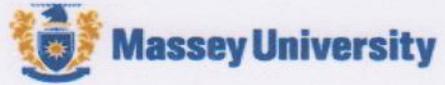


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A MUSIC THERAPY STUDENTS EXPLORATION OF SINGLE SESSION MUSIC THERAPY FOR CHILDREN ON A PAEDIATRIC WARD USING ACTION RESEARCH METHODOLOGY

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A MUSIC THERAPY STUDENT'S EXPLORATION OF SINGLE SESSION MUSIC
THERAPY FOR CHILDREN ON A PAEDIATRIC WARD USING ACTION RESEARCH
METHODOLOGY

A dissertation presented in partial fulfilment of the requirements for the degree of

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Pornpan Kaenampornpan

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Abstract

This study aimed to answer the question “How can I, as a music therapy student in a paediatric ward, provide children with beneficial single session music therapy?” In order to answer this question, action research methodology was employed. This methodology allowed the researcher to monitor and question her actions in order to improve her practice. Furthermore, principles from music therapy and other disciplines were applied and adapted. The researcher’s practice would be made more appropriate, therefore, for a paediatric ward where only brief information about the children was provided and limited time was available to work with them. There were four cycles in the study. The challenges and concerns that emerged through the course of this research were 1) how to approach the children or get the music therapy session underway, 2) how to provide suitable sessions for the different needs and developmental stages of the children; 3) how to be more aware of the children’s needs, and 4) how to maintain my inspiration. All the findings from these concerns were formulated into some helpful principles that played an important role during the course of this study. The principles are: 1) being flexible; 2) keeping the patients’ and the therapist’s control in balance; 3) being sensitive to children’s responses and to their needs; 4) being familiar with background knowledge; 5) being able to build a rapport in a short time; 6) being available; 7) being open-minded; and 8) being able to reduce the therapist’s anxiety. It is recommended that these principles be employed in other contexts where the therapist has little time at his/her disposal to assess or establish a rapport with the children, and where it is hard to predict the situation or plan the session ahead.

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Introduction

Through this study, I¹ hope to improve my practice of music therapy so as to provide greater support to hospitalised children. In the course of my work, I have tried to answer the question “*How can I, as a music therapy student in a paediatric ward, provide children with beneficial single session music therapy?*” In order to find an answer, I have employed action research methodology (which includes reflective thinking). Being the sole participant in this study, I acted as both the practitioner who ran the music therapy sessions in the children’s ward and as a researcher who was studying the result of her own practice in single session music therapy.

In this chapter I will explain my reason for undertaking this study, considering the question from both from the professional and the personal (motivational) point of view. I will then describe the context for the project (the children’s ward and the playroom), and how this context influenced my practice. I will also discuss the play therapy philosophy in the children’s ward, the playroom atmosphere that I encountered and the disciplinary tactics followed by the play specialist team. There were many different ethnic groups at the hospital; I will need therefore to discuss some implications of working with multicultural awareness. Finally, my personal and educational beliefs and values will be considered, as these have had a major influence on my decisions and actions.

¹ This study is mainly about examining and improving my own practice. I was the only participant in this process; therefore, I intend to write in the first person throughout. Further explanation is in Appendix 1

1. Reason for undertaking the study

1.1 Motivation for Research

My initial interest in my research question came from a wish to develop my understanding of music therapy so far (on placement and in class) to suit the new context of my placement on the busy paediatric ward of a general hospital. I was aware that it would usually take at least a few music therapy sessions to build relationships and set goals for clients; and that changes in the client would not normally be apparent for a while. However, my new hospital situation was very different in that the main part of my work was single sessions. I had very little prior information about the clients and no time to develop goals over weeks or months. I found it very new and a challenge to me, and it really encouraged and motivated me to improve my performance in order to provide useful single session music therapy for the children I was working with on the paediatric ward.

1.2 Personal Motivation

I was faced with a particular challenge insofar as I am an international student living abroad for the first time in my life. Everything that has happened in my new environment has served as a learning experience. Therefore, my primary goal was not only to gain knowledge and experience in music therapy but also to develop personally. This research has also been an opportunity for me to improve some personal skills necessary both in music therapy work and in other aspects of my life.

I chose action research methodology because it would help me to monitor my development more carefully. Moreover, it would allow me to question my own actions and attitudes. It would make me see my own challenges more clearly, and help me appreciate the things that need to be adjusted and developed to be suitable in such a context.

2. Study Aims

These are based on my research question, which is: *“How can I, as a music therapy student in a paediatric ward, provide beneficial single session music therapy to children?”*

With this in mind I have formulated the aims of the study, which are:

- 2.1 To adapt music therapy techniques from literature relating to different situations and also combine those techniques with single session therapy from other disciplines. This would help me focus on improving my practice in order to provide beneficial single session music therapy for the children I work with.
- 2.2 To bridge the gap between the theories proposed by other music therapists and in other disciplines, and my own practice and context.
- 2.3 To understand and gain greater consciousness of my learning process.

3. The context of the study

It is important to describe the context of the study because that will highlight its uniqueness and its challenges. It will also show how the context has influenced this project.

3.1 Working in the children's ward

The study was carried out in a children's ward where there were 18 beds. The ward is able to add more beds to serve 25 children for the maximum capacity. Care was provided for patients aged up to 14 years. The ward was decorated with colourful cartoon drawings, and consisted of two big rooms each containing six beds, and also eight small rooms for isolated patients.

Due to the limited space in the ward, it was difficult for me to have my own space to offer music sessions: therefore I usually worked in the playroom where other activities were taking place. Occasionally, I worked by a bedside or in the isolation room. To work in a shared space was quite a challenge, especially when I had to bear in mind other patients' privacy and their need for silence. Every patient was vulnerable and some of them might have been upset if there was noise around. It was hard to see one child lying down and obviously sick while another was active and happy on the opposite side of the big room. My concern was not only for the patient I was working with but also for other patients who might passively witness the session.

When working in the hospital, it is important to be aware of hospital routine: the checking of temperatures, the carrying out of blood tests or the doctors needing patients to lie down on their beds. These procedures sometimes happened in the middle of the session.

The children were often full of energy. When they were sick, they did not seem to be aware of it, and some children showed no sign of being unwell. They still wanted to play energetically and investigate things around them without restraint. Therefore, when working with them I had to remind myself of their individual limitations of which they themselves were sometimes probably unaware. Furthermore, it was crucial that my own expectations should be realistic, and in keeping with their state of health.

My study was taking place in a busy children's ward where much of what happened was unpredictable. I could not set a fixed timetable for the patients or have a fixed place for music therapy. Besides the hospital routine, most of the activities in the ward depended on the children's health. They might be active for ten minutes then feel tired and need a rest. Moreover, it was really hard to know who was coming to participate in the session because it was not possible to have a clear system of referral in the ward, as might have been expected in another context. As a team, we did discuss the children in the ward at the handover from the play specialist team in the morning; I could also arrive at an assessment of the children's needs by drawing upon personal observations from both before and during the session. So it was really challenged my skills, resources and knowledge as to whom to work with and how.

3.2 Working with the play specialists team in the playroom

There was a play service and a big playroom in the ward which aimed to maintain learning and development, minimise the stress associated with illness and hospitalisation and help children to master and cope with anxieties (*Children's Ward Orientation Manual*, 2005).

Play in hospital is invaluable for both the patients and their families. It creates an environment where stress and anxiety are lessened, helps children and young people to understand why they are in hospital and what will happen, assists them to cope with illness, with being in hospital, and with treatment, helps them to regain confidence, independence and self-

esteem, provides an outlet for feelings, aids in assessment and diagnosis, speeds recovery and rehabilitation and enhances family involvement in the child's care ("About Hospital Play Specialists," 2010)

The playroom was divided into a kitchen corner, an art table, a computer corner, a reading corner and a toddler zone. There was also a music corner where I always set up different kinds of musical instruments: two keyboards (big and small), a guitar, one wooden xylophone and two toy xylophones, an ocean drum, and small percussion instruments such as egg shakers and maracas.

The playroom was another open space in the ward, but much more noise was allowed there than elsewhere. This playroom was open to every patient, and also to families and visitors. There were all kinds of things to do, games to play and places to explore for children of different ages. The children were able to choose whatever they wanted to participate in, and enjoy each activity freely. The play specialist team did not always play directly with the children; their role was rather to facilitate the play. This room provided the patients with a variety of activities such as building blocks, medical toys, art activities, puzzles, books, board games which the patients could play together with their families, and soft toys for the babies.

To work in this open space had both advantages and disadvantages. The room's atmosphere was very helpful because it was decorated with plenty of artwork and toys which made the room lively and very welcoming. These toys helped reduce the patients' anxiety because they were surrounded by familiar things inside the rooms. Moreover, they were permitted to play with or handle things in the room freely, something which did not apply in other parts of the ward. They could feel more in control of their lives because when they were in the playroom, the play specialist team let them choose what they wanted to do. The team also offered choices of things to do which were suitable for their age and development.

However, when the music therapy session was conducted while other children were doing various alternative things nearby, it was not an easy task to keep the children focused on the music. Not only did the children find it hard to focus; I also found myself easily distracted

when there were other children who wanted to participate in the music. The patients were frequently sidetracked by the different kinds of toys in the room; there was also the possibility that the music might disturb other patients. Therefore it was very hard to set ground rules within the session such as when the session should start or finish.

I sometimes had opportunities to work alongside the play specialist team; already, in the course of my placement, I had observed them working and the way they interacted with the patients. This experience had quite a strong impact on me. They developed an initial rapport with the patients and their families very quickly, and they made quick decisions or plans in order to provide suitable things for individual patients. I was fascinated by their ability to get along with a variety of patients, often of very different personalities. I found Axline's eight principles of non-directive play therapy very helpful, and similar to what I observed with the play specialist team:

1. The therapist must develop a warm, friendly relationship with the child in which a good rapport is established as soon as possible.
2. The therapist accepts the child exactly as s/he is.
3. The therapist establishes a feeling of permissiveness in the relationship so that the child feels free to be completely open about whatever s/he is feeling.
4. The therapist is alert to recognise the feelings that the child is expressing and reflects those feelings back to him or her in such a manner that s/he gains insight into his or her behaviour.
5. The therapist maintains a deep respect for the child's ability to solve his or her own problems if given the opportunity to do so.
6. The therapist does not attempt to direct the child's actions or conversation in any manner. The child leads the way; the therapist follows.

7. The therapist does not attempt to hurry the therapy along. It is a gradual process and is recognised as such by the therapist.
8. The therapist establishes only those limits that are necessary to anchor the therapy in the world of reality and to make the child aware of his or her responsibility in the relationship. (Axline, 1989, pp. 69-72)

These principles are very suitable for application in this hospital environment because they allow the therapist to increase patients' sense of autonomy, control and way of expression. To have the principles in mind also makes it easier for the therapist to build a relationship with the patient.

3.3 Multicultural context

New Zealand is a new country to which many people from around the world migrate. While I was working at the hospital, I encountered a wide variety of ethnicities: European, Asian, Pacifica, South African and also Maori, the original inhabitants of this land. They have each their own culture, language, accent and background. Moreover, I, as an international student from Thailand, also bring my own values, beliefs and culture with me to this country.

Seniority and respecting someone older are very important in Thai culture. Someone younger has to be very careful about how he or she speaks directly or makes suggestions about the elder's action. Therefore I found it hard to react to the patients' parents confidently and naturally. It created a kind of communication barrier between them and me when trying to build a relationship of trust. Also when the children talked to me or reacted to me in a friendly manner, I felt sometimes uncomfortable because I thought that the manner was not quite respectful. This is because of my background culture.

Therefore, awareness of different cultures is needed in this context. The staff in the ward, including myself, had to respect and accept the patients' cultures and their differences in order to adhere to one aspect of the ward's philosophy. This stated that the children should be

treated as individuals with a right to dignity, privacy, safety and confidentiality (*Children's Ward Orientation Manual*, 2005).

Oosthuizen stated some of her difficulties when she was working in South Africa where she could not understand the clients' language and the clients could not understand hers (Oosthuizen, 2009). This was similar to my situation inasmuch as English is not my first language. Even if I was able to communicate in some degree with the patients, I was still aware of misunderstandings arising from language or from my accent.

4. My educational and personal values

From the beginning of my placement, I retained enormous autonomy and influence within the sessions even while adhering to the ward and play therapy principles. It is important therefore for me to state my educational and personal values, as these guided me when I was just starting to work in the children's ward. Furthermore, my educational and personal values have influenced my choices, and, I believe, had some effect on the benefit of the sessions.

My values are based on my belief that music has the power to benefit everyone, irrespective of their state of health. It can serve numerous needs in different situations. Everyone has a different way to enjoy or profit from music.

I am influenced by client-centred therapy, which was developed by Carl Rogers. The client's power and decision-making are rated highly, and the therapist in this therapy respects and accepts the client's wishes (Wigram, Pedersen, & Bonde, 2002). Within this approach I aim to 'be with' the patient at the moment they are present with me and to accept the patients just as they are. I also believe that the therapeutic process starts when the relationship between the music therapist and the patient is established. However, sometimes the situation in the ward did not allow me to employ those values or to hold them strongly enough in mind. In the course of this study I therefore hope to adjust my values to make them more appropriate within the context of, and situation in, the ward.

Literature Review

The literature below provides background knowledge from which I was able to develop my practice. Disciplines other than music therapy, as they sometimes contained valuable resources for challenges which are not often mentioned in the music therapy discipline. Furthermore, the chapter will provide information as to how single session music therapy in the course of this study benefited the children in the hospital.

1. Music therapy for hospitalised children

Literature about hospitalised children's needs and about music therapy in a hospital context is very important, as it is used as background knowledge to provide beneficial single sessions in music therapy.

As working in a hospital does not allow much time to assess the patient's needs or gain a lot of information from the patients, this literature about hospitalised children will provide some understanding of a young patient's needs. This in turn will serve as a guide to provide suitable music therapy approaches or techniques for different needs.

1.1 The Hospitalised Child

Generally speaking, the experience of being in hospital is an unpleasant one for children (Bishop, Christenberry, Robb, & Rudenberg, 1996; Brodsky, 1989). They are away from their normal routine and normal environment and surrounded by unfamiliar equipment, smells, sounds and people (Bishop, et al., 1996; Brooks & O'Rourke, 2002; Lane, 1991; Maranto, 1996; Stouffer & Shirk, 2003; Wallace, 1996). Moreover, children's privacy is minimised due to the limited space in the ward. This is especially distressing for an adolescent who has to share space with young, sometimes noisy, children (Bray, 2007). Besides that, adolescents might feel awkward when they have to answer personal questions while there are other people in the room (Bray, 2007). Furthermore, adolescents prefer to be around members of the same age group, but being hospitalised prevents them from attending school or participating in activities with peers.

Therefore, they probably feel isolated (Bray, 2007) and separated from sources of support (Yates, Payne, & Dyson, 2009).

While they are in hospital, children's sense of independence is diminished because they are usually restricted by treatment routines and lack of sense of control in their life (Brooks & O'Rourke, 2002; Lorenzato, 2005; O'Neill & Pavlicevic, 2003). They are also commonly exposed to unknown or unfamiliar treatment which makes them feel anxious (Longhi & Pickett, 2008) and apprehensive about what is going to happen to them. Some patients are probably more anxious because they have to go through the unfamiliar treatment by themselves (Bull & Gillies, 2007). Therefore they need something to distract and reduce their anxiety by providing them with chances to express their feelings (Aldiss, Horstman, O'Leary, Richardson, & Gibson, 2009). While waiting for treatment or being discharged, some patients probably get bored because there is no stimulation and they are perhaps suffering from reduced mobility (Wallace, 1996). The patients should be encouraged to remain active, and should be surrounded by facilities that decrease boredom (Aldiss, et al., 2009).

1.2 Benefit of Music Therapy in the children's ward

Many documents have noted the effectiveness and benefit of music therapy for children in hospital. To set some boundaries for the large amount of literature published in the field, this topic – which will provide some possible and suitable goals to set for children – will be reviewed mainly on the basis of the benefit that might realistically be achieved in single session therapy.

To provide positive experience and prevent stress

Music therapy can provide entertainment for patients and prevent negative feelings (Lorenzato, 2005; O'Neill & Pavlicevic, 2003), and it can also constitute a bridge leading from distress and resistance to relaxation and calm (Edwards, 1995). Moreover, music, especially lullabies, may help to provide a sense of trust, security and safety (Loewy, 1999). Music is able to supply, or bring back, good memories or comfortable feelings while patients are coping with the challenges of this new situation (Edwards, 1995).

There are various ways in which exposure to music can reduce stress: through playing an instrument, for example, or listening to music. It provides some form of activity for children who are frustrated because of limited movement (McDonnell, 1983). To play an instrument such as a drum can provide a creative outlet for the patients' energy (Dun, 1999; Loewy, 1999). During the treatment process, participation in musical activities such as singing or choosing songs or playing an instrument can relax the patient and distract him/her from pain and distress (Dun, 1999; Edwards, 1999a; Froehlich, 1996).

Offering positive experiences for the patients can distract them from the fact that they are in hospital. Moreover, positive experience during hospitalisation could affect the children's expectation of their future hospitalisation (Sims & Burdett, 1996).

To provide normalisation

Music is part of normal childhood experience (Dun, 1999; Robb, 2003). Familiar music can provide comfort and security which then encourages action (Robb, 2003). It is used to submerge the child in such normal recreational and leisure experiences as might enable him/her to cope better with his/her current situation (Hurt-Thaut & Johnson, 2003). To comfort them and help them feel more at ease in this alien hospital environment, music familiar to them should be used (Lorenzato, 2005). Participation in activities normally followed outside the hospital helps to normalise the hospital environment and encourages the children to be active participants who use their developmental skills (Bishop, et al., 1996). Furthermore, "familiar music is often desirable so that the patient may feel secure, particularly under the pressures of a stressful situation. The predictability inherent in familiar music may more greatly facilitate positive experience" (Maranto, 1996, p. 61).

To increase a sense of autonomy

Because of their state of health and treatment routines while in hospital, any feeling of control that patients would normally have over their lives is reduced. Music therapy can offer choice and control to the patient from the moment s/he is exposed to it. The patients can decide

whether or not they want to participate in a music therapy session (Lorenzato, 2005) and also when to stop. As well as that, music therapy offers choices regarding instruments to play, songs to sing (Bishop, et al., 1996; Lorenzato, 2005), and how to play the music (Ayson, 2008). By creating their own music, patients become active agents, in contrast to the usual hospital situation whereby they follow and accept hospital routines (McDonnell, 1983). The study by Sheridan and McFerran (2004) discusses choices and control through storytelling, song writing, and the power to decide another person's movement through musical improvisation. Providing children who have limited mobility with the chance to actively move their bodies by playing a musical instrument can help prevent frustration and decrease a sense of dependence (McDonnell, 1983).

The patient's feeling of autonomy increases when various choices are offered (McDonnell, 1984). These opportunities for choice serve to empower children and renew their sense of independence (Robb, 1999).

Learning an instrument not only provides opportunities for the patients to experience a greater sense of mastery despite their illness and physical weakness; it also encourages patients to make decisions allowing them to feel empowered at a time where independence is compromised (Abad, 2003).

To provide a chance to express their feelings

In music therapy sessions, patients are allowed to verbalise what they are feeling through lyric substitution, choosing songs, and also by playing musical instruments (Brodsky, 1989; Dun, 1999; Edwards, 1999a; Loewy, 1999; McDonnell, 1983). For patients whose verbal communication is non-existent or limited, musical improvisation can be a starting-point for them to practice interactive skills such as turn-taking and following skills (Bower & Shoemark, 2009). Music is not used merely as a channel to express patients' frustration, but in addition motivates and encourages the patients to be positive during a hard time (Kennelly, 1999).

Supporting caregivers (parents)

Music therapy can help the patient's family to nurture the patient's wellbeing (Brodsky, 1989) and can also assist parental involvement in a supportive role during treatment (Edwards, 1999a). Soft or quiet music is not only able to soothe or calm the patients; it also nurtures and decreases the parents' or caregivers' nervousness and worries about their children's health (Loewy, 1999). Ayson (2007) and O'Neill & Pavlicevic (2003) suggest that during a music therapy session parents are able to witness the happiness their children can feel at such times, and this can positively affect the parents' mood. While the patients are having a music therapy session, their parents can also perhaps take a break of some kind. Also, some parents who participated in the session with their child are able to learn how to use music to interact with their children at home (Ayson, 2007).

2. Single session music therapy

There are few studies about single session music therapy. Those that have been carried out have related mainly to hospitalised patients and also to areas such as special needs children (Rickson, 2006) and mental health (Silverman, 2009; Silverman & Marcionetti, 2004).

Some of the studies were conducted using a quantitative approach and the results were shown in statistical form. The participants in these studies were identified by their specific needs. The goals in the interventions were set, and the activities prepared for those specific needs. The research by nature did not investigate the choices or possibilities for the therapist, but looked at the effectiveness of the intervention in changing the condition of the patients. The results from those studies have shown the positive effect of single-session music therapy on pain control, on the physical comfort and relaxation of hospice patients (Krout, 2001) and on the mood of hospitalised children (Lane, 1991). They have also pointed to reduced anxiety and increased relaxation for adults in intensive care units (Chlan, 1999), and to benefits for psychiatric patients (Silverman, 2007, 2009; Silverman & Marcionetti, 2004). Armstrong (2009) studied children's moods before and after a music therapy session, in a situation similar to the current research study described here. The results, which were measured by the Affective Facial

Scale, did not show a significant difference between before and after assessments. The results of her study were influenced by several significant factors. Firstly, she found that as many children chose the happiest face at the beginning of the session, they could not indicate a further increase in positive feeling. Secondly, the children were asked to choose one face to represent their moods; and some might have found it difficult to do that, as they had many feelings at once when they were hospitalised. Lastly, the nature of the hospital environment affected the children's choice of faces; interruptions because of medical treatment, for instance. Therefore, the children's ratings were probably not explained solely by their music therapy session.

Single session music therapy is not only mentioned statistically, but also descriptively. Some music therapists have presented their single session work through use of case studies (Dun, 2007; Rees, 2005). They have explained situations and challenges such as a limited time to assess the patients' needs (Rickson, 2006; Wallace, 1996), or various unpredictable factors (Dun, 2007). Moreover, those articles have also presented some helpful guidelines to follow in such situations.

Flexibility

Because of the various needs of the patients and the high rate of change in them and in the context itself, music therapists should always adjust their practices and be flexible to each patient's presence and responses, so that they can approach the patients appropriately and select the appropriate musical experience (Dun, 1999, 2007; O'Neill & Pavlicevic, 2003; Wallace, 1996).

Ability to build a relationship in a short time

Wallace (1996) has suggested that the use of toys in the session enables the music therapist to establish a rapport with the patients because toys can distract them from stress, stimulate them to be more active and explorative, and encourage them to express their feelings. Moreover, Rickson (2007) has invented the acronym "presence", which comprises "Playfulness, Relationship, Encouragement, Support, Exploration, Nurture, Connection and Enjoyment" as a

reminder of some of the musical techniques she employed to build a relationship with a child during their musical encounter (p.40).

To understand the children's needs and have some basic knowledge about the context

The assessment of hospitalised children's needs is usually conducted briefly on the spot (Rees, 2005; Wallace, 1996). Therefore, in order to arrive at a rapid understanding and interpretation of the responses or reactions of these children, music therapists should have gained some understanding of patients' medical history, their needs and their experience while in hospital (Dileo & Zanders, 2005; Dun, 2007); and also some knowledge of child development. Child development models are suggested for use as background information when working in paediatric wards (Lorenzato, 2005). Moreover, the music therapist's clinical and life experience, knowledge, and familiarity with the hospital context are considered important elements in preparing him/her for work in this situation (Dun, 2007).

To be with the patient at every moment

In some single music therapy sessions, the session might last less than thirty minutes. While it is going on, the music therapist should give the children his or her undivided attention (Dileo & Zanders, 2005; Dun, 2007; Rickson, 2006). Rickson (2006) and Dun (1999; 2007) have both emphasised how important it is for the therapist to be aware of the children's immediate response (their verbal and non-verbal communication, for example, and their responses to music). Besides that, Dun (2007) has suggested that the therapist should blend these responses with background knowledge relating to the children, and also draw upon the therapist's own skill and knowledge when s/he has only a short time at his/her disposal.

Even though these principles have been used widely in the general practice of music therapy, they certainly need to be highlighted when working in single session situations.

3. Single session therapy work in other disciplines

As there is a relatively small amount of literature devoted to single session music therapy, some relevant documentation from related disciplines will also be presented here. Such

material has served as a starting-point for work in this context, but might also provide guidelines for such endeavor.

Single session therapy has been widely used in various disciplines such as family therapy (Campbell, 1999; Curtis, Whittaker, Stevens, & Lennon, 2002; Sommers-Flanagan, 2007), mental health (Bisson, 2003; Emmerik, Kamphuis, Hulsbosch, & Emmelkamp, 2002; Harper-Jaques, McElheran, Slive, & Leahey, 2008); and in hospital with groups of terminally ill patients (Kosoff, 2003). Many studies have shown a positive outcome from single session therapy. Talmon and his colleagues' study showed that 88 percent of their single session therapy patients reported that their problems were much improved or improved (Talmon, 1959). Therapy provides time for clients to express their concerns and be listened to (Kosoff, 2003; Slive, McElheran, & Lawson, 2001). It also helps clients to identify their resources or their strengths (Slive, McElheran, & Lawson, 2008) and to focus more on concrete strategies to deal with their problems (Sommers-Flanagan, 2007).

This kind of intervention is utilized in both general and walk-in situations. The single session in a walk-in situation differs from any in a general situation because there is no prearranged appointment and little prior information about the client (Slive, et al., 2008). Therefore, "therapists usually encounter some challenges which are how to engage the client at the same time as incorporating an effective beginning and end in the same session, providing a focus among the many factors presented and how to concentrate on the client's strengths rather than pathology (Hurn, 2005, p. 38)."

Not every situation is suitable for single session therapy. However single session therapy can be an effective and efficient approach at a time of increasing demands for services and decreasing resources (Campbell, 1999). It can be an option for patients who have concerns about their ability to afford the fees involved in long-term therapy (Bloom, 1981; Miller & Slive, 2004). Besides that, some clients are reluctant to commit to long-term counseling (Sommers-Flanagan, 2007). Single session therapy can also occur because the client is referred to another practitioner or the client has decided not to come even after the appointment has been made. Sometimes both a client and a therapist agree that a single session has accomplished

enough and there is no immediate need for further sessions (Rosenbaum, Hoyt, & Talmon, 1990).

Although single session therapy employs a number of principles that therapists feel to be most effective for their clients, the therapists do not base their practice on any single model (Campbell, 1999; Slive, et al., 2001). Some authors have presented helpful guidelines which they found important and useful when employing single session intervention. Some of these guidelines have proved relevant to my work.

Always available and easily accessible

Most clients benefit from single session intervention because they have easy access to the service (Campbell, 1999; Slive, et al., 2001). Clients can decide when they want or are ready to have the intervention (Slive, et al., 2008). If they themselves are allowed to choose the time, they probably enter the service at the moment of sufficient “intensity” and “motivational readiness” for change (Prochaska & DiClemente, 1992). Furthermore, they do not have to wait for the appointment; as, in common with traditional therapy, this might decrease the client’s motivation to have the intervention later on (Miller & Slive, 2004). Moreover, the fact of being always available to clients could also develop a therapist’s relationship with members of the community. Everyone is invited in a friendly manner at whatever time they feel to be most appropriate for a session (Slive, et al., 2001). However this kind of intervention might not be suitable for every client’s needs; it might be recommended to the client who has a specific problem or problems, and who has access to good sources of support (Campbell, 1999).

Supportive (positive) environment

The area for providing service should be able to promote an experience free of anxiety and with a courteous, friendly staff (Miller & Slive, 2004). A similar point is made by Sommers-Flanagan (2007), who concluded from his study that one of the desirable components in single session parent consultation is a non-judgmental atmosphere.

View a session as a whole therapy process

Each session is completed in a limited time (Slive, et al., 2008; Talmon, 1959). The therapist has to make the most efficient possible use of this time and focus on a goal that can reasonably be achieved in one meeting (Slive, et al., 2008), as single session therapy doesn't allow much time to gather the client's history or information about him/her. Moreover, the therapist has limited time to build a rapport with the client. Talmon (1959) suggested that the intervention can start right away and that the assessment process is an ongoing one. In each session, the problem and its resolution must be arrived at in that one meeting. "Each move by the therapist, together with the clients' response, includes both a probe for information and an intervention requiring a response, providing feedback for succeeding interaction" (Rosenbaum, et al., 1990, p. 175). As the single session has to terminate in one meeting, some therapists might have a feeling of incompleteness after the session has ended. They might be disappointed because they are unable to prolong what is pleasurable. Rosenbaum, et al (1990) suggested that the termination allows both client and therapist to think back upon the therapy process. "Understanding what did happen and what did not gives new implications to what can happen in the future, as well as to what problems need not be repeated any more (p.184)."

The clients have the capacity to make changes

The therapist in this intervention emphasises the power of the clients. The clients know themselves much better than others can hope to. The therapist's task is to make it easier for the client to find the problem and its solution (Campbell, 1999; Rosenbaum, et al., 1990). With this approach, the client is viewed by the therapist as an equal in the change process, as the therapist assumes a more "non-expert" position (Miller & Slive, 2004). Clients are thereby empowered to make effective changes in their own lives (Rosenbaum, et al., 1990).

Focus on the client's strengths

To avoid spending too much time on finding the problem, the therapist in a single session intervention highlights the clients' abilities and strengths rather than their diagnosis or medical history. Instead of gathering a large quantity of data relating to a client's experience, the single session therapist tends to find skills s/he already has (Rosenbaum, et al., 1990; Slive, et al., 2001) or to establish resources such as a network of family or friends who might be able to provide the client with some assistance (Slive, et al., 2008).

Making use of the moment with the client

As a single session allows the therapist and the client to meet only once, there is no chance to repair or revise the interactions or interpretations that take place during the client-therapist encounter (Kosoff, 2003). Therefore, every moment in the session is crucially important. When the therapist focuses on the small detail or responses from the client which led to the present moments, a different clinical sensibility arises. Moreover, the therapist is able to be more aware of small events especially, non-verbal and implicit events (Stern, 2004). Furthermore, Kosoff (2003) believes that a good single session comes not only from focusing on the moment inside the session but should also entail an understanding and awareness of the common issues and the goal of the clients. This understanding will help both the client and the therapist to stay more focused on "here and now" in the session and allow the therapist to develop a deeper understanding of the needs of the client.

Think small

The outcome from single session therapy should not be underestimated. For example, it allows terminal patients to feel empowered and enhances their self-esteem (Kosoff, 2003). However, it is important for the therapist to be aware that the limited time in each session might not be sufficient to bring about significant change in the client. Therefore, looking for a small change can help the therapist to take pressure off himself/herself and not make the error of promoting more change than the client wants (Slive, et al., 2008). One small change is enough

to offer some hope for the client (Talmon, 1959). Moreover Slive and his colleagues (2008) stated that “Change is constant and that small change leads to big change” (p.14). Hurn (2005) argued that a small improvement in single session therapy may be recognized more easily because the clients have lower expectations. This change may have a greater impact than when the clients expect significant change from lengthy therapy (Hurn, 2005).

4. Child development understanding

Child development understanding is suggested for use as background information when working in the children’s ward (Edwards, 1999b; Lorenzato, 2005) Edwards has suggested that “this information is used in paediatric music therapy to help understand the needs of the child in relation to developmental stages and to prepare and plan interventions appropriate to the child’s cognitive stage (Edwards, 1999b)”.

4.1 An Infant (under 1 year old)

During these first few years of life, attachment and bonding is gradually formed with the primary caregiver (Kallay, 1997). Infants learn to trust people when their needs are responded to promptly and consistently (Adam & Towle, 2009; Nuttall, 1995; Petrillo & Sanger, 1980). When they are around seven months, they start to make talking sounds to respond to others’ talking (Bruner & Suddarth, 1983) and by 12 months, some infants can say their first understandable words (Nuttall, 1995). During this stage infants should learn how to sit, hold their heads up, roll over, and reach out and hold objects (Bruner & Suddarth, 1983; Nuttall, 1995). Moreover, they learn to discriminate between their caregivers’ voices and faces and those of strangers (Bruner & Suddarth, 1983).

Recommended Interventions

The family should be encouraged to participate in their infant’s care as much as possible (Petrillo & Sanger, 1980) because family members are the most important emotional support for very young children (Kayes, 1999). Furthermore, infants should not be forced to interact with strangers (Nuttall, 1995).

Infants like to explore things with their mouths (Nuttall, 1995), therefore the toys they play with should not have small, removable parts or long cords that could be dangerous for them (Adam & Towle, 2009). Brightly coloured, different textured and easily grasped toys such as a rattle might be able to nurture infants' tactile and visual senses (Bruner & Suddarth, 1983). Encouraging infants to locate sound sources can stimulate their development (Bruner & Suddarth, 1983; Nuttall, 1995). Moreover, exploring these instruments can be used as a distraction while infants are having hospital treatment (Kallay, 1997). It is good to imitate infants' vocalisation because this helps to increase such vocalisation (Bruner & Suddarth, 1983; Petrillo & Sanger, 1980). Maintaining eye-to-eye contact while interacting with an infant is important. Petrillo and Sanger (1980) have suggested that "the infant begins to develop a self-image from the attitudes and responses he evokes in a caretaker. When the caretaker's face is responsive, the infant gets a reflection of himself. Thus, the mother's face serves as a mirror" (p.214).

4.2 A Toddler (1-3 years old)

Both fine and gross motor skills in toddlers are more developed. They are very active and have short attention spans (Malley, 1995b). They start to walk upstairs, climb, kick a ball and ride a tricycle. Moreover, with an increase in fine motor skills, they start to scribble with a pen and turn pages in a book (Adam & Towle, 2009; Bruner & Suddarth, 1983). The toddler becomes more mobile and explorative. Injuries, minor or major, at this stage usually involve falling, burning, drowning, and poisoning (Adam & Towle, 2009). As toddlers want to explore their environment and everything in reach but do not yet have the skills necessary for that, they become easily frustrated and misbehave (Malley, 1995b). Moreover, they begin to develop independence but they are still dependent on their caregivers (Adam & Towle, 2009; Bruner & Suddarth, 1983; Malley, 1995b). Parallel play is commonly seen in toddlers. They like to have the company of other children but there is little interaction between them (Adam & Towle, 2009). Toddlers' concerns about their own needs and ideas are very important to them, therefore they often have problems with sharing (Malley, 1995b).

Recommended interventions

It is recommended to provide toddlers with action toys and toys that encourage creativity such as puzzles, sports equipment, musical instruments, crayons (Adam & Towle, 2009) and safe medical equipment (Petrillo & Sanger, 1980). Allowing toddlers to play with medical equipment can turn their experience from the toddlers themselves as objects to subjects who actively use the equipment. This playing helps the toddlers to overcome any anxiety associated with treatment (Petrillo & Sanger, 1980). During their hospitalisation, limitations should be set in order to enhance their sense of security. Therefore, they can explore and learn in an environment in which they feel safe (Bruner & Suddarth, 1983; Kallay, 1997). They like to imitate other behaviours (Malley, 1995b) therefore they should be encouraged to learn and explore their skills and environment through imitation; new movement for instance (Barrickman, 1989).

4.3 Preschool age (3-6 years old)

A sense of independence is more developed during this stage. Children learn to take responsibility for their own safety but they become careless and want to experiment and explore their environment (Adam & Towle, 2009). Preschoolers often misunderstand or misinterpret their illnesses and some of them blame themselves if they have become unwell (Kayes, 1999). Also, they perceive their separation from parents as abandonment or a sign of lost love (Robb, 1999). Some of them find it difficult to cope with too many new experiences and people (Kayes, 1999).

Recommended interventions

During preschoolers' hospitalisation, the opportunity to explore the environment is limited, therefore they should be given chances to make their own choices, to be involved in their own care (Kayes, 1999; Robb, 1999). Moreover, the experience of independence, success and being active explorers should be part of helping them to cope during their hospitalisation (Robb, 1999). The early preschooler is highly imaginative (Malley, 1995a; Petrillo & Sanger, 1980); therefore "pretend play" is probably useful to assess a child's understanding, teach

coping skills and provide chances for them to convey their concern and fear (Kayes, 1999). Also, the child can express their feelings through playing instruments (Barrickman, 1989).

4.4 School Age group (7-14 years old)

A child in this age group is energetic, restless. The child needs order and consistency in his/her life to cope with doubts, fear, unacceptable impulses and unfamiliar experiences (Bruner & Suddarth, 1983). Their concept of self is developing during these years. Also, their self-esteem will be nurtured by allowing them to make decisions and solve their own problems (Adam & Towle, 2009). They are able to understand more of verbal explanations and view the world more realistically (Kayes, 1999). While they are hospitalised, the opportunities for children to engage in normal activities such as attending school, spending time with peers and engaging in sport, are diminished. The children might feel different and miss out on experience that is part of their normal development (Kallay, 1997).

Recommended Interventions

The child in this age group should be provided with opportunities to take part in normal activities; to enjoy the company of peers and involvement in other group activities. These activities need to include opportunities for the child to master tasks and see himself/herself as successful and competent (Edwards, 1999b; Kallay, 1997; Kayes, 1999). Encouraging children to participate in their own care, ask questions and express feelings about their state of health can nurture their sense of responsibility, independence and mastery of environment (Kallay, 1997; Petrillo & Sanger, 1980).

Summary

From the literature review, it appears that the outcomes from single session music therapy and single session therapy in other disciplines indicate valuable and beneficial approaches. Some helpful strategies and knowledge from different sources in this literature review shed light on the possibility of providing single session music therapy for children in hospital. The studies helped me develop concepts and improve my own practice in ways that

also generated suitable responses to the children along the way of this research journey. However, not all the literature above was directly related to my situations and sometimes, applying ideas from the literature in the session turned out to have some different outcomes. Chapter 5 (Discussion) provides a good opportunity to discuss some of the reasons for these differences.

Methodology

In this chapter, I intend to discuss some of my understanding of action research and then explain the reason why action research methodology was used in this study. Finally, I will look at the design of the study, which includes each cycle period, data gathering method and tools, the method of data analysis, the peer-debriefing process and ethical considerations.

1. Understanding of Action Research

Many authors have explained action research and similar themes; the main objective of such research, as it seems to me, is to improve and gain a greater understanding of the participant's (practitioner's) own practice (Kemmis & McTaggart, 1992; McNiff, Lomax, & Whitehead, 2003; Rickson, 2009; Robson, 2002).

I found the explanation of action research by Stringer and Genat (2004) very helpful. It showed the main key point of the methodology and also differentiated it from other methodologies.

“Action research is a systematic, participatory approach to inquiry that enables people to extend their understanding of problems or issues and to formulate action directed towards the resolution of those problems or issues. Unlike basic research that seeks to formulate explanations that are generalizable to a wide range of contexts within a given population, action research seeks local understandings that are specifically relevant to the particular context of a study.” (Stringer & Genat, 2004, p. 4)

Basically, the cycle processes in action research comprise identifying the problem, planning, observing, reflecting and then modifying the plan before using modified actions. The process may be similar to problem-solving or day-to-day things that all good practitioners do in order to solve their problems or improve their practice. However, action research consists not only of defining the challenges or questions and finding the solution; it also relates to the

practitioner's values and interpretations. Moreover, it shows the practitioner's motives and reasons for his/her actions (McNiff, et al., 2003).

Although this methodology places major emphasis on the practitioner's learning and improvement process, the context within which the action research is taking place is expected to improve as well. It is also important to show how the learning process and the outcome from the learning affects the work within the setting (McNiff, et al., 2003). This re-emphasises how action research attaches more importance to the process than to the result. Researchers need to pay more attention to demonstrating the stages of their learning progression as a means of improving their practices; in other words, how this learning process or journey influenced the situation rather than what they actually accomplished.

2. Rationale for using action research methodology

In accordance with my research question "*How can I, as a music therapy student in a paediatric ward, provide beneficial single session music therapy to children?*" I intend to improve my practice in a context in which my values, culture, situation and background count as crucial factors. I did not try to fit my practice within someone else's theory or context. Even though there are innumerable documents relating to music therapy for hospitalised children, they were not all suitable for my situation or for me. Each music therapist has a different personality and works with different clients and situations. Importantly, each therapist has different values and experiences, therefore they think and act differently within their particular situation. Most of the related studies did not emphasise working in a brief session. Furthermore, the authors of those studies were experienced practitioners from a western background. Their professional skills were practiced in their own hometown and within their community.

The challenge for me was therefore that there was a gap between my experience and knowledge and the literature produced by the experienced music therapists. Even though there were studies by music therapy students who had worked in similar contexts, these studies had different focuses. I intended to find the methodology that allowed me to relate my research to

my own situation and my personal values and experience and knowledge of music therapy so far.

I chose action research methodology for my study as the action research process allowed me to look insightfully into my practice in order to improve both my practice and my situation. Moreover, I wanted to bridge the gap between theory and practice in a way that would not only lead to an improvement in my own practice but also be of benefit to the children. I wanted to put theory into practice, thereby enabling me to theorise my practice more adequately than before.

To do this the action researcher sometimes has to participate in the clients' situation in order to understand how to construct processes or practices that "make sense" within their everyday lives. Besides that, the researcher has to be objective; observe and stand back from the situation so as to assess and evaluate events in unemotional and disengaged terms (Stringer & Genat, 2004, p. 24).

3. Design of the study

This section shows the duration of, and the issues relating to, each cycle. Then the process that was used to collect and analyse data will be described.

3.1 Participant

This is an action research study which focuses mainly on improving music therapy practice in a single session context by studying and reflecting on my own practice. Therefore there is one participant only in the research: myself, as both clinician and researcher. I act as both researcher and also as the music therapy student who ran each session.

3.2 Cycle Phase

This study took over 18 weeks and was divided unevenly into four cycles. The table below showed the duration and issue in each cycle.

Table 1

Cycle Issues	Started	Finished
1st Cycle <ul style="list-style-type: none"> How to approach the children and to get the music therapy session underway? 	10 August 2009	26 August 2009
2nd Cycle <ul style="list-style-type: none"> How to provide suitable music therapy sessions for different needs and development of children 	21 September 2009	14 October 2009
3rd Cycle <ul style="list-style-type: none"> How to be more aware of the children's needs? 	27 October 2009	4 November 2009
4th Cycle <ul style="list-style-type: none"> How to keep up the inspiration? 	19 November 2009	30 November 2009

3.3 Action Cycles

My action cycles were influenced by different authors (Kemmis & McTaggart, 1992; McNiff, et al., 2003; Stringer & Genat, 2004). Their cycles generally comprise these steps:

1. **Identify** challenges or issues which the researcher wants to improve.
2. **Design the plan** to improve the situation and the practice.
3. Start to **try out the actions** according to the plan.
4. During **the acting out of** the plan, the researcher will **observe** how **it** works.
5. **Reflect** on what the researcher has done in order to understand more about the practice.
6. **Modify** the plan for the next cycle.

However, McNiff et al. acknowledged that the cycle contains a good deal of overlapping, retracing of steps, review, redirection and refocusing (McNiff, et al., 2003). Therefore, my action cycles were not neatly following those steps as stated above. I employed these steps as a guideline rather than as a step-by-step approach.

4. Data Collection

As the researcher, I collected the data by keeping an ongoing research journal and clinical notes, and also by observation. In this study, observation was used both inside and outside music therapy sessions. I observed the patients' responses to my music therapy in order to improve my practice and make it more suitable for the patients. I also observed my clinical liaisons and my visiting music therapist's work because some of their practices were used as a model in this context.

Observation is very necessary in this context, because a children's ward is usually busy and the staff did not have much time to explain and teach me everything. The differences between our two disciplines made it harder for them to do this anyway. A sense of respect for each discipline is rated highly in this context; therefore telling other people how to do things is not part of the culture in this workplace. However, as I was a student with limited experience and knowledge of working in a hospital environment, I still needed to learn from others. In this situation I just adapted my learning style in order to gain as much knowledge and experience as I could. Observation is a very powerful learning tool in this context.

I observed my clinical liaisons from a variety of perspectives: firstly, how they interacted with patients of different ages; secondly, how they managed their emotions in a challenging situation; lastly, how they communicated with other members in a multi-disciplinary team.

Additionally, I made use of ongoing data from my regular clinical notes and kept an ongoing research journal. The clinical notes were used as a data source which was concerned with these areas:

1. Action and responses from the children in a music therapy session, as would be normal clinical practice.
2. My spontaneous reflections immediately following the sessions as to how the session had contributed to the child's wellbeing.

The research journals were used to:

1. Record relevant readings from music therapy and other disciplines of relevance to my work. Since ongoing work with reading literature played an important role in this study, reflections from the variety of ideas in literature were discussed in the research journals.
2. Identify strategies or approaches from the literature that I decide to work on in order to improve my practice.
3. Appraise and evaluate the planned strategies.
4. Reflect on supervision meetings with my clinical liaisons and my visiting music therapist.
5. Reflect from my observation of my clinical liaisons and my visiting music therapist's work.

5. Data Analysis

This process aimed to separate the data that had been gathered, to identify the information that was most relevant and that supported the issues upon which the study had focused (Stringer & Genat, 2004). At the stage of data analysis, I employed some of the reflective thinking cues from Christopher Johns (2009) which are relevant to my study. This allowed me to clarify, understand and then improve my own practice in this context.

1. Started to analyze the data; to move from a description of what has happened to why it has happened, using some of the cues from Johns (2009). It is not necessary to use these cues for every part of the data. They were used as a helpful guide that allowed the

practitioner to access the depth and breadth of reflection necessary for learning through experience (Johns, 2009).

- What are the issues I should pay attention to?
 - How was I feeling, and what made me feel that way?
 - What was I trying to achieve and did I respond effectively?
 - What were the consequences of my actions for the patient, for others and for myself?
 - What factors influenced the way I was feeling, thinking or responding?
 - How do I feel about this experience now? (Johns, 2009)
2. Identified the evidence that shows my improvement in my practice and also my understanding of my practice [see chapter 4]
 3. Looked for themes that related to my study's focus.
 4. Categorised the analysed data into the themes that have emerged and are discussed in chapter 5.

6. Peer Debriefing Process

The peer debriefing process took place with a fellow music therapy student who reviewed my findings in all four cycles. She highlighted some unclear sentences and suggested some phrases for use. Therefore some changes were made and more explanation was added in order to make the sentences clearer.

7. Ethical Considerations

This study was reviewed by the Health and Disability Ethics Committee, under the systems of "Expedited Review" in July, 2009. The approval number is CEN/09/28/EXP.

I was the participant in this action research. Music therapy practice continued as normal so there were no specific risks to children or staff. There was a very slight risk that staff, caregivers and children at the hospital involved in music therapy could be identified through

association with me or my work. The consent form and information sheet were given to my clinical supervisor and clinical liaison for a review of the supervision notes. Pseudonyms were used for supervisor and liaison, and the location of the hospital was not revealed. Also, the names of the children who participated in music therapy sessions were not mentioned in the study.

Additionally, I needed to be aware of the dual role of the researcher as both music therapist and data gatherer. I also needed to remember the biases or influences that might occur during the reflective process, as these could have a crucial impact on the study's result.

Findings

In this chapter, I will describe my findings for the research question “How can I, as a music therapy student in a paediatric ward, provide beneficial single session music therapy for children?”

At the beginning of this research process I had some questions in my mind that I wanted to explore and develop. However, there were many anticipated issues and a high rate of change in this context of findings. The four main findings which I will present as issues of concern did not emerge at the same time at the beginning of the research process.

In describing my findings from each cycle, I am influenced by the framework of questions McNiff and Whitehead (2009) suggest for writing an action research report. The questions are

1. What was my concern?
2. Why did I feel concern?
3. What can I do or what will I do?
4. What did I do?
5. What did I learn? (McNiff & Whitehead, 2009)

During each cycle, there were similar situations that I encountered and I used similar strategies as planned. Therefore, with word limits and avoidance of repetition in mind, I will demonstrate below some examples of my experience. The examples² were chosen for presentation because I found they showed clearly how the plans were used, how the patients reacted to my approach and then how my planned actions affected my practice.

² In order to preserve confidentiality, all through this study, pseudonyms will be used when referring to the children. The examples which were used were chosen from my clinical notes and research journals. The different fonts will be used to differentiate these two sources. Clinical notes are in *Italic* and research journals are in *Garamond*

The 1st Cycle

WHAT WAS MY CONCERN? AND WHY WAS I CONCERNED?

As there was no clear system of referral in the ward, my first concern when I started to work there was how to approach the patients or how to get the music therapy sessions started in different situations to suit different children's needs and their personalities. I believe that music is of benefit to everyone, but not all patients will choose to participate in a music therapy session while they are in hospital because of their limits and their personal situation. Some patients might be too sick and tired to be up to doing things; some might not want to participate in the activity with a stranger, and some might be more interested in other things at that time. There were many factors which made me feel hesitant about whether or not to approach the children.

After a few months of working in the ward, I summarised and categorised challenging situations that I found.

1. No child comes to the session

Some days, after I had set up the music instruments in the playroom there was no one there or no one there who seemed to be interested in the music. I usually sat in the playroom and felt uncertain about what to do; whether to invite anyone in the ward who was not too sick and who might be up to doing something, or whether to wait for a while for someone who might be interested in music. The atmosphere in the ward always influenced me; therefore I had to be aware of how active or passive I should be, because if I was too active I and the music might interfere with the children who needed rest, and if I and the music were too passive, a child might miss the opportunity to benefit from a music therapy session.

Excerpt from research journals for 1st July 2009

“I sometimes helped the play specialist team clear the room as I also shared their space and their facilities. I also spent time reading articles that related to my work. These things helped me to feel less anxious and useless. However, I still asked myself whether I was simply avoiding approaching the children, or whether I was approaching them enough. Then I started to blame myself.”

2. *Many children want to come to the session at the same time*

On many occasions, another child came to the music corner while I was already having a session with a child, and they seemed to have different needs because of their ages and individual limits. I usually felt nervous because while I did not want to lose the opportunity to work with a new child who seemed to be interested in music, I did not want the child I was working with to be distracted by another child either. It was hard to protect the space and the relationship I had with the child I was working with, but I did not want to miss the chance to offer another child music therapy. Additionally, I worried that I, and the music I had to offer, would not make a good impression on the child who was asked to wait. Here is an example of the kind of challenge I found:

Summary from my clinical notes for 10th July 2009

“After I had been working with Brook, a two-year-old girl, for a while, a seven-year-old boy came to the corner. He showed an interest in playing on the instrument. I was quite anxious because they were of markedly different ages and the playroom was going to close soon. If I did not respond to the boy at that moment, he would miss the opportunity to participate in the music session. At the same time, I did not want to finish the session with Brook yet because I felt that our relationship was just established.”

3. *A shy child who seems to be interested in music*

Many children, both very young and in the young adolescent category, feel unfamiliar with the hospital; and this probably makes them shy and not very receptive to strangers. Sometimes the children refused to come to a music therapy session when I invited them; and some, who were usually very young, withdrew from music activities or ran away from the music corner when I joined in.

Excerpt from my clinical notes for 22nd July 2009

“Ed appeared to be a little upset and very shy, dependent on his parent probably because he could not walk properly by himself and was unfamiliar with the hospital ambience and the strangers within it. His father put him on the chair and stood nearby behind him. I turned to say hello to both of them, then I asked Ed what song he liked but he did not answer. He made eye contact with me briefly, and turned to his dad. I felt that he was interested in musical instruments but he might be too tired to play or he was not comfortable exploring when a stranger was around.”

1ST CYCLE PLANS: WHAT WOULD I DO?

These plans below were intended to help me gain more confidence and skill in approaching the children. I hoped the plans would help me to decrease my anxiety and stop blaming myself when I was rejected by the children. I would be able to increase the opportunities/possibilities for the children to have music therapy sessions.

Plan for the 1st challenging situation: No children come to the session

- Verbally invite them and introduce myself and my service to them
- Invite them through use of music
 - o Play some songs while waiting for children to come. Make some noise in the ward to let them know that there is music there. Hopefully, some soothing

music will help the children and their parents in the playroom feel relaxed (Longhi & Pickett, 2008). Some young children like to copy adult actions (Malley, 1995b), so a child who is entertained by the music I play might be interested in what I am playing and want to copy me.

- Leave the corner open for anyone, because when I sit there that might convey to the child that the musical instruments are not available. Let the children themselves choose whether or not they want to come, and let them decide also when they want to come (Campbell, 1999; Slive, et al., 2001, 2008).

Plan for 2nd challenge: More than one child wants to come to the session at the same time

- Be more aware of the children's individual programmes (their treatment routines or operation appointments) for each day in order to help myself prioritise the children.
- If it is a busy day, I should be clearer about how much time each child can spend on the session. In that way, the children who are interested in music are able to have a music therapy session.

Plan for 3rd Challenge: A child who seems to be interested in music but who is shy or unable to play much

- During my discussion with the play specialist, she suggested that I build a rapport outside the music environment before I invited the child to take part in music activities. I could use a toy as a transition object in order to encourage interaction (Wallace, 1996).

1ST CYCLE ACTION: WHAT DID I DO?

1st challenging situation: No children to work with

Summary from clinical notes for 11th August 2009

When I arrived in the playroom, there were no children there. I introduced myself to a boy who was on his own in the big patient's room. I invited him to play music with me and suggested that he bring the musical instrument to his bed. He did not answer, just shook his head to say no. I did not think he seemed quite well enough for music therapy session, therefore I asked him whether he wanted to do something else such as colouring or playing a board game. He said to me softly that he wanted to do colouring. I brought a few pages of cartoon pictures for him to colour. I tried to make some conversation with him to build some rapport but he did not talk much; then unexpectedly he had a nosebleed. After the nurse came, I left because I felt that he might need some rest.

Later, I went into one of the isolation rooms and saw Georgia, a four-year-old girl who was colouring with her mother in the room. I introduced myself to the girl and her mother. She did not speak to me and hardly looked at me. Her mother said that her daughter liked music and encouraged her to play something. However, the girl shook her head and looked uncomfortable when I was around. I tried to talk to her and ask her in a friendly way about what she was drawing. She still did not talk to me even when her mother really encouraged her to respond. Her mother said that she was just shy. After a while I decided to leave the room because I thought I did not want to push too much. The minute that I opened the door to leave, she started to talk to her mother happily. (On the following day, Georgia was willing to participate in the music therapy session, which was probably because she started to feel more comfortable with me.)

Reflection from these actions

Although these two approaches were not particularly successful in bringing the children to participate in a music therapy session on that day, I was still able to hope that they would come to me of their own volition later because I had made myself known to them. Moreover, after my approach I felt less anxious because I had done something instead of waiting for things to happen. However, I still found it was challenging to tell myself when to step back or stop persuading the children after an invitation had been extended.

2nd challenging situation: Many children want to come to the session at the same time

Summary from clinical notes for 18 August 2009

I was working with Tina (10 years old) when Kim (5 years old) was playing around on the xylophone toy. I did not respond to her right away because I was helping another girl work on a song. After a while, I offered Kim a small colourful shaker; she seemed very pleased and smiled. Then I invited her to play the xylophone (while I was still working with another girl). I gave her an easy song to play which she did not need too much support with. After a while I asked Tina to give Kim a turn on the keyboard; Tina had no problem with that, and went back to her room.

Reflection from these actions

I was nervous because two children who had quite different needs were at this session at the same time. Tina was waiting for her operation, and she seemed to find a helpful distraction from her anxiety over the operation in playing on the keyboard. Kim is a sibling of a child who was waiting by herself while her mother took her sister for hospital treatment. I could not concentrate much on both children and was concerned that I would lose a connection with one of them. I was really hesitant to ask Tina to finish playing on the keyboard, but she had spent some time on it and I felt that she might want some rest as well. I think the keyboard should be shared as well as me in order to provide sufficient service for other children. I did feel more

comfortable and more able to concentrate on Kim's needs, and I think I was able to provide a better session for her.

(Interaction between two children that might lead to a group session was overlooked because during this cycle I had been thinking about using what I had planned.)

3rd challenging situation: Working with a child who seems interested in music, but who is shy or unable to play much.

Summary from clinical notes for 18 August 2009

Leo is eight months old. His mother brought him into the playroom while they were waiting for discharge. He was playing around on the floor and his mother sat nearby. He crawled around the music corner area. He was playing with a small toy and blocks when I walked into the room; I joined in his activity, and offered him a small drum. He put his hand on this drum and seemed to be beating it softly; then I offered him an egg shaker and a frog castanet. He chose the shaker. I improvised a song to encourage him to shake the shaker. After I sang the song a few times and held his hand to shake, he started to shake by himself. His mother seemed to be happy to see him play and told him a few times how clever he was.

Reflection from the actions

His mother did not ask me to provide her son (the child) with a music therapy session but I decided to approach him. He was playing by himself and I thought music could be something stimulating for him when he had been feeling unwell and was limited in the amount of playing and exploration he could do. Moreover, the mother could have some rest while I worked with the child. The mother seemed very tired because of not being able to get a good sleep in the ward and having to take care of the baby during the night. I was a bit nervous because the mother was around and I felt that I should be aware of both the child's and the mother's needs. Therefore, to approach the child also meant I had to approach the mother.

Overall reflection on the 1st cycle

After I followed the plans in this cycle, I felt less anxious about not approaching the children enough. The plans helped me to respond to the different situations and to children's needs more quickly and appropriately. Moreover, I felt better prepared and could accept the children's "rejection" because after I had acted as best I could in the circumstances, I had to respect the children's ability to make choices for themselves about when they wanted to, or felt ready to, join the session (Slive, et al., 2008). I blamed myself less when there was no child to work with because I realized that I did not hold all the power to start the session. The children and I were equal in this process (Miller & Slive, 2004) . Moreover, having different ways of inviting the children helped me to increase possibilities for working with more children. For example, some children would easily accept my invitation to participate in the session while others were not comfortable with a stranger and would probably refuse to have music therapy because I was new to them. Therefore, having other strategies available to suit a variety of personalities might influence whether or not children participated in the session.

1ST CYCLE REFLECTION: SUMMARY OF WHAT I HAVE LEARNT

Making quick decisions

Working on the paediatric ward did not allow me much time to prepare or think carefully about everything I did: it was more important to make a quick decision as to which strategy I should employ or how to change from one strategy to another. It was difficult for me to feel confident that I had made the best decision for both the children and myself. However, after I had made a decision, it was very important to accept the consequences and focus on what was happening next.

The importance of a second attempt

Because children need time to become comfortable with and trust new people, and because therapy is a gradual process and a therapist should not hurry to start a session (Axline, 1989), I should not give up inviting children to the sessions after the first invitation has met

with no response. However, I should be aware of whether or I am pressuring the children to participate in the session (Lorenzato, 2005). The most important thing is to emphasise to the children that the music therapy is available for them any time when they are ready.

Being aware of the ward atmosphere

Working in a shared space it is important to be aware of the needs of others using that space; those of both children and staff. The children should be allowed to make some noise but they also need to be aware of other children's privacy. Although there are limits in the amount of noise that children are permitted to make, working in this shared space allowed the children or anyone in the ward to feel comfortable about joining in a music therapy session because it was situated in the open space where everyone was welcomed.

Involving the parent

As some children are not used to being with strangers, they are often hesitant to participate in the session. Therefore, involving someone in the session whom the children trust and are comfortable with (parents, for instance) can motivate and encourage children's participation.

Group work³

Group work could be another option when there is more than one child showing an interest in music. However, I did not employ it during this study, often because I was anxious about differences in age and needs. Therefore, I missed the chance to nurture interactions which could have led to establishment of relationships among patients. This might have given them opportunities to share their fears and difficulties during hospitalisation, even if their situations were in some ways different.

³ The idea of employing group work emerged for me after this cycle. However, this issue was discussed as part of this cycle because the incident in this cycle clearly showed how group work could be of benefit for children in this kind of situation.

The 2nd Cycle

2ND CYCLE CONCERNS: WHAT WAS MY CONCERN? AND WHY WAS I CONCERNED?

The most important challenge when I was working in the ward was that there was not much time to assess the children's needs or learn their history or music experience. Therefore, it was very hard to plan the session to suit their needs and their personalities. The assessment had to be done on the spot in accordance with how the children came across at that time. Therefore, after the children chose to participate in music therapy sessions, it was usually a struggle for me to provide activities or approaches that were both suitable and beneficial, given the varied needs of the children. Before I started this cycle, I had already been interacting musically with the children by providing some of the activities and approaches which I would also employ during this cycle. However I sometimes felt stuck in the middle of the session and could not extend my musical interaction with the children. This made me feel very anxious and frustrated when the children's attention wandered from our interaction after ten minutes or less.

2ND CYCLE PLANS: WHAT WOULD I DO?

I planned to bring activities or approaches which formed part of my experience so far and which had also been influenced by a variety of techniques offered by music therapists working with children. Such techniques were intended for use in combination with some understanding of children's different needs. I increased my awareness of the different needs and characteristics presented by young people at different stages of their "growing up" or development, by periodic recourse to the literature review presented in the 2nd chapter⁴ of this study.

These activities or approaches were not fixed plans to be followed step by step. Instead, they were choices of things in my tool bag which I could use and provide to suit the children at

⁴ This was discussed in depth in the literature review chapter; pages 10-14 and 20-23

that moment (I also left the children some leeway to guide me in what they wanted). Keeping these activities or approaches in mind was intended to help me respond to the children more suitably and spontaneously, and decrease my anxiety if I did not know what to offer them.

2ND CYCLE ACTION: WHAT DID I DO?

The examples below were chosen from across the age range of the children I worked with. I can show thereby how my plans for the different ages impacted on/affected my practice.

Summary from Clinical notes for 23 September

Session with an Infant

I was playing on the guitar by myself when David and his mother came in. David is eight months old. He was crying when his mother brought him into the playroom. I invited them to listen to music. David's mother sat on the chair nearby and put David on her lap. David looked uncomfortable and upset. I gently started to play familiar songs such as "Twinkle twinkle little star", "Baa Baa black sheep", "Mary had a little lamb". His mother also sang and rocked him in time to the music. Sometimes I played songs that David's mother suggested to me; sometimes I let his mother sing for her child while I just accompanied them softly on the guitar. He looked calmer and looked at me most of the time when I sang. I offered him a pink egg shaker; he grabbed it and his mother held his hand to shake it. I sang a song to encourage him, changing the words in the "Wheel on the bus" song from "the wheel on the bus goes round and round..." to "the shaker in your hand goes shake shake shake...". He shook it a few times by himself during our singing. After about 15 minutes he seemed to be calmer and his mother wanted to move him to the floor so he could crawl around and have some exercise.

Reflection from the actions

Before David came to the playroom, he was distressed because a doctor had just given him a blood test and a medical check. He was probably uncomfortable at being in an unfamiliar place, surrounded by strange equipment and people. It was really lovely to see David interested in the music, and appearing to be calmed by it. Familiar music could provide him with the comfort of

a more or less normal moment, and help him feel less alienated in the ward (Lorenzato, 2005; Robb, 2003). Besides that, involving his mother would have reduced the stress probably experienced by a child this age when forced to interact with a stranger (Nuttall, 1995), and would have provided him with valuable, perhaps indispensable, family support (Kayes, 1999). Additionally, the fact of giving David a pink egg shaker might have helped to stimulate his development (Bruner & Suddarth, 1983). Furthermore, I felt like I was working with his mother as part of a team because she was sharing songs David liked with me. Also she responded to my cue when I left some space for her to sing to David and rock him as she sang. Music offered David's mother a chance to support David when he was sick (Brodsky, 1989). I hoped that this contact would be of benefit to the mother also, by decreasing her nervousness and worries when she saw David looking calmer and ready to do other things (Ayson, 2007; O'Neill & Pavlicevic, 2003).

There was a moment when I felt stuck because I did not know what to do next and I kept forgetting what I had planned. However, David's mother helped me by initiating David's favourite songs for me and I also gave myself some space to think while I made conversation with David's mother.

Summary from clinical notes for 30 September 2009

Session with a toddler

Harry is a two-year-old boy. He appeared to be a bright child and had a lot of energy. He was interested in playing on the keyboard, and started to randomly play on it. I sang familiar songs to him such as "Mary had a little lamb", "Baa Baa black sheep" and "Eency Weency spider" to accompany his exploration, and asked him what song he wanted to sing. He also moved his body, performing some actions along with the music and sometimes singing while I was playing the familiar songs to him. His mother left us alone and when she came back suggested that he could sing "She'll be coming round the mountain". I could not remember the song properly so I sang just the first sentence and asked him to join in, but he did not do so right away. Then I hummed the song instead and he hummed along with me.

Then I initiated the game ‘‘Stop and play’’. In this game, we took turns to play on the keyboard: when one of us said ‘stop’, the music had to stop and the one who was playing had to freeze. I moved along with his music and so did he, and sometimes we were freezing in funny positions. He seemed to be really enjoying himself. He laughed and we played the game for a few minutes. Then I brought out my bird puppet and said to him that the bird would dance along with his music. I moved my puppet following his music (fast-slow), then I asked him to play following my bird’s movements. He was able to follow these quite well, and seemed very amused when I changed the speed of the bird puppet’s movement.

Reflection from the actions

Harry had severe wounds for which he was being treated. It was distressing for adults to see such a small boy with these wounds. He did not appear too troubled by the wounds, and he carried on playing. In the session, he was able to take turns to be leader and explored some of the music which constitutes a normal part of his life.

It was fun to work with Harry because he was willing to try different things. Exploring the keyboard might have served to encourage his creativity (Adam & Towle, 2009). He responded to music very well, and performing the actions probably stimulated his fine and gross motor development; as children this age need to nurture these skills (Adam & Towle, 2009). While he was engaging in the music therapy session, he could gain a sense of autonomy over a situation in which he was restricted by his state of health and treatment routine. Providing him with various options (choosing what songs to sing, deciding when the music would stop in our ‘‘stop and play’’ game, or how the music should be played) had the potential to help empower him and renew his sense of independence (Robb, 1999).

During our contact he appeared to be very relaxed and explorative as children his age should be (Adam & Towle, 2009; Malley, 1995b). I tried to think of him as a normal and healthy boy and I hoped that his mother would be happy to see her son having a good time with music even though he had experienced quite severe injury. I felt that his behaviour encouraged me to be more explorative so that I could serve his needs.

Summary from clinical notes for 13 October 2009Session with a preschool age child

This was a short session with Nora, a four-year-old girl. She felt better after she had been resting in bed all day the day before. She came to the playroom while waiting for the doctor to discharge her. She showed interest in playing with a small keyboard, and explored the keyboard by playing each key. I matched her by playing the same thing on a big keyboard. She turned to me and smiled. Then I initiated her into different ways of playing the keyboard such as playing to give an impression of running, walking or jumping. She tried these ideas out on the small keyboard, and seemed to really enjoy what she was doing. After that she wanted to explore on a xylophone and while that was happening, I sang familiar songs to accompany her. I invited her to sing with me by singing softly myself, and left some space for her to fill in the word. She sang along with me for some phrases. While she was continuing to explore other instruments in my music bag such as a drum and a shaker, I sang familiar songs and sometimes changed the words in order to match her actions.

Reflection from the actions

To allow and to facilitate her exploration of musical instruments would hopefully have nurtured her sense of independence and helped her towards greater activity when she had not been doing much for a few days. Moreover, when she participated in singing familiar songs with me she probably felt more secure, as the songs offered her something predictable while she was in an environment where things were usually unpredictable.

I was quite upset when she left the session after just a short time. I did not feel that I had run out of ideas and Nora seemed to be having a good time. Besides that I was disappointed that I could not employ very much of what I had prepared (see the table). However, she probably had a short attention span (as would be normal at her age), and there were many other toys around.

Summary from clinical notes for 30 September 2009Session with a primary school age child

Jimmy is an eight-year-old boy. He is a sibling⁵ of one of the children in the ward. I offered to show him how to play “Mary had a little lamb”. Next he suggested the “Chopsticks” tune; I simplified the song and showed him slowly how to play that too. After he started to get the hang of the tune, I initiated him into playing a part of it on the xylophone while I accompanied him on keyboard. I talked to him about his music experiences at school. He could sing and had been involved in a drum competition. He sang for me and did some drum improvisation from the keyboard. Before the session finished, we played a copy game on the xylophone.

Reflection from the actions

Jimmy was having a considerable period of waiting at the hospital because his sister had come back to the children’s ward for her medication and was also having blood tests. Although he was not a patient, having to wait in the hospital might be boring for a child his age; depriving him of the chance to be at school and spend time with his peers, or play outside engaging in normal activities (Kallay, 1997). Therefore, I hope that this contact alleviated his boredom and provided him with a good hospital-related experience. Moreover, he seemed to be proud to show his parents what he could play on the keyboard.

In this session we took turns to be leader and follower. I introduced him to what I knew and he shared something of his experience with me. I let him express his ideas and accepted his leads. Moreover, with some help from me he had the chance to overcome the challenge of learning new songs. This was a way of nurturing his self-esteem, as he was able to make decisions and solve his own problems (Adam & Towle, 2009). Sometimes I extended our activities from what

⁵ I consider working with a sibling to be an important task because the siblings are also affected by their family member’s sickness and hospitalisation. Further explanation is given in appendix 1.

he initiated. I felt quite anxious that I was not able fully to employ what I had prepared (see the table⁶), but I was also pleased that our session flowed from the ideas of us both.

Summary from clinical notes for 10 October 2009

Session with a school age child

Ella is a ten-year-old girl. She had an operation yesterday morning and had bed rest all day. She looked quite tired and seemed very fragile to me. I joined her while she was playing the keyboard and softly introduced myself to her. Then I asked her whether she wanted to try to play the keyboard. I offered my music sheets to her. She chose the Christmas song "We wish you a merry Christmas", and I showed her how to play the song slowly. Then I invited her to play with me slowly. She followed me carefully, but seemed very anxious when she made mistakes. I told her not to worry, and that it is all right to make a mistake. I played along on the small keyboard and sang along while she played the song. I asked if she would like to try playing on the small keyboard because it is easier to play than the big one. After that she seemed to be more familiar with the song, and I invited her to choose a new one.

Reflection from the actions

Even though this was quite a brief contact for a ten-year-old girl compared to other ten-year-old girls I had worked with, it was still nice to see Ella doing something after her operation. From my observation she barely did anything during her hospitalisation. It was probably because of her limitations in movement resulting from sickness, or else this was all Ella could manage in terms of energy. However, playing the keyboard did not require much energy but could provide Ella with a sense of success and provide a normal activity outside the hospital routines. This could probably minimise the feeling of missing out on normal experience. Furthermore, it was interesting enough from her point of view to encourage her to make an effort to move from her bed to come to play the keyboard in the playroom.

⁶ The table was shown pages 51-52

Overall reflection from the 2nd cycle

During this cycle, I was aware that my sessions did not flow very naturally. There were some sessions where I still found myself running out of ideas for providing suitable activities for the children. However, having some strategies in mind made me feel more secure because I knew that I had choices for dealing with different situations and the situations were not totally unplanned. Moreover, during this cycle I started to gather together the activities or approaches that I had employed, and put them on a table. It also encouraged me to develop my “tool bag” to suit a variety of ages, and helped me to feel more prepared for the wide age range from birth to 14 years old. The table⁷ was divided according to age group, and had on it some possible activities or approaches which I thought would be appropriate for different age groups. Possible benefits resulting from the activities were also identified. Therefore, I could quickly pick something beneficial that seemed appropriate for the children.

⁷ The table was shown pages 51-52

Table 2

Age	Singing	Playing	Movement	Listening	Improvising & Composing
Under 1 Year old	<ul style="list-style-type: none"> ☞ Encourage vocalisation 	<ul style="list-style-type: none"> ☞ Explore instrument 	<ul style="list-style-type: none"> ☞ Encourage to reach out the instrument ☞ Playing “Pat a Cake” 	<ul style="list-style-type: none"> ☞ Lullaby- Rocking ☞ Tracking the sound source 	-
	<p><i>Benefit</i></p> <ul style="list-style-type: none"> ☞ Stimulate their development (verbal skill) 	<p><i>Benefits</i></p> <ul style="list-style-type: none"> ☞ Physical exercise ☞ Stimulate their development ☞ Experience different texture 	<p><i>Benefit</i></p> <ul style="list-style-type: none"> ☞ Physical exercise 	<p><i>Benefits</i></p> <ul style="list-style-type: none"> ☞ Soothing ☞ Stimulate their development ☞ Nurture parent and the child’s attachment 	-
1-3 Year old	<ul style="list-style-type: none"> ☞ Clapping with chanting ☞ Rhyme ☞ Choice making about “How” to sing ☞ Leave word in familiar song ☞ Encourage to add simple actions in the songs 	<ul style="list-style-type: none"> ☞ Explore instrument ☞ Copy/Conducting game ☞ Play simple percussion along- chant/sing (unsteady?) ☞ Choice making of who and how to play, which instrument to play) 	<ul style="list-style-type: none"> ☞ Change movement according to the song 	<p><i>Same as above</i></p>	<ul style="list-style-type: none"> ☞ Substitute lyric in familiar melody ☞ Change some verse/word ☞ Turn taking ☞ Making sound effect to the story ☞ Improvisation with theme
	<p><i>Benefits</i></p> <ul style="list-style-type: none"> ☞ Soothing ☞ Co ordination ☞ Gaining control ☞ Creativity ☞ Physical exercise ☞ Stimulate development ☞ Nurture parent and the child’s attachment ☞ Fun ☞ Distracting from stress 	<p><i>Benefits</i></p> <ul style="list-style-type: none"> ☞ Creativity ☞ Normalising ☞ Gaining control ☞ Empowering ☞ Stimulate their development ☞ Fun ☞ Distracting from stress 	<p><i>Benefits</i></p> <ul style="list-style-type: none"> ☞ Creativity ☞ Fun ☞ Distracting from stress 	<p><i>Same as above</i></p>	<p><i>Benefits</i></p> <ul style="list-style-type: none"> ☞ Empowering ☞ Creativity ☞ Building relationship with new person ☞ Sense of success ☞ Fun ☞ Distracting from stress

Table 2 (Continue)

Age	Singing	Playing	Movement	Listening	Improvising & Composing
3-5 Year old	<ul style="list-style-type: none"> ☞ Singing with action, clapping and playing percussion along ☞ Choice making about “How” to sing ☞ Leave word in familiar song 	<ul style="list-style-type: none"> ☞ Copy/Lead-Follow ☞ Play simple percussion along-chant/sing (unsteady?) ☞ Choice making (who and how) ☞ Music Lesson ☞ Simple music instrument making 	<ul style="list-style-type: none"> ☞ Change movement according to the song 	<ul style="list-style-type: none"> ☞ Drawing while listening ☞ Sharing thought about the chosen song 	<ul style="list-style-type: none"> ☞ Substitute lyric in familiar melody ☞ Change some verse/word ☞ Turn taking making sound effect to the story ☞ Lead- Follow with cue (how to play) ☞ Imitate animal/environment sound ☞ Turn taking making up story
	<ul style="list-style-type: none"> <i>Benefits</i> ☞ Creativity ☞ Normalising ☞ Gaining control ☞ Empowering ☞ Stimulate their development ☞ Fun ☞ Distracting from stress 	<ul style="list-style-type: none"> <i>Benefits</i> ☞ Creativity ☞ Normalising ☞ Gaining control ☞ Empowering ☞ Stimulate their development ☞ Fun ☞ Distracting from stress 	<ul style="list-style-type: none"> <i>Benefits</i> ☞ Creativity ☞ Fun ☞ Distracting from stress 	<ul style="list-style-type: none"> <i>Benefits</i> ☞ Creativity ☞ Express their feelings and thoughts ☞ Develop relationship with new person 	<ul style="list-style-type: none"> <i>Benefits</i> ☞ Creativity ☞ Normalising ☞ Gaining control ☞ Empowering ☞ Fun ☞ Distracting from stress
6-14 Year old	<ul style="list-style-type: none"> <i>Same as above</i> ☞ Recording their singing 	<ul style="list-style-type: none"> <i>Same as above</i> ☞ Recording their playing 	<ul style="list-style-type: none"> <i>Same as above</i> 	<ul style="list-style-type: none"> <i>Same as above</i> 	<ul style="list-style-type: none"> <i>Same as above</i> ☞ Improvisation with theme and rules
	<ul style="list-style-type: none"> <i>Same as above</i> ☞ Having positive memory during hospitalisation 	<ul style="list-style-type: none"> <i>Same as above</i> ☞ Having positive memory during hospitalisation 	<ul style="list-style-type: none"> <i>Same as above</i> 	<ul style="list-style-type: none"> <i>Same as above</i> 	<ul style="list-style-type: none"> <i>Same as above</i>

Furthermore, during this cycle, I started to value my actions more as meaningful and purposeful activities because I did not feel that I was just randomly offering the children anything that came up or that I was simply following leads from the children. I felt that having some ideas for activities or approaches would increase my confidence when I had to work with the children because the ideas ensured that I had something concrete to offer them. The ideas I had were not always suitable for every child, but being able to experiment and apply some of the ideas offered me chances to learn how to adapt the ideas of others and make them more suitable for the children in the hospital, as well as for myself and my situation.

However, almost at the end of this cycle I felt that I was not able to follow my own belief that I stated in the 1st chapter⁸; i.e., that everyone has a different way of benefiting from and enjoying music. I found myself becoming more anxious when the children did not respond to me in the way I had expected, and I was also too strict with myself over the activities that I had in mind. I felt a lack of spontaneity and less awareness of the children's needs. I was overwhelmed by worry at not being able to employ the plan and I thought that the plans were failures because I could not follow them correctly. There were a few times that I was disappointed that the limits of the children's state of health did not allow them to explore music with me. I misused the word "plan" in this cycle. I did not use plans as guides as I had intended at the beginning of the cycle, but became rather rigid in how I employed them. These plans helped me improve some aspects of my practice but also gave rise to another challenge which appeared in the third cycle.

⁸ More detail was provided on page 8

2ND CYCLE REFLECTION: SUMMARY OF WHAT I HAVE LEARNT

Some techniques for extending the sessions

- Even when taking into account the children's attention span and their state of health, they should be given encouragement to stay on the activities long enough to acquire some valuable experience.
- Carefully observe their responses and use these as a guide for extending the session.
- Be flexible with the plans. Vary small things in the activities such as changing the instrument, songs, or changing the way of playing the songs.
- When the session had ended I asked myself the question:

“What will I do if they come back?”

This question led me to plan and develop new strategies and provide more beneficial sessions.

Below are some music therapy techniques that were always used and which provided effective outcomes for the children I worked with during this cycle. I would like therefore to discuss what I learnt from these techniques.

Learning to play the keyboard

As the hospital is full of unpredictability, offering the children some simple structure in the session is important; especially for school-age children who need order and consistency in their lives in order to cope with this unfamiliar experience (Bruner & Suddarth, 1983). According to Robb, “structure refers to environments that communicate clear expectations and consequences, provide optimal challenge, and also provide positive feedback regarding competence” (Robb, 2003, p. 28). I offered the children structure by teaching them to play familiar songs on a keyboard in a relaxed and playful way. Learning a musical instrument is part of children's normal activity; therefore they know what to expect during such an activity. This

feeling might help to minimise any feeling of uncertainty during their hospitalisation. Moreover, learning to play an instrument is a lot of fun for children (Lorenzato, 2005). It provides opportunities for mastery and increase of self-esteem (Abad, 2003; Lorenzato, 2005).

I put stickers, each with a letter of the alphabet, on each key of the keyboards, and wrote the alphabet on my music sheet instead of musical notation. In this way the children were able to play the keyboard easily just by following the alphabet on the sheet notes. The music sheet was colourful so as to gain the children's interest. Besides that, the sheet could help the children master the songs in quite a short time. They could just follow the letters on the music sheets. Most of the songs in the folder were familiar to the children; therefore the sheets did not need to indicate the rhythm symbols.

Story telling

This technique started when children came to the keyboard and wanted to try out the instrument. The technique allowed them to make their music more meaningful. For preschool-age children especially, who are highly imaginative (Malley, 1995a; Petrillo & Sanger, 1980) and want to explore their environment (Bruner & Suddarth, 1983), taking turns at telling the story with me could provide another means for them to express and share their thoughts and feelings (Kayes, 1999). The principle is similar to that followed by Sheridan and McFerran (2004), whose clients communicated their feelings of potential loss of control over their bodies and their fear of the unknown through story telling.

Sometimes I used toys in the story telling, and this led to making music to match the dolls' and puppets' movements. The children gained a sense of control when they were able to make the dolls, and I would play the music to match their movements. Moreover, they could play the music to control the dolls' movements.

Singing familiar songs

For children who were not used to being surrounded by new people and who were quite sick and unable to do active things, singing familiar songs to them seemed a good start. This allowed them to observe what was going to happen in the music session before they decided whether or not to participate. Moreover, I felt that singing songs to them – especially lullabies – could also convey an impression of love, care, and sense of security (Loewy, 1999); and this in turn would help to establish trust in me. Besides that, as infants are starting to discriminate between their caregivers' voices and faces and those of strangers (Bruner & Suddarth, 1983), involving the caregivers by engaging them in singing a lullaby to their infant would probably nurture bonding between them.

For very sick children, listening to the music also distracted them from their pain and anxiety. Besides that, singing familiar songs allowed their parents to participate easily in nurturing their children's wellbeing.

Improvisation

I found it was hard to invite the children to improvise if they did not know or trust me. Besides that, the children probably did not know how to improvise, because asking them to play anything they wanted to play was too open. The children were in an unpredictable setting; therefore, giving them some clues as to expectations or direction would minimise the chaotic element in their current surroundings. Sometimes, improvisation can emerge from other things such as a copy game or improvisation based on a familiar song. These techniques gave the children some structure to guide them in what and how they should play. Furthermore, it was important to let them feel more comfortable with me and the musical instrument first.

The 3rd Cycle

3RD CYCLE CONCERNS; WHAT WAS MY CONCERN? AND WHY WAS I CONCERNED?

During the entire course of this study, I had to handle two roles at the same time. I acted as a practitioner who ran the music therapy sessions and also as a researcher who was gathering the data for this research. It was very challenging to balance these two roles and prevent one from overlapping with the other.

During the 2nd cycle, when I was working with the children I did not concentrate enough on or pay sufficient attention to their needs and initiations because I was focusing more on how I could use the plan, how and why it would or would not work, and what else I needed to do to improve it. I was anxious and worried about my own practice and about not being able to employ what I had prepared and also not being able to gather the data or not producing informative data. I felt I was not thinking enough about the children's wellbeing and seemed unable to sit back and let the situation take its course. Moreover, I probably missed various signals and clues at that time; including some relating to the young patients' state of health. It is likely, therefore, that I did not approach the children appropriately.

3RD CYCLE PLANS: WHAT WOULD I DO?

In the first two cycles, my plans were very detailed and specific. There were probably too many specific things to remember and feel concern about. These made me anxious, and worry about my plans rather than concentrate on what was happening and be aware of the children's needs and responses. In this cycle, I decided to simplify my plans and use them as philosophies or principles to be kept in mind while I worked.

During this cycle I intended to

- Be “here and now” with the children and keep the 2nd principle⁹ from Axline (1989) in mind.
- Be more aware of and more focused on the children’s needs, and consult the literature in chapter 2¹⁰ when necessary.
- Allow the children’s initiations to lead my practice more and keep the 3rd, 5th, 6th and 7th principles¹¹ from Axline (1989) in mind.

3RD CYCLE ACTION: WHAT DID I DO?

Summary from clinical notes for 20 October 2009

Dena was a two-year-old girl who had just arrived in the ward. While she was waiting for the doctor, she came to the music corner with her grandmother. She appeared to be a very bright little girl. She was exploring the keyboard randomly so I played it and sang familiar songs along with her keyboard exploration. She did not often make eye contact with me while I sang, but each time the song finished she turned to me and giggled and said “more”. I tried not to leave a long pause between each song because I did not want Dena to lose interest in the music. I felt a bit rushed into the next song and I sometimes felt I was running out of songs; so I asked Dena and her grandmother what song they would like to sing. Dena’s grandmother suggested “The wheel on the bus” and while I was singing, I accidentally forgot the lyrics and stopped during her favourite song. We all laughed, then I quickly asked Dena and her grandmother to help me sing the song.

Reflection on the actions

I still drew upon some approaches from the table¹² that I developed during the 2nd cycle but I did not put pressure on myself to use them; thus I felt more flexible and better able to follow the patient’s lead. In addition, I did not get too anxious if things could not be as planned. Moreover,

⁹ Reiterated principle from Axline, given on page 7

¹⁰ This was discussed in depth in the literature review chapter; Pages 10-14 and pages 20-23

¹¹ Reiterated principle from Axline, given on page 7-8

¹² More detail was provided on page 51-52 (in Table 2)

I saw my mistakes differently. Before, I had usually felt embarrassed when I made some mistakes in front of the children and especially their parents.

In this session, when I sang the song incorrectly and we all laughed, I think this mistake made the atmosphere more relaxed and playful and decreased our anxiety at being surrounded by strangers. Furthermore, the ability to accept my mistake encouraged me to take some more risks in other sessions.

This was quite a short session; around 15 minutes. I found it was quite helpful for this little girl who had just arrived in a new environment and had to wait for her unknown treatment. The musical contact might have served as the transition point from a new and strange environment to a friendly and warm one. Moreover, it might have helped to relieve her anxiety at not knowing what was going to happen to her.

Summary from clinical notes for 21 October 2009

Kim is a six-year-old girl. She appeared to be a bright and explorative child but did not talk much, especially with new people. I participated in her activities before inviting her to the music corner. She started playing the keyboard randomly. I accompanied her on the other side of the keyboard, and tried to match her playing with a similar tempo. After a few minutes of following her playing, I decided to invite her to learn an easy song on the keyboard. After a few tries, she seemed to struggle a bit and went back to simply exploring the keyboard. So I initiated her into playing the keyboard using different sounds and ways of playing. Even if she did not make much eye contact, when I initiated her into trying things she accepted and tried them out. Around 20 minutes later, she left the corner to play with other things. Later that morning, she returned to the corner and started to explore the keyboard again. I played along with her with simple chord progression in order to give some focus to her playing. She did not look at me or appear to be interested in what I was playing, but when I changed the way I played or the tempo, I noticed that she adjusted her playing to blend with mine.

Reflection from the action

At the beginning of the session, I was nervous that Kim seemed to be unaware of my presence because she was barely responding to my questions. However, when I realised later that she was struggling with verbal communication because of an operation she had had on the inside of her mouth, I felt less anxious and accepted her condition and limitations. I allowed myself to follow her needs without worrying or blaming myself when things did not go well.

Even though during the session she might only have played around on the keyboard, this playing probably provided her with a chance to express her thoughts when she found it difficult to communicate verbally. Moreover, the music session provided opportunities for her to interact with others through music. In the same way she understood my signal when I changed the tempo, I too acknowledged her music pattern. She was able to create a musical pattern which she returned to once in a while, and I showed her that I was listening to her by playing along with her and playing it back to her. For this young girl with verbal communication difficulties, having a chance to share her thoughts and have someone who was listening to her might have minimised her frustration at communication limitations.

Reflection regarding my own thinking during my case study working process: from research journal for 5 November 2009

Thinking about only one case in a long-term process is very different from what I have usually done in this placement. Normally, I tended to get an impression of the children from the moment they appeared at the session. I usually responded to their needs then and there, and it was hard to understand each as a whole person.

In contrast, while I was working on the case study presentation, I studied one child's responses in more than one music therapy session. I was able to gather more detailed information about the child. Therefore I was in a better position to understand and make sense of my case study's (Rachael) responses to my approaches and evaluate how my approaches had affected her during her hospitalisation. Importantly, I was able to see some development in the patient and also appreciate how my thinking had developed during the few sessions we had had together. Working on my case

study helped me to identify in more detail the approaches that had brought about the outcomes of this case study.

In the current process I had to bring my understanding from related literature into my practice, and this helped me to look at this practice in a more meaningful way. Reading more related literature also helped me to see more possible benefits for hospitalised children as a result of music therapy. This in turn enabled me to see small responses from children in a more meaningful way.

Overall reflection on the 3rd cycle

During each session, I think I am able to focus more on the patient's initiations and needs. Being able to do that has helped me to lessen my anxiety and worries about following my role as a researcher, so I do not worry about not being able to try out my plans. I feel freer to work with the children and do not worry so much about making a mistake and about the result at the end of sessions; and this freedom has allowed me to take more risks. Moreover, when I was more aware of the children's situations and responded to them from their point of view, I could see and understand their interactions more vividly. This led me to put less blame on myself and to see the children that I was working with as partners who had equal power and responsibility in leading and running the session.

3RD CYCLE REFLECTION: SUMMARY OF WHAT I HAVE LEARNT

Mistakes can be fun

Mistakes in the sessions can be perceived in a positive way; as a source of entertainment helping to make the environment more relaxed and playful. The mistake can allow both the children and me to laugh at it. Moreover, I was probably able to gain the children's trust up to a point, as I was honest and pointed out my mistakes to them. I was showing them that I trusted them enough to let them see my mistakes.

Not being too strict with plans so as to be more aware of the patient's lead

Having plans is good as it can be a backup and starting-point to offer the children things to do. However, when I thought too much about the next thing in my plans, this limited my awareness of the children's responses. Therefore, the plans should be employed loosely in order to allow myself to see the children's responses and initiations more clearly.

"To be there" with someone

After I tried to leave my concern about producing good research and good practice outside the sessions, I started to find the difference between being with the children and appearing "to be there" with them. In this cycle, I began to notice that I was able to have more fun with the children and was able to anticipate their response from their situation and state of health. I was able to see the session as a place where the children and I were working together, and not just as a place for me to work and take all responsibility for the session.

Think and be aware of the children's needs; both easily and not so easily noticeable

Some children appeared to be less sick than they really were. Therefore, it was very important for me to keep their condition in mind and remind myself of it with related literature. It helped me to have appropriate expectations for their responses. Moreover, I was able to respond to them more suitably.

The 4th Cycle

4TH CYCLE CONCERNS: WHAT WAS MY CONCERN? AND WHY WAS I CONCERNED?

It was almost the final stage of my placement. I felt more settled and I was starting to see things as less unpredictable. Almost every day at work I was meeting different children; and because of the short period of time working with them, there was very limited opportunity to create a relationship, get to know them and come up with significant variations in programme. I noticed that I was always providing the children with the same things. The activities might be new to the children but they were not new for me. Repetition ensured that the children would react, so I started to become stuck in my comfort zone and was not providing the children with the variety of activities that I should have been using. This led me to unconsciously prevent myself from extending my knowledge base. The children and also the setting were missing out on the varied benefits available from music therapy. I started to notice that I was bored with my own practice, and I think this affected the way I looked at my work as well. I started to question my practice's value and its meaning.

4TH CYCLE PLANS: WHAT WOULD I DO?

In order to keep up my inspiration and encourage myself to enjoy my own practice, I planned to do the following things:

- Learn new songs
- Observe my visiting music therapist at her workplace
- Remind myself to go beyond my comfort zone
- Create activities and songs myself

4TH CYCLE ACTION: WHAT DID I DO?

Summary from clinical notes for 19 November 2009

None of the children were showing any interest in music when I arrived in the playroom. I started to play Christmas carols which I had just learnt for the approaching Christmas season. Then I heard someone singing along. A patient's mother was doing some colouring with her child while they were waiting for discharge; she sang along with me and also suggested other Christmas carols to me.

At the same time the play specialist brought in Stephen (one year old) who seemed to be distressed because of separation from his caregiver. I kept singing softly to the toddler while the play specialist helped Stephen hold the shaker and shake it along with my playing. He became calmer, then after a while his mother came to take him back to his bed. Right after that there was another boy who wanted to play on the guitar.

Reflection from the actions

I thought the songs that matched the occasions presented more interest to the various age groups. From a situation where nobody seemed to be interested in music, we moved to limited participation and then to someone fully participating in the music therapy sessions.

It also helped me to feel more comfortable because I felt that I was able to enter into the mood of this special occasion. By successfully learning new songs and using this knowledge to good effect, I was able to gain more confidence and improve my practice.

Summary from observation of my visiting music therapist's work; from research journal for 27 November 2009

I went to observe my visiting music therapist at work. My primary intention in observing her was to gain some new ideas and hope to apply them to my work with the children in the ward. Although her workplace is quite different from the children's ward (she has worked with the children for a while and the goals for each child are set) the children that she works with are of a similar age to

those in the ward. I observed her during five sessions, each one of thirty minutes. She laid out her different kinds of instrument on the table so that the children could easily choose one to play. She started every session with the “Hello” song, but she had different versions for different sessions. She invited the children to choose what they wanted to do: as she had been working with some of the children for a while, they were quite familiar with the activities. The main ones used were turn taking, improvisation with a theme, a conducting game, playing an instrument such as a drum, a piano, a xylophone and small percussion instruments (such as shakers, bells, and tambourine), and singing familiar songs.

Seeing another music therapist at work helped me reflect on many different aspects of my own practice.

- The way she used the music

She composed various songs for various activities and the songs allowed the children to add some musical ideas. Furthermore, when she invited the children to do improvisation with a theme, she was able to support their musical ideas, and her music matched the themes very well and helped the children’s music to be more meaningful. I started to realise that I was not preparing my musical resources enough; and therefore, that my music did not always give much support to, or really match, the children’s music. Her activities and songs helped give greater structure to the session, because each one chosen had a clear purpose. She explained simply and clearly how the activities went, and sometimes demonstrated them to the children: therefore, they knew what they were expected to do (for example when to start and stop playing). This might also have helped the children accomplish the tasks more easily: for example, in music improvisation with themes, the music therapist invited the children to choose an instrument and play it to express a mood that they had chosen. The lyrics of the song, and the music therapist, indicated when the children should fill in their improvisation. The music therapist’s music both supported and matched the children’s music and their themes.

- Her approaches to the children and her personality

Before she started any activity, she usually let the children know what the activity was and asked them to choose what to do next. She moved smoothly from one activity to another, using not only verbal communication but also musical and bodily expressions to start and stop the music, and give a cue as to whose turn it was to play.

During the session, she took a brief break from the music to allow the children to talk about their own music. She acknowledged the children's ideas and supported them with her positive comments. I think this approach showed the children that their music and opinions were meaningful and acceptable. In my view, this can lead to positive relationships among the children themselves on the one hand, between the therapist and the children on the other.

The music therapist was quite relaxed and enjoyed herself with the children. If they became a bit naughty, she appeared to be firm but gentle with them. For example, when a boy started misbehaving and refused to participate in the session appropriately, she insisted that he sing the song properly again but instead of forcing him and repeatedly telling him, she motivated him positively by pointing out how nicely another boy was singing and encouraging him to do it nicely as well. Although her plans were very well prepared, she was still ready to respond spontaneously to the children, and she allowed them to create the activities that they wanted to do. She not only accepted their ideas but was also willing to participate in the activities they created. At the end of one session she used colourful stickers, as that child needed a lot of positive reinforcement.

Reflection from the actions

Even though I knew the importance of some of these issues from other sources, to see someone using them in a real situation reinforced that awareness, and also reminded me that I should have used those approaches in my own situation. Moreover, it reminded me that I was already employing some of the techniques unconsciously.

Summary from clinical notes for 30 November 2009

Danny is a five-year-old boy who appeared to be very quiet and tired. He seemed interested in playing on the keyboard. I invited him to play a copy game but this time I sang a simple song that had lyrics explaining what the child was expected to do. He quietly and carefully copied me. We also took turns to be leader. When he seemed more at ease with me, I started to change my patterns to make them more challenging and stimulating. He giggled when he listened to them and he laughed at me when he performed some challenging patterns and I could not copy his. Then I guided him into playing the copy game on another instrument (a xylophone and a drum). After playing at the copying game, I invited him to play a song about expressing different emotions. Before we started, I demonstrated to him how he could participate in the song (the child can show different moods through playing music). He seemed to enjoy the song and started to talk to me more.

Reflection from the actions

Danny seemed to be more at ease and more confident after a few successful instances of copying my leads. I might probably have gained his trust more because he was able to tell his needs and talk to me more about being in hospital: and this helped me to understand why he was quiet and seemed tired. It turned out that he was distressed from the treatment: he had a PICC line¹³ inserted in his arm for receiving medication, which he said made him uncomfortable.

He seemed to be really enjoying the music therapy session; after he had been through unfamiliar hospital treatment, it was providing him with opportunities to do normal things; i.e., play and explore with a musical instrument. In this session I used the songs that I had been inspired with when observing my visiting music therapist at work; these provided a clear structure but still left some spaces for Danny to exchange his ideas with me. He probably felt safe exploring things during the session. This feeling probably led him to trust other people in the ward besides his family, and encouraged him to explore and try different activities in the playroom.

¹³ See explanation in appendix 2

At the end of the session, even though he had had quite a hard time in hospital I hope that he still took away some positive recollections. That would also create another kind of link for the future, if he were to be hospitalised again.

Overall reflection regarding the 4th cycle

It was good to feel settled after working in the children's ward for a while, but it was also important to remind myself not to fall into my own comfort zone or routine and be careless about providing maximum benefit for the children. From this cycle, I learned that to keep up my inspiration does not need to involve anything very complicated; it can be achieved by doing something simple and small such as learning new songs and creating simple lyrics to go along with a simple melody and employing it with a 'call and copy' game. The important thing is to keep doing it constantly.

When I made a point of doing some things beyond my comfort zone and avoided falling into a routine, I could see my practice became more creative and acquired greater value. I learnt to do some things which were probably more beneficial to the children, and this increased my sense of empowerment. What I did was not meaningless; activities were undertaken to good purpose, and with a view to improving and empowering my practice.

4TH CYCLE REFLECTION: SUMMARY OF WHAT I HAVE LEARNT

Empower myself by learning new things

I found myself feeling more enthusiasm for my work when I set myself some tasks to accomplish. Therefore, to learn new songs and sometimes successfully use them helped me to gain more confidence and inspired me to try or experiment with other things.

To observe other people at work encourages me to improve my practice

While I was observing my visiting music therapist at work, I asked myself many times "what would it be like if I tried "that" in my practice?" This provided me with a strong incentive to apply different strategies instead of getting used to a particular routine.

Be more familiar with current trends in music

As I come from another country and have a different musical background and different preferences from the children I met in the children's ward, learning songs that are popular for children of different ages is a very important task. This is not only so as to interact successfully with the children and be helpful to them, but also to help me feel part of this environment.

Verbal communication¹⁴

Verbal communication might have helped me to understand more about the children's make-up, and might also have established greater trust, as this was of course another channel through which exchange or interaction would have been possible. Sometimes I felt that I was not able to respond appropriately to the children; quite possibly because I had not explained to them clearly enough what they were expected to do.

This chapter contained a broad description of data I collected during my placement and also my thoughts relating to that data. These findings were expected to show how my practice had improved and what I had learnt. This chapter shows how I was able to accomplish my first aim as I adopted techniques from a variety of sources and also used literature to inform my own actions and make them more meaningful. After I fulfilled the aim, I feel I learnt a great deal overall from engaging in this study, and also that I gained various strategies for managing the challenging situations I discussed at the end of each cycle. In the next chapter, these findings will be formulated so as to yield answers to my research question.

¹⁴ I did not learn to improve my verbal communication during this cycle, but I learnt how this issue would have a positive effect on my practice if I could improve it.

Discussion

In this chapter I intend to discuss the findings I have reached relating to the research question and which fulfil the aims I set out at the beginning of this study. I will then review the limitations of the study and indicate some future research possibilities.

During this research process, I have considered many different aspects of my practice, all of which are helpful and of significance to both my music therapy practice and my personal development. However, there are some main findings that I would like to emphasise because I found them very important for provision of single session music therapy while I was working in the hospital, and they always emerged in my mind. The findings discussed in this chapter emerged, in some cases, after one cycle was finished, but also accumulated in the course of the four cycles. I would like to reaffirm the importance of the findings for music therapy practice which are 1) a need for flexibility; 2) keeping the therapist's and children's power of control in balance; 3) sensitivity to children's responses and their needs; 4) familiarity with background knowledge; 5) ability to build rapport in a short time; 6) the need for availability when required; 7) open-mindedness; and 8) ability to reduce anxiety. Moreover, I will demonstrate how these findings were used in this situation. Furthermore, I will discuss these findings and relate them to the reviewed literature in Chapter 2, and some other literature which I found later on.

Being flexible

This principle emerges most often throughout this study, and is needed both inside and outside the music session. Firstly, the children were allowed to choose when they wanted to participate to the session: not only the timetable, but also the way of approaching or inviting the children had to be flexible. The findings from the 1st cycle¹⁵ showed that having various ways of approaching the children could increase possibilities for working with them and help them decide to participate in a session. Moreover, the sessions were sometimes interrupted by treatment routine, so I had to be flexible where that routine was concerned and also be aware of the possibility that the children might come back to the session at any time. Secondly, a definite

¹⁵ More detail was provided on pages 34-42

space for music therapy sessions could not be established; not only because of the children's choices but also because the ward had limited space. Therefore, I needed to be flexible when the children preferred to play a small xylophone on the floor rather than in the corner, for instance. Thirdly, as the children came to the ward with various needs, to be able to serve them I needed to be flexible with the activities I had so I could adapt what I had planned to suit their needs and responses (Wang, 2008). This process is emphasised in the literature¹⁶ by Dun (2007), who wrote about blending the children's responses with both knowledge about the children and appropriate music therapy skills so that the contact would be formed appropriately.

Lastly, as the music therapy session always took place in the playroom, I shared space with other activities in the room; therefore sometimes these activities and the music therapy sessions affected each other to some extent. As they were part of the playroom, my music therapy sessions needed to be flexible, in accordance with the goals, themes or principles that applied in this room. For example, during the time coinciding with the 4th cycle, the playroom was bedecked with Christmas decorations; and for my session to be in keeping with this atmosphere, I started to learn Christmas carols. I was able to feel part of the community not only because of the music I played, but also because I could engage other people in the playroom in celebration of the special occasion. During my playing, the mother of a patient encouraged the patient to sing along, and the play specialist joined in a conversation with the mother and me to suggest other popular Christmas songs. This would have made it possible for the mother to share her worry about her child with the play specialist. This example shows the importance of blending in with, or being flexible regarding, the room's atmosphere, because my flexibility had the potential to influence other people and bring about a convivial, celebratory ambience.

¹⁶ More detail was provided on page 14.

Keeping the therapist's and the children's power of control in the sessions in balance

There was no fixed strategy or approach that was entirely suitable for working in the children's ward because the children had different needs and personalities, and also the situation had a high rate of change. Some children were confident and knew what they wanted to do, while others were shy and waited for me to initiate activities. Therefore, I had to balance and adjust myself to suit the different character of each child, and the different situations.

For instance, I could not be a leader or follow my plan rigidly all the time. Some clear and simple directions needed to be given so the children would know what to expect in a session and would feel safe enough to explore (Oldfield, 1995 ; Robb, 2003). At the same time, it was important that I also allow the children's ideas to lead the session, as happened for example in the 2nd cycle¹⁷ when Jimmy and I took turns to be a leader and a follower. He brought up his ideas and we tried them out together. In this instance, I felt that I was able to keep a balance between Jimmy's and my influence or domination. My ability to do that probably put Jimmy in a position of being able to control or influence me in realisation of his objectives (Holmes & Stubbe, 2003); and this led to the chance for me to show my appreciation of his ideas and musical experience.

Be sensitive to children's responses and to their needs

As I did not have a chance to gather much detail about the children before the session started, I normally reviewed the caseload for the day and obtained brief information about the patients from the play specialist team. The information, and the short period of time before meeting the children were not enough to assess the children's needs or formulate appropriate music therapy goals for them.

Moreover, the children had limited opportunity to participate in music therapy sessions, so every tiny thing in the sessions was counted as important. Small responses from the children such as the way they reacted to new people, the amount of eye contact they made, their smiles,

¹⁷ More detail was provided on pages 51-52.

and compliments from both children and their parents, were to be highly valued and not underestimated. These had the potential to lead to positive relationships or promote some other significant change (Slive, et al., 2008). Besides that, these small responses could be considered as signals and cues from the children as to the success or otherwise of the session.

However, I sometimes found it was more difficult than I expected to be aware of the children's needs, because many children did not obviously show their illness or were themselves not fully aware of it. In the case of the child Harry, for example, with whom I worked in the 2nd cycle¹⁸, I felt quite distressed by the wound on his face; whereas he did not appear to be uncomfortable with it or even aware of it. Some of the children might have wanted to be perceived as healthy, normal children. Therefore, I needed to respect them for such capabilities as they then had¹⁹, and at the same time be aware of any limitations resulting from their state of health.

Moreover, the expectations and goals for sessions need to be easier to accomplish than in a traditional music therapy session because of the limited time available. Any expectations with regard to the children's responses had to be of a kind appropriate to their state of health, but meet their needs of the moment. Keeping the goal achievable in a single session was very important. This prevented me from forming unrealistic expectations concerning either the outcome or the children's responses; and such expectations would have led to stress for both the children and myself (Slive, et al., 2008). During the 2nd cycle²⁰ I sang some familiar songs to a distressed little boy David and his mother; the session in that particular case took approximately 15 to 20 minutes. Initially, I hoped to provide some relaxation for the child. He did not smile or show any sign of interest in the music, and I was not sure whether my singing was helping to relax him or not. After I had sung a few songs, he started to look at me more and participated in what I was trying to do by accepting the shaker. Soon he started to settle down. In that short contact, a relaxing interlude could help take his mind off his distress. Moreover, after he settled down his mother was able to have some rest as well.

¹⁸ More detail was provided page 45-46.

¹⁹ Reiteration of the 2nd principle from Axline, given on page 6

²⁰ More detail was provided on page 44-45

Be familiar with background knowledge

Although every child is unique and individual, having some understanding about child development and a hospitalised child's needs²¹ can help in quick assessment of individual requirements and provide guidance for provision of suitable intervention (Edwards, 1999b). This understanding influenced my formulation of the table 2²² in the 2nd cycle. Although the table was not fully developed, it helped me to feel more prepared; moreover, this understanding was helpful for clarification and appropriate interpretation of the children's responses. Significantly, I noticed that I understood more about the children's responses during the process of making case study presentations²³, because I read more related literature and used this to inform my actions and my case study responses. This made me more sensitive to the latter.

Ability to build a rapport in a short time

There was a limited amount of time available to work with each child. The assessment and therapeutic processes usually took place concurrently with establishment of a rapport with the children (Rees, 2005; Wallace, 1996). It was possible to establish this rapport before the music therapy session started. As in the 1st cycle, I found the suggestion from the play specialist about building a rapport outside the session very useful. From my experience, the rapport could be established quickly when the children felt safe in their comfort zone. Moreover, they could gain more trust in me when I followed their rules and their initiations or facilitated their playing.

During the 3rd cycle when working on the case study presentation, I re-read Rickson's (2006) article about her acronym "PRESENCE", which was helpful in informing me as to how I could establish a relationship with my case study participant during a few sessions with her. At this stage of my study when I looked back at my cycles, it seemed that this acronym also fitted my developing practice well. Each letter of the alphabet in the acronym was referred to as an essential component that I needed in order to establish a rapport with the children in a short time. I explain below how the acronym was used in my context.

²¹ This was discussed in depth in the literature review chapter; pages 9-10 and 20-23

²² The table was shown on pages 51-52

²³ More detail was provided on page 60-61

Playfulness, (We are entering a game)

Hospitals are potentially alienating and frightening places for children. A playful and relaxed approach involving singsongs, the exploration of a musical instrument, the learning of new skills or music games (copy or conducting games) can stimulate them and take their minds off the experience of hospitalisation. Moreover, humour is an important part of these playful activities. Humour can be used as a diversion for children who become aggressive in child psychiatry and also enable a child to feel freer and more able to play (Haire & Oldfield, 2009). Animated and funny melody patterns for the children to copy were usually used during my time in the hospital; as in, for example, the 4th cycle²⁴ when Danny and I played a copy game and he smiled and began to look more relaxed. Then he started to create more challenging patterns for me to copy. Cheerful music and funny poses were also used with Henry in the 2nd cycle²⁵. We both laughed at each other's funny poses when the music stopped. While they were engaging in these playful activities, both children seemed to be distracted from their hospitalisation and more relaxed at being around new people.

Relationship (I trust you enough to begin)

During the course of the study, I was able to see a relationship established between some of the children and myself. I could see the children's trust in me had increased when they accepted my invitation to participate in different musical activities. One example of this is provided by a child in the 4th cycle²⁶, Danny, who initially appeared to be shy and quiet. After he had successfully played the copy game and felt more confident, he started to share his feelings and experiences of being in the hospital with me. Similarly in the 3rd cycle²⁷, when I accidentally sang a word incorrectly both Dena and I laughed at that. It not only made the atmosphere in the session more playful, but

²⁴ More detail was provided on page 67

²⁵ More detail was provided on pages 45-46

²⁶ More detail was provided on page 67

²⁷ More detail was provided on pages 58-59

also showed her that I trusted her enough to make some mistakes while working with her.

Encouragement (I can do this)

To provide the children with pleasure time in music therapy sessions, it was essential to engage them in some achievable tasks first. Allowing the children to achieve some small task was a way of encouraging them to feel bolder and eager to take another step. In music therapy sessions, I provided them with achievable tasks by inviting them beforehand to learn an easy song, giving them a simple melody pattern to copy, or simplifying the song that the children wanted to learn.

Support (“I am good at this”)

Indicating support and approval in both verbal and non-verbal ways (clapping hands, giving the “thumbs up” sign, or giving the children my full attention) was very important. I sometimes invited their parents or other staff members to witness the children’s achievement. In the 2nd cycle²⁸, Jimmy was given a sense of accomplishment by completing the songs; he also felt more empowered because of his parents’ compliments.

Exploration, (“I can try more challenging things”)

When some of the children began to feel more confident and at ease with me, they were able to share their feelings and experiences or tell me directly what they wanted to do. I therefore started to encourage the children to do something more challenging, such as learn to play new songs, change the instrument they were playing; or I offered them slightly more complicated music patterns to copy. By trying these, the children were probably able to gain a greater feeling of success and confidence in a challenging situation such as being in hospital.

²⁸ More detail was provided on page 48

Nurture (I am comfortable playing with you)

The children came to the hospital where they were familiar with neither the people nor the medical equipment, which might look scary to most children. A gentle, polite manner with the children would normally lessen their anxiety because politeness indicates respect and concern for the feelings of others (Holmes & Stubbe, 2003). Especially with distressed children, who appeared to be fragile, I tended to speak softly and remind myself to approach them at a slower pace and leave enough time for them to respond; as I did with Ella in the 2nd cycle²⁹. Therefore the distressed and fragile child was not made to feel uncomfortable by being pushed quickly into another unfamiliar situation.

Connection (We are playing together)

Many hospitalised children missed their school environment, and opportunities for contact with family members and peers were minimised. Music therapy sessions offered the children chances to connect with other people through playing or singing songs. The children and I had a connection while we were playing music together. As we played, we listened to each other, completed things together, took risks together; and in addition, some of them felt able to share their success with me.

Enjoyment (I can do it with you again)

Giving the children an enjoyable time was usually the first goal for most of the sessions I provided in the hospital. To see the children smile or laugh during this distressing stage in their lives was a highly valued experience for me while I was working in the hospital. When they smiled and laughed, it probably meant that they were distracted from their pain, and were feeling less stress and anxiety because of unfamiliar people and surroundings. Dena for example, during the 3rd cycle³⁰, did not communicate much

²⁹ More detail was provided on page 49

³⁰ More detail was provided on pages 58-59

with me verbally, but her giggling while I was singing familiar songs to her might have indicated that she was distracted from her anxiety about the unknown.

As important as the child's experience of pleasure was the need for parents to witness their child having fun and enjoying a sense of autonomy. It was also beneficial for parents to participate actively in music therapy sessions, thereby experiencing fun jointly with their child (Ayson, 2007; O'Neill & Pavlicevic, 2003).

Be available

It is hard to tell when children want to participate in a music session, and there were new children coming into the ward every day. Some of them did not know that there was music therapy available. Therefore, letting the children know that I was on hand to offer them a session and that they could make a choice to come later, needed to be highlighted. The literature³¹ shows the benefits of being available for single session therapy. Sometimes I could not invite them in person, or they decided not to participate after receiving the invitation. I still needed to emphasise to them that I would be available for them when they were ready. As the 1st cycle³² showed, a girl who refused to participate in music therapy the first time she was asked, decided to come later on after I invited her and participated in her activity: this might have made her feel more comfortable with me.

However, sometimes it was impossible to allow every child total freedom in choice of time to come to the session when there was only one music therapy student and limited space to provide the session (I found these considerations to be a challenge in the 1st cycle³³). Therefore, sometimes I need to establish a boundary to prevent one child from interfering with another needed to be established. The boundary in this context might be determined by the limited duration of each session; and the approximate period of time that I was available in the ward also required clarification. It helped the children to understand clearly when they could ask to have a music therapy session; and it enabled me to give appropriate attention to making and

³¹ This was discussed in depth on page 17

³² More detail was provided on page 38.

³³ More detail was provided on pages 34-36

finding resources. Furthermore, the boundary protected me from having conflicting needs of children occurring at the same time, and allowed me to provide fair access to the sessions for all. It also provided me with some time for preparation of resources such as learning new music or reading some articles to find different strategies that are suitable in this situation.

Playing music in the playroom was a good strategy for encouraging the children to participate. The evidence was provided in the 4th cycle³⁴ when I played some popular songs in the room and there were a few people who started to realise that my service was available. This was another safe way for the children to choose whether to come or not. They were not afraid of refusing to come, as they could approach me themselves.

Being open-minded

In order to learn new things and improve many aspects of practice within the constraints imposed by time and experience, it is very helpful to be open-minded and accept comments or suggestions from different sources (Lorenzato, 2005). This will increase opportunities to learn not only from sources or people in the same field, but also from other disciplines or even from the children themselves.

All through the course of this study, I learnt both directly and indirectly from my clinical liaisons and my visiting music therapist. For instance, in the 1st cycle³⁵ I accepted and tried out my clinical liaison's suggestion of establishing an initial rapport with the children before the session started, and it had been very useful strategy for me in establishing a relationship with them. Moreover, through all four cycles my clinical liaison recommended songs that were suitable and popular for different age groups. Furthermore, in the 4th cycle³⁶ when I went to observe my visiting music therapist at work, watching her gave me inspiration for ways of using music and approaching the children.

³⁴ More detail was provided on page 64.

³⁵ More detail was provided on page 37

³⁶ More detail was provided on page 64-66

As the children know best what suits them, following and accepting their suggestions made a positive outcome for the venture much more likely. Moreover, with this approach the children might feel more empowered and see me as being in an equal position to themselves (Bunt & Hoskyns, 2002; Miller & Slive, 2004). Meeting rejection when offering a music therapy session was part of working in the hospital, because it was more likely that I had referred myself to the children than that the children had been referred to me. This may sometimes have caused me to question my sense of competency and might have lowered my self-confidence. Being open to the children's feedback also included accepting their rejection, because they knew best what they wanted to do and when they wanted to do it. Moreover, allowing them to refuse things during a time when they did not have much control over their lives, might have given them a greater sense of empowerment (Lorenzato, 2005). This awareness helped protect me from taking rejection too personally.

Expect small and gradual change in myself

The aim of this study has been to improve my practice. When I began my research, I was very anxious about perhaps not being able to show an improvement. This is evident in the 2nd cycle, where I was concentrating more on trialing my plan than on the needs of the children. I was more focused on employing what I had prepared and missed out the children's signals and needs. After the 2nd cycle, I started to appreciate a small change both in my thinking and my practice skills (such as being able to learn and use new songs, ability to notice small responses from the children, and better acceptance of the children's rejection). When I stopped expecting big changes and began to appreciate small but gradual change, I felt less stress and enjoyed myself working with the children. Talmon's (1959) comment³⁷ about the value of small changes in the client that can lead to big changes also applied in my process of improving my practice.

Ability to reduce anxiety

Working in a ward where there is a high rate of change and it is difficult to predict what will happen next, I always felt anxious about not being more in control of the situation, and

³⁷ Reiterated the statement on page 20

worried about possible inability to provide a good session for the children. From the 1st cycle³⁸, after I took more initiative and did not simply wait for the children to come to me, I learnt that the longer I thought or hesitated about taking action, the worse my anxiety became. Taking action helped me reduce my anxiety and regain a sense of control over the situation, because I did not wait for something to happen or wait for someone else to act for me. Instead, I acted as an “agentic” person. According to Johns (2009), “agentic” people know clearly what they want to accomplish, understand how intended actions will contribute to achievement of their goals, and are confident that they can complete the intended action and attain their objectives (Johns, 2009).

Furthermore, positive feedback received from the play specialist team and the children was important, as it served as a reaffirmation for me that I was going in the right direction. It was also something that could support me and encourage me to keep working when I encountered some challenging sessions. The fact of being able to reduce my anxiety brought me greater relaxation, enjoyment, calm; and also enhanced my ability to focus on what was happening.

Cultural Considerations

In this section I would like to discuss cultural issues from my perspective, as I am an international student who comes from a different culture and am also a practitioner who has worked in a multicultural environment.

Musical background

Learning different kinds of music from different cultures has been a very important part of this study. However, it was very challenging to keep up-to-date with musical trends and learn a wide range of songs suitable for different age groups and different cultural groups. My musical background was different from that of the children in the ward, and there was limited time to learn. This sometimes made me feel intimidated and inadequate because of “knowing

³⁸ More detail was provided on pages 38-42

less” and not being able to provide or satisfy the children with the songs they requested. However, there was good support provided at the hospital, and good suggestions from the play specialist team, my visiting music therapist and some of the children and their families, about songs that they recommended for use with the children. This helped me cope with the challenge to some extent. In addition, that feeling of “knowing less” might have helped me to gain the children’s trust, as they did not perceive me as an expert who knew better all the time; instead, we were in an equal position. Allowing the children to teach me their music was also a way of taking turns at being leader and follower in the session. Moreover, learning the children’s favourite music helped me to gain more of a sense of belonging in this environment; as came through in the 4th cycle.

Language

Even though my English is at a level where I can communicate with people reasonably well, the language barrier had an enormous effect on my confidence in interacting or communicating with the children, their parents and the staff. My accent and my comprehension of English made me acutely aware of possible misunderstandings. Without conscious intention on my part, this probably led me not to take full advantage of the chance to employ verbal communication effectively. However, there were also many children and their families who did not use English as their first language. They probably felt similar to me, and even more stressed because they could not express or communicate fluently their stress and concern over their children. Music as a universal language played an important role in providing them with opportunities to express themselves without any concern about language.

The children’s and their caregivers’ perceptions

The children perceived me not only as a person who was new to them but also, in some cases, as someone who looked quite different. I have different hair, skin and eye colour, and other physical differences as well. This might mean that some children found it difficult to trust me. Therefore, awareness of that helped me to be careful not to rush into starting the session.

I found that many caregivers did not know what music therapy was: also, my professional viewpoint is not yet fully developed. Some of them might not have been sure, therefore, what their children would do in the music therapy sessions. Ability to communicate with and explain clearly to the caregiver was a further necessary skill in the hospital environment. During the course of the study, I felt that I lacked confidence in communicating with the caregiver or working with children in front of their caregiver because of my background culture about seniority and respecting someone older³⁹. Additionally, it was probably because I was aware of myself as a student and did not feel very confident about my knowledge and skills. The perception of myself as a member of a minority group also discouraged me.

Limitations of the study

In action research methodology, the steps in the cycles seem to be clear. The researcher is expected to plan some strategies in order to improve a situation or manage specific challenges, but the steps of this methodology did not necessarily match the reality of this hospital situation because it was hard to predict what would happen in the children's ward. Sometimes the challenging situation that I planned to improve in the cycle did not happen in the time period that I planned. Also, I sometimes encountered more than one challenge. It was very difficult, therefore, to plan things such as the length of each cycle, and inflexible or specific order plans were not suitable in a particular unplanned situation.

It is challenging for me to explain or prove how my practice has become better. There are many different aspects of my practice that I intend to improve. Some of them did not appear significantly, or were not measurable from outside: the extent of my personal development, for example; how far I succeeded in controlling my nervousness; or my increased confidence in myself. Therefore, it was difficult to find evidence of ways in which my practice improved simply from "*what I did in the session*". It depended a great deal on my own interpretation and

³⁹ More detail was provided on page 7

reflection; so that the findings from this study would probably be applicable only in particular situations.

The data from this study was recorded only from my memory and perception. Furthermore, on a busy day, I was not able to write my clinical notes immediately after each session finished. It is possible therefore that I might have missed out some other important responses by child patients. However – to look at this challenge from another angle – that would have helped me to limit the amount of data.

Future Research Possibilities

As I am the only participant in this study, all interpretations and perceptions as to how the patient benefited or felt himself or herself to have benefited from the session were only from my perspective. Therefore, it would be advantageous to study the patients' and their caregivers' perceptions of single session music therapy. A study of the kind suggested would underscore the efficacy of single session music therapy.

From reviewing literature both in music therapy and other disciplines about single session therapy, I found that there has been limited experimental study relating to the effectiveness of single session therapy (Hurn, 2005). Therefore, development of rigorous quantitative single session music therapy research in different populations or contexts would add to knowledge in this area.

Throughout this study, I have focused mainly on the positive outcomes that emerged in the session itself or right after it finished. This led me to wonder how one music therapy session could affect the client over a longer period, and also whether the outcome from the single session could be sustained/extended in the longer term.

Conclusion

This study has suggested some helpful principles which have played a very important role in providing single session music therapy for children in hospital. These principles emerged from adapting precepts of music therapy and ideas drawn from other disciplines, and combining them with my experience working in a children's ward. The principles are highly recommended in a context where there is only a brief time to assess, and limited opportunity to interact with clients; a high rate of change; and difficulty in predicting or planning the session ahead. The principles are: 1) a need for flexibility; 2) keeping the therapist's and children's power of control in balance; 3) sensitivity to children's responses and their needs; 4) familiarity with background knowledge; 5) ability to build a rapport in a short time; 6) the need for availability when required; 7) open-mindedness; and 8) ability to reduce anxiety.

During the course of this study I feel I have achieved all of my aims and answered the question I set out to address. Employing action research methodology has helped me to accomplish the third aim, which was to understand and to gain greater consciousness of my learning process. Action research methodology encouraged me to question and to monitor my own actions in order to improve them, and make them more suitable in the context. Also, it has allowed me to review what I have learnt and evaluate how I can use this new knowledge. It has not only allowed me to bring various principles from music therapy and other disciplines into my practice, but has also helped me to see how these principles work both in this specific context, and in terms of my personal approach. This has led me to feel more "at one" with the theories or principles from different sources.

Understanding research in this way helped me to feel more confident in my knowledge and skills because it has encouraged me to monitor my own learning process and the process involved in improvement of my practice. To be able to see how my practice had changed has gradually extended my knowledge and informed my style of working. However, this study is

just the beginning of my music therapy journey. Everything that I have learnt I need to continue practising.

Finally, I was able to adjust my values and beliefs so as to make them more suitable in the situation. I still firmly believe that the therapeutic process starts when the relationship between the music therapist and the patient is established⁴⁰. Moreover, to establish the relationship and set goals for clients; and see those changes in the client these processes are also possible for single session therapy, not only a long period therapy as I stated in the 1st chapter⁴¹. Employing the principles that I stated above enables me to make the most use of a brief time with the children and provide them with a beneficial music therapy session.

As a result of this study, I have total confidence in the power of single session music therapy to help children through a challenging period in their lives and provide positive moments in that period for them to hold on to when they have to encounter a further difficult time. Therefore, I hope the outcomes from the study might be applied in other contexts, so that the benefits of single session music therapy will be experienced more widely. Moreover, having acquired greater skill and knowledge as a music therapist, I can feel confident in offering music therapy work in my country with a hope of enhancing music therapy in areas found to be limited. In the course of the study, I have been learning how music therapy can impact on people's wellbeing in various ways: mental, physical and cognitive. Therefore, it is my firm intention to take my learning experience home and use it in ways appropriate in Thailand. I hope to nurture people's wellbeing with music so as to minimise the risk of illness in the areas suggested.

⁴⁰ Reiterated my statement on page 8

⁴¹ Reiterated my statement on page 2

Appendix 1: Further Explanation

Writing in the first person

A first person writing style allows me to express my perception as well as my opinions, because I was involved in those real situations (which naturally reflected my experiences and feelings). Moreover, use of the first person will show how I take responsibility for improving both my own performance and the overall situation: it can also emphasise my ability to influence the context (McNiff, et al., 2003). Furthermore, this kind of methodology gives much importance to the participant's background and values. Therefore, use of this style would emphasise the importance of the participant's values, and his/her similarity to Amir (2005) who stated that choosing "*a writing style should reflect the writer's world-views, beliefs and values as a human being, therapist and writer*".

Working with siblings

When their sister or brother is admitted to the hospital, the impact on siblings is considerable. They might be witnessing pain and distress, needing to wait for their sibling to be assessed; having to be in the hospital with their family if there is no other carer. Therefore they also need support. They need someone to talk, listen and play with them (Lorenzato, 2005).

Appendix 2: Definition of Terms

PICC Line⁴²

It is a long, slender, small, flexible tube that is inserted into a peripheral vein, typically in the upper arm, and advanced until the catheter tip terminates in a large vein in the chest near the heart to obtain intravenous access.

A PICC line may be requested for a variety of treatment options which include some of the following:

- Prolonged IV antibiotic treatment
- IV access obtainable by less invasive and longer lasting methods
- Multiple accesses obtainable with one access line
- TPN Nutrition
- Chemotherapy
- IV access related to physiological factors
- Home or sub-acute discharge for extended treatment.

⁴² Reference for this term: *Vascular Access Management*, Retrieved February 18, 2010, from http://picclinenursing.com/picc_why.html

Appendix 3: Information Sheet for Clinical Supervisor



“A Music Therapy Student's Exploration of Single Session Music Therapy for Children on a Paediatric Ward Using Action Research Methodology”

INFORMATION SHEET for CLINICAL SUPERVISOR

This information is provided you as the clinical supervisor of Pornpan Kaenampornpan, at Hospital's name. It describes an action research project to be undertaken by Pornpan Kaenampornpan, for the completion of Master of Music Therapy Program, New Zealand School of Music.

About the Study

In this research as a 2nd year student, I will review and evaluate my approaches to music therapy practice in single sessions with children on a paediatric ward. In the early stages of my training I learnt that usually the music therapy process would take at least a few sessions to build relationships and to set goals for clients. Additionally, it would usually take some time to see changes in the client. However, my placement in the children's ward of a large general hospital this year is very different: the main part of my work is single sessions. I have very little prior information about the clients and no time to develop goals over weeks or months. Through this study I intend to improve my practice so that I can provide beneficial (or helpful) single session music therapy to the children I work with on the paediatric ward.

I, the researcher/music therapy student will be the main participant of this study. I will closely study and reflect on my own music therapy practice. I would like to ask you if you would be

happy to give consent for me to study the supervision notes in order to improve and provide a beneficial single session music therapy to the children I work with.

The Study Procedures

As you know, it is part of music therapist's practice to receive regular supervision and take clinical notes of the sessions. In order to collect data about my music therapy practice for this research I will need to review the clinical notes and notes from my clinical supervision. This particular style of research I am proposing poses minimal risks to you; in both data sources the children, their families or anyone who participates in the session will not be identified, and also your name will not be mentioned. As music therapy is still a small profession in New Zealand, there is a chance that you could be identified, through connection with my practice, but I will make every endeavour to minimise this with the strategy outlined above.

If you have any question about this study, please do not hesitate to contact my research supervisor, Sarah Hoskyns or myself.

Researcher/Music Therapy Student

Pornpan Kaenampornpan

Email: nongjjenny@hotmail.com

Phone: 021 035 8060

Researcher Supervisor

Sarah Hoskyns

Associate Professor,

Master of Music therapy programme,

New Zealand School of Music

Email: sarah.hoskyns@nzsm.ac.nz

Phone: (04) 801-5799 x641

Ethical Approval

This study has been reviewed and approved by the Central Regional Ethic Committee, Ministry of Health, New Zealand. If you have any concerns about the conduct of this research that you wish to raise with someone rather than the researcher, please contact Sarah Hoskyns (Research Supervisor) or the Central Regional Ethics Committee:

Central Regional Ethic Committee, Ministry of Health, New Zealand

Level 2, 1-3 The Terrace

PO Box 5013

Wellington

Email: central_ethicscommittee@moh.govt.nz

Phone: (04) 496 2405

Fax: (04) 496 2191

Appendix 4: Consent Form for Clinical Supervisor



**“A Music Therapy Student's Exploration of Single Session Music Therapy for Children on
a Paediatric Ward Using Action Research Methodology”**

Clinical Supervisor Consent Form

For Review of notes from Supervision Meetings

This consent form will be held for a period of 10 years

- I have read the Information Sheet and have had the details of the study explained to me.
- My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.
- I agree to the notes of my supervision with Pornpan Kaenampornpan to be reviewed by Pornpan in her research.

Therefore, I agree to give permission for the supervision notes to be reviewed and included in the data of this study under conditions set out in the Information Sheet.

Signature: _____ Date: _____

Full Name-Printed: _____

Appendix 5: Letter for Asking Permission from the Hospital



To whom it may concern,

This letter is written in order to ask for your permission for me, Pornpan Kaenampornpan, to conduct my research project in your facility for the completion of Master of Music Therapy Program, New Zealand School of Music. Additionally, I also would like *to ask for your permission* to review the clinical notes which will be collected during the course of the study. The notes will record the actions and responses from the children in music therapy session and also my spontaneous reflections immediately following the sessions about how the session contributed to the child's wellbeing.

I, the researcher/music therapy student will be the main participant of this study. I will closely study and reflect on my own music therapy practice in order to improve and provide a beneficial single session music therapy to the children I work with.

This particular style of research I am proposing poses minimal risks to your facility, your staff and also the children who will be involved in my music therapy session. In the data source, your facility, location, your staff, and also the children, their family or anyone else who participates in the session will not be mentioned by name. A pseudonym will be used to protect the identity of them and your facility. There is a chance that your facility could be identified, through connection with my practice, but I will make every endeavour to minimise this with the strategy outlined above. Additionally, my intention to conduct music therapy session for the children is to enhance children's wellbeing and the session will not give any influence or interrupt the hospital routine.

If you have any question about this study, please do not hesitate to contact my research supervisor, Sarah Hoskyns or myself.

Researcher/Music Therapy Student

Pornpan Kaenampornpan

Email: nongjjenny@hotmail.com

Phone: 021 035 8060

Researcher Supervisor

Sarah Hoskyns

Associate Professor, Master of Music
therapy programme, New Zealand School
of Music

Email: sarah.hoskyns@nzsm.ac.nz

Appendix 6: Example of Clinical Notes

Ella is a 10-year-old girl. She had an operation yesterday morning and had bed rest all day. So I did not see her yesterday. She came to the playroom in the morning with her mother. I introduced myself to them and invited her to play music. She spent a few minutes in the playroom before she went back to her bed. She needed her mother to help her to walk. After lunch break, I heard someone playing the keyboard in the playroom. So I came in the room and saw the girl was sitting at the keyboard. I joined her and softly introduced myself to her again. She seemed very fragile to me. She could not move properly because she was still sore from her operation yesterday. I asked her what song she had just played because I could not hear it properly from the office. She said back to me softly that she just turned the demo music from the keyboard on. So I asked her whether she wanted to try to play some songs. She nodded then I offered my music sheets to her which I put the songs that suitable for her age in front of the pile.

She chose Christmas song "We wish you a merry Christmas" I showed her how to play slowly. Then I invited her to play with me slowly. She followed me carefully and seemed very anxious when she made mistakes. I told her not to worry and it is alright to make a mistake. I played along on the small keyboard and sing along while she played the song. After she seemed to be more familiar with the song, I invited her to choose a new one. She chose Old McDonald. I played the chord along with her. After we played that song for a few time, I noticed that she kept looking for her mother so I asked her whether she want to finish or not and she said yes. Then her mother came to the corner and helped her standing up and helped her walked back to the room.

Pornpan Kaenampornpan

10 October 2009

Appendix 7: Example of Research Journal Entry

Am I avoiding working with the kids?

- I did try to build the rapport with the children by participating their plays then introduced myself and invited them to the music session, but there were a few kids to work with??

Am I too passive while I work here?

- I rather let the children chose to come

I feel a bit useless when no one want to participate in music session

Am “I” too boring to play with?

Why am I afraid of approaching the kids?

- They seem to be enjoying themselves with their activities.
- I am not sure that I can offer the children beneficially.
- The children seem not to interest in music

Pornpan Kaenampornpan

24 August 2009

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