Action Research: Improving my music therapy practice with hospitalised adolescents through building relationships and meeting their developmental needs

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*"**Medicine** at its best is based on **relationship** and **connection**, on opening to the vulnerability of the other and moving into that vulnerability in order to respond to the person who inhabits it... It is not about requiring the other to move towards us in search of care, in search of responsiveness. Rather, it is about **equipping those who provide care with the tools, the spirit**, to move into the place of vulnerability that is inhabited by the sick person."*
(Clarke, as cited in Arnason, 2006, p.16)

Abstract

This study examines the researcher's music therapy intervention with hospitalised adolescents within a paediatric hospital The hospital is located in a New Zealand city serving a broad multicultural population of mainly Pākehā, Māori and Pacific Island people. There is a large body of literature showing that experiences of hospitalisation are often unpleasant and that the challenges adolescents encounter during hospitalisation can also be detrimental to their development. The researcher employed an action research model of cycles of planning, action and reflection to explore the potential for practice improvement in meeting the needs of hospitalised adolescents. In addition, young people's feedback on the sessions and input from supervisors also contributed to the researcher's planning. Personal goals in clinical practice and specific planning for the needs of individual participants were the starting points of each cycle. Subsequently, each cycle had a learning analysis to relate planning to action and to collect the knowledge for the next cycle or future practice. The researcher found that through scrutiny of her clinical work she was able to improve her professional practice. The findings also showed that relationship-building through music therapy was able to support the developmental needs of hospitalised adolescents.

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Contents

List of Tables and Figures

Chapter 1. Introduction

This action research was conducted within a paediatric ward as part of the requirement for the course of Master of Music Therapy. This research is linked to clinical training onsite. The researcher[1] was fully supervised in both the clinical and research process. The clinical practice included two days per week based in the surgical playroom. There were also sessions which took place in the patient's room depending on a request or the needs of the patient. The age of the children in this hospital ranged from newborns to 15 years. In this research, the researcher has focussed on adolescents between the ages of 9 and 15. This research aimed to improve the researcher's music therapy practise with hospitalised young people to meet their developmental needs through relationship-building.

1.1 Motivation for Research

Personal Stance

Being in a paediatric hospital was a new experience for me, both personally and professionally. Working with young people in the paediatric hospital, therefore, became an exciting and challenging experience. I have a cultural background as an Asian immigrant[2]. The majority of young people who had admission into this hospital were Māori or Pacific Island people[3] due to the population within this region. Both the young people's ethnicity and their youth culture meant they were almost a 'third culture' to me. It was therefore difficult, as a practitioner, for me to be confident in working with these young people and build relationships with them.

One of the factors that may have contributed to me lacking in confidence whilst working with these young people could be the gentle disposition of my nature and manners I was brought up to have within my own family and culture. Similarly, to these young people, I may have appeared just as foreign to them as they were to me.

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[1] Due to multiple roles I had during this research, the following terms are used, as each role has a different perspective:
- Researcher
- Practitioner/clinician
- Music therapy student

[2] The researcher's ethnicity is Taiwanese.

[3] Pacific Island people implied here include people from Samoa, the Cook Islands, Tonga, Fiji, and Niue.

Professional Concerns

The hospital staff, along with myself, recognised the unique needs of the young people who had hospital admission. Most of the young people in this hospital were long-term patients with conditions such as; rheumatic fever[4], osteomyelitis[5] or SUFE (Slipped Upper Femoral Epiphysis)[6]. Though they appeared to be more independent than other younger children, they were harder to engage and had a short attention span for activities. Their length of hospitalisation was also unpredictable. As a music therapy student I needed to take all of these factors into consideration to ensure I could plan, facilitate and assess individuals effectively.

The playroom has a teen room attached to cater for young people's needs for space and age-appropriate activities. During my clinical work in the first few months of my placement, I noticed that most of the time, the young people seemed to feel intimidated when I offered to have a music session with them. It usually took time to build a one-on-one relationship between us. I used conversation as a tool to find out their interests and to cater for their needs first, before I could naturally introduce music. Therefore, relationship-building became a key task.

In addition, once I came to understand the impact of long-term hospitalisation[7] on young people, (which was boredom and frustration due to the limitations of their independence and mobility), I felt the need to improve my music therapy practice to support them better through their period of hospitalisation. Therefore, I identified areas to focus on improving through my action cycles. These areas included improving; confidence, flexibility, decision making, capturing or creating musical opportunities and my facilitation skills.

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[4] Refer to the medical term definition in Appendix 1.
[5] Refer to the medical term definition in Appendix 1.
[6] Refer to the medical term definition in Appendix 1.
[7] Refer to 'hospitalised adolescents' (p. 8) for impact of hospitalisation.

1.2 Aims of Research

The motivation for the research discussed above led me to these research aims:

1. To improve relationship building with adolescents in a paediatric hospital.
2. To improve music therapy practice with adolescents in a paediatric hospital.
3. To find ways to actively engage hospitalised adolescents within music therapy sessions.

Chapter 2. Background

2.1 The setting

The capacity of patient intake for this surgical department was 30 beds. The age of children ranged from newborns to 15 year olds, therefore, the playroom was set up with three compartments. The first compartment from the door was set up for younger children with play-dough, toys and puzzles. The second compartment was set up for art based activities, dress-up corner, home corner and medical corner. The third compartment was a teen room where there was a computer, some games, books, a pool table and other youth based activities. There was a quiet room offered to the young people for them to use, at the end of one corridor in the ward, if they needed to. There was also a healing garden on the ground floor for patients and family to get some fresh air. The healing garden was used for my music sessions on two occasions with supervision by another play specialist during my one year clinical placement.

2.2 The staff

There were usually three play specialists[8] working on the days when I was present. Each hospital play specialist had their specialised areas for working with children. One specialised in working with children with burns in debridement, another specialised in working with children in the operating theatre, and the third one was based in the playroom and had a passion for working with young people, especially those with rheumatic fever. I joined this team of experienced and able professionals and aimed to complement their work with sound and music-based activities.

2.3 The resources

The music resources that were available included a small collection of percussion instruments - mostly suited for young children; a ukulele, guitar, CD player and two keyboards. I brought in some more musical instruments to add to the collection; a guitar, ukulele, keyboard and some more percussion instruments – drums, shakers, and some small African instruments.

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[8] Refer to Appendix 1 for a description of hospital play specialist's role.

Chapter 3. Literature Review

Most available music therapy literature related to hospitalised adolescents and focused on patients with recognised special needs or emotional trauma[9]. However, the group of adolescents who took part in this research did not have such recognised needs. Therefore, a wide range of literature sources were drawn upon to situate the context of music therapy with hospitalised adolescents. I will cover areas; in youth development, challenges that hospitalised adolescents are facing, interventions with adolescents, music therapy with adolescents, and finally, the importance of relationship development and its relevant assessment and intervention.

3.1 Adolescents

3.1.1 Youth Development

Adolescence, as a stage of development (see Table 1.1), is characterised with immense changes in both mind and body (Eccles & Gootman, 2002; Robb, 1996). The key themes that constantly arose in the relevant literature highlighted the adolescents' development of identity/self-image, independence, interpersonal relationship, influences by family, peer, school, and community, and the key tasks that young people develop to master (Eccles & Gootman, 2002; McLaren, 2002; Robb, 1996).

The age limit for young people to transfer into an adult ward in this hospital was 15 years old. Therefore, the young people that were relevant to this research included 9 to 15 year olds, across the latency age stage (McLaren, 2002) to the adolescence stage. The need for skill learning, friendship and membership in peer groups was evident in the young people that were encountered during the clinical work for this research. Butler, Gusella and Ward (1998) surveyed 69 hospitalised adolescents regarding their satisfaction of their hospital experience, and their opinions regarding how their hospital experience could be improved to better meet their needs. They found that although a high ratio of adolescents that were satisfied, they made further suggestions for improvement. Adolescents that were older or had chronic conditions reported more disadvantages of hospitalisation and offered suggestions. The five basic

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[9] These identified emotional needs may emerge from adolescents that were traumatized from severe injury or burns (Robb, 1996; Edwards, 1999; Edwards, 1998; Daveson, 1999) in addition to stressful procedures such as cancer treatment (Bailey, 1984), heart transplant (Dun, 1995) bone marrow transplant (Kennelly, 2001) or children in isolation (Robb, 2000).

needs that were surveyed based on Denholm and Ferguson's literature (1987) were; privacy, peer visits and contact, mobility, independence and educational continuity. The strategies Denholm and Ferguson (1987) provided to meet these adolescents' needs included opportunities for communication, offering choices, and appropriate encouragement.

Table 1.1: Erikson's Developmental Stages and Developmental Tasks

The following table summarises the tasks required to move through different developmental stages.

Infancy (Birth to 2) Trust vs. Mistrust	Social Attachment Maturation of Sensory Perceptual and motor functions Sensorimotor Intelligence and Primitive causality Understanding the nature of objects and creation of categories Emotional development
Toddlerhood (2 to 4) Autonomy vs. Shame and Doubt	Elaboration of Locomotion Fantasy Play Language Development Self-Control
Early School Age (4 to 6) Initiative vs. Guilt	Sex-Role Identification Early Moral Development Self Theory Group Play
Latency Age (6 to 12) Industry vs. Inferiority	Friendship Concrete Operation Skill Learning Self-Evaluation Team Play
Adolescence (12 to 18) Identity vs. Role Confusion	Physical Maturation Sexual Relationships Membership in Peer Groups Emotional Development Formal Operations

(Gallo-Lopez, 2005, p.20; Eccles & Gootman, 2002, p.317)

3.1.2 Hospitalised Adolescents

According to Erikson's (1963) stages of psychosocial development, adolescent development is an identity versus role confusion stage. Consequently, it is believed that adolescents are one of the most difficult age groups to work with particularly for staff who have had little experience working with them (Moon, 2007). It is sometimes just as challenging for the staff to understand adolescents as it is for the adolescents to understand themselves.

Furthermore, the impact of hospitalisation for adolescents can include; stress from 'separation from family, pain and discomfort, injury or medical treatment, unfamiliarity with the hospital environment and staff, and immobility imposed by the nature of the injury or illness' (Edwards, 1999, p.21). Hospitalisation for adolescents also imposes limitations in many areas of their developmental needs such as independence, sense of control, choices, privacy, and involvement with their peers (Robb, 1996, Butler, Gusella & Ward, 1998). McClintock (2007) stated that the most common challenges for hospitalised adolescents included boredom, poor discharge planning, lack of parental support, poor social skills, illiteracy, uncertainty as to what the future holds, and loss of control and independence. In McClintock's (2007) study, the young people who were hospitalised expressed feelings of being scared, having no-one to socialise with, and a loss of connection. It is believed that often their psychosocial issues are overlooked.

In order to understand children's comprehension of hospitalisation, Bibace (1980) discussed children's concepts of illness. The author found that children's explanations for their illnesses were reflected in Piaget's stages of cognitive development (pre-logical, concrete logical, and formal logical). This finding provided insight into the development of meaningful, age-appropriate strategies to educate and reassure children, to help them gain a sense of control over their illnesses. Philip (1974) explored different elements that contribute to psychological effects on children admitted to hospital. The duration of hospital admission can have a different impact on the adolescent. For example, the longer the duration of hospital admission or when adolescents experience chronic illness, the greater the impact on their psychological

state. Therefore, it is recognised how important it is to address the needs of this special group.

3.2 Intervention with adolescents

3.2.1 Intervention within the paediatric hospital

Accordingly, the paediatric hospital recognised the importance of the unique needs of adolescents. A team of play specialists and hospital staff had gathered as an adolescent focus group to share their strengths in contributing towards meeting the hospitalised adolescents' needs.

McClintock (2007), a nurse who worked with an 'adolescent focus', discussed the 10 key themes in working with hospitalised adolescents:

1. Engagement
2. Privacy
3. Confidentiality
4. Independence
5. Giving the adolescent a voice
6. Flexibility
7. Create adolescent-friendly environments
8. Recreational needs
9. The team approach
10. Think beyond the hospital

These themes recurred and were addressed by the New Zealand hospital play and recreation professionals. They also drew up some developmental guidelines to help the children who may experience the impact of hospitalisation. These were categorised into issues, stresses in hospital, interventions, and alternative focus. Children under 12 years of age are considered to be school age, and those between the ages of 12 and 18 are considered to be young people. However, the recurring themes between these two groups were the concerns of body image, loss of control and independence, and loss of peers. The interventions that were suggested included involving the child in their own healthcare and gaining an understanding of procedures through discussion. The

importance of encouraging peer interaction among the young people was also highlighted.

3.2.2 *Alternative therapies for adolescents*

There are many other professional disciplines that specialise in working with adolescents. In order to integrate the strengths of other professional disciplines, related work and tools will be examined in this section. Some of the fields included here are play therapy (Gallo-Lopez & Schaefer, 2005), art therapy (Moon, 2007), and social work (Eccles & Gootman, 2002; Parker & Bradley, 2003). Moon (2007) described her work to reach 'tough' adolescents through means of group art therapy incorporating psychotherapy. She discussed the importance of group warm-up activities and an adolescent's personal space within a group.

The assessment tools developed within social work with children and families also provided useful insight into their needs within a multidisciplinary practice.
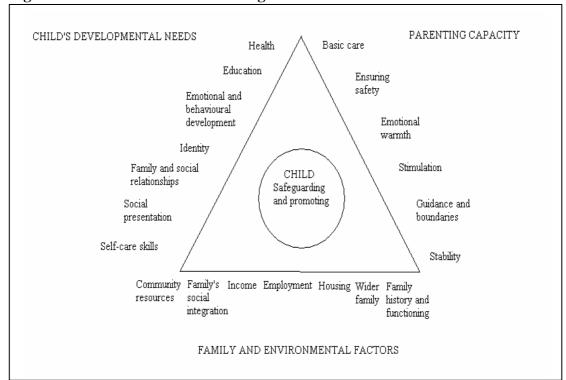
Figure 1.1   The Assessment Triangle

(Parker & Bradley, 2003, p.19)

This diagram illustrated a balance scale of elements that are combined to promote a healthy child and family development. These elements can be considered by a music therapist or any hospital staff to provide better holistic care for young people in hospital.

Moreover, in a social work field, group work with adolescents is considered significant in meeting their developmental needs. Malekoff (2004) focused on the value of working with adolescents in group work. The processes of planning group work included assessment, screening, engagement, education, orientation, and contracting. Moon (2007) also stated the benefits and importance of group therapy for young people. Group settings provide safety and familiarity that reflects their school life and peer groups. Bandura (1989) emphasised that adolescents learn and develop through social interaction with others or by observing. "The group setting provides a safe space where the adolescents can learn and practise social/interpersonal skills, such as cooperation, turn-taking and anger management" (Moon, 2007, p.2). Similarly, group music therapy sessions have significant potential for hospitalised adolescents.

3.3 Music therapy and adolescents

3.3.1 Music therapy with hospitalised adolescents

The music therapy literature which describes work with adolescents who have undergone hospital treatment or hospitalisation; focuses on goals to increase self-expression and self-esteem (Clendenon-Wallen, 1991), facilitation of patient adjustment to hospitalisation, improvement of interpersonal communication, and the recovery of repressed material (Robb, 1996). Robb (2003) provided a contextual support model of music therapy (e.g. structure, autonomy and involvement) for hospitalised adolescents. This model of music therapy improves coping thresholds through the reduction of stress and the promotion of active behaviour. Henderson (1983) found positive effects from music therapy in hospitalised adolescents' awareness of group cohesion and self-esteem. The use of music therapy can also provide extensive emotional support for adolescents in oncology (Kennelly, 2001).

Music therapy can provide patients with; active coping strategies, decreased feelings of helplessness, promotion of self-expression (which has positive effects on

immune function and physical well-being), socialisation and/or cognitive-linguistic development and retraining (Robb, 1996, p.31). Freed and James (1989) commented that a successful group therapy experience is where a 'healthy' atmosphere is present. Yalom (1985) discussed that theorists and clinicians have referred to this 'healthy' atmosphere as 'group cohesion'. However, fostering a 'healthy' atmosphere within a group session is incredibly challenging due to the diversity of the patients that may be involved. These can include different cultural backgrounds, family backgrounds, diagnosis, strengths, interests, needs, and length of hospital admission.

Consequently, Edwards (2005), in discussing her reflection on the music therapist's role in supporting patients in pain management and psychological stress included roles such as being a learner rather than the expert, and learning from the patients about what they need and what can be offered. 'The music therapist has a role to discover and works with the existing musical capacities and interests of the patient" (Edwards, 2005, p.38). It is essential for the music therapist to observe the children's response and interpret these responses to guide his or her practice and to provide information to the multidisciplinary team. The following section will examine some of the music therapy methods that have been discussed in literature in relation to young people.

3.3.2 Music therapy methods

There are several music therapy methods used to work with young people ranging from singing familiar songs, song writing, instrumental improvisation, and instructional teaching. Another area that is also important to music therapy work with young people, verbal processing, is also discussed in this section. The music therapy session may be facilitated in individual sessions or group sessions depending on the needs of the young people and the goals for music therapy.

Song singing

A simple music therapy activity such as song singing offers the patients an opportunity to choose their favourite songs, whether in a group or as an individual. It is considered that through this activity; they gain a sense of control, their needs are being

met, and a sense of belonging and security is promoted (Tatro, 2002). Bailey (1984) stated,

> "Songs have the potential to establish human contact and can provide a framework for enhanced communication… people choose to hear and participate in songs which support their needs and which convey the mood and the messages they want to hear" (p.7).

The author (Bailey, 1984) also discussed the song choice themes that occur in music therapy. In his work with cancer patients he argued that there are different stages of song choice for the client and the therapist depending on the client's state of well-being.

Song writing

Robb (1996) described a number of therapeutic song writing techniques with adolescents who may be experiencing physical and emotional stress from traumatic injuries. The author provided insights to different approaches targeting hospitalised adolescents. She discussed the importance of understanding that not all adolescents are interested in self-expression intervention. It is vital to build up rapport by focusing on their interests and to provide successful experiences. The length of time to build up this rapport may vary depending on the individual. One way to introduce song writing is by asking questions and filling the answers into a song script that contains information about the therapist and the patient. Another way to facilitate the fill-in-the-blank format of song writing can be introduced by finding out the patient's favourite songs. Hence develop a script with gaps to fill in based on the melody of their favourite song. Robb (1996) skilfully structured the activity into introduction, facilitation and discussion. It was emphasised during the facilitation that it is important not to *lead* their contribution towards a specific direction.

> Tatro (2002) highlighted the benefits of song writing. Song writing allows "children to creatively express their emotions…, refocuses attention from negative stimuli, increases communication opportunities…, gives children a sense of accomplishment and mastery, and promotes positive self-esteem. It is also a helpful assessment tool, fun for the child and informative for the

clinician, as the finished product can be a catalyst for discussion about the stressors of illness and treatment." (Tatro, 2002, p.2).

Discharge songs have also been suggested, to be used for children who have been admitted for a long period of time (Robb, 1996; Tatro, 2002). This can be a collaborative task, gathering staff's positive and negative memories about the child's admission. Adapting a familiar song with newly created lyrics to celebrate a child's discharge could be a positive experience for both the child and staff.

Robb (1996) stated, "groups provide patients the opportunity to get together to share and affirm feelings, socialise within a peer group setting, receive peer approval, and express feelings in a safe and confidential environment" (p.34). The music therapist acts as a facilitator, and draws out feedback and ideas. Song writing in groups is often based on serious issues but with a more humorous approach.

The Instruments: improvisation/group drumming/instructional teaching

Musical instruments offer an extension of non-verbal expression. In order to cater for a range of choices, the collection of instruments should be extensive. Also, children's choice of musical instrument could provide information for the music therapist (Brooks & O'Rouke, 2002). Although a musical instrument can be used extensively in a music therapy session, Steve (2003) believed that the real instruments are the *people* by using their own voices.

Improvisation with musical instruments in music therapy elicits creativity, memory, inspiration, intention and intuition (Nachmanovitch, 1990). Improvisation is believed to be a self-portrait from the client, and 'through the shared musical interaction, a therapeutic relationship can be gradually formed' (Darnley-Smith & Patey, 2003, p.72). There is a continuum within improvisation from structured to free improvised music. This could be therapist-directed or client-directed.

The ability to listen to improvisation from different listening perspectives can highlight inter-relationships within a group, both musically and non-musically. McFerran (2007) narrated and analysed an improvisation session by exploring different

listening perspectives of; open listening (ambience or based around a theme), musical listening (instrumentation and different elements of music, i.e. colour, rhythm, tonality), intra-musical listening (partnerships between different voices/instruments), and group leader listening (synchronisation with the leader's sound).

Steven (2003) discussed the benefits of group drumming and the techniques to facilitate a successful session. Group drumming allows "creative freedom and unity found in the common pulse" (p.13). It also "offers an immediate portal into musical expression, a quick-start experience with an instant learning curve" (p.19) compared to other instruments that may require more cognitive processing.

Instructional teaching on how to play an instrument when requested by the patient, or offered by the music therapist, may lead to the beginning of a music therapy session. In a hospital setting, young people may not want to expose their feelings about hospitalisation. However, they may be drawn into interest-based or skill development music sessions. It could be argued that a music therapist is a "facilitator, not a teacher. The facilitator is more like a coach, serving to inspire, direct, conduct, and lead a group of people through the discovery of the rhythm that has been waiting inside them all along." (Stevens, 2003, p.29).

Teaching a pre-composed song or groove allows musical structure that may be needed by some children. Flower (1993) described how a teenage boy used a pre-composed melody repeatedly to give himself 'a safe musical starting point from which he could begin to explore the potentially unsafe world of the music therapy session' (p.42-43). Priestly (1994) also identified the multiple roles a music therapist may take as: "observer, listener, audience, accompanist, teacher, pupil, playmate, the mirrorer of emotions and the introducer of the odd complementary or compensatory ideas" (p.263).

Verbal Processing

Bunt and Hoskyns (2002) explained that the use of words within music therapy sessions is vital. Frisch (1990) discussed the importance of the verbal components in music therapy work with adolescents. "Until the adolescents have acquired a minimal mastery of the symbolic medium of the music, and can therefore relate in the session

on a symbolic level, they will need verbal directions (concrete communication)" (p.20). Verbal instructions to direct specific elements of the music can enhance the process of musical competence and communication. As a result, the music therapist is teaching them the skill of connecting music with their internal process.

Verbal and written words can also be an important form of self-expression (Robb, 1996). Nolan (2005) suggested the two main purposes of verbal processing are that firstly, it increases one's awareness of internal thoughts and connects feelings to external events. Secondly, it provides information for the therapist to validate, or gain insight about the clients. Verbal processing may take place within a range of contexts, including expressive to receptive language and spontaneous singing to spoken discussion. However, Nolan (2005) also argues that it can be difficult at times for the therapist to determine the need to facilitate a verbal discussion, especially after an intense musical activity. Potter (2007) discovered the commonality of awkward silence after a music activity which could be bridged by making a comment about the music to one of the participants. This could be a way to bridge the activity and verbal discussion without intrusion. It also allowed the acknowledgement of a shared musical experience between the therapist and the participant.

3.4 Relationship development

3.4.1 Importance of relationship development

In the music therapy field, much literature discusses relationships from different perspectives. The relationship between a music therapist and a client is believed to be defined as; a friendship, 'dual relationship' as friendship and professional relationship, therapeutic relationship, and even, comradeship (Arnason, 2006; Foster, 2007, Lee, 1996, Pavlicevic, 1997, Robb, 1996).

It is believed that there is not much to our lives if we have no emotional bonds with essential people, e.g. family. Gutstein and Sheely (2002) devised an intervention model for children with Asperger Syndrome and Autism Spectrum Disorder to develop essential relationship skills. A series of relationship development assessments (RDA) are employed prior to the intervention. The authors categorise the different skills and stages of relationship. These include, "Enjoyment, referencing, reciprocity, repair, co-

creation, we-go, social memories, maintenance, alliance and acceptance" (p.19). Furthermore, the authors emphasise the difference between the two types of social skills; instrumental skills to relationship skills. "Social skills such as making eye contact, waiting for your turn, smiling and asking polite questions does not lead to friendships" (p.21). However, both are essential for different purposes. Whereas the instrumental skills can be scripted to certain situations, the 'right' relationship skills are determined by 'referencing' to the opponents and situations. "It is like an ongoing juggling act – we try to add as many balls as possible without dropping any of them" (p.23). The authors commented on the complexity of rapidly observing and processing the information during the relationship-building process.

3.4.2 Assessment and Intervention of Relationship Development

There are tools that different professionals developed to assess relationship development. Gallo-Lopez & Schaefer (2005) focused on communication elements within relationship-building. The authors divided the communication into three different stages including mechanical, verbal and emotional communicators. The aspects of communication among adults can be classified as body language (the mechanical), words (verbal), and the affect or tone of our voice (emotional communication). Gutstein and Sheely (2002) discussed the six levels of relationship development in the RDI curriculum – Novice, Apprentice, Challenger, Voyager, Explorer, and Partner (24 stages in total). The therapists, parents, teachers, or 'coach', will focus on supporting the 'participants' through each stage. The 'participants' will gain an insight into themselves and become more expressive in their relationships.

Gallo-Lopez and Schaefer (2005) also addressed the practical elements of intervention with adolescents. The choices of clothing, therapy environment, language, and self-disclosure have significant influence on relationship development. Furthermore, the authors discussed five issues to be considered within an appropriate relationship between a therapist and a client: limits and boundaries, time, exclusivity, safety, and confidentiality. Relationship-building is the very first stage of the therapy process, followed by process, empowerment and closure.

Finally, the 'power' between a therapist and a client can be used to encourage growth in a relationship. Authors such as Arnason (2006, p.16), Miller and Stiver (1997, p.16) and Kenny (1989, p.88) emphasise that this 'power' is not power over others but 'power with' and 'power that' empowers others. In other words, this 'power' is believed to bring 'changes' from within.

3.4.3 Cultural Issues

Through the researcher's experience of working in this particular hospital, she discovered the importance of cultural understanding. It was not intended to be the focus of this research, but considering different cultures within the researcher's practice contributed towards connecting with some New Zealand adolescents. Therefore, the relevant literature will be discussed.

"A culture can be simply and usefully defined as 'a system of shared understandings' – understanding of what words and actions mean, of what things are really important, and of how these values should be expressed" (Kinloch & Metge, 1978, p.8). Samovar and Porter (2002) also discussed the importance of understanding intercultural communication. Kinloch & Metge (1978) carried out a study examining different methods of communication among Māori, Pākehā and Samoans. The authors discussed the different expressions, both verbal and non-verbal, that exist among these groups. Interestingly, silence in a different context can be interpreted in diverse ways. The definition of 'family'[10] can also extend to other family members, in Polynesian culture, depending on the circumstances.

Moreover, the extended meaning of *culture* can have implications ethnically, developmentally (i.e. 'youth culture'), or religiously. This became more relevant than first anticipated in this clinical work with the hospitalised young people. Fortunately, "culture is not innate; it is learned" (Samovar & Porter, 2002). We can learn about one's values, attitudes, and beliefs through interaction, observation and, at times, through imitation (Samovar & Porter, 2002).

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[10] Sometimes the cousins, aunties or uncles are called sister or brother depending on their age difference. There are also cases when the child calls their aunty or uncle 'mother' or 'father' respectively, when the child is under their care.

Finally, most of the hospitalised young people in this particular hospital appeared to be most comfortable with music either of their own choice, or music from their cultural background, (either by religion or of their own language). Young people that shared a similar musical preference or background could be encouraged to 'share' their music through singing, rapping, playing musical instruments or percussion improvisation. This music structure can provide group cohesion and encourage peer interaction. Therefore, through peer support, it provides coping strategies for those in hospital and also meets their need for peer interaction to enhance self-esteem.

Chapter 4. Methods

4.1 Methodology

This research was carried out using an action research approach. Action research is a 'process of systematic reflection, enquiry and action carried out by individuals about their own professional practice' (Frost, 2002, p.25 from Costello, 2003, p.4). An action researcher examines ongoing actions, or cycles of actions, that are taken in the chosen setting or within the chosen population (Anderson & Herr, 2005). The basic model of steps taken in action research involves studying and planning, taking action, collecting and analysing data, and reflecting to enhance the next cycle of the same process (Riel, 2007). This model of research was developed to assist professionals to problem-solve, and become more flexible and receptive to new ideas. The purpose of action research is to work towards change compared to quantitative and qualitative research which describes the subject 'as it is' (Munn-Giddings & Winter, 2001).

Nevertheless, Munn-Giddings and Winter (2001) discussed the weaknesses of this research approach. These include the possible interpretation of oversimplification that the 'overall focus has to remain fixed'. Another weakness is the emphasis on repeated cycles requires a large amount of time to complete basic tasks such as reflections. It is also difficult to implement when there is a high rate of turnover among participants.

"In an action research project all participants are researchers. Data-gathering is thus a *joint* enterprise, undertaken by all participants in order to give a 'voice' to differing perspectives (Munn-Giddings & Winter, 2001, p.19)." McNiff (1996) stated the choices available for collecting data in action research, including: 1) To observe the effects of one's own action or being observed by others; 2) To ask other people for their opinions, i.e. feedback, which can contribute alternative points of view; 3) Fingerprint data, i.e. audio/video, children's work, written records or documentary information.

Though the focus of action research is 'I', self-study and self-improvement, it cannot be done in isolation from others. Different groups of people that are likely to be

involved in this collaborative task include participants, critical colleagues, supervisors, fellow action researchers and validating groups (McNiff, 1996). Additionally, an informed action research does not base itself solely on the observation and reflection of our actions, but also requires the input of these different groups of people.

Anderson and Herr (2005) discussed the continuum of positionality in action research. The positionality of researcher can range from insider (researcher studies own practice), collaboration with other insiders or outsiders, outsiders study insiders, to multiple positionalities. Furthermore, the authors (Anderson and Herr, 2005) stated the quality criteria for action research. The criteria included "*quality, goodness, validity, trustworthiness, credibility*, and *workability*" (Anderson & Herr, 2005, p.49).

There have been a few music therapists who have utilised the action research approach in improving or reflecting upon their own music therapy practice (Hunt, 2005; Potter, 2007; Rickson, 2006; Wilkinson, 2007). This particular research model, action research, was chosen because it provides the opportunity to support and improve the practice of the researcher in order to offer better service for hospitalised young people.

4.2 Recruitment

In this study, there were several young people invited to participate in the research over an approximate three month period. The criteria for potential participants included young people aged from 9 to 15 years, and young people who had the possibility of staying in hospital longer than a week. To avoid researcher coercion, the potential participants and their caregivers were approached by the hospital play specialist who invited them to take part in this research. If they accepted the invitation, both the information sheet and consent form were provided to parents/caregivers[11] and the young people involved[12]. However, there were only four who were able to give consent within the time available to participate. Others were invited but did not give consent due to; their length of stay, complications related to the need for play

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[11] See Appendix 2 and 3.

[12] See Appendix 4 and 5.

specialists to meet their parents, or when the young person or their parents were not interested in participating.

In addition, young people who participated in a music session were invited to submit session feedback forms. Ten people responded.

4.3 Ethical Considerations

There were some ethical complications to the study because the sessions themselves were not restricted solely to young people who had given consent to take part in the research. In order to not affect the natural practice of music therapy sessions facilitated in the hospital setting, there were others involved in the sessions who were not part of the research. In the interests of accurate observation, the presence of others in the group, and their potential influence upon the participant, may be mentioned. However, in consideration of ethical approval and confidentiality, their presence will only be noted as another boy/girl or a family member.

Also young people in hospital are vulnerable and sometimes quite ill, so it was important to have short, simple ways to gather data, and not to disrupt the support that music therapy might be providing as a clinical intervention. Therefore, I did not involve the young people as fully within the action research process as might have been the case with a less 'ill' population.

4.4 Description of Participants[13]

The four young people who consented to participate in the research came into the hospital for surgery or medical care. They all underwent different medical procedures. Richard, Christine, Rachel and Megan attended school in the hospital as they each stayed in hospital for a long period of time. The school programme usually took two hours in the morning.

Richard was a 12 year old boy who had hospital admission for rheumatic fever. Richard usually had at least one family member accompanying him in the playroom. The family member sometimes also joined in the music sessions.

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[13] Pseudonyms are used throughout this research.

Christine was a 12 year old girl who had hospital admission for chronic fatigue syndrome. She would feel 'dizzy' easily when she stood up or concentrated for too long. She had a low threshold for noise, e.g. when other boys played music.

Rachel was a 10 year old girl who had hospital admission for tendon lengthening. Rachel's family members also joined in the first session with her and other group sessions with some other boys.

Megan was a 10 year old girl who had hospital admission for SUFE (slipped upper femoral epiphysis) that required her to stay on bed rest during the times that I visited. Megan had a family member who also joined in both of her music sessions prior to her discharge.

4.5 Data Collection

Data was systematically collected via,
1) Clinical notes (by myself as the clinician)[14]
2) Journal entries (by myself as the researcher)[15]
3) Session feedback (by the adolescent participants)[16]

A peer debriefing process[17] also took place with a fellow music therapy student to ensure the relevance and quality of data collected in my clinical notes and journal entries.

A detailed description of each is as follows:

4.5.1 Clinical Notes

The clinical notes were usually written up either after each session, or at the end of the day depending on the workload. The notes described what happened during the session. However, due to ethical considerations, only the consenting participants will be described in this research, whereas other participants in the group sessions will not be discussed.

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[14] Refer to a template in Appendix 7.
[15] Refer to an example in Appendix 8.
[16] Refer to the template in Appendix 6.
[17] Refer to Appendix 9.

The clinical notes describe the music therapy intervention used. It generates a pattern of preference of interventions for different young people. The clinical notes helped to form the basis of my reflections in areas of development, issues that arose and ideas for solutions.

4.5.2 *Journal Entries*

The journal entries gather my reflections and discussions with supervisors, colleagues and peers. This journal consists of challenges, questions, dilemmas and possible solutions that arose regarding the clinical work. These journal entries also include interactions each participant had with myself, other staff and peers outside of the music therapy sessions.

4.5.3 *Session Feedback*

This was designed for the young people to respond to the session(s) they took part in. The young people were invited to participate in this process but they did not have to if they chose not to. Due to the hospital setting, a participant could participate in a session ranging from 10 minutes to one and a half hours, or participate in several sessions during their stay in hospital. Young people gave consent to be part of this process by filling in the feedback form. No identifying details other than gender, age, and languages spoken were recorded. (See Appendix 6)

4.6 Action Cycles

The short-term, 'choice-based' nature of this clinical practice meant that the action cycles were planned around the availability of participants. Each cycle included two clinical sessions. The collected session feedback and notes about other issues that arose in the clinical work were then reflected upon in journal entries. There were four cycles in total.

Each cycle of available sessions included the implementation of the following steps:

1) Planning based on previous contact or information from a referral.

2) Conducting the session according to the planning.

3) Reflecting on the session or interactions in order to plan for the next cycle.

Table 4.1: Action Cycles

Action Cycle	Date	Participant	Data collection
1	23/10 - 30/10	Richard	* Planning * 2 Sessions * Journal entry * Session feedback
2	30/10 - 31/10	Christine	* Planning * 2 Sessions * Journal entry * Session feedback
3	5/11 - 6/11	Rachel	* Planning * 2 Sessions * Journal entry * Session feedback
4	20/11 - 21/11	Megan	* Planning * 2 Sessions * Journal entry * Session feedback

Chapter 5. Findings

The findings are organised into four cycles of two sessions each. Within each cycle, the data will be presented in the order of 1) Planning, 2) Clinical notes, 3) Journal entries, and 4) Analysis of learning. Some of the participants' session feedback comments and my thoughts reflecting on my personal goals will also be included here.

The sessions are presented chronologically to document the process of change in my practice through the cycles of action research. Some of the journal entries include extra information about interactions that occurred outside the music therapy sessions to provide context and detail. Each cycle highlights some of the different characteristics of working with young people within this hospital setting. The time span between cycles varied in length due to the availability of encounters with the young people and the time at which they gave their consent. In addition, in the final action cycle, I have included a discussion with my supervisors regarding an issue that arose within the clinical practice. At the end of each cycle, the section on 'analysis of learning' discusses features of professional and personal learning that have been highlighted in the cycle. These 'learning' portions will be brought together at the end of this chapter in a discussion summary on the overall learning, challenges, ideas and future considerations gained through this research, in relation to relevant literature in this field.

The following table provides a summary of the dates of contact, and music therapy sessions that took place, with young people who consented during the period of research.

Table 5.1   Dates of contact with participants

Name	Dates of Contact
Richard	15 Oct, 23 Oct, 30 Oct 2007
Christine	23 Oct, 30 Oct, 31 Oct 2007
Rachel	5 Nov, 6 Nov 2007
Megan	12 Nov, 13 Nov, 20 Nov, 21 Nov 2007

(Highlighted dates were the days when music sessions occurred following consent).

To comply with ethical requirements, there are some sessions that cannot be described here due to the date that the consent was given (that is, consent could not be

given retrospectively). However, my planning of the sessions was based on previous contact to provide clinical continuity. A summary of knowledge gained from previous sessions will be identified to provide context. It should also be noted that it was often difficult to execute session plans directly on account of the unpredictability and fluidity of other participating group members and situations. As a clinician, I recognise that it is always important to be open and flexible to the needs of the day and patients who are present. However, I still felt that planning based on previous learning was relevant to my development as a practitioner and could be stored for future use.

The following table presents data of session feedback collected prior to the first cycle. These results contributed to the process of generating personal goals.

Table 5.2   Music Session Feedback A

Music Session Feedback			
Participant 1: Girl, 13 years old			
Participant 2: Boy, 11 years old			
Participant 3: Boy, 12 years old			
	Participant 1	**Participant 2**	**Participant 3**
Languages Spoken	Samoan	Cook Island	Samoan
Hospital Satisfaction (1-bad, 5-good)	5, it is really fun	3	5
Music Session Satisfaction	5, learning about music is very fun. I have been able to play different tunes and enjoy myself.	5	Bad
Likes or Dislikes in the session	Liked everything. Thanks to LJ for being supportive.	To play the piano	It was good
Music session again? Group/individual?	Yes Individual	Yes	No
Any suggestions?	Work with others more often so that they can enjoy it and like it.	No	No thank you
General comments	The session was really fun. LJ was a very good teacher and I hope she can help me some more.		It was kind of boring

5.0 Planning of Personal Goals

Throughout my half year of clinical practice in this paediatric hospital, I had identified certain areas of my music therapy practice with hospitalised adolescents that

would benefit from scrutiny and development. I planned personal goals based on my own reflections, discussions with supervisors and the clinical assessment process within the clinical practice. For the sake of continuity and coherence, I decided initially to focus my development on five areas, with the possibility of adjustment as my knowledge developed through my research. These five areas will be reflected upon and described in the 'analysis of learning' section of each cycle. The five areas of development are as follows:

Figure 5.1 Personal Planning Cycle 1

> *Personal Goals:*
> - *Confidence: To become more confident.*
> - *Flexibility: To become more flexible at adapting my planning.*
> - *Decision Making: To improve my ability to make instantaneous decisions.*
> - *Opportunities: To improve in being able to 'capture' or 'create' musical opportunities.*
> - *Facilitation: To improve my facilitation skills in order to encourage young people to be empowered and take the 'lead'.*

These five personal goals emerged from the recurring recommendations of colleagues and supervisors prior to the commencement of the research. It was recognised that I needed to gain confidence in working with adolescents to build relationships and to facilitate sessions. The ability to be flexible and be able to adapt my planning according to the circumstances was crucial in this setting. In comparison to my previous clinical experience, where the sessions could be timetabled, it was not possible within this setting. I struggled to 'create' a spontaneous session. Therefore, I wanted to improve my ability to make instantaneous decisions and capture opportunities. Through discussion with a colleague regarding allowing the adolescents to have their own ownership of the session, I found there were times I was dominating without facilitating this.

There was potential for new elements to be added, as part of the nature of action research (depending on how the clinical work and research developed), to meet the clients' needs. These five areas allowed a regular framework and starting point for my thinking.

5.1 Action Cycle 1: More group sessions!

(Challenges of balancing the dynamics in a group setting)

During previous sessions, I encountered challenges balancing the dynamics of the group setting. Some young people were dominating others, both personally and musically. I found I needed to learn how to observe and respond sensitively in these situations.

Session with Richard

5.1.1 Planning

Summary of previous contact:

Richard had a group music session (15th Oct) with two young boys from the hospital. He showed interest in playing the drums the most. His music preference was Bob Marley songs.

Planning for Richard based on previous contact:

- As Richard appeared to enjoy the drums the most: I will explore different drumming activities.
- Continue to build a relationship with Richard through conversation and shared experiences in music.
- Provide opportunities for successful experiences to build his self-esteem through the use of positive encouragement, and offering tasks that can be challenging yet achievable for him.
- Provide opportunities for him to build relationships with other staff or children through shared musical experiences in group settings.

5.1.2 Clinical Notes

23rd October 2007

Session: Group with family members

Richard brought the keyboard to the centre table after my invitation. He was rough with the instrument. I asked him to play the tune again (the one that he was playing prior to my invitation). He withdrew and did not want to play. I assured him that I would play with him on the guitar. He played. Halfway through the song, he got lost. He then asked his friend's brother to play and said, "He is better at it". I encouraged and affirmed that his playing was good. However, his friend's brother started playing the keyboard after Richard's invitation.

Richard started to look through some of the songs in the 'Teen Song Book' (a folder that is a compilation of the lyrics of some well-known songs for this population). He requested "I Tried So Hard" (Akon) and did the rap with his friend's older brother while I accompanied them on the guitar. Richard also showed interest in the song "Me Love" (Sean Kingston). I showed him a simple riff of the bass line on the keyboard so he could join to play. He showed determination in playing his part but he lost the beat after several repetitions. He was frustrated. Richard then moved on to playing the drum. His friend then moved from the pool table and came to join the group. Because Richard was hitting the cymbal really hard (there is a limitation of shared space within the hospital, and other staff and children in hospital may not like the noise level), I offered him a pair of drum brushes to which he commented, "Yeah right! You've got stupid stuff". He hit the cymbal really hard with the handle of the drum brushes. I asked him to play with the bristle not the handle. He insisted on hitting the cymbal with the handle. Not long after, one of the brush handles snapped from the middle. Richard just laughed and continued with the other one. I went to pick up the broken brush from the floor and pretended to look sad and asked Richard, "What do you say?" Richard apologised with a look that showed he knew he shouldn't have done that. I diverted the attention to a solution. So I asked the young boys in the playroom, "Is there any handyman here who can fix the drum brush for me?" Richard's brother offered to fix it with some sticky tape. After the incident, Richard asked for the drumsticks to play the drum. I explained to him that the drum skin would break if he used the sticks because they were not expensive tough drums. Richard said, "Yeah? Like $10?" Richard went on to mock a bit more about the drum. His friend's brother then commented, "Like you have one at home". All the other boys laughed.

We had an interactive session with Richard, his friend and both of their brothers. There was lots of laughter and conversation between one another. Towards the end, another young boy joined the group as well and played the egg shaker. They also requested the song "I Can See Clearly Now" which we all sang and played together. There were times when I sang, that Richard would ask his friend's brother to be quiet, because he wanted to hear me sing. He appeared to be much more interested in what I could offer, compared to the beginning of the session.

30th October 2007

Session: Individual in group setting (brief encounter)

Richard showed interest in the ukulele when he was previously participating in a medical play group in the medical corner. He picked the ukulele string and experimented, holding it down and moving his finger up and down the neck of the instrument. I picked up the guitar and tried to engage him by imitating a similar motion to make a response to his playing. After several moments playing, he looked at me as if I was doing something strange. I then asked if he could make different sounds by showing him how to slide down the string after plucking. He first listened and took interest. He copied several times but not for long. I went on and asked if he would like to learn some chords. He agreed. We worked on the chords C and F on the ukulele. He was determined to get better at how to switch from one chord to the other. I then tried to show him the chord G. He learned. But once I started to sing the song "Me Love" (Sean Kingston) to go with the chords he was playing, he said, "This is dumb", and did not want to play anymore.

5.1.3 Journal Entry

Most music therapy sessions with adolescents in this setting, during my clinical work, were usually initiated by the patients. They could choose whether or not to accept the invitation for music sessions. Therefore, it was important to make contact or build a relationship with the young people prior to music sessions. This journal entry describes the initial stages of relationship-building with young people. The process may include standard greetings, conversations and observations.

> *"During the day, two teen boys (Richard and another boy of similar age) came into the teen room, each with their older brother to play pool. Since there was only a short time before they had to go to school in hospital, there was not enough time to start a session with them. I greeted them and found out the other two boys were their brothers. I then left them to play and just observed alongside while I worked with another younger child in the playroom".*

> *"After lunch, all the young people came into the teen room again. The boys were taking turns at the pool table while I was helping another patient. After awhile,*

Richard started to doodle on the keyboard, trying to figure out the tune of "Lean on Me". I then gathered some instruments on the table in the centre of the room and invited Richard to bring the keyboard over to where I was."

Taken from Journal Entry 23rd October 2007

The interactions with young people were often initiated by the staff when a young person felt unfamiliar with the environment. This journal entry described how Richard had grown in confidence to initiate interactions with me, both non-musically and musically.

"Richard came into the playroom early this morning. He initiated the greeting but followed by asking, "What's your name again?" with a laugh. He made that same comment several times today. I wondered if he was playing a joke; experiencing the impact of hospitalisation; really did find it hard to remember my name because of the inconsistency of my presence; or maybe he didn't know how else to initiate a conversation with me."

Taken from Journal Entry 23rd October 2007

"After I entered the playroom with my bag of instruments after another session elsewhere, Richard was participating in a medical play with a child life specialist and a much younger boy. He positioned himself on the peripheral, almost as an observer but made comments regarding the play. I walked up to the group as they greeted me. As soon as I put down the bag of instruments, Richard picked up the ukulele from my bag to play".

Taken from Journal Entry 30th October 2007

There were some challenges and dilemmas encountered in this cycle. These will be discussed in these following journal entry descriptions.

"Richard appeared to be very unhappy at first when he came into the playroom. He made remarks about people and objects. He was rough with the instruments. He appeared to have low self-esteem. He appeared to challenge my authority by making cheeky comments about the instruments, my musical skills, and insisted on doing what he wanted to do even after he was asked to do otherwise".

"There were times during the session when another hospitalised adolescent's siblings showed interest in taking part. I had a dilemma as to whether or not to include these newcomers. My concern was; if I included them it may make Richard feel 'not good enough', if the newcomers tried to dominate. However, if I did include the newcomers it may draw their hospitalised sibling into the session. In doing so, Richard could benefit from this shared experience to develop peer relationships".

Taken from Journal Entry 23rd October 2007

"When Richard chose to stop playing the ukulele with me, was it because it was getting too challenging for him to cope with? Could it be because there was a young child beside him who made him feel self-conscious of his success? Or was it the song I chose that he may not have liked? Though I chose a song that was popular at the time, it may not have been what Richard liked".

Taken from Journal Entry 30th October 2007

This cycle was the beginning of my dual role journey as both the clinician and the researcher. These thoughts from the journal entry highlight the emergence of this dual role thinking.

"When Richard made negative comments about me or my session, could there have been a better way to react to the situation? I know at the beginning of my clinical work with young people, I would not have had the confidence to confront these issues. I've noticed I don't take the comments as personally as I did before. I've become more able to analyse the situation and comment objectively. This has

enabled me to work through any issues that arise, and help me work towards potential solutions".

"The other play specialist commented that they had a good session and I seemed more comfortable working in a group situation with the teenage boys than before. Did it work better because I have grown in confidence working with them? Did my role as a researcher complement my clinical work?"

Taken from Journal Entry 23rd October 2007

5.1.4 Music Session Feedback

The following table presents data collected from individuals who provided session feedback in the first cycle. These results also contributed to the process of generating my personal goals.

Table 5.3   Music Session Feedback B

Music Session Feedback		
Participant 4: Boy, 12 years old		
Participant 5: Boy, 12 years old		
	Participant 4	**Participant 5**
Languages Spoken	Tongan	
Hospital Satisfaction (1-bad, 5-good)	5	5
Music Session Satisfaction	5	4, music session was exciting
Likes or Dislikes in the session		It was cool
Music session again? Group/individual?	Yes	Yes Group session
Any suggestions?	No	I think more group sessions would be better
Anything else?	No	No

5.1.5 Analysis of Learning

Through interactions with Richard, I was exposed to various situations suitable for building a relationship with him or others that were with him. Our first encounter was when Richard was playing pool while his foster mother watched. I felt I needed to build a relationship with his foster mother and explain my role as a music therapy student. Richard was listening and he would join in with the conversation occasionally.

I was usually nervous, at first, when interacting with the parents of patients, especially with the parents of young people. I was concerned with how parents might perceive the way I interacted with their children. Parents that were friendly made it easier.

Even though Richard was the only participant of this research among his group of peers in the hospital, it was important for me to involve them all in the clinical process. It was sometimes overwhelming managing so many different relationships, especially with the high turnover rate. Building relationships within a short time gradually became easier as I worked towards my personal goals.

There were five personal planning goals implemented in this cycle. Each goal has been reflected upon as follows:

Confidence

When Richard was rough with my instruments and made negative remarks about me, I had to resist the feeling of being undermined. Some of my personal emotions had emerged from Richard's behaviour towards me (see Journal entry 5.1.3). It resurfaced the feelings of dreadfulness I had at the beginning of the placement when I was being undermined by a group of young people. However, the role of being a 'researcher' helped me to examine the incidents in the clinical situation, from a third person point of view (see Journal entry 5.1.3). The resolution was to realise that it was not for a personal reason that Richard chose to behave that way. Therefore, I attempted to find solutions rather than allow the fear to overwhelm me (see Clinical notes 5.1.2). Since that session, I felt my confidence has grown in working with groups, and especially in resolving potential conflicts. Consequently, I discovered that displaying confidence is essential when working with young people, and it is important to understand that I am not 'defeated' when they try to overpower me.

Another factor that affected my confidence during this cycle was the comments young people gave in the session feedback. The comments included, 'the music session was exciting', 'it was cool', and 'more group sessions'. These positive comments became some of the building blocks to my confidence. Nevertheless, there was a negative comment, 'it was kind of boring', that made me concerned. In reflection of all

the comments that were given, there were some potential elements that may have affected the nature of the response:

1) The young people who wrote the feedback may have felt pressured to write positive comments due to their relationship with me.

2) When I invited the boy (who later commented, 'it was boring'), to fill out the feedback, he asked what he needed to do. I joked with him about how he could write about how bad the session was and how I did not sing in tune, or anything he could suggest to help me facilitate the music sessions better. He may have responded honestly, or my way of explanation could have invited his negative response.

3) Another potential factor that could have affected a feedback response may be that the person who filled out the feedback form was not prioritised in the group situation, leading them to feel unsatisfied with the session. In contrast, others that were prioritised may have given more positive feedback, as the session had more readily met their needs.

Even though the comments were more often positive than negative, it was important to take the criticism constructively rather than have my confidence suffer.

Flexibility

One of the keys to working in this setting was flexibility. There is no delegated time, space, or patients. Hence, my ability to be flexible was ultimately stretched when allowing a 'session' to happen. On most occasions, there was no formal referral for candidates for music therapy. I either chose the patients who would potentially benefit from music therapy or, I met the children in the playroom and chose potential candidates based upon our encounters. Initially, it was nerve-racking to work using this approach. However, as I developed aspects of my practice (i.e. my confidence, music repertoire, and content of conversation), it supported my ability to be more flexible in many situations. For instance, I planned to have a music session with Richard as the priority, but Richard invited some other boys to join the session (see Clinical notes 5.1.2). I felt Richard needed his peer support for a sense of safety, enjoyment and well-

being. A group session was adapted to provide those needs. Consequently, my ability to be flexible was challenged and developed.

Decision Making

I often had to make instantaneous decisions in my interactions with Richard. There were times I felt I had made reasonable decisions, whilst there were some that could be improved over the next few cycles. Those instantaneous decisions included; what music or activities should I do next? How much attention should I give to the family members (See Clinical notes 5.1.2)? Should I start a music session now or later, when there would be a better length of time available (See Journal entry 5.1.3)? How should I approach young people for music sessions so that we both feel safe enough to start a session? There were times that I felt I had missed an opportunity or spoiled a chance by approaching a young person in a way that did not suit them (See Journal entry 5.1.3). Being an 'action researcher' allowed me to examine those moments and work towards improvement for the future.

Opportunities

In this cycle, one of the challenges for me was to create a spontaneous group session while some of other people in the room were involved in other activities. It was a battle to draw the young boys into a music session when the pool table or Playstation were readily available. It was critical to capture the 'cue' and the 'moment' that young people offered. The 'cue' could be a phrase that they used in a conversation which could be linked to a popular phrase in a song. It could be a push on the keyboard switch; a bang on the cymbal with the pool cue; or simply humming along to a song that was on the radio. It was important that I responded to their 'cues', even in small ways, to connect with them. This allowed a relationship to grow gradually and could possibly lead to a music therapy session. When Richard tried to figure out the tune of "Lean on me", I felt it was the moment to invite him to join me for a music session (see Clinical notes 5.1.2). It became an appropriate start that developed into a group session.

Another tool to increase the 'cues' that young people offered was to set up the music instruments in the room. I often felt the need to amplify the 'cues' that were offered by young people who appeared to be tentative. This required a sensitive

approach to avoid drawing too much attention, especially in group situations. I have also learned that by increasing the interaction *between* young people, (by referring young people to support one another in the session), it can ease the tension of them being the centre of the attention.

Facilitation

In this cycle, I had the intention to facilitate an individual session for Richard. However, he invited his peers into the musical space. I understood the importance of Richard having a shared experience with his peers, so I had to change my facilitation to include others. It was helpful that his peers were included in the session because they supported me when Richard was venting his frustrations (See Clinical notes 5.1.2). I felt Richard started to trust me more once his peers did.

There were some feelings that arose in this action cycle, which led me to add another personal goal for the next action cycle:

Figure 5.2 Personal Planning Cycle 2

> ***Personal Goal:***
> - ***One-on-one relationships: To reduce the awkwardness in one-on-one situations***

My encounter with Richard in music therapy sessions had begun within a group setting and had transitioned into an individual session. Richard appeared to be more comfortable interacting with me musically within a group setting. Although he had taken the step from passive interaction to taking the initiative, he was not confident in interacting with me musically. I felt there was a sense of awkwardness and uneasiness when Richard interacted with me on an individual basis. I wondered if it was because he felt safer in a group, or maybe he was shy or embarrassed having to interact with a female authority figure. I also wondered if it was the tension that usually presents itself in a new relationship, when in a one-on-one setting. I will explore the dynamics of one-on-one sessions in the next few action cycles as it is appropriate.

5.2 Action Cycle 2: Too much noise!?

(Group versus individual needs)

Christine participated in a group session but she was very sensitive to the noise. This made the group session very challenging for me.

Session with Christine

5.2.1 Planning

Summary of previous contact:

Christine was sensitive to sound. She complained of headaches and dizziness

Planning for Christine based on previous contact:

- Suggest some gentle music activities that she may participate in.
- Use music that she has a connection with.
- Her favourite TV programme is 'Friends'.
- Suggest a goal for the music session.
- Recording and implementing the computer technology.
- Extend her comfort zone of skills.
- Suggest new songs? Or suggest new musical activities?
- Explore Christine's capacity of teaching others what she knows about music to facilitate relationship-building with other young people.

when the level of sound was beyond what she could cope with (see Christine's medical condition in Description of Participants 4.4). She refused the idea of joining a music group. She enjoyed doing quiet activities such as crafts and colouring in.

5.2.2 Clinical Notes

30th October 2007

Session: Individual

Christine was initially playing Nintendo prior to the session. I approached her and prompted, "Guess what I brought?" I displayed the lyrics of the song and started to strum lightly, testing how much noise she could accept, and sang the song "I'll be there for you" (Theme song from 'Friends'). She instantly engaged with the music. She joined in singing though slightly out of time. She did not mind. Christine grew in confidence and her singing dynamic grew stronger. I suggested playing the introduction on the keyboard. I brought the keyboard over to the centre table.

(Richard came in with his brother and wanted to join in but was told by his brother that we were having a session. Richard continued to stay around where Christine and I were. He told us that he was going home today).

Christine was determined to get it right. She constantly asked for my opinion on how she should play. What sound should she use? Just as I started to suggest song writing activities for that song, her physiotherapist came in to take her for a physiotherapy session. Christine said she would continue her music session when she came back. Upon her return we continued singing, playing and arranging the song which repeated for about 30 minutes. Then a nurse came in to take her for a check-up.

31st Oct 2007

Session: Individual/Group

When we were setting up for a music session with Christine, a child life specialist invited another boy to join the music group. That boy then also tried to invite another boy. The second boy refused to join in but observed throughout the session.

The first boy participated in the group. Christine made funny faces at the level of noise the boy produced when he played the drum or cymbal. The interaction between them was tentative at first. After some shared musical experiences, their verbal interactions increased. They then started to express their opinions of each other.

Then, during the recording session, there were constant interruptions from a much younger child. Christine and the other boy in the group became so frustrated with the discontinuity of their performance that the boy decided to leave.

Christine then requested to do the recording in her room. So we moved the instruments into her room. Christine wanted to operate the camera to record, and at the same time play and sing her music. After the first recording, she wanted to make improvements, so she did a second and third take until the memory card was full. We went back to the playroom and uploaded the movie clip onto the computer.

5.2.3 Journal Entry:

This journal entry demonstrated the skills Christine gained from the music session that could be developed to interact or build relationships with others. This also showed Christine's growth in confidence.

> *"Christine was playing a game with a child life intern after our session. After they had finished, Christine wanted to show the child life intern what she had learned on the keyboard (the theme song from 'Friends'). Christine also offered to teach the Child Life intern to play."*

Taken from Journal Entry 30th October 2007

These two quotes from the journal entries included questions that arose from the sessions. They also reflected the need for 'space' and 'variety' in relationships, both musically and non-musically.

> *"How could I change the use of one song? She seemed to be engaged with one song for a long time. Does she actually enjoy playing just one song or did she just want to stay in her comfort zone?"*

Taken from Journal Entry 30th October 2007

> *"Christine was engaged with one song for nearly two hours. During this time we tried different tasks related to the song and interacted with a range of different people. I was exhausted. I wonder if she was too."*

Taken from Journal Entry 31st October 2007

This journal entry described the multiple roles that a music therapist may be required to take on within this hospital environment, to build relationships with young people. It also highlighted the importance of recognising and supporting young people's other interests in a practical way.

"This morning, Christine wanted to make cards on the computer for Halloween. She asked for my help. We also explored the functions on the digital camera and figured out how to upload pictures and video onto the computer. Afterwards we discussed the possibility of recording the song we had played yesterday using Movie Maker."

"In the afternoon, Christine asked for help to make some crafts. Following this, Christine requested to do music."

Taken from Journal Entry 31st October 2007

It has always been a challenge to make decisions in prioritising individual or group needs in this setting. This journal entry discusses my dilemma of whether or not to include others in Christine's music session.

"It was difficult including the other boy at first as Christine was my priority. But since Christine interacted comfortably with him at first, I felt it could damage our session if I turned him away in a shared space. They joked about singing 'Campfire Song' (from SpongeBob SquarePants). I did not know the song. When I look back, maybe I should have taken this opportunity to change the focus of the session to let them build a relationship."

Taken from Journal Entry 31st October 2007

5.2.4 Music Session Feedback

The following table presents data collected from individuals who provided session feedback in the second cycle. These results also contributed to the process of generating my personal goals.

Table 5.4 Music Session Feedback C

Music Session Feedback	
Participant 6: Girl, 14 years old	
	Participant 6
Languages Spoken	Tongan, Niuean
Hospital Satisfaction (1-bad, 5-good)	4
Music Session Satisfaction	4
Likes or Dislikes in the session	I was happy nothing to worry about
Music session again? Group/individual?	Yes Group session
Any suggestions?	Have some more people
Anything else?	I have enjoyed what I did today

5.2.5 Analysis of Learning

The sessions with Christine had been quite different from those with other young people that I had worked with. She appeared to be confident and was helpful to others. However, due to her condition the sound level was an issue. At first, I had to build a relationship with her, so she would be able to trust me that the music we were going to make would be safe and not give her a headache. A lot of conversation and support in other activities was required. I needed to pay more careful attention to using a gentle prompt when inviting her to partake in music activities, and ensure that there was a successful initial musical experience for Christine.

In discussion with a play specialist regarding how it was possible to engage Christine with one song repeatedly for two hours, it was suggested the possibility of attention seeking. Even though I could not be certain this was the explanation, it made me wonder where the balance of music therapy lies. If Christine found the attention needed through music therapy, was that good enough? Or as a music therapist, do I need to encourage the young people to see other people's needs as well as their own? How shall I appropriately respond?

Finally, working in the paediatric hospital setting, it was helpful to be orientated with the playroom and activities that were available, particularly for young people in this case. Having the knowledge or skills to plan and set up other activities for young people offered me another key to relationship-building. It was also important for both

the young people and myself to interact in non-musical activities. Participating in other activities allowed exploration of young people's interests outside of hospital.

There were six personal planning goals implemented in this cycle. Each goal has been reflected upon as follows:

Confidence

My first encounter with Christine took place in her room. She appeared to be a competent girl with many talents. When I asked her if she liked music, she responded that she did not like noise. My confidence initially declined. I felt I was rejected in what I could offer even though I knew she was not targeting me directly. Therefore, I started to ask her questions about her other interests to cover my feelings of uselessness. However, through other interactions in the playroom, I was able to discover her interests in television programmes and identify her favourite celebrities. The use of the theme song to her favourite television programme gained her interest to start a music session with me. My confidence to offer music continued to develop throughout these sessions (See Clinical notes 5.2.2).

Flexibility

Although I had planned sessions for Christine in an individual setting (as it would be easier to monitor the sound level), I had to adapt the session to include others (See Clinical notes 5.2.2). Initially, I was not willing for change to occur as I was concerned as to what Christine's response might be. Knowing that Christine was my priority in that particular music therapy session, I felt I should let Christine decide. I observed Christine's response and asked her preference for other young people to join the music session. Another boy joined after Christine's permission. They started to build a relationship within the session through playing music together and talking about the music they liked or disliked. However, as the boy got more comfortable with the relationship and the music session, he wanted to do the songs *he* liked. It was difficult for me to explain that Christine was the priority for the session. We then discussed if he could have his song after we first finished her song. The unexpected situation and how it evolved made me realise that although it is important to be flexible, at times the

situation may require an instantaneous decision to be assertive in order to maintain boundaries.

Decision Making

In both of Christine's sessions there were constant interruptions. I had to decide whether or not we should move into a more private location for the second session. The only private spaces available were the preparation room or the patient's own room. However, the preparation room was often occupied with other activities or patients' family members. It was sometimes a dilemma whether to offer young people music sessions in their own room, as it was a private space to work and I did not want them to feel I was intruding on their privacy. However, in the second session, with Christine's agreement, we moved the music session into her room (See Clinical notes 5.2.2). When we were in her private space, the atmosphere of our session changed. Christine became more animated and expressive. Therefore, I believe it is important to consider the adolescent's preference of privacy vs. an open space, to enhance the relationship development within the session.

Opportunities

In this cycle, Christine did not offer any musical 'cue' or show any interest in music. Through verbal conversation I was able to find out her likes in order to 'create' or 'capture' musical opportunities that related to her favourite TV theme tune (See Clinical notes 5.2.2). This helped me to gain confidence in 'creating' or 'capturing' opportunities for music sessions even when the adolescents initially refused.

Facilitation

I felt Christine had the confidence in her interpersonal skills to be able to 'lead' the situations once a safe environment was established. I provided the musical structure and then asked for her opinions in possible performance directions. Christine was able to express her ideas when I suggested that we record the song (See Clinical notes 5.2.2). I felt Christine's 'lead' in the session had developed throughout our interactions.

One-on-One Relationship

It felt a bit awkward when I first encountered Christine in her room. Our one-on-one relationship developed through conversation and other activities. I learned that it is possible for the awkwardness of a one-on-one situation to be naturally present in an initial encounter, regardless of the participant's gender. Trust needs to be earned. The feeling of awkwardness could be projected from one to another or could exist on both sides.

From this action cycle, I felt the need to add the issue of boundaries into my personal planning for the next action cycle.

Figure 5.3 Personal Planning Cycle 3

> ***Personal Goal:***
> - ***Boundaries: Session length and professional boundaries***

As mentioned earlier in the journal entry, Christine was engaged with one song for nearly two hours. This made me exhausted and I wonder if it was the same for her (See Journal entry 5.2.3). It was difficult to close the second session as we had a goal to achieve. We also did not know if we would have another session before she was discharged. Therefore, we took as much time as we needed to finish our ICT project incorporating the music. In reflection, I felt it could have been detrimental to our relationship-building, as there was no appropriate boundary for the length of our session.

It was also important to have a professional boundary when other professionals wanted to work with the patient, whom I was working with at the time (See Clinical notes 5.2.2). Therefore, I aimed to improve on keeping this professional boundary in the next few action cycles.

5.3 Action Cycle 3: My own world!

(Moving from my world into other's)

Rachel loved music. She loved to play on her own. It was interesting to explore her capacity to connect with others through music.

Session with Rachel

5.3.1 Planning

It was mentioned in the handover meeting that Rachel really liked music. A child life intern went into her room and asked if she would like a music session. Her family agreed but due to Rachel's mobility problems, they requested that the session take place in Rachel's room.

Planning for Rachel based on previous experience with young people:

- Explore Rachel's interest in instruments.
- Assess Rachel's musical background.
- Observe Rachel's relationship with her family.
- Examine any possible concerns with hospitalisation.
- Increase her sense of belonging.
- Assess the potential for further music therapy sessions. If 'yes', then decide on group or individual sessions.

Planning for the second session:

- Continue the game-like music activities and develop into a story?
- Explore a different instrument or develop her strumming?
- Integrate conversation into music making.

5.3.2 Clinical Notes

5th November 2007

Session: Individual with two family members

When the instruments were offered to Rachel, she chose the guitar. She had a shy manner yet was very absorbed in her strumming. Picking and playing different notes on one string did not appeal to her. So I changed the tuning to an open G chord. At first, I just improvised to her G chord on the keyboard. I started small melodic motives which Rachel naturally responded to rhythmically. I added singing a simple melody, then added words. We explored different songs with the open chord. After singing some songs, I played a short rhythmic pattern on the keyboard. Rachel

instinctively copied, and so it became a game. We took turns to copy each other. It came to a natural ending with a cadence progression. Rachel's mother laughed and Rachel smiled too. I asked if she would like to do one more song before we finished. Rachel said she sang 'YMCA' at school so we sang that together. After the session, her mother asked me where they could learn music.

6th November 2007

Session: Individual

Rachel came into the teen room and started jamming and exploring different sounds on the keyboard. I joined her and we played a few different games. I played a short tune and she tried to guess what the tune was. I was trying this out to explore her interest in playing a particular tune. However, it did not last long. She initiated the copy game again.

She found the 'motorcycle' sound on the keyboard. She enjoyed just pressing different keys to get a different pitch for the motorcycle sound. I asked: "What are the cars doing?" She said, "Racing". We then made a quick game with cars going around the race track, and I asked which car was leading the race. She replied, "G" (the key G).

Session: Group of three boys and Rachel

This group was prioritised for the other three boys. However, Rachel wanted to be part of the group. We sang songs that allowed space for each individual to take turns playing their own instrument.

5.3.3 Journal Entry

Currently, in New Zealand there are no music therapists employed within the paediatric hospital field. Hence, the role of an innovative practice would, at times, require clarification. This journal entry noted one of the dilemmas I faced regarding my role as a music therapist in a hospital setting.

"When Rachel's mother asked me if I could continue to 'teach' her daughter music after her discharge, it made me wonder if I was more like a teacher than

a therapist to them, or could it be that music therapy is unknown to them so 'teaching' was more familiar for them to relate to? Or, maybe Rachel's mother became more aware of the importance of developing her child's interest?"

Taken from Journal Entry 5th November 2007

The individual music therapy sessions with Rachel demonstrated the versatility of using music in building relationships. This journal entry excerpt described the potential for entering Rachel's world through musical conversation.

"I felt it was difficult for Rachel to follow teaching instructions or demonstrations. She would rather 'play' for enjoyment. Rachel could get very absorbed in her own playing, constantly strumming with open strings. However, when I attempted to 'converse' with her by creating fragments of music rhythmically or melodically, she had a strong natural instinct to respond, within a musical conversation, by turn-taking."

Taken from Journal Entry 5th November 2007

5.3.4 Music Session Feedback

The following table presents data collected from individuals who provided session feedback in the third cycle. These results also contributed to the process of generating my personal goals.

Table 5.5   Music Session Feedback D

Music Session Feedback		
Participant 7: Girl, 12 years old		
Participant 8: Girl, 14 years old		
	Participant 7	**Participant 8**
Languages Spoken	Maori	Maori, Cook Island
Hospital Satisfaction (1-bad, 5-good)	5, Because you can go to the playroom everyday	5
Music Session Satisfaction	5, Because I can play the drum all the time	5, it was cool because I haven't played with those instruments in ages
Likes or Dislikes in the session	Good, I liked everything	It was cool because I like music
Music session again? Group/individual?	Yes I prefer group	Yes Group
Any suggestions?	To have more children play with you	No. She's cool because she's funny and gets everyone involved.
Anything else?	Play the drum	IT WAS COOL!!!

5.3.5 Analysis of Learning

Rachel was one of the very few young people that I made contact with for music therapy sessions through a referral. She was also the only participant I did not have any interaction with prior to the initial session. Relationship-building with her was limited to the music therapy sessions, yet we were empowered through our shared music space.

Due to Rachel's restriction in mobility, the first session had to be conducted in her room. Her mother was present in the session. Observation of their relationship and interactions showed that Rachel had a supportive relationship from her mother. However, there were times when I wondered about Rachel's independence in interacting with others. However, the second day showed that Rachel was comfortable

interacting with me through music. She was also able to participate within a group of people she did not know. Although she did not take initiative in interacting with others, she was comfortable in other people's music space.

There were seven personal planning goals implemented in this cycle. Each goal has been reflected upon as follows:

Confidence

I recognised that before I entered Rachel's room, the anticipation of entering a young person's room to have a music session as our first encounter, was not as daunting as it had been previously. Instead, because of the confidence I now had, I was intrigued to meet a young person and wondered how the session would progress. Rachel's mother was present in the room also. My confidence with interacting and including parents in sessions had also developed. I felt that by having the confidence to interact with the parents, it would positively influence the young people's interaction with me.

Flexibility

At the beginning of my clinical work, I struggled to have more than one or two sessions with the same child on the same day. Firstly, I felt the need to use the time available to work with children who would benefit rather than being occupied with the same children throughout the day. Secondly, I felt the need to set a limit for the amount of time a young person should have music sessions with me. In this cycle with Rachel, she had participated in three music sessions over one day (6th Nov); one individual session and two group sessions (but only one was documented). In the two group sessions Rachel was more of an observer or a quiet participant, and I needed to be flexible in order to make her feel more included.

Decision Making

This element was not applicable to this cycle apart from the natural decisions that a music therapist would make in any music therapy session.

Opportunities

This element was also not very relevant in this cycle because Rachel had her music session in her room through referral. On the second day, it was Rachel who took every opportunity she could to participate in a music session.

Facilitation

Rachel appeared to enjoy exploring the guitar and keyboard when she was by herself. She became very self-absorbed in what she did. When other musical ideas were suggested, they did not appeal to her. However, she would respond intuitively when I responded to her musical ideas. She really came alive when her musical ideas connected with mine. This enhanced our relationship.

One-on-One Relationship

Even though Rachel appeared to be shy and quiet, she knew what she wanted to do with her music. It did not feel awkward for me to have her in a one-on-one session.

Boundaries

The sessions were kept to an appropriate length in this cycle. However, a medical interview took place in the middle of one of our sessions. The staff recognised Rachel's enjoyment at playing the guitar, yet did not recognise the music therapy work. I felt undermined in an environment where there may be a hierarchy of professions. It became important to hold on to my belief that each professional position has its value. It may be valuable to communicate to other professionals how music can help their patients. This would highlight the benefits of music therapy.

For the next cycle, I added this element into my personal goals:

Figure 5.4 Personal Planning Cycle 4

> *Personal Goal:*
> - ***Directive and choices: To be direct but also offer choices***

I felt girls who appear to be shy or quiet require the facilitator to be directive but also offer choices. I thought they may feel more comfortable when the music

therapist 'creates' the music choices first, compared to some boys who may prefer a suggestive tone of facilitation.

5.4 Action Cycle 4: I am different!?

(To be accepted, recognised and understood)

Megan appeared to be quite talkative with the staff but would shy away from her peers. She would refuse when I suggested she play a game with other peers.

Session with Megan

5.4.1 Planning

Summary of previous contact:

Megan was on bed rest. She was very reluctant to participate in any musical activities in the playroom. She would play iCamera, games or make crafts. She was, at times, accompanied by one of her family members.

Planning based on previous contact:

- Explore her musical interests and experiences.
- Increase her self-esteem by creating successful experiences through music.

Planning for the second session:

- Continue to observe Megan's choice of words and ask open-ended questions.
- Continue to record the songs that she wrote and provide successful experiences through music.
- Continue to build a relationship with her and with others (young people or staff) through music making or conversation.

5.4.2 Clinical Notes

20th November 2007

Session: Individual with a family member

I went to visit Megan in her room while she and one of her family members were watching TV. They commented that they were bored but did not want to come to the playroom either. I asked if they would like to have a music session with me in the

playroom or alternatively, in their room. They asked if I could help them to write a melody to their lyrics.

Megan had a song that she had written yesterday, with words about her 'homie' friends. She wrote lyrics about what her friends think when she is sad, or upset. She had used some negative emotional words in her song, but soon decided to discard the song. She wrote a second one titled "Blues". It was about a time when she felt blue and someone came along to cheer her up. Words just flowed out from Megan's pen. She was fluent in writing sentences that rhymed. I asked what kind of style she wanted for her melody. She said, "Hip Hop". She then tried to play some Hip Hop tunes from her mobile phone for me to listen to. I tried with two minor chords, D minor and A minor, with lively strumming. There was not much response from her, but once I started improvising short fragments of melody, Megan said, "Yeah, that's how it goes!" She then started singing and made up her own melody to the words she had written.

21st November 2007

Session: Individual with a family member

When I entered Megan's room with the guitar and keyboard, she told me that she had written another song that she would like to record. She mentioned that she would also like to try playing the keyboard that day. The new song she wrote was about going to a party and being caught by her mother. Although the lyrics of her new song did not contain emotional words (i.e. upset, sad or cry), she agreed to use a melancholy chord progression after I suggested some different examples. During our previous contact, she had usually asked politely for permission or waited for others to ask her first. But in this session, she instructed what she wanted for her song, in terms of style, speed and its ending. She grew in confidence singing into the Mp3 player that we used for recording. After the song recording, we explored different tunes that she was interested in.

5.4.3 Journal Entry

During the first music therapy session with Megan, she gave the impression of being frustrated at being hospitalised for such a long period of time. It could be observed in Megan's expression of boredom and her choice of subject in her lyrics. I

faced dilemmas in discussing Megan's emotions. This journal entry excerpt demonstrated some of the dilemmas I experienced in verbal discussion.

> *"Megan used a few emotional words (i.e. upset, sad or cry) in her writing. I wanted to find out more about the words she chose to use. The verbal discussion became difficult for me, as I did not want to assume nor ask questions that could lead to a situation, where I did not have the skills or time to contain her emotions. Is it good enough to just leave her emotions expressed within the music?"*

Taken from Journal entry 20th November 2007

> *"Had I built enough trust in our relationship to discuss the possible issues reflected in Megan's lyrics?"*

Taken from Journal entry 21st November 2007

However, in the second music therapy session, Megan started to take the 'lead'. This journal entry noted some of the changes in Megan, I have observed.

> *"Megan had started a new song after our session yesterday to be worked on today. She appeared to be more confident in her song writing and singing into the recording device. She also started to take the 'lead' in what she wanted to do in the session."*

> *"There seemed to be quite a change in Megan's choice of content in the new song. I wondered if there had been a change in her state of mind."*

Taken from Journal entry 21st November 2007

The following journal entry was written after a discussion with the clinical liaison and visiting music therapist regarding issues that had arisen from young people's choice of songs. There was an incident where a young person had requested some popular songs, with lyrics that were considered inappropriate. The nature of the

lyrics was not immediately obvious due to the use of a cheerful melody, or use of youth-orientated metaphors. It highlights the importance of being more aware of young people's song choices, and whether they are appropriate for the setting.

> *"It may be a way to build relationships with young people to show interest in their interests. But, what is the rationale of using a requested song that may have a negative message in the lyrics? How could I adapt the song or address the possible issues that arise in the song? How important is it to help the young people be aware of lyrics in the songs if they already sing the songs so often in their own time?"*

Taken from Journal Entry 21st November 2007

5.4.4 Music Session Feedback

The following table presents data collected from individuals who provided session feedback in the fourth cycle. These results also contributed to the process of generating my personal goals.

Table 5.6   Music Session Feedback E

Music Session Feedback		
Participant 9: Girl, 10 years old		
Participant 10: Boy, 9 years old		
	Participant 9	**Participant 10**
Languages Spoken	English	English
Hospital Satisfaction (1-bad, 5-good)		5
Music Session Satisfaction	5, it is really cool and lots of fun	5
Likes or Dislikes in the session	I liked everything	I liked recording songs on the small iPod
Music session again? Group/individual?	Yes	Yes
Any suggestions?	No	
Anything else?	It is very cool learning music	

5.4.5 Analysis of Learning

It would have been possible to write down the melody of the song Megan wrote, but it would have taken a long time and spoilt the moment of inspiration. Though most young people in this setting did not read music, they showed very good sense of aural memory. It felt appropriate to record the songs they wrote or played. They then could be played back. Discussion could come from this and changes to the recording could be made. Consequently, on one of the session feedback forms the participant commented how they had enjoyed recording songs into the iPod (Mp3 recorder).

In response to discussion with the supervisor, regarding instances where young people were choosing songs containing inappropriate lyrics, steps were put in place to improve future practice should the issue arise again.

The steps were as follows:
- First, try asking them why they like the song, then whether or not they know what the song is about? Follow with open questions according to their response.
- If it is the style of the song they like, try adapting the lyrics to more appropriate content. Alternatively, if there is an instrumental part they like, try to arrange it on the keyboard, and add other elements such as a different instrumental melody or rap.
- If a child with a particular concern (i.e. suicidal tendency) were to choose a song with hidden messages relating to the concern, a similar plan (as above) could be followed. However, a safe environment may be necessary to provide further discussion. Alternatively, refer the issue to another professional team member.

There were eight personal planning goals implemented in this cycle. Each goal has been reflected upon as follows:

Confidence

The development of my confidence when interacting with Megan had been an interesting progression. Megan seemed to be interested in what my role was in the

hospital, but when other staff invited her to join as a participant in my research, she refused. However, one of her parents gave consent, then later Megan reconsidered and gave consent too. I was confident and comfortable interacting with Megan even though she was very shy. She did not like to interact with other young people in the playroom, and would at times want to leave the playroom because other young people were around. However, when I heard that she did not initially consent to the research, I wondered if I had been refused as a clinician or a researcher. I felt that either she did not want to be involved in music, was feeling uncomfortable with my presence, or maybe she did not want to be 'analysed' in the research. I tried to stay positive and after Megan's consent, was pleased that I had worked to maintain my confidence levels, in my interactions with her and her sister.

Flexibility

There were occasions when another family member was present in the session. Sometimes they showed an interest in learning a particular song. I felt there were times when it was helpful to respond to the other family member's request, to draw the young people into participating together. However, it was important to give priority to the needs of the young patient, if they were feeling less important or inferior, when their family members became more dominant.

Decision Making

I have learned that not all young people want to be part of a 'group' if it makes them uncomfortable. I decided to accept Megan's preference to have her own space. I recognised her need for privacy and support. From then on, Megan grew in confidence.

Opportunities

I attempted a few times to 'create' musical moments when Megan was in the playroom but it did not appeal to her. I visited Megan in her room to invite her for a music session, and she happily requested my support, to help her with her song writing (See Clinical notes 5.4.2).

Facilitation

As mentioned earlier (See clinical notes 5.4.2), Megan had taken on a clearer 'leading' role in our second session. It was important to recognise a young person's comfort zone in a leading role, and in combination with development of my confidence, to adapt my facilitation style to suit the situation.

One-on-One Relationship

This element was not relevant in this action cycle as Megan was always accompanied by her sister during the sessions.

Boundaries

In this cycle, I kept my session length within my boundaries.. I did not encounter the professional boundary dilemma I experienced previously, within the two sessions I had with Megan. No medical procedures took place during Megan's music sessions.

Directive and Choices

The most challenging part of the music therapy session with Megan was the verbal discussion in relation to her lyrics. The lyrics were written in the context of friendships or party themes. There was the possibility that the words she chose to use portrayed her current state, or could have simply been where the rhyming words had led her next line of lyrics. It was challenging to ask questions without making assumptions or directing. It was afterwards suggested by one of the play specialists that the situation could be improved by using an open-ended question like, "Can you tell me more about…?" Other possible open-ended questions could be based on the material the young people had already provided, e.g., "Why did you choose to write the lyrics based on that theme?", "Which part of the lyrics did you like/dislike the most? Why?" However, due to the limits of session availability and the time span of my research, this may need to be explored in the future.

However, in music sessions, when I was able to be direct (i.e. by adapting Megan's ideas for her song style), Megan was able to be decisive in the choices she made (See Clinical notes 5.4.2).

Chapter 6. Discussion

This section provides discussion on the overall development of cycles of learning analysis. The findings will be linked to the research aims and the relevant literature discussed previously. Furthermore, some of the challenges which came up during the research process will be included. There were also unanticipated issues which caused limitations in providing some information.

6.1 Summary of Learning Analysis

I intended to work towards my personal goals in order to improve my music therapy practice with hospitalised adolescents. The areas that I identified to be developed included confidence, flexibility, decision making, opportunities, facilitation, one-on-one relationships, boundaries, and balance between being directive and offering choices. The last three elements were included after reflection upon each previous cycle.

Although it was a challenging experience executing the clinical work in this research process, I found it *significantly* beneficial. Action research allows the researcher to examine her ongoing actions, or cycles of actions, undertaken in the chosen setting and with the chosen population (Anderson & Herr, 2005). My clinical practice was therefore developed through reaching these personal goals.

As has been noted, I have examined my interactions with the participants in the context of reaching my personal goals, through the use of clinical notes, journal entries, collection of session feedback, and discussions with supervisors and other staff. This was to ensure the development of the research process. Within the given time period, this research provoked me to improve my music therapy practice and therefore, better meet the needs of hospitalised adolescents.

6.2 Improving Relationship-Building

The findings showed that I improved my music therapy practice with hospitalised adolescents through relationship-building. This was particularly observed in the areas of; enjoyment, communication and changes, and is detailed as follows:

Enjoyment

According to Gustein and Sheely (2002), enjoyment is a basic skill of relationship-building. Other skills will progressively build upon 'enjoyment' over a period of time. Throughout the action cycles, I noticed that the young people increasingly enjoyed the music sessions as I improved my practice. The feedback from young people who had music therapy sessions, included comments such as "it's really fun", "I enjoyed it", "she's cool because she's funny and gets everyone involved", "IT WAS COOL!!!" Nine out of ten individuals commented that they would like to have a music session again. There were four who responded that they would prefer a group session and one responded how she would prefer an individual session. This suggested that the music sessions were able to meet some of the developmental needs of a majority of young people, in the specific areas of team play and peer interaction.

Some of the young people commented how they enjoyed being able to play on the drums, or being able to learn to play tunes on the keyboard e.g. "I have been able to play different tunes and enjoy myself", "I liked recording songs on the small iPod". This feedback reflected young people's need for finding enjoyment through mastering a skill (Gallo-Lopez, 2005, Denholm and Ferguson, 1987, Eccles & Gootman, 2002, McLaren, 2002; Robb, 1996). I found my enjoyment of the music sessions increased as I improved my ability to develop relationships with young people.

Communication

Gallo-Lopez and Schaefer (2005) discussed the different stages of mechanical, verbal and emotional communicators as a key to assess relationship-building. There were some aspects of communication from the participants that showed changes, such as; their body language, the depth of their conversation, and the affect or tone of their voice when expressing emotions. I found my communication also showed improvement in relation to connecting with youth culture.

Changes

Gustein and Sheely (2002) addressed the developmental shift in the focus of relationship. The 'power' in a relationship can encourage 'changes' when the 'participants' gain insight into themselves (Arnason, 2006, Miller & Stiver, 1997, Kenny, 1989). The changes in the participants can be seen in; Richard's change in attitude towards me as music therapy student, Christine's change in her threshold to noise, Rachel's change in independence, and Megan's change in the content of her lyrics. There were also changes in my ability to build positive relationships with young people.

6.3 Improving Music Therapy Practice

The continuous development of music therapy practice is an ongoing journey. This action research provided opportunities for me to examine and develop different areas of my music therapy practice. Through the action cycles, I increased my confidence in a range of areas relating to my personal goals including: flexibility in adapting my planning; ability to make instantaneous decisions; being able to capture or create musical opportunities; facilitating skills; building one-on-one relationships; setting boundaries; and being able to be directive and also offer choices. According to Darnley-Smith and Patey (2003), the personal suitability of the music therapist is as essentially important as her musicianship. The authors also discussed the process of self-learning and confronting one's own defence and vulnerability to improve one's practice. Therefore, I was able to improve my music therapy practice by improving my personal awareness, my flexibility, confidence and reflective capacity.

Some of my music therapy practices are linked to relevant literature as follows:

Song singing

The use of song folders provided a gateway to assess young people's repertoire, music preference and musical ability. Appropriate songs that were suggested could be added to the folder. The song folder offered choices that allowed me to respond to young people's requests. In the process of song singing, young people were offered choices, support and independence. Bailey (1984) also stated that the use of songs have the potential to establish human contact.

Song writing

Song writing did not appeal to all of the adolescents. However, I gained confidence in encouraging song writing through different techniques. Song writing in groups could be introduced through familiar songs, grooves from popular songs, or personalised lyrics when appropriate.

The Instruments: improvisation/group drumming/instructional teaching

The musical instruments tended to be the most popular way to intrigue young people for music sessions. Most of the young people in this hospital had musical backgrounds, either through family, school or church. There were a variety of ways to develop a music session using an instrument. Stevens (2003) showed how the musical instruments can be an extension of people's voices. I noticed that the way a young person improvises or 'practises' on an instrument, often offers a range of non-musical information in the assessment stage. This includes; attention span, interests, personality dynamics, interpersonal skills, intrapersonal skills, and the level of impact hospitalisation is having on them.

Verbal Processing

The depth of verbal discussion was what I found most challenging. Therefore, I believed there was a need for more training to develop the skills needed to discuss personal or sensitive topics. However, verbal discussion had become more comfortable as my knowledge of young people, my medical knowledge, and my understanding of the impact of hospitalisation on adolescents developed.

6.4 Ways to Actively Engage Adolescents

Throughout the process of finding ways to actively engage adolescents within music therapy sessions, I implemented the following methods; instrumental playing, recording, project based music activities, playing or singing favourite/familiar songs, and lastly, peer interaction through group music sessions. The instruments had the potential to draw adolescents' attention and allowed the opportunity for adolescents to initiate and become engaged in a music session. Instrumental playing also offered skill learning for the adolescents to give them a sense of achievement. Most adolescents

were intrigued by technology (such as recording devices) that appeared to be up-to-date, hence the incorporation of an Mp3 recorder or iPod encouraged them to set a higher standard for their own 'performance'. In order to achieve the standard the adolescents wanted for themselves, they became motivated to practise and communicate with one another regarding their role in the recording. Project-based music activities allowed the adolescents to have a goal to work towards. Most adolescents that were hospitalised could not anticipate which day they would be discharged. An achievable project that adolescents could accomplish could promote self-esteem. Playing or singing familiar songs provided structure, for adolescents to share what they knew with one another. Hence, the methods that are discussed above could be incorporated to enhance positive interactions between adolescents in group sessions, and help to build peer relationships.

6.5 Research Challenges

Initially, during the ethics approval period, I intended that for each action cycle, I would recruit two adolescents to take part in an individual session, over a three week cycle. They would be co-participants in this research. However, it was difficult to restrict the cycles to a specific time period, as the adolescents' admission to hospital occurred at different times in the cycle, and the length of their stay also varied. In addition, it was my intention to recruit one or two adolescents to participate in the session feedback process of every cycle (these may have overlapped with those that gave consent to be the co-participants of the research). Nevertheless, it was practically too difficult to structure the cycles as planned for the following reasons:

1. The length of young people's hospital admission was unpredictable and uneven.
2. The challenge of recruitment due to the stress of hospitalisation, or the absence of parents/caregivers during playroom hours.
3. The complication that arose with having sessions in conjunction with other young people who did not have consent to be part of my research.

Therefore, I considered that what was learnt from each participant may be a cycle in itself, which could contribute towards the next cycle or participant.

It was challenging to be both a practitioner and researcher. The dual roles could cause a bias in the clinical work by prioritising the patient who gave consent, in a group setting. This was constantly reflected upon to minimise the effects of the dual roles. However, it was standard practice, within this setting, for some patients to be considered a priority by staff, depending on the level of concern.

In contrast, the aim of this research was to improve my music therapy practice through relationship-building. Because of this, there were some factors that got overlooked. For example, when young people's song choice was inappropriate for the setting, it was considered important to make a professional decision, to discuss why their choice was inappropriate, rather than just agreeing to their choices for the sake of 'building a relationship'. There was also a dilemma in relation to the amount of information I would disclose when the young people asked me personal questions. Therefore, any questions that I deemed to be too personal were usually answered in humour.

6.6 Unanticipated Issues

There were some unanticipated issues that were raised during the research period. Firstly, it was not anticipated that we would record some of the music therapy sessions. The audio/video consent form was not given to the participants or their caregiver(s) in advance. Secondly, there was more family involvement than I had anticipated. However, there was no consent form for family members to be included in the prepared research. It is common in Pacific Island cultures for extended family to be called as the siblings, even though they may be an uncle, aunty or cousin. At times it was confusing for me as to what relationship existed between the family member and the adolescent. Thirdly, the participant's 'parents' might actually be their foster parents. There were times when obtaining consent from birth parents was not appropriate. It could be that the foster parents had all legal rights. It was therefore important to have some information about a family's background before recruitment.

Furthermore, most young people participated in school within the hospital, in the mornings. By the time they came down to the playroom after lunch, there were less

than three hours left for me to work with them. Sometimes they would request to play pool, games or do other art activities. There were many other young people who were interested in participating in music sessions, who did not consent or did not have the opportunity to be invited as a participant in the research. It became difficult to work with everyone who was interested in having a music session on an individual basis.

Finally, the spontaneity of group sessions allowed young people with a wide range of ages and backgrounds to participate. Hence, there were times when it was difficult to engage all of those present in a group session.

6.7 Considerations for Future Research

Due to 1) limited length of time for this research, 2) the high rate of turnover of patients, and 3) the nature of action research, it would be valuable to carry out more music therapy action research in this setting, either over a longer period of time, or for a more intense block of contact such as three to five days a week. This would allow the observation of continuous changes.

Music therapy sessions that occur in this setting with young people may frequently involve other family members, especially siblings. A study of how music therapy can support both young people in hospital and their families may be explored.

Finally, there is a wide range of diverse professionals working in the paediatric ward. A study to draw out the strengths of other professionals, and the possibility of team work, incorporating music therapy and other disciplines could be undertaken. This would provide insight into how *inclusive* 'medical treatment' could benefit young people, physically, emotionally and socially within a hospital setting.

Chapter 7. Conclusion

The action research process allowed me to examine my own music therapy practice with hospitalised adolescents, through systematic reflection, enquiry and action. Though many challenges arose whilst incorporating an action research model within this setting, it has provided valuable learning in both my researcher and clinician roles. I initially set goals in relation to my personal attributes, professional techniques and approach.

The four participants and those anonymous young people who participated in the session feedback procedure, provided a range of useful information and responses when relating the music sessions or interactions they had with me. The findings have shown the benefits of music therapy for providing enjoyment, support and skills for hospitalised adolescents.

This research has helped me to scrutinise my practice and thus develop my confidence and ability, to work within the professional field of music therapy. The cycles of action research led to growth in my intuition, and increased my capacity to build relationships with hospitalised adolescents.

In conclusion, hospitalised young people encounter many challenges especially at this stage of their development. The experience of hospitalisation for them may be detrimental in many aspects. There are many professionals such as child life specialists (hospital specialists), psychology team members, doctors, nurses, and professionals of other disciplines who recognise and work with the unique needs of this group. It is hoped that the result of this study will 1) promote the use of music therapy with hospitalised adolescents in New Zealand paediatric hospitals, 2) encourage other music therapists to engage with this particular group, and 3) encourage other music therapists to carry out action research in hospital settings. As "music" is an important and attractive culture for young people, it is a strong tool with which to make contact, build relationships, and ultimately provide support throughout their period of hospitalisation.

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Appendix 1: Glossary

Hospital Play Specialist (Child Life Specialist)

The hospital play specialist (child life specialist) aims to provide therapeutic play within a paediatric hospital to minimise the trauma or anxiety of hospitalisation, and is concerned with meeting the emotional and developmental needs of paediatric patients and families (Froehlich, 1988; Ayson, 2007).

Osteomyelitis

Osteomyelitis is an acute or chronic bone infection, usually caused by bacteria. When the bone is infected, pus is produced within the bone, which may result in an abscess. The abscess then deprives the bone of its blood supply. The symptoms can include fever, pain in the bone, local swelling or nausea.

Rheumatic Fever

Rheumatic fever is common worldwide and is responsible for many cases of damaged heart valves. Rheumatic fever mainly affects children between the ages of 6 -15, and occurs approximately 20 days after strep throat or scarlet fever. The symptoms can include fever, joint swelling and pain, and heart problems that result in shortness of breath and chest pain.

SUFE

A slipped upper (or capital) femoral epiphysis is a condition that is most common in growing children, especially between the ages of 11-15. This disease may affect both hips. An epiphysis is an area at the end of a long bone that is separated from the main part of the bone by the physeal plate (growth plate). In this condition, a displacement occurs in the upper epiphysis while the bone is still growing. The symptoms can include knee pain, hip pain, restricted hip movement, or difficulty walking.

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Appendix 2: Information Sheet for Parents/Caregivers

NEW ZEALAND
SCHOOL ᴼᶠ MUSIC

Your child is invited to take part in a project where the researcher will explore how she can develop and improve her skills in building relationships with hospitalized adolescents. It will also explore whether it is valuable to have a music therapy programme during your child's stay and aims to develop good music therapy service with adolescents in a hospital setting. This project is undertaken as part of the Master of Music Therapy under the supervision of Sarah Hoskyns (Director of Master of Music Therapy Programme).

I will invite adolescents who are willing to participate as a co-participant to be part of the project by participating in music therapy sessions or contributing towards session feedback procedures. The music therapy sessions could range from 15 minutes to 1 hour, depending on the circumstances. The session feedback can be completed within 15 minutes. As to standard practice, I will record what happened during the music sessions. For this study, the relevant material recorded in the session notes may be used for reference if the adolescents and their parent / caregiver have given consent to be part of the study. As to the session feedback, it can be completed in either written form or audio recorded as you and your child choose. However, your child will not be excluded from the music therapy service if you or your child does not wish to take part in this study.

There will be no information used in this project which could personally identify you or your child. I will protect the confidentiality of identity by using pseudonyms for the write-up of the research. Data from the study will be stored in a secure room at the New Zealand School of Music for a period of ten years. Only the researcher and her supervisor will have access to the data. Once the process is completed, a copy of the dissertation will be held in the Massey and Victoria University libraries.

Participation in this project is entirely voluntary. You have up to a week to decide, and can decide after the music therapy session if you wish. Your child will not be excluded from the music therapy clinical service if you do not wish your child to take part in this research. You are under no obligation to accept this invitation. If you decide to give consent for your child to participate, you have the right to:

- withdraw your child from the study at anytime up to the completion of the study (January 08);
- ask any questions about the study at any time during participation;
- provide information on the understanding that your and your child's name will not be used;
- have access to a summary of the project findings when it is concluded.

If your child consents to participate in an anonymous session feedback:
- He / she has the right to decline to answer any particular question.

If you wish to have a copy of the summary of the project findings, it will be available upon request. However, the results may not be ready for publication until midway through 2008 as this may be a progressive process. You could get hold of the researcher through contacting the Play & Recreation Service in ███████, or through her contact. If you prefer, a copy of the relevant results can be mailed to an address supplied.

If you have any concern or require more information regarding the project, please contact Lisa Wang (LJ) or my supervisor, Sarah Hoskyns, as the contact provided.

Researcher:	**Supervisor:**
Lisa Wang	Sarah Hoskyns (Director of music therapy)
Music therapy student	New Zealand School of Music
Ph: 0212671117	PO Box 2332
09 4182668	Wellington
tzuyaya@gmail.com	04 801 5799 extn 6410

This study has received ethical approval from the Northern X Regional Ethics Committee.

If you have any queries or concerns regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act:

Telephone (NZ wide):	0800 555 050
Free Fax (NZ wide):	0800 2787 7678 (0800 2 SUPPORT)
Email:	advocacy @ hdc.org.nz

Lisa Wang (LJ)
Researcher

Appendix 3:   Information Sheet for Young People

Lisa (LJ) is going to offer music sessions to some young people in our hospital. She will write a project about the young people and their music for her university teacher to mark. The project will be made into a book for people to read. The project will not have our real names in it. The project will be about how young people who have music think of the music program.

You are invited to take part in LJ's project. LJ will have music sessions, group or individual, with young people. If you'd like to be part of LJ's project, part of your story can be written into the project. We can play musical instruments together, singing, or any music activities that you can think of. The music group will be about half an hour. The individual session can be 10 minutes to 40 minutes depending on how you feel. You are also welcome to give your comments about the session to help LJ work better with young people. You don't have to answer all the questions in the feedback if you don't want to. You can also join in the music session as normal and not be part of the project, if you would prefer.

This project will be read by other music therapists, doctors, nurses or play specialists when it is finished. You can take some time to think about whether you would like to be a part of this project or not. You can talk to XXXX (*member of play specialist staff*) or LJ, and ask questions about the music session or the project before you sign this paper. XXXX will read it through with you and make sure you know what's involved. If you would like to have music and be in the project, please sign the 'consent' page.

If you have any worries or want more information about this project, please contact Lisa Wang (LJ) or my supervisor, Sarah Hoskyns, as below.

Researcher: **Supervisor:**
Lisa Wang   Sarah Hoskyns (Director of music therapy)
Music therapy student   New Zealand School of Music
Ph: 0212671117   PO Box 2332

09 4182668   Wellington
tzuyaya@gmail.com   Ph 04 801 5799 extn 6410

This Study has received ethical approval from the Northern X Regional Ethics Committee.

If you have any queries or concerns regarding your rights as a participant in this research study, you can contact an independent Health and Disability Advocate. This is a free service provided under the Health and Disability Commissioner Act:

Telephone (NZ wide):   0800 555 050
Free Fax (NZ wide):   0800 2787 7678 (0800 2 SUPPORT)
Email: advocacy @ hdc.org.nz

Read and explained to: _____(name of patient)

By: _____(Name of staff member)

Signature:_____Date: _____

Appendix 4:   Consent Form for Parent/ Guardian

1. I have read and I understand information sheet dated 19 September 2007 for volunteers to take part in the project to investigate how music therapy can support young people facing hospitalisation and whether it is important / valuable to have music therapy sessions in the hospital.

2. I understand that it is my choice for my child to be part of this study and that we can withdraw from the study at anytime before the completion of this project (Jan /08) and that this will not affect my child's eligibility to receive music therapy outside of the project.

3. I understand that any information relating to my child's participation in this study is confidential and that no material that could identify him / her will be used in any form in this study.

4. I understand that the research will cease if it should appear harmful to my child.

5. I have had time to consider whether I will give consent for my child to take part in this study.

6. I know who to contact if I have any questions or concerns regarding to this study.

7. I understand that the study will be presented by the researcher as a project towards the qualification of Master of Music Therapy, New Zealand School of Music.

8. I give consent for the researcher to use the session notes relating to my child: YES / NO

9. I wish to receive a copy of the results: YES / NO

I _____(full name of parent/guardian), hereby give consent for _____ (full name of child) to take part in this study.

Signature:_____

Date:_____

Signature of witness:_____

Name of witness:_____

Appendix 5:   Consent Form for Young People

1. I have read and I understand information sheet dated 19 September 2007 as explained to me about having music sessions with Lisa (LJ) and being in her project. I know LJ will include parts of her notes about what happened in the session with me in her project to share with other people.

2. I know that my real name will not be used in the project for confidentiality.

3. I have had the chance to ask questions, and am happy with the answers.

4. I know that I do not have to have music sessions with LJ and that I can say no at any time.

5. I have had enough time to think about whether to take part in the music sessions.

6. I know I can talk to LJ or XXXX about my feelings about the music session(s), and that I can ask LJ or XXXX any questions about the music sessions.

I _____ would like to have music sessions with Lisa (LJ) and be part of her project.

Patient signature:_____

Date:_____

Project explained by: _____

Appendix 6:   Music Session Feedback   Date _____

Are you a boy / girl? (please circle)

How old are you? _____

What language (s) do you speak? _____ _____

Please score how you feel about your stay in hospital from 1 to 5
(1 – not so good, 5 – really good). Comment (s)?

Please score how you feel about the music session in the hospital from 1 to 5. .
Comment (s)?

How was the session for you? (Was there anything you liked or did not like?)

Would you like to have a music session again next time? Y / N (please circle)
If yes, would you prefer a group or individual session?

Is there anything you could suggest to help LJ work better with you or any other young people?

Is there anything else you want to say about the session?

Thank you very much for joining in and doing this for me!!

Appendix 7: Example of Clinical notes

20th November 2007

I went into Megan's room while they were both watching TV. Megan and her family member (A.) appeared to be quite bored but did not want to come down to the playroom either. They asked if I could help them to write a melody to their lyrics. I asked if they would like to do that in the playroom or in their room. They chose to stay in their room. So, I went to gather some instruments and materials.

Megan showed me the lyrics for a song that she had written yesterday (with words about her homie friends). The lyrics mentioned what they thought of her if she was sad or upset. She wanted to discard that song and start a new one. The second song she started writing was titled "Blues". It talked about 'when I feel blue, you cheer me up'. When I asked if she was thinking of someone when she was writing the song, she jokingly said it was her cute nephew and niece. Megan continued to write lyrics, and asked for words that would rhyme with her lines, even though she came up with all the words by herself. Megan tried to complete her song 'Blues' but she was stuck with the phrase "when life was not OK". I asked her, "How about now?" She commented, "Still not OK".

When we wanted to develop a melody for Megan's lyrics, I consulted Megan for the style of song she wanted. She played some songs from her mobile to show me the 'Hip Hop' style she was after. I tried with Dm and Am chords with lively rhythm. Megan stared at me looking lost. I started making up fragments of melody by humming. Megan listened and said, "Yeah, that's how it goes". She then started making up her own melody to the words she had written.

I asked Megan if she would like to record the song. She agreed. Megan did not want to hold the recording device (Mp3 player) close to her, so her voice sounded quite faint

when we listened to it together at the end. We finished the session by agreeing to continue working on the song the next day.

Appendix 8: Example of a Journal Entry

20th November 2007

Megan seemed to have a close relationship with her family member (A.). A. was also quite supportive of Megan's choices and interests. During previous contact, Megan did not want to be part of the music therapy research process, so I felt that she was slightly defensive towards what I could offer. After a period of contact through non-musical circumstances, Megan accepted the invitation to participate in the research. I wondered if she had changed her decision due to our relationship development, or maybe due to her curiosity about being part of a research project.

I wondered if I should have encouraged Megan more than I did, to go to the playroom to interact with others, when I offered the choice of where to have the music session. In hindsight, Megan had already been to the playroom a few times but was not comfortable interacting with others. We would probably not have had the privacy and space to develop what Megan and I wanted to achieve, in a space that was shared with others.

Megan used a few emotional words (i.e. upset, sad or cry) in her writing. I wanted to find out more information about the words she chose to use. The verbal discussion became difficult for me, as I did not want to assume nor ask questions that could lead to a situation, where I did not have the skills or time to contain her emotions. Is it good enough to just leave her emotions expressed within the music? Was there an issue regarding Megan's emotional state? I expressed my concerns with one of the play specialists. Together we decided to observe Megan's state further to see if other intervention was needed. If Megan expresses herself similarly in the next session, maybe I should ask more 'open' questions such as "Can you tell me a bit more about…?"

Appendix 9: Peer Debriefing Process

The peer debriefing process took place with a fellow music therapy student who reviewed my findings from the fourth action cycle and its relevant appendices (Appendix 7 and 8).

The main points suggested and discussed were:

- Paraphrasing some of the sentences.
- Some potential misunderstandings which required clarification.
- The tone of language needed to be more formal/academic in the 'learning analysis' section (even though it was written from a first person perspective). It was suggested that I try to be more objective and consider how the reader would perceive the information.
- The reasons for journal quote selection needed to be elaborated on, to communicate the significance of why it was being referred to.

Therefore, the changes made included:

- The introductions to journal entries were extended to give better context. Instead of presenting journal entries in one section from day-to-day, they were broken down into different categories.
- Words that were considered too informal were replaced with more formal alternatives. e.g. 'typical' changed to 'conventional'.
- I have added examples of what 'emotional' words meant.
- Some of the phrases which started with "it felt like" were taken out and paraphrased.