2) ensured that my observations were as objective as possible. Field notes were descriptive rather than evaluative in order to accurately capture the phenomenon that was occurring. A heightened awareness of biases likely softened the impact that they had on this study.

Access to Sunrise Care Home was straightforward due to my former employment at the RCF as a MTA. I had a strong working relationship with the management team who were supporters of research conducted at the RCF. Sunrise Care Home provided research access to its special care unit, residents and staff.

4.2. Data Collection

Data collection included multiple methods: observations, focus groups, and formal interviews. Supplementary data was also collected through relevant documents and personal reflections as a MTA. Fieldwork was carried out over a 3-month period.

4.2.1. Observations

In-depth observations, conducted over a three-month period, were the primary method of data collection in this study. Observations captured the quality, nature, richness, and nuance of interactions and behaviours and provided a thick description of the everyday lives of RCF residents with dementia, the MT and recreation programs that they attended, and the influence that these programs had on their quality of life. Observation is an especially appropriate data source in research with people with dementia as these individuals often experience challenges with memory and language, making other methods, such as interviews, more challenging.
While conducting observations, I was an overt observer collecting data *in situ*. Collecting data in situ means that myself as the observer, was close enough to capture comments and conversations, but was not a participant in the MT sessions and other activities observed (Lofland et al., 2006, p.85). Observations were limited to the dining room, lounge areas and hallways to respect residents' privacy in their bedrooms and bathrooms. Being an overt observer meant that I exercised full and complete disclosure of my identity and research focus. Patton (2015) supports using full disclosure stating: “people are seldom really deceived or reassured by false or partial explanations—at least not for long” (p.342). I was known as a researcher to all present on the special care unit and did not attempt to disguise my identity or the purpose of my research from the participants, staff, or family members. As impaired memory is one of the products of dementia, I had to reintroduce myself and restate my role as needed throughout the study.

An observation guide (see appendix A) was utilized in order to focus observations and to prompt myself, the observer, to record certain important details. At the onset of each observation period I recorded the date, time, location, activity being observed, residents present, staff members present, and family, friends and companions present. The observation guide included reminders to record social interactions, conversations, behaviours, engagement and participation in the activity, facial expression, and body language, as well as the physical location and arrangement of furniture.

In this study, different aspects of the special care unit were observed. Although Patton (2015) states that “everything that goes on in or around the program or other setting being observed is data” (p.370), he suggests focusing observations on “those things that relate most directly to the focus of your inquiry” (p.368). Focusing observations allows the researcher to get the most out of a limited amount of resources and time in the field. During the observations in this study, special attention was given to social action and talk in action. Social action, as described by Lofland et al (2006) is “the basic, intertwined forms of human interaction, talk and action” (p.85). In this study, social action took the form of verbal and non-verbal interactions between care staff and residents, the MTA and residents, as well as among residents. Lofland (2006) describes
*talk in action* as “accounts or patterns of talk formulated for a particular end in a naturally occurring situation that is part of some ongoing system of action” (p.87). In MT sessions, talk in action included running commentaries about the session between residents and residents calling out song requests. Both types of observations provided rich data on how participants were interacting with others and experiencing the sessions.

During the three-month observation period, a total of 172 hours over 40 days were spent on the unit conducting observations, with a range of 1.5 to 6 hours of observations each day. Although MT sessions were the focal point of this study, observations were not restricted to scheduled MT sessions and included recreation activities and meals. I observed 32 MT sessions and five recreation programs. A total of 47 meals were observed: 24 breakfasts, 20 lunches, and three dinners. A large proportion of observations, 135 hours, occurred when no planned activities were taking place, including before and after MT sessions; these times provided opportunities to explore resident’s behaviour, engagement levels, and social interactions outside of activities. This downtime also allowed for opportunities to engage staff, family and companions in informal exchanges to build rapport and clarify observations as needed.

There was a shortage of recreation activities during the 3-month observation period due to understaffing in the recreation department, which meant that many scheduled activities did not happen. Recreation staff members were often pulled from Emerald Lane to help with larger programs in other parts of the building. Programs may have been more readily cancelled on Emerald Lane compared to other floors as these residents are less likely to remember that a program was scheduled to occur, making them less likely to complain about cancellations. Because of this, I was only able to observe five hours of non-MT activities even though I was frequently present on the unit at times when recreation activities were scheduled to occur.

Observations primarily occurred on days when MT sessions were happening on Emerald Lane. Observations typically commenced at least one hour prior to the MT sessions and concluded at least one hour after the close of the sessions. Two MTAs and one MT intern led the groups: one therapist conducted a session once a week and the other conducting two sessions a week. The intern conducted one session per week.
over a three-week period. All the MT sessions on the unit were formal, planned programs that occurred at the same time, in the same place, each week. Patton (2015) describes these types of programs as having “a kind of unity about them: a beginning, some middle point, and a closure point” (p.368). As an observer, I paid special attention to the form of the MT programs and any behaviours and interactions that changed during these different segments. Patton (2015) suggests keenly observing the following through each section: who is present, what is being said, what are the responses and reactions to the interventions, the therapist and other residents. Also, when are behaviours happening, what are the variations in participant engagement and how are behaviours and feelings changing over the course of the session? Being aware of changes in behaviour in the different sections of the session allowed for a better understanding of the participants’ experience of the MT session, and pointed to which portions of the session are most engaging and meet the specific needs and preferences of the residents.

The social and physical environment on the special care unit is also of interest in this study. Patton (2015) emphasizes the importance of being aware of group dynamic indicators such as who controls the interactions, who follows and who is not heard. The direction of communication, the patterns and frequency of interactions, and the ways in which residents organize themselves into groups and subgroups are also important. The physical environment was closely observed and details of the setting such as the layout of the rooms, furniture placement, lighting, and decorations were noted. These environmental elements were observed in order to determine how they augmented or detracted from the participants’ experience and affected their level of engagement during MT sessions.

Observations were recorded in the way of detailed and descriptive field notes. Patton (2015) explains the importance of field notes stating that they “contain the descriptive information that will permit you to return to an observation later during analysis and, eventually, permit the reader of the study’s findings to experience the activity observed through your report” (p.387). Observations were recorded as jottings on a word document on a laptop and expanded into full field notes shortly after leaving the field in order to preserve the details of the observations. The field notes were dated
and included a description of the location, physical setting, and participants present. A rich description of all social interactions and behaviours that take place were recorded as well as meaningful direct quotations of what people say. Based on recommendations by Patton (2015), “feelings, reactions to the experience, and reflections about the personal meaning and significance of what has been observed” (p.388) were also included. He also advises recording any “insights, interpretations, beginning analysis, and working hypotheses about what is happening in the setting and what it means” (p.388). These notes were in a separate area in the field notes so as not to confuse observations with feelings or interpretations of what happened.

4.2.2. Focus Groups

Morgan (1996) defines focus groups as “a research technique that collects data through group interaction on a topic determined by the researcher” (p.130). Focus groups originated in the fields of advertising and marketing and later expanded into a commonly used method of inquiry in social research (Agar & MacDonald, 1995). Morgan (1996) explains how focus groups are used in combination with other research methods, such as interviews and surveys, and as a self-contained method of inquiry. In this study, the individuals recruited for the focus groups were chosen because they know the residents best and are in a unique position to observe subtle changes in the mood and behaviour of residents, indicating their level of engagement and well-being. These individuals may also be able to speak of any changes they observe during or after a MT session that someone who does not know the individual as well, such as myself, may not detect.

The data produced from focus groups is unique and has several advantages. Focus groups differ from individual interviews in that the group dynamics affect individual responses. The group effect, dubbed by Carey (1994), is created through the interaction of the participants in the focus group and provides data that is greater than the sum of separate individual interviews as participants question one another and feel they need to explain themselves to one another (Morgan, 1996). Furthermore, Agar and MacDonald (1995) state that focus groups have advantages, especially when combined with other forms of ethnographic data collection. One advantage is that focus groups provide
“broader frames of interpretation in terms of which focus group details take on added significance” (p.78). Another advantage is that depth may be added to the understanding of what happened during a specific focus group session through ethnographic approaches of transcript analysis.

There are also several critiques of the use of focus groups in social research. Morgan (1996) points out that the impact of the moderator on the group is unknown and may shape responses to the questions. Another concern is that when using focus groups to research sensitive topics, participants may be shy and unwilling to disclose personal information and discussion may be limited. In the study, using sampling segmentation, which Morgan (1996) describes as the organization of different categories of participants into different focus groups, increased participant comfort and allowed for the individuals in the groups to feel that they had enough in common to speak freely within the focus groups.

Morgan (1995) describes that recruitment is often challenging with focus groups and suggests over-recruiting, providing incentives for participation, and having repeated contact with the participants. In this study, 8 participants were invited to participate, with the goal of 6-8 participants participating in the focus group. I also provided light refreshments and offered an honorarium in the form of $10 gift cards to a coffee shop. After participants were initially invited to participate in the focus group, they were reminded with a follow-up phone call on the day of the focus group. Also, the focus group was located in a convenient location in the RCF and scheduled in the evening as this time was most convenient for the focus group members.

The number, order and type of questions asked are important in maximizing participant engagement and interaction in focus groups. Morgan (1996) warns that good focus group questioning takes into account what is important to the researcher as well as what is important to the focus group members and to have a balance of both in order to maintain the group members' interest. A sufficient amount of time must also be provided for each discussion topic and focus group participants will also have the freedom to direct the conversation to a certain degree. For this study, I used an interview guide with 5 questions. The issues to be explored are: 1) participants’ opinions of MT, 2)
what meanings MT has and roles it plays in the lives of residents, and 3) what effect they believe MT may have on residents’ quality of life. The focus group utilized a Focus Group Agenda (See appendix C) and questions were pre-tested in informal conversations with family, friends and companions during observations as a way to better understand what is most likely to generate a meaningful discussion among participants.

Although two focus groups were originally planned, one with staff members and one with family, friends and companions of the residents, only the latter focus group was possible. During recruitment, staff members expressed an unwillingness to come early or stay after their shifts to participate in a focus group due to exhaustion from working long hours and concerns about being stuck in rush hour traffic if they left later. Consequently, in lieu of a staff focus group, staff members were interviewed individually during work hours.

The focus group with family, friends and companions was scheduled approximately halfway through the data collection period. This allowed enough time for the observations to inform the focus group questions and probes. Also, the information gained through the focus group informed subsequent observations that occurred over the second half of the data collection period. In this study, family members, friends and companions who had spend time on the unit on a regular basis over the last three months and who had observed at least one MT session were invited to participate in the study. Eight participants were verbally invited to participate in the focus group when encountered on the unit. Each potential focus group participant was given a Family, Friend and Companion Information and Consent Form (See Appendix B) and was followed-up with at a later time. Those who expressed an interested in participating in the focus group received a reminder phone call the day of the focus group.

The focus group was comprised of three individuals: two family members and one companion. The session lasted approximately 1 hour and with the permission of the participants, was audio recorded. The audio was later transcribed in order to document participant responses for coding and analysis. The focus group was facilitated by a neutral facilitator, due to many of the focus group participants knowing me as a MTA in
the care home. This individual was trained and cautioned to be aware of their potential impact on responses and to limit their participation to the bare minimum. I was present in the room as the second facilitator and observed participants and took field notes, paying special attention to participants’ reactions, interactions, and non-verbal communication. I was also available to raise additional issues, questions and probes as needed and provide clarification when participants had questions.

4.2.3. Formal Interviews

DiCicco-Bloom and Crabtree (2006) describe individual, semi-structured interviews as a common qualitative interview design that allows researchers to explore social and personal matters. These researchers explain that this type of interview is “widely used by health care researchers to co-create meaning with interviewees by reconstructing perceptions of events and experiences related to health and health care delivery” (p. 316).

In this study, staff members and volunteers who had worked on the unit for a minimum of three months in direct contact with the residents and who had observed at least one MT session were invited to be interviewed. These individuals were verbally invited to participate in the interview when encountered on the unit. Each potential participant was given a Staff Information and Consent Form (See Appendix B) and was followed-up with at a later time.

Formal, semi-structured interviews were conducted with two MTAs, two care aides, one recreation assistant, one housekeeper, one volunteer, and one nurse. These interviews ranged between 20-45 minutes in length. Interviews were conducted near the end of the three-month data collection period in order to allow the staff members to reflect upon the experience of being observed for research purposes. I utilized an Interview Guide (See appendix D) with five open-ended questions with additional probes. These questions were designed to “direct the conversation without forcing the interviewee to select pre-established responses” (Lofland et al., p.17). I recorded the interviews using a digital audio recorder and transcribed each interview for subsequent analysis and coding.
For the two MTA interviews, a separate interview guide was utilized (See appendix D). Interview questions focused on the MTA’s observations, beliefs, and opinions on residents’ quality of life and what changes they see before, during and after MT sessions. The therapists’ approach and techniques, and the reasons for the decisions made during sessions were also explored. Lofland et al. (2006) state, “the goal is to elicit from the interviewee rich, detailed materials that can be used in qualitative analysis” (p.17). Interview data provided an additional perspective in the search for the meaning and influence of group MT sessions for people with dementia living in care homes. The MT intern was not interviewed as her internship ended early in the data collection period prior to when interviews were being conducted.

The information gained from the interviews with the two MTAs was especially rich due to the many differences between the two individuals. The therapists differ in age, gender, ethnicity and experience as MTAs. The two individuals play different instruments, use different interventions and have different MT approaches. The opportunity to observe and interview two different MTAs added depth and diversity to the data collected and provided a richer description of MT in the context of a special care unit.

4.2.4. Supplementary Data

Supplementary data was collected through a variety of sources, including: document review, informal conversations, and personal reflections as a MTA. The documents reviewed included the MTA’s progress notes, the participants’ recreation program participation statistics and the participant’s Recreation Therapy Assessment/Treatment Plan. Informal conversations were conducted with staff and the residents’ friends, family and companions. Personal reflections occurred as I was previously working as a MTA with residents with dementia before conducting the research, thus many insights were gained from being in the position of therapist in the past. The data from these sources helped frame and contextualize the data collected through observations, interviews and the focus group.
The analysis of the RCF documents allowed for a broader view of the MT sessions as well as provided a better understanding of the participants in these programs. The MTA’s progress notes allowed me to cross-reference what I observed in the session, as well as provided another perspective of the session. The MTAs did not write progress notes for each resident after each session, but rather when something out of the ordinary occurred, or when a resident’s care conference was approaching. These notes were included in a section of the Recreation Therapy Assessment/Treatment Plan.

The participation records document all of the recreation programs that each resident attended each day. These participation records gave a rough estimate of the participants’ engagement by indicating whether they were actively or passively involved in the program. The records also included whether the participant needed one-on-one assistance, left the program part way through, or fell asleep during the program. These documents were analyzed for participants’ patterns and frequency of participation in all programs and were compared to their participation in MT programs. The analysis of these documents allowed me to identify how often participants attended MT programs, how often they attended other programs and their general level of engagement in all programs.

The Recreation Therapy Assessment/Treatment Plan was an important source of data in this study. This document contains the resident’s date of birth, diagnosis and length of stay, as well as a brief assessment of the resident’s visual acuity, hearing, speech/communication, musculoskeletal limitations, mobility, transfer ability, and emotional and cognitive concerns, including a mini mental status examination (MMSE) score. The MMSE test is designed to give a rough estimate of the cognitive functioning of an individual at the moment of the test, which provides an approximation of the severity of their dementia. The form also covers psychosocial, leisure and lifestyle information, social interaction preferences, past and present leisure interests and skills, personal strengths and barriers, safety issues and a recreation services treatment plan. Due to the comprehensive information contained in the Recreation Therapy Assessment/Treatment Plan, resident charts were not included in this study.
Access to the above mentioned resident documents allowed for a fuller description of the participants involved in the study and were not used as a measurement tool. These documents were accessed with permission from the resident, their families and the RCF. Anonymity was preserved through removing names and other identifying information from the documents. Documents are attached to individuals through a number and are saved on a password-protected computer and backed up on an encrypted removable hard drive.

Informal conversations were another important source of supplementary data in this study. Lofland et al. (2006) describes informal conversations as being “structured by the interviewer’s interests and the flow of conversation” (p.87). Staff and visitors on the unit, including family and friends, were informally interviewed for this study. These discussions occurred at different times as “informal interviewing, involves asking questions in situ, during naturally occurring activities” (p.88). These interviews provided insight into how those who work on, and visit the unit view the MT sessions and the meaning and value that they place upon it.

Personal reflections as a MTA were another source of data. Shortly before the time of data collection and analysis I was working part-time as a MTA at Sunrise Care Home, including facilitating a weekly MT session on Emerald Lane. All impressions, thoughts and feelings were recorded by way of self-reflexive memos. These memos provided additional insight into the effect of MT from the perspective of a MTA.

4.3. Study Participants

The primary participants in the study were residents who had lived on Emerald Lane for at least three months, who had been diagnosed by a physician as having Alzheimer’s disease or a related dementia (e.g. vascular dementia or Lewy body dementia), and who had participated in at least one MT session during the last month. Twenty-three residents met the qualifications and twelve agreed to participate in the study.
Staff members, family, friends and companions who had been working on or visiting the unit for at least three months prior to the onset of observations, were also invited as participants. These individuals were observed less frequently, as they were only included in observations when interacting with residents participating in the study. Focus group participants included family members and a companion who had worked on or visited the care home for at least three months prior to the onset of the study. Interview participants comprised primarily of staff members, including MTAs, care aides, a nurse, a housekeeper and a recreation assistant, as well as one volunteer. These individuals had worked on the unit within the three months prior to the study. This variety in participants provided different types of information and diverse perspectives.

All participants were given the opportunity to opt out of the study at any time, although none chose this option. There was participant attrition as two resident participants passed away during the 3-month observation period. These individuals were not replaced in the study as any new residents who move onto the special care unit would be going through an adjustment period and their behaviour may not be typical of how they react to others and to the MT sessions.

4.4. Data Management

All jottings, field notes, memos, journal entries, as well as focus group and interview audio recordings and transcripts, were created and stored on a password-protected laptop. A copy of the data was stored on an encrypted external hard drive as a backup, which was kept in a locked drawer in my locked home office. All hard copies of data, including informed consent forms, were also stored in the locked drawer. De-identified data was imported for analysis to the computer software program NVivo. All confidential information, including MT session notes and participation documentation, was de-identified before the data left the RCF to protect the anonymity of participants.
4.5. Data Analysis

In order to allow emergent findings to direct/refine the course of the study, data analysis occurred immediately after the first data was collected and continued throughout the data collection phase of the study. As data was collected, it was immediately analyzed for patterns and themes by way of inductive coding. To code data is, as described by Bruscia (2005), “to fix a label or title on each unit of data that best describes or represents the unit” (p.183). Codes can be thought of as category labels, with each category being a meaningful unit of data (Miles & Huberman, 1994). Coding began as open or descriptive coding, then moved to more interpretive codes. These first level codes were eventually grouped into larger categories of concepts, known as second level codes, and finally into themes known as meta-codes (Miles & Huberman, 1994).

The transcripts of the focus group and interviews were coded in the same manner as the observational data. One common problem to be aware of when it comes to the analysis of focus group data that Morgan (1995) describes is “the confusion between the individual and the group as a unit of analysis” and that group dynamics affect what is said within a group. Morgan (1995) suggests that instead of counting individual or group responses to a question, take note of the amount of interest in the topic and the level of agreement both within and between groups.

Several issues were taken into account in data analysis. As recommended by Wheeler and Kenny (2005), I was mindful of “treating each case as unique, employing inductive analysis and creative synthesis, taking a holistic perspective, being sensitive to context, and being mindful of the researcher’s voice and perspective and the need for flexibility in the research” (p.65). These researchers also recommend maintaining a methodological log as a way to assist in the complex decision-making process that accompanies data analysis. A methodological log consists of a journal of all day-to-day thoughts, insights and decisions that are made in the research process.
4.6. Establishing Scientific Rigour

In order to improve the consistency and quality of qualitative research, methodological rigour is crucial (McBrien, 2008). In qualitative research, scientific rigour is established through the following five techniques proposed by Lincoln and Guba (1985): prolonged engagement and persistent observation, peer debriefing, member checking, triangulation and audibility. These five techniques, as well as reflexivity, were utilized in the study to maximize scientific rigour.

4.6.1. Triangulation, Prolonged Engagement and Persistent Observation

Using a combination of data types is called triangulation. Triangulation is important because, as Patton (2015) states, “no single source of information can be trusted to provide a comprehensive perspective” (p. 390). Obtaining different data sources increases validity and allows for the cross-checking of findings. “The strengths of one approach can compensate for the weakness of another approach” (Patton, 2015, p. 390). This study used triangulation by collecting data through observation, interviews, focus groups and supplementary data including informal conversations, document review and personal reflection. The combination of these diverse data sources provided a more comprehensive understanding and completeness to the study.

Patton (2015) explains that observations should be continued and total, in that they should continue for many weeks or months and should be conducted at different times of the day and during different activities. Patton (2015) also states “the major determinant of the length of the fieldwork is the investigator’s own resources, interests, and needs” (p.405). Because this study was part of a master’s thesis there were significant restraints on resources, especially time. The time engaged in fieldwork was relatively short compared with more prolonged ethnographic enquiries. In this study, the fieldwork was limited to three months. During these three months, approximately 15 hours per week consisted of observations. These observations occurred at various times during the day ranging from eight in the morning until eight at night, although the majority of observations occurred in the mornings in order to observe the MT sessions.
4.6.2. Reflexivity

“Reflexivity is focused on making explicit and transparent the effect of the researcher, methodology and tools of data collection on the process of the research and the research findings” (Cruz & Higginbottom, 2013, p.42). Angen (2000, as cited in Johnson & Waterfield, 2004) states that reflexivity recognizes the researcher’s role in shaping the data and their analysis based on their participation in the world being studied. One way in which reflexivity was accomplished in the present study was through in-depth self-reflection. A reflexive journal was maintained throughout the study. I made journal entries after each day of observations, after each focus group and as needed during data analysis.

Self-reflection is important in qualitative research due to its personal nature. Cruz and Higginbottom (2013) explain how personal reflection is especially important in focused ethnography if the researcher is familiar with or has experience working with those being studied. Because of my past position of MTA and current position of researcher in this study, it was imperative for me to be aware of any potential blurring effect of these roles. A conscious attempt was made to bring awareness to my own personal and professional perspectives with regard to all aspects of the study. Self-reflection allowed for awareness of any concerns that surface regarding my perception of the quality of the MT sessions as a MTA, my reactions, thoughts and feelings as a researcher, as well as my personal values and beliefs.

Cruz and Higginbottom (2013) explain, “we are imbued with ideologies, values, and belief systems that are not necessarily salient to our thinking and may be difficult to deconstruct. The aim of reflexivity is to acknowledge this influence in a transparent fashion” (p.42). Wheeler and Kenny (2005) suggest asking oneself the following questions to begin the process of self-inquiry: 1) What are my beliefs regarding ontology, epistemology and axiology? 2) How is my understanding of this study influenced by my position in my profession, country and culture? 3) What are my reasons for conducting a study on this particular topic and how is my professional, personal and cultural perspective reflective in my research questions? 4) What is my rationale for using these research methods and how does this reflect my professional, personal and cultural perspective? 5) What are my expectations for the results of the study and how are they
affected by my personal, professional and cultural biases? 6) How open am I to discovering something that I didn’t expect and how are my personal, professional and cultural biases associated with how I analyze and make sense of the data? 7) How is the write up of this study affected by my perspectives and biases? These questions will be frequently asked throughout the study in order to facilitate the process of self-inquiry.

There are two well-known approaches in dealing with the discoveries made through self-inquiry. The first approach is bracketing, in which the researcher suspends or holds inactive their perspectives or biases in order to decrease their consequence on the study. The second approach, which is typically done in heuristic or hermeneutic studies, is to incorporate the material discovered through self-inquiry into the study (Wheeler & Kenny, 2005). The first approach of bracketing was used in this study as a tool to manage the information uncovered through reflexivity. The reflexive journal is an ideal place to record this information. Putting something in writing is often the first step in achieving a better understanding of it. The reflexive journal provided insight into how my perspective and biases could affect my roles as MTA and researcher and allowed for bracketing of the information discovered.

4.6.3. Peer-Debriefing

Lincoln and Guba (1985) describe peer-debriefing as one of the most effective ways of increasing credibility in qualitative research. Peer-debriefing is a tool that may assist the researcher in detecting biases or subjectivity in the data through exposing the data to a peer who is not involved in the research project in order to engage in an analytic discussion on the topic. This process should assist in uncovering aspects of inquiry that may otherwise remain unacknowledged. Throughout the study, I engaged in unstructured peer-debriefing sessions with MT colleagues, fellow-graduate students, and my supervisory committee members. Insights gained in this process were particularly useful in the data analysis phase of the study.
4.6.4. Member Checking

Lofland et al. (2006) stress the importance of critically assessing the truth and meaning in every piece of data that is collected through naturalistic inquiry. Truth refers to the accuracy and factual representation of the verbal and non-verbal events and actions observed, while meaning “refers to the contextualized understanding of ‘the facts’” (p.90). The meaning of some data may be difficult to pinpoint, as the same event may have various meanings to different participants. This is why it is important for the researcher to engage in member checking in order to ensure that the truth and meaning in data are accurate. Member checking “occurs when participants review collected data or data analysis and confirm or challenge their validity” (Johnson & Waterfield, 2004, p.125).

Two challenges of member checking are that over time people may have a change of opinion or may forget how they felt about the phenomenon under study (Johnson & Waterfield, 2004). These two concerns especially relate to the study in that many participants in the study have dementia, making member checking more difficult due to challenges with memory and cognition. Participants in the MT program were often unable to remember or put into words how a MT program in the past made them feel. Member checking was, however used in the moment to check participant responses in real time. Member checking was used more effectively in the current study with staff, friends, family and companions.

4.6.5. Auditability

This study made use of an audit trail (See Appendix E) to keep track of decisions made and the reasons for making them. Johnson and Waterfield (2004) describe how an audit trail in qualitative research “derives from a fiscal audit that looks for sources of error or deception by examining the way in which accounts are kept” (p.127). This technique, when applied to qualitative research, allows for an impartial auditor to “clearly follow the procedures and decisions taken about the theoretical, methodological and analytical choices used in the chosen study” (McBrien, 2008 p. 1288).
4.7. Ethical Considerations

Any research involving human participants conducted by a student of Simon Fraser University must be reviewed and approved by the Simon Fraser University Research Ethics Board (REB) before the research begins. This study received Delegated Minimum Risk Approval on February 12, 2016 from the Associate Director, Office of Research, on behalf of the Research Ethics Board in accordance with University Policy R20.01. The recruitment and data collection for this study began after the ethics approval. This study did not require ethics approval from a health authority, as Sunrise Care Home is not affiliated with a health authority.

4.7.1. Obtaining Informed Consent

Stelmach, Konnert and Dobson (2001) describe informed consent as having three main requirements: 1) that the client is competent, 2) consent is voluntary and the client has not been coerced, and 3) the client is provided with adequate information. The Tri-Council Policy Statement for Ethical Research Involving Humans (MRC, NSERC, & SSHRC, 1998) states that the researcher must inform research participants of the purpose of the research, the project time-frame, the nature of participation, including all research procedures, all possibilities for harm and as well as any benefits and the voluntary nature of participation in the research.

Informed consent was obtained from the staff that worked on the special care unit, and the family, friends and companions that came to visit. I explained the project in language that was both accessible and comprehensible and all participants were informed of the option to refuse or withdraw from participation at any time. Verbal consent was sought before the study began as well as before each observation throughout the research process.

The Canadian Association for Music Therapy (2002) Code of Ethics describes how additional consent must be sought when working with persons with a diminished capacity, such as cognitive impairment. The code states “the music therapist will carry out informed consent processes with those persons who are legally responsible or appointed to give informed consent on behalf of individuals who are not competent to
consent on their own behalf” (p.8). For this study, as all residents on the special care unit had moderate to severe dementia, they did not have the capacity to provide consent on their own behalf. Instead, consent by proxy was obtained from each resident’s power of attorney. Written informed consent forms that include a description of the study, assurance of confidentiality and the potential risks and benefits to participants were mailed to these individuals.

Because many of the residents participating in the study had communication difficulties, I was sensitive to any non-verbal indications of a desire to discontinue participation in the study. Dissent may be expressed verbally, behaviourally, or emotionally. Verbal dissent includes any statement indicating that the resident does not want to be observed or does not want the researcher present, such as saying “no” or “go away”. Verbal dissent may also include more general statements that indicate that they feel uncomfortable by the researcher’s presence. Emotional dissent may be expressed through residents showing distress or unhappiness in regards to the researcher and/or being observed.

Although I was sensitive to looking for any indications of residents’ desires to discontinue participation in the study, no such indications were observed during the data collection period. Had they occurred, I would have respect the participants wishes by immediately and permanently excluding these individuals from the study and ceasing to record data on their behaviours and interactions. Participants do not need to provide a reason or justification for dissenting and may have discontinued their participation at any time throughout the study. If a resident dissented from participation in the study at any time, all data collected on that participant prior to the point of dissent would have been destroyed. If any residents had become distressed, I would have left the room and not returned until they had been consoled.

4.7.2. Ensuring Confidentiality

Lofland et al. (2006) describe confidentiality as “one of the central obligations that field researchers have with respect to those they study” (p.51). Confidentiality was maintained in this research project by use of pseudonyms instead of participants’ real
names right from the onset of data collection and by not releasing any information that may disclose the identity of participants. All names of people, the special care unit, and the facility was kept confidential using pseudonyms. All jottings, field notes, memos, journal entries, as well as focus group audio recordings and transcripts, was created and stored on a password-protected computer. Audio files were destroyed after transcription. Another copy of the data was stored on an encrypted external hard drive as a backup. All documents and data were identified only by code number and kept on a password protected laptop, and an encrypted USB drive. Cleaned data was imported for analysis to the computer software program NVivo. All confidential information, including MT session notes and participation documentation were de-identified before the data left the RCF to protect the confidentiality of participants. The computer and encrypted USB drive, and any hard copies of documents, are kept in a locked cabinet in a locked office in which only the principal researcher has access.
Chapter 5.

Setting the Scene

This chapter presents descriptions of the special care unit Emerald Lane, the residents living on the unit who participated in the study and the MT sessions that occurred there. These accounts are followed by four case studies of residents who were key participants in the study and who appeared to be particularly influenced by the MT sessions.

5.1. Emerald Lane

Emerald Lane is a 33-bed secured special care unit. This unit is situated in a campus of care facility providing independent senior housing, assisted living and residential care. The unit is located in the residential care section of the building and encompasses one entire floor. The building is 36 years old and did not originally contain a special care unit; hence the space was not specifically designed for residents with dementia.

The physical environment of the unit has an institutional layout and design with long hallways, neutral colours, and a single large dining and recreation space. The dining and recreation room is the centre of life on the unit with many residents spending the majority of their day there. The room is large, poorly lit, and has institutional-looking furniture. There are washrooms on either side of the entrance and a small kitchenette on one side with a sink, dishwasher, microwave and refrigerator. On the other side of the room is a lounge with a television and several armchairs. As you walk further into the room, there are approximately seven square/rectangular tables of varying sizes spread out throughout the space. There is a row of chairs and an acoustic upright piano along
the back wall, which has many windows. Doors on either side of the room lead to a secure patio.

The recreation and dining room is not an ideal space for MT sessions. Many tables and chairs need to be moved to create an area large enough for MT sessions to occur. A care aide explained:

It doesn't seem like this is the best space to have [MT], because we have so many wheelchairs now and that by the time you get your five or six wheelchair and that, then, yeah, it gets really difficult, I think, with all the tables”.

Also, because the space is one large room, everyone in the room is exposed to the MT sessions while they are occurring. This has both positive and negative aspects; it allows residents to engage in the MT session from anywhere in the room, but it is also a challenge, as residents who may become agitated or over-stimulated from the MT need to be removed from the room. There is no other space available for MT sessions to take place on the unit; two care aides suggested the unit be redesigned to create a separate recreation room out of an existing resident bedroom, stating, “Honestly, I think that's about the only thing I could ever see working”. Although reportedly needed, there are no renovations planned for Emerald Lane.

### 5.2. MT Sessions

The MT sessions on Emerald Lane occurred Monday, Tuesday and Wednesday mornings starting between 10:00 and 10:30 and lasting 45 to 60 minutes. On average, six residents (with a range of two and fifteen) were seated within the inner circle of the MT group and were generally active participants in the sessions. Between one and eight residents, with an average of seven, were seated on the outskirts of the MT group or elsewhere in the room and were generally more passively involved in the MT sessions. There were two MTAs who facilitated the sessions who differed in multiple ways.
Jane (pseudonym), the MTA who facilitated the sessions on Mondays was Caucasian, middle-aged, female, and played guitar and sang. She conducted the MT sessions in the small lounge area near the television. Jane started each session with a greeting song played on the guitar and sang individually to each resident. This song incorporated each resident's name and offered a personalized 'hello'. Jane had a different theme for each session, such as ‘spring’, ‘films’, ‘flowers’, ‘countries around the world’, ‘colours’, and so forth. The sessions were primarily song-based, with Jane playing and singing songs that were familiar to the residents and that fit into the theme for the day. When asked about MT interventions, Jane replied that she used “the old music therapy tricks, you know, lining-out (when the MTA leaves out the words at the end of a phrase and cues clients to fill them in), getting them to sing along…. Instrument playing is always really good”. Jane also incorporated dancing by playing a CD in the stereo and inviting each resident to dance, either standing or in their chairs, for a few moments.

Jane also tended to incorporate sensory stimulation, choice, reminiscing and discussion into each session. She noted:

Sometimes I try and incorporate questions that involve either reminiscing or some kind of philosophical... thing in there. And it's interesting, sometimes they surprise you, you know, with an interesting comment about, you know, "Do you ever think there's going to be peace in the world" you know. You ask these really good questions, they come up with these really interesting responses, you know?

Jane offered choice primarily through song and instrument selections and she incorporated sensory stimulation into the sessions by using visuals such as photographs and objects, sometimes to represent different songs. Jane also brought such things like cherry blossoms and other flowers for the residents to touch and smell. The therapist stated, “I like to engage all of their senses”. She had a playful, enthusiastic personality:

I'm fun! I like to have fun with them! You know?.... Yeah. I try-- I'm a hambone. I just ham it up, you know? The hammier the better for them,
especially with visual things, like that stupid hat…. You know. I overemphasize, you know, things. Just to make them laugh.

Bill (pseudonym), the MTA who facilitated the MT sessions on Tuesdays and Wednesdays was young, male, and of Asian descent. He played guitar, violin and sang. Bill conducted the MT sessions in the far right corner of the recreation and dining room, near the door leading out to the patio. His sessions differed from Jane’s in that he did not use an individualized greeting song, themes, instrument playing, dancing, or sensory stimulation into his sessions. Bill often switched between playing guitar and playing the violin throughout the session. He consistently incorporated each resident’s favourite songs into the sessions with residents becoming more engaged when they heard ‘their’ song. Bill played a broad range of styles on the violin, from classical pieces to lively jigs. Bill also used humour and facilitated discussion among residents. When asked about MT interventions, Bill replied that he used “Familiar [music], upbeat [music]” to stimulate and engage residents.

In conclusion, the two MTAs working on Emerald Lane differed in gender, age and background. They also had different musical repertoire, used different interventions and had vastly different styles and personalities. Because of these differences, Jane and Bill attracted different residents to their groups, resulting in a higher number of residents attending MT sessions. Bill explained this benefit, stating: “But at least with two of us, we kind of cover each others backs”.

5.3. The Residents

Twelve residents were observed at Emerald Lane. All residents had a diagnosis of dementia and ranged in age from 72 to 100 years old, with most residents in their 80s and 90s. Of the twelve residents, eleven were female and one male. The residents were varied in their mobility and ability to eat independently. About half the resident participants used wheelchairs and the others ambulated independently or with a walker. Three residents needed assistance at meals, while nine ate independently. Eight residents communicated verbally, while four were non-verbal or mostly non-verbal. Most residents spent their days in the recreation and dining room or in their bedrooms. All
twelve residents rarely left the unit, the exception being a few of the ladies who were occasionally escorted downstairs to the salon to get their hair done.

Yvonne, Doris, Angie, Marge, Betty, Rose, Pat, Olga and Daisy (pseudonyms) all attended MT sessions regularly. Arthur (pseudonym) was usually present in the room during the sessions, but rarely sat within the MT circle, preferring to sit at a nearby table. Loo and Helen (pseudonyms) were seldom in the recreation and dining room. They infrequently attended MT sessions, preferring to spend time in their rooms. Angie, Marge, Betty, Pat and Rose were often active participants and could be seen singing, tapping, clapping, playing instruments and engaging in conversations. Table 2 provides a profile of the observed residents in terms of age, diagnosis and functioning.

**Table 2. Emerald Lane Resident Participants**

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Age</th>
<th>Diagnosis</th>
<th>Length of Stay</th>
<th>Mobility &amp; Eating</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yvonne</td>
<td>90</td>
<td>Dementia</td>
<td>6.5 years</td>
<td>Wheelchair &amp; assistance eating</td>
<td>Verbal</td>
</tr>
<tr>
<td>Doris</td>
<td>95</td>
<td>Dementia</td>
<td>2 years</td>
<td>Wheelchair</td>
<td>Verbal</td>
</tr>
<tr>
<td>Angie</td>
<td>83</td>
<td>Dementia (Alzheimer's Type)</td>
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5.4. Case Studies

5.4.1. Rose

Rose is a petite, 91-year-old woman with a diagnosis of dementia, hypothyroidism, hypertension and osteoporosis. She has lived at Sunrise Care Home for 14 years, initially living on one of the care floors, and then transferring to Emerald Lane a few years back when her behaviour became problematic. Rose is severely disoriented and confused and has both short and long-term memory loss, although no Mini Mental State Exam (MMSE) score was available in her Recreation Therapy Assessment/Treatment Plan. Rose has a son who visits occasionally, but otherwise does not have any other visitors. Little is known about Rose’s background, as no social history is available in her chart. Staff members have discovered, perhaps through Rose’s son, that she used to be a piano teacher. Rose often wanders throughout Emerald Lane, pushing her walker. Due to perceptual problems, Rose frequently pushes her walker into the furniture as well as staff members and other residents. She is verbal and engages in conversations with others, but the content is often jumbled or related to events from the distant past. Rose enjoys being around people and attends all of the programs offered on Emerald Lane; as her attention and focus are limited, she needs cueing to participate.

Rose loves music and can often be heard singing her favourite song, *Let Me Call You Sweetheart*. Rose often beat rhythms on the tables or clapped her hands rhythmically throughout the day. This behaviour appeared to both stimulate and soothe Rose, although it often had negative repercussions as it bothered staff members and other residents. The following observation field note demonstrates this:

Rose is sitting alone at the small table near the lounge and loudly bangs her mug of soup against the table rhythmically. Another resident yells, “Stop it!” and Rose asks “Pardon?” and stops banging for a few minutes and then starts up again. A care aide approaches Rose and says, “Hey, Rose! Stop” but Rose continues banging. Another resident angrily approaches Rose and wrestles the mug out of Rose’s hand then walks away. The resident returns a moment later and angrily shakes her fist at
Rose. The resident then grabs Rose’s hand and tries to hit it against her head.

Outside of MT and other activities, Rose often appears restless, anxious and bored. Rose wanders aimlessly around the unit pushing her walker. The following excerpts demonstrate this:

Rose continues walking around the room and is now walking through the lounge area. Rose says, “I can't... do anything... everything is too small, too messy”. No one appears to notice her. Rose continues, “Why can't she give me one of those?”

Rose enters the room, pushing her walker, appearing to aimlessly wander throughout the space. Rose asks no one in particular, “Where can I go?” No one appears to notice her and no one answers her question. Rose continues walking throughout the room. Rose eventually does a big circle and leaves the room.

When not wandering, Rose would sit at a table in the lounge and go back and forth between resting her head on the table and looking around the room. Rose’s facial expression was often a grimace, appearing as if she was in pain. The following excerpt illustrates Rose’s anguish while sitting at a table in the recreation and dining room:

Rose is quietly talking to herself saying, “It hurts, it hurts so much… terribly sore, all over. I don’t know what to do about it.” A few minutes later Rose says, “Please help me”, sounding exasperated. A care aide is within earshot but she does not say anything or approach Rose.

Rose sometimes became agitated and verbally aggressive towards staff and residents. The following excerpts are examples of this behaviour: “Rose says to a resident who has wheeled up beside her, ‘If you do that again I’m going to smack you in the face!’”
A resident approaches Rose, who is sitting at the small table in the kitchenette. Rose yells, “Who told you that you could do that? Who was it?” The resident does not reply, appearing not to understand. Rose says, “Go on, I don’t want you around here. Go back and do it again.” The care aide hears and says, “Rose! That’s not nice.” Rose ignores the care aide and says to the resident, “Are you afraid to get out of my way?” The resident looks at Rose but does not react to what she says, appearing not to understand.

Rose is now banging her spoon against the table. The higher functioning resident walks up to Rose and quickly takes her spoon away. Rose shouts, “Bring it back! Bring it back! And don’t be so damn stupid!” The ‘higher functioning’ resident says, “Nope” and walks away. Rose angrily claps rhythms on her hands.

Rose was a different person while she was participating in the MT sessions. The rhythmic tapping and clapping behaviours that disturbed others outside of MT were appropriate and appreciated by others during the sessions. Because of Rose’s musical talent, she was often given the opportunity to shine during the MT. The MTAs offered Rose opportunities to make song choices, sing and play instruments. This is demonstrated in the following excerpts from the field notes:

Jane plays the guitar and sings and Rose plays the xylophone. Rose plays very well, playing melody notes and keeping to the rhythm of the song. Jane invites Rose to play a solo, saying, “Rose, take it away!” Rose plays a beautiful solo on the xylophone and also hits the wooden parts on the ends. Jane shouts, “Yeah Rose! Give it up for Rose!” and several residents and companions applaud loudly. As the song ends Jane says, “Brava! Did you enjoy that? Rose replies, “I did!” Jane exclaims, “She says it’s fun people!” then asks who wants to play the xylophone next.

Jane describes the instruments that she brought today: the bell tree and a xylophone. Rose repeats the name of the Bell Tree several times; saying “Isn’t that wonderful!” Jane places the bell tree on Rose’s walker and
demonstrates how to play it with the mallet. Jane then gives Rose the mallet and invites her to play. Rose hits the bells, as well as the wooden frame of the instrument. Jane says, “Oh, you’re hitting the wood! Outside of the box there.” She asks Rose how it made her feel to play the bells. Rose says, “Oh, it’s nice!”

The act of playing instruments was a very positive experience for Rose. First, this was a familiar activity, as she used to play the piano. This likely brought back positive memories of performing or playing the piano with friends. Second, playing instruments is something that Rose could be successful at. This success likely provided her with a feeling of accomplishment, which could be a rare feeling for someone with dementia living on a care unit. The instruments that Jane used during the sessions were simple, allowing for successful experiences. Jane increased the success rate of the xylophone by removing some of the wooden blocks for the notes that were outside of the key of the song they were playing. This adaptation allowed for almost any note played to ‘sound good’. Third, being featured on instruments provided Rose with praise from others in the form of applause and compliments. This approval and positive social interaction with peers likely provided Rose with a boost to her self-esteem.

Similarly, the act of singing was also very positive for Rose. Rose knew all of the words to most songs and would sing along even when others were not singing. The joy Rose gained from singing was evident in her body language and facial expression during MT sessions. A companion explained: “Rose, she sings to every single song she knows pretty much”. The following excerpt from the field notes demonstrates Rose’s expertise with song lyrics: “Rose sings all the words, even though Bill, the MTA, is only playing the melody on violin without singing. Rose also taps the top of her walker. Another resident joins in singing at the end and several residents applaud enthusiastically”.

The MT sessions decreased Rose’s agitation levels, wandering and aggression towards others. Rose consistently sat calmly during MT session, and the pained expression disappeared from her face. No aggressive behaviours were noted in the field notes during the MT sessions or for approximately an hour afterwards. These sessions
provided opportunities for Rose to feel relaxed and interact with others in a positive manner. The happiness and calm that the MT sessions brought Rose often lasted well after the session was over. A companion explained: "Rose continues to sing now all the time! She's beating her rhythm on the... on the table pretty much all the time now". The recreation assistant explained how beneficial the MT is for Rose: "Ok, yeah, Rose. And there's a few who just, they need to be at the music".

5.4.2. Marge

Marge is a 93-year-old woman who has lived on Emerald Lane for the past nine years. She has diagnoses of Dementia, Parkinson’s disease and Anxiety Disorder. Marge’s MMSE score is 10/30 indicating disorientation, severe confusion and short and long-term memory impairment. Marge also has moderate visual impairment and mild hearing loss. Marge communicates verbally in a high-pitched, shaky voice. She mobilizes independently with a walker and frequently wanders throughout the unit. A note in Marge’s Recreation Therapy Assessment/Treatment Plan states that she is sometimes verbally and physically aggressive, although no physical aggression was observed during the observations.

Marge’s anxiety level fluctuated greatly and appeared to always be present at some level. The following field note displays what might be considered Marge’s ‘baseline’: “Marge is sitting quietly and still in the chair resting her head on her hands, looking slightly distressed. Her face is scrunched up as if in pain”. Occasionally, her anxiety escalated and she exhibited agitated behaviours, such as calling out and repetitive movements. A note in the Recreation Therapy Assessment/Treatment Plan advised: “During the periods of time when her anxiety disorder is at the point where she is too stressed to concentrate, or even sit still, it is more suitable to minimize the stimulus around her and provide her with a calm, quiet environment.” The following excerpt from the field notes shows Marge experiencing increased anxiety: “Marge stands up abruptly and starts walking around the room. Doris walks in front of Marge, unintentionally cutting her off. Marge cries, ‘God! I can’t go anywhere!!!’ in a shrill and panicked voice. Marge appears distressed and changes directions”. 
The MT sessions appeared to decrease Marge’s anxiety. On one occasion, Marge was agitated and declined to attend the MT sessions when invited by Bill. Marge stayed in the room and listened to the music from afar, appearing to settle as the session progressed and eventually joining the group. This was recorded in the field notes: “Marge walks over and sits down to the side of the MT group and rests her face in her hands.... Marge closes her eyes, and appears to relax”.

Marge is a social woman and enjoys being around people. She spends most of her time in the recreation and dining room and can often be seen sitting with other residents at the tables. Marge has a nephew who occasionally visits and a paid companion that spends time with her each Saturday. No social history is available in her chart to indicate Marge’s past occupation, interests or hobbies. Marge attends all the recreation programs offered on Emerald Lane and is often an active participant.

Marge is usually also an active participant in the MT sessions. Throughout the observations Marge was documented playing a variety of rhythm instruments, including maracas, tambourines, bells and shakers. Marge even played solos when encouraged by Jane. The following field notes show Marge’s engagement in instrument playing: “Marge enthusiastically plays her tambourine, stops partway through the song, then starts playing again”.

Jane invites the people with the bells to play. Marge and another resident shake their bells vigorously. ‘Let’s hear it, Marge!’ Jane says, inviting Marge to play a solo. Marge plays her bells loud and strong.

Jane brings the instrument in front of Marge. Marge holds the mallet independently and plays the instrument beautifully and gently. She appears very focused as she plays.... Marge pauses then continues playing the instrument, more rhythmically this time. Jane stands nearby, watching and smiling. A resident applauds as Marge stops playing. Jane asks, “What did you think of that?” Marge replies, “It’s very unique, very unique!”

Singing, dancing, and engaging in conversations were other ways Marge participated in the MT sessions. Examples follow: “Jane leans forward towards Marge
and says, ‘Come on Marge!’ and they sing the last line together, Marge singing quiet and slow,”

Jane invites Marge to dance. She stands up slowly, saying, “It’s hard to stand”. Jane says, "It’s ok, I’ll hold you up. We’ll hold each other up”. The two hold hands and move their arms up and down to the beat of the music. Marge is smiling broadly.

Marge also enjoyed attending the other activities that took place on Emerald Lane. She was a regular participant in the exercise programs, facilitated by a recreation therapist. Marge was very engaged during exercises, especially during the ‘balloon toss’ activity where residents hit a balloon back and forth around the circle with metal racquets. An example from the field notes: “Marge is very alert. She hits the balloon with her racquet and watches as it moves around the circle”.

Like many residents living on Emerald Lane, Marge’s engagement levels were quite different during MT and recreation sessions compared to when no activities were taking place. Marge seldom engaged in self-directed activities, such as reading magazines or watching television. When no activities were taking place, Marge either sat at a table and looked around the room anxiously or wandered throughout the unit pushing her walker. An example of this behaviour:

Marge slowly stands up, grabs onto her walker and starts walking. Marge walks forwards toward the windows, then loops back to the table and sits down in the same seat. Marge stands up again a moment later, appearing restless. Marge walks in the other direction, turns around and walks back to the same chair and sits down.

Marge also sometimes wandered during the MT sessions, especially between songs. The MTAs would try to regain Marge’s attention if she stood up to leave during a session. If Marge wandered out of the MT group, the therapists invited Marge back into the group once she had walked around the room. These behaviours are demonstrated in the following field notes: “Marge stands up as the song ends and watches the Jane
intently. Marge begins walking throughout the room, and then sits down at a table closer to the MT group as the next song begins”

Marge slowly stands up and grabs her walker…. Jane, who is approaching the end of the song, walks towards Marge and plays the ending louder and more dramatically, grabbing Marge’s attention. Marge sits back down but continues holding her walker.

Marge stands up and walks out of the group. A moment later Marge walks back towards the lounge and Jane walks over and asks, “Do you want to come back and join the music?” Marge slowly walks back over and Jane pulls out a chair and says, “Here you go Marge, saved your seat for you here”. Marge walks over to the chair and slowly sits down in it.

In summary, the MT sessions on Emerald Lane provided Marge with opportunities for social interaction and active engagement in meaningful activities. The sessions provided Marge with an escape from her endless wandering and perhaps some relief from anxiety by giving her something positive to focus her attention on.

5.4.3. Betty

The notes in the Recreation Therapy Assessment/Treatment Plan describe Betty as “a neatly dressed, well groomed older lady, who looks much younger than her years”. Betty is 90 years old and has been living on Emerald Lane over the past seven years. She has diagnoses of Dementia and Hypertension and has mild visual impairment and mild hearing loss causing her to have trouble hearing in loud settings. Betty is disoriented and severely confused with both short- and long-term memory loss, although no MMSE score is available in her Recreation Therapy Assessment/Treatment Plan.

Betty is a friendly and pleasant lady who ambulates independently in her wheelchair by propelling herself with her feet. She is often awake and “up and about” throughout the day, either wheeling around the unit or sitting in the dining room. An example from the field notes of Betty’s regular behaviour:
Betty slowly propels her wheelchair away from the table and across the room. Betty passes Rose’s table and goes to the door leading to the patio and looks through the window. Betty reaches up and touches the push bar on the door, trying to turn it as if it was a door handle. Betty cannot open the door and leans forward to look through the window again. Betty looks around the room, and then slowly turns around and wheels forward. Betty passes Arthur and silently picks up the newspaper on his table and looks at the cover for several moments without opening it. She then continues propelling around the room, the newspaper on her lap.

The *Recreation Therapy Assessment/Treatment Plan* states, “She willingly attends most recreation programs but needs considerable assistance, guidance and direction. She is a participant in the social programs and enjoys conversing, but her ability to communicate is hindered due to her aphasia. [Betty] is alert and engaged”. In the document, Betty’s past interests are listed as knitting, sewing, gardening, local travel, visiting friends and family and listening to music. It states that she also was into sports and enjoyed baseball, basketball and skating when she was younger.

Betty is a very social woman. Although she receives regular visits from her son and a paid companion, Betty appears to desire more social interaction on a day-to-day basis. She can often be seen trying to interact socially with those around her by vocalizing conversationally and attempting to make eye contact with others. Betty also reaches towards staff and other residents as they walk by. These attempts at social interaction are often unsuccessful as residents are often unaware of Betty trying to interact, uninterested or unable to engage socially. The following field note illustrates Betty’s attempt at socializing with residents seated at the same table:

Betty is sitting at a table with Olga and another resident who is looking a magazine…. Betty looks at the resident, then picks up her spoon, which has a little bit of egg on it, and places it close to the resident’s magazine, appearing as if she is trying to get the resident’s attention. The resident glances at the spoon and does not say anything. The resident then picks up the magazine and continues looking at it, ignoring Betty. Betty then points
at the juice cup and mug that are in front of Olga and Olga quickly swats her hand away. Olga scowls at Betty and moves the cup and mug farther away from her without saying anything. Olga has a stern expression on her face.

Staff members are often too busy to stop and socialize and ignore Betty when she reaches towards them.

The MT sessions and recreation activities that occur on the unit provide opportunities for Betty to engage socially with the therapist as well as other residents. Two examples from the field notes: "Betty watches Bill and reaches towards the resident on her left, smiling. The two residents hold hands throughout the rest of the session" and "Betty looks over at Marge in a friendly manner and smiles. Marge smiles back". An example of Betty socializing outside of MT sessions is during a Pet Therapy visit: “The volunteer approaches Betty and says, ‘Hi! There’s a dog here to see you’ Betty looks at the dog, vocalizes, and pets him, appearing very animated”.

Betty appears to greatly enjoy the MT sessions on Emerald Lane. Betty shows her enjoyment through smiling, vocalizing, laughing and applauding. Three examples from the field notes follow: “Several residents applaud at the end of the song, including Betty, who continues applauding enthusiastically for a moment after everyone else has stopped”

Betty appears to enjoy the ‘tra-la-la’ part in the chorus, leaning her head back and laughing deeply and smiling... Betty makes eye contact with Bill and smiles and laughs again, appearing to enjoy herself immensely.

And, “The song ends and several residents applaud. Jane collects the instruments and asks Betty, ‘Did you have fun?’ and Betty vocalizes affirmatively”. Betty’s amusement during the MT sessions appears to put her in a good mood that lasts after the MT sessions are over.

Betty’s participation in the MT sessions ranged from passive to active depending on the day. When actively participating, she clapped and moved to the beat, danced with
the therapist and vocalized conversationally. Three examples from the field notes: “Betty smiles and laughs as she dances with Jane while sitting in her wheelchair”, “Betty claps her hands to the beat as Jane picks up the tempo and does an instrumental interlude…. The song ends with a loud ‘hey!’ and many residents applaud” and “Betty moves her hand to the music, as if conducting. Betty then looks over to the resident sitting beside her and raises her eyebrows, as if saying, ‘Look at this!'” On days when Betty was more of a passive participant she was still very alert and could be seen following the MTA with her gaze and smiling. Examples of Betty’s passive participation in the MT sessions follow: “Betty is sitting quietly in the outer circle watching attentively but not singing or moving to the music”, “Betty watches Bill intently and smiles at him as he sings”.

The MTA leading the session appears to affect Betty’s involvement in the session. Betty appeared to really like Bill. Betty and Bill have a therapeutic relationship that appears to promote active participation in Betty as she is more engaged and involved in his sessions compared to those facilitated by Jane. The reason for the stronger relationship with Bill may be due to him being a man, as care aides have mentioned that Betty generally likes men. The following excerpt from the field notes illustrates this relationship:

Betty is very alert, watching Bill with a large smile on her face and gently clapping her hands to the music. Betty vocalizes and makes eye contact with Bill and points towards the window. Bill says, “Beautiful!” and continues singing. Betty vocalizes, laughs, and applauds as the song ends. Betty vocalizes again, this time with the inflection of a question and Bill chats with her as if he knew what she had asked him. The two interact socially in this manner for several moments.

Betty has an excellent sense of humour that came out during the MT sessions. She could often be seen laughing during the sessions and sometimes joked around and poked fun at the MTAs. Two examples:

Bill trades the guitar for the violin and introduces an Irish Dance Tune. Betty laughs comically, as if making fun of the Bill’s choice of song....
The companion is singing along to the song. Betty watches her, and then vocalizes to the music in a silly manner. The companion notices and asks Bill if he thinks Betty is singing along sincerely or making fun of her singing. Betty laughs and the therapist says that he thinks Betty is making fun of her. Bill, Betty and the companion laugh together.

This case study is an example of how MT and other activities provided one resident with opportunities for social interaction, enjoyment, and participation in activities that are meaningful to her. The case study also demonstrated the benefit of having two MTAs facilitating sessions on Emerald Lane, as a special relationship with Bill encouraged playfulness and active participation in Betty during the MT sessions.

5.4.4. Angie

Angie is 83 years old and has lived on Emerald Lane for four years. Angie has diagnoses of Hypertension and Dementia of the Alzheimer’s Type. Angie is severely confused and has both short and long-term memory loss. An MMSE score is not available in her Recreation Therapy Assessment/Treatment Plan. She is physically strong and ambulates independently although she has gait problems and limited balance. Angie is mostly non-verbal, but does respond verbally to simple yes/no questions. When Angie speaks, her words are garbled and difficult to understand.

Angie has strong social support and regular visits from her son, two daughters, and a friend. Angie also receives visits from a paid companion who spends several days a week with her. Angie’s Recreation Therapy Assessment and Treatment Plan stated that she “enjoys arts and crafts, active games, exercise, music therapy, art therapy, dogs, [and] gardening”. The plan also specified that she enjoyed “art, painting, small dogs, church, volunteering, music, opera, [and] socializing” in the past. Angie’s love of dogs is evident in her habit of carrying one or two dog teddies with her everywhere she goes. Angie can often be seen stroking and lovingly gazing at her dog teddies.

Angie’s mood fluctuates throughout the day. When she is in a bad mood she can be quite irritable. The following excerpt from the field notes demonstrates Angie’s behaviour while in a bad mood:
Angie finishes eating and the companion asks, “Can I take it off?” indicating her clothing protector. Angie indicates no and the companion leaves the clothing protector on. Angie appears to be in a bad mood today. The companion tries to cheer Angie up by chatting with her about her puppy teddies. Angie does not answer and has an annoyed expression on her face.

There are certain residents that Angie does not get along with, and she can become aggressive towards these residents if they get too near. Angie’s companion explained: “Angie definitely has few people who she doesn’t like and there’s nothing that will ever change that I think”. Examples from the field notes follow: “Angie stands up and a resident behind her accidentally runs into her with her wheelchair. Angie says, in an angry tone, ‘Don’t do that!’ and pushes the lady in her wheelchair away from her”.

Angie is sitting still in her chair until another resident wheels up to her. Angie pushes the other resident away, but she wheels back over. Angie looks annoyed and is staring at the other resident and softly muttering, with a stern expression on her face.

Angie is walking throughout the room angrily pushing another resident in a wheelchair, moving forward in a jerky motion. She lets go of the resident’s chair and walks back to the table. Angie holds her teddy briefly and then puts in on the table. Angie walks towards the table where Olga is sitting and stands behind a vacant chair and mumbles to another resident sitting at the table. The resident says, “She went over there!” pointing towards the kitchen. Angie mumbles incoherently and walks towards the kitchen. Angie stands for several seconds near Pat, looking at her with her hands on her hips. Pat is looking down at the table, oblivious to Angie. Angie mumbles angrily then walks quickly up to the lady in the wheelchair who she was pushing earlier, and shoves her wheelchair violently, then reaches back to hit the resident. A care aide runs over and moves the resident in the wheelchair away saying, “We don’t hit here!” Angie mumbles something that sounds like “I do” and appears quite upset.
MT often improved Angie's mood and decreased challenging behaviour. No aggression was witnessed in the field observations during MT sessions and Angie’s facial expression and body language often appeared to relax. One MTA explained:

Angie used to, not do very well in the mornings. [MT] definitely helped. ...And just like, gentle music that she knew, kind of started to soothe her just a little bit. And a little bit more, get a little bit faster and you'd see a little bit of smiles. ...it's definitely benefited a lot... And she trusts me. Whereas she didn't trust a lot of the other people (laughter)"

Angie’s companion described the change in mood during MT sessions:

Yes, definitely Angie is one of those [whose mood improves with MT].... Sometimes, her moods can change very, very quickly and I usually see it coming! And she can get really aggressive sometimes, especially if... you get her to do something she doesn't want to do. But with music, every single time, afterwards she feels better. She might not want to do something afterwards, but her mood generally improves. That's pretty much, I would say, every single time it improves.

Angie’s change in mood appeared to continue after the MT sessions finished. One care aide noticed: “I do see a difference in Angie after music therapy.... A lot, ah, happier, hey?... You can see it on her face actually, she’s just... smiling more, that kind of thing”. The companions explained how sometimes MT motivated Angie to do other activities, such as exercises, puzzles or art:

"For Angie depends on the days, there have been days where before music she wasn't interested in doing anything and afterwards she would be, but then there are other days when afterwards she just ‘no, I'm staying here and I don't want to do anything' "

The enjoyment that Angie experiences in the MT session was evident from her behaviour. During the MT sessions Angie was often smiling and laughing. Angie moved her teddy to the beat of the music as if the teddy was dancing. Angie often tapped her
foot to the beat and mouthed the words to the songs. Occasionally, Angie sang along if it was a song she knew well. The following excerpt shows Angie’s pleasure: "Angie closes her eyes and moves to the music, appearing to greatly enjoy the song. Angie opens her eyes and smiles broadly at Jane as the song ends".

Bill described how Angie’s agitation levels have decreased, due to what he believes to be a team effort between different disciplines, including MT:

Angie used to be really agitated. Like she used to cry a lot, right? And it would, I would like to think, maybe it’s a collective team effort, medication changes.... Lots of meeting with doctors, and rec therapy, and a little bit of me. Maybe (coughing) just, you know, mood-wise she's, she's so much better... She's definitely improved.

In conclusion, the MT sessions on Emerald Lane influenced Angie in many ways, most notably by improving her mood and reducing aggressive behaviour. These changes affected the staff on the unit as it made working with Angie easier. Angie’s enhanced mood also improved life for those residents who Angie did not get along with, as she was less likely to show aggressive behaviour towards them after MT.

The four case studies described above illustrate the diversity in residents on Emerald Lane and the flexibility of group MT to suit the needs of multiple residents at once. Rose, Marge, Betty and Angie each have distinct abilities and challenges and received different benefits from the group MT sessions. MT reduced wandering behaviour in Rose and Marge and helped Rose and Angie get along with other residents. Marge experienced decreased anxiety while Betty found opportunities to connect socially with others. All four residents experienced an increase in positive mood during and following the MT sessions.
Chapter 6.

Findings

The findings were derived primarily from the field notes taken during the 172 hours of observation on the unit, the focus group with family members and a companion and the individual, one-time interviews with a nurse, three care aides, a housekeeper, a volunteer, a recreation assistant and two MTAs. The recreation participation statistics and the Recreation Therapy Assessment/Treatment Plan forms helped to further articulate residents’ background information and participation in recreation activities and MT sessions.

All field observations, interviews and focus group data were analyzed by myself and managed within NVivo, a qualitative data analysis software. Inductive coding was used to analyse the data for patterns and themes. Coding began as descriptive, then moved to more interpretive codes and finally larger categories emerged containing two or three themes each. The process of peer-debriefing helped develop and refine the themes in each category and the meaning of data was verified through engaging in member checking with those who know the residents best, primarily family members and the companion.

6.1. Categories and Themes

<table>
<thead>
<tr>
<th>Categories</th>
<th>Definition</th>
<th>Themes</th>
<th>Definition</th>
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<tbody>
<tr>
<td>Engagement</td>
<td>Level of interest and attention in surrounding environment and activities</td>
<td>Idle Time</td>
<td>Time spent waiting or sleeping, not engaged in surroundings or activities</td>
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<td></td>
<td>Drawn In</td>
<td>Being engrossed in MT sessions, recreation activities and/or self-directed activities</td>
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### Table 1: Themes and Definitions

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<thead>
<tr>
<th>Category</th>
<th>Definition</th>
<th>Example</th>
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<tr>
<td><strong>Autonomy</strong></td>
<td>Opportunity for self-determination and choice in decision-making</td>
<td>Left Out: Lack of freedom to make decisions and dependence on staff</td>
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<td></td>
<td>Simple Choices: Choices offered through activities (i.e., participation level, where to sit, song choices, instrument choices)</td>
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<td><strong>Social Interaction</strong></td>
<td>The interplay between two or more individuals through eye contact, vocalizations and/or touch</td>
<td>Endless Silence: Being alone while surrounded by people. Not having social exchanges with others</td>
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<td>Staff Disdain: Lack of respect and consideration by staff in interactions with residents</td>
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<td>Side by Side: Making social connections with others through shared experiences, communication, touch, and being together</td>
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<tr>
<td><strong>Well-being</strong></td>
<td>Psychological status that causes positive or challenging mood and/or behaviours</td>
<td>Something’s Not Right: Feelings of poor mood, confusion and anxiety resulting in calling out, wandering, aggression and/or repetitive movements</td>
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<tr>
<td></td>
<td></td>
<td>Soothing Scene: Distraction from worries, improved mood and reduced anxiety through positive experiences</td>
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### 6.1.1 Engagement

The category of Engagement focuses on residents’ interest in their surroundings and their level of attention, concern, curiosity and absorption in self-directed and planned activities. Some of the ways residents show engagement is through being alert, having their eyes open, making eye contact with others and showing attentive body language. Engagement is also demonstrated through active participation in activities. In the case of MT, engagement was demonstrated through singing, clapping, tapping, moving to the music or engaging in verbal exchanges with others. The first theme, *Idle Time*, demonstrates the general lack of engagement in residents on Emerald Lane. The second theme, *Drawn In*, shows an increase in engagement levels during MT sessions, recreation activities and self-directed activities.

**Idle Time**

Many residents on the special care unit spend their entire day sitting in the large dining and recreation room. The room is often completely still and silent, other than the occasional sound of housekeepers or care aides performing various tasks. One care aide described the lack of action: “It’s quiet in here… I wish there was more going on”.

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Similarly, Bill stated: "...if I'm not here, it's just so quiet, right?" With many residents simply sitting in the room but not doing anything, there is a sense that they are waiting for something to happen. The residents appear to be “killing time” rather than engaging in their surroundings or self-directed activities.

Perhaps because of memory loss and cognitive impairment due to dementia, the residents of Emerald Lane may not realize how long they have been waiting for something to happen: this lack of awareness of time may allow residents to wait for extended periods without complaining. This situation could result in less effort being made by management to provide activities for residents of Emerald Lane, even though these residents may be in need of these activities more than those living in other areas in the care home who are more able to engage in self-directed activities.

In general, there were infrequent planned activities on the unit to engage, stimulate or entertain residents. Although there were one or two activities, including MT, marked on the calendar each day, many of the non-MT activities did not happen due to staff being unavailable. The lack of planned activities on the unit allowed for many unstructured hours each day where residents sat idle, still and silent. One MTA described the consequence of the lack of activity: “If there's nothing going on, it's always so…. I hate to use the word, but just, it feels so dead, you know? It's just, everybody's so flat and so quiet”.

Family, friends, companions and volunteers noticed the lack of activities taking place on Emerald Lane. One volunteer commented: “I see something not being able to happen... a program can't go on because someone has to be pulled to go over there”. A companion noticed: “There used to be a lot more going on but now music therapy is all they have.... It used to be a lot better. There used to be games.” Similarly, a family member stated: “You know, activities or entertainment, woefully lacking.... Woefully lacking. Because I know about other facilities [where more activities take place]”. One companion even took matters into her own hands and occasionally gathered residents together to toss around a balloon. The companion did this even though she was not getting paid for facilitating this activity.
Nurses and care aides made small efforts to entertain and engage residents. Staff members sometimes put on a film and arranged residents in front of the television. Often, the film did not hold the residents' focus, with most residents falling asleep or staring straight ahead. Staff members also placed reading material, such as picture books, newspapers and magazines on the tables. Some residents, such as Angie and Arthur, flipped through the reading material throughout the day. A family member described a typical day on the unit, "They'll just sit in one spot. Sometimes if they'll give them newspaper or magazines, they might leaf through that, but for the most part, some of them will just stare in one spot the whole day if nothing happens". Many residents who live on Emerald Lane spent their days sitting still and silent, rarely moving. Residents sat slumped over in their chairs, head drooped forward chin-to-chest, with their eyes closed. A few residents continuously drifted between sleep and wakefulness throughout the day. Those who were awake often had blank, bored expressions on their faces, their eyes staring across the room or at a wall in front of them.

Other residents were alert and constantly fidgeting, appearing agitated. One volunteer, who spends a lot of time on the unit, pointed out, "You know, there's not a lot of stimulation." For example, Olga gazed around the room continuously, as if waiting for something to happen or trying to find something to entertain her. Olga also tapped her toes, rubbed her hands together, and straightened her clothing protector over and over again, an irritated expression on her face. Rose, on the other hand, went back and forth between resting her head on the table, and sitting up and looking around the room.

Meals are important events on Emerald Lane. Residents spent a large portion of their day waiting for meals. Many residents put their clothing protectors on hours ahead of time and sat quietly at the tables, waiting. This was likely due to lack of activities and environmental cues for positive stimulation, which created a strong atmosphere of boredom and apathy. Some residents, like Arthur, were only engaged at meal times. Arthur was often reclined in his chair, drifting in and out of sleep for most of the day. When a meal was served, Arthur was engaged and quickly ate his food. When Arthur finished eating, he returned to sleeping or staring straight ahead.
Although the MT sessions that took place on Emerald Lane generally increased engagement levels, this did not occur in all residents. Arthur, for example, often sat at a table near the MT sessions, but rarely appeared engaged in the music. Arthur could be seen looking around the room or flipping through a newspaper during the sessions and was not observed actively participating in the sessions through singing, instrument playing or making song choices. Another example is Olga; she preferred to sit farther away from the MTA, usually at a table outside of the immediate area where the sessions took place. Olga sometimes watched the MTA, and sometimes flipped through a magazine or looked elsewhere in the room. Olga’s participation was generally passive, but she was sometimes observed tapping her foot to the beat and applauding after favourite songs.

Energy levels fluctuated greatly on Emerald Lane. On some days, many residents appeared quite tired and despite the MTA’s best efforts, some residents fell asleep during the MT sessions. A family member noticed: “[The MTAs] have, ah, trouble keeping some of them awake…. Many of them doze off, you know?” Another family member states, “[The MTA] tries to, wake ’em up and that. It works sometimes and sometimes it doesn’t”. On these low-energy days, residents are less likely to actively participate through singing and instrument playing, resulting in more passive participation. One resident's companion explained, “Some days nobody will touch [the instruments]…. It’s just like, ‘nope, not doing that today’”.

**Drawn In**

The MT sessions and recreation activities that occurred on Emerald Lane appeared to have a significant impact on residents’ engagement levels. The sessions also seemed to positively affect the general milieu of the unit as well as the morale of the staff members and family, friends and companions who spent time on the unit. The impact of the MT sessions was likely amplified by the fact there was very little going on in the way of recreation programs. One family member explained:

> Without [MT] they're just, just sitting there. Nothing. It doesn't seem to be--
> It's really sad that that floor can really get to you if there is nothing going on.
> And most of the time there is nothing going on. So music therapy's that one
bright spot in the day when they're involved in some--. On some level at least, in something.

A companion who spends a lot of time on the unit described an interaction that she had with a resident:

Well, the new lady, she told me, 'It's always boring here'. She just wants to get out of here. And that's because most of the time there is nothing going on, but when there is music therapy she'll come in, not always, but she'll clap along, sometimes tap her foot, I've seen it, and other days she's just like, 'I just want to die'.

Residents expressed engagement in the MT sessions in various ways. On a very basic level, residents tended to be more alert during the sessions and followed the MTA with their gaze. Residents spontaneously responded to the music through singing, vocalizing, or mouthing the words to the songs. A few residents instinctively responded to the rhythm by clapping hands, tapping toes, bobbing heads or swaying to the beat. Engagement was also evident by the residents taking part in conversations with the MTAs, commenting on the music, and applauding at the end of the songs.

MTAs are adept at promoting engagement in their sessions, as they are able to make musical decisions in the moment based upon what is currently happening in the room and who is present in the group. MTAs also individualize the music to the preferences of the residents present. The following excerpt from the field notes shows how Jane used one resident's rhythmic clapping as a jumping off point for a personalized MT intervention.

Jane starts by playing along to the beat that Rose is clapping, then sings and individualizes the welcome song, putting each resident's names into the song. Rose continues clapping along. One resident is vocalizing along to the music. Angie is mouthing the words and watching Jane intently. Marge is smiling and watching Jane. Betty looks over at Marge in a friendly manner and smiles. One resident laughs softly at one funny part in the song.
Residents of all cognitive and physical abilities participated in the MT sessions. A family member commented: "I've never been here and witnessed any of the music programs and not noticed a good thing. I've always noticed something positive." Those who are considered ‘higher functioning’ played rhythm instruments, such as maracas and tambourines, danced (standing up), filled in missing lyrics when the therapist lined out, sang song lyrics, and made song requests unaided. Those with moderate levels of dementia moved their bodies to the music, clapped to the beat, chair-danced, and made simple decisions around song choices when asked by the therapist. Residents with severe dementia followed the MTA with their gaze, smiled, laughed, hand-danced with the therapist’s help, vocalized to the music, and moved their bodies to the beat.

Engagement in the MT session allowed residents to focus their attention on a task, and they likely felt a sense of purpose in performing that task. The following excerpt from the field notes shows two residents who were seldom engaged maintain focus while playing an instrument in the MT session:

Doris appears very focused and plays the tree chime slowly and purposely, appearing to enjoy playing the instrument... Jane brings the instrument in front of Marge, who holds the mallet independently and plays the instrument beautifully and gently. Marge appears very focused as she plays.

The scene depicted above is in sharp contrast to the residents’ engagement levels outside of MT, as Doris is often slumped forward in her wheelchair sleeping and Marge is often agitated and pacing the room.

Enjoyment appears to go hand-in-hand with engagement in MT sessions. The following two excerpts from the field notes show residents engaged in MT sessions and the resulting pleasure that they take from the experience:

Rose is enthusiastically playing the tambourine…. Marge is shaking her maraca double time to the beat. Betty begins clapping to the music, a large smile on her face. Several residents applaud at the end of the song; everyone is smiling and laughing.
The resident for whom this song is dedicated vocalizes energetically to the song, ‘Aaaahh babababa!! Yeah!!!’ obviously enjoying the music. Rose is clapping along energetically and singing the words. Betty is watching Bill attentively and looks over to the companion and points at Bill and smiles, then continues watching him. The one resident continues vocalizing until the end of the song, appearing to have a great time, yelling ‘Yeah!!’ as the song ends then saying ‘Thank you’. Bill replies, ‘No, thank you’. Angie is watching and smiling broadly.

MT not only engages residents who sit within the group and participate in the sessions, but it also engages residents sitting elsewhere in the room. Residents do not join the group for various reasons; some residents are not suitable for the group due to over-stimulation or are unable to participate at that time due to schedule conflicts with receiving care or eating breakfast. Residents sitting in the recreation and dining room outside of the MT session may still reap some of the benefits. Engagement from afar is demonstrated in the following excerpts from the field notes: "A resident sitting at a nearby table eating her breakfast moves her toast to beat of the music" and, "A resident seated in the middle of the room bangs on the table in the rhythm of the song".

Although often less noticeable, MT has a powerful influence on those with severe dementia. One care aide explained how she has noticed that those who have lost the ability to speak can often still sing: “See, you can look at so many of them, they don't know how to talk. But when they're singing, live music, they're singing, they're singing with them”. A companion described other ways residents participate in MT, "Well, during [the MT session], many of them will clap along, or tap their foot, or... dance a little bit, as much as they can in their wheelchairs or whatever". MT is something that everyone can participate in regardless of ability, even though the expression might be subtle. A care aide noted, “Because even exercises, they can't follow, but everybody can tap, everybody can hum, or... not even everybody can do that but, I mean you... even if the person can't speak you can [participate in music]". Jane explained, "Oftentimes, especially with lower functioning residents, that music's, music's sometimes the only thing that they respond to". Jane recounted a story of a resident with late stage dementia:
We used to call her the Russian Princess.... She used to sit like this the whole time (hunched forward fingers stiff and in an uncomfortable looking position). But I would invite her to the group.... and often times she'd-- there was no response? ... But then I remember one day, I went and I started dancing with her and I had to actually physically take her hands, and we were dancing together and everything? And then at one point she looked me right in the eye and she went like this (Face lights up with a big, broad smile) ... And was just like, I just about fainted, I was like 'Oh my God!!'... I just had no idea, she was just like, you know, it made my.... year practically!... You know, 'Wow, [this resident] smiled at me!' And if you weren't... somebody who was a music therapist or somebody who is tuned in with this, you'd think, 'What's the big deal?'.... But it was like, ‘Oh my God! This person's actually listening’ and.... you are kind of, reaching them. You might not necessarily be aware that you're reaching them, but.... Something's getting in there.

MT also benefited family members by providing them with opportunities to see their loved one engaged and participating in activities with others. MT provided friends and family members with opportunities to see a side of the resident that is still whole. One family member explained, "And the shakers and the sound. I see it. It's something.... that gives me some hope for the first floor, that there's something good happening for people part of the day".

Other activities that took place on Emerald Lane also promoted high levels of engagement in residents. The exercise program was one such activity and usually consisted of active games, like passing a beach ball around the circle or hitting balloons with badminton racquets. These activities were very successful because they take advantage of natural reflexes to hit something away that is coming towards you. These activities are also suitable for people with dementia as balloons and beach balls move slowly through the air, giving residents time to react. Also, because balloons and beach balls are soft, they are unlikely to hurt anyone if the ball or balloon hits them. These activities were well received by the residents and great joy could be seen on their faces as they participated in the activity. One family member noted: "When they ah, one of the
therapists comes up with the balloons or balls or whatever, some of them really kick it, smack it around”.

The weekly *Happy Hour* program was another opportunity for residents to engage in music, but in the context of a pub. This program consisted of a volunteer playing piano and the recreation therapist serving non-alcoholic beer and wine, and snacks to residents. The atmosphere was light and social, with residents seated together at tables. This program differed from the MT sessions in that the music was entertainment rather than ‘therapy’, in that residents were audience members rather than active participants in the music making. Nonetheless, residents were often engaged in the music and would sometimes clap along, or applaud at the end of a song. A family member recalls one resident who was particularly engaged in the Happy Hour one week: “The other day, [a resident] wheeled up, sat beside the piano [player]. Probably the whole session. Sat there and clapped. Listened to him. You know, intent.”

It is important for special care units, such as Emerald Lane, to have a variety of therapeutic and recreation programing available to their residents. Different programs suit the needs, abilities and preferences of different residents, allowing for more individuals to be engaged in activities. For example, while Arthur is rarely engaged in the MT sessions, he is often engaged in the exercise program, especially when the recreation therapist tosses the balloons around the circle. Similarly, Rose is not as easily engaged in exercises, but is consistently absorbed in the MT session and Happy Hour entertainment. More programming, as well as an increase in the variety of programming, is crucial to the engagement of residents on Emerald Lane.

More MT is also needed on Emerald Lane. There is a consensus between all staff members, family, friends, companions interviewed that more frequent MT sessions are needed on the unit. One care aide stated, “Yeah. And honestly, I think there should be way more of it”. This need was also demonstrated in the field notes: “Several residents applaud as the song ends. One resident says, ‘More, more, more, more!!’ ”
6.1.1. Autonomy

The category of Autonomy refers to the availability of opportunities for residents to have self-determination and take part in decision-making regarding aspects of their lives. Fetherstonhaugh, Tarzia and Nay (2013) explain how those with dementia are often capable of participating in decision-making, but “the attitudes of those around them, including health professionals and family carers, can sometimes be a barrier” (p.143). The first theme Left Out describes the general lack of autonomy and choice in residents’ lives on Emerald Lane, while in contrast, Simple Choices shows what is possible when residents are provided with opportunities for decision-making and autonomy in MT and recreation programs, as well as in their every-day lives.

**Left Out**

For those living on Emerald Lane, choice and self-determination are limited. Residents are not free to leave the unit unattended, and meals and activities are at fixed times. One MTA explained, "They're stuck in these places. To me, they're like prisons, you know?" Decision-making for residents is often limited to such things as what to wear, where to sit in the room, and how to spend time between meals, although staff members often make many of these decisions as well. Fetherstonhaugh et al. (2013) explain the importance of decision-making, stating that it allows residents of RCFs with dementia to feel useful and boosts self-esteem.

On Emerald Lane, residents are often left out of even the simplest every-day decisions. This lack of choice is demonstrated in the following excerpts from the field notes: “Rose stands up and a care aide says, ‘Sit down, Rose’ as she walks by. Rose sits down”, “One resident, who is known to wander, is seated with her back against the wall with the table pushed up close to her so that she is essentially trapped and cannot stand up and walk around” and “Arthur reaches towards a newspaper on the table and the care aide sitting beside him quickly slides it away just before he can grab it. The care aide says, ‘You finish eating first’. Arthur doesn’t say anything and continues eating his food”.

Staff members often invade residents’ personal space without asking their permission. For example, staff members sometimes do simple procedures, such as
checking a resident’s vital signs, without asking permission. Another example is staff moving residents in their wheelchairs from one place to another without warning or asking their permission, often surprising them as they begin to move unexpectedly. This is demonstrated in the following excerpt from the field notes:

A care aide moves Daisy’s wheelchair without saying anything and Daisy says ‘Oh!’ in surprise. The care aide leaves to do something else. Another care aide walks over to Arthur and silently tilts his wheelchair back, also without asking permission or giving any warning.

The above behaviour can be categorized as *Imposition* in Kitwood’s (1997) updated list of *Malignant Social Psychology* that undermine personhood in people with dementia. Imposition is defined as “forcing a person to do something, overriding desire or denying the possibility of choice on their part” (p.47). Staff members on Emerald Lane are likely not intentionally limiting residents’ autonomy; they are just trying to make their job easier without realizing the consequences of their controlling behaviour.

Staff members also do things for residents that they are capable of doing on their own to save time. For example, while eating, some residents take long breaks between each mouthful of food. Staff members sometimes feed these residents although they are capable of eating independently. This behaviour may seem helpful, but it can have negative consequences for people with dementia. One of Kitwood’s (1990) original ten aspects of *Malignant Social Psychology* is *Disempowerment*. Kitwood describes disempowerment as doing things for individuals that they are able to do for themselves; not permitting them to use the abilities that they have. Providing opportunities for residents to do the things that they are capable of doing allows them to have a sense of agency, accomplishment and independence, while doing these tasks for the resident may instil in them learned helplessness. Learned helplessness is described by Flannery (2002) as “a cognitive psychological state that results when an individual experiences frequent lack of contingency between the individual's response and the desired outcome. The individual assumes that he or she cannot create the sought-after goals and stops trying to do so” (p. 345-346). Flannery (2002) explains that this may lead to feelings of helplessness and depression in persons with dementia.
Choice and autonomy were offered to residents most often through the activities that took place on the unit, specifically the exercise programs, Happy Hour and MT. Outside of these programs, opportunities for autonomy and decision-making were occasionally provided by recreation and care staff on an individual basis. One example from the field notes was when a care aide invited a resident to pick a film to play on the television. Another time, a recreation therapist honoured a resident’s autonomy by participating in an activity suggested by the resident:

The recreation therapist enters the room with a beach ball…. She asks Rose how she is doing and Rose replies, “I’m fine, but not too good. Can I get somebody to help me?” The recreation therapist asks, “What can I do?” Rose replies, “Can I get out of here and walk around?” She replies, “Sure, let’s go for a walk, why not, why not”, and the two walk together out of the room and down the hall.

The recreation therapists typically incorporated choice in the exercise and Happy Hour programs. The therapists often allowed residents to decide whether they wanted to attend the program and gave them a choice of where to sit within the group. During the exercise program residents were sometimes offered a choice in what colour racquet to use, and during the Happy Hour program residents had a choice in what drink to order.

Similarly, the MT sessions consistently provided opportunities for residents to make choices. Residents were offered the choice of whether or not to attend the MT sessions. Although the MTAs invited residents to the program and encouraged them to participate, during the observations I noticed the MTAs consistently respecting residents’ decisions to participate or not. As a contrast, other staff members, particularly care staff, often brought residents to the MT sessions and other activities without consulting them, or even sometimes against their will.

During the MT sessions, both MTAs offered opportunities for residents to make decisions. The most frequent decisions were around song and instrument choices. The following excerpt shows how instrument choice was facilitated in one MT session:
The intern and Jane take out the instruments. The intern offers Angie a choice between a shaker and bells and she points towards the bells and grabs them. Jane offers Marge a choice between a maraca and a tambourine and Marge says, ‘Tambourine’. The intern offers Doris a choice between a blue or red shaker and Doris choses the blue one. The intern asks if Rose would like to play a big shaker of a little one, and Rose choses the big one.

Although the choice of what instrument to play is a relatively small decision, it may be one of the only decisions that the individuals have made that day.

The MTAs tended to keep decision-making simple and used creative ways of facilitating the decision-making process for residents with varying degrees of dementia. The MTAs often simplified decisions into yes or no questions or used visual cues. The following excerpt from the field notes demonstrates how Jane used pictures and photographs to help residents with decision-making:

Jane approaches Angie and asks, “Which one do you like better, tulips or mountains?” showing her the two pictures. Angie points towards the mountains. Jane says, “Mountains, she chose mountains” and talks a bit about the beautiful mountains we have around here.

The MTAs used other creative ways to let residents make choices. Jane wrote movie titles on pieces of paper and put them in a hat and asked residents to choose one of the pieces of paper.

The MT sessions also promoted autonomy in various ways. Residents sometimes made spontaneous song suggestions, which is demonstrated in the following field note: “Rose says, ‘Let’s do Let Me Call You Sweetheart for the next one’. Bill replied, ‘Ok, but you have to sing with me’.” Residents may also practice their autonomy through deciding not to participate in a certain activity within the session. For example, they may choose not to play an instrument as shown in the following field note:
Jane approaches Betty and helps her shake her bells, hand over hand. Betty appears to resist Jane’s help, and the therapist says, ‘You don’t want to play? That’s okay’ and gently lets go of her hand. Betty watches the other residents playing their instruments but does not shake the bells.

Another example:

The music therapy intern gives Olga a choice between two instruments and Olga shakes her head indicating that she does not want an instrument. The intern moves on and offers Rose the same choice and she choses the maraca. The new resident also chooses a maraca and starts shaking it vigorously.

6.1.2. Social Interaction

Social interaction is the interplay between two or more individuals through eye contact, speech and/or touch. With 33 residents and several staff members on the unit at any given time, it would seem likely that social interactions involving residents are a common occurrence; unfortunately, this is not the case. There is a marked absence of social interaction involving residents of Emerald Lane. The lack of social interaction exists among residents as well as between staff and residents, with the most common social interactions in the recreation and dining room occurring between staff members.

The first theme in the category of Social Interaction is *Endless Silence*, referring to the silence in the recreation and dining room due to the lack of social interaction involving residents. The second theme, *Staff Disdain*, depicts the deficiency in the quality and quantity of social interactions between staff and residents. The third and final theme, *Side by Side*, shows how the MT sessions and recreation activities brought residents together and stimulated social exchanges.

*Endless Silence*

The majority of residents’ days are spent in silence. Countless hours of field observations were recorded as, “The room is completely still and silent”. Spontaneous social interaction between residents was scarce with few residents instigating social
exchanges. Most residents appeared unaware or uninterested in those around them. There were few structured activities outside of MT sessions, such as recreation programs, to promote social interaction between residents on Emerald Lane, with a weekly Happy Hour program and the occasional exercise group as exceptions. These activities were seldom observed on the unit, as they did not occur often.

Although one of the goals of programs like Happy Hour and MT is to increase social interaction among residents, social interaction was not always a common occurrence during these programs. Spontaneous interactions among residents occurred much less frequently than between the session facilitator and the residents. Although residents were seated beside one another during the MT sessions and Happy Hour, residents were often focused on the MTA or recreation therapist rather than on one another. Social interaction among residents sometimes only occurred when the recreation therapist or MTA specifically facilitated it by introducing residents or drawing their attention to one another.

There are likely many different reasons for the lack of social interaction among residents. Some residents appeared unable to engage in conversations due to advanced dementia, while others appeared capable but disinterested in others. A few residents were not interacting with others due to being asleep for much of the time they spent in the recreation and dining room. Sometimes, a resident attempted to converse with another resident only to become frustrated when they did not or could not respond. Consider these observations:

A resident walks by Rose and she asks, ‘Can I bring these in?’ pointing to the dishes in front of her on the table. The resident does not answer and Rose repeats, ‘Can I bring these IN!? ’ The resident still does not answer and walks away. Rose shakes her head and says, “I just don’t know”, looking annoyed.

Olga slowly walks back into the room, holding her mug of coffee. Across the room, one of the residents sitting near the TV watching I Love Lucy looks up and sees Olga and shouts “Hi!! Hi!!” loudly, and waves quickly at her. Olga looks over, but does not acknowledge the resident. The resident says “Hi!
Come sit here!” and vigorously taps the chair beside her, motioning for Olga to come sit beside her. Olga looks away and continues walking to the table, and places her coffee mug down and sits in the same place she had recently vacated. She stares straight ahead and does not move for several minutes.

Residents of Emerald Lane often did not acknowledge one another’s presence in the same way that most people without dementia generally acknowledge one another in social situations. Residents generally did not greet one another when seeing each other for the first time that day or when they entered the room or were seated together at a table. Residents also did not say ‘goodbye’ when leaving the table or room. Two examples of this phenomenon follow:

A care aide seats a resident at the table with Rose and Angie. Neither Rose nor Angie acknowledges the resident or the care aide. The care aide silently feeds the resident, scraping the spoon loudly against the bowl to scoop up the last bite of food.

One of the residents sitting at the table with Angie stands up and walks out of the room without saying anything to Angie or the other resident.

There were many different situations observed in the field notes that resulted in a resident not responding to another, including the resident being unable to respond appropriately to another resident’s social advance due advanced dementia, lack of verbal communication abilities, profound deafness or being asleep.

When interactions did occur between residents of Emerald Lane, they were not always positive. Sometimes the level of confusion and anxiety in residents caused misunderstandings, verbal altercations and physical fights. The following is an example of two residents arguing due to confusion and misunderstanding one another:

Rose rams her walker into Daisy's wheelchair and Daisy exclaims, ‘What are you doing to me?’ Rose asks, ‘Pardon?’ and Daisy repeats her question but Rose does not reply. Rose gets close to Daisy and asks her what she should do. ‘I don't know you’ Daisy says. Rose repeats, ‘I don't know you.’

**Staff Disdain**

Social interaction between staff members and residents was minimal. The employees with the most contact with residents are care aides. In the context of the recreation and dining room, interactions between care aides and residents occurred most frequently at meal times. Often, care aides only interacted with residents in ways that were essential for them to complete their job. An example: when care aides were feeding residents, they were often multi-tasking; rather than sitting down and helping one resident eat her/his meal, care aides often fed several residents at once, moving around the table from one resident to another and giving each one a mouthful of food without interacting socially with any of them. The lack of social interaction between staff and residents may be partially explained due to the high workload that many staff members experience in their jobs. This high workload forces staff members to prioritize the physical needs of residents over their psychological need for social interaction. That being said, ‘being too busy’ is not always the reason for the lack of interaction between staff and residents as staff members were often seen interacting with one another rather than with residents.

Staff members often talked over residents to other staff members while working directly with residents. Staff members also sometimes ignored residents when the resident attempted to connect socially with them. The field notes contain many instances of staff members ignoring residents when the residents greeted them or asked them direct questions. Staff members also ignored non-verbal attempts at interaction by moving away from residents who reached towards them for attention or consolation. An example from the field notes: “A resident sitting at the corner table is hitting the table with her palm. None of the care aides notice or approach her to see what she needs, and continue talking to one another”. It was very rare that a staff member took a few moments and socialized with a resident outside of the tasks they had to complete. This behaviour may be seen as *withholding*, as described by Kitwood (1997) as “refusing to give asked-for attention, or to meet an evident need” (p.47).
Staff members were observed to lack respect in their interactions with residents. Staff members sometimes talked about residents in their presence as if they were not there. Some staff members only engaged in conversations with “higher functioning” residents and ignored other residents when they attempted to jump into the conversation. Also, residents were often treated as children, with staff members using 'baby talk' or a singsong voice, and pinching the resident’s cheeks. Staff members sometimes used condescending language such as, “Are you a good girl?” and gave orders, such as “Eat your toast young lady”. This type of language is demonstrated in the following excerpts from the field notes:

The higher functioning resident and a care aide are chatting. The care aide turns to another care aide and asks, “Someone is coming to take [the resident] out, aren’t they?” referring to the resident that she was talking with. The resident hears and corrects the care aide saying, “We are going out together, she’s not taking me out. Get your language straight” in a friendly, but serious tone.

The care aide approaches Betty and says, “Oh, dirty, dirty, dirty!” Looking at the mess of porridge in front of her. The care aide takes Betty’s clothing protector off without asking her and Betty grabs for it, wanting to keep it on. The care aide wrestles the clothing protector away from Betty, saying, “It’s dirty”. Betty looks upset and lifts her arms and swings them towards the care aide in an uncoordinated fashion and the care aide laughs and says that she’s naughty and pushes her chair away from the table. The care aide picks up the dishes and the housekeeper cleans the table. Betty appears angry.

This behaviour is listed as another of Kitwood’s (1990) aspects of Malignant Social Psychology: Infantilization. Kitwood describes infantilization as “a more extreme and persistent form of [disempowerment], but accompanied by messages, subtle or otherwise, that the dementia sufferer has a mentality and capability very much like that of a young child” (Kitwood, 1990, p.182).
Some staff members, especially two long-time care aides that frequently worked on the unit, interacted with residents in a way that severely undermined their dignity. The two care aides sometimes made disrespectful comments, told jokes at the expense of residents, and mocked residents. The following is an example from the field notes: "Rose says, 'Pardon?" The care aide repeats her, in a mocking tone, saying 'Pardon, pardon, pardon!?' as this is something that Rose often says due to being hard of hearing". Another care aide shamed a resident by yelling at her for entering the dining room without pants on. Care aides often toileted residents in the washroom right off the recreation and dining room with the door wide open. An example from the field notes:

The care aide exits the washroom, leaving the door open. Rose shouts, "Close the door! Close the door!" The care aide says, "I'm coming back". Rose continues shouting, "Close the door!!" sounding very distressed. The care aide re-enters the bathroom and closes the door behind her. The care aide and Rose can be heard talking loudly to one another, the care aide giving instructions to Rose and Rose refusing and resisting care, sounding upset.

These care aides’ behaviours could be categorized as mockery, one of the more recently added elements on the list of Malignant Social Psychology (Kitwood, 1997). Mockery is described as “making fun of a person’s ‘strange’ actions or remarks; teasing, humiliating, making jokes at their expense” (Kitwood, 1997, p.47).

Care aides also talked about residents in ways that undermined their dignity, for example saying, "She’s a pooper" when talking about a resident who is incontinent. The following excerpts from the field notes further demonstrate this lack of respect:

A resident is sitting on the floor. Two care aides walk over to the resident, and laughing ask, "What did you do?" The two care aides work together, each holding one of the resident’s arms, to lift her up into a standing position. The two care aides then walk the resident to the small table near the kitchenette, patting her bum a few times while laughing. The care aides leave the room.
A care aide brings Yvonne her meal and Yvonne takes a swipe at her. The care aide yells loudly and exclaims, “I’m bringing you your food, you don’t need to hit me!” and then makes the sound of a cat screeching, as if suggesting Yvonne is a feral cat.

Staff members also sometimes lacked consideration for residents, which was demonstrated in the small things that they did. For example, staff members often changed the radio station to a channel that they liked, such as modern popular music, instead of one that suited residents’ musical tastes. Another example is staff members and companions’ texting, playing on their phones, or reading books instead of interacting with residents. Staff members also sometimes rushed residents, forcing them to walk faster than they were comfortable by pulling their walkers ahead of them.

Side by Side

Social interactions involving residents were more likely to happen when certain individuals were in the room or during specific activities. For example, one ‘higher functioning’ resident regularly initiated short conversations with other residents, including Rose, Olga and Marge. Although these conversations were often brief and sometimes one-sided, they broke up the monotonous silence in the room and gave some residents a moment of social connection. One of the housekeepers also regularly engaged socially with residents by asking them how they were doing and chatting with them while he cleaned their tables or mopped the floor around them. Other situations where residents were more likely to engage with one another was during the recreation and therapeutic programming offered on Emerald Lane.

The MT programs that occurred on Emerald Lane brought residents together physically as well as socially. During the MT sessions, residents were seated in a circle around the MTA. The MTAs interacted socially with residents and also purposely sat residents beside one another, made introductions between residents and drew residents’ attention to those sitting around them. A volunteer noted, “When [the MTA] was just here, you can see them all sitting together there, and that’s, ah... maybe you can’t see what that's doing for them, but I think that it is a good group thing”.
All those interviewed felt that MT elicited social integrations among residents. When asked, Bill stated, “I think that it enhances social interaction…. I think they're more social, I think they're more, generally speaking, more awake”. Jane explained, “Today, I certainly noticed that there were more interactions among them. Like they started singing that song after?… Going into the Blue Danube”. One housekeeper stated, “I think they interact more”. A care aide noticed that residents sometimes interacted socially through helping each other during the MT sessions: “They maybe sorta nudge each other about... this group, if you're using a musical instrument somebody might tap somebody and help them get the beat right”.

Staff members also noticed an increase in social interaction after MT sessions. For example, one housekeeper stated, “There was a lot of energy. Ah, yeah, and, and, and after that session they keep on doing the nice things, very kind. Ah, they can be joking around with”. A volunteer explained,

And I think it can be, um... a little bit of a community builder. I think when they all come together and they're all watching someone, they might... you might not notice that group dynamic, but I think it's good that they feel they're kinda in their own little community. … ‘Cause for lots of them, that, they've just got each other, you know? They're not out of here and they're not in the main... and lots of their families don’t come and whatever, so I think that the music is kind of like a bonding thing

The music itself also provided opportunities for interaction as music is an inherently social activity as the act of singing or playing instruments together is social in nature. Residents sometimes spontaneously interacted with one another during the MT sessions. An example from the field notes: “Doris and Betty look at each other and smile”. There were several residents who enjoyed holding hands while sitting beside one another during the MT session. One companion described this occurrence:

Many of them like holding hands during music, I noticed that. Betty always likes to hold somebody’s hand and they'll reach across to anybody who'll take it…. I don't think there was a single time when they were in music
therapy that they weren't holding hands... She and Betty always, always, always held hands.

The MT sessions were also an opportunity for family, friends, companions, volunteers and staff to interact with the residents in a meaningful way. For example, one companion explained how she likes to hold one of the resident's hands during the MT program: "I'll hold [a resident's] hand when we're... when I'm with her listening to the music. Sometimes I can feel, ah... her getting the beat type thing. Doesn't happen as much now as it used to". A volunteer explained how she likes to visit residents during the MT sessions:

Just coming in as a volunteer, I've been really glad coming in on Wednesdays, because sometimes conversation is not easy and, you know, I want to relate with them all in here? ...But we'd have that common activity to come and go to. ...So as a volunteer I like the music, the therapy and all that too because I can talk to them or get them out there. Or sit with them when it's happening and it's uplifting. And make it a nice visit... So, I really like when that's coming on... I think, oh that's a good time to come visit... A little before, or a little after. Just to kind of reap the benefits of the mood of that, or hearing some of those old songs myself.

Another example is one housekeeper who found that the MT sessions allowed him to interact with residents: "If you also participate yourself, like, ah, I'm a housekeeper right? ...Like I try to interact with them? And they're very ah... they're very open". Some MT interventions are more effective at initiating social interaction than others. Jane explained that dancing to music is very effective at eliciting social interaction in residents of Emerald Lane:

It seems like everybody loves to dance... And I think it brings up really good memories. A lot of them used to go out dancing... it's a social connection? ... Sometimes people will make eye contact with you that wouldn't normally.... Sometimes they'll-- A lot of people, today, everybody was trying to tell me things! ... I couldn't understand what they were saying.
6.1.3. Well-being

Well-being refers to an individual’s mental and emotional state and has a broad range extending from happy and calm to anxious and distressed. An individual’s psychological state has a direct effect on their behaviours. When behaviours are problematic, they may be categorized as agitation. Anxiety and agitation are closely related. Twelftree and Qazi (2005) define anxiety as one’s inner thoughts and feelings, while agitation is one’s outer behaviour. These researchers caution that although anxiety is correlated with agitation and is often the cause of agitation, agitation is not the only indicator of anxiety in those with dementia.

The category Well-being contains two contrasting themes. The first theme, *Something’s Not Right*, demonstrates the high occurrence of anxiety, agitation and unhappiness in residents of Emerald Lane. The second theme, *Soothing Scene*, represents how certain activities, especially MT, ameliorated negative feelings and behaviours in some residents.

*Something’s Not Right*

Feelings of unease and sadness are common in those with dementia living on special care units. Ballard, Neill and O’Brian (2000) found the prevalence of major depression ranged from 8% to 19% in those with dementia living in the community. Additionally, these researchers found that 38% to 70% of those with dementia had two or more symptoms of anxiety. High anxiety levels were apparent in residents of Emerald Lane. Staff, family members, companions and a volunteer all noted resident anxiety. A volunteer explained: “Like, some of them go around and they're (demonstrates repetitive banging on the table). And they can't help that, that's where their mind is; it's occupied by that”.

Anxiety was observed in many residents throughout each day of field observations. These negative feelings were shown non-verbally through facial expression, body language and behaviours. Residents were observed fidgeting, pacing, and fighting with one another. The following observation shows non-verbal expressions of anxiety in one resident:
Olga looks around the room, a pained expression on her face. She taps her feet slowly, not to the beat of the faint music playing on the radio. Olga takes her clothing protector off and folds and refolds it over and over.

Anxiety was also demonstrated verbally through conversations, comments and vocalizations. This expression is demonstrated in the following two observations: “Daisy is chatting to herself a mile-a-minute, sounding fearful. She is talking about having nowhere to go, being all alone and not knowing who she is”, and “Marge and Rose are pacing throughout the room. The two residents end up beside one another, with a table in front of them. Marge shouts, ‘Well don’t fence me in... I’ve fenced myself in!’ in a shaky, panicked voice”. The field notes also contain instances of residents asking for help, yelling at one another and crying: “Someone can be heard screaming and crying from in the washroom, sounding as if they are in great distress”, and:

Suddenly, Marge yells, “Help!!” No one says anything or goes over to Marge. Marge takes a bite of her soup and cries out, louder, “HELP!!!” The dietician walks over and asks, “What’s going on?” Marge replies, “I need somebody to feed me.”

Sometimes resident agitation took the form of aggression between residents. An example of resident-to-resident aggression is demonstrated in the following excerpt from the field notes:

A resident walks into the room and sits down at the large table with Angie and another resident.... The resident points at the ‘higher functioning’ resident and says, ‘Dirty bitch!’ and tells me to ‘get up from there and sit somewhere else’. The resident appears anxious and distressed, repeating the words ‘dirty bitch’ over and over.... ‘I’m going to kill you’ she says. The resident looks at me and points to the higher functioning resident, repeating, ‘She’s a bad person!’

Agitation in one resident was observed to sometimes cause or exacerbate problematic behaviour in other residents as they became irritated by the first resident’s behaviours:
Two residents are sitting together at the table in the corner. One resident is vocalizing loudly and quickly tapping the table in front of her, appearing agitated. The other resident is sitting quietly, but reaching and grabbing towards the table and her wheelchair…. A resident who is new to the unit walks up behind the resident who is vocalizing. The new resident says, ‘Shut up!’ and hits the other resident several times with a handful of paper towel…. A care aide comes over and asks the resident, ‘Are you all right?’ The resident looks at the care aide but does not reply, then continues vocalizing. The other resident walks away and then sits down at the large table with Olga, Angie and Angie’s companion. The resident sitting at the corner table continues vocalizing loudly and hitting the table. The other resident yells, ‘Shut up!’ then imitates the resident’s vocalizations, appearing furious.

Agitation in residents also took the form of aggression towards staff members. The following excerpt from the field notes demonstrates this:

A care aide wheels a resident who appears to be agitated into the room. The care aide seats the resident at a table in the back of the room with another resident and puts of bowl or porridge in front of her. The resident violently pushes the bowl of porridge across the table and it slides towards the other resident. The nurse takes the bowl away and returns a moment later with another bowl of porridge. The resident reaches towards the nurse as she places the bowl of porridge on the table, trying to hit her. The nurse is quick and promptly leaves the area, avoiding getting hit by the resident. The resident picks up her bowl of porridge and loudly bangs it down on the table. The resident gestures to the resident in front of her, pointing to the care aide, indicating that she doesn’t like her. The resident eventually picks up the bowl of porridge and starts eating and watches the care aide walk by with a scowl on her face.

Anxiety levels seemed to be exacerbated by a lack of activity on Emerald Lane. A nurse observed, “They get agitated when there is nothing to do”. Several care aides
stated that residents are more agitated in the afternoon, when there are few activities offered: "I find after lunch they're very antsy and.... they're all over the place", "[They] start looking for fights with each other and stuff like that", and, "fiddling with everything" in the afternoon. A volunteer also noticed a change in behaviour: "I've seen [residents] being very fussed up.... I've seen people being very fussed up later in the afternoon".

**Soothing Scene**

Residents' psychological well-being appeared to be influenced by many factors, most notably the time of day and the activities occurring on the unit. Data reveal residents to be less agitated and in better moods in the morning with more agitation, wandering, aggression and negative moods in the afternoons. Most activities on the unit occurred in the morning, including all of the MT sessions. The only program observed in the afternoon was the weekly Happy Hour program.

The MT sessions on Emerald Lane appeared to have a positive influence on residents' psychological well-being. Field observations revealed improved mood and decreased anxiety and problematic behaviour, including repetitive movements, wandering and aggression. Each individual interviewed, including MTAs, care aides, a nurse, housekeeper, volunteer and companion, all noted positive changes during and/or following MT sessions. A volunteer summarized: "When the music is on and you can see them really looking, or listening, or moving, or nodding or smiling. That to me is a good mood. It's an involved mood. It's a participatory mood".

Perhaps one of the most noticeable changes during and after MT sessions is regarding residents' moods. The field observations captured residents laughing, smiling, and acting 'silly' during MT sessions. Facial expressions and posture were often more relaxed and the tone in the room was more light-hearted. Jane explained, "Generally speaking, not 100% and not with everybody, but [MT] seems to elevate their mood". Bill agreed: "They get engaged in the music and most of the time, lots of smiles afterwards".

A volunteer who spends a lot of time on the unit also noticed changes in mood in several of the residents who frequented the MT sessions. The volunteer explained:
I think it's a mood changer, you know? Because they might have just been sitting there, and it's a daily thing, and then when that comes on... You know even the way Yvonne... She'd get that nice smile and everything and you can see, right? That was a mood enhancer. And I know I've seen it all the time with Rose, and it's so obvious. And it really was with Pat.

The volunteer continues, "They become more happy, relaxed.... I just notice they really enjoy the music, and they're calm when they're listening to the music."

The recreation programs and interactions with friends, family members and companions also enhanced residents' moods. The following excerpt from the field notes shows Betty's enjoyment during Happy Hour: "Betty’s companion sits beside her and feeds her chocolate ice cream. Betty appears to greatly enjoy the ice cream. Betty feeds herself more ice cream and says something incoherent to the companion. The companion and Betty smile at one another”. One family member described how leaving the building and getting outside consistently put his loved one in a good mood:

“[My wife] sits there, and she's quiet. Very seldom does she... say anything. I can't understand what she says anyways, but when I take her for a walk down [name of] Street she sings all the time.... When she gets outside she sings. I just push her, walk a couple blocks...”

The change in mood associated with the MT sessions helped some residents get along with others. A care aide stated, "Well, they're definitely happier.... I think people get along better". Similarly, the housekeeper stated, "[MT] helps with aggressiveness, it helps with ah, maybe something with the ah, depression or mood. It helps with that". The volunteer also noticed how a change in mood may curb aggressive behaviour: "For somebody that maybe was, kinda, getting angry or, or hitting out at another resident, I've seen it totally change that person to, kinda become a kind person again afterwards".

Sometimes the sight of the MTA alone was enough to put some residents in a better mood. For example, both therapists explained that although many residents had severe memory impairment; they often remembered how the MTA made them feel. Jane and Bill describe this phenomenon:
The interesting thing about music therapy I've noticed is that with people who [have dementia], they don't remember specific things, like they might not remember who I am when they see me come in... they certainly don't remember my name... or what I do, but they have a feeling about me. The feeling is registered. They know that I do something for them that they like. And so they greet me in a way that's really-- they welcome me because they know I'm somebody that's going to do something positive.... It's like the emotions register, if not the cognitive thoughts. So I think that's got to be a good thing.

From what I can see, for maybe a handful of them that kind of recognize me, who I am and what it means when I'm here.... When nothing's going on they're just flat. But when they see me, like, right away, they know this is going to be a good morning.... So, for some of them that kind of retain that 'This equals music'.... There's that, that connection. That therapeutic relation.

The two MTAs working on Emerald Lane also noticed that MT resulted in changes in anxiety levels in residents during and after MT sessions. When asked if MT influenced anxiety levels, Jane replied:

Definitely. And certainly with people who are really anxious, like say, Marge.... I'll see her at the beginning and she'll be like (demonstrates a nervous facial expression) and at the end she's like (demonstrates a relaxed facial expression).... You can definitely notice a difference.

Bill found similar results, particularly with one resident in the past:

[One resident] used to be more agitated.... but I know this person would benefit a lot from music.... And it would take quite some time to try to bring this person there.... And usually when they are there.... they get more relaxed.
Other staff members and the volunteer also saw changes in residents’ anxiety levels due to the MT sessions that occurred on the unit. One care aide said, "I think, ah, music really helps a lot to calm also their nerves." Another care aide explained, "Oh, it's very calming. I think it's very calming, very soothing". Similarly, the volunteer noticed: "They're relaxed. Not agitated. Very relaxed, more relaxed".

Agitation was observed less frequently in residents during and immediately following MT sessions. No instances of aggression were recorded in the field notes during the MT sessions. Fidgeting, wandering and repetitive behaviours all subsided while residents participated in the music. Staff members and volunteers noticed the decline in agitation levels; one care aide stated, “Yeah, their agitation is a lot lower”. Jane described, “I see [agitation] go down mostly. Like [a resident] today, she was super [agitated].... Then she was like (demonstrates a peaceful expression on her face). She was still trying to stand up, but.... [she had a smile] on her face”. Similarly, a volunteer who spends a lot of time on the unit explained,

I've seen some of them be quite agitated at times. But I don't ever see them being agitated like that when the music's on.... I think it's, it's taking them out of whatever place was bugging them.... And so for that time, they're calmed.

Staff members and the volunteer also noticed that MT sessions tended to reduce challenging behaviour, such as aggression and wandering. The recreation assistant stated, "[MT creates a] change in behaviour, they seem to be settled more". The volunteer remembered one particular resident’s behaviour and how it would change during MT sessions:

So [one resident's] behaviour was sometimes really difficult, but when the music was around she was like a lamb. I think some of the people were really quite nervous and scared of her kind of.... And yet, when the music was here it would be like a different person, and I'd think, ‘wow’. That's amazing. It seems so extreme, you know?... Kind of scary because you couldn't seem to reach her, it was the music that was reaching her and the aftereffect on the behaviour was amazing.
Residents who tended to wander throughout the unit often sat down, either within the MT ‘circle’ or elsewhere in the room, to listen to the music. The recreation assistant confirmed, "Yeah, [the MT] stops wandering.... Keeps them together.... They don't seem to wander after. They'll sit in their chair". A reduction in wandering behaviour makes staff members’ jobs easier as they can more easily locate, care for and supervise residents.

MT made some staff members’ jobs easier in other ways as well. The promise of MT was helpful for care aides to motivate some residents to get out of bed in the morning. One care aide explained: "Some [residents] do remember, they look forward [to the music].... Sometimes, I get them up by telling them, 'We're going to have live music today', 'Are you going to get up now?' 'Yes!'" Some residents were more receptive to care after MT sessions. A care aide explained: "Yeah, and then you just kind of dance with them along.... Yeah, [giving care] is easier".

A housekeeper noted that residents are often more aware and helpful after MT sessions:

When I'm working with them they're also very cooperative. Like ah, since they know what I'm doing and what I'm doing after they have this therapy session, as if their minds are all aware, or open?... When I'm ah, mopping, or no, ah... cleaning the table... And if I miss a portion and one of the residents, she just point it, she's just smiling and, 'Yeah, ok, thank you for helping me' (laughter).

Some staff members believe MT to have a lingering effect on residents, improving their mood and behaviour for several hours after the hour-long session. For example, a recreation assistant described, "Yeah, and they're calmer, throughout the day... Yeah, calmer mood, and.... easier to deal with". The nurse explained, "Very typically aggressive people.... definitely come out after music therapy and are a lot easier to, sort or, redirect". Another care aide also noticed a long-term effect of MT, "Well, it's in the moment and then for... like for the rest of the day I find they're calmer.... Yeah, it has a lingering effect for their whole day".

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To summarize, residents’ experiences on Emerald Lane, including their engagement, autonomy, social interaction and well-being, were constantly fluctuating and evolving. Residents were influenced greatly by the people around them and the activities taking place on the unit. Increased engagement and a greater number of opportunities for autonomy were seen during the planned activities that took place on the unit and especially during the MT sessions. Social interaction involving residents were generally scarce, and occurred most frequently between staff members and residents and less frequently among residents. Spontaneous resident-to-resident interactions were seen during MT sessions in the form of handholding, eye contact and smiling. Residents’ well-being was ever changing on Emerald Lane, with mood, anxiety and agitation levels fluctuating throughout the day. Instances of improved well-being were observed and noted by staff members during interactions with loved ones and participation in activities, especially MT.
Chapter 7.

Discussion

This qualitative study explored the influence of group MT on quality of life in residents with dementia living on a special care unit. Specifically, the study examined the influence of group MT on engagement, social interaction, autonomy, and well-being. The inquiry was guided by multidimensional conceptual considerations that took into account the MTA’s assessment, the MT sessions and resident outcomes. These considerations were framed by the Need-driven, Dementia-Compromised Behavior Model (NDB) and Kitwood’s framework of person-centered care.

Over the past twenty-five years, many quantitative studies have examined the effect of MT on residents with dementia. Research has focused on various areas, including depression (Ashida, 2000; Chu et al., 2014; Guetin et al. 2009), agitation (Brotons & Pickett-Cooper, 1996; Gardiner et al., 2000; Ledger & Baker, 2006; Lin et al., 2010; Vink et al., 2014; Vink, et al., 2013), memory (Carruth, 1997; Ceccato et al., 2012), communication (Brotons & Koger, 2000; Schall et al., 2015), social behaviours (Namazi et al., 1992), psychotropic medication use (Bronskill et al., 2009; Ridder et al., 2013; Rolland et al., 2012), and late stage dementia (Clair, 1996; Clair & Bernstein, 1990a; Clair & Bernstein, 1990b). Only five qualitative studies have been conducted in this area. Abad (2002), Dennis and Rickson (2014) and Kydd (2001) each conducted case studies. Abad (2002) looked at social isolation in persons with Alzheimer's disease, Dennis and Rickson (2014) described community MT with people with dementia and Kydd (2001) illustrated how MT impacts adjustment to living in a RCF. Gold (2014) analyzed staff case notes to measure the impact of MT on people with advanced dementia, while Melhuish et al.’s (2015) phenomenological study explored the attitudes and perceptions of staff who regularly participated in MT and dance movement therapy groups. To the best of my knowledge, no other qualitative study has explored the influence of MT on
quality of life in persons with dementia living in a special care unit. Furthermore, few qualitative studies in this area have used in-depth observations, focus groups and interviews as the primary data collection methods.

In this study, the 172 hours of focused observations immersed me into both the community and the individual lives of residents of Emerald Lane. The long duration of observations allowed residents, staff and visitors to grow accustomed to my presence on Emerald Lane. Spending many hours in the dining and recreation room allowed me to experience, to some degree, what it is like to be a resident. I was able to know first hand the reality of sitting for hours on end, the waiting and the boredom that are the consequence of a lack of stimulation and planned activities on Emerald Lane. I was also able to appreciate the difference that MT and other planned activities made on engagement levels, the number and quality of social interactions and residents’ well-being once these activities did occur.

The interviews with staff and a volunteer, and the focus group with family members and a companion were invaluable to this study. These interviews provided the opportunity for these individuals’ thoughts, feelings and opinions about MT, recreation programming and life on Emerald Lane to be known. The interviews and the focus group provided different perspectives on MT on Emerald Lane and corroborated findings from the field observations.

A strength of this study is the utilization of triangulation through using data from a variety of sources, including observations, interviews, a focus group and document analysis. These different data sources increase the trustworthiness of the findings by corroborating the evidence found. Another strength was the length of time spent in the field conducting in-depth observations. Persistent and prolonged observations were achieved in the form of 172 hours of focused observations conducted over a period of three months.
7.1 Reflections as a Certified Music Therapist (MTA)

Before commencing this study, I worked four days a week at Sunrise Care Home as a MTA and facilitated one MT session each week on Emerald Lane. The role of MTA at Sunrise Care Home came to an end shortly before starting the recruitment for this study, allowing me to focus solely on my role as researcher. Being a researcher provided me with a very different perspective on the quality of life of those residing on Emerald Lane compared to when I was working as a MTA on the unit.

As a MTA on Emerald Lane, I arrived on the unit 30 minutes before the start of the MT sessions, set up my equipment, gathered residents, conducted the hour-long program, then left the unit. The one-and-a-half to two hours that I spent on the unit each week was a whirlwind of activity. I saw many residents engaged in the sessions and I expected that many of those who were not involved in the MT were engaged in other group or individual recreation or therapeutic activities that took place on the unit at other times. Judging from my limited time on Emerald Lane, I was under the impression that Emerald Lane was a reasonably stimulating and engaging environment for people with dementia. Because I was usually only on the unit to conduct MT sessions, I only witnessed the MT sessions and the times just before and after the sessions. As a result, I did not witness the silence, waiting, lack of social interaction or the full extent of the agitation that happened on Emerald Lane. In the role of researcher, especially during the extensive observations when no activities were taking place, the bleak reality of the emptiness and boredom of many residents’ lives was revealed.

It is difficult to determine how much of the situation on Emerald Lane was due to the shortage of recreation staff that occurred during the observation period and how much was due to the culture of care on the unit. No field observations occurred while recreation activities were happening at the frequency in which they normally happened on the unit. Judging by the calendar of activities, approximately three to five activities were cancelled each week, including group exercise programs, a trivia program and individual recreation therapy visits. It would be beneficial to know what difference the regular occurrence of these programs made in the lives of residents of Emerald Lane.
My MT training and experience likely affected the quality of the field observations. Throughout my six-year career as a MTA, I have primarily worked with care home residents with dementia. The Capilano University MT program, where I received my training, teaches MTAs to look at health from a holistic perspective, paying particular attention to seven domains of functioning: cognitive, social, physical, emotional, spiritual, communication and musical abilities. As a MTA, I understood the goals and objectives that the therapists were working towards; I could recognize different interventions and was aware of subtle signs of engagement in residents, such as focused gaze, facial affect or faint toe-tapping. I also understood many of the choices the MTAs made in the moment during the MT sessions to work on resident goals of engagement, social interaction and well-being. I was aware of the possibilities for resident participation, social interaction, autonomy and well-being that could happen during the sessions.

As a MTA I have certain assumptions on the topic of this study. I believe in MT’s capacity to affect positive change in people, especially residents with dementia. Before conducting this study, I had expectations that positive outcomes were likely to occur and it is possible that I was subconsciously looking for these results throughout the study. That being said, I was acutely aware of this “bias” and used the technique of bracketing to decrease its influence on the study. It is important to note that I only recorded what I objectively saw and heard during all observations. Nonetheless, I accept that it is impossible for anyone to completely suspend or hold inactive their perspectives and biases and that my training, experience, personality, and beliefs likely permeated some or all aspects of the study.

Having worked with residents of Emerald Lane in the past meant that I knew most of them and had had a therapeutic relationship with some of them. However, it appeared that most residents did not explicitly remember me in this role and those who were more aware quickly came to know me as a “the researcher.” My knowing the residents likely created expectations and biases. I knew how residents reacted to my sessions and had expectations that they would respond in a similar manner to the sessions conducted by the two MTAs working on the unit during the data collection period. Nonetheless, I did my best to view each resident as if I did not know anything
about them and attempted to bracket all expectations. As the study progressed, my perception of some residents changed as I observed them in different contexts. I had the opportunity to get to know some residents’ family members, friends, and companions, which provided me a more complete understanding of who the residents are as people outside of their diagnoses of dementia.

Observing MTAs’ sessions was essential to this study. I also found it personally beneficial, as I was able to observe two contrasting MT styles and discover different techniques and interventions to integrate into my practice. The fact that I was observing the MTAs likely influenced the facilitation of their sessions to some degree, although both MTAs appeared to be comfortable with my presence. Jane was likely minimally influenced by my presence due to being experienced and accustomed to being observed by practicum students and interns. Also, the large number of MT sessions included in this study allowed the MTAs to become habituated to my presence and likely resulted in their sessions representing what would normally occur on the unit when not being observed.

One unknown in this study is the relative influence of the therapeutic relationship between the MTA and the residents versus the impact of the music chosen and played by the therapists. The therapeutic impact of MT is likely the combination of the influence of the therapist and the influence of the music, with these two elements overlapping and intertwining because the MTA is the one creating the music. The manner in which a piece is played, as well as the correlating MT interventions, are determined greatly by knowing the resident and the resulting therapeutic relationship between the MTA and the resident. Several studies compare MT with music listening, including Ragilo et al.’s (2013) and Raglio et al.’s (2015) studies. Although both studies found no significant statistical difference between the influence of MT and music listening, Ragilo et al.’s (2013) study found that quality of life tended to increase with MT and decrease in the music listening group. The researchers state that the therapeutic relationship and “the direct involvement of [persons with dementia] in the MT approach” (p.646) makes MT more beneficial than music listening, although more research is needed in this area.
7.2 Meaning

This section explores the meanings of the emergent themes described in the findings. Connections are made between the themes, the literature on MT and the broader literature on dementia, personhood and long-term care. Many of the findings in this study concur with findings of earlier studies on MT and dementia, such as those on the topics of well-being, social interaction and anxiety. Other findings, such as those on autonomy, are not mentioned in previous MT research; adding to the body of knowledge in this area.

Idle Time and Endless Silence

Engagement requires caring about what is going on in one's surroundings. If there is nothing worth paying attention to in one's environment, then there is no engagement. Residents likely lacked engagement throughout much of the day on Emerald Lane because of the absence of meaningful activity on the unit. The theme Idle Time means that residents' are in a sort of 'limbo' when nothing is happening on the unit to attract their attention and focus; it is almost as though residents are suspended in time due to the lack of activities to gauge the passing of time. Memory and cognitive impairment likely augment this feeling of perpetuity, further distorting the passage of time and creating the impression of endless waiting. When there is nothing to engage in, residents lack the initiative to take part in their lives and take interest in their surroundings.

The themes Idle Time and Endless Silence are related in that they are both caused to some extent by the experience of lack of engagement. When residents are not engaged in their surroundings, they are not aware of those around them. Disengagement brings residents inwards, deep into their minds, essentially blocking their awareness of everything around them. People cannot connect socially with one another if they are unaware of one another.

Drawn In and Side by Side

Being Drawn In means that the activity taking place in a person's environment is judged to be worth focusing on and paying attention to. For residents to be drawn out of
their inner worlds and fight the pulls of sleepiness, their surrounding environment must be engaging. The need for an engaging environment is likely greater for those with dementia because of increased drowsiness due to medications that interfere with sleep (Rose & Lorenz, 2010). Engagement in activities appears to have positive effects on the well-being of residents living on special care units. An observational study by Beerens et al. (2016) revealed that residents who engaged in active, expressive and social activities had higher quality of life and better mood scores than residents who were less engaged in activities.

The themes of *Drawn in* and *Side by Side* are related in that when residents are alert and engaged, they become aware of their surroundings including the people around them. This awareness provides opportunities for residents to interact with one another within the context of an activity, or in the very least participate in the activity side by side with another individual, creating a feeling of kinship or connection. Social interaction is important; studies show that frequent social interaction is associated with higher quality of life for residents with dementia (Beerens et al., 2016; Cahill & Diaz-Ponce, 2011; Moyle et al., 2011).

The field observations revealed few spontaneous social interactions among residents of Emerald Lane. This finding is similar to those of Schroll, Jonsson, Mor, Berg, and Sherwood (1997) who reported that care home residents with dementia spend little time interacting with one another outside of planned activities. There are many possible explanations for this behaviour, the first being the severity of residents’ dementia, which likely affects their awareness of others, their ability to interact and their confidence in initiating social interaction. Other residents may attempt to interact with these individuals only to feel slighted when they receive no response. Second, memory and cognitive impairment may result in residents forgetting past interactions with one another, making them unaware that they are in contact with one another on a daily basis. This forgetfulness may give residents the impression that they are strangers rather than housemates, making them more hesitant in initiating interactions. Third, the polite ‘niceties’ like greeting and small talk may disappear with more severe dementia as people lose social awareness. These factors, and likely many more, accumulate and
interact to make social interaction very difficult, or impossible, for those residing on Emerald Lane.

Campo and Chaudhury (2011) found that spontaneous social interaction among residents was influenced by certain elements of the social and physical environment of special care units. These researchers suggest “policies that recognize the importance of and promote informal social interaction within [special care units] by creating a culture that values these goals as important” (p.419). They also stress the importance of creating ‘social spaces’ within special care units that take into account “sightlines, transition spaces, scale, seating, and the overall ambiance” of the unit (p.419).

The present study supports the findings of earlier research that MT increases social interaction in residents with dementia (Pollack et al., 1992; Sole et al., 2014). Residents were observed to have social interaction with the MTA, and also occasionally with one another. This increase may be due to various factors, including residents being more alert and awake, thus more aware of one another due to the stimulation of the MT. Also, music is an inherently social activity, present in all cultures around the world; thus the music itself may have elicited more social behaviours based on societal norms instilled in the residents from earlier in life. A volunteer explained,

We’re all listening to music and we all do that. Even though they're here, even though that they have so much challenges... its a common, human thing that they're taking part in. And I think that that's so important. So important. And it’s the most kind of, alive time, and upbeat”.

**Left Out and Staff Disdain**

The theme *Left Out* means that residents feel powerless in the trajectory of their lives due to decisions being made for them. Being left out of decisions likely reduces residents’ investment in the outcome of decisions as they feel as if someone else is “holding the steering wheel” of their lives, resulting in apathy. Residents are forced to be passive participants in their lives rather than active creators of their destinies. Opportunities for autonomy may have a significant influence on residents; Menne and Whitlatch (2007) explain: “involvement in decision making and maintenance of autonomy
may contribute to less depression and enhanced well-being even as impairments worsen for the [individual with dementia]" (p.818).

*Left Out* relates to the theme *Staff Disdain* in that they both are largely a result of insufficient training, understaffing and dominance of a medical model of care. The behaviours described in the *Staff Disdain* theme were also related to individual staff members’ personalities and their beliefs about people with dementia. Because the two care aides who mocked residents had worked on the unit for many years, they likely shaped the culture on the unit and set the precedent for acceptable behaviour. Many changes are needed on the unit to change how residents are treated and to promote a culture of respect.

There was little mention of the influence that MT has on resident autonomy in previous literature. Because of the holistic and person-centered focus of MT, MTAs are taught to provide residents with opportunities for autonomy in their sessions. The fact that MT often strengthens autonomy in residents with dementia may be a ‘given’ thus has not been directly researched. This absence in the literature does not mean that autonomy is not an important part of MT sessions. MTAs are taught the importance of autonomy and are trained to provide as many opportunities as possible for decision making in their sessions. For example, Jane stated, “I think it's really important to acknowledge that people have their thoughts and their opinions still, and their autonomy”.

**Something’s Not Right and Idle Time**

The meaning of *Something’s Not Right* is that people with dementia sometimes experience stress, anxiety, sadness and confusion. At times, these feelings result in ‘agitated’ behaviours such as wandering, crying, calling out, repetitive movements and aggression towards others. Whall and Kolanowski (2002) describe these behaviours within the *NDB model* as resulting from a combination of background and proximal factors. They describe background factors as neurological features, cognitive abilities, health state and psychological history and proximal factors as physiological and psychological need states and the physical and social environments.
**Something’s Not Right** and **Idle Time** are linked in that residents more often appeared distressed during times when they were idle. A lack of engagement likely resulted in residents being more likely to focus on negative thoughts and feelings, increasing the sense that something was not right. Whall and Kolanowski (2002) describe how ‘disruptive’ or ‘problematic’ behaviours indicate an unmet need, and that responding appropriately to the need enhances quality of life. Often, residents of Emerald Lane were in need of engagement; when this need was met through meaningful activities, such as MT, residents’ behavioural problems subsided.

Several staff members and a volunteer mentioned that agitation levels were higher in the afternoon and evening. This increase in agitation could be linked to the phenomenon called was **Sundowning**. Sundowning is a state of increased agitation and restlessness that occurs in the late afternoon and evening and presents as reduced cognitive ability and attention, psychomotor disturbance, increased disorientation, wandering and aggression, visual hallucinations, resistance to care, confused verbalizations and reversed sleep-wake cycle (Nowak & Davis, 2007). Sparks (2011) states that one of the most effective interventions for managing and preventing sundowning behaviour is providing appropriate social activities that are of interest to the resident. No MT sessions and few recreation programs were scheduled on Emerald Lane during the afternoon. Several care aides suggested that programming in the afternoon, especially MT programming, would be beneficial.

**Soothing Scene**

The theme **Soothing Scene** means that certain situations and activities, such as recreation and MT programming, promote feelings of well-being and calm in residents of Emerald Lane. The enhanced mood and decreased agitation described in the interviews and witnessed in the field observations concur with two earlier studies by Hsu et al. (2015) and Schall et al. (2015) using quantitative methods. Hsu et al. (2015) described higher levels of well-being and Schall et al. (2015) reported more frequently expressed positive emotions and higher levels of situational well-being after participation in MT.

MT may enhance well-being by drawing residents’ focus to the music, distracting them from negative thoughts and feelings. A volunteer speculated, “I think it goes back
to the point of being absorbed or focused when the music is on.” When residents are idle, they may concentrate on negative thoughts or aches and pains in their bodies. Disorientation, a common product of dementia, may result in residents not recognizing their surroundings and making them feel lost. Hearing a favourite and/or familiar song may ground and comfort residents. The melody, harmony, rhythm, and lyrics may occupy residents’ minds leaving little room for worry. A MTA recaps, “They can find something to focus on.”

MT may also increase well-being by facilitating reminiscing and allowing residents to connect with their past. Familiar music from the residents early years may flood residents with memories and trigger positive emotions. Music takes residents out of their current situation, where dementia and other ailments limit them, and brings them back to a time when they were healthier, happier, and more able. One of the housekeepers explained: "Ah, it soothes them…. It’s part of their past. I mean, music sometimes reminds them of some beautiful moments, nostalgic moments".

The improved well-being that residents experienced through the MT sessions on Emerald Lane likely impacted their need for psychotropic medication. Research shows that residents with dementia who display agitation and irritability are more likely to be prescribed psychotropic medication in care homes (Rolland et al., 2012); therefore when residents do not display this type of behaviour due to their needs being met, they should conceivably receive less medication. MT is valuable as it is a non-pharmacological treatment that is comparable to pharmacological care in its impact on challenging behaviours, agitation, and mood, but without the negative side effects.

7.3 Conceptual Considerations

The findings of this study are framed by the conceptual considerations outlined previously as well as two conceptual frameworks: The need-driven, dementia-compromised behavior model (NDB) and Kitwood’s Model of Person Centered Care.

The following paragraphs examine the findings of the current study in the context of the five needs of personhood. The first need of comfort is described by Kitwood
(1997) as “tenderness, closeness, the soothing of pain and sorrow, the calming of anxiety, the feeling of security which comes from being close to another” (p.81). The field observation on Emerald Lane captured countless instances of residents seeking comfort through calling for help, wandering, and reaching towards other residents and staff members as they walked by. Residents occasionally received comfort from staff, while most comfort appeared to be gained through interactions with companions, and participation in recreation and MT programs.

Residents were comforted in the MT sessions in many ways. During the sessions, residents were seated close to one another with some occasionally holding hands. The social interactions with the therapist and with other residents, either spontaneously or facilitated by the therapist, likely made residents feel emotionally and/or spiritually close to others. For residents who experienced high anxiety in their day-to-day lives, comfort was achieved through increased feelings of calm and relaxation during and after MT sessions. Comfort was achieved for residents with depressed moods through increased happiness during the sessions, which often lingered afterwards. Residents likely found the music from their era familiar and soothing and the act of participating in the music through singing or playing instruments comforting.

The second need of personhood is inclusion. Kitwood (1997) explains that inclusion “within face-to-face groups” (p.83) is vital for the psychosocial well-being of those with dementia because it allows them to have a “distinct place in the shared life of a group” (p.83). Although residents live together on Emerald Lane, they may not experience the feeling of being part of a group. Residents do not regularly engage in activities together and are often excluded from care decisions and staff conversations on Emerald Lane.

Residents experienced inclusion through taking part in the group recreation and MT programs. Residents of all abilities were invited to the programs on Emerald Lane. Residents who could not actively participate in the group exercises were invited to participate passively, seated near the group so they could observe the sessions. During the MT sessions, feelings of inclusion were supported by residents of all abilities being
invited to participate in the music making process through singing, instrument playing, clapping, tapping and moving to the music. Residents sat in close proximity to one another, with a few holding hands. Even residents with severe dementia were included in the sessions and often able to participate in the music in some way.

Kitwood (1997) describes the third need of personhood, identity, as having continuity with one’s past and knowing who one is emotionally and cognitively. Maintaining one’s identity through the progression of dementia is challenging due to increasing memory and cognitive impairment. The MT sessions that occurred on Emerald Lane likely strengthened residents’ identity. People identify most with music that they listened to in their childhood, teen years and early adulthood, including the music that their parents listened to in the household (Krumhansl & Zupnick, 2013). The MT sessions on Emerald Lane reinforced residents’ identity through playing music that was familiar and meaningful to them. Identity was especially strengthened in Bill’s sessions as he made a point of playing residents’ favourite songs each week. For residents like Rose, who was a piano teacher in the past, singing and playing instruments likely provided her with continuity with who she was in the past.

The fourth need of personhood, occupation, is defined by Kitwood (1997) as being “involved in the process of life in a way that is personally significant, and which draws on a person’s abilities and powers” (p.83). Opportunities for occupation were lacking on Emerald Lane as there were few activities available for residents to use their abilities. Residents were seldom provided with opportunities to be involved in their care or other aspects of their lives as staff or family members usually made decisions for them. Occupation was supported through the choices the MTAs and recreation therapists provided in their sessions. In the MT sessions, residents were encouraged and supported in making song and instrument choices and participating in activities. Jane drew on residents’ abilities by inviting residents to play instruments and occasionally play solos.

There appeared to be a different mindset in MTAs and recreation staff compared to nurses and care staff when providing residents with choice. MTAs and recreation staff appeared to be acutely aware of the importance of autonomy and choice and did their
best to create opportunities for decision-making and autonomy at every opportunity. Other staff members did not seem to be as aware of the importance of autonomy and did not provide as many opportunities for choice. The reason for this contrasting mindset could be due to differences in training; recreation therapists and MTAs’ training embraces a holistic view of residents and focuses on a person-centered approach, while care aides and nurses are trained in the medical model, with most care aides receiving only six months of training. Care staff are also under greater time constraints, making it harder to spend the time to provide residents opportunities for choice.

Lastly, Kitwood (1997) defines attachment as the fundamental and universal need of individuals to form bonds or connections with others. Although many residents are together in the recreation and dining room most of the day, they seldom interact in a way that is likely to form these attachments. This lack of interaction is probably due to residents’ dementia making them unaware of one another or unable to interact socially. Attachment was supported during the MT sessions on Emerald Lane primarily through the therapeutic relationship between the MTA and the residents and the resulting therapeutic alliance and rapport with the MTA, which was particularly evident in Bill’s relationship with Betty. Attachment between residents was also supported during the sessions through spontaneous interactions with one another and interactions facilitated by the therapist. This attachment could be seen in the two residents who enjoyed holding hands.

The NDB model is described by Whall and Kolanowski (2002) as “a template for the constellation of behavioural symptoms that accompany dementia” (p.106). These researchers explain that in the model, ‘problematic’ behaviour is considered a direct result of an unmet need. Discerning and meeting these unmet needs improves the quality of life of people with dementia. Looking at the results of the current study, categories were comprised of opposing themes, one that described unmet needs and the other that revealed ways in which the needs were met.

In examining the category Engagement, Idle Time could be viewed as the unmet need for engagement, while Drawn In shows how this need was met in some residents through participation in MT and recreation programs. Similarly, the category Autonomy
includes *Left Out*, which can be thought of as the unmet need for independence and self-determination. On the other hand, *Simple Choices* shows how this need was met through opportunities for autonomy and choice in day-to-day life, and especially in MT sessions. Lastly, the category *Social Interaction* contains *Endless Silence* and *Staff Disdain*, which demonstrate the unmet needs to connect with others, respect and dignity. The theme *Side by Side* shows how involvement in shared experiences with others and social interaction with residents, companions and staff, including MTAs, met the need for social interaction in residents with dementia.

Rather then showing a contrast between unmet and met needs, the last category of *Well-being* can be thought of as demonstrating the consequences of each side of the dichotomy on resident’s health, mood and behaviours. The theme *Something’s Not Right* demonstrates the feelings of anxiety and sadness in residents whose needs for engagement, social interaction and autonomy were not being met. This anxiety and sadness often resulted in ‘agitated’ behaviours including wandering, calling out, crying and aggression. In contrast, the theme *Soothing Scene* shows how mood, behaviours and anxiety levels changed when residents’ psychosocial needs were met. In conclusion, the results of this study fit nicely into the NDB model and show the importance of staff members changing the way they view agitation and address unmet needs in RCF residents with dementia.

The conceptual considerations proposed earlier, consisting of the MTA’s *Assessment*, the *MT Sessions* and the *Resident Outcomes*, are analyzed in the following paragraphs. In order for MTAs to support the needs of residents with dementia, as described by Kitwood’s (1997) Model of Person Centered Care and within the NDB model (Whall & Kolanowski, 2002), it is essential that they first know more about the residents they are working with through assessment. MTAs must learn residents’ preferences, interests, desires, background, culture, skills, abilities, deficits as well as their schedule. This knowledge allows for the MTA to comfort the resident through choosing appropriate and familiar music. MTAs support residents’ participation in group MT sessions through knowing their preferences, abilities and deficits. MTAs support resident’s identities through knowing their social history and musical preferences and incorporating both into the MT sessions. Also, knowing the resident allows the therapist
to choose appropriate interventions that draw on the strengths and abilities of each resident. Attachment comes through the process of getting to know the resident and building rapport.

During the *MT Sessions*, the therapeutic relationship between the therapist and the resident is developed, starting with rapport and trust. The individualized and person centered therapeutic interventions used in the MT sessions are used to facilitate inclusion and occupation as they are specifically designed to match the residents’ abilities and interests. The MT sessions are the place where unmet needs discovered in the assessment are worked on in the form of goals and objectives. For example, if a resident has a need for social interaction that is not being met in their day-to-day lives, the therapist would facilitate MT interventions to increase increased social interactions between the resident and the therapist and between the resident and other residents in the group.

The final component, *Resident Outcomes* aligned with the results of the study through the theme *Drawn In* which showed increased mood, engagement and sensory stimulation in residents through the MT sessions. Likewise, *Side by Side* showed increases in social interaction and sense of belonging and *Soothing Scene* showed increased relaxation and decreased anxiety, depression and anxiety in some residents during and after MT. The need of identity is addressed within the *quality of life outcomes* through the MT allowing residents to connect with a ‘whole’ and well part of themselves, thus reinforcing a positive identity.

In conclusion, the results of the study indicate that each of the five needs of personhood outlined by Kitwood (1997) may be supported in some way through MT programming. Unmet resident needs demonstrated through agitated behaviour described in the NDB Model may also be met through MT sessions and enhance quality of life for residents with dementia living on a special care unit.

### 7.4 Implications for Practice

The primary goal of this research was to discover how MT may increase quality of life for residents with dementia living on a special care unit. The results revealed that
on Emerald Lane, residents’ lives are lacking in the areas of engagement, quality and quantity of social interactions, well-being and autonomy. These findings are likely similar to what would be found on other comparable special care units. MT appeared to provide a large improvement in quality of life for many residents. Observational, interview and focus group data revealed that MT had a considerable influence on engagement levels, autonomy, social interactions and psychosocial well-being. The following four recommendations are based on the results and aim to improve quality of life in persons with dementia living on a special care unit.

The first and most pressing recommendation for the RCF is to take actions to change the culture on the unit from one of apathy to one of respect and caring. Culture change is a challenging process and requires committed leadership at all levels, from front-line staff to administrators to increase staff buy-in. As many staff members have been working on the unit for years, even decades, they are firmly set in their ways of care and interaction practices, making any change difficult. Training all new and existing staff members on dementia, personhood, and person-centered care is the first step. Staff members must also be provided with mentorship, role models, supervision and guidelines for respectful patient-resident interactions and consequences for behaviours that are disrespectful and undermine residents’ dignity.

Because MT is holistic, non-pharmacological, and person-centered, MTAs working in RCFs are ideal leaders in a culture change movement. Within the proposed culture change initiative on Emerald Lane, MTA’s could take a leadership role in advocating for residents’ rights, providing education and training on person-centered care, modeling respectful interactions with residents, and suggesting creative solutions to address challenging behaviours. Because of their expertise in music and engagement, MTAs are in a position to educate family, friends, staff, volunteers and companions how to involve residents in music outside of MT sessions in the form of singing, dancing and reminiscing. The informal use of music is a tool that all individuals can use in their interactions with residents, as a way to keep them engaged outside of activities and to reduce anxiety, agitation and apathy throughout the day.
The second recommendation is to increase MT programming on Emerald Lane from three to seven days a week. The results of the present study include increased engagement, social interaction, well-being and opportunities for autonomy during and following MT sessions, with much more boredom, loneliness, dependence and unhappiness on days when there were no MT sessions offered. Ideally, a consistent dosage of MT would be delivered throughout the week, and sessions would be strategically scheduled at times of the day when residents are more likely to become agitated, such as in the afternoon or evening when some residents are affected by sundowning. By providing MT before agitation levels are expected to increase, MT may be proactively used as a buffer to prevent or decrease anxiety and challenging behaviour. Timing the dosage of MT in this manner could reduce residents’ excess or unnecessary need for psychotropic medication and reduce the amount of time spent by care staff in dealing with the challenging behaviours associated with agitation.

The third recommendation is to resolve the staffing shortage in the recreation department and resume daily recreation activities on Emerald Lane. The theme Idle Time showed a lack of activity on Emerald Lane that likely contributed to the lack of engagement in residents. Because the data collection of this study occurred during a staff shortage in the recreation department resulting in few recreation programs offered, insufficient data was collected to determine the influence of these programs on residents’ quality of life. However, research by Beerens et al. (2016) shows that care home residents with dementia who were more involved in social activities had a higher quality of life. Also, because MT is not necessarily appropriate for every resident, a variety of individual and group recreation and therapeutic programming is required to engage and stimulate all residents living on the Emerald Lane. Likewise, it is recommended that materials for self-directed activities be provided throughout the day, and especially at times when no planned activities are taking place on the unit. Staff members may require training on how to engage residents in various reading materials, picture books, photo albums, puzzles, objects to be sorted, and games.

The fourth and final recommendation is to better incorporate MTAs into the interdisciplinary team on Emerald Lane by including them in huddles, nursing rounds, and care conferences. This increased involvement would allow MTAs to be more aware
of the happenings on the unit, better able to collaborate with other members of the interdisciplinary team, and better able to understand the residents’ needs. Due to the therapeutic relationship between the MTAs and the residents, MTAs are in a unique position to inform the interdisciplinary team of residents’ psychosocial status and needs. MTAs may also advise the interdisciplinary team on non-pharmacological strategies to address agitation in residents, such as singing residents’ favourite songs while conducting care activities that are known to be distressing to the resident, such as dressing or bathing.

MTAs may also be able to educate the interdisciplinary team on ways to keep residents engaged in music outside of the MT sessions. MTAs should oversee volunteer and paid musical performers to ensure the music they chose is appropriate for the residents and to train them on looking for signs of overstimulation or distress. MTAs may create a music listening library for more able residents and friends, family, companions, volunteers and staff members to play appropriate music on a stereo and hear through speakers or headphones depending on the situation on the unit and the needs of the resident. MTAs may also oversee any individualized music listening projects, such as iPod listening, to ensure that these are being used safely and appropriately with residents. MTAs may also contribute other innovative ideas on ways to create a pleasant musical environment on the unit, such as the use of an adapted easy-to-use jukebox, a stack or records for resident to look through and reminisce, or satellite television channels pairing appropriate music with visually appealing photographs and images.

7.5 Limitations & Future Research Directions

This study has limitations. The definition of the term quality of life was problematic. This study broadly defined quality of life as consisting of many aspects, such as engagement, well-being, mood, agitation level, quality and quantity of social interaction, and communication abilities in residents with dementia. The literature on dementia includes many different definitions of quality of life, making comparisons between studies challenging. The second limitation in the study design was that indirect methods, such as observations and interviews with family, friends, companions and staff, were used to determine residents’ experiences and no interviews were conducted.
with the residents themselves. Although special attention was given to observing residents’ vocalizations, facial affect and behaviours, it is hard to understand the meaning behind behaviours, to gauge residents’ internal states and to know their subjective experiences through observation and interviews with others.

This study only included residents who attended MT sessions. This study design meant that we did not gain any insight on why some residents do not attend MT sessions or why some residents do not benefit from MT sessions. A larger study, including all the residents living on a special care unit as participants, would be able to explore the reasons why some people attend MT programs, why others do not, and why this type of therapy is not appropriate for some individuals. Also, the data collection portion of the study took place while significant changes were happening in the recreation department of the RCF, resulting in the recreation department being short-staffed and many activities being cancelled on Emerald Lane. This temporary lack of activity on the unit likely led to worse than usual quality of life for the residents living on the unit and made the positive changes accompanied by MT sessions more pronounced as it was often the only activity taking place on the unit.

Finally, this study was conducted by a MTA. While this can also be considered a strength, it may have resulted in interpretations influenced by prior assumptions and missed information. Because I know so much about MT and was looking through the lens of a MTA, I may have been looking for specific outcomes and may have missed things I was not expecting. Being a MTA may have also skewed the data derived from the interviews, as most staff members, volunteers and family members knew me as a MTA, thus knew what answers I was likely looking for. These interview participants may not have been entirely honest and may have over-exaggerated the benefits of MT on the residents of Emerald Lane.

Replicating this study with a larger sample size, several sites, and a researcher who is unknown to the residents, staff and family members would be beneficial. A study conducted by a researcher who is unknown to the participants would allow us to determine if data found in the interview and focus group were shaped due to me being known as a MTA. Because my background as a MTA brought certain assumptions and
views, a study conducted by a researcher who is not a MTA would allow us to determine how my lens as a MTA may have shaped the observations and data analysis.

Replication of this study on a special care unit with regular recreation programming would be valuable as it would explain if the differences observed in quality of life between when MT sessions were occurring and when no activities were taking place were due to the MT sessions or to the fact that activity was happening on the unit. Similarly, comparative studies are needed that look at MT and other activities that provide a similar amount of attention, such as recreation activities, to determine the specific value of MT. This research would provide insight into what effects the MT causes and what effects are due to the increased attention and human contact during the sessions. The findings would provide hard evidence on whether MT has a uniquely therapeutic effect, through the MT interventions and the therapeutic relationship, beyond what is caused by the attention being paid to residents.

Further studies are needed to determine the optimum timing and dosage of MT for residents with dementia living in RCFs. This research would give insight on how long the residual effects of MT last and how many days a week and sessions per day are required for residents to retain a positive influence from the sessions. Information on MT timing and dosage would allow for facilities to schedule the optimum frequency and timing of MT sessions to provide a continuous therapeutic influence. This modification in the scheduling of MT would likely result in the maintenance of a higher level of quality of life in residents with dementia, decrease the workload of care staff, and reduce the need for pharmacological interventions in residents of RCFs.

This exploratory research represents a first step in understanding how MT influences quality of life in residents with dementia living on special care units. This study provides insight into residents’ experiences on special care units and the influence of MT for people with dementia. Additional qualitative studies on the topic are needed to understand further how MT may be useful in improving the lives of residents with dementia.
7.6 Conclusion

This study provides insight into residents’ experience of MT sessions and the influence that these sessions have on their quality of life on the special care unit. It offers a glimpse into the lives of a sample of people with dementia living on Emerald Lane, including their engagement levels, quantity and quality of social interactions, opportunities for choice and autonomy and general well-being and mood. The study took into account other planned and unplanned activities that occurred on the unit and the activity deficiency that was occurring on the unit at the time of data collection due to a recreation staff shortage.

This study contributes to a growing body of literature documenting how MT may be used as a non-pharmacological treatment to enhance the lives of care home residents with dementia. The themes Idle Time, Left Out, Endless Silence, and Something’s Not Right, show the stark reality of the lack of engagement, social interaction, autonomy and well-being that many residents experience living on a special care unit. Residents were observed sitting for hours in the dining and recreation room, not engaged in their surroundings, sleeping and staring across the room. Many residents were often anxious and demonstrated agitated behaviours such as wandering, calling out, repetitive movements and aggression. Residents seldom interacted with or spoke to one another. Interactions with staff were often task oriented rather than social, and staff often made decisions for residents rather than providing them with choices. Staff Disdain revealed how the culture on a special care unit is sometimes harmful to residents’ personhood, dignity and well-being through care staff not respecting residents, treating them like children and mocking them.

In contrast, the themes Drawn In, Simple Choices, Side by Side and Soothing Scene show the positives happening on the special care unit. Residents showed engagement in life through participating in self-directed activities and group MT and recreation programs. Residents interacted socially with family, companions, volunteers, MTAs, recreation therapists and other staff members. A large difference was observed between when MT sessions and other activities were taking place and when nothing was happening on the unit. For instance, more choices were provided to residents through
attendance and participation in activities as well as more opportunities for interaction and engagement.

Many positive changes were observed in residents during the MT sessions. Residents were more often alert, calm and engaged during the sessions. Some residents showed a marked lift in their mood and others a decrease in anxiety. Residents participated in the sessions through playing instruments, performing solos, singing and dancing. Residents were offered choice in their attendance at the program, their participation level and instrument and song choices. Residents expressed joy verbally, as well as through smiling, laughing, vocalizing and joking around with the therapists. Residents interacted with the therapists during MT sessions, and occasionally with one another through their gaze, hand holding, engaging in conversations and singing together. Considering the results of this study, as well as other literature on the topic, MT is determined to be extremely beneficial for improving quality of life for residents with dementia living on special care units.
References


Cahill, S. & Diaz-Ponce, A. M. (2011). 'I hate having nobody here. I'd like to know where they all are': Can qualitative research detect differences in quality of life among nursing home residents with different levels of cognitive impairment? *Aging & Mental Health, 15*, 562–572.


Appendix A – Observation Guide

Date & Time: __________________

Location: ________________________________

Activity being observed: ________________________________

Residents present: ________________________________

Staff members present: ________________________________

Family, friends, & companions present: ________________________________

• What social interactions are taking place? Between residents? Between residents and staff/family/friends/companions?

• Are participants engaging in the music/activity? How?

• Are participants active or passive participants in the activity?

• What are participants’ facial expressions and body language saying about their current mood?

• What behaviours are taking place? Are participants’ doing something/wandering/self stimulating?

• Are participants talking to one another? What are they saying? What is the tone of their voice?

• How alert are participants? Is anyone sleeping? Are their eyes open?

• Describe the physical location and arrangement of furniture.
Appendix B – Consent Forms

Staff Information and Consent Form

The Influence of Group Music Therapy on Residents with Dementia in Residential Care Facilities

Principal Investigator: Madeleine Bourdages, BMT, MTA, MA (Candidate)
Department of Gerontology
Simon Fraser University Vancouver
#2800-515 West Hastings Street
Vancouver, BC
V6B 5K3
Phone: […]
Email: […]@sfu.ca

Senior Supervisor: Dr. Habib Chaudhury
Professor and Chair
Department of Gerontology
Simon Fraser University Vancouver
#2800-515 West Hastings Street
Vancouver, BC
V6B 5K3
Phone: […]
Email: […]@sfu.ca

Dear [insert name of staff member]

As a staff member working at […] you are invited to take part in a research study. Your participation in this study is entirely voluntary; therefore it is up to you to decide whether or not to take part. Before you decide, it is important for you to understand the purpose of the research and what participation in the research involves. This consent form will give you information about the study, why the research is being
done, what will happen during and after the study, as well as any possible benefits, risks, and/or discomforts.

If you wish to participate, you will be asked to sign this consent form. If you do decide to take part in this study, you are always free to withdraw at any time, without giving any reason for your decision. Your decision to participate in this study will have no effect on your job or your relationships you have with residents, other staff, management, or family members. All information will be kept strictly confidential and will only be used for the purposes of this study. No information obtained in this study will be connected to your personal information. All names will be replaced with ID numbers and pseudonyms in any databases, papers, or presentations that are produced from this research.

Please take the time to read the following information carefully before you decide to give your consent.

Who is conducting the study?
This study is being conducted by Madeleine Bourdages under the supervision of Dr. Habib Chaudhury, as part of a Masters of Arts in Gerontology at Simon Fraser University.

What is the purpose of the study?
The purpose of this study is to learn more about the influence of group music therapy on residents with dementia living in special care units.

The goal of this research is to learn how residents’ moods and behaviours are impacted by music therapy and how they, and others around them, feel about this treatment. In order to do this, we would like to observe life on [...] during group music therapy sessions and at other times throughout the day and week. We will also be conducting one focus group with staff and one focus group with family, friends and companions of the residents on the unit.

Who can participate in this study?
You can participate in this study if you are a full or part-time employee who has been employed at [...] for at least three months, and are directly involved with residents on [...].

What does participation involve?
For this study care, nursing and interdisciplinary staff members will be observed interacting with residents during music therapy programs and at other times throughout the day and week. To do this the observer will sit off to the side where she can clearly observe the residents’ facial expressions, verbal and non-verbal communication, and
physical movements, but will not be participating in music therapy sessions or other activities. The observer will not have any physical contact with residents or staff. She may interact with residents and staff in casual conversations. Observations will occur over a three-month period.

In order to gain a better understanding of the influence of group music therapy on residents with dementia from a staff perspective, you will be asked to participate in a focus group with coworkers. The focus group will last 60-minutes and will cover several topics. Discussions will focus around your thoughts and feelings on the music therapy programs offered in [...] and how you feel the residents are impacted by these programs, including their behaviours, including interactions with others, as well as how their mood may be affected.

**What are the possible harms and side effects of participating?**

There are no known risks to participating in observations or focus groups. You are free to withdraw participation at any time.

**What are the benefits of participating in this study?**

Information obtained through this research study will enhance our current knowledge of the impact of music therapy on people with dementia living in special care units, and may contribute to advancements in future therapeutic treatments for people with dementia.

**What happens after the study is finished?**

Information collected through this research will be analyzed and discussed in Madeleine Bourdages’ MA thesis, along with any subsequent publications and presentations. Again, all names and data will be kept strictly confidential and anonymous by using ID numbers and pseudonyms and by presenting data in group form. No information that discloses your identity will be released or published.

**What will the study cost me?**

You will not incur any personal expenses as a result of participating in this study, other than 60-minutes of your time for the focus group.

Focus group members will receive complimentary refreshments and snacks, as well as a $10 gift card to a coffee shop as a token of our appreciation.

**Who do I contact if I have questions about the study during, before, or after I consent?**

If you have any questions or desire further information about this study before, during, or after participation, you can contact:
Madeleine Bourdages at [...] or [...]@sfu.ca
or
Dr. Habib Chaudhury at [...] or [...]@sfu.ca

Who do I contact if I have any questions or concerns about my rights as a participant in the study?

If you have any concerns about your rights as a research participant and/or your experience while participating in this study, contact Simon Fraser University Ethics Board:

Dr. Jeff Toward at [...] or [...]@sfu.ca

Please retain this document for your own records.

CONSENT TO PARTICIPATE

I have read and understand the information and consent form.
I have had sufficient time to consider the information provided and to ask for advice if necessary.
I have had the opportunity to ask questions and have had satisfactory responses to my questions.
I understand that all of the information collected will be kept confidential and that the results will only be used for the research objectives.
I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time.
I understand that I am not waiving any of my legal rights as a result of signing this consent form.
I understand that there is no guarantee that this study will provide any benefits to me.
I have read this form and I freely consent to participation in this study.
I have been told that I will receive a dated and signed copy of this form.

Signatures

______________________  __________________  _____________
Printed Name of Participant  Signature  Date

Madeleine Bourdages  __________________________  __________________
Printed Name of Principal Investigator  Signature  Date
Music Therapist Information and Consent Form

The Influence of Group Music Therapy on Residents with Dementia in Residential Care Facilities

Principal Investigator: Madeleine Bourdages, BMT, MTA, MA (Candidate)
Department of Gerontology
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Phone: […]
Email: […]@sfu.ca

Senior Supervisor: Dr. Habib Chaudhury
Professor and Chair
Department of Gerontology
Simon Fraser University Vancouver
#2800-515 West Hastings Street
Vancouver, BC
V6B 5K3
Phone: […]
Email: […]@sfu.ca

Dear [insert name of music therapist]

As a music therapist working at […] you are invited to take part in a research study. Your participation in this study is entirely voluntary; therefore it is up to you to decide whether or not to take part. Before you decide, it is important for you to understand the purpose of the research and what participation in the research involves. This consent form will give you information about the study, why the research is being done, what will happen during and after the study, as well as any possible benefits, risks, and/or discomforts.
If you wish to participate, you will be asked to sign this consent form. If you do decide to take part in this study, you are always free to withdraw at any time, without giving any reason for your decision. Your decision to participate in this study will have no effect on your job or your relationships you have with residents, other staff, management, or family members. All information will be kept strictly confidential and will only be used for the purposes of this study. No information obtained in this study will be connected to your personal information. All names will be replaced with ID numbers and pseudonyms in any databases, papers, or presentations that are produced from this research.

Please take the time to read the following information carefully before you decide to give your consent.

Who is conducting the study?
This study is being conducted by Madeleine Bourdages under the supervision of Dr. Habib Chaudhury, as part of a Masters of Arts in Gerontology at Simon Fraser University.

What is the purpose of the study?
The purpose of this study is to learn more about the influence of group music therapy on residents with dementia living in special care units.
The goal of this research is to learn how residents’ quality of life, including moods and behaviours, are impacted by music therapy and how they, and others around them, feel about this treatment. In order to do this, we would like to observe group music therapy sessions conducted on the unit.

Who can participate in this study?
You can participate in this study if you are a music therapist who has been employed at [...] for at least three months, and are directly involved in leading group music therapy sessions with residents on [...].

What does participation involve?
For this study residents, as well as music therapists, other staff, family, friends and companions, will be observed during music therapy programs and at other times throughout the day. To do this the observer will sit off to the side where she can clearly observe the residents’ facial expressions, verbal and non-verbal communication, and physical movements, but will not be participating in music therapy sessions or other activities. The observer will not have any physical contact with residents or staff. She may interact with residents and staff in casual conversations. Observations will occur over a three-month period.
Music therapists are also invited to participate in one 30-45 minute formal, semi-structured interview to explore observations, beliefs, and opinions on residents’ quality of life and what changes they see before, during and after music therapy sessions. The music therapists’ techniques, approaches and the reasons for the decisions made during sessions will also be explored.

**What are the possible harms and side effects of participating?**

There are no known risks to participating in observations or interviews. You are free to withdraw participation at any time.

**What are the benefits of participating in this study?**

Information obtained through this research study will enhance our current knowledge of the influence of music therapy on people with dementia living in special care units, and may contribute to advancements in future therapeutic treatments for people with dementia.

**What happens after the study is finished?**

Information collected through this research will be analyzed and discussed in Madeleine Bourdages' MA thesis, along with any subsequent publications and presentations. Again, all names and data will be kept strictly confidential and anonymous by using ID numbers and pseudonyms and by presenting data in group form. No information that discloses your identity will be released or published.

**What will the study cost me?**

You will not incur any personal expenses as a result of participating in this study, other than 30-45 minutes of your time for the interview.

Those participating in the interview will receive a $10 gift card to a coffee shop as a token of our appreciation.

**Who do I contact if I have questions about the study during, before, or after I consent?**

If you have any questions or desire further information about this study before, during, or after participation, you can contact:

**Madeleine Bourdages at […] or […]@sfu.ca**

or

**Dr. Habib Chaudhury at […] or […]@sfu.ca**

**Who do I contact if I have any questions or concerns about my rights as a participant in the study?**
If you have any concerns about your rights as a research participant and/or your experience while participating in this study, contact Simon Fraser University Ethics Board:

Dr. Jeff Toward at [...] or [...]@sfu.ca

*Please retain this document for your own records.*

**CONSENT TO PARTICIPATE**

I have read and understand the information and consent form.

I have had sufficient time to consider the information provided and to ask for advice if necessary.

I have had the opportunity to ask questions and have had satisfactory responses to my questions.

I understand that all of the information collected will be kept confidential and that the results will only be used for the research objectives.

I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time.

I understand that I am not waiving any of my legal rights as a result of signing this consent form.

I understand that there is no guarantee that this study will provide any benefits to me.

I have read this form and I freely consent to participation in this study.

I have been told that I will receive a dated and signed copy of this form.

**Signatures**

<table>
<thead>
<tr>
<th>Printed Name of Participant</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Madeleine Bourdages</td>
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<table>
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<tr>
<th>Printed Name of Principal Investigator</th>
<th>Signature</th>
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Family, Friend and Companion Information and Consent Form

The Influence of Group Music Therapy on Residents with Dementia in Residential Care Facilities

Principal Investigator: Madeleine Bourdages, BMT, MTA, MA (Candidate)
Department of Gerontology
Simon Fraser University Vancouver
#2800-515 West Hastings Street
Vancouver, BC
V6B 5K3
Phone: [...]  
Email: […]@sfu.ca

Senior Supervisor: Dr. Habib Chaudhury
Professor and Chair  
Department of Gerontology
Simon Fraser University Vancouver
#2800-515 West Hastings Street
Vancouver, BC
V6B 5K3
Phone: [...]  
Email: […]@sfu.ca

Dear [insert name of family, friend or companion]

As a family, friend or companion of a resident living on the special care unit of […] you are invited to take part in a research study. Your participation in this study is entirely voluntary; therefore it is up to you to decide whether or not to take part. Before you decide, it is important for you to understand the purpose of the research and what participation in the research involves. This consent form will give you information about the study, why the research is being done, what will happen during and after the study, as well as any possible benefits, risks, and/or discomforts.
If you wish to participate, you will be asked to sign this consent form. If you do decide to take part in this study, you are always free to withdraw at any time, without giving any reason for your decision. Your decision to participate in this study will have no effect on the care that your loved one receives or your relationships with the researcher, staff, or management. All information will be kept strictly confidential and will only be used for the purposes of this study. No information obtained in this study will be connected to your personal information. All names will be replaced with ID numbers and pseudonyms in any databases, papers, or presentations that are produced from this research.

Please take the time to read the following information carefully before you decide to give your consent.

Who is conducting the study?
This study is being conducted by Madeleine Bourdages under the supervision of Dr. Habib Chaudhury, as part of a Masters of Arts in Gerontology at Simon Fraser University.

What is the purpose of the study?
The purpose of this study is to learn more about the influence of group music therapy on residents with dementia living in special care units.

The goal of this research is to learn how residents’ moods and behaviours are influenced by music therapy and how they, and others around them, feel about this treatment. In order to do this, we would like to observe group music therapy sessions conducted on the unit.

Who can participate in this study?
You can participate in this study if you are a family member or companion of a resident on [...] and have witnessed them participating in one or more music therapy programs within the last three months.

What does participation involve?
For this study, family members, friends and companions will be observed interacting with residents during music therapy programs and at other times throughout the day and week. To do this the observer will sit off to the side where she can clearly observe the residents’ facial expressions, verbal and non-verbal communication, and physical movements, but will not be participating in music therapy sessions or other activities. The observer will not have any physical contact with residents or family, friends or companions. She may interact with residents and family, friends and companions in casual conversations. Observations will occur over a three-month period.
In order to gain a better understanding of the influence of group music therapy on residents with dementia from a family member and companion perspective, you will be asked to participate in a focus group with other family, friends and companions. The focus group will last 60-minutes and will cover several topics. Discussions will focus around your thoughts and feelings on the music therapy programs offered in [...] and how you feel the residents are impacted by these programs, including their behaviours, including interactions with others, as well as how their mood may be affected.

What are the possible harms and side effects of participating?
There are no known risks to participating in observations or focus groups. You are free to withdraw participation at any time.

What are the benefits of participating in this study?
Information obtained through this research study will enhance our current knowledge of the influence of group music therapy on people with dementia living in special care units, and may contribute to advancements in future therapeutic treatments for people with dementia.

What happens after the study is finished?
Information collected through this research will be analyzed and discussed in Madeleine Bourdages’ MA thesis, along with any subsequent publications and presentations. Again, all names and data will be kept strictly confidential and anonymous by using ID numbers and pseudonyms and by presenting data in group form. No information that discloses your identity will be released or published.

What will the study cost me?
You will not incur any personal expenses as a result of participating in this study, other than 60-minutes of your time for the focus group.

Focus group members will receive complimentary refreshments and snacks, as well as a $10 gift card to a coffee shop as a token of our appreciation.

Who do I contact if I have questions about the study during, before, or after I consent?
If you have any questions or desire further information about this study before, during, or after participation, you can contact:

Madeleine Bourdages at [...] or [...]@sfu.ca
Or
Dr. Habib Chaudhury at [...] or [...]@sfu.ca
Who do I contact if I have any questions or concerns about my rights as a participant in the study?

If you have any concerns about your rights as a research participant and/or your experience while participating in this study, contact Simon Fraser University Ethics Board:

Dr. Jeff Toward at […] or […]@sfu.ca

Please retain this document for your own records.

CONSENT TO PARTICIPATE

I have read and understand the information and consent form.

I have had sufficient time to consider the information provided and to ask for advice if necessary.

I have had the opportunity to ask questions and have had satisfactory responses to my questions.

I understand that all of the information collected will be kept confidential and that the results will only be used for the research objectives.

I understand that my participation in this study is voluntary and that I am completely free to refuse to participate or to withdraw from this study at any time.

I understand that I am not waiving any of my legal rights as a result of signing this consent form.

I understand that there is no guarantee that this study will provide any benefits to me.

I have read this form and I freely consent to participation in this study.

I have been told that I will receive a dated and signed copy of this form.

Signatures

Printed Name of Participant ___________________________ Signature ___________________________ Date __________

Madeleine Bourdages ___________________________ Signature ___________________________ Date __________

Printed Name of Principal Investigator ___________________________ Signature ___________________________ Date __________
Dear [insert name of family member or Power of Attorney],

As a resident living with dementia at the [...] [insert name of resident here] is being invited to participate in a research study. Participation in this study is entirely voluntary; therefore it is up to you to decide whether or not [insert name of resident here] should take part. Before you decide, it is important for you to understand the purpose of the research and what participation in the research involves. This consent form will give you information about the study, why the research is being done, what will
happen during and after the study, as well as any possible benefits, risks, and/or discomforts.

If you wish to provide consent for [insert name of resident here] to participate, you will be asked to sign this form. If you do provide consent for [insert name of resident here] to take part in this study, you will be free to withdraw [insert name of resident here]’s participation at any time and without giving any reason for your decision. Your decision to involve [insert name of resident here] in this study will have no effect on the care he or she receives in this facility, nor will it have any effect on the relationship you or [insert name of resident here] have with the staff or administration of this facility. All information will be kept strictly confidential and will only be used for the purposes of this study. This will be done by replacing all names with ID numbers and pseudonyms in any databases, papers, reports or presentations that are produced from this research.

Please take the time to read the following information carefully before you decide to give your consent.

Who is conducting the study?
This study is being conducted by Madeleine Bourdages under the supervision of Dr. Habib Chaudhury, as part of a Masters of Arts in Gerontology at Simon Fraser University.

What is the purpose of the study?
The purpose of this study is to learn more about the influence of group music therapy on residents with dementia living in special care units. Music therapy offers opportunities for autonomy, social interaction and engagement in a meaningful activity and may improve quality of life for these individuals.

The goal of this research is to learn how residents’ moods and behaviours are influenced by music therapy and how they, and others around them, feel about this treatment. In order to do this, we would like to observe residents during music therapy programs, as well as at other times throughout the day. We would also like to access residents’ recreation program participation records, recreation assessments forms, and the music therapists’ session notes.

Who can participate in this study?
Any residents who has been diagnosed by a physician as having Alzheimer’s disease or a related dementia (e.g. vascular dementia or Lewy body dementia), and who has lived in […] for at least three months.

What does participation involve?
As individuals with dementia are sometimes unable to communicate their likes, dislikes, feelings, emotions, and preferences through verbal communication, researchers will
often use a technique called “observations” to gain insight into an experience. Observing
a resident during music therapy programs interacting with the music therapist and other
residents allows for a more comprehensive and richer understanding of their experience.

For this study, residents will be observed during music therapy programs, as well as at
other times throughout the day, in order to gain an understanding of how music therapy
influences these residents. In order to do this, the observer will sit to the side of group
where she can clearly see the residents’ facial expressions, verbal exchanges, and
physical movements, but will not be participating in the sessions. The observer will not
have any physical contact with residents in the group. She may interact with residents
and staff in casual conversations. Observations will occur over a three-month period.

What are the possible harms and side effects of participating?

There are no known risks associated with observations of residents with dementia.
However, if at any time a resident appears to be upset by the presence of the observer,
she will discontinue the observation and exit the room until the resident is comforted.
Observations will only continue if all residents in the group appear uninfluenced by the
presence of the observer. You are free to withdraw consent for [insert name of resident
here] to participation at any time.

What are the benefits of participating in this study?

Information obtained through this research study will enhance our current knowledge of
the influence of group music therapy on people with dementia living in special care units,
and may contribute to advancements in future therapeutic treatments for people with
dementia.

What happens after the study is finished?

Results of the observations and informal interactions will be analyzed and discussed in
Madeleine Bourdages’ MA thesis, along with any subsequent publications and
presentations. Again, all names and data will be kept strictly confidential and anonymous
by using ID numbers and pseudonyms and by presenting data in group form. No
information that discloses a resident’s identity, or your identity, will be released or
published.

What will the study cost me?

Neither you nor your loved one will incur any personal expenses as a result of
participating in this study.

Who do I contact if I have questions about the study during, before, or after I
consent?

If you have any questions or desire further information about this study before, during, or
after participation, you can contact:
Who do I contact if I have any questions or concerns about the resident’s rights as a participant in the study?

If you have any concerns about your rights as a research participant and/or your experience while participating in this study, contact Simon Fraser University Ethics Board:

Dr. Jeff Toward at [...] or [...]@sfu.ca

Please retain this document for your own records.

CONSENT TO PARTICIPATE

I have read and understand the information and consent form.

I have had sufficient time to consider the information provided and to ask for advice if necessary.

I have had the opportunity to ask questions and have had satisfactory responses to my questions.

I understand that all of the information collected will be kept confidential and that the results will only be used for the research objectives.

I understand that [insert name of resident here]'s participation in this study is voluntary and that I am completely free to refuse their participation or to withdraw their participation from this study at any time without changing in any way the quality of treatment or care that [insert name of resident here] receives.

I understand that none of [insert name of resident here]'s legal rights are waved as a result of signing this consent form.

I understand that there is no guarantee that this study will provide any benefits to me or my relative.

I have read this form and I freely consent to [insert name of resident here]'s participation in this study.

I have been told that I will receive a dated and signed copy of this form.

Signatures

________________________________________  __________________________________________  __________
Printed Name Family Member/POA                      Signature                      Date

Madeleine Bourdages

________________________________________  __________________________________________  __________
Printed Name of Principal Investigator                      Signature                      Date
Appendix C – Focus Group Agenda

Family, Friend and Companion Focus Group Agenda

The Influence of Group Music Therapy on Residents with Dementia in Residential Care Facilities

Introduction

I’m interested in learning about the influence and meaning of group music therapy on people with dementia living in care homes, and how this therapy might affect quality of life for these individuals. Specifically, I’m interested in what you as family, friends and companions notice in the way of how your loved ones react to music therapy and how it may change their mood and behaviours before, during and after the sessions. There are no right or wrong answers; I am looking to understand your experience as family, friends and companions.

Potential Questions:

QUESTION 1:
I am interested to know your thoughts on music therapy in general. Can you tell me what you know about music therapy and what you think of it?

   Potential Probes:
   • In your opinion, what is the value of music therapy?
   • What are your experiences with music therapy on this floor?
   • What does a typical music therapy session look like on this floor?
   • What are some of the benefits of having music therapy on this floor?
   • Are there any challenges due to having music therapy on this floor?
   • In general, how suitable is music therapy for your loved one?

QUESTION 2:
This next question is related to mood. You’ve seen your loved one participating in music therapy, what have you noticed before, during and after music therapy in regards to their mood?
Potential Probes:

• What changes, if any, do you notice in their facial expression, vocalizations or engagement?

• What changes do you notice, if any, in their agitation levels?

• If a change in mood does occur, how long does it typically last after a music therapy ends?

• Have you noticed any long-term changes in your loved one?

QUESTION 3:

This question is related to behaviour. Can you tell me about any changes in behaviours that you may notice before, during or after music therapy programs?

Potential Probes:

• How does your loved one typically react to the music? (singing, instrument playing, tapping foot, naming or choosing songs, reminiscing, moving to music, etc)

• What is the influence of music therapy on your loved one’s engagement levels? (Such as looking more alert, increases in vocalizations)

• What changes, if any, do you notice in your loved one’s social interactions with others during and after music therapy sessions? (with other residents, staff, family members).

• Does music therapy affect your ability to interact with your loved one? Make it easier or harder? Has it helped your relationship?

QUESTION 4:

What impact do you think regular music therapy programming can have on quality of life for persons with dementia living in special care units?

Potential Probes:

• Can participation in music therapy affect engagement in life?

• What impact can music therapy have on well-being?

QUESTION 5:

Is there anything that I have missed that you would like to talk about regarding this subject?
Appendix D – Interview Guides

Staff Interview Guide

The Influence of Group Music Therapy on Residents with Dementia in Residential Care Facilities

Introduction

I’m interested in learning about the influence of group music therapy on people with dementia, and how this therapy might affect quality of life for these individuals. Specifically, I’m interested in what you as care aides, nurses and members of the multidisciplinary team notice in the way of how residents react to music therapy and how it may change their mood and behaviours before, during and after the sessions. There are no right or wrong answers; I am looking to understand your experience as staff members.

Potential Questions:

QUESTION 1:
I am interested to know your thoughts on music therapy in general. Can you tell me what you know about music therapy and what you think of it?

Potential Probes:

• In your opinion, what is the value of music therapy?

• What are your experiences with music therapy on this floor? On other floors you work on? Other care homes?

• What does a typical music therapy session look like on this floor?

• What are some of the benefits of having music therapy on this floor?

• What are some of the challenges of having music therapy on this floor?

• In general, how suitable is music therapy for people with dementia?

QUESTION 2:
You’ve seen residents participating in music therapy, what have you noticed before, during and after music therapy in regards to residents’ mood?
Potential Probes:

• What changes, if any, do you notice in facial expression, vocalizations or engagement?
• Are some residents more receptive to care after a music therapy session?
• What changes do you notice, if any, in residents’ agitation levels?
• If a change in mood does occur, how long does it typically last after a music therapy ends?
• Have you noticed any long-term changes?

QUESTION 3:
Can you tell me about any changes in behaviours that you may notice associated during or after music therapy programs?

Potential Probes:

• How do residents typically react to the music? (singing, instrument playing, tapping foot, naming or choosing songs, reminiscing, moving to music, etc)
• What is the impact of music therapy on residents’ engagement levels? (Such as looking more alert, increases in vocalizations)
• What changes, if any, do you notice in residents’ social interactions with others during and after music therapy sessions? (with other residents, staff, family members)
• Does music therapy reduce challenging behaviour in residents with dementia? (wandering, calling out, aggression)

QUESTION 4:
What impact do you think regular music therapy programming can have on quality of life for persons with dementia living in special care units?

Potential Probes:

• Can participation in music therapy effect engagement in life?
• What impact can music therapy have on well-being?

QUESTION 5:
Is there anything that I have missed that you would like to talk about regarding this subject?
Music Therapist Interview Guide

The Influence of Group Music Therapy on Residents with Dementia in Residential Care Facilities

Introduction
I’m interested in learning about the influence of group music therapy on people with dementia, and how this therapy might affect quality of life for these individuals. Specifically, I’m interested in what you as a music therapist notice in the way of how residents react to music therapy and how it may change their mood and behaviours before, during and after the sessions. There are no right or wrong answers; I am looking to understand your experience as a music therapist.

Potential Questions:

QUESTION 1:
I am interested to know your thoughts on working with people with dementia in general. Can you tell me the benefits and challenges of working with this population?

Potential Probes:
- In your opinion, what is the value of music therapy for these individuals?
- What are your experiences conducting music therapy on this floor? On other floors you work on? Other care homes?
- What does a typical music therapy session look like on this floor?
- What are some of the benefits of having music therapy on this floor?
- What are some of the challenges of having music therapy on this floor?
- In general, how suitable is music therapy for people with dementia?

QUESTION 2:
Of the residents with dementia who participate in your music therapy programs, what have you noticed before, during and after music therapy in regards to residents’ mood?

Potential Probes:
- What changes, if any, do you notice in facial expression, vocalizations or engagement?
- What changes do you notice, if any, in residents’ agitation levels?
- Have you noticed any long-term changes?
QUESTION 3:
Of the residents with dementia who participate in your music therapy programs, what have you noticed before, during and after music therapy in regards to residents’ behaviours?

Potential Probes:

• How do residents typically react to the music? (singing, instrument playing, tapping foot, naming or choosing songs, reminiscing, moving to music, etc)
• What is the impact of music therapy on residents’ engagement levels? (Such as looking more alert, increases in vocalizations)
• What changes, if any, do you notice in residents’ social interactions with others during and after music therapy sessions? (with other residents, staff, family members)
• Does music therapy reduce challenging behaviour in residents with dementia? (wandering, calling out, aggression)

QUESTION 4:
What impact do you think regular music therapy programming can have on quality of life for persons with dementia living in special care units?

Potential Probes:

• Can participation in music therapy effect engagement in life?
• What impact can music therapy have on well-being?

QUESTION 5:
What interventions do you find the most effective for persons with dementia?

Potential Probes:

• Are there certain interventions that are more successful for persons with later stage dementia?
• What are the main considerations that influence your choice of intervention for a particular group session?

QUESTIONS 6:
What is your music therapy approach when working with persons with dementia?

• Is it different than your approach when working with residents without dementia?
QUESTIONS 7:

Is there anything that I have missed that you would like to talk about on this subject?
## Appendix E – Audit Trail and Research Timeline

### The Influence of Group Music Therapy on Residents with Dementia in a Special Care Unit

<table>
<thead>
<tr>
<th>DATE</th>
<th>DECISION</th>
<th>REASON</th>
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<tbody>
<tr>
<td>12/01/2014</td>
<td>To use a qualitative research design</td>
<td>- To understand individual’s subjective realities</td>
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<td></td>
<td>- To fill a gap in the literature (there is a lack of qualitative research on this topic)</td>
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<td>- To make research applicable to what MTAs actually do in sessions</td>
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<tr>
<td>04/17/2015</td>
<td>LITERATURE REVIEW COMPLETE</td>
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<tr>
<td>05/01/2015</td>
<td>To use Kitwood’s Model of Person Centered Care and the NDB Model as</td>
<td>- To provide consistency within the literature on MT and dementia</td>
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<td></td>
<td>theoretical frameworks</td>
<td>- To provide an explanation for agitated behaviours exhibited by persons with dementia</td>
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<td>- To frame the results of the present study</td>
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<tr>
<td>05/01/2015</td>
<td>To create a collection of conceptual considerations for MT with persons</td>
<td>- To address the lack of conceptual frameworks or models in the literature specific to MT</td>
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<td></td>
<td>with dementia in RCFs</td>
<td>and dementia</td>
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<td>- To break down the key components of MT and attempt to describe/explain the MT</td>
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<td>process with residents with dementia</td>
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<tr>
<td>06/16/2015</td>
<td>To use <em>Focused Ethnography</em> as the primary data collection method</td>
<td>- To emphasise the realities created by individuals’ subjective experience and provide a</td>
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<td>rich and multidimensional description of the happenings on the unit</td>
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<td>- Preferred over resident interviews as would be challenging due to the severity of dementia</td>
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<td>and would likely complicate the ethics approval process as it is more intrusive</td>
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<td>06/16/2015</td>
<td>To use focus groups with staff, family, friends and companions as a</td>
<td>- To gain information from individuals who know the residents well</td>
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<td></td>
<td>secondary data collection method</td>
<td>- ‘Group effect’ in focus groups will provide rich data, greater than individual interviews</td>
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<td></td>
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<td>- Less time consuming than individual interviews</td>
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<td>06/21/2015</td>
<td>To use […] as study site</td>
<td>- To provide straightforward data collection due to convenient location</td>
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<td>- Has self-contained special care unit</td>
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<td>- Has two different MTAs working on special care unit to potentially observe and interview</td>
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<td>- Easy access to facility due to connections from working at facility</td>
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<td>Date</td>
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<tr>
<td>06/29/2015</td>
<td>ACCESS GRANTED TO STUDY SITE</td>
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<tr>
<td>08/18/2015</td>
<td>MUSIC THERAPISTS AGREE TO PARTICIPATE IN STUDY</td>
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<tr>
<td>09/03/2015</td>
<td>To use formal, semi-structured interviews with music therapists as another secondary data source</td>
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<td></td>
<td>- To learn MTA’s observations, beliefs, and opinions on residents’ quality of life and what changes they see before, during and after MT sessions.</td>
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<td>- To discover the therapists’ approach and techniques, and the reasons for the decisions made during sessions</td>
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<td></td>
<td>- To explore differences between the two MTAs</td>
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<tr>
<td>09/05/2015</td>
<td>To use MTA’s session notes, the participants’ recreation program participation statistics, and the participant’s Recreation Therapy Assessment Forms as supplementary data</td>
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<td></td>
<td>- To allow for a broader view of the MT sessions and provide a better understanding of the resident participants</td>
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<td>- The MTA’s progress notes will allow for cross-referencing of observation, as well as provide another perspective of the session</td>
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<td>- The participation records will give a rough estimate of the residents’ engagement in MT and recreation sessions by indicating whether they were actively or passively involved in the program</td>
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<td>- The Recreation Therapy Assessment/Treatment Plan will provide personal information and a rough physical and psychosocial assessment of the residents</td>
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<tr>
<td>09/09/2015</td>
<td>To use informal conversations (with staff, friends, family, companions and volunteers) and personal reflections as a MTA as supplementary data</td>
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<td>- Informal interviews will provide insight into how those who work on and visit the unit view the MT sessions and the meaning and value that they place upon the sessions.</td>
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<td>- Personal reflections, including impressions, thoughts and feelings will provide additional insight into the effect of MT from the perspective of a MTA.</td>
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<tr>
<td>12/14/2015</td>
<td>RESEARCH PROPOSAL DEFENSE</td>
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<tr>
<td>02/12/2016</td>
<td>ETHICS APPROVAL GRANTED</td>
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<tr>
<td>02/17/2016</td>
<td>To commence participant recruitment</td>
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<td>- Research proposal accepted</td>
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<td>- Ethics approval granted</td>
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<td>- Access to resident powers of attorney contact information granted by facility</td>
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<tr>
<td>02/29/2016</td>
<td>To commence data collection</td>
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<td></td>
<td>- Consent to participate in study granted by 10 residents and their power of attorneys’ (2 more consent forms likely to come back in next few days, totalling 12 resident participants)</td>
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<tr>
<td>03/01/2016</td>
<td>To commence preliminary data analysis (coding)</td>
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<td></td>
<td>- To allow preliminary findings to shape the data collection process</td>
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<tr>
<td>03/15/2016</td>
<td>To schedule and recruit participants for two focus groups</td>
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<td>- Approaching halfway point in data collection period; a focus group within the next month allows for the observations to inform focus group questions and probes and the information gained through the focus group will inform subsequent observations</td>
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<tr>
<td>Date</td>
<td>Event Description</td>
<td>Details</td>
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| 03/29/2016 | To use individual interviews with staff instead of focus group        | - Staff members expressed an unwillingness to come early or stay after their shifts  
|            |                                                                         | - Staff members are willing to be individually interviewed during their shifts |
| 04/14/2016 | FOCUS GROUP WITH FAMILY, FRIENDS & COMPANIONS                           |                                                                         |
| 05/19/2016 | To cease collecting data                                              | - 3 month data collection period completed                               
|            |                                                                         | - Data saturation reached                                                 |
| 05/27/2016 | FIRST LEVEL CODING COMPLETE                                           |                                                                         |
| 06/08/2016 | To begin second level coding                                          | - First level coding complete                                            
|            |                                                                         | - Second level codes emerging from data                                  |
| 07/15/2016 | THEMES AND SUBTHEMES EMERGE                                           |                                                                         |
| 08/10/2016 | To change meta-themes to categories                                   | - Suggestion from Habib                                                   
|            |                                                                         | - Categories make more sense as they act as containers for group of themes |
| 08/27/2016 | To change names of themes                                             | - Suggestion from Habib to try out different theme names, make them more catchy  
|            |                                                                         | - Upon reflection theme names evolved                                     |
| 09/04/2016 | To use Kitwood’s list of Malignant Social Psychology                  | - To frame observations in the theme *Staff Disdain* within the context of *Person Centered Care*  |
| 10/27/2016 | DRAFT OF THESIS COMPLETE                                              |                                                                         |
| 12/05/2016 | THESIS DEFENSE                                                        |                                                                         |