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Spring 5-18-2019

"Music and Memory": Is it Personalized Music Therapy or Just 'Good Music'?

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"Music & Memory": Is it Personalized Music Therapy or Just 'Good Music'?

Capstone Thesis

Lesley University

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Abstract

This review of the literature focuses on the benefits of music and music therapy for persons diagnosed with dementia. A summary of the role of music therapy is given and compared to the Music & Memory program. The question is whether it is fair to call the latter *music therapy* when assessments are carried out by individuals not qualified in music therapy, but trained in the Music & Memory program. The consequence of the lack of knowledge of this distinction is inconsistent communication which misleads stakeholders about the role of music therapy in healthcare. In my experience through volunteering in the Music & Memory program, I realized that there is a need to distinguish between what is music therapy and what is personalized recorded music listening. The focus of this paper will be on whether Music & Memory can be called "personalized music therapy" or if it is just therapeutic music. This will be done through a comprehensive literature review primarily focusing on the use of music with dementia patients. In order to establish a clear delineation between music therapy and Music & Memory, the aim will be to examine the two in terms of the history, populations served, key components, and practitioner qualifications. Secondly, the paper explores the definition of dementia, the role played by music therapy and Music & Memory in dementia treatment, and finally where music therapy and Music & Memory diverge and overlap.

"Music & Memory": Is it Personalized Music Therapy or Just 'Good Music'?

Music has been viewed as a memory enhancer for decades in both anecdotal (Prickett & Moore, 1991; Koger, Chapin, & Brotons, 1999) and more extensive literature (Tomaino, 2002; Tomaino, 2013). Sherratt, Thornton, and Hatton (2004) define the concept of *music* as it pertains to dementia care as any music intervention, including listening to music; where as- *music therapy* involves music activities implemented by a trained music therapist (p. 3). According to the American Music Therapy Association (AMTA, 2018a), music therapy is "the clinical and evidence-based use of music interventions" where "individualized goals within a therapeutic relationship" are used (para. 1).

Music & Memory is a program initially developed for use in nursing care facilities with clients experiencing dementia and other memory issues (Music & Memory, 2018a). It incorporates listening to personalized music playlists to trigger a memory response in an attempt to improve the quality of lives of these individuals. Various claims have been made that Music & Memory is music therapy (SCES, 2017) even though the assessments and implementation are not carried out by a qualified music therapist. According to the AMTA (2018a) "A person with Alzheimer's listening to an iPod with headphones of his/her favorite songs" is not music therapy and at most can only be considered "therapeutic music" (para. 5). While the Music & Memory advanced training targets occupational therapists (OTs), physical therapists (PTs), and speech language therapists (SLPs) (Music & Memory, 2018b), this program is primarily designed to inform and involve caregivers and nurses in nursing homes, case workers, and elder care organizations who want to become certified in Music & Memory.

For organizations or professionals with limited funding and resources, it is difficult to employ the skills or input of a licensed music therapist. However, it is important not to

undervalue the contribution of programs like Music & Memory to populations such as the elderly, who have issues with cognitive impairment due to dementia. Music therapy is becoming more important as the population ages and persons are looking to improve the quality of life of the elderly. Programs such as Music & Memory are being touted as music therapy (SCES, 2017) even though they cannot be considered "clinical and evidence- based" practice (AMTA, 2018a, para. 1). If the stakeholder implements a program without the input of a music therapist, they run the risk of not foreseeing issues such as increased depression, injury due to falls, an exacerbation of behavioral issues which go unmonitored, and an overall reduction in quality of life of their clients (Williams, Peckham, Rudoler, Tam, & Watkins, 2014).

My involvement began when I saw coverage of the Music & Memory program through a public TV network and contacted the featured certified organization to become a volunteer. I had the opportunity to conduct a music preference assessment over the phone, but requested to either observe or conduct one face-to-face with supervision by someone trained in Music & Memory. This was because of the considerations I needed to make as a music therapy student, even though I was not technically offering music therapy services. In the Music & Memory program, some musical preference assessments are not carried out with the client due to communication difficulties, but with the caregivers instead - either in person or over the phone. The caregiver can also complete the assessment form and return it to the case worker. However, I felt it would be inappropriate for a musical preference assessment to be determined without paying attention to non-verbal communication. The musical preference assessment is used as a prompt for the client, family member or caregiver to identify songs which are significant to the client in order to compile the playlist. As a volunteer, I have completed two playlists and updated another. This process involved looking for songs listed on the Musical Preference

Assessment on iTunes and purchasing them. They were added to a personalized playlist and downloaded to an iPod which was then issued to the respective clients.

To begin this inquiry, I first obtained a copy of the movie *Alive Inside: A Story of Music and Memory* (Rossato-Bennett, 2014). Second, I gathered information on the studies conducted in various states on Music & Memory. I learned music therapists do not have an opportunity to serve an official role, outside of consultation, with certified Music & Memory sites. I had hoped to locate information about the training available for OTs, PTs and SLPs to do a comparison with the training available to become certified. Unfortunately, the Music & Memory website I was directed to only provided basic information on the webinar (Music & Memory, 2018b). Therefore, I was unable to conduct a comparative study between the training for health care professionals versus other team members. I was able to attend a webinar offered on the Music & Memory platform: *Music Listening Guidelines with the American Music Therapy Association* (Lombardo & Spring, 2018). Through this webinar, I was informed of the current AMTA protocol for using personalized music listening with clients.

The focus of this paper will be on whether Music & Memory can be called "personalized music therapy" (SCES, 2017, para. 4) or if it is just therapeutic music (AMTA, 2018a). This will be done through a comprehensive literature review primarily focusing on the use of music with dementia patients. In order to establish a clear delineation between music therapy and Music & Memory, the aim will be to examine the two in terms of the history, populations served, key components and practitioner requirements. Secondly, the paper explores the definition of dementia, the role played by music therapy and Music & Memory in dementia treatment, and finally where music therapy and Music & Memory diverge and overlap.

Literature Review

What is Music Therapy?

History. The use of music was implemented after World War I and World War II when doctors and nurses working in veteran's hospitals acknowledged the healing properties of this intervention (AMTA, 2018b). At the time, it was offered by community musicians in a voluntary capacity; however, once the benefits were recognized and musicians became more of a staple in these settings, the importance of some degree of formalized prior training was recommended (AMTA, 2018b). As a profession, music therapy became more established in the 1940s with both educational and organizational frameworks being created (AMTA, 2018b). Associations for music therapy were developed in 1971 with the most recent umbrella body, the American Music Therapy Association (AMTA), being established in 1998, with the mandate "to advance public knowledge of the benefits of music therapy and to increase access to quality music therapy services in a rapidly changing world" (AMTA, 2018b, para. 10).

Key components. Primarily, music therapy is used to establish a therapeutic relationship between the therapist and the client. Music is the tool that allows the therapist to address the physical and psychological needs of their clients. The therapist will do an assessment to determine the strengths and needs of each client and to establish if music therapy is a suitable intervention. Then, the therapist will create a treatment plan which can include "singing, moving to, and/or listening to music" (AMTA, 2018a, para. 2). Further evaluations are done periodically to ensure that the treatment is appropriate, and adaptations are implemented where necessary. The music therapy outcomes should be "measurable and contribute to the best physical, social, emotional, communication and/or cognitive functions possible" (AMTA, 2015, para. 3) and are considered effective if they produce positive results, such as "overall physical

rehabilitation and facilitating movement, increasing people's motivation to become engaged in their treatment, providing emotional support for clients and their families, and providing an outlet for expression of feelings" (AMTA, 2018a, para. 2).

Populations. While music therapists may work in a variety of settings with different populations, AMTA (2018c) provides fact sheets for the following individual populations: military populations, autism spectrum disorder (ASD), Alzheimer's disease and related dementia (ADRD), persons in correctional and forensic settings, in response to crisis and trauma, medicine, mental health, music education, pain management, special education, and young children (AMTA, 2018c). These could be considered primary population categories.

Practitioner requirements. The Certification Board for Music Therapists (CBMT), incorporated in 1983, is responsible for the certification of "Music Therapist- Board Certified (MT-BC)" (AMTA, 2018a). To become a "credentialed professional, " not only must an individual have "completed an approved music therapy program" (AMTA, 2018a, para. 1) but in addition, a candidate must complete "at least 1200 hours of supervised clinical training" (AMTA, 2015, para. 5). This is because "(e)ducation and training are necessary for music therapists to design appropriate interventions and to respond properly when any negative reactions occur to music" (para. 3).

What is "Music & Memory"?

History. The premise behind the Music & Memory program was documented in the movie *Alive Inside: The Story of Music and Memory* (Rossato- Bennett, 2014). In 2006, the concept for Music & Memory originated when Dan Cohen, a social worker, considered that if he ever was in a nursing home, he would want access to his favorite music (Music & Memory, 2018a). After hearing anecdotal news about the popularity of iPods and discovering there was

no current music listening programs in long- term care facilities that were using them, Cohen issued around 200 iPods that contained personalized playlists to elderly persons in nursing homes around New York (Music & Memory, 2018a, para. 5). Cohen video-recorded their reactions while they listened to the preferred music (Rossato- Bennett, 2014; Williams et al., 2014). Music & Memory became a registered charity in 2010, with Dan Cohen as the Executive Director (Music & Memory, 2018a). Through this intervention, Cohen discovered that music had the ability to recreate previous life experiences. It evoked strong emotions to these memories; for example, "while all respond positively, some responses are extraordinary; individuals who had been uncommunicative and withdrawn prior to accessing music now smile, express themselves and show pleasure" (Williams et al., 2014, p. 1). Furthermore, family and caregivers were rewarded by observing and participating in these moments (Music & Memory, 2018a). One individual resident, Henry, was highlighted in 2012, and a vignette showing his personal reaction to his music was shared on YouTube to promote the program (Music & Memory, 2018a; Rossato- Bennett, 2014; Williams et al., 2014).

Key components. A site such as an elder care service or nursing home must become certified by Music & Memory in order to offer the program. Music & Memory uses iPods and headsets- which can be either ear buds or over ear head phones- depending on what the patient tolerates. Personalized playlists are created by interviewing the patient; or a caregiver about the musical preferences of the patient using a questionnaire. Songs are selected and purchased by staff at the certified site. They are responsible for creating the personalized playlist for the patient, downloading it to an iPod and then issuing it to the patient.

Populations. Initially, Cohen developed Music & Memory program for residents in long-term care facilities, primarily nursing homes; but began to target "individuals in hospice

care, adult day care, assisted living, hospital and home health care" (Music & Memory, 2018a, para. 9).

Practitioner requirements. To become certified to offer this program, a prospective site must first become a Music & Memory Certified Care Organisation through the completion of a registration process, including fees, and a webinar (Music & Memory, 2018a). The site is then expected to have their staff participate in three 90 minute webinars (AMTA, 2015). Music & Memory program trains primarily nurses and elder care workers (Music & Memory, 2018a). They also offer separate training for occupational therapists, physical therapists, and speech and language pathologists who work with elderly populations at certified sites (Music & Memory, 2018b).

What is Dementia?

Dementia was considered an umbrella term to describe cognitive impairment and neurocognitive decline in the DSM-IV (American Psychiatric Association, 1994). According to DSM-5 (American Psychiatric Association, 2013),- dementia is now categorized as either Major or Mild Neurocognitive Disorder (NCD). If the diagnosis is Major Neurocognitive Disorder, there will be significant impairment in one or more of the following cognitive domains: complex attention, executive function, learning and memory, language, perceptual motor and social cognition; whereas in Mild Neurocognitive Disorder, there will be moderate impairment of such functioning (American Psychiatric Association, 2013, pp. 593-595). It is significant to note that, "Major and mild NCDs exist on a spectrum of cognitive and functional impairment. Major NCD corresponds to the condition referred to in DSM-IV as *dementia*" (American Psychiatric Association, 2013, p. 607).

There are several diseases which present with dementia (NCDs). In terms of music therapy intervention, the most common ones are Alzheimer's disease (AD), Vascular disease and Traumatic Brain Injury (American Psychiatric Association, 2013, p. 603; p. 605). Alzheimer's disease and related dementias (ADRD) is defined by degrees of cognitive impairment (Gerdner, 2012, p. 26). Behavioural and psychological symptoms of dementia (BPSD) create an amalgamation of untenable characteristics in persons with ADRD (Williams et al., 2014 p. 28). These include anxiety and aggression and can also lead to caregiver burnout (p. 28). Of the many concerning symptoms of BPSD, agitation occurs in 70%-90% of persons considered to be in the late stages of ADRD (Gerdner, 2012, p. 26). In addition it impacts "care delivery and social interaction" (p. 26) with negative outcomes on quality of life. Agitation is identified "as restless behavior, or improper physical and verbal actions that may cause trouble for family members, caregivers and other service users" (Ijaopo, 2017, p. 1), a significant cause of caregiver burnout, as well as a trigger for other residents in shared accommodation. Although there is no FDA approved drug for the treatment of agitation, in emergency situations it is viewed that non-pharmacological treatment cannot be applied (p. 1). However, the goal is to have non-pharmacological interventions as the first line of care. Examples of non-pharmacological interventions "include multisensory stimulation, aromatherapy, music therapy, cognitive behavioral therapy, animal-assisted therapy, electroconvulsive therapy (ECT) and physical exercises" (p. 2).

Theoretical orientation and dementia. The theory of personhood (ToP) was proposed by Kitwood as a framework for prospective music therapy research (Sherratt et al., 2004). According to ToP, argument could be made between two types of music therapy modalities: live music and recorded music. Suggestions were made to assess them in terms of which would

produce levels of "well-being" or "ill-being"(p. 11) in order to determine which method had more efficacy. Beard et al., (2011) also explore Kitwood's ToP, where family members played a significant role in Kitwood's "personal – centered care" to trigger memories of place and person which are essential to quality of life. This is essential even as cognitive decline and issues in communication intensify. Instead of the selfhood and sense of the self (Tomaino, 2002), there is a stress to maintain not only "personhood" but "couplehood" and sense of "us identity" (Beard et al., 2011, p. 3) for the relationship dyad where one member of a couple has a diagnosis of ADRD. This is important to facilitate "aging in place" and "the complexity of dementia as something that is *shared*, for better or for worse, by offering an intimate understanding of the lived experiences of spousal dyads" (p. 8).

Music Therapy and Dementia

The concepts of *music* and *music therapy* were lumped together as "Music/music therapy" (Brotons, Koger, & Pickett- Cooper, 1997; Williams et al., 2014) in describing the application to populations with dementia. Sherratt, Thornton, and Hatton (2004) make the distinction that *music* refers to a variety of music intervention including listening to music, while "music therapy is reserved for music activities, which are carried out by a trained music therapist" (p. 3). Music therapy was acknowledged for helping

> reduce anxiety and depression; reduce depressive symptoms and improve cognitive
> function; reduce activity disturbances, aggressiveness and anxiety; impact positively on
> BPSD such as delusions, agitation, anxiety, apathy, irritability, aberrant motor activity,
> and night-time disturbances; reduce the severity and distress of patients and caregivers;
> (and) reduce frequency of agitated behaviours. (Williams et al., 2014, p. iii)

While the benefits of music therapy have been touted in the literature, the authors and researchers tended to not be practitioners in the field, but non-music therapists referring to studies in music therapy or utilizing music as a modality (Cox, Nowak, & Buettner, 2014; Williams et al., 2014).

Much has changed in the literature as to what is known about the impact of music on memory. This is because of both the evolution of what is known about dementia and the effects of music on the brain. For the purposes of this paper, the literature included was limited to no more than 20 years. In Brotons, Koger, and Pickett- Cooper (1997), a literature review of studies carried out between 1985 and 1996 on "the benefits of music/music therapy and dementia" (p. 205) was used to inform available literature prior to 1998. Brotons et al. (1997) stated that there appeared to be no literature on the topic submitted prior to 1985. It was significant to note that apart from a professional music therapist, music interventions were also employed by creative arts therapists, occupational therapists, physical therapists, registered nurses, and social workers (Brotons et al., 1997). Therefore, it is fair to assume that additional relevant studies were published in non- music therapy journals, following the trend of 48% of the publications being authored by at least one music therapist with 52% being authored by other health professionals in addition to being published in "a variety of professional, refereed journals" (Brotons et al., 1997, p. 232). Also, the DSM-IV (American Psychiatric Association, 1994) definition of dementia as "an impairment in cognitive functioning" was utilized (Brotons et al., 1997, p. 205), which is no longer applicable due to changes in the DSM-5 (American Psychiatric Association, 2013).

Prickett and Moore (1991) studied the benefits of live music on singing, reciting, and recalling lyrics and poetry in elderly persons with dementia. The study comprised of 10 patients with a diagnosis of what was described as "Alzheimer type dementia" (p. 102). The selection of

the subjects was not done by the music therapist, and it was never explicitly stated whether either of the practitioners who carried out the intervention were music therapists. At the time of this study the DSM-III (American Psychiatric Association, 1987) was in use, in which "clear indications of progressive deterioration, and the elimination of other reasonable causes for the symptoms" (Prickett and Moore, 1991, p. 102), was the diagnosis requirement which differs from current changes in the DSM-5 (American Psychiatric Association, 2013). Video and audio recordings were conducted, and two therapists/ facilitators were involved in the process of analysing. The application to music therapy was discussed in terms of how many patients could be served by a single music therapist, as the assessments were carried out individually; how close to the client a therapist would need to be to assure engagement; and, how beneficial it was viewed to involve caregivers. Additionally, it examined targeting single patients who were homebound, and group sessions in nursing homes (Prickett & Moore, 1991). Maintaining quality of life and level of activity for their clients were considered the goals of caregivers. It should be noted that singing was seen as the most appropriate intervention for "providing an avenue for interpersonal interaction which fluent speech no longer can" (p. 109). Dassa and Amir (2014) conducted an analysis of group music therapy with six Iranian patients with middle and late stage AD. The sessions were video recorded and the identified themes were on the benefits of group singing, as well as conversation related to the songs.

Koger, Chapin, and Brotons (1999) critiqued Brotons et al. (1997) for not identifying the "most effective music therapy practices" in dementia care due to the qualitative nature of the review (p. 3). Koger, et al. (1999) aimed to distinguish between studies carried out by music therapists versus other health care professionals, active participation versus passive involvement, and studies using live music versus recorded music (p. 3). Prickett and Moore (1991) was

excluded from the meta-analysis for including both spoken word and song lyrics (Koger, et al, 1999, p. 4). From the research, Koger et al., (1999) did not find "the relative efficacy of different protocols within the existing literature" (p. 9) because the results were too diverse.

Han, Kwan, Chen, Yusoff, Chionh, Goh, and Yap (2010) conducted a study involving the "live music, person-centered engagement approach whereby participants were actively assisted by the therapist to participate within a group setting in singing, rhythmic drumming, vocal or percussion improvisation, dancing and movement" (p. 544). The familiar music served as a motivator which was evident through positive facial expressions, increased energy and motivation in the participants (p. 544). Han et al. (2010) proposed the use of non-pharmacological therapies, such as music therapy and occupational therapy activity groups run in tandem for the treatment of dementia.

Otera, Horike, and Saito (2013) applied Murata's concept of "spiritual pain" (p.286) and the Sato's measurement, "Musical Life Review (MLR)" (p.286) to the case studies of two women in Japan, one with vascular dementia and the other-with Pick's disease. Meaningful and memorable songs were considered stimuli to both patients, and evaluations were made of how the clients worked through what the authors perceived as thematic problems in their lives.

Ledger and Edwards (2011) set forth to query why arts-based research (ABR) was not used more in music therapy research. The self-criticism and lack of confidence that music therapy practitioners and students have in their personal art production might be the reason for the dearth in ABR. It also varied significantly from the expectations afforded to music therapy clients and the value placed on the process of therapeutic improvisation (Ledger and Edwards, 2011). Moss and O'Neil (2017) discussed three artist residencies that took place in Ireland over

a five-year period: 2011-2016, in a geriatric hospital setting, encompassing music composition, visual arts, and dance.

Due to the organic nature of the creative process, consideration was given as to how ABR can complement scientific understanding. Ledger and Edwards (2011 cited in Moss and O'Neil, 2017) stated that ABR offered "opportunities for '…developing rich and evocative findings, accessing the voices of people who receive…services, and communicating music therapy research findings to a broader audience eager for this information' (p. 9)." This is significant as the third category noted that findings were presented mainly to medical and fine arts students and not music therapy students.

Music & Memory and Dementia

The Alzheimer's Society of Toronto (AST) conducted the *Music & Memory: iPod Project* where iPod shuffles with personalized playlists were issued to individuals with Alzheimer's and other dementias (ADOD) as well as their caregivers (Williams et al., 2014). Initially the iPod project started off with 60 pairs of individuals and their caregivers with the long term goal "to engage a total of 10, 000 participants as a way of improving their communication, cognition and quality of life" (Gerdster, 2013, cited in Williams et al., 2014, p. 1). From the research, it seemed that Music & Memory offered personalized music at a lower cost, and with less risk compared to drug interventions and physical restraints (Williams et al., 2014, p. 10). Caretakers reported positive changes in the persons with ADOD such as tapping or dancing to the music or engaging in some form of reminisce (pp. 12-13). The use of iPods was helpful during mealtimes, and as a distraction from triggering noises- such as a vacuum cleaner, allowing the caregiver to complete household tasks without the person with ADOD becoming agitated (p. 13).

Kulibert et al. (2018) studied 24 subjects comprising of 10 men and 14 women, along with their spousal partners-and in two cases their children who served as caregivers. The purpose of the study was to observe whether personalized music improved quality of life, decreased problem behaviors as well as impacted the relationships between subjects and their caregivers. Two notable differences to the standard Music & Memory protocol were the offering of speakers so that listening to music could be a shared experience between persons with dementia and their caregivers; and offering of a list with "a one-page description of activities they could do together while enjoying the music using the speaker (e.g. singing along, tapping, dancing, talking about associations with the music)"(p. 3). As a result, reported observations were that persons with dementia "engaged with the music by humming along or tapping their feet and the use of the music to focus attention when engaged in other activities like walking, doing projects, and working on jigsaw puzzles" (p. 7). Unfortunately, there was a high level of attrition in the three month follow up, and this was linked to the difficulty some caregivers had in initiating the use of the music for the client. Those that did respond validated the researchers hypothesis that there would be notable benefits to the caregivers.

Comparison of Music Therapy to Music & Memory.

Active versus passive. Based on the current literature it is evident that there exists a significant difference between music therapy and Music & Memory. For the most part, music therapy seems to require active music participation. Koger et al. (1999) gives examples of active music participation with activities "such as singing, playing instruments and games," whereas "passive involvement" was involved in "listening to music" (p. 3), such as with Music & Memory.

Music therapists were involved as music facilitators in a study of music listening (ML) conducted by Sakamoto, Ando, and Tsutou (2013), where thirty-nine individuals with severe AD were placed in passive and interactive music listening groups, as well as a no-music control group. It was found that there was a reduction of BPSD and stress in the individuals with AD, with the greatest short-term and long-term results found in the interactive group. While laughter, joy and reminisce were expressed in both groups, "one participant with hyperkinesis and three participants exhibiting severe apathy or reduced attention in the Passive group did not exhibit clear responses to music intervention" (p. 781). While the passive ML group evoked special memories, the interactive ML group also exhibited a reduction in "affective disturbance, anxieties and phobias, paranoid and delusional ideation, aggressiveness and activity disturbance" (p. 782).

Untrained individuals who utilize Music & Memory may believe that any response is significant, so that if an individual begins to cry (Rossato-Bennett, 2014) it would be an acceptable emotion; whereas a music therapist would be concerned about an increase in depressive symptoms. Fundamentally, music therapy is active because it involves the individual with dementia in meaningful activity that is pleasurable. This is indicated through the therapist making observations of both non-verbal and verbal behaviors such as increased eye contact, opening eyes, and engaging in singing (Lombardo & Spring, 2018) and signs of attention such as humming and foot tapping in order to gauge the level of engagement the client has with the music intervention. There was one significant incident with a music listening study reported by

> a daughter who described how upset her mother became when listening to some Johnny
>
> Cash songs because the songs mentioned guns. Her mother was convinced there were
>
> guns in the house and talked about guns and violence during everyday conversations. We

could not have predicted this because, in the initial interview, she noted that she liked

Johnny Cash's music. Overall, these issues illustrate the importance of acknowledging

individual differences and following up to ensure a good fit between the person and the

music. (Kulibert et al., 2018, p. 9)

There are instances where music therapists will design interventions for persons with

dementia which involve passive exposure to music, for example during mealtimes, for bathing,

and in general, as a form of behavior modification (Koger et al., 1999, p. 6). This

implementation is quite different from caregivers and family members who take the opportunity

to carry out household chores and leave the person with dementia alone and unsupervised,

listening to the Music & Memory playlist, in order to have a 'break' and inadvertently avoid

caregiver burnout. Williams et al. (2014) reported that "the music provides informal caregivers

with opportunities to disconnect for a moment and focus on other everyday tasks such as

housekeeping or meal preparation in peace and alone" (p. iv).

Practitioner requirements. There is a stark difference between music therapy and

Music & Memory requirements. In order to become certified in Music & Memory, a site such as

an elder care service, must register and pay a fee of $500-$1250 to become a certified Music &

Memory organization (Music & Memory, 2018c). An additional $450 is required for the

webinar which targets OTs, PTs, and SLPs (Music & Memory, 2018b). An annual renewal fee is

subsequently due of $200. From the perspective of overall time commitment, staff are trained by

participating in three 90-minute webinars to be certified to implement Music & Memory.

Meanwhile, in order to become qualified to practice as a board certified music therapist (MT-

BC), an individual must first complete an academic and training component at either the

baccalaureate or graduate level at a university with an AMTA approved curriculum (AMTA,

2018e). The length of time studying could vary between two to four years depending on the

tertiary level being studied at, and previous music proficiency and academic qualifications/

prerequisites. Also, "at least 1200 hours of supervised clinical training" (AMTA, 2015, para. 5)

must be completed where the individual will participate in fieldwork placements and/ or a period

of internship alongside a board-certified music therapist (MT-BC).

Williams et al. (2014) viewed Music & Memory as an intervention which came at little to

no cost to the client with AD. Shiltz et al. (2018) further indicate that "Professional music

therapists are not required for ML, which can be implemented by nursing home staff and family

members (p. 18). Due to the high level of specialization, music therapy services are more

expensive but music therapists require training in order to carry out assessments, including risk

assessments; and treatment of a wide range of populations in a variety of settings. Music &

Memory primarily focuses on persons with dementia situated in long-term care facilities such as

nursing homes. Music in the form of "mass group singing or listening activity with little

personal attention" (Prickett & Moore, 1991, p. 109) was identified to be the norm in

institutional settings, usually conducted by non-music therapy professionals such as nursing

staff. Live music interventions could also be carried out by non-music therapy professionals

such as an occupational therapist (Cox et al., 2014). However, music therapists implementing

music interventions in these settings would considering the risk assessment component, and seek

to identify issues for persons with dementia such as potential for emotional lability, falls or

increased agitiation. Therefore, it is evident that in the utilization of live music interventions,

they were usually designed so that music therapists could respond quickly and appropriately to

any negative reactions which may occur to the music (AMTA, 2015, para. 3).

Lombardo and Spring (2018) stress the importance of knowing when a music therapy referral is appropriate. As a result, music listening guidelines were developed for individuals who were non-music therapy professionals, and also members of the public, involved in providing Music & Memory to persons with dementia which looked at the following: auditory safety; infection control; music content considerations; physiological considerations; psychological considerations; cognitive communicative & sensory considerations; music listening and safety considerations (Lombardo & Spring, 2018).

Evidence-based research. According to the AMTA (2018a), music therapy involves "evidence-based use of music interventions" in terms of setting "individualized goals within a therapeutic relationship" (para. 1). This is accomplished because music therapy

> involves the systematic utilization of rhythmical and melodic musical instruments to improve communication between a trained music therapist and a patient by enabling the patient to convey his/her emotions and feelings in a way that enhances self-adaptation to the social environment (Owens, 2014). Thus, music therapy promotes a sense of renewed identity that can stimulate general cognitive functioning (Owens, 2014). (Shiltz et al., 2018, p. 18)

This highlights the importance of the therapeutic relationship between the therapist and client, and the need for the therapist to work from a theoretical orientation such as ToP (Sherratt et al., 2004) which is linked to "person-centered care" (Beard et al., 2011).

Music & Memory, in comparison as an individualized intervention "engages individuals with dementia in *passively listening* [emphasis added] to prerecorded music that is highly personalized to his or her preferred genre, typically via headphones" (Shiltz et al., 2018, p. 18). Two music therapists, Lombardo and Spring (2018) conducted a webinar for Music & Memory

entitled, *Music Listening Guidelines with the American Music Therapy Association*. Four

different types of therapeutic music programs and services were identified for which each was

assigned individual music plans of care:

1. live music performance;

2. music activities/ music ensemble participation e.g. choir;

3. personalized recorded music listening; and,

4. music therapy. (Lombardo & Spring, 2018)

From this, there is clearly a distinction between music therapy and other forms of

therapeutic music programs, including Music & Memory. Yet some certified Music & Memory

organizations mirepresent themselves as offering "not only music therapy" (SCES, 2017, para.

4), but "personalized music therapy to persons with dementia" (para. 5). The Music & Memory

program is fundamentally a form of passive involvement identified as "personalized recorded

music listening" (Lombardo & Spring, 2018). When Music & Memory is used by persons with

dementia,

> the goal of (music listening) is to provoke the reminiscence effect – the ability of older
>
> adults to better recall specific autobiographical information linked to strong emotions
>
> when listening to music experienced during their late teens and early twenties
>
> (Krumhansl & Zupnick, 2013). Listening to personalized and preferred music from their
>
> past may provide a recognizable stimulus for patients with ADRD, thus reducing their
>
> attention to extraneous environmental stimuli that otherwise cause confusion and
>
> agitation. (Shiltz et al., 2018, p. 18)

This is in contrast to music therapy which "may involve numerous activities such as

singing, playing instruments, listening to prerecorded and/or live music during individual or

group sessions, and/or creating music via a defined program" (p. 18). It should be highlighted that Music & Memory is individualized and the person with dementia listens through over ear headphones so that it cannot be utilized during group sessions. There was one exception where Kulibert et al. (2018) implemented the use of speakers so that music listening could be experienced by both caregiver and the person with dementia, but this was due to the nature of the study being conducted and not standard practice for Music & Memory. Some caregivers reported experiencing difficulty with individuals with dementia not tolerating the over ear headphones.

Anecdotally, preferred familiar music is considered to give the best results with any music listening activity. However, it should be noted that in some cases it is actually unfamiliar music and not preferred familiar music which yielded the most significant results (Tomaino, 2013). In one instance, electroencephalograms were taken while individuals with severe AD listened to 3 types of recordings: a familiar song, an unfamiliar song with the same dynamics and rhythm as the familiar song and a contemporary rock song with a strong rhythmic beat. It was found that the strong rhythmic beat "had the greatest effect in altering patients' EEG states, especially in increased background rhythms" (p. 234).

From the perspective of the American Music Therapy Association (AMTA), there is no set population (Lombardo & Spring, 2018 personal communication) which could benefit from music listening programs in general. Anecdotally, families of individuals with autism use music listening between music therapy sessions to deal with behavioural issues; as well as its application by music therapists in Neonatal Intensive Care Units (NICU) (Lombardo & Spring, 2018 personal communication).

Recently, the AMTA approved an Advance Music Planning directive for individuals to develop their preferred playlists prior to the onset of cognitive decline from conditions such as traumatic brain injury (TBI), stroke (CVA) and dementia (AMTA, 2018d). The AMTA also currently offers an e-course on personalized music listening and music therapy to familiarize music therapists with the tool of Music & Memory (AMTA, 2018d).

Discussion

Purpose. The paper focused on whether Music & Memory could be called music

therapy or if it should only be identified as a form of therapeutic music. SCES (2017) purported

to be offering personalized music therapy for persons with dementia through Music & Memory,

while AMTA (2018a) emphatically stated that at the most, Music & Memory could only be

referred to as a form of therapeutic music. This question was explored through the lens of

therapeutic music interventions and services currently offered to persons with dementia.

Approach. An extensive literature review of several peer-reviewed journal articles was

carried out, along with an analysis of information gleaned from several websites such as the

American Music Therapy Association and Music & Memory. The aim was to establish a clear

delineation between music therapy and Music & Memory, through an examination of the two in

terms of the history, populations served, key components, and practitioner qualifications. Then,

the paper explored the definition of dementia, the role played by music therapy and Music &

Memory in dementia treatment, and finally a comparison between music therapy and Music &

Memory was made.

Findings. Music & Memory is not music therapy. It is actually a form of music

listening (ML), specifically "personalized recorded music listening" (Lombardo & Spring).

Furthermore, music therapy and Music & Memory differ in several ways. With Music &

Memory, there is passive involvement with the music, while music therapy requires the person

with dementia to be actively engaged in the music intervention with the therapist. Due to the

upfront fees paid by the certified Music & Memory organization, there is usually little to no cost

for the person with dementia to receive an iPod and personalized playlist. As a result, many

long-term care facilities use Music & Memory because it is cheaper than employing the services

of a music therapist. Due to the degree of specialization, music therapy is more expensive.

Music therapy is evidence-based in terms of its specific application to dementia care, whereas

Music & Memory is, for the most part, anecdotal with more evidence-based research needed.

Music & Memory has the potential to be a music intervention tool utilized by music

therapists, and to engage music therapists in the process of music preference assessment and

evaluation of potential risks from a consultant capacity. As Music & Memory is a form of music

listening, the evidence already supports and gives examples of music listening being used by

music therapists as an intervention.

In the application of music therapy, Prickett & Moore (1991) stated that maintaining the

overall quality of life and level of activity of their clients were considered the goals of

caregivers. Music therapy was proven to reduce the level of distress experienced by caregivers

and family members (Williams et al., 2014) over a longer period of time than compared to the

temporary distraction provided by Music & Memory. In instances of BPSD, music therapy

actually reduced BPSD such as anxiety and agitation (Sakamoto, Ando, & Tsutou, 2013;

Williams et al., 2014) in the short-term and long-term. This carried over in both cases to a

reduction in caregiver burnout. On the other hand, Music & Memory served as an environmental

distraction with short-term impact on persons with dementia while they are passively listening to

the preferred playlist. With Music & Memory, caregivers may take the opportunity to leave the

client unsupervised listening to the preferred playlist in order to experience a period of respite,

and get chores done that would otherwise have proven difficult. Kulibert et al. (2018) suggested

that speakers be used so that listening to music is a shared experience for the person with

dementia and their caregiver.

Using Kitwood's ToP, the benefits of live music in active music participation versus recorded music in passive music listening can be analysed according to concepts of "well-being" or "ill-being" (Sherratt et al., 2004,p. 11) to develop prospective music therapy research. Furthermore, ABR can be applied to increase the existing knowledge base of music therapy and inform current evidence-based practice.

Recommendations and Further Research

Since the publication of Brotons et al. (1997) and Koger et al. (1999), there has not been a thorough meta-analysis, either qualitatively or quantitatively, which reviews the music therapy literature to support or further examines its effectiveness as a treatment modality for dementia. There have been significantly more studies done since these two articles were published, with updates and changes to the definition of dementia, so a dire need arises for music therapists to carry out updated research into this area of practice. ABR can be implemented to facilitate expanding the body of literature on this topic, specifically in the field of music therapy.

More education is needed for non-music therapy professionals and the public about what music therapy is and why Music & Memory cannot be referred to as music therapy. This can be done through advocacy for the profession, and clarification being offered to certified Music & Memory organizations in the process of training their staff to implement personalized recorded music listening. In order to facilitate this, Music Listening Guidelines (Lombardo & Spring, 2018) should be made more readily available to non-music therapists and the general public to inform them and ensure that necessary precautions are taken when implementing music listening interventions such as Music & Memory. This corresponds to the mandate of the AMTA "to advance public knowledge of the benefits of music therapy" (AMTA, 2018b, para. 10).

The AMTA, whose mandate is also "to increase access to quality music therapy services in a rapidly changing world" (AMTA, 2018b, para. 10), plays a significant role in making fact sheets available to music therapists such as, *Clinical Music Therapy and the Music & Memory Memory Program* (AMTA, 2015). This would serve to educate music therapists working in the field of dementia as to why Music & Memory cannot be described as music therapy. Also, more emphasis should be placed on promoting the e-course on personalized music listening and music therapy currently on offer by the AMTA.

More arts-based research should be conducted to increase the available music therapy literature on the use of active engagement in music versus passive involvement in music as interventions; live versus recorded music-employing Kitwood's ToP; and the benefits of music interventions being carried out by a music therapist versus a non-music therapy professional such as a nurse, social worker or occupational therapist.

With the introduction and approval of advanced music planning by the AMTA, more research is needed into whether the development of musical preference playlists prior to the onset of cognitive decline in persons with dementia is more successful than when playlists are developed by family member and caregivers of persons with moderate to severe neurocognitive impairment.

Conclusion

It must be acknowledged that Music & Memory is not music therapy, but a form of personalized recorded music listening. As a result, Music & Memory remains but a tool that is available to both music therapists and non-music therapy professionals alike to use as a therapeutic music intervention with persons with dementia. However, it must be emphasized that use by a non-music therapist involves a higher degree of risk. Music & Memory does not

have a standardized set of guidelines or offer the degree of specialization that a music therapist is

able to employ when implementing a music intervention. It would be better to utilize the input

of a music therapist to ensure clients with dementia are receiving the best standard of clinical and

evidence-based care. Certified Music & Memory care organizations should refrain from

describing themselves to stakeholders and the general public as offering music therapy. Instead

Music & Memory should forge a partnership with the AMTA to ensure that a music therapist is

always available and where possible, involved in the offering of the therapeutic music

intervention of personalized recorded music listening.

References

AMTA. (2015). Clinical music therapy and the Music & Memory memory program. Retrieved

from https://www.musictherapy.org/assets/1/7/ML-MM-MTFactSheet.pdf

AMTA. (2018a). Definition and quotes about music therapy. Retrieved from

https://www.musictherapy.org/about/quotes/

AMTA. (2018b). History of music therapy. Retrieved from

https://www.musictherapy.org/about/history/

AMTA. (2018c). Music therapy with specific populations: Fact sheets, resources &

bibliographies. Retrieved from https://www.musictherapy.org/research/factsheets/

AMTA. (2018d). Guidance for music listening programs. Retrieved from

https://www.musictherapy.org/research/guidance_for_music_listening_programs/

AMTA. (2018e). Information for becoming a music therapist. Retrieved from

https://www.musictherapy.org/careers/information_for_becoming_a_music_therapist/

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental

disorders* (3rd ed., DSM-III). Washington, DC: American Psychiatric Publishing.

American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental

disorders,* (4th ed., DSM-IV). Washington, DC: American Psychiatric Publishing.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental

disorders,* (5th ed., DSM- 5). Arlington, VA: American Psychiatric Publishing.

Beard, R. L., Sakhtah, S., Imse, V., & Galvin, J. E. (2011). Negotiating the joint career:

Couples adapting to Alzheimer's and aging in place. *Journal of Aging Research, 2012*,

1-12. doi: 10.1155/2012/797023

Brotons, M., Koger, S. M., & Pickett- Cooper, P. (1997). Music and dementias: A review of
     literature. *Journal of Music Therapy, 34*(4), 204-245.
     https://doi.org/10.1093/jmt/34.4.204

Cox, E., Nowak, M., & Buettner, P. (2014). Live music promotes positive behaviours in people
     with Alzheimer's disease. *British Journal of Occupational Therapy, 77*(11), 556-564.
     doi: 10.4276/030802214X14151078348477

Dassa, A., & Amir, D. (2014). The role of singing familiar songs in encouraging conversation
     among people with middle to late stage Alzheimer's disease. *Journal of Music Therapy*,
     51(2), 131-153. doi: 10.1093/jmt/thu007

Gerdner, L.A. (2012). Individualized music for dementia: Evolution and application of
     evidence- based protocol. *World Journal of Psychiatry*, 2(2), 26-32.
     doi:10.5498/wjp.v2.i2.26

Han, P., Kwan, M., Chen, D., Yusoff, S. Z., Chionh, H. L., Goh, J., & Yap, P. (2010). A
     controlled naturalistic study on a weekly music therapy and activity program on
     disruptive and depressive behaviors in dementia. *Dementia & Geriatric Cognitive*
     Disorders 30, 540–546. doi: 10.1159/000321668

Ijaopo, E. O. (2017). Dementia-related agitation: A review of non-pharmacological
     interventions and analysis of risks and benefits of pharmacotherapy. *Translational*
     Psychiatry, 7(10), 1-11. e1250. doi: 10.1038/tp.2017.199.

Koger, S. M., Chapin, K., & Brotons, M. (1999). Is music therapy an effective intervention for
     dementia? A meta-analytic review of literature. *Journal of Music Therapy, 36*(1), 2-15.
     doi: 10.1093/jmt/36.1.2

Kulibert, D., Ebert, A., Preman, S., & McFadden, S. H. (2018). In-home use of personalized

music for persons with dementia. *Dementia, 0*(0), 1-14. doi:

10.1177/1471301218763185

Ledger, A., & Edwards, J. (2011). Arts-based research practices in music therapy research:

Existing and potential developments. *The Arts in Psychotherapy*, *30*, 313-317. doi:

10.1016/j.aip.2011.09.001

Lombardo, R., & Spring, E.K. (2018). Music listening guidelines with the America Music

Therapy Association. [Video webinar]. New York, NY: Music and Memory.

Moss, H., & O'Neil, D. (2017). Narratives of health and illness: Arts-based research capturing

the lived experience of dementia. *Dementia*, 0(0), 1-10. doi:

10.1177/1471301217736163

Music & Memory. (2018a). Our Mission and Vision. Retrieved from

https://musicandmemory.org/about/mission-and-vision/

Music & Memory. (2018b). Music & Memory for PT, OT, SLP. Retrieved from

https://musicandmemory.org/training-publications/music-memory-therapy-applications/

Music & Memory. (2018c). Pricing & Equipment. Retrieved from

https://musicandmemory.org/training-publications/pricing-overview/

Otera, M., Horike, H., & Saito, T. (2013). Musical life review for the elderly with dementia as

spiritual care-Clinical functions and roles of meaningful and memorable songs. *The Arts*

in Psychotherapy, *40*, 285-290. http://dx.doi.org/10.1016/j.aip.2013.05.012

Prickett, C. A., & Moore, R. S. (1991). The use of music to aid memory of Alzheimer's

patients. *Journal of Music Therapy, 28*(2), 101-110. https://doi.org/10.1093/jmt/28.2.101

Rossato-Bennett, M. (Producer/Director). (2014). *Alive Inside: A Story of Music and Memory*
[Motion picture]. USA: Projector Media.

Sakamoto, M., Ando, H., & Tsutou, A. (2013). Comparing the effects of different
individualized music interventions for elderly individuals with severe dementia.
International Psychogeriatrics, 25(5), 775–784. doi: 10.1017/S1041610212002256

SCES News. (2017). SCES brings music therapy home for dementia patients. *SCES News*
(Online). Retrieved from: https://eldercare.org/sces-brings-music-therapy-home-dementia-patients/

Sherratt, K., Thornton, A., & Hatton, C. (2004). Music interventions for people with dementia:
a review of the literature. *Aging & Mental Health*, 8(1), 3-12. doi:
10.1080/13607860310001613275

Shiltz, D.L., Lineweaver, T.T., Brimmer, T., Cairns, A. C., Halcomb, D. S., Juett, J., Beer, L.,
Hay, D. P., Plewes, J. (2018). Music first: An alternative or adjunct to psychotropic
medications for the behavioural and psychological symptoms of dementia. *GeroPsych:
The Journal of Gerontopsychology and Geriatric Psychiatry*, 31(1), 17-30.

Tomaino, C. M. (2002). The role of music in the rehabilitation of persons with neurologic
diseases: Gaining access to 'lost memory' and preserved function through music therapy.
Music Therapy Today (online), August. Retrieved from: http://musictherapyworld.net

Tomaino, C. M. (2013). Meeting the complex needs of individuals with dementia through
music therapy. *Music and Medicine,* 5(4), 234-241. doi: 10.1177/1943862113505775

Williams, A. P., Peckham, A., Rudoler, D., Tam, T., & Watkins, J. (2014). Evaluation of the

Alzheimer Society of Toronto iPod Project. Retrieved from: https://alz.to/wp-

content/uploads/2014/12/IPod-Project-Evaluation-Final-Report-April-2-2014-FINAL-

REV.pdf

THESIS APPROVAL FORM

Lesley University
Graduate School of Arts & Social Sciences
Expressive Therapies Division
Master of Arts in Clinical Mental Health Counseling: Music Therapy, MA

Student's Name: Tamara D. Adams

Type of Project: Thesis

Title: "Music & Memory": Is it Personalized Music Therapy or Just 'Good Music'?

Date of Graduation: _____

In the judgment of the following signatory this thesis meets the academic standards that have been established for the above degree.

Thesis Advisor: _____