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**CARE STAFF PERSPECTIVES OF THE ROLE OF
MUSIC IN THE CARE OF PEOPLE LIVING WITH
DEMENTIA**

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PhD Thesis

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Care Staff Perspectives of the Role of Music in the Care of People Living with Dementia

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Aim

The aim of the study was to examine the perceptions and experiences of care staff who might use music with older people living with dementia, in order to assess its potential to promote a holistic culture of care that supports the well-being of people living with dementia and their care givers simultaneously.

Abstract

The rationale for this study was grounded in the current emphasis on developing non-pharmacological interventions for people living with dementia in the UK. The study investigated the common practice amongst care staff caring for people living with dementia to commission music activities as a recreational pastime. It examined staff perspectives on the value of these activities and the potential to develop the scope of therapeutic benefits that might simultaneously support the well-being of both the cared-for and the care-giver. It investigated personal and professional factors that might underpin inhibitions to staff training to facilitate music activities themselves and to staff exploring music as an education tool to develop creative and reflective practice. The study sought to generate original findings and to contribute to an evidence base to inform future practice.

Method triangulation involved a questionnaire survey, telephone and face-to-face interviews, focus group discussions and participant observations. One hundred and ninety two participants took part in the study, comprising 149 care staff and 13 music practitioners who collectively worked in one or more of 27 care settings for older people in east Kent, 27 older people and three informal carers. The results showed that musicians and music practitioners were typically engaged by staff to deliver a fairly similar range of activities, around ten times per year on average. Practical barriers to staff taking part in these activities centred on issues of time-tabling and the challenges of balancing routine care-giving with non-routine activities. Psychological barriers appeared to be influenced by: cultural backgrounds; staff experiences of music education at school; preconceptions about musical skill; personal levels of confidence; social pressures; inter-staff relationships; and the relationships that staff have with visiting musicians. Barriers to formal training for staff to explore music as a catalyst for creative and reflective practice

also included low or non-prioritisation of music in relation to their care-giving role and a belief that only musical staff would benefit.

Introduction

This study investigated the perceptions and practices of care staff, with an emphasis on the day-to-day care-givers, and music practitioners relating to the value of music in their own lives and the lives of people living with dementia for whom they care. The work is the result of many years of the researcher's personal observations in her role as a registered nurse and as a music practitioner. The study was driven by a quest to better understand the potential role of music to enhance the quality of life and relationships between people living with dementia and their professional care-givers. The journey leading to the study's inception can probably be best illustrated by the following account of the researcher's personal experience.

Some years ago, I attended a five-day residential course at the Britten-Pears School for Advanced Music Education, Aldeburgh, Suffolk. As a nurse/music practitioner, I had a particular interest in the course which focused on music interventions between music practitioners and older people with living with dementia in care settings. Students on the course comprised fifteen or so professional musicians from various backgrounds. In addition, two care assistants were seconded onto the course from a local care home to which students were assigned for experiential training sessions. In preparation for the sessions, one young musician who wished to avoid offence asked the care-assistants, 'What should we call the inmates; 'residents' or 'clients' or something else?' The two care assistants looked puzzled; 'You call them 'Elsie' or 'Frank'; or whatever their name is!' The response illustrated an encouraging change in how older people living in care settings are regarded by the people caring for them. However, the issue of referring to people by name arose very little during the training sessions. What did occur illustrated the power of music to connect human beings in a way that appeared to transcend differences in cognitive capacity, age, gender and social or

professional hierarchy. The music practitioners, care staff and people living in the care setting worked together, without any verbal interaction, to produce a number of improvised performances that were reported by many participants to have a powerfully positive impact on their sense of well-being.

It is the potential for music to act as a mutually uplifting medium for therapeutic engagement that inspired this study. A move towards a more holistic approach to caring for people living with dementia requires of care-givers an intuitive understanding of a diverse range of human needs, as well as an understanding of their own professional perspective and their personal needs. In terms of people living with dementia, the apparent inability to coherently express their basic needs may appear to present some insurmountable challenges for care-givers. Music therapist, David Aldridge suggests that the ability to express oneself, or to *perform*, as Aldridge puts it, relies on rational notions of purpose and subsequent co-ordinates of time and space (Aldridge 2000). When these elements are defused or absent altogether, as apparently so in some people living with dementia, person-to-person relationships can become distorted and disconnected. Disconnection between care-givers and the people for whom they care frequently leads to misunderstandings of expressions of need. Such misunderstandings can, in turn, provoke symptoms that are typically associated with people living with dementia, such as screaming and wandering. Inevitably, when are faced with a seemingly relentless cycle of events, some care-givers lose self-confidence, self esteem and a sense of job-satisfaction. The consequences of poor quality of life amongst care-givers is well documented and may have a significant impact on the future workforce needed to care for the projected rise in the number of people living with dementia over the next four decades. Given this scenario, the necessity to identify strategies to support staff is critical.

It has been my observation that, in addition to a general belief in music's value for people living with dementia, many care staff also use music to good effect in their personal lives. Engaging in music appears to enable mood reflection and/or mood shift, stimulation, relaxation and/or diversion. A previous study showed that a radio tuned to a music station that plays a predominance of up-beat, youth-orientated music in a communal area in a care setting can help to support a sense of well-being amongst staff. Although some

tensions may have arisen in terms of this being appropriate for the older people, the positive impact on staff moods appeared to help to create a congenial environment in which both staff and the older people benefited (Vella-Burrows 2001). However, most music-based experiences amongst people living with dementia and their care-givers, and thus their beneficial consequences, usually occur independently. Benefits gained by people living with dementia are not generally perceived as transferable to care-givers when music takes place in the workplace. This study centres on the premise that new models of music-sharing have the potential to reconnect people living with dementia and their care-givers. It may do so by providing a platform to explore Aldridge's *performance* concept, in which shared musical interactions become acts of purpose. This may involve care-givers using music directly with the people in their care, or music being used as a catalyst to train care-givers' to view their care-giving role more creatively. These processes may engender situations in which care-givers and the people for whom they care are better able to express their needs to one another.

The study

The study aimed to answer the following questions:

1. What level and nature of musical activities are currently provided by visiting musicians in care settings for people living with dementia?
2. How are musical interventions perceived and their impact understood?
3. How do staff feel about training to develop skills to use music in care-giving?
4. How might musical interventions relate to wider perspectives of care-giving and the health and well-being of both care staff and the people for whom they care?

Chapter One of the thesis explores the context in which people living with dementia exist in the UK today. This is framed by an examination of attitudes towards older people and attitudes towards people living with poor mental health. Chapter Two compares models of healthcare currently practised in the UK and looks at how their philosophical underpinning impacts on the care of people living with dementia. It examines the influence of training and education for healthcare professionals and care staff over the last decade and half. Chapter Three examines the role of music in human-kind and the

potential influence of socio-musical practices on care-givers. Chapter Four provides a review of literature on music and the care of people living with dementia. It explores the apparent retention of musical ability from biological and neurophysiology perspectives and comments on the physical, psycho-social and emotional impact of music. Chapter Five describes the study's methodological paradigm and the methods used to gather and analyse the data. Chapter Six provides details of the final sample and lays out the results of the research. Chapter Seven discusses the study's findings, limitations, conclusions and recommendations for the future practice.

Reflecting Aldridge's (2004) observation that anecdotes are 'the everyday stuff of clinical practice', this thesis includes a number of illustrative case reports that support the literature and findings of this study. The following report acknowledges the central role that one person played in shaping the researcher's professional and personal development which eventually led to this study.

Illustrative Case Report No. 1: Meeting

I first met John and his family in September 2000. John had been newly diagnosed as suffering from Alzheimer's disease and I had been introduced to the family in my professional nursing capacity, to help with John's care. I remember making a point of reading a couple of up-to-date journal articles on the latest thinking and practice on Alzheimer's disease in the previous months' nursing journals. My motivation for doing so was a wish to appear knowledgeable in a way that would instil confidence in John and his family and in order to create an environment that I felt was within my professional control. It was a fundamental duty to the people for whom I cared, I felt, to present a proficient professional position. So, satisfied that I had fulfilled this obligation, I set off to meet my new client.

I eventually worked with John and his family for over six years. After he had died, John's wife gave me John's self-kept diary, which poignantly plotted the changes in his cognition over the years. The entry on the day we had first met, read, 'New nurse came; nice but a bit cold'.

By the time I had read John's salient comments, seven years later, I had radically changed the way that I viewed the people in whose lives I shared in my professional capacity. This transition centred on the premise of non-hierarchical, human-to-human connectedness, which developed as result of my time with John and has since underpinned all of my professional relationships. The change has enabled a greater degree of professional satisfaction that I can now build upon. I could not have achieved this transformation without the companionship of an extraordinary man, John, his loving family - and music.

This thesis is dedicated to Mr William Ash.

Heart-felt thanks go to Professor Grenville Hancox, Professor Stephen Clift and Dr Sally Robinson for their dedication and personal commitment to the production of this thesis

Chapter One

People living with dementia: the context within the United Kingdom

Over the next thirty years, the number of older people living in the UK is expected to rise. The associated rise in the number of people living with dementia will present specific challenges, particularly for those who seek to provide good quality health and social care. This chapter aims to present broad contextual factors in which caring for this group of people occurs, and discusses the potential for social attitudes to affect the way in which professional care-givers perceive and approach their care-giving role.

1.1 An Ageing Population

1.1.1 Definition of 'old age'

Defining old age is not straightforward. The Department of Health (DH 2001a) and the Office for National Statistics (ONS 2008) indicate that people aged between 50-65 are 'entering old age', those aged between 65-70 are the 'young old', those aged between 70-85 are in 'old age' and people 85 + are in 'very old age'. However, an illustration of the difficulties of such definitions is seen in a study undertaken in the United States in 1998. The results reflect shifting perceptions of the concept of age as individuals themselves get older. For example, 30% of 18-to-29-year-olds rated 65 as old compared with 7% of people aged 60. On average, people aged 30 rated 67 as old compared with people aged 60 +, who classified 77 as old. Cross data from people aged 18 to 49 showed gender-specific differences whereby women rated 71.5 and men rated 69 as old (Roper Report 1998).

If self-perceptions of old age hamper clear definitions, relevant literature by no means provides a standardised formula or straightforward solution. Some Government documents refer to people aged 50 + as 'older people' (e.g. OPSI 2006; DWP 2006). Others assign 'old age' to people aged 60 + (e.g. Hays *et al* 2001; Cattan 2001; Bowling 2005) and 65 (e.g. Blazer 1982; Bridgwood 2000; Tones 2001). In their study on quality of life in old age, Breeze *et al.* (2004) focused on 'old' people aged 75 +. Borglin, Edberg,

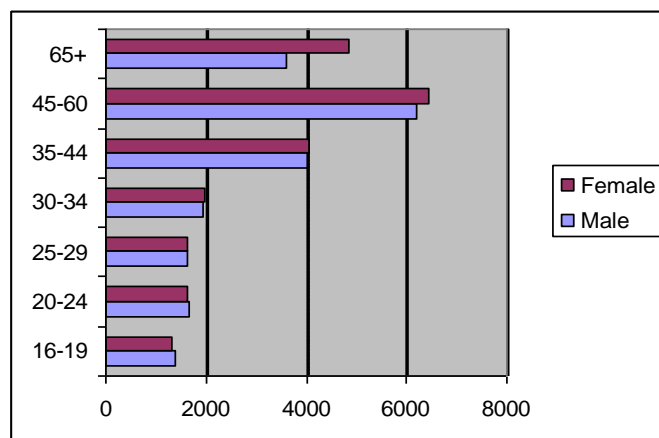
Hallberg *et al.* (2005) concur with this definition by rating 75+ as 'old' and 85+ as 'oldest-old' (p. 202). However, Jong-Gierveld and Solinge (1995) rated 65-85 as 'old' and 85 + as 'very old'. Some authors avoid chronological measurements altogether favouring generic terms such as 'the elderly', which was popular in the UK until the mid 1990s and currently in America, (e.g. Willis, Goodwin and Lee *et al.* 1997; Nemmers 2004). Others use terms such as 'older people' (Estes and Phillipson 2002) or the 'greying population' (Hodgetts, Chamberlain, Bassett *et al.* 2003) and some refer to the 'retired population' as an indicator of older age (e.g. Clift and Morrissey 2001; Tulle and Mooney 2002).

The vast range of scenarios relating to people's life-styles, life-psychologies and states of health make an agreed definition of old age impossible. References to literature on old age issues within this thesis therefore will adhere to each authors' definitions, where given.

1.1.2 Demographics

In a comparative study looking at the future demography of older people across Europe, de Jong-Gierveld and van Solinge (1995) predicted a rise in both actual and relative numbers of older people. The authors observed that in 2002 there were 19.8 million people aged 50 + in the UK. Four decades before there were just 16 million, reflecting a 24% increase.

Fig. 1.1 Age and Gender Population across England and Wales in 2003

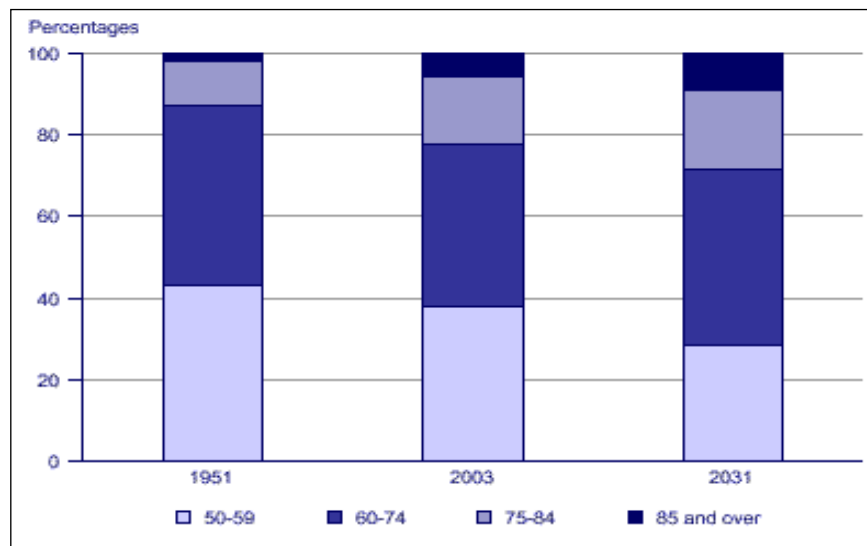


Numbers on horizontal axis x 1000

(ONS 2003)

Figure 1.1 illustrates the consequences of this rise representing a relative population imbalance weighted towards older people. Put another way, the rise of mean age across the UK will change from 38.6 years in 1998 to 41.9 in 2021, and 44 in 2040 (Young 2002). Data from the 2001 Census shows that, if current trends continue, between 1995 and 2025 the number of people over 80 will increase by 50% and the number over 90 will rise by 100% (ONS 2008). By 2031, a further projected rise will bring the number of people over 50 to 27 million. The number of people of pensionable age, which, at the time of writing, is 65 for men and variably between 60 to 65 for women, will also rise from 11.4 million in 2006 to 15.2 million in 2031 (Seabrook 2003). The over-85 group is the fastest growing in number and is expected to lead the upward trend with a further 10% increase by the end of 2008.

Fig. 1.2 Predictions of age composition of the older population in the UK



(ONS 2008)

Figure 1.2 shows that by 2031, the over 85s are predicted to comprise 3.8% of the UK population (Goodwin 2003; ONS 2008).

1.2 Consequences of an ageing population

Changing demography in the UK is the result of advances in medical research and technology, improved education and health promotion, better living conditions, a falling

birth rate over the last three decades and the so-called 'baby boomer' cohort, born just after World War II, reaching retirement age (Walker, Barnes, Cox *et al.* 2006).

Some reports present an optimistic view of the future (Benjamin and Pollard 1980; Midwinter 1990; Shaw 1994; Mullan 2000 and Clark, Burkhuaser, Moon, *et al.* 2004). The authors of these reports refuse to be intimidated by the oft-quoted mantra of a future ageing time bomb, observing that, historically, demographic forecasting beyond a period of 20 years has been notoriously inaccurate (Raeside and Khan 2007 p.4). They present arguments for case scenarios, in which, for example, the cost of dependent older people is offset by a decrease in the number of dependent children (Mullan 2000) and/or medical advances and health promotion herald an increasingly productive older society.

In contrast, the majority of authors commenting on demographic predictions over the next four decades present a worrying scenario associated with potential economic and health and social care challenges.

1.2.1 Economic consequences of an ageing population

Estes and Phillipson (2002) observed a preoccupation with the ageing population as a threat to the economy from the 1980s onwards. The authors pointed out that the changing demography will have serious economic consequences at both a macro (national) level and a micro (individual) level.

Recent public health documents and media coverage present a bleak picture of the economic consequences relating to predicted longevity in Britain over the next four decades (DH 2006; Laing and Buisson 2006; Joseph Rowntree Foundation 2008; Beckford 2008).

The predictions mean that the ratio of younger people to people of pensionable age will drop from 4:1 today to 2.5:1 by 2035 and 2:1 by 2050 (Employers Forum on Age 2009). Young (2002) observed that demographic changes of this size will impact upon three crucial economic factors. The first concerns a reduction in the size of the labour force and subsequent tax revenue. The second relates to expectations of the continued development

in technology. This has been the major driver of economic growth since the 1950s and will impact in terms of productivity and information-access with decreased need for traditional inter-generational exchange of skills and information. The third factor relates to potential for falling consumption levels due to frugal spending tendencies amongst older people created by the need to spread resources over more years.

Young's report highlighted areas of economic tension *without* the added burden of health and social care costs. Yet even in the case of the ageing population remaining healthy, the decline and retrenchment of pensions in the UK may demand unsustainable subsistence benefits for which the country is ill-prepared (Seib 2005). Up to 2006, the average income in a household where the head is 30 – 40, was approximately two thirds more than households where the head is 75 + (Office of the Deputy Prime Minister [ODPM] 2006). Approximately 50% of retired households have incomes at or below the average for younger households dependent on state benefits (*ibid.*). If this trend persists, the added consequences of long-term health care will challenge the Treasury to the extreme (Hancock, Wittenberg, Pickard, *et al.* 2006). Kelly (2005) captures the two concerns in the statement:

How best to pay for the cost of providing long-term care for older people is one of the wicked issues to set alongside the even bigger issue of adequate pensions.
(Kelly 2005 p. vi)

To keep pace with expectations of a rise in age-related morbidity, residential home and hospital bed occupancy would need to increase by 151% and the number of care hours in private homes would need to rise by 137% by 2051. In monetary terms, the collective NHS and social service expenditure would rise from around £12.9bn in 2000 by 2.5% per year to approximately £53bn in 2051 (Hirsch 2005).

Against the backdrop of the predicted rise in older people and subsequent health and social care costs, the King's Fund commissioned a report by economist Derek Wanless to examine alternative ways of funding services (Wanless 2006). This report highlighted inequalities in means-testing for service users in which people who had saved money were often penalised. The report went on to present a number of models for the future

which will variably impact on the financial resources of individuals. Some options involve insurance schemes, possibly linked to pensions, and equity release from property. These schemes are likely to be complicated, not least because of the uncertainty of risk (Johnstone 2005). Tulle and Mooney (2002) suggest that the scenario will force people into make financial decisions based on anticipation of disability. Many schemes will be associated with investments made by financiers on behalf of older people. Such schemes historically have variable success and failure rates with a number being withdrawn from the market to the detriment of contributors (*ibid*). However, in the growing shift from public to private pension provision, the practice of investment is likely to grow to support lengthy old age. This means more older people could be at risk of losing money through ineffective financial plans and/or the inconstancy of the global market (Young 2002).

Low-levels of personal economic resources will ultimately result in a greater draw on the public purse to adequately care for people in their later years. This factor is likely to impact negatively on levels of pay for care-givers and on levels of training that may promote and support practices to benefit both the cared-for and the care-giver.

1.3 Health, ill-health and disability in older age

The ability to generate sufficient resources to cope with an increasing imbalance of older to younger people will depend largely on state of health of older people in the future.

Epidemiological data show that older people are significant users of healthcare services. For example, in 2006, even though only 16% of the population were over 65, they nevertheless occupied over 66% of acute and general hospital beds (Commission for Healthcare Audit 2006). The statistics indicate a clear rise in morbid conditions¹ as people age and subsequent potential for disability.

In 2004, a survey of over 8,000 people living in the community aged 75 and over on issues of perceived quality of life, revealed that most did not have significant problems

¹ Morbid conditions refer the incident rate (new cases) and prevalence of disease.

with home management, personal care and mobility, social interaction or morale (Hennessey and Walker 2004). Furthermore, at around the same time, Clarke (2005) reported that many people aged 80 and over were living satisfactory and productive lives. Despite these encouraging findings, a survey carried out the same year on the health of older people showed that 71% of people aged 65 and over reported long-standing illness (Craig and Mindell 2005). Forty-two per cent of men and 46% of women reported that these illnesses disrupted activities of daily living (ADL) in some way. Prevalence of disruption increased with age with 71% of men and 73% of women aged 70 -79 and 75% of men and 78% of women over 85 affected (*ibid*). These collective statistics illustrate the variability of older peoples' experiences and perceptions.

1.3.1 Physical health in older age

In 2005, UK statistics estimate that men aged 65 could have 16.9 years of life expectancy, out of which they could expect 12.8 healthy years. Women aged 65 could have 19.7 years of life expectancy with 14.5 healthy years (ONS 2008).

The detail of health/ill-health in older age is complex. To begin with, Squire (2002) suggested that older people's experience of ill-health and dysfunction tends to be associated with chronic (longer-term), rather than acute (short-term) conditions. Lyketsos, Galik, Steele and Steinberg (1999), pointed to the likelihood of co-morbidity in older age, in which people tend to have more than one condition at a time. Further compounding complications can also arise from the side effects of multiple drug treatments prescribed to address a range of conditions. These combined factors variably impact on what determines a sense of physical well-being, such as being pain-free, being able to see or hear and to move from place to place (Craig and Mindell 2005), and an individual's sense of mental well-being.

1.3.2 Mental health and well-being

Lee (2006) and De Hert, Schreurs and Vancampfort (2009) highlight a frequent association between enduring physical ill-health and mental ill-health. Across the age spectrum from 18 to old age, in any one year, one in six adults are believed to have a mental health disorder (ONS 2000a). In epidemiological terms, these disorders are broadly split into two categories, *common neurotic disorders*, such as depression and anxiety and associated symptoms including obsessive compulsive disorder, phobia and panic attacks, and the more enduring *psychotic disorders* such as schizophrenia and bipolar affective disorder (*ibid*).

Predisposing factors to psychotic disorders in older age are complex. They include a history of juvenile psychiatric disorder or intellectual disability (Deb, Thomas and Bright 2001; Kim-Cohen 2003), low socio-economic status (ONS 2000a; Huxley and Thornicroft 2003; Lee 2006), perceived stressful life experiences, (Gomm 1996; Lee 2006), low levels of social support and reduced levels of independence (ONS 2000b), gender, with a higher susceptibility in women (Kohen 2000), and the negative attitudes of other people (Jorm 2000; Clarke 2005; DH 2008).

A number of studies in the late 1980s showed that depression was most common in older people (Morgan, Dalloso, Arie *et al.* 1987; Copeland, Dewey, Wood *et al.* 1987; Lindsay, Briggs and Murphy 1989), with the highest prevalence (40%) of clinical depression amongst older people living in residential and nursing homes. This factor highlights the importance of equipping care-givers with an understanding of the complexities of physical and mental health, and how their care-giving approaches affect the complexities of their clients' perceptions of health.

1.3.3 Dementia

The condition of dementia is currently labelled as an enduring psychiatric disorder alongside schizophrenia and other conditions associated with delusional states (Clarke 2005). In 2001, in order to address the well-being in people living with the types of conditions described above, the Department of Health published a number of National Service Frameworks (NSF). The Frameworks aimed to improve and standardise care and

treatment. One focused on the care of older people, another on people experiencing mental ill-health and a third focused on long-term conditions. Some reviews and evaluations of the NSFs stated that the mental health of older people fell between the remit of these documents, in particular, people experiencing the symptoms of dementia (Alzheimer's Society undated; Manthorpe, Clough, Cornes *et al.* 2005). This omission indicated a problem in how dementia is categorised. Although mental symptoms often parallel those seen in psychiatric disorders (Clarke 2005), most commonly irritability, agitation, anxiety, distress and dis-inhibition (Banerjee *et al.* 2006), unlike some other psychiatric disorders, the organic origins of dementia are recognisable.

The term 'dementia' is a generic description for various complex syndromes adversely affecting the function of the brain. In 1986, the World Health Organisation defined this group of syndromes thus:

Dementia is the global impairment of the higher cortical functions, including memory, the capacity to solve the problems of day-to-day living, the performance of learning perceptuo-motor skills, the correct use of social skills and control emotional reactions, in the absence of gross 'clouding of consciousness

(World Health Organization 1986)

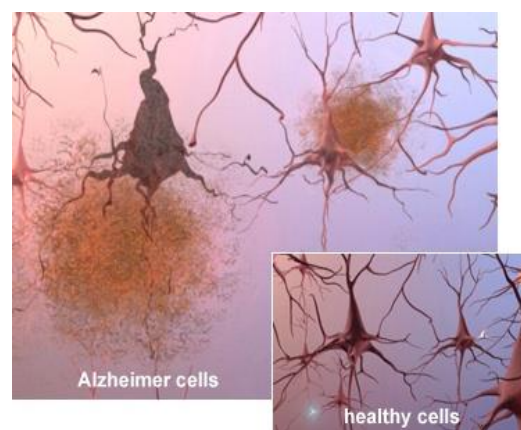
The main histopathology (microscopic detail of diseased tissue) shows widespread changes usually affecting different regions of the brain (Grabowski and Damasio 2004). These changes cause multiple dysfunctions in the higher cerebral cortex (Hale 2006). The consequences are difficulties in maintaining cognitive function, including thinking, orientation, comprehension and calculation, learning capacity and memory. Language and judgement are also commonly affected at some level (Warner, Butler and Wuntakal 2006). These symptoms are commonly experienced by people living with dementia and can act as clinical indicators of the condition when presented to health professionals.

The field of neurology currently identifies four main causes leading to these varied symptoms. The most common is *Alzheimer's disease* (AD), described by German-born neurologist, Alois Alzheimer, in 1906 and currently accounting for 55% of all symptoms of dementia in the UK. This is followed by *Vascular or multi-infarct dementia* (VD), *Parkinson's dementia* (PD), and *Lewy Body dementia* (LBD). Rarer causes of dementia

symptoms include *Huntington's Chorea*, *Creutzfeldt-Jakob disease*, which affects predominantly young and middle-aged adults, and *Frontotemporal dementia* (FTD) or *Pick's Disease* (Jones and Miesen 2004; Alzheimer's Society UK 2006).

Alzheimer's disease is described by the Medical Research Council as a 'progressive brain disorder that gradually destroys a person's memory and ability to learn, make judgements, communicate and carry out daily activities' (Medical Research Council 2006).

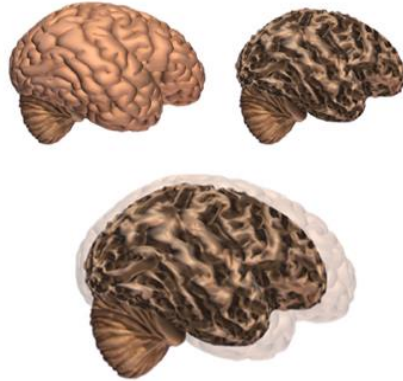
Fig. 1.3 Plaques and tangles associated with Alzheimer's disease



(Image source Alzheimer's Association 2008)

Figure 1.3 illustrates a comparison between healthy brain neurons and neurons affected by AD. In the latter, neurons become tangled with protein fibres called *tau*. The spaces between the fibres become filled with 'plaques' of beta-amyloid peptides (Rose 2003 p.337). These abnormal deposits disrupt cholinergic neurotransmitter (brain chemical) activity and destroy cells in areas of the brain known to control memory and mental functions (*ibid*).

Fig 1.4 Brain atrophy in Alzheimer's disease



(Image source Alzheimer's Association undated)

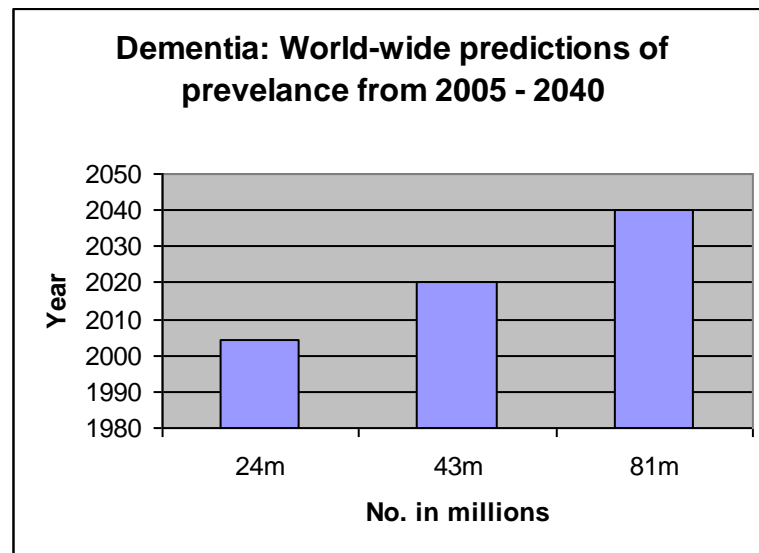
Figure 1.4 shows progressive brain atrophy (shrinking of brain tissue) which eventually becomes global (Bennett and Jones 2001).

1.4 The rise in the number of people living with dementia

1.4.1 Demographic predictions

In a major epidemiological study, Ferri, Prince, Brayne *et al.* (2005) estimated the numbers of people living with dementia across the six World Health Organisation regions. The study showed that around 24.3 million people were affected in 2005 with approximately 4.6 million new cases arising every year. Figure 1.5 shows that the numbers of new cases are predicted to double every twenty years. By 2040, 81 million people will be affected across the six regions.

Fig. 1.5 Dementia: World predictions of prevalence from 2005 – 2040



(Based on Ferri, Prince *et al.* 2005)

In the UK, the estimated number of people living with dementia in 1998 was 461,000 (MacDonald and Cooper 2007). In 2009, the number was over 750,000. Comas-Herrera, Wittenberg, Pickard *et al.* (2003) predict that the total number of people living with dementia in the UK will rise by 38% over the next 15 years and by 154% over the next 45 years. Assuming the continued trend in incidents, by 2051 over 1.7 million people will be affected.

Table 1.6 Age-related prevalence of late-onset dementia in the UK

Age	Female %	Male %	Total
65 - 69	1.0%	1.5%	1.3%
70 - 74	2.4%	3.4%	2.9%
75 - 79	6.1%	6.5%	5.9%
80 - 84	13.3%	10.2%	12.2%
85 - 89	22.2%	16.7%	20.3%
90 - 94	29.6%	27.5%	28.6%
95 +	34.4%	30.0%	32.50%

(Based on figures from Knapp, Prince, Albanese, *et al.* 2007)

Table 1.6 shows that risk is age-related, doubling with every five-year age increase across the entire range from 30 to 95+ (Knapp, Prince, Albanese, *et al.* 2007). This means that as the older population increases, so will the proportion of those with dementia.

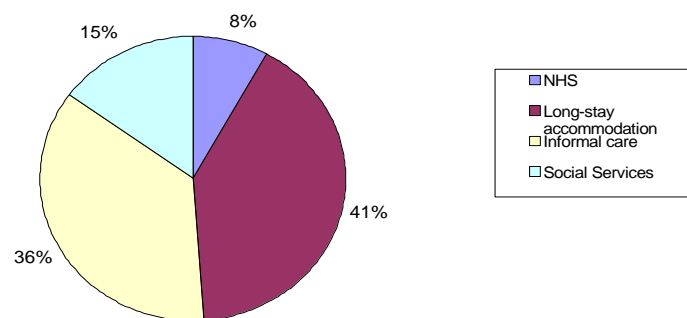
In addition, the proportion of people living in institutions will inevitably rise in both actual numbers and relative to cohort numbers. Knapp, Prince, Albanese, *et al.* (2007) reported that 55.6% of people aged 65 to 69 currently reside in institutions because of dementia. The figure rises to 64.8% in the 95+ age group. By 2031, the overall number of people living in institutions as a result of dementia is expected to increase by a further 63% (Comas-Herrera *et al.* 2003). In this case, the predicted rise in the UK older population will place very significant demands on the providers of health and social care. In particular, there will be a need for a large, adequately supported, sustainable workforce to care for a growing number of older people who are living with dementia.

1.4.2 The economic consequences of people living with dementia

The cost of caring for people living with dementia is significant. From the early 1990s, a number of cost models were produced by focusing on specific economic perspectives. Evaluation of the models provided important information on direct and indirect costs, such as the cost of medication (Stewart 1997), the relationship of cost and dependency (Gray and Fenn 1993; Livingston, Katona, Roch *et al.* 2004), comparisons of cost in different types of care settings (Kavanagh, Schneider, Knapp *et al.* 1995: 2007), the cost of caring for people aged 75+ (Stewart 1997), cost comparisons of different severity levels of Alzheimer's disease in people being cared for at home (Souetre, Thwaites and Yardley 1999), gender-specific cost variations between men and women aged 65+ (McNamee, Bond and Buck 2001), cost comparisons of formal and informal care (Schneider, Hallam, Islam *et al.* 2003) and a 40-month cost comparison of caring for people diagnosed with either Alzheimer's disease or vascular dementia (Wolstenholme, Fenn, Gray, *et al.* 2002). The work of Murray, Schneider, Banerjee and Mann (1999) provided an extensive economic evaluation of the experiences of 132 people living with cognitive change and their carers. Using a standardised inflation index, the authors mapped current costs and projected future costs. Their work was relied upon in an important report, *Dementia UK* (Knapp, Prince, Albanese, *et al.* 2007), which focused on

the people affected by dementia care in Britain today. The report showed that the cost of caring for people living with dementia in 2005/6, was £17.04 billion. The figures illustrate costs in terms of overall health and social care and included indirect costs such as calculated lost tax revenue from unemployed informal carers.

Fig 1.7 Percentage costs of long term accommodation



(Based on figures from Knapp, Prince, Albanese, *et al.* 2007)

Figure 1.7 shows the percentage of costs apportioned to long-term residential accommodation. In 2007, the estimated cost for caring for a person with severe dementia residing in a care home was £31,263 per annum (Knapp, Prince, Albanese, *et al.* 2007). Knapp *et al.* reported that the national cost of care is likely to treble over the next 30 years to reach £50 Billion by 2038.

1.5 Social perceptions of older people

In addition to the economic consequences of rising numbers of people living with dementia in the UK, Raeside and Khan (2007) predicted that the social impact will have far reaching implications across many facets of human life. The overarching view that society adopts of older people, and how they view older people living with dementia, is at some level bound to influence health industry workers' perceptions and behaviours, which, in turn, will ultimately determine the ease or dis-ease by which the former adjust to their changing circumstances.

Amongst many other commentators, Letvak (2002) and Bytheway (2005) emphasised the presence of pervasive negativity towards ageing and older people throughout British society at the beginning of the twentieth century. The phenomenon relates to the way in which society embraces age and ageing and the value that younger people place on older people and how these values might be expressed privately and in widely-accessed media.

In the late 1960s, American gerontologist, Robert Butler, coined the now familiar term, *ageism*. Butler defined the concept as 'a systematic stereotyping of, and discrimination against people because they are old' (Laws 1995 p. 112). Doty (1987) later redefined the phenomenon as 'thinking or believing in a negative manner about the process of becoming old or about old people' (p.213). Kimmel (1988) and Bytheway and Johnson (1990) suggested that these definitions are too straightforward. The authors developed considerably more complex definitions that emphasise an intricate range of cofactors such as stereotype categorisations and content, values of prejudice and perceptions and experiences of discrimination. Consideration of these cofactors is likely to lead to better expression of the complex psychology behind attitudes and behaviours of younger people towards older individuals.

In 2005, Age Concern England (ACE) stated that any degree of ageism is unacceptable, whether relatively mild, as in ageist captions in birthday cards, or severe, as in withholding medical treatment (ACE 2005). To gauge the extent and nature of ageism in the UK, the organisation conducted two empirical research studies, 'How Ageist is Britain?' (ACE 2005) and 'Ageism: a benchmark of ageist attitudes in Britain' (Ray and Sharp 2006). The first of these studies surveyed 1843 people aged 16 and over, who were asked how older people are viewed by society at large. One in three respondents said that the over 70s 'are viewed as incompetent and incapable' and more than 30% of people believed there is more prejudice now than five years ago. Thirty three percent felt that the demographic shift towards an older society 'would make life worse' (ACE 2005 p. 3) and just over 29% of people reported suffering age discrimination themselves (*ibid*).

Chasteen, Schwarz, and Park (2002) noted that the intensity and prevalence of ageism varies nationally and regionally within countries. Focusing on societies in which

fragmentation and *decentralisation* has occurred, Turner (1993) concurred with Parsons' (1951) earlier observation that the wide-spread collapse of faith as a single rationality, and its inherent value systems, which tended to include some form of support for older community members, played no small part in plotting social changes that were to prove detrimental. Other social and economic changes which occurred as a consequence of *fragmentation* and *decentralisation* from the mid-twentieth century, included the growth of social mobility, a rise in the number of women in work, and increased family wealth (Phillipson 2001). Phillipson suggested that these changes embodied the *functionalist* social theories of the 1950s and 1960s and the later *modernisation* theory of the 1970s (Cowgill and Holmes 1972). Such changes helped to place older people at the periphery of family relationships. McConatha, Schnell, Volwein *et al.* (2003) observed gender differentials relating to ageism, whereby women, whose role has changed more over time, are more likely to experience negativity towards ageing than men.

In the two ACE studies mentioned above, a significant number of respondents revealed benevolent attitudes towards older people, believing them to be considerably more moral, friendlier, more admired and equally as intelligent as younger people (ACE 2005; Ray and Sharp 2006). Gatz and Pearson (1989) however, argued that studies on ageism are problematic because the responses of participants, which are bound to their contextual cultural experiences, rely on how they imagine old age. Denmark (2002) observed that negativity towards older people is frequently based on flimsy assumptions about the experience of old age, which Denmark refers to as *myths of ageing*. Garrett (1990) discussed two social models of ageing that demonstrate Denmark's myth-conception. One, the *inevitability myth*, depicts older people as dejected and rejected. The other, the *tranquillity myth*, depicts older people as serene, contented and resigned. Neither view is helpful because of the implication that older people behave as one or two amorphous masses.

Cuddy and Fiske (2002) explain that myths of ageing develop from the human desire to understand that which is not easily fathomable, and the impulse of others to assign people into meaningful categories. These processes are fraught with psycho-social complexities that inevitably lead to the formulation of certain attitudes. Isaacs and Bearison (1986) and

Davidovic, Djordjevic, Erceg *et al.* (2007) and Robinson, Callister, Magoffin and Moore (2007) observe that whilst negative attitudes relating to ageing and older people are not generally present amongst very young children, attitudes form as a matter of course through discursive social practice from the time children enter formal education. Such practice is the prime conduit for influencing the way in which the identity of individuals or a group of individuals is perceived (Adams and Manthorpe 2003).

Seabrook (2003) suggests that the underlying psychology around ageism is connected to the journey towards death. The author observes that fear of death and the later stages of life leading to death, is both innate and embedded in most cultures. Turner (1993) refers again to the decline of religious faith and its coherent rationalisation concerning the after-life, from which people experience more uncertainty about infirmity and death and of what follows. However, with the exception of certain ideologies, such as neo-shamanism of the New Age movement (Boyce-Tillman 2000), the prevailing ideology of a youth-driven, capitalist system in the UK largely precludes a conscious contemplation of values associated with decay and death (Nelson 2002). In this case, the identity of older people is commonly constructed on an unconscious level by younger people who are rejecting the reality of their destiny. The process tends to lead to the marginalisation of the *evidence* of ageing, in this case, older people themselves. Cuddy and Fiske (2002) suggest that by keeping older people at a distance, stereotype-incongruent information is unlikely to be accessed by younger people. In other words, the less frequently young people are in direct contact with older people, the less likely they are to challenge discursive discourse that underpins ageism. In terms of care-givers of older people, who have day-to-day physical contact with their clients, distancing may be psychological.

1.5.1 Media representations of older people

Seabrook (2003) suggests that discourses that are likely to influence the formulation of views relating to older people have been affected over the past 50 years by 'a new dedication to the cult of living' (p. 71). Seabrook (2003) and Garrett (1990) observe that market-driven, youth dominated societies devalue older people increasingly the more sophisticated they become. Likewise, the access that younger people, including care-givers, have to modern-day media technology is completely unprecedented. Such

technology can act as a powerful mechanism for forming, changing and/or reinforcing stereotypical perceptions (*ibid*).

Healy and Ross (2002) examine the ways in which older people have been portrayed on television since the 1950s, suggesting that the number of appearances and type of role undertaken by older people have changed very little over the last half-century. Westerhof and Tulle (2007) suggest that older people today are often depicted on television as 'asexual, incompetent or having health problems' (p. 241). A study compiled on behalf of Age Concern and the Independent Television Commission investigated the portrayal and representation of people aged over 50 on television (Hanley and Webster 2000). The study showed that the dominant genres involving the appearance of older people were sit-coms and soaps, in which stereotypical portrayals, such as being deaf, confused or persistently lethargic, were common - likewise in factual programmes and advertising – and that 16-24 year olds were less likely to view these portrayals as negative compared to the 65+ age band. In response to the statement, 'When older people are shown in factual programmes, it is often in a negative way', 35% of the younger group agreed (vs 62% of the older group). Similarly, 49% of younger participants believed that older people's views were ignored, compared with 70% in the 65+ group. This discrepancy between the younger participants' beliefs about the experiences of older people and the older participants' self-reported experiences may have relevance for care-givers of older people, particularly for older people who have difficulty expressing their responses, desires and needs.

A number of other media-related factors can engender difficulties for people to distinguish between aesthetic and moral judgements relating to older people (Turner 1993). Firstly, an imbalanced media perspective that presents stories in a way designed to attract an audience has resulted in an increasing amalgamation of mythical, political and science-supported ideologies. This can result in confusing representations of older people (Sweet 2006). Secondly, ageist humour, now a sub-speciality in the study of ageism, reinforces the idea that older people are not part of the main social gang (Palmore 2005). Thirdly, the media undoubtedly perpetuates the notion that youthful beauty is positive whilst ageing and old age is to be fought against. This concept is proliferated by the media's gradual rejection of some super-celebrities as they age.

The allied relationship between the media and the global growth of capitalism may also have an impact on younger people's views of older people. McDonald (2004) observes that a consequence of materialism is the presence of social comparisons. The desire to conform to an increasingly fast-flow accumulation of material goods can lead to 'immunity to larger ethical sensibilities' (p. 69). Such social models arguably fail to induce sympathy for older citizens who, for various reasons, may play less of a part in a fast-flow materialistic system.

Writing on behalf of The Mental Health Foundation and Alzheimer's Society, Williamson (2008) reported on media representation of people with living with dementia. The report suggested that negative images of people in late-stage dementia were the most frequently seen. Images of people 'dribbling and nodding' should be replaced with people 'just getting on with it, after diagnosis'. (p. 46). Prominent media personalities have since presented a more positive media profile of dementia, including Tony Robinson's TV programme about his mother and programmes about Norman Wisdom and Terry Pratchett. The portrayal of a person living with dementia in the radio soap, *The Archers* provided a realistic, extended story line in which the character's general level of cognition plateaued for a long period, within which he experienced good and bad days.

1.5.3 Perceptions of people with poor mental health

If perceptions of old age present problems in terms of the well-being of individuals and societies, stereotypical perceptions of people with poor mental health are arguably even more insidious.

The term 'social exclusion' is omnipresent in social health and policy documents that aim to improve the quality of life for people who are discriminated against. In this context adults with long-term mental health problems are one of the most excluded groups in society (ODPM 2005). The phenomenon flies directly against the ideology of the National Mental Health Institute's rationale for de-institutionalisation of people with mental illness in the 1960s and 70s (Anthony 1993), in which integration and inclusion were the prime intended outcome.

The late Professor Tom Kitwood discusses historic cultures of care in the UK that have contributed to present day perceptions of people with mental ill-health. Starting in the seventeenth century, when commercialism began its rise, social 'misfits' who were unable to contribute to productivity and trade were increasingly taken out of societies and placed in institutions (Kitwood 2004). Kitwood cites the seminal work of French philosopher, Michael Foucault who, in his publication 'Madness and Civilisation', described three main phases of this 'great confinement', *bestialisation*, *moralisation* and *medicalisation* (Foucault 1967). The phases span three hundred years and variably treated people as animals, caged and paraded in public, to needy recipients of benevolent treatment and re-education. The third phase of *medicalisation* laid the foundation for current perceptions of mental ill-health which assigns it to 'non-conformity' in relation to social norms (Kitwood 2004 p.7).

1.5.4 Perceptions of older people living with dementia

Marshall (2006) observed that older people living with dementia are usually twice negatively labelled as a result of ageist attitudes in the UK and stereotypical attitudes towards mental ill-health. In the same way that perceptions of mental ill-health relate to other people's view of social norms, people displaying the symptoms of dementia are likely to induce certain judgements. Langdon, Eagle and Warner (2007) described how 12 men and women living with dementia viewed other people's reactions to them. All 12 were anxious to appear in control to avoid being judged as abnormal. Some participants pointed out that the medical labels, *dementia* and *Alzheimer's*, elicited preconceived judgements that emphasised the condition, rather than them as individuals. This, and difficulties in how and when to disclose their condition in private and public and dealing with subsequent reactions, frequently led to social exclusion. The study's participants reported that these problems impacted negatively on the relationships that they had with the other people with whom they shared their world.

Kitwood (1997) recognised a spectrum of attitudes towards people living with dementia. The worst-case scenarios elicit negative assumptions about (dis)ability and incompetence (Werner 2006) and can cultivate what Kitwood describes as, 'malignant social psychology' (p.46).

Such psychology adds to the challenges of living with dementia because of other peoples' negative attitudes (Bell and McGregor 2004).

1.6 The implications of social perceptions on policy and practice for people living with dementia in the UK

Marshall (2006) highlights the challenges of achieving positive changes in health care environments when health professionals and care givers remain influenced by negative attitudes in the wider society. Other commentators have also observed a relationship between stereotyping in a society and damaging attitudes and behaviours in the healthcare industry (Grimley-Evans 1997; Adams and Manthorpe 2003 p. 4; Nemmers 2004). Weir (2004) pointed out the importance of identifying the roots of negative attitudes, which, where present, have usually existed before a healthcare professional and/or worker enters the industry.

Understanding the perceptions and experiences of people who are living with any debilitating condition has the greatest potential to positively influence health and social care policies that is designed to support them. Indeed, Hubbard, Downs and Tester (2003) and Sherratt, Soteriou and Evans (2007), amongst others, highlight the importance of including people who are experiencing the reality of living with dementia in research that is designed to shape policy and practice in this field. However, despite the growing body of dementia care champions who are challenging pre-conceptions about the condition, there remains a perception that this group of people are unlikely to be able to express themselves coherently. In the absence of a strong voice, Innes (2002) observed poor political interest in the care of people living with dementia historically.

Current perceptions, attitudes and practice, which arguably continue to do too little justice to the lived experiences of people living with the dementia, can be traced back to the work of Sir William Beveridge (1897-1960). Beveridge aspired to address some of the challenges associated with their care. His Social Democratic health and social reforms of 1942, and the subsequent National Health and National Assistance Acts of 1946 and 1948, heralded a system which made clear a distinction between *health* and *social* need. The

distinction was crucial in terms of allocating subsistence because people needing health care were treated free of charge (Section 21 of The National Assistance Act 1948), whilst social care was a purchasable service. At the time, the National Assistance Act envisaged people with senile dementia as having *health* needs. Responsibility therefore lay with the NHS. Then, as now, the burden was considered to be financially insurmountable (Glasby and Littlechild 2004). As the embryonic welfare state struggled to adequately address issues of care for older people living in states of confusion, the 1947 Committee of Enquiry, chaired by Seebohm Rowntree, offered some solution in placing ‘senile dements’ in large asylums (Dalley 1998).

In the presence of ambiguity between the *health* and *social* needs of this group of people, tensions arose around responsibility for care. The Minister of Health from 1952 to 1955, Iain Macleod, described older people with long-term mental health needs as becoming stranded in no man's land (Glasby and Littlechild 2004). Often an individual was not sufficiently sick to justify admission to hospital and yet too disabled for placement elsewhere (Warren 1951). Means and Smith (1998) suggest that the care of the senile was never satisfactorily addressed during the 1950s.

In the UK, post World War II, social reform had been increasingly dedicated to the provision of a common safety net with which the Government aspired to support all needy members of society (Glennerster 1996). A range of community care reforms during the 1960s, 70s, 80s and 90s contributed to the emergence of the present day proposition for integrated, cross-agency services. These included, for example, the *Mental Health Act*, 1959; *The Hospital Plan*, 1962; the White Papers *Better Services for the Mentally Ill*, 1975 and *Caring for People: Community Care in the Next Decade and Beyond*, 1989; the *National Health Service and Community Care Act*, 1990 and *Report of the Royal Commission on Long Term Care of the Elderly*, 1999. However, despite contemporary aspirations of collaborative health and social support for people living with dementia today, the provision of services continues to suffer from lack of clarity over the responsibility for economic resources.

At the beginning of the twenty-first century, a report compiled for the Department of Health illustrated the continued challenges:

If patients are to receive the best care, then the old divisions between health and social care need to be overcome.The NHS and social services do not always work effectively together

(DH, 2000 p.70)

This demonstrates the perpetuation of Iain Macleod's analogical 'no man's land', described over 50 years previously.

In response to the predicted rise in the number of people living with dementia, a growing number of statutory and non-statutory workforce directorates have embarked on evaluative research to assess the efficacy of current-day dementia services in order to plan and inform strategic policy and practice in the future.

Table 1.8 (a) Examples of documents from statutory organisations concerned with strategic policy and training

Agency	Domain	Publication	Date	Outline
Department of Health	UK	<i>Assessing older people with dementia living in the community. Prractice issues for social and health services</i>	1996	Highlights issues of care responsibilities and multi-agency collaboration in care planning
Department of Health	UK	<i>At home with dementia</i>	1997	Evaluates arrangements and services in place to support and maintain community living in eight local authorities across England
Association of Directors of Social Services <i>et al</i>	National – England and Wales	<i>Forget Me Not. Mental Health Services for Older People</i>	2000	Compares data on commissioning and delivery methods and resourcing of services
Office of Fair Trading	UK	<i>Care Homes for Older People in the UK: A market study</i>	2005	Evaluates quantitative measures in relation to growing demand of care home place
National Institute for Health and Clinical Excellence	UK	<i>Dementia: Supporting people with dementia and their carers in health and social care</i>	2006	NICE Clinical Guideline 42 report for health professionals
Bamford Review of Mental Health and Learning Disability (Northern Ireland)	Northern Ireland	<i>Living fuller lives: Dementia and mental health issues in older age</i>	2006	Reports on sustainable practice in dementia care in view of demographic changes
Royal College of Nursing	UK	<i>Meeting the health needs of people with learning disabilities</i>	2007	Training resource guide for nursing staff.
Department of Health	UK	<i>Living well with dementia: A National Dementia Strategy.</i>	2009	Strategy document prioritising 17 core needs in the care of people living with dementia

Table 1.8 (b) Examples of documents from non-statutory organisations concerned with strategic policy and future practice in dementia care

Agency	Domain	Publications	Date	Outline
Alzheimer's Disease International	International	<i>Influencing Public Policy</i>	2000	Public activist document aiming to assist public members to campaign for rights
Dementia Voice & University of the West of England, Bristol (DCDS network)	Regional: South West England	<i>Serving the needs of marginalised groups in dementia care: younger people and minority ethnic groups</i>	2002	Report examining the needs of people under 65 with dementia and black and minority groups
Alzheimer's Society (Personal Social Services Research Unit, London School of Economics and Institute of Psychiatry at King's College, London)	UK	<i>Dementia UK</i>	2007	Detailed report on prevalence and current and future costs of dementia caregivers
Alzheimer's Scotland Action on Dementia	Scotland	<i>Dementia Epidemic Report</i>	-	Report on strategies needed to manage or reduce predicted increase in dementia
Age Concern England	England	<i>Supporting People with Dementia</i>	2008	Training manual for care staff

Table 1.8 (c) Examples of documents from academic and research bodies concerned with the management of dementia

Agency	Domain	Publications	Date	Outline
Bradford Dementia Centre, University of Bradford (Brooker and Wooley 2004)	UK	<i>Enriching Opportunities for people with dementia in specialist Nursing Homes: Unlocking potential, searching for keys.</i>	2004	Report contributing to on of a range of training resources entitled <i>Guidelines to Practice Manuals</i>
Alzheimer's Research Trust 1. Ballard et al. (2005)	International	<i>1. Quetiapine and rivastigmine and cognitive decline in Alzheimer's disease</i>	2005	1. Randomised double blind placebo controlled trial evaluating drug treatment efficacy
2. Fossey et al. (2006)		<i>2. Effectiveness of psychosocial care on anti-psychotic use in nursing home residents with severe dementia</i>	2006	2. Cluster randomised trail evaluating non-drug interventions by staff
Dementia Services Development Centre, University of Stirling	UK	<i>Best Practice in Design for People with Dementia</i>	2007	Training resource document to maximise environmental factors

Tables 1.8 a, b and c give examples of documents compiled by, or on behalf of statutory agencies, non-statutory agencies and academic and research organisations in the UK over the past decade. Collectively, these documents focus on health and social welfare policies, strategic planning, efficacy of treatments and management, education for healthcare workers and information for the public.

The most recent national document, The National Dementia Strategy, was published in February 2009. The title of the strategy is 'Living well with dementia' (DH 2009). The focus of the document is on enabling people living with dementia to live a full and satisfying life, which is enabled by the provision of effective care for the person themselves and their carers. The strategy makes recommendations for reducing drug therapy by exploring alternatives therapeutic support mechanisms. This includes the use of the arts. However, the mechanisms to implement and sustain therapeutic arts in these settings are not made clear.

Chapter One Summary

The evidence examined in this chapter has shown that there is an aspiration at policy level to improve social attitudes towards older people and those living with dementia. However, the evidence also demonstrates that long-established negative social attitudes towards these two groups of people can perpetuate unyielding stereotyped reactions that are grounded in perceptions of economic, social and healthcare burden. Older people living with dementia may find themselves at the heart of tensions created by the wish to improve their social status against the perceived challenge of resourcing their fast-growing number. The evidence suggests that these tensions might extend to approaches to care-giving, which are themselves shaped by the presence of cultural norms in the wider society.

Chapter Two

Caring for people living with dementia

This chapter will critique the current provision of care for people living with dementia from a range of different perspectives of health. It will examine how historical and contemporary concepts of health have influenced health and social care over the last three decades and how those changes have affected the care of people living with dementia.

2.1 Caring for older people with dementia

Most people living with dementia are cared for at some level by an informal (unpaid) carer. At some point, support is also likely from a range of health professionals and health workers from primary, intermediate and end-of-life care disciplines. This may include hospital consultants, general practitioners (GPs), registered nurses and qualified and non-qualified care-givers. In addition, allied healthcare professionals, such as occupational therapists, physiotherapists and clinical psychologists, and management personnel from social services may be involved in an individual's care programme. For clarity within this thesis, doctors, nurses and allied professionals will be referred to as 'healthcare professionals'. Other paid healthcare workers, such as care assistants, will be referred to as 'care-givers', and unpaid, informal/family care providers will be referred to as 'carers'. The body of people working in care settings for older people living with dementia will be referred to collectively as 'care staff'.

2.1.1 Care settings for people living with dementia

A large proportion of the care provided for people living with dementia in the UK today takes place at home (Thompson, Spilburg, Hall, *et al.* 2007). When this is no longer tenable, a range of formal services outside the home are provided by NHS Trusts, local authorities, the independent private sector and voluntary and charitable organisations (Valins 2002). Services include day-care centres that provide help with personal and recreational activities in a social setting, sheltered housing, which offers on-call assistance if the necessity arises, 'adult placement', whereby people are placed with selectively

matched care-givers in the care-giver's home, and institutional residential care, which variably provides respite (short-term) or continuing care residencies (Valins 2002; National Audit Office 2007).

Residential care is provided variably by local authorities, private organisations or individuals, and/or charitable/voluntary organisations. An audit of continuing care homes for people living with dementia in the UK in 2005 showed that 76% of the care homes were run privately for profit, 15% by voluntary organisations, and 9% by local authorities. This all but reverses the trend of forty years ago when in 1976, 64% homes were managed by the local authorities (MacDonald and Cooper 2007).

2.1.2 Residential care settings

In lay terminology, *residential home* is often used as a generic description for assisted-living establishments in which, in this case, older people reside. However, until 2002, under the mandate of the Registered Homes Act 1984, the term related to a care home registered under Part I of the Registered Homes Act 1984. These homes provided residential accommodation with board and care-givers to help with personal care, such as washing and dressing and taking medication (OPSI 1991). *Nursing homes*, by contrast, were registered under Part II of the Registered Homes Act 1984. The more frequent levels of inspection assigned to nursing homes, and the higher ratio of registered nurses compared with *residential homes* related to the personal and additional nursing needs of clients (Nazarko 2002).

In order to accommodate people living with enduring mental ill-health, under which the condition of dementia falls, *residential* and *nursing* homes could also apply for Elderly Mentally Infirm (EMI) registration. However, the frequently complex inter-related health and social needs of people living with dementia resulted in a blurring of these category distinctions (Ford 1998). This led to perceptions that people living with dementia were seen as 'challenging' in terms of care setting placement (*ibid.*).

2.1.3 Standards of care homes 1984 – 2001

Care services are underpinned by the professionalism of staff, whose various levels of experience and qualifications determine their roles and level of responsibility. Up to 1984, less than clear governances over care procedures meant that staff roles were defined on a local level within each care setting. Lack of clarity in terms of distinguishing levels of disability or the needs of clients, and poor differentiation between nursing and residential homes often resulted in inappropriate services (Dalley, Denniss 2001). In response, since 1984, statutory governance and regulations have attempted to standardise the care for older people living in residential establishments. At this time, the CPA published the first standards guidance for care homes in England. The document, entitled *Home Life, a code of good practice*, was adopted by the Government as the official guidance for the inspection of care homes under the Registered Homes Act 1984 (CPA 1984).

The subsequent *NHS and Community Care Act 1990* heralded aspirations for a new system of care, which centred on independent community living for people affected by age and/or disability (Angunawela, Barker and Nicholson 2000). In long-term care for older people, clearer definitions and better categorisation of residential facilities through improved systems of assessment of clients' needs were proposed. Crawford, Beringer and Stout (1999) referred to the success of the reform in terms of more appropriate care for individuals in relation to dependency. Although the emphasis of the Community Care Act was on the maintenance of independent living, Crawford *et al.* (1999) highlighted an increase in the number of people admitted to residential institutions from 1993, which, the authors suggested, related to better assessment of unmet need.

With the number of older people living in institutions increasing, the Department of Health commissioned two key documents to formalise codes of practice. The first, *A Better Home Life: a code of good practice for residential and nursing home care*, published in 1996, reflected major proposed changes in all aspects of continuing care for older people. The impetus was the recognition of people's fundamental right to be treated as individuals and to be treated with dignity and respect.

The document stated:

Whatever their age, whether sound in mind and body or experiencing disability, residents have a fundamental right to self-determination and individuality. Equally, they have the right to live in a manner and in circumstances which correspond as far as possible with what is normal for those who remain in their own homes

(CPA 1996 Section 2.1)

A second document, published in 1998, entitled, *Fit for the Future*, heralded a new set of statutory national standards relating to the care of older people living in residential and nursing homes.

2.1.4 Standardising care in care homes from 2001 onwards

Fit for the Future formed the basis for the current *National Minimum Standards for Care Homes for Older People* [NMS] (DH 2001b) published by the Secretary of State under section 23(1) of the Care Standards Act 2000, which came into force in April 2002. The Act ended the distinction between residential and nursing homes in relation to inspection mandates (Nazarko 2002). Standards of care, and inspection to ensure compliance, now applied equally to all homes. Thirty eight individual Standards, which focused on the environment, staffing, health and personal care, complaints and protection procedures, management and administration issues aimed to provide guidance on maintaining residents' quality of life (Parish 2001).

The NMS stated that all continuing care settings should aim to enable residents to achieve positive outcomes relating to their physical, intellectual, spiritual, emotional and social endeavours even when they have a progressive condition such as dementia (DH 2001b p. ix). The central mechanisms for achieving these positive outcomes were the proposed provision of resources and activities that safeguard the health, welfare and quality of life of service users (*ibid*).

Judging the outcomes of these Standards is complex. Parish (2001) pointed out that some Standards are suited to quantitative measures. For example Standards 19 to 26, refer to specifications relating to the physical environment, such as minimum measurements of

‘usable floor space’ per resident. In this case, assessing compliance is simple. The assessment measures of other Standards, however, are necessarily qualitative due to their conceptual nature. In these cases, perceived fulfilment is often a matter for an individual’s own judgement. For example, residents are asked to self-report on a set of indicators relating to Standards 7 to 11, which apply to issues of privacy and dignity:

- How am I treated by staff when they are bathing me and helping me dress?
- How do they speak to me?
- Am I consulted on matters to do with my own care and matters that concern residents as a whole?
Are my wishes taken into account?
- Are my wishes respected?
- Are my views taken into account?
- Do staff regard me as real person with desires, hopes and expectations just like them?

(DH 2001b p. 8)

Despite this apparent aspiration for residents’ self-reporting quality-of-life (QOL), a report published by Joseph Rowntree in October 2008 on care in residential homes acknowledged a continued paucity of appropriate QOL measures that reflect the resident’s voice (Joseph Rowntree 2008).

In terms of people living with dementia, measuring care outcomes based on subjective responses may present even more of a dilemma, not least in terms of ensuring authenticity of responses (McCarney, Warner, Iliffe *et al.* 2007). Firstly, compliance may occur, in which a person may give an answer that he or she perceives to be the right one. Secondly, the social constructs of politeness may affect responses, or in the case of residents living in care settings, a sense of loyalty towards the care settings and/or care-givers. In addition, residents may feel vulnerable and/or fear negative consequences if appearing to criticise. Lastly, the phenomenon of institutionalisation may skew perceptions of truth due to the creation, acceptance and normalisation of certain concepts and behaviours. For people living with dementia, the capacity to coherently challenge the system may be further impaired because of the perception of limited understanding. In this case, the assessment and recording of QOL issues are often undertaken by staff (DH 2001b) who in turn are

bound to the macro and micro institutional cultures, the presence of social norms and his or her professional and personal life experiences.

The National Minimum Standards acknowledge the limitations of addressing the widest range and diversity of clients' needs. To this end, the document sets out guidance for staff quota, training and qualifications. The UK benchmark currently recommends a staffing quota for residential homes of 16 care assistant hours per resident, per week (no nursing staff) as set out by the National Care Standards Commission (NCSC) (Laing 2002). The recommended staffing quota for nursing homes is 8.1 qualified nurse hours and 18.9 care assistant hours per resident, per week (*ibid.*). According to the NCSC, care hours can be amended to meet local commissioning requirements. This means that individual homes can rationalise staffing levels under or over the benchmarks. As staff wages absorb between 45 – 60% of care home fees, there is a clear economic consideration, particularly in the case of for-profit homes (*ibid.*).

It may be argued that challenging financial factors can impede adequate staffing levels, which can negatively affect valid and safe practice in the care of people living with dementia. However, these financial factors are likely to have been driven by the presence of perceived healthcare norms and expectations, which are formed through established models of health and healthcare.

2.2 Models of health for people living with dementia

The first health professional that people usually access at a point of crisis is their local General Practitioner (GP). How a GP responds is underpinned by their philosophical perspective of medical practice which is influenced by their preferred model of health. It is likely, however, that once a person living with dementia is in the healthcare system, assigned biomedical labels will determine, to some large extent, the way they are perceived by health professionals and the society at large and this in turn will shape the type of care they receive.

Bates, Boote and Beverly (2004) described two main approaches to treating and caring for people living with dementia in the UK, the bio-pharmacological, or bio-medical model, and a range of alternative models, which include bio-psychosocial and psycho-social models (Earle 2005). The latter encompasses fringe models such as the humanistic model and the salutogenic model (Seedhouse 1986).

2.2.1 The biomedical model and its role in caring for people living with dementia

Over at least the last three centuries, health care in the UK, including the formalised care of people living with dementia, has been dominated by a biomedical model of health. The model is grounded in *positivism* in which only that which is scientifically quantifiable is an acceptable basis for diagnosis, treatment and management. Traditionally, proponents of the biomedical model have dismissed as superstition the intangible or mysterious (Alderson 1998).

Emanating from the extensive influence of Hippocrates' scientific model of the fourth century B.C. (c. 460-370 B.C.), the biomedical model encompassed *mechanistic* notions of the physical body and *reductionism*, which related to a focus on discrete body functions, such as the heart or endocrine system. These *positivist* concepts were reinforced significantly through the centuries by, for example, Galen (131-201 A.D.) and his dogma of realism in human function and William Harvey's discovery of the blood circulatory system (c.1628) (Berger 1999).

Five years into the twenty-first century Earle (2005), amongst others, observed that the biomedical model continues to dominate health practices in the UK, and remains grounded in *positivist* evidence-based research. The biomedical model upholds the single premise that *illness*, described by Wade and Halligan (2004) as *sensations of disease*, always has a causal relationship with *positivist* health measures relating to: pathology, the nature of organs and tissues; biochemistry, the components of bodily fluids; and physiology, the processes of body-systems, such as the nervous system. From a biomedical perspective, the symptoms associated with the range of conditions collectively termed 'dementia' are largely considered through the examination of *positivist* health measures.

Illustrative Case Report No. 1: Health Professionals management of people presenting with possible dementia

Consultant Physician - *'Sometimes people present with query cognitive impairment but all they are is severely absent minded. It's a bit of an age thing. It doesn't mean they're demented. You get people like that. They still score 10 out of 10 [of Abbreviated Mental Test] so by definition they cannot be demented. If they can come back with who's the prime minister it's just absent mindedness or an age thing. But we always examine them of course. Do a few bloods, make sure they're not hypothyroid; we do B12, full blood count; kidney, liver function; blood glucose.'*

Researcher - *Would you think of a pathological cause first?*

General Practitioner – *'Yes; syphilis, anaemia.'*

Consultant Physician – *'I'd test for glucose; electrolytes. That kind of thing. And then a thorough neurological examination and any whiff of a physical sign, they get scanned.'*

(By kind permission from the commentators)

A conversation between the author of this thesis and two colleagues, a General Practitioner and a Consultant Physician, illustrated their emphasis on *positivist* measures in the diagnosis of a person with possible dementia (Case Report No.1)

Current-day policies on the care of people living with dementia advocate the wider use of these mechanisms for early diagnosis to enable appropriate drug interventions and referral to a growing range of support services (DH 2009).

2.2.2 Drug therapy for people living with dementia

One of the most significant economic factors of the biomedical model is revenue generated by the multi-billion-pound pharmaceutical industry. Jones and Miesen (2004) suggested that the biomedical approach to people living with dementia places the condition of dementia in terms of a major health catastrophe. Amidst aspirations for change to a non-drug dependent culture drug therapy for people living with dementia is rationalised as effectively slowing catastrophic changes in the early to mid-stages of the condition, and in alleviating distressing neuropsychiatric behaviours in the later stages (Cohen-Mansfield 2001; Sink, Holden and Yaffe 2005; Ayalon, Gum, Feliciano and Areal 2006).

Figure 2.1 Range and type of anti drugs used in the UK		
Drug type	Examples	Benefit
Pre-morbid stabilisers	Anti-hypertensives, Anti-thrombotics, Cholesterol lowering agents, insulins	Drugs used to prevent or delay the onset of dementia by controlling blood pressure and cholesterol levels, preventing blood clots and stabilising diabetes
<i>Acetylcholinesterase</i> (AChE) inhibitors	Donepezil, Galantamine, Rivastigmine	Drugs administered to people with mild to moderate-stage dementia to slow the rate of decline by boosting levels of a group of signal transmitters in the brain known to gradually diminish in dementia
<i>N-Methyl-D-Aspartate</i> (NMDA) receptor antagonists: <i>Glutamate</i> stimulants	Ebixa	Drugs used in the later stages of dementia to support the production of <i>glutamate</i> , important in learning and memory
Psychotropic drugs	Risperidone, Olazipine	Drugs used to address neuropsychiatric symptoms associated with dementia, such as anti-depressants, mood stabilisers, hypnotics (sedatives) and antipsychotics.

Figure 2.1 shows an example of the range and type of drugs prescribed for people living with dementia, which were, and/or are, legitimately prescribed to help to alleviate distress (Banerjee 2009). In the early stages, drugs called *acetylcholinesterase* (AChE) inhibitors can support neurotransmitter processes in the brain that are critical in processing and controlling sensory information, memory storage and retrieval (Darton 2006). The *N-Methyl-D-Aspartate* (NMDA) range of drugs may be used in the later stages of the condition to stimulate the amino acid, *glutamate*, which is implicated in learning and memory. Other drugs are used to control pre-morbid conditions with a known link to dementia, such as hypertension (high blood pressure) and cerebral vascular accidents (stroke) (Griffith and Arnold 2005).

Since the start of the twenty-first century, controversy around the true benefit of drug therapy prompted wide-spread discussion amongst clinicians and researchers globally, with debate accelerating to a peak during 2005/6 (Wilcock, Lilienfeld and Gaens 2000; Clegg, Bryant, Nicholson, McIntyre, *et al.* 2001; Fajemisin 2002; Chiu and Jeste 2006; Pelosi 2006). The weight of scepticism around the efficacy of AChE inhibitors in the UK meant that in June 2006, amid strong objections from pro-drug campaigners such as

Action on Alzheimer's Drugs, the National Institute for Health and Clinical Excellence (NICE) made public its decision to control NHS prescribing. A new policy meant that prescribing criteria were based entirely on a standardised clinical assessment test known as the Mini Mental Score Examination (MMSE) (Folstein, Folstein and McHugh 1975). Drug therapy was restricted to people measuring a score of between 10 and 20 points on the test. Further, the NMDA drug, Memantine (Ebixa), commonly prescribed to people with moderate to severe dementia pre-NICE guidelines, was not recommended due to inadequate evidence of effect and for reasons of cost-effectiveness (Chiu and Jeste 2006).

Despite action from pro-drug campaigners, such as the Alzheimer's Research Trust (ART), which published a report suggesting that NICE's decision was 'seriously flawed' and even 'unethical' (Alzheimer's Research Trust 2006 p. 1), advocates for limiting the use of drugs for people living with dementia, argue strongly for their overall negative benefits. Bottiggi *et al.* (2006) argued that too few clinicians were aware of potentially contradictory effects of AchE inhibitors on executive brain functioning² and psychomotor speed when prescribed long-term to older patients. The British National Formulary (BNF) also warns of side effects of this group of drugs in longer term use with older people. These include hypotension (low blood pressure), exacerbation of Parkinson's and cardiac problems, such as bradycardia (low heart rate) (BNF 2006 p. 269/10). Side effects of NMDA receptor antagonists, used in the later stages of dementia, include psychosis, depression and a tendency towards suicidal feelings (*ibid.*). Speaking at the Tenth Dementia Conference, Dr Peter Bentham pointed to the ambiguity of findings on the efficacy of psychotropic drugs for controlling behaviour (Bentham 2008). Bentham advised that overall, the avoidance of drug therapy for people living with dementia is desirable.

The drug-benefit debate, which is argued strongly by both pro and anti-campaigners, illustrates the complexity of biomedical management for people living with dementia.

² Functions most commonly linked to the frontal cortex controlling the processes of how information is stored and retrieved from memory; planning, multitasking, and remembering delayed intentions (prospective memory) (ref)

2.2.3 The need for a broader picture of health for people living with dementia

Shuval (2006) argues that care-giving in formal care settings is likely to be framed within task-orientation systems, involving routine and regimentation that is driven by the biomedical model. However, in terms of caring for people living with dementia, Innes (2002) draws attention to the models' limitations as it provides little support for engendering insight amongst care staff into the day-to-day *experience* of living with the condition.

Problems associated with people expressing the experience of ill-health arise partly due to the relationship they have with healthcare professionals, the attitudes they have towards the biomedical body of knowledge and healthcare institutional cultures. Jones and Miesen (2004) observed that these relationships prevail out of a need for people to resolve uncertainties. Stainton Rogers (1991) Young (1980) and Taussig (1980) critiqued the relationships from an anthropological perspective. All three authors expressed unease in how norms relating to diagnoses and treatments in the biomedical model are formulated and unquestioningly accepted by the professionals, and recipients of care, as reflecting facts of nature (Young 1980 p. 136). The biomedical model also negates any responsibility for healing from the patients' perspective, rather, it is placed firmly in the hands of health professionals (Seawood 2009). Friedson (1970) suggested that this elevates the status of health professionals and assumes their superior knowledge of nature, to which patients readily submit. Taussig (1980) argued that the language of biomedicine reproduces political ideologies in the guise of science. Lyng (1990) concurred with this premise relating it to all knowledge systems and their predilection for supporting some ideological interests and undermining others. Lyng argued against the biomedical model logic which accepts the practitioner as the healer and patient as a passive recipient. Lyng observed that this is not the most effective approach to support an individual's health and well-being.

Snowden (1997) neatly demonstrated the need for a fusion of health models by using a bio-medical procedure to highlight problems of basing the management of dementia care purely on bio-medicine. The author showed that at post-mortem, degeneration of brain tissue of a person with dementia did not always correlate to his or her expression of

cognition before death. Snowden concluded that some people may have protective factors that resist the expression of physical brain disease. This presents a situation whereby medical professionals sanction care based on science rather than complex co-factors that affect the way in which an individual perceives their condition and lives their lives accordingly. In their tellingly entitled paper 'Specialists without spirit: Limitations of the mechanistic biomedical model', Hewa and Hetherington (1995) suggest that the biomedical model is incomplete or even useless in terms of addressing quality of life. Froggatt (1995) endorsed this viewpoint, observing that whilst the biomedical model offers technical solutions, it ignores human skill, insight and warmth.

The argument that a state of health cannot always be expressed in terms of pathology, chemical or physiology, strongly suggests the presence of complex psychological processes that underpin an individuals' sense of health or ill-health (Ader 1980). Schneider and Conrad (1983) pointed out that the experience of illness elicits a complex continuum of moral consequences that influence the way in which people take ownership of abnormalities and how they are defined and re-defined by themselves and by observers.

Figure 2.2 Model of illness (Wade and Halligan 2004)

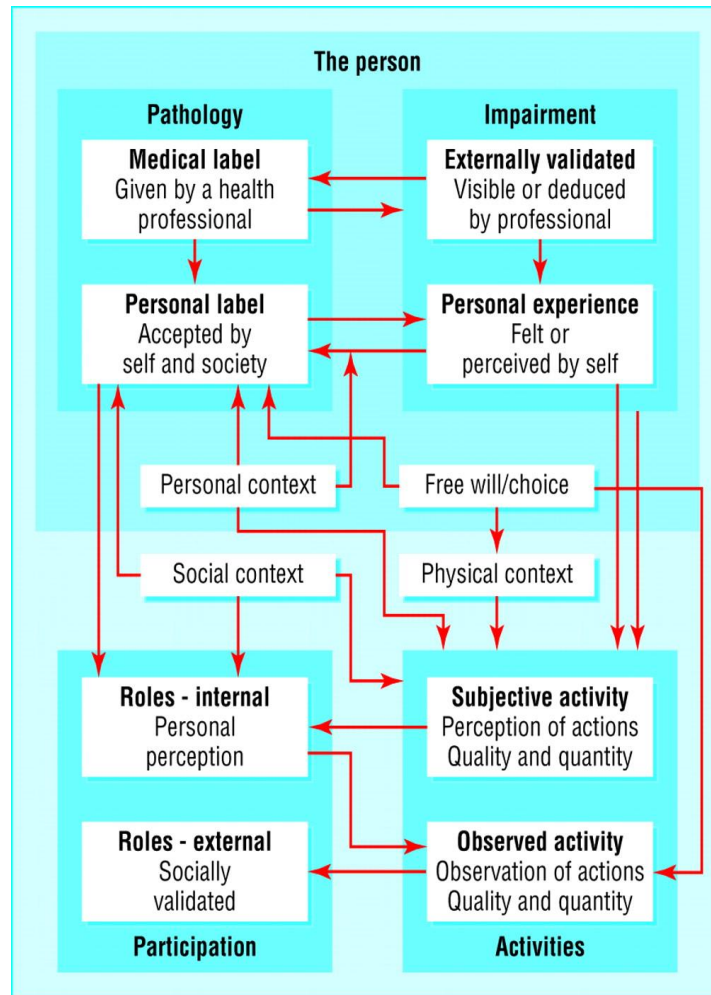


Figure 2.2 shows Wade and Halligan’s (2004) model of illness. The model separates out the subjective components of illness (an individual's experiences) from the objective (external components). The authors suggested two main notions that lead to a sense of illness, the whole self with dysfunction, termed *impairment*, and organ dysfunction, termed *pathology*. Influencing these notions is an individual's personal context (cultural beliefs, attitudes, expectations and values) and his or her free will or choice. Added to this are the physical and social contexts of his or her environment, the interactions he or she may choose through free will and experience, and the way in which each of these are interpreted. This mixture influences an individual's actions, or as Wade and Halligan put it, activities. These activities express to others a state of health or disease.

In terms of people living with dementia, Bruce (2004) observed that a discrepancy exists between how observers rationalise their view of people living with dementia and how the people themselves feel about their changing condition. This sets into motion a whole raft of questions on the capacity of the latter to express their sense of well-being and to self-actuate a life-balance continuum to support good quality of life. Lyng (1990) pointed out that this reflects Marxist rationale for the right for every individual to seek to discover what it personally means to be human. Accepting this premise as a starting point requires of observers a flexible view of the concept of health, around which the biomedical model struggles to accommodate.

2.3 Alternative models of health and their role in caring for people living with dementia

Jones and Miesen (2004), observe that a strong affiliation with the biomedical model continues even though there has been prolonged dis-satisfaction in its power to support people through the lived experiences of ill-health. During the mid-twentieth century, a growing body of critics began to systematically challenge the model's philosophical underpinning for this very reason (Sheridan and Radmacher 1992). George Engel (1913-1999) described the model as having an assumed dogmatic superiority, in which data that conflicts with, or distorts its philosophies, were rejected or ignored (Engel 1980). Illich (1976) went as far as to suggest some of the practices embedded within the model were detrimental to health. Illich wrote:

...the pain, dysfunction, disability and anguish resulting from technical medical intervention now rivals the morbidity due to traffic and industrial accidents and even war-related activities, and make the impact of medicine the most rapidly spreading epidemics of our time (p. 24).

Even though the biomedical model was, and continues to be, acknowledged for its unprecedented contribution to scientific developments in medicine (Wade and Halligan 2004), over the last four decades proponents of alternative theories have highlighted limitations in its ability to address how people might take control of self-actualising good quality of life through perceptions of being healthy (Illich 1976; Engel 1977 and 1980; Seedhouse 1986; Graber and Johnson 2001).

Longino and Murphey (1995) pointed out that the maintenance of good quality of life is viewed in biomedicine as the province of public health. The field of Public Health in the UK, which now involves activities conducted by health professionals and allied health professionals, such as social workers and psychoanalysts, emerged as a new discipline in the mid-twentieth century. Its inception was grounded in a growing distrust of the biomedical model's capacity to address the complex range of factors that relate to a person's overall quality of life (Naidoo and Wills 2000).

Turner (1987) emphasised three dynamic factors that determine wider perspectives relating to quality of life. These are *the individual*, *the social* and *the societal*. *The individual* relates to the impact of interactions on a person's perceptions and experiences of disease, *the social* relates to institutional dynamics and the behaviours of health professionals, and *the societal* relates to the wider macro-society and its perceptions and behaviours around health and ill-health.

Fig. 2.3 Co-factors that determine perceptions of health and ill-health.

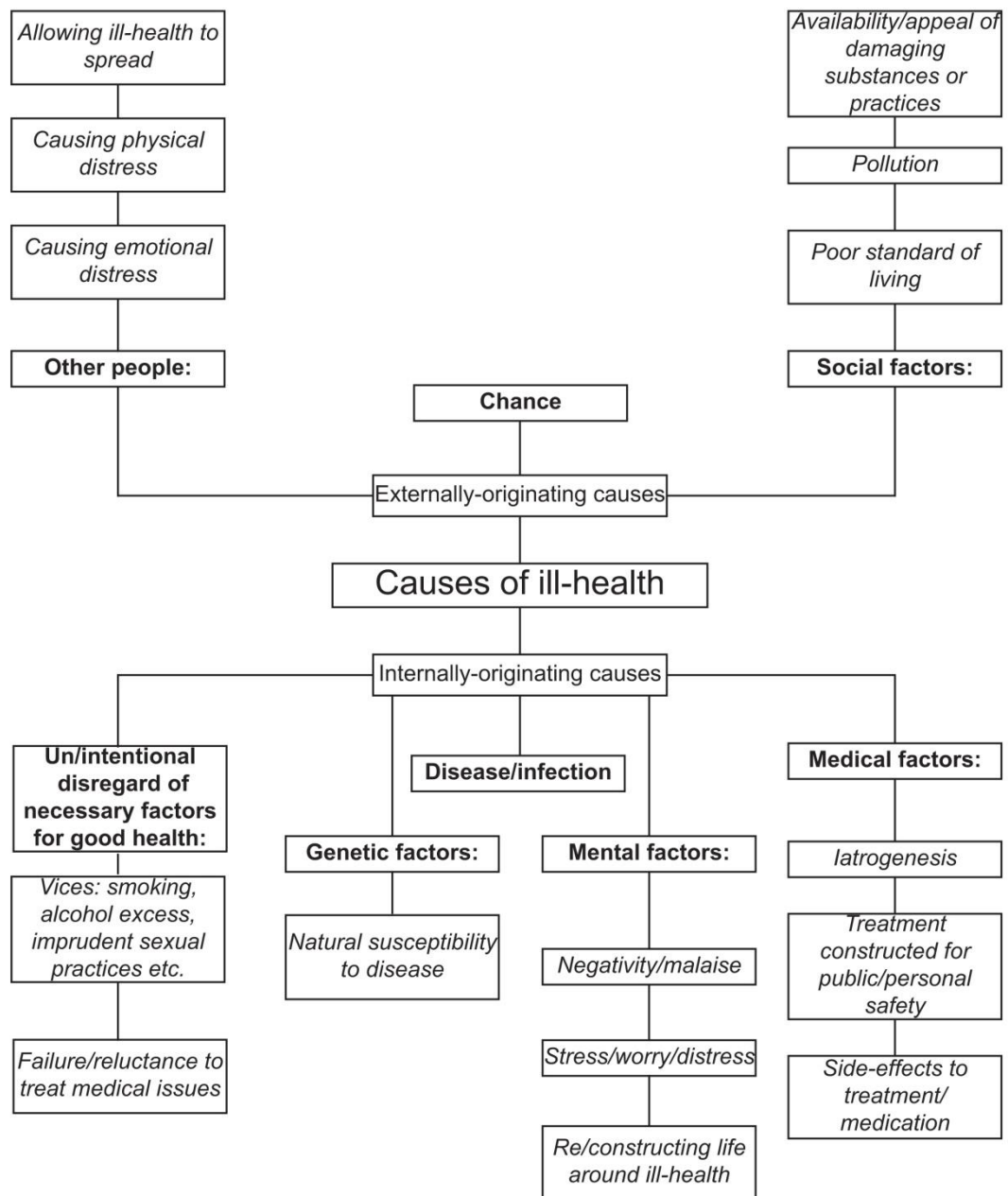


Figure 2.3 shows a model, derived from Longino and Murphy (1995) that demonstrates the complex co-factors that determine an individual's perceptions of health. Naidoo and Wills (2000) discussed these co-factors in terms of social stratification (age, gender socio-economic status and ethnicity), environmental factors (such as housing and access to leisure activities) lifestyle factors (such as stress levels), nutrition and exercise habits, and physiological factors (such genetic predisposition). How people rationalise their health

status within these given determinants affects their quality of life.

Earle (2007) explained a number of alternative models of health that centre on a synergy between good quality of life and a sense of health and well-being. The first discussed here, inverts the biomedical model's philosophical perspective of health by focusing on what *keeps* people healthy, rather than concentrating on illness, disease and death (Antonovsky 1984).

2.3.1 Salutogenic model of health and its role in caring for people living with dementia

Aaron Antonovsky's model of *salutogenesis* is based on identifying health-producing processes, which take into account life stressors and disruptions. Antonovsky observed that health encompasses a range of internal and external forces which variably equip individuals with the resources to comprehend and manage a meaningful life (Earle, Lloyd, Sidell and Spuss 2007).

Downie, Tannahill and Tannahill (1996) gave a number of scenarios which highlight different ways of thinking about health when related to a sense of well, or ill-being. The first relates to freedom from ill-health and a correspondingly high sense of well-being. The second relates to a state of ill-health and a correspondingly low sense of well-being. The third and fourth relate to conflicting states of health and the sense of well-being. For instance, in the case of social isolation, where health is unaltered, but a sense of well-being is diminished, or in the case of a person with a terminal illness, who is well-adjusted to the consequences of their condition. This latter state, which takes into account people who may live comfortably with an existing, but well-managed medical condition, demonstrates salutogenic thinking. In this, Antonovsky (1984) suggests that physical and emotional stressors should be considered integral to the human condition. Rather than accepting the absence of disease as normal and disease as abnormal, as proffered by the biomedical model of health, salutogenesis accepts *entropy*, that is, disorder, disruption of homeostasis (body-function balance) and inevitable decline, as a normal state in the human organism (Sidell 2007).

Antonovsky suggested that a sense of order can be achieved in the face of *entropy*. The condition of dementia is certainly an example of *entropy*, and one in which finding a sense of coherence is often challenging. The discovery of a sense of coherence, which represents an emotional and mental reality that is unique to every individual, is the fundamental principle of salutogenic thinking (Byrne 2004). Antonovsky (1979) proposed that coherence may be achieved by emphasising preserved abilities rather than focusing on loss. This focus can lead to a sense of predictability and a sense that things will work out as well as can be expected. Verghese, Lipton, Katz *et al.* (2003) showed that quality of life can be significantly improved for people living with the potential for dementia through the promotion of activity and creativity based on salutogenesis. Such activities can elicit resistance to overwhelming stressors that lead to a sense of ill-being. Pretorius, Walker and Malan Heyns (2009) studied stressors and coping mechanisms in male carers (n = 10) of spouses living with dementia, from a salutogenic perspective. In this, there appeared a gender contrast. When compared with female peers (n = 10), the study's sample of men were better able to adopt a problem-solving approach to find meaning and satisfaction within the context of their care-giving. This finding may illustrate the complex factors associated with relationships and with gender-specific expectations within certain cultures.

2.3.2 Social, bio-social and structural models of care and their role in caring for people living with dementia

Salutogenesis is grounded in perceptual and behavioural adaptations in the face of changing circumstances. These adaptations occur variably according to a whole range of factors which influence the way an individual perceives their health. Affecting factors include relationships and interactions and behavioural-cultural and material-structural influences. Earle (2007) discusses a range of what are collectively termed social models of health, which explain health in this way. Subsets of this model include holistic and bio-psychosocial approaches, structural accounts of health and lay people's subjective models of health. As most of the day to day care of people living with dementia occurs in social settings, outside the biomedical arena, these social models of health are highly significant.

Turner's (1987) tripartite model of health and illness and Longino and Murphey's (1995) model reflected the earlier, seminal work of George Engel. Engel (1977) produced one of the most influential theoretical frameworks of health from a social perspective which he entitled the *biopsychosocial* (BPS) model. Engel aimed to challenge professionals' views of health beyond the telescoped biomedical model, which Engel believed to be deficient. Without dismissing biomedicine as an important component to the maintenance of health, hence the retention of the prefix *bio* in the title, Engel nevertheless rejected it as a single rationality for whole well-being. The BPS model is closely allied to holism, in this sense.

The BPS model is based on a *general systems theory*, which makes the assumption that nothing exists in isolation. This view of health embraces the phenomenon of *lived experiences* which grounds the understanding of illness and disease in the context in which an individual exists (Tone and Green 2004). This takes into account a whole range of lifestyle systems, such as economic status and the environment, as well as the human qualities of care providers and the cared-for. Some commentators have criticised this healthcare approach because of the potential power it gives health professionals to encroach on every aspect of a person's life (Nettleton 1995). Others advocate the model's value in terms of breaking down unhelpful boundaries between health and social care (Hek, Singer and Taylor 2004). Such boundaries have been highlighted as a major contributor to inconsistent provision of good quality care for people living with dementia.

The models of health described above are concerned with the conceptualisation of reality as it affects different individuals. For this reason, they are frequently referred to as *conceptual* models. Seedhouse (1997) explained how *structural* models of health differ by centring on way in which societal institutions enable or inhibit definitions of health from an individual's perspective.

2.3.3 Feminism

A key structural model of health emerged due to the achievements of the feminist movement (MacPherson 1983). The movement argued against hierarchies and oppressive systems, as evident in the so called 'heroic' biomedical model, which upheld notions of male superiority. MacPherson observed that the women's health movement propelled a

paradigmatic shift from biomedicine to a more human-centred model. Whereas the biomedical model of health grew largely from male dominated practices, practical care-giving has historically been the domain of women (Kohen 2000). In the current decade, women have a fifty-fifty chance of needing to give substantial care during their working lives (Carers UK 2005). In 2000, Maher and Green (2000) reported that 18% of women in the population were giving informal care to family members, compared with 15% of men. In formal healthcare environments, around 90% of registered nurses and non-registered care-staff are women (Nursing & Midwifery Council 2006 p.5). In terms of the ethics of caring, Koehn (1998) argued that whilst male ethics stress the logic of deductive reasoning, female ethics place more importance on imaginative insight into the perspectives of other people's experiences. This perspective, Koehn suggests, is based on care, trust and empathy. The women's movement also largely rejected approaches to care-giving that are grounded wholly in socially constructed perceptions of health and the resultant categorisation of health and illness.

Despite the synergy between the feminist movement and improvements in care, Radsma (1994) argued that up to the final decade of the twentieth century, recognition for the movement's influences on a paradigm shift was largely unforthcoming. Radsma argued that this shortcoming relates to the perpetuation of patriarchal institutions in which women caring for their families continues to be perceived as an essential social role (Walsh 2004). The movement fundamentally questions this perception of duty in relation to women and caring (Hunt 2004).

Rose and Bruce (1995) highlighted a gender-related difference in people's perceptions of carers of people living with dementia, in which male carers tended to be admired and praised, whilst women were seen as fulfilling a duty. Walsh (2004) suggested that an ideology that defines women as 'natural carers' in the context of childbearing and practical sustaining of a family, relates directly to the low status and poor pay of professional care-givers today.

2.3.4 Lay and subjective models of health

The characteristics that embody the feminist perspective of health and care-giving influenced the subsequent growth of subjective or lay perspectives of health. Earle (2007) explained that interest in subjective accounts of health began to emerge from the 1970s, influenced by the sociological theory of *symbolic interactionism*.

Gadamer (1975) pointed out that concepts of health and illness are not absolute. Their subjective nature prevents standardisation in which health and illness are perceived uniformly between individuals and across different cultures. An interactionist approach to health evolved from the idea that people gain meaning from their social interactions and their interpretations of these interactions in the context of their social cultures (Blumer 1962). In contrast to viewing disease and illness in terms of problems that need to be resolved in relation to normative, rule-governed performances (Parsons 1951), interactionists stress how the definitions of illness need to remain elastic because they are constructed and manipulated through interactions (Bilton, Bonnett, Jones *et al.* 2002). The following account of a meeting that took place between the researcher and a fellow-other, named John, illustrates tensions arising from the researcher's biomedical frame of mind and care grounded in interactionism.

Illustrative Case Report No.2: Towards interactionism in care-giving

Before being introduced to John and his family, I had been asked to visit 'a 62-year-old man with Alzheimer's disease'. The introduction would not be difficult nor surprising, I sensed. After all, I had spent over twelve years working with people who had dementia of one sort or another. I expected a range of psychological reactions on the part of the patient and his family; less quantifiable than the physical manifestations of the condition but nevertheless still within the realms of my previous experience. During that first visit, I briefly encountered John's son, who was similar in age to my own son. The young man spoke with the utmost courtesy to his father who struggled a little before responding in the same polite manner. Later John spoke with great affection about his children. He wished he had spent more time with them in their early years and he expressed concerns about being unable to support them in the future. John sensed unease in his son and felt that he had undisclosed worries. It was the ordinariness of these typical and overwhelming parenting concerns - to which I could wholeheartedly relate - that began to unravel my professional mask. Nowhere in the wealth of literature around pathology and management of early-stage dementia, could I learn how to respond to such individual concerns. The resource upon which I had to draw was entirely intuitive and personal. I was, I realized, simply in dialogue with a 'fellow other', whose way of being in the world was just the same as my own. His medical diagnosis, and my professional response to that diagnosis, was, after all, irrelevant.

By kind permission from John's family

2.3.5 Humanistic model of health

Humanistic psychology developed at the around the same time as *symbolic interactionism*. A humanistic model of health reflects the focus of social models in terms of people making meaning of the world through self-actualisation. The model is grounded in this premise and the belief that people have an instinctive drive within themselves to pursue creativity and wisdom which leads to a sense of health (Seedhouse 1986). In other words, people naturally strive for capabilities (Simon, Irwin and Drinnin 1987). Seedhouse explained that the humanistic approach, therefore, focuses on potential.

The approach is characterised by the belief that the provision of skills and knowledge can empower people to reach their own goals for health.

Sabat and Harré (1992) put forward the argument that, far from being passive victims, people living with dementia can be active agents in addressing their own sense of health by seeking meaning and reacting to their world in a humanistic way. Given the right environment and opportunities, this group of people can self-actuate in the same way as others. Walker (1999) suggested that the term *thriving*, relates well as a theoretical perspective of self-actualisation in frail older people in residential establishments. The phenomenon of *thriving* in this context was first described by Newbern (1992) in the early 1990s. By implication, the term refers to the multidimensional concepts of physical well-being, such as maintenance of weight, motor skills and cognition, and psychological and psychosocial-well-being, such as motivation and the maintenance of social skills.

Figure 2.4 Maslow's Hierarchy of Human Needs (Simons, Irwin and Drinnien 1987, based on Maslow 1943)

Need in order to human satisfaction	Detail
Physiological Need	Biological needs: Oxygen, water, food, sex, sleep, homoeostasis, excretion.
Safety Needs	Security: of body, of employment, of resources, of family, of health, of property .
Needs of Love, Affection and Belongingness	A sense of belonging: family, friendships, overcoming loneliness and alienation, sexual intimacy.
Needs for Esteem	Stability and respect: respect from others, self-respect, self-confidence, self worth.
Needs for Self-Actualization	To be meaningful: engagement, creativity, spontaneity, achievement, acceptance.

These factors collectively relate to theories of health that correspond to holistic well-being brought about by the maintenance of human needs, as first set out by Abraham Maslow in the early 1940s, shown in Figure 2.4 (Simons, Irwin and Drinnien 1987). Simons *et al.* explained Maslow's seminal work. The following illustrative case report, which was recounted by a community dweller on the Isle of Skye in July 2006, demonstrates a humanistic approach to health, administered by a whole community.

Illustrative Case Report No 3: Humanistic model of care-giving

An elderly, life-long resident of a remote crofting community on a Scottish Hebridean island was diagnosed by the local GP with dementia. The old man had lived and worked his small croft, first with his parents, and then alone after their death, for the whole of his adult life. He had never married. When people from the old man's community observed his gradual physical and mental decline, they began to worry about his personal safety. It was then that the whole community of around fifty people of varying ages and lifestyles joined forces to devise a support programme for the old man. A rota of care-giving and companionship was drawn up by community members who set about resolving their concerns for the old man. For every day of each month, one community member stayed with the old man in his croft, helping him to maintain his usual activities, cooking with him and acting as a companion. The old man eventually died in the small croft that had been his home for over eighty years. He was surrounded by people, some of whom he had known all his life, but all of whom had shared in his remarkable journey to the end of his life.

By kind permission from S. Dougall

The development of a new care paradigm at the end of the twentieth century, which focuses on overarching human needs, heralded new ways of thinking about and caring for people living dementia (Kitwood 1997). In so-called *person-centred care*, a pivotal component is the acknowledgement that people living with dementia have as strong an urge to make sense of the world as anyone else. Kitwood and Brendin (1992) suggest that physical brain dysfunction in people living with dementia is likely to be adversely affected by an impoverished environment, which includes too few or inappropriate interactions.

Kitwood (2004) argued strongly for the need of wide-spread cultural change in perceptions and attitudes of people living with dementia. He referred to old cultures of care that seriously limit potential for personal development and a sense of well-being for both the cared-for and the care-giver. Such cultures run deep and are strongly influenced by the biomedical legacy. Kitwood cited the work of Henriques and Holloway, Urwin *et al.* (1984), who claimed that cultures do not develop through the actions of human beings responding to a set of beliefs, as might be supposed. Rather, institutions arise first, they establish control and power in some form, *then* follows a manipulation of beliefs in order

to rationalise what is happening within. A recent television exposé of a residential home for abandoned children in Bulgaria provided an example of Henriques and Holloway's assertions. In this case, children who were kept in the bleakest of conditions without any form of mental or physical stimulation, often for years at a time, demonstrated extreme psychological distress. This was manifested by repetitive rocking, pacing, screaming or self-harming, such as biting or scratching. Some children were tied with bandages to prevent these behaviours. Senior staff at the children's home and a spokesperson for the Bulgarian Ministry of Health rationalised the need for severe management tactics by explaining the children's behaviour in terms of their high levels of mental disturbance. This conclusion was reached even though many of the children had demonstrated normal behaviour on admission (BBC 4 2007).

Kitwood (2004) wrote, 'each culture has its special way of occluding, or hiding away parts of the truth about human existence that are too difficult or inconvenient to bear' (p. 8). Reflecting with Kitwood's observation, Post (2005) recognised that people with mental infirmity are frequently excluded from moral concern. This puts them in a position of differentiation, dehumanisation and depersonalisation. Post argued for practice that upholds the affirmation of a common humanity and rejects, as he puts it, 'the arrogance of exclusion' (p.224). Kitwood asserted that such attitudes are grounded in the aforementioned established old cultures, which normalised difficult behaviours by explaining them in terms of the biomedical process of the condition. Kitwood compared this with a new culture of care which aims to free the establishment from insidious pre-conceptions and subsequent prescribed ways of managing people living with dementia. Rather, Kitwood advocated a holistic approach, which takes into account not only biological perspectives but the psychological and social situations that occur around, and because of, the condition. This model of healthcare is centred in concepts of *subjective interactionism*.

2.3.6 Interactionism and relationships between care-givers and people living with dementia

The importance of human to human interactions, and what it means in terms of making sense of the world, or self-actualisation, is by no means a new concept. Mitchell (2006) reported on the perspectives of phenomenologist, Martin Heidegger (1889 – 1976) who referred to the writings of sixteenth century philosopher, Rene Descartes (1596 – 1650). Heidegger rejected the now notorious Cartesian conception, '*cogito ergo sum*' ('I think, therefore I am'), in which the only certainty is the presence of the human mind, because of the rift it created between the thinking being and the outside world. Heidegger's main objection centred on the implicit notion that human beings are spectators, looking out from within and ostensibly isolated. Unlike Descartes, who described the world as a collection of objects existing alongside each other, Heidegger explained people not as autonomous individuals, as Descartes suggested, rather they are part of one large collective orbit. Constantly changing relationships with the world's objects, which includes other people, are, according to Heidegger, dealt with by adapting interactions. In this case, rather than choosing to relate to one another because of some moral imperative, the interactions and the forming of relationships is fundamental to human existence. For most of the time, human beings are submerged in these relationships. Hughes, Louw and Sabat (2006) suggested that it is only through this joint venture of being-in-the-world alongside others, that people can orientate themselves and make meaning of the world within their cultural context. Adopting this premise, Mitchell (2006) suggested that relationships are far more than social constructs calculated to create affect.

Over the last twenty years or so, new care approaches have increasingly embraced interactionism as the optimum approach to care (Kitwood 1997; Cheston and Bender 1999; Bender 2003; Balfour 2007). When considering Sidell's (2007) main health ideals relating to this model, the ideal of health as a thinking, feeling, and reflecting being, capable of change and growth, and the ideal of health in terms of reaching a state of self-actualisation, it is clear that special attention needs to be given to how this might occur for people living with dementia . This is not to imply that individuals living with dementia are incapable of self-actualisation and personal growth but rather, in order to do so, they may need to be enabled by the people around them. Buckland (2004) advocated a care

approach that reflected this concept. He described the nature of good care in terms of supporting quality of life, helping to piece together broken experiences and strands of well-being and to nurture people towards a sense of self-actualisation.

A number of interactionist models of care have emerged over the last two decades. For example, Specialized Early Care for Alzheimer's (SPECAL), developed by Penelope Garner in the early 1990s, aimed to provide a rich care paradigm based on finding and nurturing the real person beneath the condition (Pritchard and Dewing 1999). At around the same time, the late Professor Tom Kitwood and his associates at the Bradford Dementia Group developed *Dementia Care Mapping* (DCM), an evaluation tool designed to maximise effective care. The 'mapping' is undertaken by trained external personnel. It involves their detailed recording of observed behaviours and interactions between staff and the people for whom they care and in-depth discussion with staff post observation (Kitwood and Bredin 1992). A number of evaluative studies have lauded the value of DCM, suggesting that it provides insight into the world of the person with dementia in a way that few others can (Brooker, Foster, Banner *et al.* 1998; Fossey Lee and Ballard 2002; Brooker, Edwards, and Benson 2004; Jaycock, Persaud and Johnson 2006). The Eden Alternative is one of the most recent models to emerge. It was designed in the United States by medical practitioner Dr William Thomas and focuses simply on vision to eliminate *loneliness*, *helplessness* and *boredom* through person-centred care and individualised care programmes.

The ideological underpinnings of SPECAL, DCM and the Eden Alternative, which are closely allied to the feminist/interactionist *structural* care philosophies, sit comfortably within the National Minimum Standards' guidance on procedural care for care home residents. The wider picture however demonstrates some challenges in terms of advocacy amongst staff, who act as the main agents for change (Jaycock *et al.* 2006). In terms of DCM, Jaycock *et al.* showed that some staff (number unclear) reported apprehensions in being judged by the external mappers. Rigidity of organisational cultures was also felt to prevent long-term changes. This may also have underpinned the findings of Thoesen Coleman, Looney, O'Brien *et al.* (2002), who compared the effects the implementing the Eden Alternative model in a nursing home in Kentucky, with a similar control site.

Despite some qualitative evidence of value, the authors observed no quantifiable improvement in cognition, functional status, rates of infection, survival rates or prescription of drugs amongst residents, or staff retention at the end of a one- year period. Jaycock *et al.* (2006) suggested that a resistance to any proposed change in culture may emanate partly from the increasing level of service closures, or planned closures. These situations frequently de-motivate staff, place extra pressure on those remaining and subsequently limit their motivation to change.

2.4 The challenges of caring for people living with dementia in care settings

Some of the challenges of caring for people living with dementia are common to both informal and formal care settings. Bruce (2004), for example, suggests that conflict commonly arises as a result of differing perceptions of need between carers/care-givers and care recipients. Other factors that may engender conflict concern carer/care-giver/care-recipient personal characteristics such as mental disposition and/or physical robustness, and personal traits, such as innate cognitive abilities, likes and dislikes and skills and interests (McHugh and Slavney 1998). Some of the challenges of caring for people living with dementia are more likely to emerge as a consequence of formal care-setting, particularly issues of loss and grief and issues relating to institutionalisation.

2.4.1 Care staff stress

At the beginning of the twentieth century, over 75% of people living in non-EMI care settings were reported to have dementia (Macdonald, Carpenter, Box *et al.* 2002). Hughes *et al.* (2006) place an emphasis on developing and maintaining an infrastructure of appropriately trained and supported staff to uphold good quality care for this group of people. Arksey and Hirst (2005) agree that inadequate support for care-givers can result in poor and inconsistent care, not least due to care-giver stress.

Felgate (2008) observed that there was little hard evidence of training and support for staff to cope with emotional challenges. This was particularly evident in view of the diverse cultural variations of the current healthcare workforce in the UK, created by the

recruitment of staff from overseas. Currently the National Health Service nurse registration profile recognises that the major source of non-UK trained nurses is from the Philippines, Australia, India and South Africa (Royal College of Nursing 2007). A high number of qualified nurses from overseas take up care work in residential care settings due to their professional qualifications not being recognised for nursing practice in the UK (*ibid*).

At the beginning of the twenty first-century, there seemed to be two main factors underpinning the emotional challenges facing health professionals and care-givers caring for people living with dementia. The first centred on perceptions of dementia care as a *Cinderella* discipline (Chui and Jeste 2003; Kitwood 2004), so called because of its unpopularity with many health professionals and care-givers. This has meant that, up to recent years, it has been difficult to adequately resource in terms of staff recruitment and staff retention. Secondly, despite a concerted effort by dementia care champions' determination to bring the condition out of the shadows and onto an equal footing with other enduring health problems such as heart disease and stroke, long-standing economic under resourcing has perpetuated problems for managers to support and educate for their staff on a sustainable level. This relates most notably to non-registered care assistants (Innes 2002). These factors potentially inhibit practice perceived by staff as adequate and therefore give rise to poor job satisfaction (Edberg, Bird, Richards *et al.* 2008).

Hawkins (2008) stated that the most common challenges for staff who care for people living with dementia relate to balancing issues of risk and freedom, ensuring a safe and healthy environment, working with families and addressing ethical dilemmas such as end-of-life issues. Edberg *et al.* (2008) points out that when unacknowledged over time, the strain of dealing with these challenges cause stress. The authors described the main sources of strain amongst staff that centred on frustration and the inability to deliver consistently good care.

Todd and Watts (2005) observe that staff's emotional responses to clients' behaviours are critical factors in determining high quality practice. Dis-empowering responses may elicit a cyclical cause and effect pattern, as illustrated by the following case report.

Illustrative Case Report No 4: Example of negative behaviour elicited by care-giver response

At 3 am on a chilly night in September, Ann is on her hands and knees looking under the bed

Ann - *'I can't find the Christmas pudding. It needs furnishing (sic) now and I can't find it'*

Care-giver – *'It's the middle of the night Ann. Let's get you back to bed'*

Ann – *'I got to find the pudding – look, look there, over there. They won't have it ready'*.

Care-giver – *'We'll do it in the morning Ann. You'll get cold out of bed, come on now (goes to help Ann up)*

Ann – *'No, no get away! I haven't got it'*

Care-giver – *'It's not under there Ann. It's in the kitchen; we'll do it in the morning, now come on - you get back to bed'* (takes Ann's arm).

Ann lets out a piercing scream and bites the care-giver's hand. The following evening, Ann received night sedation (Vella-Burrows 2001)

This, not uncommon, scenario illustrates how a stressed care-giver can exacerbate difficult-to-manage behaviours. In this scenario, a number of complex personal and professional psycho-social factors may have contributed to care-giver stress. Not least of these maybe the practice of working throughout the night, typically for twelve-hours in duration, which is known to adversely affect care-giver performance (Fitzpatrick, While and Roberts 1992). A cyclical pattern can emerge in which stress in care-givers invokes a personal sense of inadequacy (Edberg *et al.* 2008).

In her study examining the well-being of staff caring for people living with dementia, Lloyd (2009) found that staff developed detachment strategies to protect themselves from the emotional intensity of the work and to prevent physical fatigue. The process, Lloyd suggests, can protect clients from negative interactions with staff but it can also lead to staff neglecting to notice emerging problems that might otherwise be averted at an early stage.

A study by Margallo-Lana, Reichelt and Hays *et al.* (2001) compared experiences of stress amongst 48 dementia care nurses from the National Health Service and 177 care assistants or senior care assistants working in the same field but in the private sector. The

authors reported that 20% of all study participants were ‘psychologically distressed’ (p. 796). Compared with care assistants, trained nurses were more likely to adopt coping strategies to protect against this, particularly those working in NHS settings. Reasons suggested by the authors included a better sense of community and support from larger organisations associated with NHS settings, better training and pay and more systematic opportunities for a structured career.

Murrells, Robinson and Griffiths (2007) provided evidence of a gradually worsening scenario over a three-year period of employment, in which a downward trend occurred in levels of job satisfaction amongst nurses caring for people living with dementia. Todd and Watts (2005) and Hawkins (2008) pointed out the significant relationship between job satisfaction, stress and staff exhaustion or *burn out*, in which staff are temporarily or permanently unable to work due to stress.

Table 2.5 Care staff perceptions of challenges to job satisfaction (Alzheimer's Society 2008 p. 37)	
Challenge	Percentage of care staff sample (n= 1503) prioritising factors as one of the top three most important to improving job satisfaction (%)
More training; better courses that are more relevant to job	22
Higher salary	21
Adequate number of staff	12
More time to spend with residents	11
Availability of activities	5

The Alzheimer's Society's (2008) reported perceptions of job satisfaction amongst care staff (n = 1503) working in the area of dementia care. The study showed that only 8% of staff reported that their job 'was fine as it was' (p.38). Table 2.5 lists factors thought by care staff to improve job satisfaction. Twenty-two per cent of respondents prioritised an increase in more relevant training, 21%, a higher salary, 12%, better staffing levels, 11%, the ability to spend more time with clients and 5% better availability of activities for clients (Alzheimer's Society 2008 p. 37). This was against a backdrop of a poor response rate (16%) and in the context of a very high staff turnover, in some cases relating to 30% over a nine-month period. The relatively low number prioritising each of these factors may demonstrate a cyclical pattern of inertia

Figure 2.6 Cyclical patterns leading to inertia and poor motivation to spend time with clients in meaningful activities

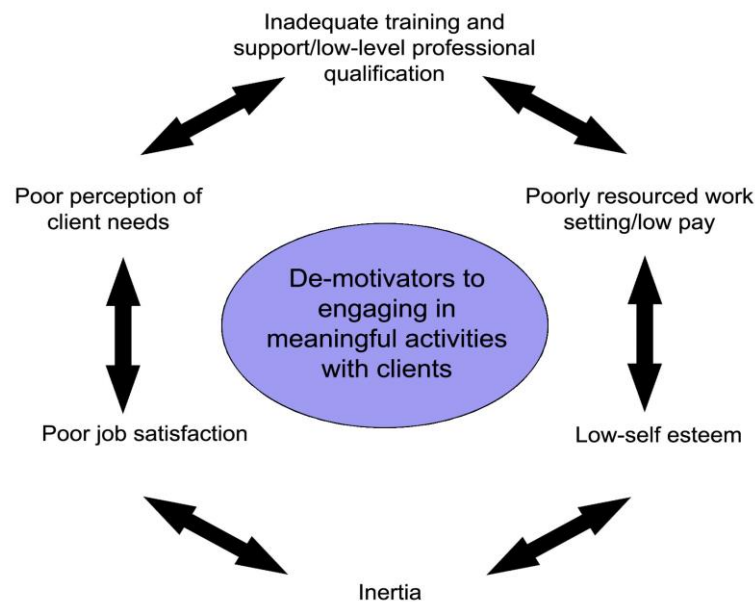


Figure 2.6 illustrates how the acceptance of institutional norms of inadequate training and support for staff and poorly resourced services (Buchan and Calman 2004) can lead to inertia that in turn inhibits care staff's motivation to spend time with clients in meaningful activities.

In conversation with the author of this thesis in May 2007, Dr Erollyn Bruce from the Bradford Dementia Group (BDG), Division of Dementia Studies, highlighted the importance of investing in the well-being of staff. Bruce quoted a number of colleagues who had observed a marked difference in staff who felt supported in their personal lives as well as their professional lives, as illustrated in the following précis of the conversation which related to the process of Dementia Care Mapping (DCM).

Erollyn referred to Hazel May, an experienced member of the DCM team, who had often observed improvements in the well-being of clients some months post-mapping. On discussing this with staff, Hazel is usually told that they had not stuck to the problem-solving strategies decided upon after the original mapping sessions but nevertheless there were observable improvements. Hazel suggested that spending time talking with staff about their perceived challenges may be enough to change how they view clients' behaviours. Erollyn believes that staff who feel supported and well-looked after are more likely to look after people with dementia sympathetically.

Toesen Coleman *et al.* (2002) also reported the positive effects of investing in staff well-being in a study investigating the effects of Eden Alternative training for care-givers in a nursing home in Kentucky. Despite difficulty of quantifying positive changes, analyses of qualitative data one-year post-training showed an improvement in staff attitudes compared with a control site. This manifested as staff enabling the people for whom they cared to self-actualise a better quality of life.

2.5 Education and training for health professionals and care-givers caring for people living with dementia

A critical factor to health professionals and care staff acting as quality-of-life enablers is their fundamental understanding of the lived experiences and ongoing needs of the people for whom they care. Packer (1999) argued that studies focusing on healthcare workers' understanding of older people living with dementia since the 1960s have often highlighted the difficulty of separating out *attitudes*, which are predominantly culture-sensitive, and *knowledge*, which is acquired through education.

Marshall (2006) and other proponents of change in the culture of dementia care (e.g. Kitwood 2004; Froggatt 2004; Tobin 2004) believe that attitudes in, and towards education in the wider UK culture need addressing in order to change attitudes in education in the healthcare industry. Küçükcan (2003) observes that most mainstream educational systems are grounded in their country's dominant culture. In this case, there is a strong probability that the moral order that underpins culture-driven attitudes will influence outcomes in healthcare education. This factor may lead to a complex set of challenges in which the learner must be enabled to identify, acknowledge and challenge his or her embedded attitudes that may inhibit good quality care.

2.5.1 Education for healthcare professionals

Milne, Hamilton-West and Hatzidimitraïdou (2005) discussed the impact of increased training of health professionals, which aimed to elicit a change of attitudes and practice. Milne *et al.* (2005) noted an improvement in GPs' responses to patients presenting with

symptoms of dementia between 1997 and 2000. These improvements manifested as a clinical emphasis on early diagnosis and quicker referral to a specialist. However, writing some years later, Gilliard *et al.* (2005) suggested that little real change had occurred over the last twenty five years, with the no-hope biomedical perspective continuing to dominate. Gilliard *et al.* cited the UK Audit on mental health services for older people, entitled *Forget-me-not*, in which half of the GPs taking part (n = 500) saw no point in taking further action when presented with a person with dementia. An illustrative comment that rationalised this viewpoint was, 'What is the point of looking for an untreatable disease?' (Audit Commission 2000 p. 21). Renshaw, Scurfield, Cloke *et al.* (2001) also reported that nearly 50% (n = 500) of GPs surveyed across twelve health authorities in England and Wales continued to perceive little benefit in early diagnosis. Bree and Meldrum (2005) suggested that poor attitudes in general practice continue to lead to little or no referral to specialists or support agencies. These, and other inadequacies in services, were highlighted in a pan-European survey of over 2,500 health professionals, people with dementia and their carers, policy makers and the general public. In this, carers reported an average duration of nine months between diagnosis and specialist consultation (Bond, Stave, Sganga *et al.* 2005). Bree and Meldrum (2005) suggested that such delays, which stem from lack of training and knowledge, give rise to wider assumptions that there are no treatment options that could improve the life of a person living with dementia. Oldman (2002) pointed out that these attitudes draw attention to a biomedical dependency culture. In this case, once diagnosis and the efficacy of medical treatments have been discounted, some GPs may demonstrate professional complacency in terms of a commitment to sustaining or improving the quality of their patient's life.

Illustrative Case Report No 5:

Researcher – *'Do you have services or information for patients newly diagnosed with dementia,, or is that under the auspices of social services.'*

General Practitioner - *'Yes, we could do an OT assessment.'*

Researcher - *'What about things like memory clinics and carers support.'*

Consultant Physician - *'Do we have one locally?'*

General Practitioner - *'Well I must say, there is enough to be getting on with. And I don't know about memory clinics. Day Care for instance though.'*

Consultant Physician - *'Yes, day care is all done by social services not by PCTs, the surgery. They're the ones who make a decision about if a patient if suitable, I assume.'*

(By kind permission from the commentators)

Case Report No 5 shows a conversation between the researcher, a General Practitioner and a Consultant Physician. The report illustrates an attitude in which the medical practitioners separate their medically orientated roles from the holistic human needs relating to Maslow's hierarchy. Encouragingly, however, over the last two or three years, public and strategic attention has pushed forward a management agenda that embraces the specialist skills of a whole range of healthcare, allied healthcare and social services professionals. The National Dementia Strategy, which was published in February 2009, acknowledges the need for single-focus specialist dementia services across the whole country. Based on the current Memory Clinic model, which aims to provide one-stop help with a wide range of problems, dementia-focused centres would complement the work of health professionals who first encounter people living with the symptoms of dementia (DH 2009).

2.5.2. Training for care staff

Knapp, Prince, Albanese, *et al.* (2007) calculated that in 2007 just over two-thirds (n = 424,378) of people living with dementia in England lived in their own homes, the remaining one-third (n = 244,185) lived in care settings.

The attitudes of primary healthcare professionals towards people living dementia arguably impacts significantly on care-givers in care settings. For example, a delay in diagnosis and early management therapies can result in swift deterioration, distress and premature admission into a residential/nursing care setting. Poor attention to early symptoms and weak management post-diagnosis may normalise symptoms that might be otherwise be reduced. Poor management can also reinforce amongst care-givers a sense of hopelessness around the condition of dementia.

Whilst always under the supervision of trained staff, the day-to-day welfare of frail and vulnerable people in care settings is largely in the hands of care-assistants (Dalley and Denniss 2001). By the time a care-assistant, or other care-giver, meets a person living with dementia, the situation of the latter is often precarious. Existing challenges and tensions can be either diminished or exacerbated by the way in which the two interact. Sink and Covinsky *et al.* (2006) highlight the importance of the ability of care-givers to administer *appropriate* assistance. The authors found that in some cases, where care-givers have little or no training and poor levels of basic education, negative symptoms were unknowingly exacerbated or even induced by care-givers' interventions.

In their survey of 418 residential and nursing homes across England and Wales, Dalley and Denniss (2001) found that care home proprietors and managers believed that levels of training related directly to the quality of care delivered. The benefits of training manifested as improvements in staff morale, reduced staff turnover and improved quality of care. A small number of studies have also highlighted an association between training in formal settings and a reduction of the use of neuroleptic drugs (Coker 2006) and improvements in the behaviour of residents (Williams, Hyer, Kelly *et al.* 2005; Chrzescijanski, Moyle and Creedy 2007). This evidence presents a strong case for systematic and robust training for all care-givers.

In 2002, the National Care Standards Commission worked alongside the General Social Care Council to develop new regulations for the training and qualifications for care assistants, who had up to then been unqualified. This resulted in statutory obligations being laid out in the National Minimum Standards for Care (NMS) (DH 2001b). In

accordance with the National Training Organisation (NTO) workforce training targets, the NMS stated that all staff should receive a minimum of three days paid training per year after induction (Standard 30.4) (Nazarko 2002).

The NTO targets aimed to ensure safe working practice by training staff in manual handling (safe techniques for moving people and objects), fire safety, first aid, food hygiene and infection control (Standard 38.1). These areas of training relate to the first of Abraham Maslow's hierarchy of human needs concerning biological and physical needs and safety (Timmins 2006). Timmins suggests that people experiencing ill-health connect strongly with these basic needs and become complicit recipients of care delivered by professionals who help address them. However, Timmins goes on to emphasise the importance for individuals to receive not merely their basic needs but higher needs relating feeling loved, maintaining a sense of self-esteem and the ability to self-actualise. Being able to self-regulate these needs underpins good quality of life.

The National Training Organisation (NTO) Standards guidance tools made recommendations to support staff to affect better quality of life for their cared-for (DH 2001b).

Table. 2.7 The NTO guidance on devising care plans (Standard 30.3) DH (2001b)	
Focus on physical domains of health	Focus on emotional/social/spiritual domains of health
Personal care and physical well-being Diet and weight Sight and hearing Oral health Foot care Mobility and dexterity History of falls Continence Medication usage Personal safety and risk	Mental state and cognition Social interests, hobbies, religious and cultural needs Carer and family involvement and other social contacts/relationships

Table 2.7 shows the NTO guidance on devising care plans that underpin the way in which a person's needs are perceived and managed. Out of thirteen needs assessment foci, ten are medically orientated, relating to physical needs. The remaining three focus on emotional, social and spiritual needs. This weighting of care priorities reflects the focus of training programmes reported by Dalley and Denniss (2001) at the beginning of the twenty-first century. The authors showed that between 20% and 44% of surveyed care homes (n = 418) had provided training for staff in basic care, which included moving and handling, food hygiene, first aid and health and safety in the workplace. Conversely only 6% of homes had provided training in 'mental health issues', 3% in 'loss and bereavement' and 2% in 'communication skills' (p. 25). The survey data indicated a continued emphasis on training in physical health promotion and the marginalisation of training to recognise and support broader quality of life, or holistic health.

In recognition of the value of training in broader holistic healthcare issues, Standards 27 to 30 of the NMS stated that every home must have a formal six-month long induction programme for all care-givers. In addition, at least 50% of care-givers in any one home were required to hold a Level II National Vocational Training Qualification (NVQ) by 2005 (Nazarko 2002). The NMS also refer to legislation, such as The Mental Health Capacity Act of 2005 and the Deprivation of Liberty Safeguards (DoLs) (DH 2007a), which promote care grounded in ethical practice and proper legal protection for people who are perceived to lack mental capacity.

At the time of writing, a wide range of training courses for care-givers is offered by Further and Higher Education establishments, NHS Trusts, voluntary, charitable, third-sector and private organisations. Their focus is varied. Many are bound to the principles of holistic healthcare. For example, the key Dementia Services Development Centres (DSDC) located across the UK, such as DSDC Stirling and the Division of Dementia Studies, Bradford Dementia Group, University of Bradford, provide a comprehensive range of training publications and literature available online (e.g. www.dementiashop.co.uk). The Centres also provide distance and in-house training programmes for care-staff, nurses and allied health professionals (e.g. www.bradford.ac.uk/acad/health/dementia). Training for care-givers is frequently linked

to the Government's *Skills For Care* training standards (www.skillsforcare.org.uk). Such programmes can provide a continuum to a National Vocational Qualification in Health and Social Care or can open pathways in Higher Education for care-givers to pursue a nursing diploma or degree. A number of courses are accredited by the Royal College of Nursing (e.g. DSDC Stirling 2009). Issues such as meeting emotional needs, enriching communication and sustaining relationships are often at the forefront of training in which upholding good quality of life is the primary goal.

2.5.3 The challenge of changing approaches to care

Despite a wealth of training opportunities for care-givers, as recently as 2007, the Alzheimer's Society claimed that many care homes fail to provide the level of person-centred care that people with dementia deserve (Knapp, Prince, Albanese, *et al.* 2007). This claim indicates a radical problem with the capacity care-givers may have to apply innate skills and/or to acquire apply newly-learnt skills. These problems may relate to institutional cultures, in other words, the established practices of individual care settings. They may also relate to limited access to training or poorly conceived training programmes, which seem irrelevant to care-givers' socio-cultural experiences or their expectations of a care-givers' role.

Chrzescijanski *et al.* (2007) reported the positive benefits of education programmes undertaken by 178 registered and non-registered staff working with severely mentally infirm clients. The study was motivated by the observation that staff often missed clients' behaviour cues which indicated impending distress, which when ignored resulted in aggressive behaviour. A study by Whall, Black, Yankou *et al.* (1999) almost a decade before, highlighted these same shortcomings, which are based on the failure of staff to recognise behaviour-cues as meaningful in the context of mental infirmity.

Buckland (2004) highlights the complex nature of caring for another human-being, which, the author points out, cannot be mechanical. Very few standardised solutions or prescribed actions exist to treat the vast variations of care situations. To achieve good quality care, Chambers and Ryder (2009) refer to an essential co-relationship between technical competence and compassion in care-giving. These elements of care must be

balanced but, unlike technical know-how, teaching, learning and assessing compassionate aspects of care-giving is complex. It requires of care-givers either innate intuition or a learnt a capacity for *aesthetic*, or insightful, inquiry and a level of critical thinking to interpret and react to improve the experiences of the people for whom they care (Chinn, Maeve and Bostick 1997).

Innes (2000) recognised that the skills required for care-givers to change the experiences of the people in their care for the better are difficult to quantify. This occurs not least because of the subjectivity of care-givers' perceptions of quality of life. Bergland and Kirkevold (2001) identified significant shortcomings in the conceptualisation of quality of life caused by a lack of theoretical perspective amongst care staff, in this case nurses. In ascertaining nurses' definition of good quality of life, Kalis, Schermer and van Delden (2005) observed a significant tendency towards 'offering residents pleasant activities' rather than emphasising 'individuality', or on 'giving meaning' (p. 1). The ability to enable individuality and give meaning to a person's life is influenced by the way in which nurses and care-givers communicate with that person and recognise their potential. The effect of this communication will underpin the nature of their relationship.

The nature of human relationships, as they may relate to interactions between care-givers and their cared-for, has inspired philosophical debate over many centuries. Martin Heidegger (1889-1976) for example, described two forms of relationships. One he referred to as the inauthentic *deficient mode*, which is characterised by indifference and neglect, the other, the *authentic mode*, which is characterised by 'considerateness and forbearance' (Heidegger 1962 H.158). The need to prioritise the latter in the provision of all healthcare may seem logical but Mitchell (2006) observed that tensions can occur when healthcare is rooted a curative impulse. However, as in the care of people with terminal conditions, caring for people living with dementia cannot be rooted in the curative paradigm. Mitchell (2006) suggests that care-giving in the field of palliative care is perhaps the most authentic because measurements of quality cannot be grounded in the rates of cure. Rather, the approach to this kind of care, which is centred on the inevitability of death, necessarily shifts the values and principles that underpin measurements of quality. In this case, care is firmly grounded in human qualities. In accepting these

principles, Heidegger's *authentic* relationship model comes to the fore and the spiritual dimensions of relationships between one human being and another take centre stage.

Near contemporary of Heidegger, Martin Buber (1878 - 1965), centralised his theories on human relationships on the primary concept that 'all real living is meeting' (Buber 1958 p. 11). Like Heidegger, Buber poses two polarising relationship theories. The first, *meeting*, which Buber refers to as the *I-Thou* mode of interaction, has no ulterior motive or ambiguous agenda. Rather it is, as Buber puts it, 'an ultimately gracious intimacy between one human being and another' (p.11). Buber's opposite mode of interaction, the *I-It* mode, centres on the banal and trivial (Olesh 2008).

In discussing the realistic potential for consistently reaching Buber's utopian *I-Thou* mode of meeting in care-giving, Gibson (1999) concluded that all endeavours must be pursued. Optimistically, the author made the observation that, in the context of relationships truly grounded in Buber's *I-Thou* concept, people living with dementia can show others a great deal about the range of human communication. Pointon (2006) agrees that the very process of dementia stripping away outer layers of self-consciousness can engender special spirit-to-spirit relationships. This can enable sensitivity to relationships based on, as Pointon puts it, *beauty and love*. Pajnikihar (2009) refers to care-giver/cared-for interactions that centre on spiritual interactions as *partner-like* relationships. Barnett (2004) believes that such interactions enable true empathy and that it is only through genuine empathetic relationships that a sense of holistic well-being may be achieved.

Achieving, and, moreover, maintaining human-to-human, partner-like relationships based on *beauty and love*, Buber's *I-Thou* concept and Heidegger's *authentic* relationship model is likely to require of care-givers a depth of self-awareness, a high level of emotional input, and an understanding of others' concepts of self and spirituality.

In the pursuit of good quality care, Burnard (1986) placed an emphasis first and foremost on care-giver self-awareness. Effective practice requires of care-givers an awareness through which he or she may reflect the complexities of the social world and the sense that people living with dementia make of it. Rawlinson (1990) observed that being self-aware enables care-givers to develop their strengths and acknowledge, respect and, where

feasible, take action against their vulnerabilities. In this sense, good levels of self-awareness can protect against professional and personal stress and can enable more appropriate interactions with other people (Smith 2007). Conscious exploration of oneself however is complex and inevitably reveals some level of insecurity. If care-givers are asked to engage in psychological introspection in this way, there needs to be a systematic infrastructure of support. Innes (2000) and Marshall (2006) emphasise the importance of recognising and properly addressing the emotional needs of staff, without which openness to new learning may be inhibited and consistently good care fail to flourish.

In addition to care-givers contemplating their own sense of self, their perception of other people's projection of self is pivotal to how they interact with them. The status of self, as bestowed by staff on a person being cared-for, can fundamentally confirm or deny the latter's sense of self (Kitwood 1997). The apparent erosion of self, or personhood, in people living with brain dysfunction has invited much discussion over the past two decades (Fox 1989; Kitwood 1997 and 2004; Normann, Asplund and Norburg 1998; Aldridge 2000; Downs 2005). Measures used to interpret levels of self are set against a backdrop of social and cultural values. In Western culture, the biomedical model links organic dysfunction of the brain to loss of self (Miesen and Jones 1997).

Hughes (2001) considers the concept of self from the perspective of people living with dementia. The author centres his discussion on the perspectives of self that were developed by John Locke in the seventeenth and eighteenth centuries and by the contemporary philosopher, Derek Parfit (Parfit 1984). Both authors rejected a common view of self as a range of connecting concepts; the physical self, mental self, spiritual self, the ego (Gallagher 2000). Rather, Locke and Parfit explained the maintenance of self as the continuity of consciousness (Parfit 1984). Locke and Parfit's explanations emphasise the importance of a continuum of *life narratives* which are strung together, each relating to the other. This view has consequences for people living with dementia. If the unity of narrative, which offers references to history, change and constants, becomes unintelligible, a sense of self may be seriously threatened.

Parfit (1984) demonstrates this by writing:

...a person can gradually cease to exist some time before his heart stops beating. This will be so, if the distinctive features of a person's mental life gradually disappears (p.323).

Buchanan (1988) emphasises this view:

...[a human being] with severe dementia, lacking the appropriate LP [Locke/Parfit] psychological continuities, is not a person at all (p. 279).

Gallagher (2000) advocates the theory of the *narrative self* and added to the debate the theory of a *minimal self*. The author explained that the *narrative self* facilitates a more or less coherent self-image that is integrated with a past and future. This theory has potential to fail people living with dementia because of the likelihood of a fractured sense of connection with the past and difficulties with projecting into the future. It is also a challenge for people living in care settings because the people with whom they share their day-to-day life often have relatively little or no knowledge of their previous life-experiences. The *minimal self*, however, is based the notion of a consciousness of self as an immediate experience, unconnected to the past or the future. In this case, Gallagher upholds the concept of self in the here-and-now, without the need for a narrative relationship. Gallagher stated:

Even if all the unessential features of self are stripped away, we still have an intuition that there is a basic, immediate, or primitive something that we are willing to call self (p.15).

Kitwood (2004) Killick and Allan (2001) and Aldridge (2000) share the belief that people with dementia remain acutely aware of their concept of self. Aldridge (2000) describes tensions between this awareness and an outward projection of self; the self that caregivers observe. The author suggests that human beings *perform* their very selves in order to interface with the social world. Killick and Allen (2001) argue that an apparently incoherent performance of self induces in spectators a denial of the presence of self. Sabat and Harré (1992) suggest that this denial may be as much to blame for disruption of self as anything inherent in the medical definition of dementia.

The authors agree that social interactions can facilitate, or otherwise, an individual's ability to express their identity:

If there is loss of capacity to present an appropriate self, in many cases the fundamental cause is to be found not in the neurofibrillary tangles and senile plaques in the brains of the sufferers, but in the character of the social interactions and their interpretation that follow in the wake of the symptoms.

(Sabat and Harré 1992 p. 460)

Training to support staff to understand different expressions of self, and to enable the bestowing of a status of self in the context of those expressions, is largely dependent on the type of individual relationships that staff have with the people for whom they care.

Buckland (2004) argues for a model of care in which the qualities, skills and care-giving styles of individual care-givers fit the personality and needs of the person requiring care. When properly supported, this type of relationship can protect the well-being of both the care-giver and the cared-for. However, setting aside time for supporting care-givers in this way is complex in terms of personnel and identified time shortages.

Chambers and Ryder (2009) suggest that a fuller understanding of other people's needs may pivot on care providers' natural or learned empathetic qualities and their ability to create a spiritual communion. Oswald (2004) however, highlights problems with definition of the terms *spiritual* or *spirituality* in care-giving vocabulary. In examining the differences in perceptions of the terms *spiritual care* and *spirituality* amongst a sample of registered nursing staff (n = 533), Oswald found that most, regardless of age, educational levels and number of years in practice, appeared to have a consistent understanding of *spiritual care*. This they related to acknowledging and embracing a person's beliefs and values. The concept of *spirituality* in healthcare was less clearly expressed but became more defined as the nurses' careers progressed. This implied that nurses with greater life and care-practice experience - and therefore, the likelihood of more training - maybe better equipped to appreciate the deeper needs of their patients and their care needs.

The evidence so far has highlighted the potential challenges for health professionals and care-staff to acquire and/or apply the highly complex set of personal qualities and professional skills needed to effect good quality care. The reported lack of job satisfaction and continued problems with care staff recruitment and retention might suggest that alternative initiatives to the hitherto conventional training are needed. Such alternatives might focus on personal development to underpin the capacity to activate more meaningful interactions that support a sense of well-being for both the staff and the people for whom they care.

2.5.6. Using the arts and music in training for care staff

Some researchers have looked at the value of using the arts and music in healthcare training to foster aspects of aesthetic inquiry and critical thinking that may support these skills (Wikstrom 2003; Wall and Rossen 2004; Freeman and Bays 2007; Casey 2009). Wall and Rossen (2004) provide an example of using music, film and literature to enhance psychiatric nurses' sensitivity to the personal experiences of psychiatric patients, and to cultivate introspection and self-reflection. Hall and Mitchell (2007) report the benefit of midwives' creating *birth-art* to explore the concept of spirituality and the holistic needs of their patients and Wikstrom (2003) reports a significant increase in student nurses' emotional engagement in an arts-based course on empathy.

Freeman and Bays (2007) point to the paucity of empirical research to demonstrate the value of using the arts and music as a tool for learning; they nevertheless advocate its use in training medical and nurse practitioners. This appears to be grounded in the premise that engagement in creative processes may help healthcare practitioners to develop critical thinking that leads to improved care practices. However, for various reasons some care staff may feel uneasy about engaging in the arts and music as a support/learning mechanism. Influences that determine a sense of ease or ill-ease in embracing arts media in this context may also relate to the level at which staff are willing to engage in creative care interventions in their day-to-day practice with the people for whom they care. This factor sits against a backdrop in which the promotion of creative care-giving is emphasised in order to address the current high use of drug interventions.

2.6 Non-pharmacology interventions for people living with dementia

Where the impetus for care is the preservation of quality of life for people living with dementia, a culture of care in which pharmacological interventions are the first-line management strategy for distressing behaviours must be challenged.

Behaviour	CMAI Scale						
	Rate of occurrence						
	1	2	3	4	5	6	7
1. Pacing, aimless wandering							
2. Inappropriate dressing or disrobing							
3. Spitting (including at meals)							
4. Cursing or verbal aggression							
5. Constant unwarranted requests for attention							
6. Repetitive sentences or questions							
7. Hitting (including self-hitting)							
8. Kicking							
9. Grabbing people/snatching							
10. Pushing							
11. Throwing objects							
12. Making strange verbal noises							
13. Screaming							
14. Biting							
15. Scratching							
16. Trying to get to a different place (out of the room/building)							
17. Intentionally falling							
18. Complaining							
19. Negativism							
20. Eating/drinking non-edible substances/objects							
21. Hurting self or others (e.g. using overly hot water)							
22. Handling things inappropriately							
23. Hiding things							
24. Hoarding things							
25. Tearing things or destroying property							
26. Performing repetitious mannerisms							
27. Making verbal sexual advances							
28. Making physically sexual advances							
29. General restlessness/fidgety							

Table 2.8 shows a commonly referred-to list of 29 behaviours identified as common in people living with dementia (Cohen-Mansfield, Marx and Rosenthal 1989). In old care

cultures these behaviours were accepted unquestioningly and attributed to the organic process of the condition (Douglas, James, and Ballard 2004). By contrast, Kitwood (2004) attributes these behaviours to an expression of poor quality of life. Notwithstanding a need for overarching change in care approaches to reduce so frequent a number of manifestations of poor quality of life amongst people living with dementia, a growing number of non-pharmacological interventions (NPIs) have been developed over the last two decades to help to divert and avoid distress.

The term 'non-pharmacological interventions' means any form of non-drug activity, response or reaction that proposes or brings about positive enhancement to the quality of life (Laurence 2010). These interventions merge well with the principles of social and interactionist care paradigms.

A number of researchers have studied the effect of a range of formally applied NPIs (Bates, Boote and Beverly 2004; Livingston, Johnston, Katona *et al.* 2005; Iliffe, Wilcock and Haworth 2006; Hulme, Wright, Crocker *et al.* 2008). These have included motor-exercise, comprising physical education, physiotherapy and occupational therapy (Christofolletti, Olini, Gobbi, and Stella 2007); psycho-therapeutic interventions such as validation therapy (e.g. Neal and Wright 2003); reality orientation (e.g. Brooker and Duce 2000); education in behaviour and social management therapies (e.g. Gormley, Lyons and Howard 2001; Beck, Vogelpohl, Rasin *et al.* 2002; Teri, Gibbons, McCurry *et al.* 2003). Other studies have investigated the value of multi-sensory stimulation (e.g. Baker, Bell, Baker *et al.* 2001; Van Diepen, Baillon, Redman *et al.* 2002); aromatherapy (e.g. Ballard, O'Brien, Reichelt *et al.* 2002); pet therapy; (Churchill, Safaoui, McCabe, *et al.* 1999); and light therapy, in which light boxes are used to stimulate the production of melatonin (e.g. Lyketos, Veiel, Baker *et al.* 1999).

Whilst more extensive, robustly designed research is needed to gain any generalisable picture of value, study results so far indicate some promising benefits to NPIs. In particular, Hulme *et al.* (2008) highlight the value of physical activity, hand massage or gentle touch, music and music therapy to address physical aggression, physical non-aggressive agitation, verbal aggression, and verbal non-aggressive agitation.

2.6.1 The challenges of administering non-pharmacological interventions

Some of the NPIs illustrated above are traditionally administered by professional therapists. It may be argued that many could be successfully delivered by care staff with training and/or support or mentoring from professional therapists or trainers.

Speaking at the Demenzforum-Meeting in Wittenberg, Germany in September 2006, psychiatrist, Professor Johannes Pantel stressed the importance of training formal care staff to use NPIs to reduce iatrogenic harm and to achieve better quality of life for all concerned. Pantel said:

Improving quality of life for people with dementia and their carers is not necessarily through pharmacology [but] in communication and training directed to patients' relatives and staff ... It [non-pharmacological therapy] should be prioritised because it has been shown to be effective and produces less side effects.

Pantel's proposition, which centres on the wide-spread use of NPIs to support well-being, appears worthwhile. However, Iliffe *et al.* (2006) presents a number of potential problems, not least in relation to the labour-intensive nature of these types of interventions. Currently there are not enough professional therapists specialising in the field dementia care to administer or train/support staff to use NPIs on any sustainable level. Even if an infrastructure for training/supporting staff was in place, the current undersized workforce is arguably psychologically ill-equipped to administer an extensive range of NPIs. Iliffe *et al.* suggest that this is largely due to a paucity of understanding amongst healthcare professionals and care staff of the theory behind therapeutic/psycho-social interventions and their practical application.

Dr Erollyn Bruce expressed concerns relating to expectations that care staff should adopt models of care that embrace psychotherapeutic paradigms without adequate training and support. In April 2007, in conversation with the author of this thesis, Bruce highlighted the challenges of changing the nature of the job in ways that may not suit some established care staff. Staff who are drawn to the work because of its practical, task-directed nature may be reluctant to engage in interventions that take their role onto a different level. Bruce

argued that care staff are not currently systematically supported or protected by the same boundaries of other health disciplines that draw upon aspects of psychotherapeutic practice.

Chapter Two Summary

This chapter has examined how the history of Government policy and legislation has moved from a bio-medical model of healthcare to one that aspires to holistic health and well-being. However, evidence suggests that this aspiration may be undermined by current mind-sets and training models, which are clearly influenced by the bio-medical model. People living with dementia may find themselves at the heart of this tension, not least because of the economic, psychological and practical challenges of training and supporting their primary care-givers to adopt different ways of caring.

There is a small body of evidence that indicates the value of the arts and music as a tool for care-givers to develop self-confidence, which may lead to broader levels of critical thinking and aesthetic inquiry. This in turn, may help to accelerate a care-paradigm shift away from task-orientation and towards a more integrative holistic approach in which the well-being of the people being cared-for is underpinned by a sense of well-being amongst the care-givers.

Chapter Three

Historic, social and educational developments in music: influences on care-givers and people living with dementia

The next chapter examines the potential for the musico-cultural and educational experiences of care staff to influence their willingness, or otherwise, to embrace music as agent for change in the care of people living with dementia. It discusses literature that argues for and against music as a universal feature of humanity (Clift and Hancox 2006) and the presence of an innate music instinct or genome in humans. It explores the physiology and neurology of music, which may help in some way to explain the apparent preservation of musical functionality in people living with dementia.

3.1 The place of music in human existence

3.1.1 The origins of music

Many theorists writing about the origins of music remind their readers that no known human culture is without music (e.g. Storr 1992; Gray, Kruase and Aterna *et al.* 2001; Hauser and McDermott 2003; Mithen 2007). The presence of music in human existence has engendered much theoretical debate, the foci of which often highlight two distinct perspectives that centre on complex evolutionary and cultural aspects of human life.

The first of these perspectives, which considers music as an evolutionary *adaptation* (e.g. Darwin 1871; Blacking 1971; Cross 1999; Balter 2004 Miller 2000; Bickerton 2000), may help to explain the perceived value of music for people living with dementia, as frequently reported anecdotally by care-givers (Aldridge 1992; Kneafsey 1997). This perspective also provides a rationale for the existence of innate musical competences in *each and every* human-being (Clift and Hancox 2006). The primary driver of these competences is thought to relate to genetic programming which equates to the survival of the human species (e.g. Darwin 1871; Blacking 1971; Gordon 1979; Sloboda 1994; Imberty 2000; Wallin, Merker and Brown 2000; Falk 2000; Huron 2003; Peretz and Zatorre 2003; Cross 2005; Peretz 2006). Cross (2005) supports the genome theory by observing the apparent universal, cross-cultural temporal organisation of some musical

constituents, such as regular and periodic rhythmic clapping or foot-tapping on the strongest musical impulse or beat. Avid proponent of the musical gene theory, Leonard Bernstein (1918-1990) referred to an inborn musical grammar that transcends eras, continents and musical genres. In support, Imberty (2000) observes that when pared down to their purest states, the same basic set of rules occur in all musical systems across world cultures.

Despite some arguments for environment-grounded acquisition of musical competence during foetal development (Parncutt 2006), a growing body of research on infant responses to music appears to add weight to the genome theory (Trainor and Trehub 1992; Parncutt 2006; Trehub 2003; Hauser and McDermott 2003). Trehub (2000) rationalises the presence of a musical blue-print with her observation of similar music perception patterns in young human infants who have had little or no exposure to music, and adults who have had extensive exposure to music. Trehub observes that both adults and very young infants from different cultures are sensitive to the first intervals of the harmonic series, that is the octave and the perfect fifth, and three month old infants can recognise changes in pitch and melody contours and changes in key signature and tempo changes (DeCasper and Sigafos, 1983; Trehub 2003).

Arguments for music as an evolutionary adaptation frequently refer to anatomical evolution that rendered human-beings capable of singing. This applies specifically to bipedalism, the squaring of the cranium and barrelling of the rib-cage (Falk 2000; Morely 2003), the marked projection of the nasal area and lowering of the larynx and the increased strength of the tongue muscle (Frayer and Nicolay 2000). These collective changes supported a more efficient bellows system, better vocal resonance, pitch range and volume, and more precise articulation.

In terms of *adaptation*, the capacity to sing and make music is critically linked to a number of survival factors, for example, mother/infant communication for the protection and survival of human young during their lengthy juvenile dependency (Dissannayake 2000). Other survival factors associated with music include the identification and selection of a healthy mate (e.g. Darwin 1871; Huron 2003), the triggering of biological

and physiological mechanisms understood to be life-supporting (e.g. Wallin, Merker and Brown 2000; Falk 2000; Peretz and Zatorre 2003; Peretz 2006) and rhythmic entrainment to support motor ability, most notably walking and running, and coordinating life-supporting group labour tasks such as hunting and warding off predators (Morely 2003).

The second perspective offers an opposing theory. This views music as an *exaptive* feature that was formed through cultural invention. Its purpose was to give pleasure and to support physical, emotional, psychological and social functioning (e.g. Pinker 1997; Kogan 1997; Sloboda and Juslin 2002; Huron 2003; Sloboda 2007; Levitin 2006). Amongst the most vigorous proponents of the *exaptive* theory, psychologist Stephen Pinker claims that music was exclusively cultural, happening by accident in the course of cultural, ritual and language adaptation. Pinker went as far as to describe music as 'auditory cheesecake', a mechanism to stimulate the brain's pleasure centre (Pinker 1997 p.524).

In terms of historic socio-musical practices, archaeological evidence dating from the Middle and Upper Palaeolithic period, which spanned c. 200,000 to 12, 000 years ago, provides some tangibility to conjecture (Wade-Matthews 2001; Morely 2003). Morely points out that most artefacts and paintings of musical activities were found in caves large enough to accommodate many people. For example, acoustic studies in the *Grotte du Pech Merle* cave showed zones marked out with animal paintings from the Upper Palaeolithic period, which demonstrated magnificent resonance properties. Other archaeological finds included clusters of different instruments.

These collective observations indicate that music was practiced as a communal activity and that a variety of timbral and acoustic affects were sought (Sachs 1942; Hickmann 2006; Morely 2003). This complexity also indicates a cognitive wherewithal in relation to organising musical sounds despite the relative un-sophistication of the early *homo sapien* brain (Mithen 2007).

3.1.2 Music and Emotion

Hargreaves and North (1999) observe that people across the world today use music to stimulate, express and embody their emotions. Once again, primal maternal and infant communication is drawn upon to help to explain these phenomena (Mithen 2007; Trehub 2003; Magee and Davidson 2004; Parncutt 2006). Parncutt (2006) explains that *motherese*, that is, proto-musical communication between infants and their carers, affects the stimulation of physiological events associated with emotional expression and interpersonal interactions. Morely (2008) and Mithen (2007) also explain that the emotional effect of singing relates to the evolutionary roots of emotive or *prosodic* (emotional tonal content) vocalisations. Mithen suggests that musical sounds were vital and integral components in a holistic, pre-speech communication system, which acted as a vehicle for expressing needs and emotions within increasingly complex social structures.

Seashore (1967) observed that the experience of music, that is sensory phenomena and emotional responses to sound waves, true pitch, dynamics and metronomic pace, take place as an amalgamated episode. Seashore approached the subject with awe, writing:

...we are confronted with one of the greatest marvels of nature, the wondrous transformation from matter to mind: out of a mere vibration is built a world of musical tones, which do not in themselves suggest vibration at all. So it is all in the senses.no one doubts the experience of beauty. The love and understanding of things seen in nature and art take for granted this physical-physiological-mental series as an integrated unit.
(Seashore 1967 p. 15)

Whilst Tramo (2001), amongst others, concurs with Seashore in observing that human beings can access music and apprehend its emotional meaning without conscious effort, Sloboda and Juslin (2001) and Sloboda (2001) are amongst those who have helped to unravel the physical-physiological-mental phenomena which are taken for granted. Arranged in a certain way, the musical structures of pitch, melody, timbre, duration, volume, rhythm and harmony can elicit in the listener a sense of fulfilment or, alternatively, disruption of expectations. The intensity of this fulfilment or disruption is importantly linked to emotional changes (Meyer 1956). Sloboda and Juslin (2001) identify specific musical structures, such as syncopated rhythms, grace notes and

harmonic variations, that are likely to induce emotional reactions. Stefano, Zhu, Cadet *et al.* (2004) suggest that these emotional reactions may be associated with music-induced alterations to opiate receptors in the brain. These alterations can induce in the listener changes in respiration, heart rate, blood pressure and temperature (Panksepp 1995). Sloboda (1991 and 1998), Panksepp (1995) and Panksepp and Bernatsky (2002) investigated music-induced tingle or shiver sensations, which the authors found correlated most commonly to melodic or harmonic sequencing, or changes in musical texture or volume. Sloboda (1991) showed that the musical features most likely to elicit tears were descending harmonies and harmonic suspensions whereby two dissonant notes linger before resolving onto a consonant.

Within the wider discussion on the origins and purpose of music sits the common phenomenon of responsiveness to music and musical functionality that is apparently preserved in many people living with dementia (Aldridge and Aldridge 1992; Kneafsey 1997). So far, the evidence indicates that this may be linked to the musical genome theory (e.g. Trehub 2003), which argues for music as an innate function of human existence. As such, music's accessibility and its expression of emotional meaning is not dependant on conscious effort (Tramo 2001). Preserved musical functionality may also be linked to music's capacity to elicit pleasure and to support and/or alter emotional and physiological states (e.g. Hargreaves and North 1997, Pinker 1997).

3.2 Music, biology and neuro-science

3.2.1 Music as a biophysical mechanism

The notion that music is not only *with*, but also *within* human-beings has provoked much discussion over the last decade (Hargreaves and North 1997; DeNora 2006; Levitin 2006). Ansdell (1995) refers to music in relation to biophysical mechanisms. In this, the interactions between cells occur rhythmically and melodically to synchronise homeostatic status (internal stability), such as respiration and temperature. Ansdell rationalises the desire in human-beings to engage in music simply in terms of extending these internal functions.

Ansdell writes:

We do not merely hear and play [music], we have prototypes of rhythm, melody, harmony and form in our physiological and psychosocial processes (p.9).

Other theories posit the presence of a hypothetical master clock or metronomic pace-maker that regulates oscillations in the brain and coordinates different neural processes (Surwillo in 1968; Church 1984; Buhusi and Meck 2005; Helmbold, Troche and Rammsayer 2006). There is a general consensus amongst the theorists that internal rhythm and timing features very highly significant in learning and memory. Within this system of thought, humans *are* music rather than merely being musically entrained. Ansdell (1995) consolidates this theoretical perspective by describing the relationship between music and human beings simply as ‘like to like’ (p.9).

3.2.2 Music and neurology

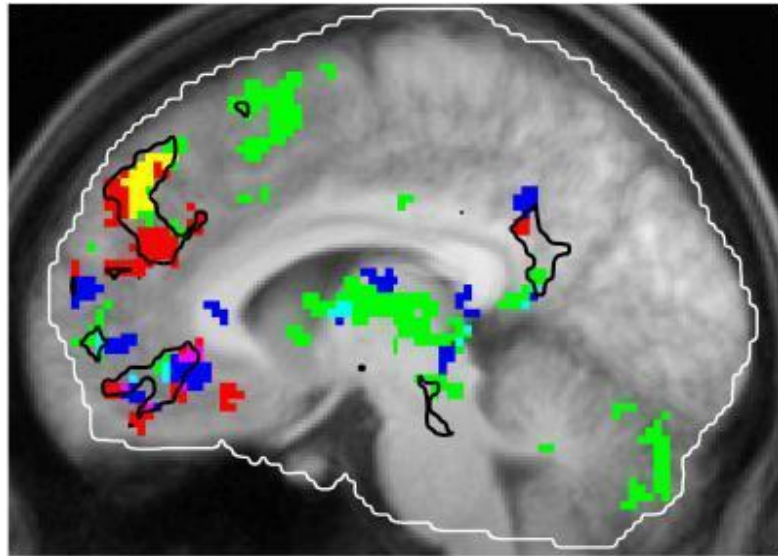
Neuro-psychologists, Isabelle Peretz and Robert Zatorre counter theories that accept music as a cultural invention, asserting that it makes little bio-physiological sense (Peretz and Zatorre 2003). Rather, Peretz and Zatorre suggest that music processing and perception can be better explained in terms of autonomous neurological functions. Discrediting early theories that explained the neurological processing of music in terms of right hemispheric activity (Morley 2003), it is now understood that the process is more complex and involves multi-lobal activity across both the right and left hemispheres of the brain (e.g. Griffiths 2007; Brust 2001; Parsons 2007).

Table 3.1 Neural processing of music			
Brain area	Position	Musical Function	Musical activity
Cochlear nuclei	Sub-cortex	Distinction of dissonance and consonance	Listening to harmonic structures
Cerebellum	Sub-cortex	Sensing music Timing circuits	Tapping a rhythm, either actually or in the mind
Auditory cortices	Temporal lobes	Perception of sound	Hearing music
Hippocampus	Inferior temporal lobe	Musical memory	Following the sound of familiar music or musical style
Pre-frontal cortex	Frontal lobe	Tracks movement of melody rooted in a sense of the tonic (home key)	
Sensory cortex	Parietal lobe	Analysis of Sound	Listening to music
Motor cortex	Frontal lobe	Control of goal-directed movement	Performing music
Visual cortex	Occipital lobe	Receipt and analysis of visual stimuli	Reading words/music
Broca's Area	Inferior frontal gyrus	Language processing speech and sign	Listening to or recalling song lyrics Singing
Wernicke's Area	Superior temporal gyrus	Analysis of spoken language	Listening to or recalling Singing

Table 3.1 shows Levitin's (2007) description of processes that transform acoustic signals into auditory perceptions. The process starts with sensations hitting the cochlear nuclei positioned in the ear. The analyses of pitch, melody, timbre, duration, volume, rhythm and harmony are widely distributed across the lobes of the brain and processed by separate but interconnecting circuits (Peretz 2003; Griffiths 2007; Brust 2007).

The identification of cerebral structures normally associated with temporal analysis of sound have been made possible by the sophistication of neural imaging, such as Positron Emission Tomography (PET), Functional Magnetic Resonance Imaging (fMRI) and magnetoencephalography (MEG) (Zatorre, Evans, Meyer *et al* 1992; Zatorre, Evans, Meyer 1994; Parsons 2001).

Fig. 3.2 Brain activity during various musical listening experiences (fMRI) (Janata, Tomic, and Rakowski 2007)



(Cross-section of the brain viewed from the left side)

Janata *et al.* (2007) provide an example of fMRI that shows the dissemination of musical neuro-stimulation (Figure 3.2). Janata and his colleagues identified increased cross-lobal activity when subjects listened to a familiar tune, shown in green. The red areas show responses to salient autobiographical memories elicited by music. The blue areas are responses to enjoyable tunes. The yellow areas, which are positioned in the dorsal medial prefrontal cortex (DMPFC) show responses both to familiar and autobiographical associations.

Janata *et al.* and his colleagues related their findings to people living with dementia. They explain that DMPFC is a region of the brain where memories are supported and retrieved. The region also links familiar music to autobiographical recall and emotion. As it is also one of the last regions to atrophy (shrink) in many dementias, particularly Alzheimer's disease, the authors suggest, that this may help to explain why music can elicit strong responses from people living with dementia.

Further explanations for the apparent retention of access to music in people living with dementia include Altenmutter and Gruhn's (2002) theory of two listening modes that

occur simultaneously and overlap. These modes, which the authors refer to as the *interval based* or local mode and the *contour-based* or global mode, enable rapid analyses of acoustic structures such as note-by-note patterns, pitch, volume and metre, as well as setting into motion a broader set of perceptual and cognitive operations. Limitations in the local mode of access may not preclude an individual from accessing music in a global sense. Raybrouck's (2007) model, which centres on music being accessed at any point along continuum of perceptions involving lower brain sensory perception and higher brain cognitive refinement, endorses this theory. Both Altenmutter and Gruhn and Raybrouck assert that at some level, access to music is possible because it is not dependent on any specific measure of higher cognitive ability. Tomaino (2002) concurs with this theory, pointing out the strong connection between the auditory system and the limbic system, the most primitive in the human brain, which also supports functions such as long-term memory and emotion.

3.2.3 Singing and health

Contributing to a growing body of evidence, researchers from the Sidney De Haan Research Centre for Arts and Health, Canterbury Christ Church University, have provided a number of papers on the impact of singing on health and well-being (Clift and Hancox 2001; Clift, Hancox, Morrison *et al.* 2008; Clift, Hancox, Starocoff and Whitmore 2008). In addition to identifying a range of singing-induced psycho-social indicators of well-being, a team from the Centre also undertook a systematic review of thirty five non-clinical studies on singing, well-being and health published between 1960 and 2007. The review highlighted the power of singing to support perceptions of positive quality of life.

A small number of studies from elsewhere in Europe have examined some of the physiological consequences of singing. Grape, Sandgren, Hansson *et al.* (2003), for example, showed that levels of *oxytocin*, which are significant in stimulating memory and social bonding, were raised in study participants during singing lessons. Beck, Cesario, Yousefi, and Enamoto (2000) and Kreutz, Bongard, Rohrmann *et al.* (2004) found raised levels of salivary *Immunoglobulin A* (IgA), which supports a healthy immune system, in singers in communal choirs.

The effect of singing on a combination of psycho-social and physiological well-being may underpin individuals' motivation to engage in these activities. This is likely to relate to individuals utilising music to manage mood, self-identity and interpersonal relationships (Hargreaves and North 1999).

The evidence so far implies that music can act as a central component to support well-being, and that this may be unrelated to levels of cognitive functioning. It may be concluded therefore that any person, including those living with dementia, as well as their care-givers, has the capacity to tap into their innate musicality to support good quality of life. However, in the UK, attitudes towards music and musical practices vary considerably between communities and individuals. It may be argued that the Western cultural, political and institutional practices that have developed over thousands of years have led to the submerging of innate musical competences to the extent that they are no longer acknowledged by many people.

3.3 Historic influences on care-givers and the use of music in care settings.

Johnson (2004) recognised that music as a distinct cultural representation of human discourse and communication was, and continues to be determined and shaped by cultural, social and political developments over time. Anderson, Castelo-Branco and Danielson (2007) plotted 3,500 years of musical developments in Europe that ultimately led to the emergence of the Western Classical Tradition (WCT), which embodied music practice and music education in Westernised countries from the early nineteenth century.

By *c.* 1500 BC, northwards migration from Egypt and the growth of trade meant that there was extensive integration between the Mediterranean people of the Aegean, Greece, Etruria and Rome. At this time music and dancing was practiced by people from all social classes but only the lower classes sang, played and danced in public. High status individuals kept slaves or employed musicians to perform at public and private functions. Sachs (1942) observed that these distinctions bestowed on music socio-musical status' that differentiated musicians, their employers, and the masses.

A sense of musical propriety was significantly propelled by Pythagoras' (born *c.* 580 BC) musico-mathematical doctrine, the *Music of the Spheres*. The doctrine equated musical components to the spiritual and physical universe and exemplified harmony between the human soul and the cosmos. Music was therefore accorded extra-musical functionality to the extent that music-making for its own sake were thought to hold little moral credence. For this reason, music-induced catharsis was generally discouraged (Grout and Palisca 1996).

The belief that music should be grounded in extra musical functionality became the core premise in the philosophical teachings of Pythagoras' later compatriots, Plato (born *c.* 427 BC) and Aristotle (born *c.* 384 BC). In their later respective and influential treatises, *Republic* (Plato *c.* 375 BC) and *Politics* (Aristotle *c.* 330 BC), both philosophers attested the power of music to significantly affect behaviour and to emit moral and political messages. Music therefore became a potent tool in Plato's cultivation of 'the ideal state', in which guardians and prominent citizens were elevated to the position of philosopher rulers to govern over the masses. Central to this new hierarchical governance was indoctrination centred in an education model, in which the media of *mousike*³, and gymnastics, were prescribed in appropriate proportions to order the mind and body (Goehr 2007).

Plato's proportionate measures of *mousike* and gymnastics related significantly to genderisation. An over-prescription of music was thought to feminise men, whereas the masculine qualities of athletic gymnastics provided a counterbalance. According to Platonic doctrine, other music and gender-related tensions reflected the juxtaposition between the sensual and matriarchal roles played by women (Harmen 2005), and the potential for simultaneous lure of beauty and temptation to decadent desires (Green 1997; Janaway 1998).

³ As an educational component, *mousike* is interpreted as any art or craft (or *muse*) such as poetry, dance and music (Goehr 2007).

3.3.1 Music and the Church

Plato's Doctrine of Ethos emphasised rationality over emotion, the latter of which was thought at the time to rise from the lower brain and to pervert reason. The notion of music's inextricable link with the pursuit of higher intelligence and its synergy with the cosmos became firmly rooted by the advent of Christianity (Boyce-Tillman 2000). Music practiced in the Christian church embraced Plato's inherent teachings on the power of music to influence character. The dangers of beautiful music to incite the pleasures of the senses and interfere with the meaning of liturgical texts were espoused over hundreds of years, most notably by the fourth-century catholic bishop Saint Augustine of Hippo (Saint Augustine/Rotelle [ed.] 2002); catholic priest, Thomas Aquinas (1224 – 1274); and in the sixteenth century, by the so-named Council of Trent, a reform body for the Catholic Church at the time of the Reformation (Grout and Palisca 1996). The doctrine ensured the continued confinement of musical forms in Christian worship, for example, single note chants and plain song, to arouse Christian devotion whilst avoiding sensual pleasure (McKinnon 1987). Musical form, structure and tuning-sophistication grew with the development of written notation and musical contextualization of liturgical text. The process propelled context-related musical practices, whereby music of the people, that is national and folk music, became disassociated with the morally grounded, notated music of the Christian church (Boyce Tillman 2001).

The lasting legacies of music's development since Pythagoras' doctrine may have a number of profound effects on care staff today. For example, Norris (1989) observed that the centralisation of church music in moral education set the scene for music's relationship with competing social and political forces, which continue in some way to influence the way in which people perceive and practice music today. Musical structure, content, performance styles and behaviours are liable to vary according to the context in which they occur. Tensions around a sense of musical propriety in care settings are likely to affect care staff at some level, because the role of music in this context is not generally defined.

In terms of the genderisation of music, there may be potential for male and female staff to use music differently in their personal lives and to use music differently between the men and women in their care. For example, for some male staff, singing or humming lullabies as an end-of-life intervention might seem inappropriate. It may also seem less appropriate for staff to sing to cared-for men than to cared-for women.

3.3.2 Music as an aesthetic experience

As the dominant institution in Europe, the church shaped music in terms of ritual and pedagogy up to the eighteenth century. The separation between the intellectual qualities of music and its *aesthetic* qualities was upheld until the sensory functions associated with the arts and music took on a new understanding. This new perspective was notably driven by Berlin-born philosopher, Alexander Gottlieb Baumgarten (1714 – 1762). Baumgarten rejected the Platonic and Aristotelian traditions that art works *must* be couched in *noesis*, a superior form of perception that was understood to be governed by high-brain cognitive reasoning, in favour of a sensory understanding of art grounded in feelings that emanate from the lower brain (Strati 2000; Koivunen 2002; Beard and Cloag 2005). This philosophical perspective was shared by Baumgarten's contemporary, David Hume (1711 – 1776) and later the empiricist, Immanuel Kant (1724 – 1804). In assigning content and meaning to art works in the absence of explicit moral, religious or rational focus (Schaper 1968), notions of immorality in relation to music for its own sake were undermined. From this point on, music composed and/or performed for its own autonomous purpose became central to establishing a synergy between the intellect and the senses.

3.3.3 Musical elitism

Goehr (2007) used the term 'the emancipation of music' referring to its disentanglement from everyday life and release from extra-musical ideologies. Small (1998) suggested that when standing alone in this way, the final product, the finished musical work, became the focal point. For this reason, from the mid eighteenth century, production of art and music was increasingly designated to skilled artists. This produced a widening schism, which prevails today, between the people who produce and perform music and people who passively receive it. This factor may discourage care-givers from actively engaging in music-making, if they regard production and performance the realm of experts.

From 1900, Longhurst (2007) suggested that a schism of musical practices and tastes arose naturally, as they might, amongst any societies with emergent social substrata of classes. Van der Merwe (1989) caricatured European musical styles of the nineteenth century with two satirical images. The first, classical or *serious* music was 'produced and performed by geniuses'. The second, folk music, 'hails from illiterate peasants, untouched by bourgeois values and practices' (p. 15). Middleton (1990) referred to a division between folk music, which was associated with peasant, traditional and national music, and music of the bourgeoisies which, from the mid nineteenth century developed commercially to form the genre of *popular* music. These definitions of classical, folk and popular music are over simplified, but they serve to illustrate the lingering legacy concerning the constitution of elite and non-elite music.

Linked to the mass migration to industrialised towns and cities in Europe, a confluence of musical styles began to ebb and flow for over two centuries. Up to c. 1850 composers and performers of serious, folk and popular music drew inspiration from one another. Born and Hesmondhalgh (2000) pointed out that by the beginning of the twentieth century, some composers demonstrated a clear rejection of the folk/popular idiom. Thus begun a new wave of music termed *art music*, which emphasised complex musical structures and theory (Tagg 1982) and deliberately disassociated itself from mass popularisation (Scott 1990). The genre of 'art music' was illustrated most dramatically by Schoenberg's twelve-tone serialism, which was the antithesis of the tonality of popular music. According to the prominent philosopher, Theodor Adorno, it is precisely the structural standardisation of tonality in popular music that underpins its appeal because the listener can relate to it automatically (Adorno 1941).

It is interesting to note that before the advent of mass broadcasting, popular music that tended to focus on domesticity and urbanisation was promoted for the lower classes in *burlesque*-style music-hall theatre (Middleton 1990). Bailey (2004) observes that this style of musical interaction centred on comic songs and ballads and their content was grounded in escapism couched in highly selective realism. Bailey suggests that the music-hall phenomenon was politically manipulated to avoid a focus on the rising tensions and conflicts resulting from mass inequality.

That the popular music of middle-class citizens was more demur and often performed with friends and family in private homes, was testament to a class divide.

Characteristic		Folk Music	Art Music	Popular Music
Produced and transmitted by	Primarily professionals		x	x
	Primarily amateurs	x		
Mass distribution	Usual			x
	Unusual	x	x	
Mode of storage and distribution	Oral transmission	x		
	Musical notation		x	x
	Recorded sound		x	x
Type of society in which category of music mostly occurs	Nomadic or rural/agricultural	x		
	Rural/agricultural or industrial		x	
	Industrial		x	x
Written theory and aesthetics	Less common	x		x
	Common	x	x	
Composer/author	Anonymous	x		
	Non-anonymous		x	x

Table 3.3 shows that in the 1980s, a clear distinction remained evident between music producers, distributors, transmission mechanisms and audience groups (Tagg 1982). This was despite an increasing fusion of musical genres which were driven by better articulation of multiculturalism in the UK through immigration and cosmopolitanism from the mid-1970s onwards (Scott 1990; Meyer 1994; Walker 2001).

At around the same time that cross-genre music was coming of age, the cult of the celebrity was escalating. This brought with it a new perspective of musical elitism. As a consequence, folk and popular music was elevated to a status previously associated with traditionally elite music, most notably illustrated by the advent of national accolades, hitherto reserved for elite classical musicians, being awarded to popularist music performers and personalities, such as Cliff Richard, Elton John and Paul McCartney.

Emmerson (2001) observed that the proliferation of media over the last century has led to increased access to a huge diversity of recorded musical genres for the masses. A consequence of this is that fewer people habitually engage *actively* in music that would in the past have embodied the music of the people. As such, a whole range of music is today subjected to a similar force of control by the powerful establishments, such as commercialism. In this, a commercial judgement is bestowed on musical genres that hitherto belonged to active music-making communities, such as folk music, in which hierarchies of excellence were not necessarily emphasised historically.

A further change in musical behaviour relates to technological development. The growth and affordability of personal audio equipment has meant a huge surge in music-listening as a solitary activity (North, Hargreaves, and Hargreaves 2004; Bull 2005). Bull (2005) suggests that these devices are often used as an interaction-avoidance strategy.

It appears that a sense of musical elitism today emanates from a long-standing attitudes and practice. Care-givers' willingness to actively engage in specific types of music-making in the workplace could be influenced by their own musical experiences and expectations and the degree to which they perceive the commercial promotion of music and its inherent suggestion of excellence in performance. Care-givers' experiences of personal music-listening devices may promote the notion that music is primarily useful as a diversion *from* interacting with others, rather than its more traditional of engaging *with* other people.

3.4 The influence of twentieth century music education on care-givers

Care-givers who took part in this study and attended school in the UK did so between the years 1950 and 2005, with the majority attending school between 1965 and 1985. In order to understand how their experiences of music education may have shaped their current-day perceptions and engagement with music, this discussion firstly examines the foundations of Western music education and how these formed twentieth-century systems of education.

Paynter (1982) pointed out that a formal synthesis of theory and practical music-making in music education developed over two thousand years, from the Latin-West influences

of the Roman Empire and its focus on the theory of acoustics, to the sixteenth century proponents of practical musicianship, most notably through the pedagogy of Sir Thomas Elyot (1490-1546) and Richard Mulcaster. (1531-1611). Over the next four centuries enduring historical influences merged with philosophical, social and economic factors in shaping and re-shaping music education up to the twentieth century (*ibid.*)

Contemporary literature on the benefits of music education between the sixteenth and twentieth centuries reflects a mix of utilitarian and aesthetic functions (McCarthy and Goble 2002; Reimer 2003; Johnson 2004). The study of music as a utilitarian function was used to enhance intellectual and social benefits. This reflected Platonic and Aristotelian ideologies. Indeed, Walker (2001) suggests that it was the integrity of the Platonic ideology of hierarchy and excellence that most significantly influenced music education as it subsequently evolved in the Western world.

Plato's ideological sense of musical propriety underpinned the later development of the Western Canon, which developed formally from the beginning of the twentieth century. It comprised a compendium of literary, musical and art masterworks considered worthy of validating and shaping the central ideals of Western Classical Tradition (Bloom 1995). Walker (2001) highlighted the dominance of the Canon in music education in the UK up to the end of the twentieth century. This, and the long-standing Roman influences of centralising music theory in education, meant that connoisseur-level musical performance and theoretical knowledge continued to be championed as major educational goals.

Walker (2001) pointed out that people schooled in the UK up to the 1970s were likely to have experienced education in different ways. For many, their experience would have centred on the ideals of the Western Canon, at least to some extent. Paynter (1982) suggested that the spectrum of music-education experiences would have ranged from the exclusive promotion of Canonic material and skill-acquisition to the inclusive promotion of music-making regardless of age, aptitude, and ability. The latter model accepted that all school children could engage meaningfully in music in some way. However, a document compiled by the Department of Education and Science in 1978 reported that although inclusive music-making was prevalent in primary schools, by the fourth year of

secondary school only 8% of schools included non-examination music activities (DES 1978). This statistic demonstrated a continued emphasis on skill-competence and theoretical knowledge in secondary schools (Paynter 1987).

For students with low academic aspirations, the relationship between music education and high institutional achievements, as opposed to personal, social and/or creative development, may have presented difficulty for some students to understand its purpose for them personally. To compound this difficulty further, changes in education brought about by the National Curriculum in 1988, marginalised music in terms of schools' main academic goals. For care-givers affected by these changes, clarity in terms of the purpose of music education may have seemed even more elusive.

3.4.1 Music education and social class

The social relevance of music education has elicited wide-spread discussion over a number of decades. Davidson and Smith (1997), Sloboda (2001) and Johnson (2004) assert that up to the end of twentieth-century music was often taught in schools in the UK in an inappropriate, socially fractured microcosm. Even though the addition of broader music genres, such as popularist, folk and world music provided opportunities that were socially relevant to more students from the 1980s (Green 2002), the abstraction of music from lived experiences meant that it related to only a narrow band of students.

O'Neill and Green (2001) and Walker (2001) observe that perceptions of music's importance in education are tied to socio-economic factors. Walker explains this by drawing again on the legacy on Platonic values relating to musical elitism. Walker (2001) observes that judgments of competence in secondary schools in the twenty-first century remain grounded in the pursuit of excellence, the apex of which is entrance into higher education (Hirsch 2007). Small (1996) observed that this system engenders states of mind in which honed technique and skilled performances are valued over and above musical processes such as improvisation, as traditionally occurred amongst the lower social classes.

Walker (2001) and O'Neill and Green (2001) point out that the emphasis on excellence tends to nurture the encultured values of middle-class students. Stains (1998) also

highlighted economic relevance, noting that a major difficulty for working-class people to maximise the advantages that music education could offer, was lack of adequate income. Sharp (1990) reported that the cost of providing instruments and instrumental tuition made it inevitable that this type of education could only be utilised by a minority of students.

In the popular music industry, an assigned state of excellence may not necessarily relate to musical excellence in the Platonic sense, but rather to the cult of the celebrity. The appeal amongst young individuals for celebrity status is no less observed than in the huge number of hopefuls engaging in contests such as *X-Factor* (Winterson 2007). Contests such as *X-Factor* arguably demonstrate Karl Marx's *conflict of interest* theory (Mirowsky and Ross 2003) in emphasising institutional control, in this case, the popular music industry, which makes its own distinctions between superiority, mediocrity and inferiority over subordinate subjects, in this case, the contestants. This example symbolises Marxist philosophy on capitalist societies, in which the ruling classes derive power from ownership and control over suppressed subordinate classes. Marx believed that schools were primary agents for transmitting ideologies that benefited the ruling classes. The capacity to flourish was significantly associated with cultural, social and economic circumstances. Achievement amongst the elite classes and non-achievement amongst the subordinate classes was institutionally normalised (Hallam and Prince 2003). This meant that individuals' self-perception of educational inferiority, mediocrity or superiority most commonly reflected institutional expectations.

Continued inequalities relating to access to Higher Education (HE) include issues of socio-economic status (Hirsch 2007). Although these inequalities are increasingly addressed by broader access pathways to HE and accredited workplace-learning programmes, it remains the case that fewer economically disadvantaged people engage in Higher Education compared with the socio-economically affluent (*ibid.*) Limited uptake of HE amongst care-givers, for whom tertiary education is not generally the norm, may relate Marx's *Conflict of Interest* theory. This relationship may centre on a tendency for care-givers to come from poorer socio-economic backgrounds. It may also relate to a cyclical process whereby limited the educational expectations of educational

establishment reflect low aspirations from students. In terms of music education, social experiences and socio-economic circumstances may influence care-givers' expectations and musical aspirations both in school and as an extra-curricular activity.

3.4.2 Music education and gender

O'Neill and Green (2004) observe that issues of gender and music education reflect wider social conditioning concerning gender roles. Harrison (2007) suggests that the most striking relationships between gender and music education relate to the male-dominated compositions of Western high art music, which is associated with scored music and superior elitism. It also relates to choice of musical activity and/or instrument. Within the context of schools, gender stereotyping associated with learning a musical instrument may be perpetuated by teachers' expectations. For example, formal choir singing usually attracts more girls than boys. Boys are more likely to choose to play a trumpet, guitar or drums, whereas girls are more likely to choose the piano, flute or violin (Harrison and O'Neill 2002; O'Neill and Green 2004).

The presence of gender norms in music may influence care-givers' receptiveness to engage in, and/or to offer music interventions to the people for whom they care. For example, care-givers may feel it inappropriate to suggest playing the drum with cared-for women, or to suggest cared-for men singing together, even though there is evidence to support the positive value of men singing songs that are rooted in their cultural practices (Bailey and Davidson 2003).

3.4.3 Classifying people as *musical* and *non-musical*

Longhurst (2007) observes that historical factors that have shaped music practices in UK today separate people into two differentiated groups, musicians and non-musicians. The grading of musical ability today, which can be traced back to Platonic ideals of excellence and hierarchical judgements of musical ability, remains common. Membership to musical ensembles, such as choirs and orchestras, is often audition-dependent. Walker (2007) observes that in terms of active music-making, that is, learning/playing an instrument and/or singing, only a small proportion of a total school population are involved. It is the notion that music is really only for the few who perform in this way that created

perceptions of two distinct groups, described by Walker as *the musical* and *the non-musical*.

However, Walker observes that in reality the vast majority of people connect with music by listening to it. Turton and Durrant's (2002) survey of 60 participants aged between 20 and 40 showed that nearly all had electively listened to pop music as teenagers. Walker urged school educators to wholly embrace listening to music as a significant and valued mode to develop students who do not engage in active music-making yet can still be respected for their musicality.

Whilst music-listening in music education may have been an important feature in the musical development of some of the participants in the current study, it is arguably unlikely to have been an overarching educational feature for all. Against this backdrop, care-givers without active music-making skills are likely to self-classify as *non-musicians*, which may lead to the belief that they have nothing musically creative to share with the people for whom they care or with their colleagues.

3.4.4 The effects of creative opportunities in music education on care-givers

Tagg (1982) asserted that the musical outlook of some school pupils was crippled by teachers who presented 'serious music' as if it could never be 'fun' and 'fun music' as though it could not have any serious implications. Care-givers' willingness to engage in active music-making in the workplace may relate to the degree to which having fun with music was encouraged or discouraged at school and how the concept of being musically creative was contrasted with technical proficiency.

Hallam and Prince (2003) observed that assessments of musical ability took place as a matter of course in education establishments in Europe as early as the 1880s with Carl Stumpf's (1848 – 1936) use of musical discrimination tests. By the mid-1950s, Hungarian psychologist Geza Revesz (1878 – 1955) had developed a battery of tests which aimed to assess what Revesz termed as 'musicality' (Revesz 1953). Over the next ten to fifteen years various definitions of musicality were put forward by music psychologists and music educators. These included a sense of rhythm, a musical ear and

a musical memory (Revesz 1953), the ability to perceive and appreciate music as a coherent entity (Wing 1961), and the ability to discriminate discrete musical syntax, such as pitch, rhythm and timbre, using a range of connected sensory skills (Seashore, Lewis and Saetveit *et al.* 1960). By the mid-1960s, Arnold Bentley (1913 – 2001) had launched what was to be a prolific research career in the assessment of musicality. Bentley (1966) identified significant shortfalls in previous studies that had compared the musicality of trained musicians and non-musicians based on the fundamental problem of defining musicians and non-musicians. Bannan (2000) suggests that people who label themselves as musical or non-musical, do so based on the level to which they have honed technical skills. Yet Bentley observed that there are a vast range of people who have achieved musician-status without having undergone any prescriptive educational learning processes. This group of people may have relied on experimentation with their own musical creativity.

The work of educationalists such as John Dewey and Margret Donnington in the first quarter of the twentieth century emphasised the importance of creativity in music education (Paynter 1982). Musical *action*, as Paynter later put it, synergizes instinctual, emotional and intellectual energy (Coll and Finney 2007). Coll and Finney observe that formal music education grounded in these principles can underpin holistic development by providing a sense of cultural relevance and opportunities for individuals to express and communicate feelings. From the mid-1950s and early 1960s this model of musical action was increasingly adopted in schools. However, by the late 1980s, the launch of the National Curriculum, which aimed to unify education for all school-aged pupils in the UK, brought about radical changes across the whole of state-maintained education (Kelly 2009). Six years after its implementation, Shepherd and Vulliamy (1994), amongst many other music educators, asserted that one of the curriculum's consequences was the curtailment of teachers' freedom to nurture holistic development through musical creativity.

These observations arguably parallel tensions relating to healthcare education for caregivers which remains largely influenced by the biomedical model. In this case, just as in music education, the long-term legacy of prescriptive learning to enhance technical

competence may inhibit instinctual and emotional creativity. Chambers and Ryder (2009) believe that the balance of technical knowledge and creativity in care needs urgent re-balancing in order for care-givers to provide the highest quality care.

Kuhn and Verity (2008) describe a special mode of caring for people living with dementia, in which the creativity of care-givers is a central asset. The authors refer to this mode as the *Art* phenomenon. It involves the care-giver in empathic interactions in which they respond to the strengths and limitations of the people for whom they care. When fully engaged in this mode of caring, care-givers can maximise the strengths and minimise the fears of the people for whom they care. Sundin and Jansson (2003) provide an example of this type of care mode in a study in which care-givers entered into a non-verbal dialogue with post-stroke patients with *aphasia* (loss of speech). The care-givers used a range of communication methods, such as touch, body language and eye contact, and found that they could understand better the implicit and explicit needs of patients. The authors observed that care-givers created opportunities for co-creating communication with patients by 'being with' them, as opposed to just 'being there' (p.111). The communicative attitude of the care-givers demonstrated a strong desire to understand their patients. The authors conclude that a 'caring communion' is a creative act, in which co-creative processes maximise co-understanding. They also provide a direct musical parallel in describing a caring communion as 'synchronicity of physical actions', 'a dance' and a 'common music' (p. 114).

The presence, or lack of opportunities to express creative endeavour at school may significantly encourage or inhibit creativity later in life. This factor may relate to the degree to which care-givers are able or willing to engage in creative modes of caring in their workplace. According to the proponents of creative modes of care referenced above, elements of improvisation, experimentation and passion, which grounds creative music-making (Green 2002), transfer well to the caring role. It may be argued therefore, that music education grounded in these creative processes may nurture broader, more effective and more fulfilling approaches to care-giving in later life.

3.4.5 Music education and perceptions of singing ability in later life

McPherson (2009) observes that although parental influence and socio-contextual characteristics are crucial in shaping a child's sense of musical development, much of the growing body of literature on children's musical identity centres on singing in schools (Davidson, Howe and Sloboda 1997; Turton and Durrant 2002; Sichivista 2003; Richards and Durrant 2003; and Pitts 2008). Moreover, a retained interest and/or willingness to sing in adult life may relate significantly to an individual's perceptions of their singing experiences at school.

One of the most significant elements to effect singing in schools in England was the widespread application of the *Tonic Solfa* method of teaching singing. The method, which was devised by 11th century monk, Guido d'Arezzo (Grout and Palisca 1997) and developed in the mid-nineteenth century by John Curwin (1816 – 1880) and Sarah Glover (1785 – 1867), revolutionised the practice of singing in educational establishments and in the wider community. However, by the mid twentieth century political tensions grounded in the method's apparent association with non-conformist religions heralded its fragmentation and eventual disappearance as a standardised teaching method in the UK (Paynter 1982).

What contribution the curtailment of *Tonic Solfa* teaching had on singing in schools over the next half century is uncertain but a survey of British schools in 1991 showed that the decline was dramatic with over 85% of schools offering no vocal curriculum at all (British Federation of Young Choirs 1991). The Office of Standards in Education (OfSTED) produced a report in 1995 that pointed to an apparent further decline in singing in secondary schools (OfSTED 1995). A few years later, Mills (2000) asserted a contrary opinion suggesting that levels of singing in schools had, on average, maintained a steady pace over many decades. However, Mills suggested that variations in both levels and standards of singing between individual schools created a wide spectrum of individual experiences for children. Moreover, the impact of these experiences may be far reaching in terms of a relationship with singing in adulthood.

Pitts (2008) reported the experiences of 71 individuals aged between 19 and 86, who had retained a life-long interest in active music-making. Pitts noted a prevalence of singing as a performance opportunity which dominated primary school years and remained a feature of secondary school experiences for over a third of participants. These important formative experiences were coloured by teachers' attitudes, which were reported by participants as a key influence on the ethos of the vocal ensembles to which they belonged. This in turn affected participants' sense of enjoyment and their levels of commitment and motivation.

Welch (2000), amongst others, refers to the damaging practice of negatively labelling school children with pitch difficulties, noting that *un-tuneness* is in any event a socio-musical construction. Welch points out that such labelling frequently invokes amongst the victims, life-long inhibitions to singing. However, Mizener (1993) found that in a sample of 542 school children in the United States aged between 8 and 11, no correlation existed between perceived singing skill and participants' decisions to stay in a choir. In another study emanating from the United States, the majority of a sample of 258 children from various ethnic backgrounds, aged between 8 and 10, who attended schools in Texas, responded positively to the statement, 'I'm a good singer' (Siebenaler 2008). In the UK, Turton and Durrant (2002) found that amongst a sample of 60 survey participants aged between 20 and 40, nearly a quarter had felt insecure about their singing voices at school. The different self-reported levels of confidence to sing and perceived singing ability may show cultural variations in attitudes relating to singing and/or a reticence or tendency to self-promote skill-superiority.

Bannan (2000) suggests that vocal confidence depends upon aural, kinaesthetic and emotional connections, each of which can be negatively influenced by family or peer group response or inappropriate teaching. Bannan advocates a model of education that nurtures an unconditional pleasure derived from singing. The model focuses on motivation to sing. It aims to synergise the element of *amusement* derived from singing, which centres on right brain activity, and the element of *power* derived from singing, which centres on left brain activity. Bannan suggests that these elements of singing are present in early childhood and help children to make sense of the world but enculturation

at school determines whether or not they are nurtured. This observation may be significant in relation to care staff's willingness to sing in their workplace.

Turton and Durrant (2002) also report that just under 20% of participants who 'sing now', had had bad experiences of singing at school, whereas, nearly 25% who had had good experiences at school, 'do not sing now'. However, overall, good experiences at school usually promoted a willingness to sing in adulthood. These somewhat ambiguous findings indicate that experiences of singing in school are not always representative of singing activity in adulthood.

Other findings in Turton and Durrant's (2002) study related to the type of singing activities that the sample regularly took part in. Over 40% of participants reported singing along to the radio, around 25% reported singing at Karaoke events and 25% sang in church as part of the congregation. A small number reported singing to their children, and a very few sang in amateur dramatic productions. One participant reported being at ease during the latter activity because he was able to focus on the co-aspects of the performance rather than solely on singing. Welch (2000) also highlighted the potential ease that singing in an informal social context with a dual focus, such as playing games, can elicit. Pitts (2008) pointed to the potential of performance opportunities to provide inspiration and enjoyment.

Some studies have raised other factors that may inhibit or support singing and other active music-making in adulthood. These include, i) a sense of embarrassment (Richards and Durrant 2003), ii) parents' and siblings' music-listening/music-making habits, iii) parental involvement and support in children's interest in singing (McPherson 2009), iv) musical resources in the home, such as musical instruments, and v) the influence of peers (Pitts 2008).

The current-day growth of televised singing competitions such as *X Factor* and *Pop Idols* may also have an influence on adults' confidence to sing in public. Such competitions encourage public glorification of some contestants and public derision of others based on an institutional judgement of their singing voice. Reijnders, Rooijackers and Van Zoonan

(2007) suggest that a complex process, which is grounded in social solidarity and a community spirit of ranking, legitimises the derision of people who are perceived not to sing well. These popular competitions are likely to impact variably on care-givers as members of a society which embraces them. Some may be encouraged to sing, having been inspired by the ordinary backgrounds of some of the contestants. Others may be affected negatively by the apparent sanctioning of public judgement.

The collective results of these observations, the demise of the *Tonic Solfa* as an overarching method to train people to sing, and expressed judgements of singing ability at an institutional level arguably compounds the notion that some people can sing and some cannot. This attitude, which is now commonly flaunted in the media, may affect the levels at which care-givers are prepared to sing in the workplace. At the University of *Västerås*, Sweden, a group of researchers is exploring music interventions for people living with dementia which require care-givers to sing (Gotell, Brown, Eckman 2000; 2002; 2003; 2009). A key recommendation of their research is the inclusion of formalised training for care staff to learn how to use their singing voice confidently and to transfer this skill to support their own well-being and the well-being of clients during day-to-day care activities in the workplace (www.dementiacaresinging.com).

Chapter Three Summary

For tens of thousands of years music has been, and continues to be, a ubiquitous feature of human existence. The current-day use of music may reflect its ancient relationship between humans-beings. This might relate to music's capacity to support community identity, engender social cohesion and affect emotional states. From a neuro-physiological perspective, it appears that most people today could benefit from their innate capacity to relate at some level from one or more musical elements, such as pitch, rhythm and timbre, regardless of their age, past musical experience and/or level of cognitive function. This collective evidence points towards the value of music for both care-givers and people living with dementia.

However, the evidence also indicates that musical interactions and indeed people's relationship with music *per se* may be significantly influenced by wide range of historic

and present-day factors. These include the stratification of musical genres across social classes and the compartmentalisation of music in education where prescribed musical activities are used as a mechanism for educational progression, rather than a tool to support personal development. These factors may also relate to the absence or presence of an individual's self-belief in his or her musical ability and compounded by the judgement of significant others on their musical ability. Care-givers who accept a judgement of *non-musicality* in childhood may never challenge it and, therefore, may not acknowledge and/or investigate their own innate musicality or natural musical creativity. This may impact negatively on care-givers' willingness to engage in music-making either as a mutually beneficial interaction with the people whom they care, or as a learning tool. Finally, the socio-musical conventions that have developed in the UK over hundreds, or perhaps thousands of years, such as performance behaviours, may over contextualise music activities, making it difficult for care-givers to see how and where it might fit into their health-giving role.

Chapter Four

Music and people living with dementia: an evidence base

The inclusion of performing and visual arts into healthcare settings has been gathering momentum over the last decade and half, latterly with some advocacy from the Department of Health (e.g. DH 2007b). This chapter examines the evidence of the value of music interventions for people living with dementia and examines the challenges of reporting this evidence when set against backdrop a technically focused healthcare system.

4.1 Music-centred services for people living with dementia

In response to need, at the time of writing, a number of regional and national organisations are aiming to help support the quality of the lives of people living with dementia and their carers and care-givers, through the provision of regular music activities. These include West Berkshire Alzheimer's Society's 'Singing for the Brain' (www.alzheimers.org.uk), 'Music for Health' (www.musicforhealth.mfbiz.com), 'Sing For Your Life', based in Folkestone, Kent (www.singforyourlife.org.uk) and 'Sing for your Life', based in West Yorkshire and 'Music for Life' based in London. These activities are reported to be grounded in a framework of literature that has begun to investigate music's therapeutic properties (Coffman 2002) and its specific value for people living with dementia (e.g. Sixsmith and Gibson 2007).

The impact of music on people living with dementia has been investigated increasingly over the past forty years. Due to the apparent responsiveness of people living with dementia to music (Aldridge and Aldridge 1992; Kneafsey 1997), the processes of its effects have been of interest to complimentary and allied healthcare disciplines and more recently to mainstream healthcare providers. Researchers from these disciplines have adopted a range of research paradigms and have viewed the subject variably from physiological, psychotherapeutic and/or psycho-social perspectives. In the following review of literature, the authors' terms used describe dementia are maintained.

4.2 Physiological effects of music on people living with dementia

A small number of studies have examined the impact of using music from bio-physiological perspectives. For example, Swartz, Walton and Crummer *et al.* (1992) used electroencephalograph (EEG) as one measure to demonstrate that people with dementia retained the ability to differentiate musical elements such as pure tones, timbre and melody equally as well as a dementia-free control group. Kumar, Timms and Cruess (1999) reported a significant increase in blood melatonin levels during, and up to six weeks following a series of twelve music therapy sessions for research participants diagnosed with Alzheimer's disease. This increase may help to alleviate symptoms of depression but, although melatonin is associated with regulating circadian rhythms, any benefits to erratic sleep patterns in people living with dementia is not yet known (NICE 2006). Norberg, Melin and Asplund (2003) compared the heart rate and respiration rates of two research participants in the late stages of dementia during three research conditions, i) preferred music (as reported by relatives), ii) touch, and iii) the presentation of a objects, such as bread, soap, fur, yarn, to elicit multi-sensory stimulation. Both participants exhibited an increase in heart rate during the music sessions and one showed a slowing of respirations. The small number of participants in this study prohibits generalisation. Suzuki, Kanamori and Watanabe (2004) used salivary chromogranin A (CgA) hormone measures to ascertain the effect of music therapy on stress in study participants diagnosed with dementia. The researchers found a significant decrease occurred during and after 16 sessions of active music therapy. Takahashi and Matsushita (2006) measured systolic blood pressure to assess the long-term impact of weekly group music therapy sessions. The study showed that systolic blood pressure measured one and two years after the start of the sessions increased slightly in the non-music control group compared to the experimental group. The study also showed better maintenance of physical and mental states in the experimental group compared with the control group over two years.

4.3 Systematic reviews of research in music therapy and people living with dementia

The majority of research on music therapy in dementia care over the last three decades has focused on the effect of music on the psyche rather than on neuro or bio-physiology (Broerson and Nieuwenhuijzen 1997). Since the late 1990s, a number of systematic literature reviews have been undertaken. These provide good insight into the emerging evidence base of music therapy interventions and their outcomes.

Table 4.1 Analysis of literature on music therapy and dementia (Brotons, Koger and Pickett-Cooper 1997)	
Type of study	Number of studies
Clinical/empirical	
Participation/preference	n = 11
Social/emotional skills	n = 7
Cognitive skills	n = 2
Behaviour management	n = 10
Empirical neuropsychological	n = 12
Anecdotal/narrative	n = 8
Theoretical/philosophical	n = 19
TOTAL	n = 69

Table 4.1 shows the range of literature reviewed by Brotons, Koger and Pickett-Cooper (1997). The authors reviewed 69 papers published between 1986 and 1996. The review encompassed 42 empirical studies (including 30 clinical reports), 12 empirical neuropsychological studies, eight anecdotal/narrative enquiries and 19 theoretical/philosophical studies. This proportionate split of methodological designs illustrates the general trend of study designs in this field before the year 2000 (Goodall and Ethers 2005).

Brotons (2000) identified several research categories in her literature review. These encompassed music's role in dementia care: music and social skills; musical preferences/participation; music and sensory stimulation; music and behaviour modification; music and cognitive skills; and music as an instrument for measuring the preservation of musical ability. Because of the close association between mood and behaviour modification, or heightened participation and social skills, for example, many studies looked at more than one category.

At the beginning of the twenty-first century, Prickett's (2000) review of 123 references focused on music therapy for older people. More than half related to people living with dementia. Sherratt, Thornton and Hatton (2004) provided a qualitative review of 21 articles reporting empirical clinical research on the effect of music on emotions and behaviour. Madan (2005) reviewed a number of studies relating to the preservation of musical ability in people living with dementia. Sung and Chang (2005) examined eight articles published between 1993 and 2005, reporting on the relevance of musical preferences and relief of agitated behaviour as identified in standardization agitation scales such as the Cohen Mansfield Agitation Inventory (CMAI) (Cohen-Mansfield 1999) (see p. 75). Witzke, Rhone, Backhaus and Shaver (2008) reviewed 16 articles published between 1994 and 2007 with a particular focus on the use of recorded music.

4.3.1 The effect of music on agitation and aggression

A large number of studies have examined the effect of music on the agitation levels of people living with dementia in their own homes and in care establishments (Clair and Beinstein 1994; Goddaer and Abraham 1994; Tabloski McKinnon-Howe and Remington 1995; Brotons and Pickett-Cooper 1996; Gerdner 1997, 2000, 2005; Olsen, Hutchings and Ehrenkrantz 2000; Sung, Chang and Abbey 2006; Helmes and Wiancko 2006). These studies have variously investigated the use of live or recorded music interventions and/or types/styles of music to assess changes in agitation. It is interesting to note that the studies assessing live music interventions emanate largely from music therapy, whereas studies using recorded music emanate from a wider range of researchers from disciplines (Aldridge 2000). These include researchers who are also nurses and occupational therapists, physiotherapists, psychologists, social workers and medical doctors.

Cohen-Mansfield, Marx, and Werner (1992) investigated some of the broader factors that influence patterns of behaviour by studying 24 nursing home residents who were diagnosed with dementia. Levels of agitation, non-agitation and interaction with care-givers were recorded periodically over one day during normal daily activities. The results indicated that structured activities lessened participants' overall agitation. This led the researchers to recommend the inclusion of regular and frequent activities, such as singing, instrument playing, dance and movement, musical games, and music composition/improvisation sessions. Brotons and Pickett-Cooper (1996) were also interested in the affect of structure. They assessed agitation levels in research participants ($n = 20$) before, during and after structured music sessions compared with non-structured background music. The structured sessions included different musical activities designed according to participants' functional ability, for example, singing, dancing, playing musical games or instruments. The non-structured background music intervention yielded no significant changes but care-givers reported significantly higher levels of agitation before the structured interactive sessions than during or afterwards, with effects lasting often for some hours. Also, there appeared to be more purposeful control over physical movement in some participants.

Goddeer and Abraham (1994) observed variations in the effect of music across the dimensions of non-aggressive agitation and aggressive behaviour in participants with severe cognitive impairment ($n = 29$). Relaxing music was played on weeks two and four, of a four-week study, compared with no music in weeks one and three. Whilst no significant reductions of aggressive behaviour were noted across any of the four weeks, non-aggressive agitation, such as wandering, verbal agitation and hiding/hoarding, was significantly reduced during the music intervention weeks. Cohen-Mansfield and Werner (1997) reported that one-to-one music therapy sessions produced the greatest reduction of verbally disruptive behaviours compared to watching a videotape or listening to music. Clair and Bernstein (1994) examined the effects of playing either stimulating or relaxing music in the background all day to research participants with cognitive impairment, residing in a nursing home ($n = 28$). The researchers found that people became habituated, showing no significant in changes in wandering, screaming, pacing or vocalisation.

Agitation during mealtimes is a recognised problem that can disrupt routine and inhibit adequate nutritional intake (Clair and Bernstein 1994; Goddear and Abraham 1994; Ragneskog Kihlgren, Karlosson and Norberg 1996; Denney 1997; Hicks-Moore, 2005). Ragneskog *et al.* (1996) and Denney (1997) observed that agitated behaviour amongst research participants decreased when recordings of soothing music were played at meal times, compared with popular music from the 1920s and 30s and popular and rock music from the 1980s. Denney (1997) observed that, even though general agitation levels did not appear to change significantly during 1920s and 30s music played at mealtimes it nevertheless appeared to motivate increased food consumption. Goddaer and Abraham (1994) used the standardized agitation scale, Cohen Mansfield Agitation Inventory (CMAI) to measure the effect of 'New Age' music at mealtimes on study participants (n = 29) with severe cognitive impairment. Cumulatively the study showed a reduction of agitated behaviours, physically non-aggressive behaviours and verbally agitated behaviours during music-activation sessions compared to no music. Hicks-Moore (2005) also used the CMAI to measure the effects of relaxing classical music played at mealtimes on study participants with severe cognitive impairment (n=33). The results showed a decrease of inappropriate verbal and/or motor activities during the music-activated sessions compared with no music.

Thomas, Heitman, and Alexander (1997), Clark, Lipe and Bilbery (1998) and Schiemann (2000) observed the impact of music on distress during bathing. Thomas *et al.* (1997) used the CMAI scale to demonstrate a decrease in agitation levels during bathing in an active recorded music intervention compared with no intervention. In their randomised control study, Clark, Lipe, and Bilbrey (1998) examined the effects of preferred recorded music in decreasing aggressive behaviour during bathing procedure amongst 18 residents diagnosed with severe Alzheimer's. In this study care-givers reported an increase in smiling, dancing and clapping in the music sessions compared to no music. There also appeared to be an increase in calmness and cooperation, as well as an improvement in the overall mood of participants.

A number of studies have looked at the effect of music on sleep patterns (Lindenmuth, Patel and Chang 1992; Cohen, Eisdorffer, Groelick *et al.* 1993). Hui-Ling and Good

(2006) found that, amongst 60 older research participants, playing slow music very softly throughout the night can reduce sleep disturbance. The authors suggested that the intervention may transfer to care settings as it is easily taught to care-givers, low in cost and practical. Lindenmuth *et al.* (1992) found a significant increase of productive sleep when recorded music was played regularly to research participants with dementia compared with a control group of healthy adults. In this case, Lindenmuth *et al.* highlighted the potential for replacing sedative-hypnotic drug therapy with music interventions of this type.

The evidence on the effect of music on agitation is largely positive but its impact on aggressive behaviours is less clear. What is clear however, is that manifestations of agitation or aggressive behaviour are indicators of heightened emotional arousal. Barton, Findlay, and Blake (2005) and Gerdner (1997) suggested that music influences arousal directly through its ability to provide a means of communication. The ability to communicate depends on there being a suitable opportunity and/or context for interaction. It also depends on the will to communicate, which is most often influenced by state of mind or mood.

4.3.2 The effect of music on mood and social interaction

A number of researchers have used music to examine the relationship between mood and social interaction in people living with dementia (Clair and Bernstein 1990; Pollack and Namazi 1992; Lord and Garner 1993; Clair 1996; Clair and Ebberts 1997; Groene, Zapchenk, Marble, and Kantar 1998; Groene 2001; Cevasco and Grant 2006; Tadaka and Kanagawa 2007).

Pollack and Namazi (1992) assessed the value of activities that combined singing, dancing and instrument playing in eight research participants diagnosed with dementia. Using a researcher-observation research design, the observers noted a 24% increase in positive social behaviour, such as talking, singing, humming, whistling, vocalising, smiling, and touching, and a 14% decrease in anti-social behaviour during and following the active sessions. Newham and Ward (1993) compared musical interactions for older people with dementia mixed with groups of pre-school children versus having no children

present. The authors reported a significant increase of spontaneous touching and extending hands in the former and an increase of holding hands, on the therapist's instruction, in the latter. The results implied a desire for older participants to prioritise bonding with the children when they were present, rather than with one another when alone.

Tadaka and Kanagawa (2007) measured mood changes in 60 study participants diagnosed with Alzheimer's disease (AD) and vascular dementia after music therapy sessions compared with the no-music sessions. The researchers used a multidimensional observation measurement scale to monitor levels of self-care, disorientation, depression, irritability, and withdrawal as mood indicators. The results showed a significant decrease of withdrawal and irritability and improved orientation following the music sessions compared with the no-music sessions.

In another larger scale study with participants diagnosed with AD (n = 60), Lord and Garner (1993) also adopted a researcher-observation design to examine the effects of music on mood, social interaction and recall. Participants were assigned one of three experimental conditions, i) listening to Big Band music from the 1920s and the 1930s, ii) puzzle-making activities, or iii) drawing and painting activities. Comparisons between each group showed significantly improved mood from pre to post-test observations in the music group compared with the other experimental conditions. Mood improvement was indicated by additional smiling, laughing, singing, dancing, and whistling to the music. There was also an indication of improved memory recall in the music group.

Lord and Garner's (1993) findings on the effect of music interventions on memory and recall coincided with results in other studies (Sambandham and Schirm 1995; Carruth 1997). Sambandham and Schirm (1995) studied 19 participants diagnosed with dementia in an experimental condition of listening regularly to reminiscence taped music over a two-week period. Participants with the poorest levels of cognitive function were reported by the researchers as demonstrating the highest relative level of improved ability to reminisce post-test. Carruth (1997) also reported improved ability to recall the names of familiar staff following music-listening sessions.

Based on the research discussed above, there appears to be a correlation between music engagement and improvements in emotional well-being, communication and memory recall, each of which impact on behaviour. Some studies have highlighted the importance of musical preference in this context and how specific delivery methods of musical interventions may elicit positive benefits for participation.

4.3.3 Musical preferences and participation

The evidence so far points to the positive effect of music in supporting the well-being of people living with dementia. A number of researchers have examined the most effective ways of eliciting engagement to maximise this positive effect (Pollack and Namazi 1992; Lord and Garner 1993; Gerdner 1997, 2000; Sung and Chang 2005; Clair and Bernstein 1990; Cevasco and Grant 2006).

Son, Therrien, and Whall (2002) suggested that familiar music from past-life experiences may provide associations through implicit memory. Associations with pleasant memories may prompt a reduction of inappropriate arousal and/or vocalization. Pollack and Namazi (1992) observed greater positive benefits to overall mood during interactive music sessions when the music has specific meaning for participants. Lord and Garner (1993) concurred with these findings and added that favoured choices were often from a period when participants were younger. Gerdner (2000) also found that agitated behaviour decreased amongst their study participants ($n = 39$) after they listened to thirty minutes of preferred music, twice a week for six weeks, compared with listening to relaxation music for the same duration and time span. Sung and Chang (2005) reviewed eight studies that centred on the relevance of musical preferences in addressing agitation levels. Although no findings of statistical significance were found, findings were relatively consistent across each study in showing that agitation appeared to decrease more during preferred music than randomly selected music.

A small number of studies have compared the apparent value of different types of musical interactions, which have been measured by comparing participation levels. Cevasco and Grant (2006) compared the average participation levels of 15 participants in various stages of AD, in three experimental conditions: i) singing and moving or playing

instruments, ii) singing only (*a capella* singing), and iii) moving and playing instruments only. Results showed that participation was highest during *a capella* singing followed by instrument playing. More participation and interactions were observed when participants were playing instruments (83%) than when moving (51%).

Clair and Bernstein (1990) compared the participation levels of six participants described as having severe cognitive regression in singing and drumming activities. The authors found that participants engaged longer in *vibrotactile rhythmic* activities, where they could feel the vibration of a drum played whilst held in their laps, and with *nonvibrotactile* activities, where drums were held by a third party in front of participants, than with singing. These findings indicate the relevance of different activities at different stages of dementia. Singing appeared to elicit greater attention during the earlier stages of dementia, whereas dance (Brotons 2000) and rhythmic activities appeared to be more beneficial in the later stages (Clair and Bernstein 1990; Clair, Bernstein and Johnson 1995; Garand, Gfeller, Hanson, *et al.* 1996).

4.3.4 Using music with other interventions

Some studies have focused on the value of a combination of stimuli where music was one element. Remington (2002) for example, compared the effect of hand massage and music. In this study, 68 nursing home residents diagnosed with cognitive impairment were randomly assigned to a control group with no intervention or one of three intervention groups: i) calming music only, ii) hand massage only, and iii) calming music and hand massage. Using the Cohen-Mansfield Agitation Inventory scale, Remington found no differences in physically aggressive behaviour of participants in any of the four groups. The most significant findings were reductions in physically non-aggressive and verbally agitated behaviours in the group that received hand massage only, while no significant additional benefits were yielded by the addition of music.

Jackson, Sterling, Templeton and Russell (2001) reported the impact a multi-sensory/music programme involving singing, recorded music and stimulation of all five senses, on levels of communication and behavioural problems in participants with dementia (n =81). The research method reflected the authors' emphasis on the importance

of quantitative data analysis. The design includes experimental and comparative control group of people living with dementia. Participants' levels of dementia were assessed using the MMSE test (Folstein *et al.* 1975). Changes in behaviours were measured using two standardised assessment tools, The Rating Scale for Aggressive Behaviour in the Elderly (RAGE) (Patel and Hope 1992) and the Depressive Signs Scale (DSS) (Katona and Aldridge 1985). The statistical data showed no significant change in behaviour pre and post intervention when compared to the control group. However, subjective observations that were recorded in writing in notebooks by the session's facilitators described perceived benefits of highly individual nature for participants.

4.3.5 Music, cognitive skills and assessments

Three studies examined music's effect on people undertaking the Mini Mental Score Examination, the commonly used clinical test to determine a diagnosis of dementia and its progression (Silber 1999; Foster and Valentine 2001; Irish, Cunningham and Walsh 2006). Foster and Valentine (2001) tested for cognitive improvements in men and women (n = 23) with early to mid-stage dementia during the tests. The researchers used a control condition with no background sound and three experimental conditions, i) playing a recording of the noise of a busy cafeteria, ii) playing a familiar section from *The Four Seasons* by Vivaldi, and iii) playing a piece of music which was similar in tempo, time signature, style and instrumentation. The results showed significantly higher incidents of accurately answered questions during the experimental music sessions compared with cafeteria noise or silence. The authors recorded no significant difference between the familiar and unfamiliar pieces of music, indicating that a familiarly structured style of music may be as beneficial as using specifically familiar music. Irish *et al.* (2006) concurred with Foster and Valentine's (2001) findings that playing familiar and similarly structured music to patients during assessments for dementia may prove beneficial to outcome. Irish *et al.* observed significant improvements in autobiographical memory recall when the 'Spring' movement of Vivaldi's *The Four Seasons*, was played in the background during MMSE tests, compared with no background noise. However, in this study, specific benefit to people living with dementia was not evident as no statistical difference was noted between this group (n = 10) and the control group of older people without dementia (n = 10).

In an earlier study, Silber (1999) disputed the potential for background music to impact positively on MMSE scores. In her randomised control study involving 18 people, described by Silber as in the 'second stage' of dementia, no significant differences in scores were observed across the experimental group - who were assessed three times, once without background music and twice with - and the control group who had no music intervention.

MMSE has been criticised by a number of researchers and clinicians because of its failure to assess the fluency of mental phenomena such as desire, hope, belief and knowing over time (Aldridge and Aldridge 1992). Aldridge and Aldridge used the term *intentionality*, to describe these mental phenomena. In response to challenges of testing these more complex phenomena, some researchers have looked at music itself to act as an assessment tool (Glynn 1992; York 1994; Lipe 1995). Glynn (1992) developed the Music Therapy Assessment Tool, to evaluate psychological and social behaviour patterns by observing dynamic musical improvisation. York (1994) developed the Residual Music Skills Test, a quantitatively measured test to assess the musical capabilities of people with probable Alzheimer's disease. The tool was based on the proposition that music may stimulate alternative neural mechanisms that trigger cognitive memory for people living with dementia. In this case, York suggests that it may be useful as initial assessment tool.

The intention of these assessment models is to provide better insight into the complex mental states encompassing *intentionality*, concentration and perseverance in people living with dementia (Aldridge 1996; Aldridge 1998). Although the current evidence is too weak to generalise about efficacy, it does suggest that a better understanding of these complex phenomena might be reached through music interventions.

4.4 Music and the role of the care-giver

A small number of authors have suggested that day-to-day care-givers of people living with dementia are very well placed to facilitate meaningful music-related care interventions (Smith 1995; Clair 1996; Brown, Gotell and Ekman 2001; Gotell, Brown

and Ekman 2002; 2003; 2009; Perry 2005). These studies, and a few others (Hanser and Clair 1995; Clair and Ebberts 1997; Gerdner 2005; Rose, de Martino, Yentis *et al.* 2008), have explored the value of musical activities in which both informal or formal care-givers and their cared-for were actively involved. With the exception of Perry (2005) and Rose, *et al.* (2008) whose research was carried out in Canada and the UK respectively, the remainder were from the USA (Smith 1995; Clair 1996; Hanser and Clair 1995; Clair and Ebberts 1997; Gerdner 2005) and Sweden (Brown, Gotell and Ekman 2001; Gotell, Brown and Ekman 2002; 2003; 2009). Each of the studies involved very small samples ranging from one to nine people living with dementia and between one and five care-givers.

The latter group of studies, which for the purposes of identification will be termed the Swedish studies, emanate from various analyses of the same data, involving seven people living with the symptoms of severe dementia and five female care-givers. Data were gathered in a Swedish residential care home via video recordings whilst the care-givers helped the patients during their normal morning care activities (washing and dressing). Three research conditions were compared: i) no specific intervention; ii) familiar, recorded background music; and iii) care-giver singing with or to the patient throughout. The results showed that when narrative instruction was replaced entirely by the care-giver singing Swedish folk songs, patients apparently showed an implicit understanding of gestural communication leading to significantly higher levels of co-operation. The singing condition also resulted in a reduction of aggression and screaming. Gotell and her colleagues later compared the impact of music and care-giver singing on posture, movement and sensory awareness in nine people diagnosed with dementia (Gotell *et al.* 2002). The results demonstrated significant improvements in posture, better symmetry of movement and an apparent improvement in awareness of environment during both the music and the singing conditions compared with no intervention. The authors reported greater levels of mutuality and interaction between the care-giver and the cared-for in the singing condition.

In addition to advocating the use of singing as a cost-effective, practical dimension to management repertoires for people living with dementia, the Swedish studies implied that

singing interventions can enhance the experiences of the care-giver by creating better communication channels with the people for whom they care. The authors also briefly mentioned the therapeutic value of singing for care-givers personally. However, the overwhelming emphasis of these studies was on the impact of care-giver singing on people living with dementia. Although there is some reference to, and reflection on how these interventions might affect care-givers, this is not dwelt upon. By contrast, Perry's (2005) study was motivated by the need to identify methods to improve the well-being and thus retention levels amongst registered nurses. Perry gathered narratives from registered nurses via an online survey. One of these narratives focused on a staff member responding to the distress an elderly gentleman patient, whose incoherent verbalising included fragments of old hymns. In response, the nurse reported the profoundly positive effect for both her and her patient when they shared hymn-singing together. Perry classified the values of the interaction as 'enabling hope', 'affirming the values of the person', 'defending dignity' and 'helping patients find meaning', each of which, Perry suggested, has potential to support nurses' sense of achievement and improve job satisfaction.

Berger (2003) centres her philosophical discussion on care-giver led music interventions on a holistic ethos. Berger uses a musical metaphor of jazz improvisation to describe the physical, psychological and emotional interactions that happen throughout every day between care-givers and their cared-for. As care-givers move amongst and interact with their cared-for, professional skill is mixed with spontaneous improvisation, or *jammin'*, as Berger puts it. These interactions reflect a mode of being in which the actions of all parties are guided by the changing shades of mood and an emphasis on who does what and when. Berger provides a further musical analogy in which the home key of a musical piece, otherwise known as the *tonic*, relates to a sense of base, or home, to which one returns for comfort. Berger suggests that the analogy highlights the important concept of security and familiarity for people living in residential care settings. She believes that care-givers can tap into music's patterns and connections with the *tonic* in order to reaffirm deeply ingrained patterns of self, and can provide ways for people to explore their creativity. The latter, Berger suggested has potential to take people to a new or different level of meaning which moves the person towards a future.

The following case report of an event that occurred between the author of this thesis and a person living with dementia. It demonstrates the significance of harmonic structures that centre on the *tonic* and the broader power of music to create a platform for communication.

Illustrative Case Report No 6: *Silent Night*: The Power of the Tonic

John and I often sang together. We would choose songs that we knew and others that I could teach John. Each Christmas we sang favourite carols, John having sung regularly in a small village-centred choir for many years previously. Indeed, the choir members continued to welcome John to rehearsals where he shared music and social interaction with long-standing acquaintances.

Before embarking on a song session one afternoon, John and I had been talking. The encounter had been frustrating for both John and I. John was visibly angry at his perceived failure to communicate his verbal messages and I was left with a sense of hopelessness and inadequacy in both professional and humanistic terms. But the sense of despair did not last.

Flicking through a book of traditional carols, we chose to begin our song session with Silent Night. We dispensed with the words and hummed the tune in unison. There were no breaks in our tuneful conversation, no hesitation and no misunderstandings. At the end of the first hummed verse, we laughed and congratulated ourselves. Halfway through the second verse, John began to harmonize. He maintained the harmonic line - which reflected natural harmonics on which are based traditional western chord structures - until the end of the verse. 'Oh, yes', he said, 'that WAS good'. Revelling in our collective pleasure, John and I repeated the song. This time John harmonized from the outset.

Initially, I assumed that John was relying on unconscious memory; material learnt at a young age and repeated over many years, until John began to vary the notes. Although the harmonic structure remained the same, John began to sing different notes of the implied chord. The first time John sang the note D (see p. 158: 1a) implying harmonic structure of chord IV (D major) in root position (the first note of the chord). The second time however, he sang the note F#, (1b) which implied the same harmonic structure but using third note of the chord instead of the first. He also swapped the note A in the bass (2a and 3a) register for an A an octave above (2b and 3b) the second time we sang the song and sang (perhaps accidentally) a 4:3 suspension on the final chord (4b) ending on the third note of the key scale.

There is of course a vast array of harmonic arrangements to Silent Night, which John may have been recalling. This would provide a theory that fits with what is expected in some cases of severe cognitive loss, where explicit memory is impaired but implicit memory remains largely intact. However, John was also able to improvise using traditional harmonic structures when I played the Kantele tuned to chords I, IV and V in D major. As I strummed the three chords in an arbitrary order, John shifted from one bass note to another in response. The notes were always part of the played chord, but they varied in position moving from the root to the third and fifth of the chord and occasionally the octave.

Our time making music together was always satisfying and stimulated a range of healthy emotions. From the perspective of a fellow human being, I could not fail to relish John's response to these apparently successful musical encounters. In contrast to our attempts at communicating through the conventions of spoken language, we shared a mutually supportive exchange that set aside John's condition. From the perspective of a professional care-giver, in which I easily sensed failure to support John in view of his vulnerabilities, the sessions provided personal value. It was, I discovered, possible in my role as care-giver to share and communicate without the conventions of spoken language in a way that mutually supported and benefited both John and I.

Figure 4.2 Silent Night: Sung rendition showing John's changes to improvised harmony

The image displays a musical score for the song "Silent Night" in G major and 6/8 time. It consists of four systems of music, each with a vocal line (treble clef) and a bass line (bass clef). The key signature has two sharps (F# and C#), and the time signature is 6/8. The score is divided into measures, with measure numbers 7, 13, and 19 indicated at the start of their respective systems. Improvised changes in the bass line are labeled as follows:

- 1a: Located in the first system, measure 5.
- 2a, 3a, 4a: Located in the second system, measures 8, 9, and 10 respectively.
- 1b: Located in the third system, measure 14.
- 2b, 3b, 4b: Located in the fourth system, measures 17, 18, and 19 respectively.

4.5 Using music with people with dementia: implications for this study

It is clear from the evidence so far that music has potential to impact positively on behavioural, social, emotional and cognitive domains of people living with dementia. Whilst acknowledging the value of formal music therapy, Berger (2003) reassured care-givers that specific musical training is not always necessary to promote the therapeutic properties of music at some level in their workplace.

The idea that healthcare workers could initiate music in their work settings with relative ease was aired over ten years earlier by Glynn (1992), who wrote:

'...nurses need not be musicians to achieve a positive effect. Music can be presented by means of tape, compact disc, or a record or it can be played or sung live' (p. 9)

At the time, Glynn's comment provoked a number of criticisms, not least from a small group of music therapists (McLean 1993). Others, such as Brotons, Koger and Pickett-Cooper (1997) were prompted to evaluate the potential for role of music therapists to include support for care-givers to use music as a more frequent care intervention. This reflects Sixsmith and Gibson's (2007) advocating training for care-givers to better understand the theory behind the therapeutic value of music in order to encourage music interventions in care programmes. Other studies have also recommended music-related training for care-givers in order that they might add music to their armoury of care-giving tools (Clair 1996; Brotons and Koger Pickett-Cooper 1997; Brown, Gottell and Ekman 2001; Gottel, Brown and Ekman 2002; 2003; 2009; Sixsmith and Gibson's 2007). Whilst such commentary highlights the desirability of training and support for care-givers to use music in their care settings, there appears no overarching consensus on how this may be achieved at a local or a policy level. Indeed, in terms of evidence-based practice, the Swedish studies alone appear to have prompted standardised training for staff to use singing in their workplace. However, Clair (1996) highlights some of the challenges, not least the issue of care-givers self-judging their singing ability as poor. Clair observes that persuading staff that the quality of their singing voice is not important in care-giver/care-receiver singing interactions remains difficult.

The type of music-related training discussed above appears to focus primarily on skilling care-givers to use music as a tool to benefit the people for whom they care. However, as more is understood about the relevance of types of music interventions, the appropriateness of musical material, and the potential for music interventions to support meaningful care-giver/cared-for interactions (Berger 2003; Rose, de Martino, Yentis *et al.* 2008), a case may be built in favour of music-related training for care-givers that has a multiple purpose. Such training may additionally focus on music as a catalyst for developing care-givers' personal and professional confidence, which may in turn lead to higher levels of reflective practice.

In recent years, a number of art-based organisations have developed in-house training for staff caring for people living with dementia to explore their personal and professional development using a range of interactive performing arts media. Some of these reflect Berger's metaphorical relationship between jazz improvisation and interactions between care-givers and their cared-for. For example, Rose *et al.* (2008) and (Vella-Burrows 2009) describe similar staff-training models, 'Music for Life' and 'Music as a Therapeutic Medium for Engagement', respectively, in which professional musicians facilitate musical improvisation, and in the case of the latter, African drumming and Forum Theatre, to help staff to develop new levels of self-awareness and self-confidence. Staff also engage in musical interactions with the people for whom they care. From this participant-perspective the staff observe and reflect on the musical processes and develop relationships over time to help them to affect change in other areas of their work. The primary intended outcome of these training programmes is improved quality of life for both staff and the people for whom they care. This is sought through raising care-givers' confidence to engage in critical thinking and creative reflection which can lead to more meaningful relationships, improved job satisfaction and improved morale.

Other initiatives that have the same vision include a partnership between English National Opera, the Royal College of Music and Turtle Key Arts, which uses the process of participants collectively composing, producing and performing community operas establish new levels of communication between care-givers and carers and the people for whom they care. The Ladder to the Moon Theatre Company is driven by the same mission

but its practitioners use, what they term as, 'Relationship Theatre' to affect positive changes in the relationships between staff in care settings and the people for whom they care. This includes the use of theatre production, dance and music to simultaneously engage staff and the older people in an inclusive, non-hierarchical manner.

Freeman and Bays (2007) point to the paucity of empirical research to demonstrate the value of using the arts and music as a tool for learning; they nevertheless advocate its use in training medical and nurse practitioners. This appears to be grounded in the premise that healthcare practitioners may benefit from initiatives that support learning through creative processes.

Inhibitions that are underpinned by cultural, social and personal experiences may result in some healthcare professionals and care staff feeling uneasy about engaging in the arts and music as a support/learning mechanism. Influences that determine a sense of ease or ill-ease in embracing arts media in this context may also relate to the level at which staff are willing to engage in creative care interventions with the people for whom they care. The research evidence discussed in this chapter may in time inspire more music-related training and support for staff but much depends on the perceived quality of the research.

4.5.1 Research validity and rigour

One problem in eliciting change at any level, may link to the quality of studies on the value of music in the care of people living with dementia *per se*. In a Cochrane systematic review Vink, Birks, Bruinsma, and Scholten *et al.* (2003) examined the literature to assess the effect of music therapy in this field. Out of 100 studies, the authors identified only five that were considered of sufficient quality to be included in their analysis. The authors concluded that 'more and better-quality research is required to investigate music therapy's effectiveness further, as it is experienced in practice both by patients, family members and caretakers' (p.11).

The challenge of research in this area is commonly acknowledged by researchers working in the field. Many conclude their studies with a warning caveat that generalisability is problematic. Inhibiting factors most notably include small sample sizes, non-probability

convenience sample groups, the uncharted effect of the novelty of a music intervention, the presence of confounding variables such as the process of the disease itself and medication (Lou 2001), and variability in practitioner approaches (Brotons and Koger 1997). Despite these challenges, since the late 1990s, a wide scope of design strengths is evident in a good number of studies. These include the selection of homogeneous sample groups, the use of reliable diagnostic assessment tools (Gerdner 2000, 2005; Hicks-Moore 2005), standardisation of intervention (Hicks-Moore 2005; Sung et al. 2006) and method triangulation (Gerdner 2000; 2005).

Witzke *et al.* (2008) observe tensions between positivist research designs, which include sample randomization, control conditions, blind raters and power analysis, that aim for quantification and generalisability, and research that aims to fully understand the minutiae of lived experiences. Witzke *et al.* explain that since the early 1980s, researchers have been building an evidence base on the effects of music and music therapy on people with the specific diagnosis of dementia (Aldridge 2000). This movement corresponded to British epidemiologist, Archie Cochrane's (1908 – 1988) challenge to the healthcare industry to compare rigorous research evidence with the tradition of accepting expert professionals' opinions. From this point there emerged two main paradigmatic emphases. One pertained to evidence-based medicine (EBM), the other to evidence based-nursing (EBN). In the former, randomised control trials (RCTs) continue to dominate research and recommendations for clinical practice. The scope of evidence aimed at supporting nursing practice, however, is much broader (Stetler 2003). Stetler highlighted the perceived need amongst nurse researchers to emphasise phenomenological factors, or lived experiences, which encompass culture, capacity and infrastructure. Melnyk and Fineout-Overholt (2005) pointed out that EBN can adopt EBM approaches to research but it should also embrace a broad range of research methods.

Brotons and Koger (1997) discuss the influences that may affect health researchers who are not music therapists. Issues of design may arise due to the philosophical approach that individuals have to healthcare and health research in relation to their training. An example of potential for interdisciplinary tensions is illustrated in the opposing perspectives of David Aldridge, Music Therapist, and dementia care specialist, and Clive Holmes,

Professor in Biological Psychiatry at the University of Southampton School of Medicine. Aldridge argues for EBN research designs, which include reflexive approaches from researchers and methods embracing narrative inquiry. These tend to be uncensored by the convention and constraints of positivist research (Aldridge 1996; 2000). Rather they are, Aldridge observes, ‘the everyday stuff of clinical practice’ (2000 p.19) on which the management and treatments of specific health conditions are based. The wholeness of these narrative stories is of paramount importance in building a true picture of causal mechanisms and processes from which management strategies and instruments are most effectively devised. In contrast, Holmes and his colleagues argue strongly for the rigour of positivist research methods Holmes, Knights, Dean, *et al.* (2006), which reflects the concerns brought up in the Cochrane Review on the effects of music therapy on people living with dementia (Vink *et al.* 2003). Holmes *et al.* acknowledge the Review’s concerns about the lack of quantification and methodical design rigour in this field of research. In response they designed a study firmly based in EBM using randomisation, placebo-control and a blind rater, in which silent video footage was observed to compare the responses of participants (n = 32) with moderate to severe dementia to live and pre-recorded music. The results showed that 69% of participants reacted positively to the live music compared to the silent placebo and pre-recorded music conditions. Despite its rigour however, the authors identified limitations of the study's design. The most significant was the inability to measure verbal responses because the video footage was shown to the analysts without sound. Whilst the analysts had no way of discerning changing levels of verbalisation and/or exchanges, attending staff and the researchers anecdotally reported a rise in both. This observation supports an argument for designs that use a mix of positivist and subjective interpretive data-collecting methods. The argument reflects Witzke *et al.* 's (2008) statement that research in this field should relate to individualism, the clinical circumstances and available resources surrounding care.

Figure 4.2 Factors influencing the research nurse

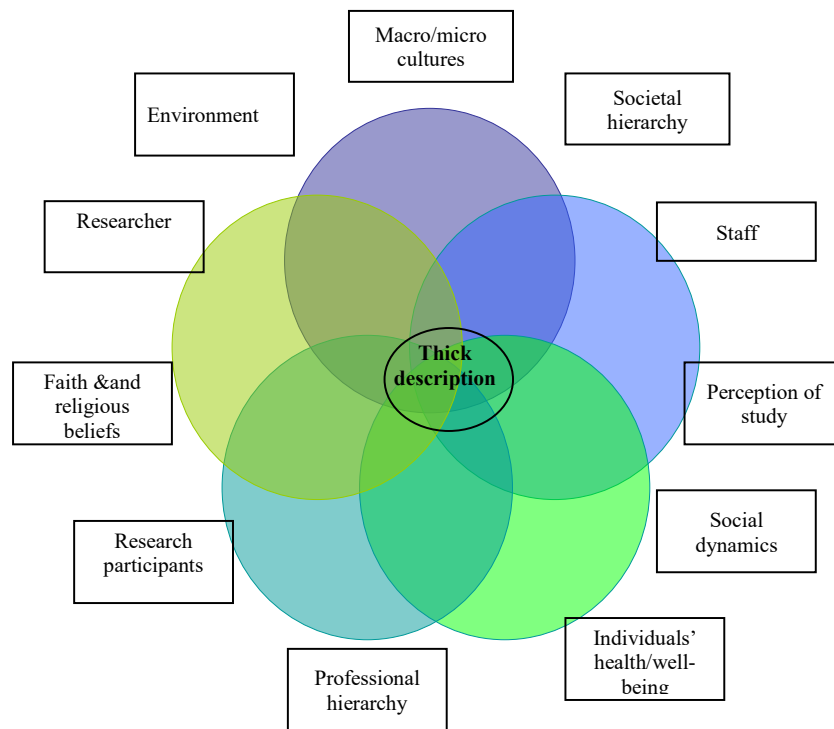


Figure 4.2 shows the complex co-factors that influence a researcher when undertaking research which entails personal interactions with research participants. In order to gain the whole picture of people's experiences, or *thick description* (Geertz 1973), and to uphold research rigour, the researcher in the current study adopted a number of principles emanating from Piper's (2006) nursing research model and reflexive and aesthetic enquiry

4.5.2 Piper's nursing research model

Piper (2006) developed a research approach that aimed to help the nurse researcher capture people's experiences through systematic research designs. Its process ultimately proposed a robust marriage between health research and nursing practice. Five elements were particularly relevant to the current study. These were, the need to formulate research aims from personal experience and insight, the need to define the concepts relating to the study, the need for a review of literature to compare and map the competing theoretical structures relating to the focus of the study, the need to select methods to best ensure

validity for the study, and the need to undertake fieldwork and report findings in a way to enable adaptation/syntheses of appropriate theory for nursing (Piper 2006).

4.5.3 Reflexivity and aesthetic enquiry

Piper's approach sets out a logical and pragmatic process for research, which also relies to a large extent on the intuitive responses of researchers. This concept, which is termed *reflexivity*, is grounded in the researcher's relationship with the world and the people therein, which in turn affects what he/she brings to the research. Factors including experience, gender, personality and the researcher's relationship with the research settings and participants are significant. The consequences of each will inevitably shape the outcome of any research and should be acknowledged in terms of process, analysis and reporting results (Freshwater and Rolfe 2001; Hardy, Phillips and Clegg 2001).

Johnson and Duberly (2003) assert that poor nursing practice can develop as a result of researchers making commitments to findings without being fully aware of their origins. Freshwater and Rolfe (2001) suggest that good nursing research relies to some large extent on the researcher's intuition and creative thought. Edvardsson and Street (2007) believe that in this approach the researcher becomes an embodied ethnographer. This, the authors suggest, is essential to gain an awareness of the *thick description*, elements of which might otherwise be neglected. Neuman (1997) puts forward a strong argument for research based on intuition and creative thought, a process which is sometimes termed aesthetic enquiry:

Nursing based on logic, left brain, and scientific principle is incomplete without the creative, right brain for balance. When building only on scientific reasoning for nursing curriculum and care, a major component of human functioning is glaringly absent (p.206).

Chapter Four Summary

The evidence in this chapter highlights the potential for music to support quality of life in care settings from three main outcomes: i) music activities to support the well-being of the people being cared-for; ii) music-centred activities to simultaneously support the well-being of staff in addition to the people being cared-for; iii) music activities to train and support staff to develop personal and professional confidence. In terms of the first two outcomes, there appears to be some professional tension around their delivery, with commentators variably arguing for and against staff taking a central role in the interventions. Only a small number of initiatives are reported to deliberately support the well-being of staff and the people for whom they care, and fewer still focus specifically on staff training and developing care-practices. Overall, care staff may find themselves at the heart of tensions resulting from a paucity of well-designed research studies that underpin evidence-based practice in these areas. This shortfall also appears to inhibit the development of any form of strategic planning for delivery of music activities in care settings in the near future.

Chapter Five

Methods

Aim

The aim of the study was to examine the perceptions and experiences of care staff who might use music with older people living with dementia. The aim was addressed through eleven objectives, which were alphabetically labelled (minus 'i' to avoid confusion) and grouped into four themes relating to the study's questions.

Objectives

Musical activities in care settings

A: To examine the numbers and types of live musical activities taking place in a sample of care settings

B: To compare the funding mechanisms for live musical activities taking place in a sample of care settings

Staff attitudes relating to music

C: To examine staff experiences of music in childhood

D: To investigate staff perceptions of the value of music in their personal lives

Staff perceptions of music and music-related training in care settings

E: To investigate the levels at which staff engage in music in their workplace

F: To investigate staff perceptions of the value of music in their care setting

G: To examine staff perceptions of the impact of music on their clients

H: To investigate staff perceptions of the practicalities of including music in their care settings

J: To investigate staff attitudes towards music-related training

The experience of using music with people living with dementia

K: To investigate the experiences and perceptions of music practitioners working in care settings

L: To examine the relationship between music practitioners and staff when working in care settings

5.1 The underpinning philosophy

Historically, and for much of the twentieth century, the main thrust of healthcare research has been influenced by a positivist paradigm. This has focused primarily on objective, scientific facts about the physical and mechanistic functions of the body (Saks and Allsop 2007). However, as health care has increasingly embraced a broadening concept of health grounded in the interpretation of an individual's experiences, researchers too have been drawn into serious debate over the best way to gain knowledge about the health of individual people (Broom and Willis 2007). In considering the best research design for the study, attention was given to the philosophical underpinning of research paradigms their relationship to the research questions, the nature of data required and the research participants from whom information was sought.

5.1.1 Positivist methodologies

The fundamental difference between positivism and interpretivism in terms of research centres on how reality is constructed. Positivist philosophy maintains that reality is fixed. The gaining of knowledge centres on objective and quantifiable measurements through rigorous research methodology.

Determinism	A knowledge of scientific laws forms the basis for predicting phenomena
Objectivity	Analysis is based on scientific evidence. Bias is limited by separating the researcher and research participant
Quantification	Only evidence that can be quantified provides new knowledge
Reliability and generalisation	A research sample that is randomly selected can support or negate a hypothesis. This enables generalisation in a wider population

Method	Example
Epidemiological/analytical design strategies	Randomised Control Trials (RCTs), Before and After studies, Cohort/Incidence studies, Cross-sectional studies
Survey research	Structured questionnaires
Secondary document analysis	Content analysis
Structured interview	Strict, systematic and ordered question- framework
Meta-analysis	Systematic review

Table 5.1 and 5.2 show the main features of a positivist paradigm and the research methods that utilize its philosophy (Broom and Willis 2007).

One of the main advantages of the rigour of positivist research is its capacity to reduce bias. For example, using randomised control trial (RCT) designs, blinding the researcher and research participant to their specific intervention and using quantifiable measurements increases the confidence of some researchers that true results are reached (Altman 2000). The methods to which these processes belong are also collectively termed quantitative research. Quantitative measurements have been used in research with people living with dementia. For example, the D-QoL (Brod, Stewart, Sands, *et al.* 1999) and DEMQoL (Smith, Lamping, Banerjee, *et al.* 2005) questionnaires aim to measure and compare quality of life. Some studies on the effect of music on people living with dementia also use quantitative measures to assess changes in behaviour and/or cognition such as the Cohen Mansfield Inventory (Cohen-Mansfield *et al.* 1989) and the Mini Mental Score Examination (Folstien *et al.* 1975).

Tritter (2007) makes a case for including quantitative methods in social science research, because they can establish the frequency, and therefore the generalisability, of a specific phenomenon, attitude or perception. However, Rubin and Rubin (2005) pointed out that they can only superficially describe people's experiences.

5.1.2 Interpretivist methodologies

Interpretivist	Focuses on subjective meaning and interpretation to gain understanding
Naturalistic	Data are gathered in everyday settings
Subjectivity	Knowledge production is gendered and partial, grounded in the subjective experiences of the research participants
Complexity	Concerned with depth of analysis
Political	Highly associated with social relations
Validity	Draws on the understandings of the individual research participants. Less focused on generalisations.

Method	Example of process
In-depth, semi-structured or unstructured interviews	Interviewer puts one or more pre-planned, open-ended questions to research participant
Participatory observation	Observer spends extended time within a natural setting and interacts socially as part of the research process
Non-participatory observation	Observer views a natural setting from a distance
Focus group discussion	Researcher takes part in and records discussion between a group of people on a topic or a range of topics.
Secondary discourse analysis	Researcher analyses linguistic underpinning of conversations from a distance

Qualitative research, by contrast, emanates from an interpretivist philosophy, which is grounded in a broader view of reality. This essentially takes into account social constructs and the subjective perceptions of individuals living within those constructs. Research methodologies that reflect this paradigm record a type of data from which the researcher can interpret subjective meanings. Again, using Broom and Willis' (2007) model, Tables 5.3 and 5.4 list the main features of the interpretivist paradigm and the methods used to gain data. These include structured, semi-structured or unstructured interviews, participatory and non-participatory observations, focus group discussions and secondary discourse analysis. Much of the research in the field of music and people living with dementia is grounded in qualitative methods (e.g. Clair *et al.* 1995; Groene 2001; Sherratt *et al.* 2004). However, recent concerns around lack of the rigour in research (e.g. Vink *et al.* 2003), have led to a few purely quantitative studies (e.g. Holmes *et al.* 2006).

In order to meet the aims and objectives of the current study, which focused on the perceptions and experiences of care-staff, informal carers and music practitioners, the research design was primarily underpinned by an interpretivist paradigm. The methods used were telephone interviews, face to face interviews, focus group discussions and participant observations. However, a quantitative method, in the form of a questionnaire survey, which is traditionally associated with the positivist paradigm, was adopted as part of the design. The mix of quantitative and qualitative methods reflected the three main design influences. These were Piper's approach to nursing research (Piper 2006) and the concepts of reflexive and aesthetic enquiry, as discussed in chapter four.

Table 5.5 Methods adopted and the objectives to which they were assigned						
		Positivist/quantitative	Interpretivist/qualitative			
Themes	Objectives	Questionnaire	Telephone interviews	Face to face interviews	Focus group discussions	Observations
Musical activities in care settings	A: To examine the numbers and types of live musical activities taking place in a sample of care settings		X		X	
	B: To compare the funding mechanisms of live musical activities taking place in a sample of care settings		X	X	X	
Staff personal histories attitudes related to music	C: To examine staff experiences of music in childhood				X	
	D: To investigate staff perceptions of the value of music in their personal lives	X			X	
Staff perceptions of music in care settings	E: To investigate staff perceptions of the value of music in their care setting	X			X	
	F: To investigate the levels at which staff engage with music in their work-place	X			X	X
	G: To examine staff perceptions of the impact of music on their clients	X			X	
	H: To investigate staff perceptions of the practicalities of including music in their care settings	X			X	
	J: To investigate staff attitudes towards music-related training	X			X	
The experience of using music with people living with cognitive changes	K: To investigate the experiences of music students and practitioners working in care settings			X	X	
	L: To examine the relationship between music practitioners and staff when working in care settings			X		X

5.2 Methods

A key feature of the design of this study was triangulation. This is where different sampling techniques, methods and analytical procedures are used to address the same objectives (Holloway and Wheeler 2002; Hansen 2006). Table 5.5 shows how the chosen methods, which centred on their perceived qualities and capacity to address the research questions, related to the objectives. Most of the objectives were addressed by at least two different methods. Objectives B and E were each addressed by three methods, Objectives A, D, F, G, H, K and L were addressed by two methods and Objective C by one.

Figure 5.6 Stages of the research process

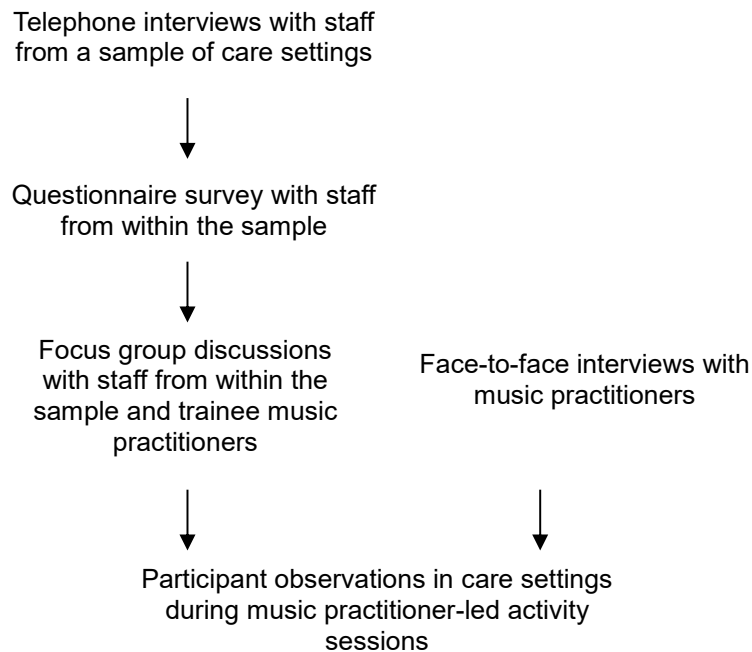


Figure 5.6 shows the stages and flow of data collection, which began with telephone interviews with care staff from a sample of settings, followed by: a questionnaire survey and focus group discussions with staff and trainee music practitioners; face-to-face interviews with music practitioners; participant observations of music activities.

5.2.1 Telephone interviews

Telephone interviews were used to address the question about musical activities in care settings and to meet two objectives:

Musical activities in care settings

A: To examine the numbers and types of live musical activities taking place in a sample of care settings

B: To compare the funding mechanisms of live musical activities taking place in a sample of care settings

This method was chosen for two equally important reasons. It was not intended that this should be a large-scale audit of musical activities in care settings but rather a mechanism for gaining information about the potential presence and levels of musical activities in the sample, and to understand the means by what they are funded. It also allowed the researcher to develop a relationship with key people who could be important in facilitating later phases of the research.

Telephone interviews can be an effective and convenient way to gain data across a broad range of settings and includes a level of anonymity which may elicit a greater sense of ease (Novick 2008). As with all person-to-person interviews, advantages over questionnaire data include the immediacy of response and the ability of the researcher to clarify and confirm data. An advantage on telephone interviews over and above face-to-face interviews is the avoidance of travelling time and cost, for either the researcher or research participant (Holloway and Wheeler 2002).

However, Holloway and Wheeler (2002) point out certain disadvantages to telephone interviews that needed consideration in this study. One relates to lack of security due to other people overhearing. To minimise this problem, the researcher ascertained that interviewees were comfortable to provide the information in the context of their environment and that they did not perceive the interview topic as overly sensitive or confidential. Other disadvantages can arise because of the impersonal nature of telephone interviews, such as the lack of reassurance provided by visual cues. This can

lead to misunderstandings and guarded responses (*ibid.*). The researcher aimed to address this by carefully wording, and re-wording, the questions where necessary. The different styles of the questions, which were both semi-structured and open ended, are well suited for the exploration of participants' perceptions on certain themes contained within loose parameters (Carr and Worth 2001). Three questions comprised the telephone interview schedule.

Telephone interview schedule

1. Can you tell me about any music activities that you've had over the last year in the home?
2. Could you tell me approximately how often they took place?
3. Do you have to pay for visiting musicians or are they voluntary, or a mix of the two?

These questions were asked because whilst much of the literature around music activities in care settings focuses on evaluation or comparison of specific therapeutic interventions, the researcher was unable to locate any which provide information on the frequency and type of music activities provided by musicians. In terms of funding music activities Vella-Burrows (2001) found that fewer care settings with small numbers of clients regularly funded music activities, compared with larger settings. Question 3 therefore aimed to highlight the presence or absence of challenges relating to funding for music activities, which was highlighted in chapter three (Iliffe *et al.* 2006). It was intended that the data gathered would help to form questions for later discussion in focus groups.

5.2.2 The questionnaire survey

Most of the methods in this study were qualitative but the second stage of the data gathering process, a postal questionnaire survey (see Appendix 1), aimed to provide numerical information on which focus group participants would be invited to elaborate upon later. This reversal of the more common procedure of qualitative data informing a quantitative survey was enabled because of the researcher's extensive experience of working in a nursing capacity with staff colleagues during various forms of music activities. Therefore, intelligence gathered informally before the research began informed the choice of questions in the questionnaire.

These were based on issues that appeared to be of interest to staff and/or appeared negatively or positively to influence staff's engagement in music activities in the workplace.

The questionnaire aimed to meet six objectives:

Staff personal histories and attitudes related to music

D: To investigate staff perceptions of the value of music in their personal lives

Staff perceptions of music in care settings and their level of engagement

E: To investigate the levels at which staff engage with music in their workplace

F: To investigate staff perceptions of the value of music in their care setting

G: To examine staff perceptions of the impact of music on their clients

H: To investigate staff perceptions of the practicalities of including music in their care settings

J: To investigate staff attitudes towards music-related training

Calnan (2007) points out that postal questionnaire surveys can provide a cost-effective overview of perceptions and attitudes in a relatively short time, across a wide sample from a dedicated geographical area. Bowling (1999) argues that respondent anonymity also maximises the potential for uninhibited responses. Each of these advantages was pertinent to the current study because of the limited financial resources, the relatively short time frame of the study and the desire to elicit truthful responses.

However, both Calnan (2007) and Bowling (1999) discuss a number of disadvantages of this method. Questionnaires are usually designed for solitary completion, that is, one respondent per questionnaire. However, this cannot be guaranteed when questionnaires are sent simultaneously to groups of people who usually interact socially or at work. Non-solitary completion increases the potential for bias due to peer influence. It was expected that this problem would be addressed at some level because staff in the care settings would receive their questionnaires at different times

over a week or more, according to their working shift patterns.

Bowling also stressed the potential for respondent bias associated with the questionnaire's design, which most frequently manifests as stereotyped marking, for example, always ticking the right-hand box. Therefore, the design of the questionnaire and the format of the questions varied (see Appendix 1).

Survey questions

As no previous studies of this kind were identified in the literature, a new questionnaire was designed. The questions were informed by the researcher's own professional experience. Questions were grouped according to the objective(s) that they aimed to meet. Respondents were asked to tick boxes that applied to them.

Objective E: To investigate staff perceptions of the value of music in their personal lives

Question 1. What does music mean to you personally? (Tick boxes that apply to you)

- I like to have music playing (radio/CDs etc.) in the background while I am doing other things
- Taking time to sit down and listen to music is important to me
- Listening to music can help me to feel good about myself
- Sometimes music is important; sometimes it's not, depending on how I'm feeling and what I'm doing.
- Music is of little importance in my life
- I like to sing in private (e.g. in the shower or the car)
- I play a musical instrument/sing regularly in an organized group
- I sing in a choir or group
- I enjoy going to hear live music (in a pub or a concert)

Question 2. I use music personally in the following ways: (Tick boxes that apply to you).

- | | |
|--------------------------|--------------------------|
| • To exercise to | • To relax to |
| • On journeys | • When I'm feeling sad |
| • While doing housework | • To give me energy |
| • To help me feel calm | • When I'm feeling happy |
| • To help me concentrate | • To help uplift me |

Objective E: To investigate the levels at which staff engage with music in their workplace

Question 3. Have you been involved in, or been present at, music sessions run by visiting musicians while you have worked with elderly clients? (Tick the box that most relates to your experiences)

- No
- A few times
- Quite often
- Very often

Question 4. Have you been involved in, or been present at, music sessions run by staff while you have worked with elderly clients? (Tick the box that most relates to your experiences)

- No
- A few times
- Quite often
- Very often

Objective F: To investigate staff perceptions of the value of music in their care setting

Question 5. Here are some statements about music sessions and how clients might respond to them. Do you agree or disagree with them? (Tick 'agree', 'disagree', or 'not sure')

- Live music with clients is OK but it does not affect their mood and/or behaviour long-term
- Live music at work usually lifts the mood of most clients during and for some time afterwards
- Most clients seem to prefer music led by familiar staff, rather than visiting musicians
- Most clients seem to prefer music with visiting musicians rather than staff led sessions
- Most clients seem to prefer live music if they are invited to join in, rather than just listening

Objective G: To examine staff perceptions of the impact of music on their clients

Question 5 (continued)

- Most clients would benefit from some form of music everyday
- Music in the home does not make any particular difference to clients

Question 6. If regular music sessions were available for clients to join in, what effects do you think this would have? (Tick 'agree', 'disagree' or 'not sure').

- Would annoy more clients than it pleases
- Would help clients to remember things
- Would help clients express their feelings
- Helps clients communicate better with staff
- Would help clients move better
- Would help clients relate with family member
- Would help staff to relate to clients more positive
- Would help improve clients' overall quality of life
- Would help to give staff insights into clients' abilities
- Could upset some clients

Objective H: To investigate staff perceptions of the practicalities of including music in their care

Question 6 (continued)

- Would annoy more staff than it please
- Would tend to disrupt the usual routine

Objective J: To investigate staff attitudes towards music-related training

Question 6 (continued)

- It can be embarrassing if visiting musicians ask staff to join in
- I would personally use music more with clients, if some form of training was available for staff

The questions aimed to elicit the perceptions and practices of music amongst the sample. As discussed in chapter three, there appears to be a paucity of published literature on this matter. In studies centred on staff-dependent music interventions in care homes (e.g. Gotell *et al.* 2006), little emphasis is placed on how staff feel about their own engagement.

5.2.3 Focus Group discussions

After analysing the questionnaires, focus group discussions were arranged in order to gain a broader and deeper understanding of the responses. This method was also used to gain an understanding of the perceptions of some music practitioners who worked in care settings. The collective focus groups aimed to meet the following objectives:

Musical activities in care settings

A: To examine the numbers and types of live musical activities taking place in a sample of care settings

B: To compare the funding mechanisms of live musical activities taking place in the sample of care homes settings

Staff personal histories and attitudes related to music

C: To examine staff experiences of music in childhood

D: To investigate staff perceptions of the value of music in their personal lives

Staff perceptions of music in care settings

E: To investigate the levels at which staff engage with music in their work-place

F: To investigate staff perceptions of the value of music in their care setting

G: To examine staff perceptions of the impact of music on their clients

H: To investigate staff perceptions of the practicalities of including music in their care settings

J: To investigate staff attitudes towards music-related training

The experience of using music with people living with dementia

K: To investigate the experiences and perceptions of music practitioners working in care settings

Holloway and Wheeler (2002) highlight the time efficiency of gaining many opinions at once in a focus group discussion, as compared to interviewing one person at a time. Such discussions enable *thick description*, which is relayed to the researcher by participants in a non-threatening, naturalistic setting (Green 2007). The method relies on the interaction between individuals whose expression of experiences is contextually framed. Kahn and Manderson (1992) note that this is maximised when members of a group ordinarily interact in work, domestic or other settings, as such people are used to drawing on social networks to deal with matters that arise from day to day. This process can stimulate thoughts and feelings beyond the superficial (Barbour and

Kitzinger 1999) because discussions that take place amongst people who know each other can give rise to stories being challenged (Green 2007). In the current study, the potential for staff to feel reluctant to talk about their musical skills, or not to recognise them until challenged, was felt relevant because the relationship between behaviour and the way people talk about it can be inconsistent (Peterson 2002).

Focus group discussion schedule

Eleven open questions aimed to meet a certain objective or objectives (see Appendix 2).

Objective C: To examine staff experiences of music in childhood was explored through:

Question 1. What do you remember about music at home and at school when you were young?

Objective D: To investigate staff perceptions of the value of music in their personal lives was explored through:

Question 2. Can you tell me about how important music in your personal life now?
Question 3. How do use music and what are the effects of different types of music for you personally?

Objective A: To examine the numbers and types of live musical activities taking place in a sample of care homes and day centres, and Objective B: To compare the funding mechanisms of live musical activities taking place in the sample of care homes settings were explored through:

Question 4. How often do you have musicians coming into the home?
Question 5. Do you know how is that paid for?

Objective E: To investigate the levels at which staff engage with music in their workplace was explored through:

Question 6. What sort of involvement do you have with music and your clients?

Objective F: To investigate staff perceptions of the value of music in their care setting was explored through:

Question 7. What is it about music that is important in the workplace?

Objective G: To examine staff perceptions of the impact of music on their clients was explored through:

Question 8. What sort of reactions to music or differences does music in the home make for clients?

Objective H: To investigate staff perceptions of the practicalities of including music in their care settings was explored through:

Question 9. How practical is it to have music activities in the home?

Objective J: To investigate staff attitudes towards music-related training was explored through:

Question 10. Do you think it would be helpful to your role as a carer to have training in using music with your clients?

Objective K: To investigate the experiences and perceptions of music practitioners working in care settings was explored through:

Question 11. What do you think are the benefits of music activities in care settings for people living with dementia?

Question 12. What issues have arisen for you personally when working in care settings?

Questions 2 - 10 invited greater exploration of themes raised within the questionnaire. Question 1, concerning childhood experiences, was added to investigate any relationship between early-life experiences and willingness to use music in the workplace in the present day.

5.2.4 Face-to-face interviews

Individual face-to-face interviews took place simultaneous to, and following the focus group discussions. The method was adopted to meet the following objectives:

K: To investigate the experiences and perceptions of music practitioners working in care settings

L: To examine the relationship between music practitioners and staff when working in care settings

The purpose of face-to-face interviews is to gain an inside view to discover participants' feelings, experiences and perceptions (Holloway and Wheeler 2002). In the current study, a *semi-structured interview* was adopted. The method uses a question framework for focusing on issues but with no fixed sequence. The process aimed to allow the discussions to flow naturally, to respect emergent themes but to maintain the focus within certain parameters (Hammersley and Atkinson, 1995).

Face-to-face interactions of this type also enable the researcher to gain on-going consent, particularly where themes are, or become, sensitive. This was relevant to the current study because music practitioners were invited to critique the way care givers behaved during music activity sessions. Other relevant advantages related to the cost-effective nature of interviews, and the relative ease with which they can be organised (Corbin and Morse 2003). In the current study the professional credentials of the researcher were also an advantage. Burgess (1984) suggested that nurse researchers are particularly suited to interviewing because of their inevitable familiarity with interview-style interactions with patients. This means that they are used to listening to and assessing meaning in one-to-one conversations.

Silverman (1998) argued against the suitability of interviews as a stand-alone method, asserting that how people express their behaviour does not always capture what they do. In the current study, this shortcoming was addressed by adopting additional research methods to address the same objectives. To minimise the potential for unwieldy data and its time-consuming analyse (Low 2007) a question schedule was devised to encourage a natural flow but within certain themed parameters (see Appendix 4). The presence of the schedule also took into account the different relationships between the participants and the researcher, which varied from distant acquaintance to a colleague/colleague relationship. The schedule aimed to avoid potential for over-informality by imposing some constraints on the interaction and to separate out information that might arise informally (Hansen 2006).

Face-to-face interview schedules

Six questions were put to music practitioners in face-to-face interviews, to gain insight into their experiences of working in care settings. The questions aimed to meet two objectives: ***Objective K: To investigate the experiences of music practitioners working in care settings*** and ***objective L: To examine the relationship between music practitioners and staff when working in care settings:***

Question 1. What sort of personality do you think is suited to this type of work?

Question 2. In what way do you think music is important for clients living with dementia?

Question 2. Do you think music has a role in helping to build and/or maintain relationships between carers and the cared-for? If so how?

Question 3. How do carers react to you?

Question 4. How do carers react to the music sessions?

Question 5. What do you enjoy about working in this field?

Question 4. What are the disadvantages?

Question 5. In your experience, what specialist training is available for practitioners?

Can you comment on training you may have been involved with?

Question 6. What do you think of the idea of music practitioners training staff to use music with their clients?

The rationale for adopting these questions was to fill an apparent research gap. As seen in chapter three, a wide range of studies illustrate the positive value of music for people living with dementia (e.g. Aldridge 1992 and 2000; Sixsmith and Gibson 2007), yet there is a paucity of research into the views of music practitioners working in the field and the feasibility of a professional liaison between care staff and music practitioners. These issues relate to wider social policy around the value placed on music as a non-pharmacological intervention.

5.2.5 Participant observation

Participant observations were carried out after the completion of the telephone interviews, questionnaire survey, focus group discussions and face-to-face interviews. The aim of participant observations was to examine the level to which staff participate in music-practitioner-led activities and the apparently complex relationship between the practitioner and staff. The method was adopted to address the following objectives.

Objective B: To investigate the levels at which staff engage with music in their work-place

Objective K: To investigate the experiences of music students and practitioners working in care settings

Objective L: To examine the relationship between music practitioners and staff when working in care settings

As a qualitative research method, participant observation is an effective mechanism for gathering direct information with ethnographic contextualization. Li (2008) suggested that potential for authentic representation is heightened due to the researcher

being immersed in proceedings in their naturalistic setting. Becker and Geer (1957) refer to the value of observation where research participants might find it difficult to verbally express complex issues. This is reflected in the very high number of studies in the field of music and people living with dementia, which include observation in their designs (e.g. Clair and Bernstein 1990; Gerdner 2000; Irish *et al.* 2006; Cevasco and Grant 2006).

Bowling (1997) also observes that participant observations are effective in highlighting a relationship between subjective perceptions, as expressed by a research participant, and outward appearances. This is significant in the current study because it aimed to compare what music practitioners and staff said in focus group discussions and face-to-face interviews with their behaviour.

Li (2008) highlights that one of the most significant challenges to participant observation is the *Hawthorn effect*, whereby the observed participants change their behaviour due to the presence of the researcher. To counter this, although the music practitioners, staff and clients were fully aware that the observation was part of a research project, and had consented to this, the researcher participated alongside the music practitioner. By presenting herself as a participant, and by being unspecific about the precise focus of the observation, the researcher hoped to minimise the *Hawthorn effect*.

Another challenge to rigour in participant observations is the significant potential for bias on the part of the researcher (Holloway and Wheeler 2002). To address this, some commentators have advocated a focus on the *description* of events, rather than researchers ascribing *meaning* to events (Silverman 1998). However, in respect of the wide body of literature that emphasises the need for nurse researchers to embed their work in creative and personal insight (e.g. Freshwater and Rolfe 2001; Piper 2006; Edvardsson and Street 2007), as discussed in chapter three, participant observation in the current study focused primarily on *thick description*. According to its originator (Geertz 1973), *thick description* includes the conceptual interpretation of the meaning and intention of participants' actions (Holloway and Wheeler 2002). In addition, an observation grid (see Appendix 5) aimed to provide a description of events.

Observation framework

Table 5.7 Observation framework
Part 1
Date/time/duration
Description of the event
Participants and their role
Part 2
1. Who answered the home's door?
2. Did the person in charge come to speak to music practitioner (MP)?
3. Was the room/space dedicated to the proposed music session used for this purpose only?
4. Were clients ready and waiting?
5. Did music practitioner ask staff to bring a specific client or clients?
5. Did staff help the MP with setting up her equipment?
6. Did staff speak to the MP during this process?
7. Was MP offered any form of refreshment?
8. Was a member/members of staff seated amongst clients at the beginning of the session?
9. Did they stay throughout the session?
10. Was a member/members of staff standing in the room but away from the central action?
11. Did they stay throughout the session?
12. Were members of staff arriving during the session greeted by CMPs?
13. Did CMP ask staff to help to give instruments to clients?
14. Did staff initiate helping to give out instruments to clients?
15. Did music practitioner give staff an instrument?
16. Did CMP ask staff to help clients to use instruments?
17. Did staff use instruments themselves?
18. Did music practitioner give staff song sheets?
19. Did CMP verbally or non-verbally invite staff to join in with singing?
20. Did staff sing with or without an obvious invitation?
Part 3
Personal reflection

The first section of the three-part observation framework (Table 5.7) focused on practical issues, as suggested by LeCompte and Preissle (1997). The second section focused on a description of what happened in the sessions and the third aimed to capture the researcher's fullest understanding of events.

The process aimed to provide some insight into music practitioners' and staff perceptions of and behaviour in their respective roles in music activities. It also aimed to identify any correlation between behaviour and what staff say about training and practice experiences and their perceptions of where music sits in terms of supporting the quality of their clients' lives (e.g. Kalis *et al.* 2005) The process also aimed to provide wider observations around how staff may assess and relate to the needs of older people living with dementia (Buckland 2004; Mitchell (2006).

5.3 Research design and rigour

During the conceptualisation, design, activation and analysis of this research, attention to rigorous practice was prioritised. A number of theoretical perspectives were considered, and practical strategies put in place to attempt the highest level of rigour.

5.3.1 Rigour in the quantitative research

In quantitative research, where data-gathering instruments are usually structured tools such as the questionnaire survey in this study, the traditional scientific measures of *objectivity*, *reliability* and *validity* form the basis for assessing rigour. The measures apply equally to the conceptualisation of the research problem, the design, the methods and their application, and the analysis.

Reliability refers to the extent to which a study's results can be reproduced when the research process is replicated and repeated in similar circumstances and conditions (Holloway and Wheeler 2002). The *reliability* of any research is grounded in the stability of the data-gathering instruments and the conduct of the researcher (Golafshani 2003). Streiner and Norman (1990) observe that the ultimate confirmation of *reliability* is usually determined by assessment parameters, such as test-retest, inter-rater reliability and internal consistency assessed across large samples. However, Streiner and Norman point out that rigorous techniques can uphold *reliability* where smaller samples feature, as in this study. *Reliability* is an essential pre-requisite for *validity*, which Calnan (2007) defines simply as *truthfulness*.

Litwin (1995) set out four aspects of *validity* in quantitative research. Firstly, *content validity* ensures that the whole range of issues that are considered important to research participants is addressed. *Face validity* ensures that the relevance of findings relates to how the questions were asked and the researcher's subjective assessment of data. *Criterion validity* ensures that a concept can be consistently confirmed by various tried-and-tested indicators. *Construct validity* ensures that the chosen research instrument has the capacity to test a hypothesis or theory.

5.3.2 Rigour in the qualitative research

In qualitative research, assessing rigour using the traditional measures of *objectivity*, *reliability* and *validity* is less clear-cut. To begin with, rather than using structured tools for gathering data, the researcher becomes the main data-gathering instrument (Holloway and Wheeler 2002). Given the variations of researchers' individual characteristics, backgrounds and experiences, the replication of unvarying measurements is rarely, if not never possible. In this case, Hansen (2006), amongst others, observes that alternative indicators of rigour centre on *credibility*, *dependability*, *conformability* and *transferability*.

Hamberg *et al.* (1994) provide a clear definition of the four indicators: *credibility*, *dependability*, *conformability* and *transferability*. *Credibility* refers to the study's representation of the truth. This is assessed by examining the findings and interpretations. *Dependability* refers to the suitability of the methods and the transparency of the data analysis. The most complex indicator, *conformability*, refers to the level of neutrality achieved by the researcher. This corresponds to detailed and transparent descriptions of large amounts of data and analyses grounded in reflexivity. The fourth indicator, *transferability*, refers to the level at which a study's relevance to similar situations is understood and recognised by others.

Sandelowski (1993) states that, unlike quantitative research in which the researcher is required to adhere strictly to the rules and procedures, qualitative research requires a broader approach but one that still results in trustworthy work.

Hansen (2006) recommends a number of strategies that a researcher should adopt to demonstrate rigour in this context. These are:

1. Familiarisation of the writings and ideas that underpin the research and the particular research questions.
2. Acknowledgment of the assumptions and ideas that underpin the research and clear expression in the writing and analysis of the researcher's 'critical gaze' of their own interpretations and conclusions.
3. Careful consideration and detailed description of the methods' suitability to the answer the research questions.
4. Utmost adherence to ethical issues such as confidentiality and/or potential harm to participants.
5. Careful consideration, competent application and detailed description of the sampling strategies, data gathering and analytic procedures in relation to the overall methodology.
6. The provision of adequate examples from the empirical data and references to the literature to support the analytic claims.

(Hansen 2006. p 45)

The remainder of this chapter aims to demonstrate the researcher's aspirations to uphold the highest level of rigour in the design of the study, ethical issues, and the sampling, data gathering and analytic procedures.

5.3.3 Rigour in the study's design

An important technique to support rigour in this study was method triangulation (Holloway and Wheeler 2002; Hansen 2006). The choice of methods centred on the researcher's knowledge of methodological paradigms in social science research, her prior professional and practical experience and her knowledge of the literature and theoretical perspectives that relate to the research questions. It also centred on ethical and pragmatic issues.

An understanding of the theoretical perspectives supported the construct of question frameworks. A consecutive data-gathering process was proposed to enable data from one method to help to inform question frameworks in others. In the questionnaire, the

questions aimed to measure variable responses to a broad range of issues that related to participants' perspectives of the research questions. Particular attention was paid to wording and grammar of the questions. To eradicate misleading wording and phrasing, the questions were devised, read and re-read by the researcher in consultation with and a number of colleagues from various health backgrounds including a care assistant, an occupational therapist and a retired registered nurse. The questionnaire also invited written narrative on any issues that participants believed to be additionally relevant.

The design of the questionnaire was given careful consideration in relation to potential problems with response bias (Bowling 1999; Calnan (2007)). Questions were grouped in different styles within and across pages to avoid patterned responses. To limit the potential for measurement error, whereby respondents always answer 'yes' or 'no', the wording of statements varied in positive and negative direction, for example, 'Taking time to sit down and listen to music is important to me' and 'Music is of little importance in my life'. The questionnaire design also incorporated a mix of response formats, closed questions to which response options were yes/no/not sure, and multiple response statements, such as, 'I use music on journeys', 'I use music whilst doing the housework', to which no restriction was placed on the number the participant may agree/disagree with. The use of SPSS statistical analysis software aimed to ensure numerical reliability on which the researcher could draw analytic conclusions.

A number of techniques that were adopted to ensure rigour in the preparation of the qualitative methods were common to all and largely related to avoidance of bias. Firstly, consideration was given to the type of interview that might be adopted. A balance was sought between *structured* interviews, which use pre-determined coding schemes and a limited choice of closed response categories to minimize bias and subjectivity, and *unstructured* interviews, in which participants are not constrained by a set of questions, nor are their narratives expected to conform to any closed coding scheme (Low 2007). Whilst Low observes that the latter can be the soundest of all interview types in terms of gaining the broadest view, the purpose of the telephone and face-to-face interviews in this study was to gain insight into a defined overarching topic. In this case, the researcher chose to use an open-ended or *semi-structured* question framework that invited narrative responses to a certain number of themes

relating to the topic and also encouraged other themes as they arose. This also applied to the question framework in the focus group discussions. With the help of the consultation team all the question frameworks were edited a number of times until they appeared able to elicit a wide range of responses. This process also aimed to address potential for a *Hawthorn effect* (McCarney *et al.* 2007), whereby participants respond in a way that they feel is expected.

The decision to use participant observation to gather data was based on Hansen's (2006) criteria, that is, when the researcher requires, i) an insider perspective, ii) detailed contextual information, iii) to conduct unobtrusive research, iii) to engage with participants (p. 80/81). However, as the method relies heavily on the observers' reflexivity, intuition and creativity to interpret events (Bowling 1999), and as the data were to be recorded in writing and analysed by the researcher alone, potential for subjectivity and bias needed considerable attention.

A number of strategies aimed to address potential threat to validity. To minimise potential for a *Hawthorn effect*, the researcher spent time in the care settings prior to the research observations taking place. In addition to familiarising the researcher with the surroundings, this aimed to normalise her presence in the settings (Baker 1994; Bowling 1999). Spending time observing the music practitioners in similar working situations prior to the research helped the researcher to gauge how typical the research observations were.

At the professional discretion of the music practitioners, observed sessions were not video recorded. This meant that data centred on the real-time observations of the researcher. Lofland and Lofland (1984) cautioned against data based merely on the observer's memories, but rather it must emanate from focused data recordings. In the current study, the researcher's understanding of the method and her experience and familiarity with observation as a research technique supported a disciplined approach. This included the use of the observation schedule and a system for making unobtrusive field notes that would underpin a vivid record of events.

In addition to the use of the carefully designed observation schedule and question frameworks, analytic rigour and bias-limitation were sought by the researcher constantly re-evaluating reflexive influences, critically analysing self-awareness (Baker 1994), reading and re-reading the data and coding the entire body of the data into themes from which to draw analytic conclusions (Bowling 1999).

5.4 Ethics

Alderson (2007) points out that, contrary to some arguments, social research, as well as medical research, can cause harm and distress if its processes are not ethically sound. This is of particular relevance when a study involves vulnerable people. For these reasons this study was considered and approved by the Faculty of Health Research Ethics Committee, Canterbury Christ Church University and that of the local NHS Primary Care Trust.

In 1964, *The Declaration of Helsinki* code of ethics set out underlying principles for research with human subjects (World Medical Association 1964). Since then the code has been up-dated six times, most recently in 2008. The code's basic principles aim to protect the life, health, dignity, integrity, right to self-determination, privacy, and confidentiality of every research participant (World Medical Association 2008). Reflecting these principles, the United Kingdom Central Council (1992) Professional Code of Conduct set out to safe guard the interest and well-being of research participants by referring to *Beneficence and Non-maleficence*, *Respect for Autonomy* and *Ensuring Justice*. The World Health Organization later referred to '...Beneficence and non-maleficence, respect for rights: free choice and protection of all subjects [including] those of diminished autonomy. Justice: equal distribution of benefit and burden' (WHO 2001 p. 142). The Economic and Social Research Council state that at no time must the personal social standing, privacy, personal values and beliefs of participant be put at risk (2005). The Department of Health's standards for research governance in health and social care focus on the maintenance of dignity, rights, safety and the wellbeing of participants (DH 2005a). Each of these definitions of statutory standards in research implies shared control between the researcher and the participants.

The following section outlines how these ethical considerations were addressed in the current study.

The foremost methods for gathering data, that is interviews and focus group discussions, centred on the researcher listening to participants' perceptions, views and attitudes of the research topic. Burgess (1984) point out that in these types of methods, ethical attention must be paid to the relationship between the people involved. If the participant group is unused to their voices being heard, due to the subordinate nature of their job, for example, then this gives rise to an important ethical advantage (Alderson 2007). The advantage can only occur however, if participants feel enabled and safe.

5.4.1 Beneficence and non-maleficence

Beneficence and non-maleficence refer to the principle that benefits must outweigh the risks of any research and that no harm is inflicted on participants. This was addressed in this study largely by its nature. Participants were invited to express their perceptions, views and attitudes, and to recount their experiences, thoughts and opinions. It was expected that the participants would view the process positively because it reinforced that their individual narratives were important and valued. Because of the subject matter, the study posed no physical risks. Neither the processes, or the questions posed, expected to cause any emotional level of discomfort or distress. However, ethical consideration was given to potential cases of upset caused by memories associated with experiences involving music. Strategies to deal with this included: comfort from the researcher and/or peers/staff; reassurance that emotional expression was valid in the research; referral to the person in charge, if necessary; reiteration of the voluntary nature of participation.

High risk participants

One group of participants, the older people's group, was considered potentially high risk because of the possibility of some to have dementia. The group was made up of individuals who attend or reside in a care setting for older people. The nature of their involvement in the study was peripheral because it occurred as a consequence of their

attending music activities in which the behaviour of staff and the music practitioner were observed. The researcher felt that the role of this group of participants was beneficent as it involved them taking part in a familiar, enjoyable activity that was designed to be therapeutically supportive.

5.4.2 Respect for autonomy

Respect for autonomy refers to individuals' rights for self-determination. In any research, this begins with the freedom and independence of an individual to choose or refuse to take part in a research project, and only to continue with a project in the absence of coercion (Holloway and Wheeler 2002). The ethical consideration centres on a participant's capacity to make an informed, autonomous choice. Participants need to be able to base their agreement or refusal to take part on a full understanding of the study, its procedures and risks as possible. In the current study, the preparatory procedures involving telephone calls, an explanatory letter and an invitation to take part. This aimed to provide participants with as much information as possible about the study's as possible. Participants were informed by letter of policies for ensuring anonymity, which included the use of pseudonyms and the avoidance of revealing data that in any way that could identify an individual or particular research setting. Issues of privacy and confidentiality were highlighted (see Appendix 6 - 11). These included the sensitive handling of emerging data, the integrity of reporting methods, the storing of data in a locked cupboard and on password-protected computers, and the proper destruction of data at an agreed time.

Due to research taking place in work settings, it was necessary to reach care staff through a *gate-keeper* that is the person in charge, such as the manager/owner/director, who has the authority to sanction their staff being approached. This was not a reflection on the capacity of their staff to give consent independently but rather it related to the so-called low-risk group of participants, who were independent, healthy and able to fully understand issues of informed consent.

Autonomy and moderate risk participants

The study included a number of moderate risk participants, for whom the *gate keeper* played a different role. For example, some participating care staff were from overseas. For some, English was not their first language. They may have had problems with understanding and literacy. The latter may also have applied to other staff. However, on questioning, all *gate-keepers* believed their staff to be capable of understanding the information given about the study, to make an informed choice to take part and to be able to contribute to the study without the need of a translator or literacy support.

Autonomy and high risk participants

Although no details were known by the researcher about the medical conditions of any participants, it was expected that some in the older people's participant group would be living with some level of dementia. In order to better understand policy on inclusion and consent in research with people living with these types of conditions, two key publications were consulted (Wilkinson 2002; Lowes and Hulatt 2005) An overriding theme in these publications was the desirability to involve vulnerable people in research but with strict adherence to scrupulous ethical practice.

It was deemed likely by the researcher, that a number of potential participants in this group would be unable to fully understand or retain understanding of informed consent. Matthews and Venables (1998) suggested that, in these cases, 'competence becomes the gate-keeper' (p.208). In other words, if individuals are perceived as incompetent, they must not be asked to give consent. The authors stated that assessment of a person's degree of understanding can be as difficult in research as it can in clinical practice. However, motivation for obtaining consent in clinical situations centres on a beneficent desire to support a person's state of health, for example through diagnostic tests, surgery and/or treatments, whereas consent for research is, to a greater or lesser extent, based on a means to an end. In the absence of adequate knowledge of each potential older person in the study, the researcher engaged the services of the care setting managers/owners/directors. In one care setting, in which two observation sessions took place, the manager gave authority for verbal

(rather than written) consent to be obtained from clients. This judgement was based on the nature of the older people's role and the potential to cause alarm by requesting a signed document. The manager also felt that setting's policy of obtaining an overarching written consent from willing clients to being observed/photographed/video recorded during events in the setting, was a sound measure of their ease with taking part in observed activities *per se*. In all cases, verbal and/or written consent procedures were conducted by the manager and the researcher together. Clients were made fully aware of the purpose of the study and the process of data gathering. Consent was sought once the manager and researcher had agreed that each participant understood the nature of the study and their role in the proceedings (See Appendix 9,10,11). Regular reminders ensured that participants understood throughout the process.

5.4.3 Ensuring justice

Justice in research relates to just and fair representation of research participants and just and fair research procedures (Holloway and Wheeler 2002). The initial process to identify research participants involved sampling of care settings for older people, in which music may or may not have used music in some way. Targeting settings that provided different categories of care and that differed in size and demographic localities aimed to ensure a fair representation of individuals working across the range of current care provision of this type. To address other issues of fair representing, participants were given written and verbal information using language deemed by the researcher, and verified by a number of other relevant professionals, as most suitable to maximize understanding across a wide range of educational experiences. All participants were treated with the same level of respect and consideration and the information they provided was analysed in a systematic way to elicit the fairest representation of their input.

5.4.4 Ethical considerations for the researcher

Hansen (2006) states that researchers have responsibility for protecting and representing study participants in the most truthful way possible. Alderson (2007) suggests that ethical dilemmas can occur for social science researchers, where the balance of emotion

and objectivity is askew. Researchers who are too detached can, in the extreme, lose connection with their moral self. Too much emotion however can cloud judgement and result in highly misleading outcomes. To attempt to balance these phenomena, a state of empathy was sought by the researcher, but a systematic protocol was adhered to. This meant that the researcher could put herself in the place of the participant to create a rapport and openness to the participant's true feelings (Holloway and Wheeler 2002) but still report findings in a relatively detached manner. The researcher also engaged in periodic de-briefing sessions with supportive supervisors and colleagues to minimise a build-up of stress and to discuss relevant issues.

5.5 The sample

Aside from ensuring the safety and well-being of research participants, a primary ethical consideration in any research relates to the sampling method. *Purposive* sampling, which is the predominant method in this and many other social science research studies, is a *non-probability* sampling method. This means that the people providing the data are not representative of the general population so data gathered cannot be generalised in this context. This places a significant responsibility on the researcher to be true to the representative group (Hansen 2006).

5.5.1 Research settings

The care settings that were approached for telephone interviews, that is the first phase of the study, formed the main body of the settings sample. The selection method was *purposive* because it deliberately targeted settings with specific characteristics (Bowling 1999). The criteria were: that they cared of people living with dementia; that they were located within a convenient geographical area along an approximate 30-mile stretch of the east Kent coast line; that overall, they reflected the varied characteristics of care establishments across the UK at the time of writing.

Sample identification method	Nursing homes	Residential homes	Day care centres	Total
Existing contacts	5	5	5	15
Kent Social Services Directory	6	12		17
E-search: Age Concern England			3	3
Total	11	16	8	35

Table 5.8 shows how the care settings were identified by the researcher and their care category. Fifteen settings were already known to the researcher in her professional capacity. The detail of their current musical activities was not known by the researcher at the point of invitation to take part in the study. Seventeen other settings were selected by the researcher blindly pointing at entries from randomly chosen pages of the County Council's Nursing and Residential Home Registry (2004). Three-day care settings were identified through an internet search of Age Concern Day Centres (www.ageconcern.org.uk).

5.5.2 Participant sampling

The sample of research participants comprised care staff, informal carers and music practitioners. In most cases they were identified via *purposive* sampling, in that those invited to take part were likely to have had some experience of music in their care settings either peripherally or centrally.

Telephone interview sample

It was planned that a senior member of staff from 35 settings would be invited to take part in telephone interviews. This number aimed to provide a fair representation of the types, size and categories of establishments that are current across the UK. In addition to *purposive sampling* of participants, there was also an element of *convenience sampling* (Davis and Scott 2007). This convenience related to certain members of staff being relatively easy to access, having the information sought and the authority to divulge it, and having the role of *gate-keeper* for members of staff who could be invited to take part later in the research process.

Questionnaire survey sample

It was proposed that a total of 240 questionnaires would be sent to the managers/owners of the 35 telephone interview settings, who would then distribute them to staff in their employ. This included direct care-givers, such as registered nurses and care assistants, and administrative, catering and ancillary workers. Although the individuals varied in role and hierarchy, they were all part of a homogeneous group in respect to work setting (Holloway and Wheeler 2002). The generic title, 'staff', was assigned to these collective individuals.

The rationale for inviting all staff was to gain a wide perspective of perceptions, views and attitudes around the use of music in care settings, and to encompass any individual member of staff who may use music to interact with clients, however briefly or informally, or may not use music in this way. Encompassing the whole range of staff in any setting also aimed to minimise potential problems of poor response rates.

Focus group discussion sample

The next sample was drawn from questionnaire survey respondents who indicated their willingness to participate in focus group discussions on questionnaire. It was proposed that ten focus group discussions would take place with around 45 participants. This overall size of sample aimed to fairly represent a wide variation of the personal and professional characteristics of care staff and the range of categories and sizes of care settings in which they worked.

The literature shows that commentators disagree with the best composition of people to elicit the most valid results in focus group discussions (e.g. Kreuger 1994; Kitzinger 1994). Kreuger, for example, cautions against using people who know each other well as inauthentic responses can occur due to social/professional hierarchy. In the current study, the composition of largely homogeneous groups of people was pre-determined by the research questions. The sample was deliberately targeted for their potential to discuss, endorse, challenge or refute the findings of the questionnaire and to raise other relevant issues (Crookes and Davis 2003). However, in respect for Kreuger's concerns, one focus group consisted of three heterogeneous participants who had different care-giving roles and were unfamiliar with one another. This provided the potential for

contrasting views and different expression of those views between participants (Holloway and Wheeler 2002).

A further sampling method used in focus groups, known as *snowball sampling*, also occurred at this stage of the study. In this, a sample is defined at the outset but remains open to others who are referred or elect to take part, providing they meet the inclusion criteria (Davis and Scott 2007). In this study, three participants elected to take part in focus group discussions, having heard they were taking place.

Face-to-face interview sample

The researcher planned to conduct up to eight face-to-face interviews with music practitioners who worked in care settings for older people. This relatively small number aimed to balance a fair representation of the music practitioners with the challenges of dealing with the time-consuming analysis of in-depth data of this nature.

The sampling method was both *purposive* and *convenience*. Participants were drawn from people known at some level to the researcher in a professional capacity. In this case, selection bias was considered but as the participants' thoughts on the research topic were previously unknown to the researcher, this was not perceived as an overriding problem.

Participant observation settings and sample

The settings for the observation were drawn from the setting sample. It was proposed that four observations sessions would take place with around 15 to 20 people in each. The participant sample would comprise a music practitioner, any staff on duty at the time and the group of clients taking part in the music activities. This was a further example of *purposive* sampling because the observations focused on interactions between the music practitioner and care staff during these activities. The proposed number of sessions aimed to give insight into a range of variable behaviours with respect to the high demand on the researcher's time in activating and analysing this type of research.

5.5.3 Inclusion and exclusion criteria

Staff and music practitioners

The inclusion criteria for staff and music practitioners to take part were two-fold: i) i) they had worked in care settings with people who appeared to have some level of dementia; ii) they were able to give informed consent to take part.

The exclusion criteria for both staff and music practitioners included people who did not work with clients living with dementia, people who worked in healthcare settings outside the arena of continuing care settings, such as on an acute hospital ward, and/or people who could not/had not given informed consent to take part.

Informal carers

The inclusion criteria for informal carers were two-fold: i) that they had cared for a close relative who was living with dementia; ii) that they were able to give informed consent to take part.

Older people's group

Apart from being present at music sessions proposed for observation, the inclusion/exclusion criteria for older people being cared-for in care settings centred largely on their willingness to take part and their capacity to consent. In order to avoid difficulties around informed consent, people who were reported by a senior member of staff as living with profound cognitive dysfunction were excluded. Because of the role of clients, it was planned that people who came under the exclusion criteria for research purposes, but who were known to enjoy music activities, would be included in sessions but excluded from any research observation.

5.5.4 Piloting

Telephone interviews and face-to-face interviews

Both telephone and face-to-face interviews were piloted with a number of colleagues prior to the study. The wording and phrasing of the question frameworks was discussed, critiqued and edited where necessary and the researcher's interviewing techniques were rehearsed, reviewed and critiqued. Critical feedback reinforced the

importance of a neutral and non-assumptive delivery of the questions and to elicit a sense of confidence which would underpin truthful responses. The researcher practised interviewing techniques with a retired dementia-care nurse, who gave critical feedback on the issues of delivery and coherence.

The Questionnaire survey

The questionnaire was piloted with the Education and Activities team from a national housing association scheme for older people, comprising a leader and two co-ordinators who work in care settings. Some language thought to be too academic, complicated or ambiguous was replaced. The design of the revised questionnaire was discussed with a retired care unit manager and piloted again with a retired care-giver.

Focus groups discussions

One pilot focus group discussion took place with a group of the researcher's former nursing colleagues. Due to the researcher's relative inexperience in facilitating groups in this context, this yielded too little in-depth data. Transcriptions of the recorded session demonstrated an inappropriate amount of input from the researcher, and the use of subtle voice nuances that could be construed by participants as judgemental. The researcher therefore conducted a further two pilot sessions with three former nursing colleagues. Improvements to technique were achieved through critical feedback, by observing an experienced focus group discussion facilitator and by reviewing the literature (Bowling 1999; Freeman 2006; Barbour 2005).

Observations

No formal observation pilot sessions for collecting data were conducted owing to the complexity of organising them with the client group of participants. However, the researcher spent approximately two hours with two music practitioners shadowing their normal working schedule prior to the observation sessions. The researcher was confident that, due to her wide experience of evaluating similar activity sessions, valid data would be forthcoming and appropriately recorded during research sessions without the need for piloting.

5.6 Procedures

5.6.1 Common preparatory procedures

Gathering data across all methods was preceded by the study being submitted to and approved by East Kent NHS Primary Care Trust Local Research Ethics Committee in June 2005. The following practical procedures comprised three steps for all methods of data collection. Firstly, the researcher telephoned potential participants and the *gate keepers* of potential participants, to ascertain their interest in taking part. Secondly the researcher sent a letter of invitation to those who had expressed interested, which introduced the researcher, explained the purpose of the study, described the proposed role of the participant, the process of data collection and what would happen to the data. Thirdly, the researcher made a follow-up telephone call to confirm continued willingness and to arrange a suitable time for the research to take place. These procedures took place over an approximate three to four-week period. Subsequent procedures related each individual method.

A consecutive data-gathering process enabled data from one method to help to inform question frameworks in others. For example, findings and issues raised in telephone interviews and the questionnaire were included in the focus group, face-to-face interview and participant observation question frameworks.

5.6.2 Procedures in telephone interviews

Telephone interviews were conducted between March and April 2006. Most took place during the hours of 1030hrs and 1600hrs. A few took place outside these times at the convenience of the participating member of staff. All calls were made by the researcher, who introduced herself and asked to speak to either the person who had agreed to take part in the study. The researcher reminded the participants who she was and the purpose of the call. She confirmed that the timing was suitable for the participants and reminded the participant of her rights to withhold information or withdraw from the interview without explanation. She gained verbal consent from each participant to use the data for the purpose it was intended.

As in all person-to-person interactions the researcher deliberately kept the opening informal to put the participants/participants at ease. The researcher aimed to speak and in a pleasant manner and to respond in a neutral way, often repeating comments back to participants *verbatim* or giving a summary to confirm confluence of understanding (Holloway and Wheeler 2002). The question guide (see Appendix 4) was roughly followed. All other information offered by participants was acknowledged and encouraged where deemed broadly relevant to the research subject.

The participants' responses were noted down in writing on a prepared grid, which was pre-labelled and dated (see Appendix 5). The interviews lasted between 10 and 20 minutes. They were concluded by the researcher thanking the participant for their time and reiterating the purpose of the interview and the intentions for the information given.

5.6.3 Procedures for questionnaire survey

Between March and May 2006, 80 questionnaires were posted with stamped addressed envelopes to the *gate keepers* of 10 care settings in batches of between five and 10, depending on the size of the setting and in prior consultation with the *gate keeper*. Sixty more were posted in similar sized batches to another eight settings between June and July 2006. A further 100 questionnaires were delivered by the researcher personally to 17 care settings between August and September 2006. A follow-up telephone call was made to the *gate keeper* of each setting approximately two weeks after posting/delivering questionnaires to remind each about the study and to request that they prompt care staff to respond if they wished. Completion of the questionnaire was taken as consent to participate in the study.

Twenty-eight questionnaires were returned by post between April and July 2006. After which, the researcher telephoned the *gate keeper* of settings that had not responded to check if they needed duplicate questionnaires and to offer a personal visit for the researcher to collect those that may be completed. Eighty-four questionnaires were collected by the researcher personally between August and November 2006. Questionnaires were labelled and grouped together in batches according to their setting.

5.6.4 Procedures for focus group discussions

Focus group discussions took place between April 2005 and December 2006. Most were conducted in participants' usual place of work but three took place in other settings, one in a participant's private home, one in a spare teaching room on a university campus and one in a community hall.

5.6.5 Setting specific preparation for focus group discussions

Some preparation for focus group discussions was setting specific. In care settings, the researcher contacted the person in charge on the morning of the proposed discussion to confirm arrangements. The researcher arrived at the setting around 30 minutes before the pre-arranged time to establish with the *gate keeper* that participants were present and still available. Discussions took place in a convenient room, chosen by the person in charge, where staff could sit comfortably and take refreshments if they wished. These were most often rooms in which staff usually took their breaks. Before the discussion started, the researcher checked that, where possible, the chairs were positioned in a semi-circle or around a table. The audio and note-taking equipment were placed in a central position. This consisted of a discreet mini disc recorder, which was placed on a table or a chair in a central position, and a notebook and pen. As participants arrived, the researcher greeted each and introduced herself. Participants were invited to sit where they felt comfortable.

Preparation in the private home

On the morning of the proposed focus group discussion in a private home, the researcher telephoned the host participant and other participants to confirm their availability. The researcher arranged with the host to arrive 15 minutes before the start of the discussion. She asked in which room the host would like to hold the discussion and discussed with her how the chairs would be positioned and where the recording equipment might be placed. As participants arrived, they were greeted by the host and the researcher. They were shown to the discussion room and asked to sit where they were comfortable.

Preparation in the community hall

One focus group discussion took place in a community hall at the end of a regular church-based social event for older people. On the morning of the proposed discussion, the researcher telephoned the organiser of the event to confirm the arrangements. The researcher arrived at the community hall before the social event started, introduced herself to the potential participants as they arrived and reminded them of the purpose of her visit. The layout of the room, which was pre-ordained by the social event, consisted of six trestle tables placed in a close oblong with seats around the outside. Ten minutes before the start of the discussion, the researcher set up the audio and note-taking equipment in a convenient place.

5.6.6 Common procedures for focus group discussions

From this point, the procedure for discussions was common to all focus groups. When all participants were in place, the audio equipment was explained. Participants were reminded of their rights and reassured that they could leave the discussion at any time without explanation. The consent form, which included consent to be recorded, was discussed according to the ethical protocol and signed by each participant.

Discussions were deliberately approached in an informal chat-style manner. Participants were told about the aims of the study in a general way, that is 'To see what staff think about music in their care setting and to see how staff might use music in their private lives'. To endorse the notion of easy social interaction the researcher had organised refreshments for participants. The researcher also aimed to put participants at ease by using a pleasant, neutral tone of voice and relaxed body language.

Type of question	Example
Collective question: factual information	'How many clients do you have at the moment?'
	'How often do you meet to sing together?' [Community hall participants]
Background questions: sharing experiences	'What do you remember about music at home and at school when you were little?'
Value questions: opinion giving	'What is it about music that is important in the workplace/for you?'
Emotional questions: sharing feelings	'How comfortable are you about doing music activities with your clients?'

Table 5.9 illustrates the gradual development of questions. This process started with collective questions put to the whole group and moved onto questions on the question guide (see Appendix 3). This began with background questions, which asked participants to share their memories, followed by value questions, in which participants were asked for their opinions, and emotional questions, which required responses based on feelings. This process aimed to promote participants' levels of ease and confidence gradually. Any secondary questions or themes that arose from the primary questions on the question framework were encouraged. During the discussions, the researcher observed for dominant individuals and occasionally directly invited quieter participants to give their views. Data was recorded on the mini disc recorder and in written note form, when deemed unobtrusive to do so.

Focus groups discussions lasted between 35 and 60 minutes. They were each concluded with the researcher thanking participants for their time and reiterating the purpose of the discussions and the intentions for the data gathered. Mini discs and written notes were labelled according to their setting and dated.

5.6.7 Procedures for face-to-face interviews

Face-to-face interviews took place between October 2005 and July 2007 in various locations at the mutual convenience of the participant and re researcher. This included the participants' private homes, the researcher's work office and researcher's private home. In all cases, the researcher telephoned the participant on the morning of the interviews to confirm the arrangements.

As with the focus group discussions, some preparations for the interviews were setting specific.

5.6.8 Setting-specific preparation for face-to-face interviews

Preparation for interviews in private homes

The researcher arrived a few minutes before the pre-arranged time and asked in which room the host would like to hold the interview. The researcher discussed with the host where the recording equipment should be placed.

Preparation for interviews in the researcher's office

The researchers checked with colleagues that the office would be still be free at the time of the proposed interview. Two chairs were placed either side of a small worktable with the mini disc recording and note-taking equipment placed in the centre. The participant was greeted on arrival, shown into the office and invited to sit in which ever chair she/he felt comfortable and offered refreshments.

Preparation for interviews at the researcher's home

In a small sitting room of the researcher's private home two easy chairs were positioned facing each other with the mini disc recording and note-taking equipment set up on a low table between them. The participant was greeted on arrival, shown to the sitting room, invited to sit in a chair of choice and offered refreshments.

5.6.9 Common procedures for face-to-face interviews

At this point the process of face-to-face interviews was common to all. When the participants were in place, the audio equipment was explained. Participants were reminded of their rights and reassured that they could leave the interview at any time without explanation. The consent form, which included consent to be audio recorded, was discussed according to ethical protocol and signed by the participant.

As with focus group discussions, in face-to-face interviews, the researcher aimed to put participants at ease by using a pleasant, neutral tone of voice. The interview process started with informal questions about the participants' current situation, such

as 'How long have you been working in care settings?' and 'How many sessions might you do in a week?' Questions on the question guide (see Appendix 4), were introduced when deemed appropriate by the researcher. Participants were encouraged to traverse emerging themes by elaborating on and expanding their narrative. Data was recorded on the mini disc recorder and in written note form, the latter, when deemed unobtrusive to do so.

Face-to-face interviews lasted between 45 and 70 minutes. They were each concluded with the researcher thanking participants for their time and reiterating the purpose of the discussions and the intentions for the data gathered. Mini discs and written notes were labelled and dated.

5.6.10 Procedures for participant observation sessions

Observation sessions took place between October and December 2007. The procedures were largely common to all. Two or three days prior to the proposed observation, the researcher arranged with the person in charge to visit the setting to confirm arrangements and to undertake the consent procedure with the client group. The day before the observation, the researcher telephoned the music practitioner to confirm arrangements.

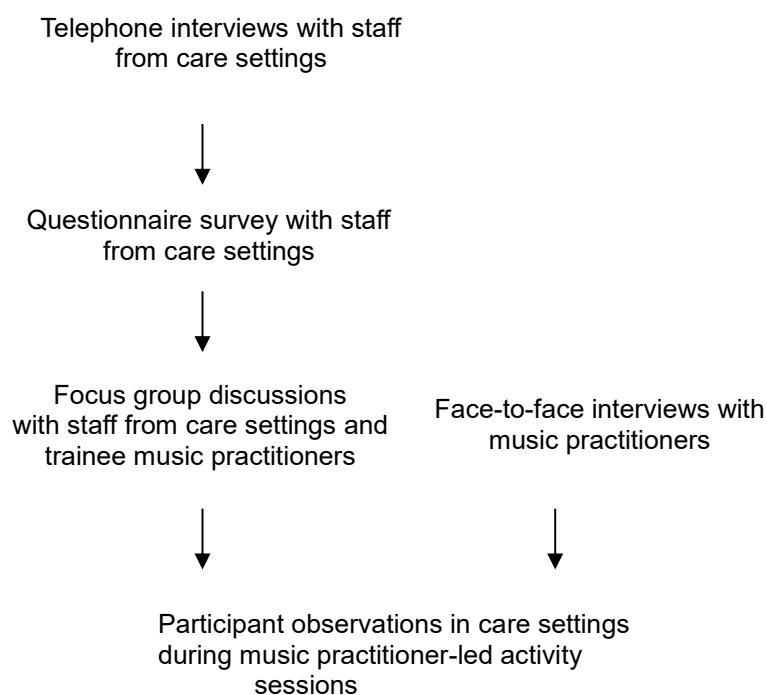
On the day of the observation, the researcher arrived early to remind the person in charge/*gate keeper* that she would be present in the music session and to ask permission to gain signed consent from staff members on duty. The researcher had arranged to meet the music practitioner in the car park of each setting ten minutes before the his/her normal arrival time. The music practitioner was reminded of his/her rights and reassured that they could stop the observation at any time without explanation. The consent form was discussed according to ethical protocol and signed by each music practitioner.

The researcher then shadowed the music practitioner entering the setting and followed her/him to the allocated space, observing for interactions between the music practitioner and staff during preparation. During the session the researcher sat amongst the client group and joined in with the activities to further observe interactions. Data

were recorded in rough form on the pre-labelled, dated observation grid (see Appendix 5) when deemed unobtrusive to do so. The sessions lasted approximately 75 minutes and concluded with the researcher thanking all participants for taking part and reiterating the intentions for the data gathered.

5.7 Data coding and analysis

The methods used for data collection in this study were:



5.7.1 Coding settings and participants

The first phase of organising the data was to assign codes to the research settings and the participants. The settings for telephone interview were collectively coded 'T', followed by a unique numerical sub-code, for example, T1, T2, and so forth. As participants were representing their care setting, they were not allocated an individually code. The questionnaire survey settings were collectively coded, 'Q' followed by a unique alphabetised sub-code, for example, QA, QB and so forth. Respondents were coded numerically and batched together according to their setting. For example, the six respondents from the first setting were coded QA 1 – 6; the five from the second setting were labelled QB 7 – 12. And so forth. The focus group discussion settings were collectively coded Fg, then each was assigned a unique

number, for example, Fg1, Fg2. Individual participants were identified using the initials of their job title: HO = home owner; RGN = registered general nurse; RM = registered manager; A = administrator; SCA = senior care assistant; CA = care assistant; RC = resident client; CT = care-taker; IC = informal carer; GP = general practitioner; CP = consultant physician; SW = social worker. Where more than one person had the same job title a numerical code followed their initials, for example, The first care assistant to speak was coded CA 1; the second CA 2 and so forth. One focus group participant, who was both a music student and a part-time care assistant was coded CA/MS. Trainee music practitioners who took part in one focus group were collectively coded TMPs, and individually by a unique numerical code, for example, TMP, TMP2 and so forth. Settings for face-to-face interviews were collectively coded 'F', and individually by a unique numerical code, for example, F1, F2. Participants were coded according to the initials of their role, that is, TMP = trainee music practitioner, MP = music practitioner. Participant observation settings were collectively coded 'PO', and individually by a unique numerical code, for example PO1, PO2, and so forth. Participants in the observations were coded according to the initials of their role, that is, HM = Home manager, MP = music practitioners, CA = care assistant, AA = administrative assistant and so forth. Where more than one person held the same role, a numerical code followed their initials, for example MP1, MP2.

5.7.2 Coding and analysing the quantitative data

The second phase of organisation was to code the data for analysis. Four of the five data gathering methods used to investigate these data groups were qualitative, but the survey questionnaire provided numerical information. The process of coding and analysis of the questionnaire data is described first.

The Statistical Package for Social Science (SPSS) data software programme was used to analyse data from the questionnaire survey. This required a coding system for the main questionnaire themes and their sub items. The systematic method of analysis, via the SPSS, aimed to identify common factors and to provide opportunities to correlate these factors.

For convenience, the questionnaire survey was divided into six main thematic headings: 1) what music means to participants in their personal life; 2) how participants use music in their personal life; 3) how often participants have been involved in music sessions with visiting musicians in the work place; 4) how often participants have been involved in music sessions led by staff in the work place; 5) staff perceptions of clients' musical preferences; 6) staff perceptions of the impact of music on all individuals in the work-place and potential for music training for staff. The themes were assigned numerical codes, 1 – 6. Under each theme were a number of items, which were also assigned an alphabetised code, for example 1a, 1b and so forth.

Using the SPSS programme, a univariate factor analysis mapped the frequency distribution of questionnaire responses (Argyrous 2007). The results were transcribed onto tables, printed and batched together in their headings. Boyatzis (1998) referred to this element of the process as generating *units of analysis*. This process is an established part of content analysis. The batches of data from the questionnaire survey, which also related to the study's objectives, acted as building blocks for coding the qualitative data.

5.7.3 Coding and analysing the qualitative data

Thematic analysis was chosen by the researcher to organise the qualitative data. A number of commentators have observed that this method is widely used in qualitative research, yet it remains poorly demarcated (e.g. Attride 2001; Tuckett 2005; Braun and Clarke 2006). One primary reason for its lack of definition centres on the prevalence of studies that inadequately describe the analytic processes and/or the potential pitfalls (Attride-Stirling 2001). The following section therefore aims to systematically map out the process of each phase of the coding and analytic process and to identify potential drawbacks that could lead to poor quality research. It is framed within the guidelines for thematic analysis in psychology research, which relates well to this study, set out by Braun and Clarke (2006).

Phase	Description
1. Familiarizing yourself with your data:	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes:	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes:	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes:	Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes:	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.

Table 5.10 shows Braun and Clarke's guided approach to thematic analysis. The process begins with the researcher becoming thoroughly familiar with the data, and moves through generating initial codes, collating codes into themes, reviewing the themes, generating clear definitions of the themes and analysing and selecting vivid extracts that relate to the research questions and the literature to form the final report.

The process of coding and analysis of qualitative data in the current study was managed in a similar way. Within a few days of each data gathering event the whole body of raw data, whether written or audio recorded, was transcribed onto a computerised word document. A printout of these transcriptions was carefully read. The data was sorted and batched together into the themed batches of sorted quantitative data. These batches were coded using the objective coding letter to which the data most closely related. Each of these coded letters was also individually assigned a colour. For example, data that related to *Objective D: To investigate staff perceptions of the value of music in their personal lives*, was coded 'D' and marked with a blue-coloured highlighter pen. This colour-coding was transferred to the corresponding data on the computer by changing the font colour, and the transcriptions were reprinted. The coloured sections were then cut out by hand and paper-clipped

together in units of corresponding colours. By repeating this process for each transcription, a framework of the main themes was formed.

Ultimately, all of the raw data were given equal attention and the entire content of the questionnaires survey and all of the transcriptions was assigned a colour code. By physically batching the coloured cut-outs together under their main headings, a visual thematic map emerged. The cut-outs could easily be moved and adjusted to see how the themes related to one another. In reviewing the map in this way, the researcher could see that some cross-thematic data combined to form new themes, and some data did not appear to relate directly to the main units of analysis. The latter were colour coded according to their topics and formed new units of analysis. This data fell into five main categories: i) staff attitudes towards age and ageing; ii) staff perceptions of dementia services; iii) staff interactions with people in their care, iv) staff understanding of person-centred care; v) the apparent importance of informal social networks amongst staff.

As the data emerged, some appeared to relate to more than one unit of analysis. In these cases, the whole section of data was copied onto a new word document and printed again in the font colour relevant to the new theme(s).

One comment from a participating care assistant provides an example of the next phase of the analytic process, that is, the identification of *coded data* (Boyatzis 1998). The comment, “*They [clients] all like the war songs. They love singing - so do I, I sing at home all the time, I won't do it here though 'cos I'm rubbish*”, related to three units of analysis: i) care staff perceptions of the value of music in their care setting; ii) staff perceptions of the value of music in the personal lives; iii) the levels at which staff engage in music in their work-place. The comment also related to two main themes: i) the perceived value of different musical material; ii) the perceived value of singing on clients' mood. These, and numerous emergent themes, were coded using a number in addition to the letter-coded unit of analysis to which it related.

Figure 5.11: Units of analyses and assigned colour codes

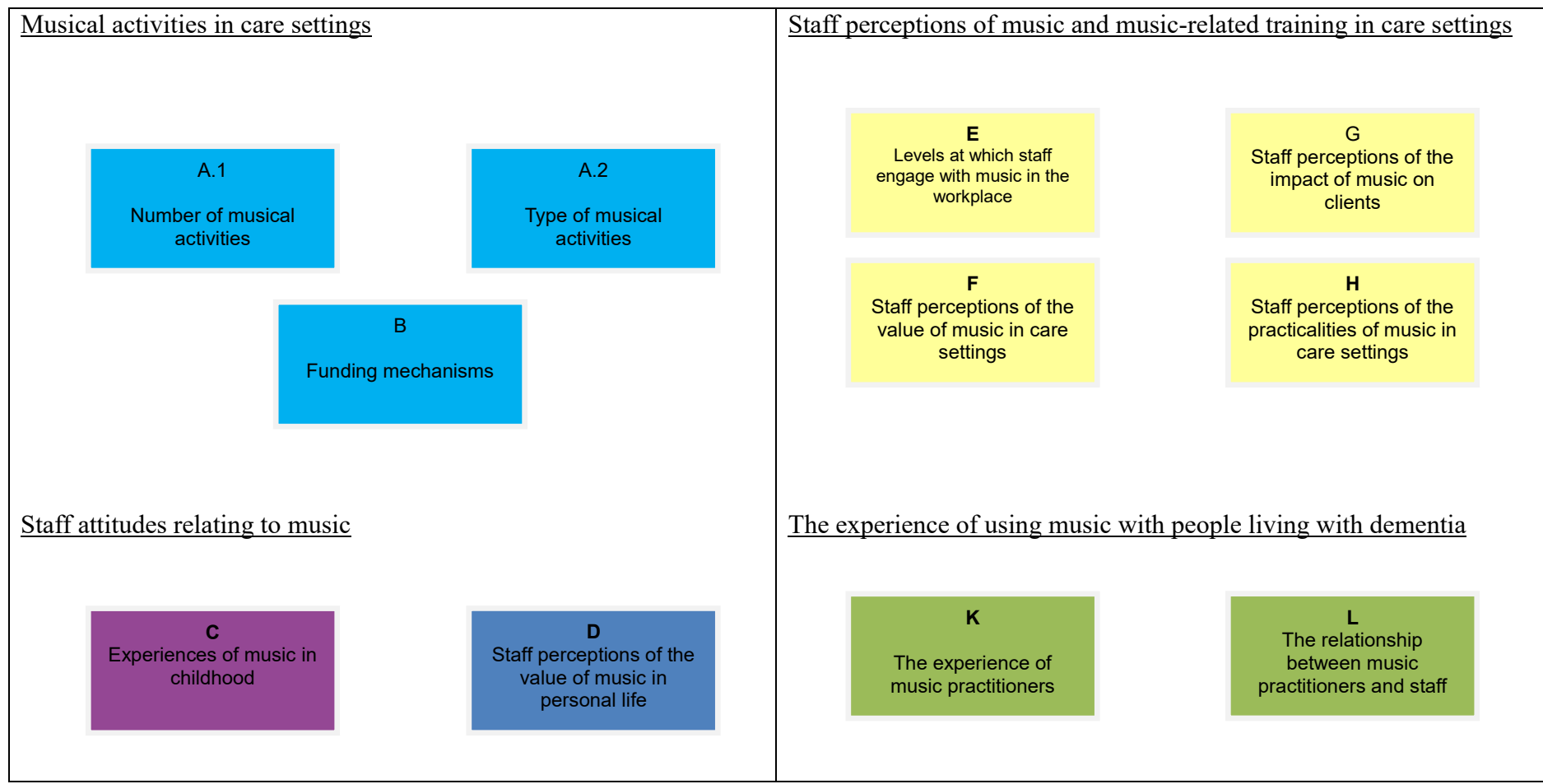


Figure 5.11 shows the main units of analysis, which corresponded to the study's objectives, and the colours that were assigned to the four main overarching themes: i) musical activities in care settings; ii) staff personal histories and attitudes related to music; iii) staff perceptions of music and music-related training in care settings; iv) the experience of using music with people living with dementia.

Figure 5.12 An example of a unit of analysis, its themes and sub-themes

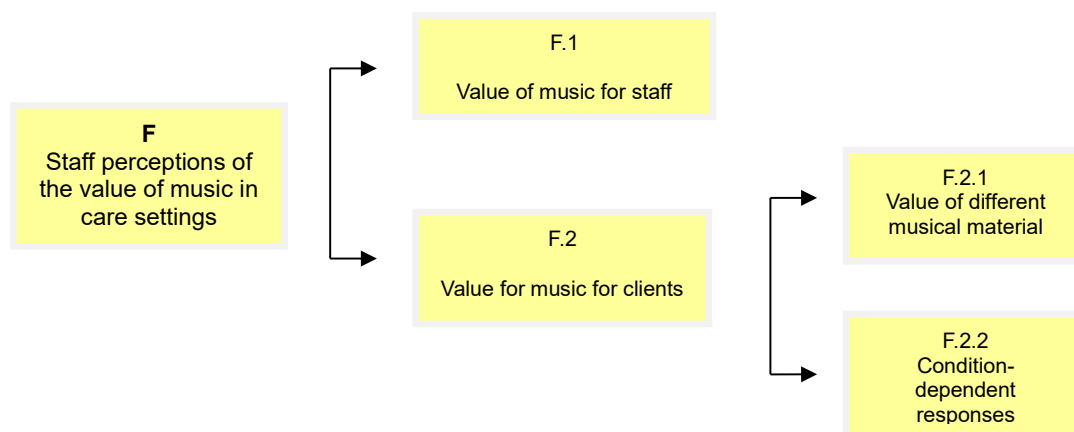


Figure 5.12 demonstrates the process of identifying sub-themes. It shows the how data relating to **Objective F: To investigate staff perceptions of the value of music in their care setting** generated two coded themes: F.1, the value of music for staff and F.2, the value of music for clients. It also shows that further dissemination resulted in two sub-themes: F.2.1, staff perceptions of the value of different musical material, and F.2.2, staff perceptions of condition-dependent responses of clients to music.

The physical process of colour-mapping data also showed the researcher which themes were given the most attention by the research participants and how they might relate to one another. This enabled the researcher to choose extracts that most vividly represented participants' views. Included in this were some of the more isolated data that, whilst apparently inconsistent with common viewpoints, nevertheless expressed some important observations. This showed the importance of coding and analysing all data and reporting data that tells its own specific story as well as data that contributes to the broader picture.

Chapter Six

Results

This chapter begins by reporting the final number and characteristics of the research sample, and by highlighting the problems and the necessary changes to the proposed methods. It then presents the results of the study in relation to each of the objectives. In the case of percentage measurements, all are rounded up to the nearest one decimal point.

6.1 Final sample

6.1.1 Settings

The final setting sample consisted of 27 care settings for older people comprising 12 residential care homes, 10 nursing care or mixed care settings and five-day care settings. Four homes were in rural or semi-rural locations, sixteen in suburban locations and seven were in towns. Other settings in which data-gathering took place were the researcher's work-based office, three private homes and a community hall. All of the settings were located within an approximate 30-mile radius in the county of Kent.

6.1.2 Number of participants

Overall, 192 participants contributed to this research study. Participants were categorised into four main groups, care staff, music practitioners, informal carers and older people.

Figure 6.1 Percentages of participant groups taking part in the study

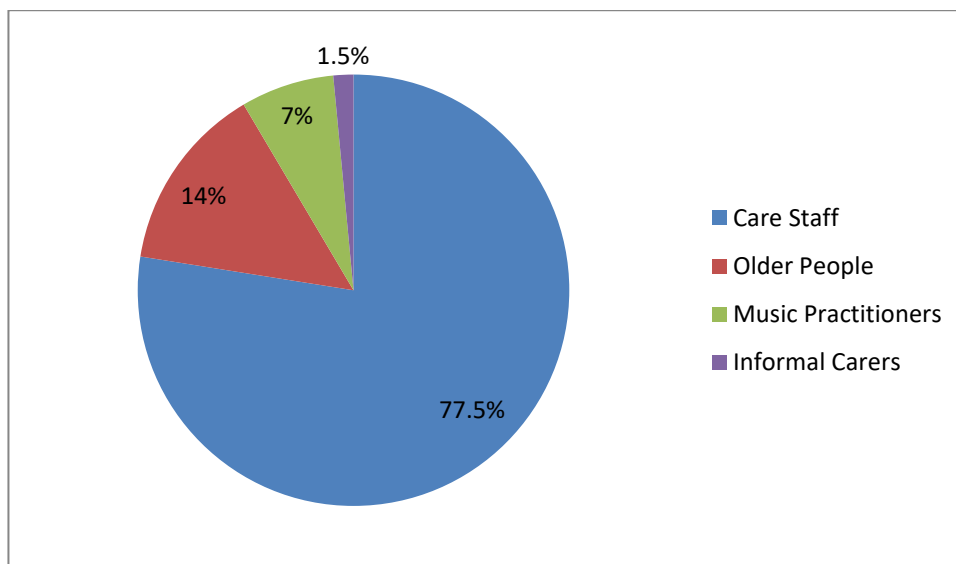


Figure 6.1 shows that 77.5% of participants were care staff (n = 149), 14% were older people (n = 27), 7% were music practitioners (n = 13) and 1.5% were informal carers (n = 3).

Main group	Subgroups			Total
Care Staff	Staff from care settings (n = 146)	Medical practitioners (n = 2)	Social Worker (n = 1)	149
Music practitioners	Community music practitioners (n = 5)	Trainee music practitioners (n = 8)	-	13
Older people	Clients from care settings (n = 22)	Community members (n = 5)	-	27
Informal carers	-	-	-	3
Total				192

Table 6.2 shows the main groups and their participant subgroups. The care staff group comprised three subgroups. These were: i) a staff from care settings (n = 146), which included nurses and care assistants (collectively termed 'care-givers'); administrative and ancillary staff; ii) medical practitioners with a specialism in the care of older people (n = 2); iii) a social worker who worked with older people (n = 1). The music practitioner group comprised two subgroups. These were: i) experienced music practitioners (n = 5); ii) trainee music practitioners (n = 8). The latter were music students studying community

music, with practice placements in care settings. The older people's group comprised two subgroups: i) clients from care settings (n = 19); ii) community members who engaged in a regular music activity (n = 5). Three informal carers also took part.

6.1.3 Participant characteristics

Participants	Telephone interviews	Questionnaire survey	Focus group discussions	Face to face interviews	Observations
Staff from care settings	27	112	41	1	15
Medical practitioners	-	-	2	-	-
Social worker	-	-	1	-	-
Music practitioners	-	-	-	4	2
Trainee music practitioners	-	-	8	-	
Clients from care settings	-	-	-	-	22
Older community members	-	-	5	-	-
Informal carers	-	-		1	-
Total	27	112	59	6	39

Each participant took part in one or more method of data gathering, as shown in Table 6.3.

6.1.4 Telephone interviews sample

The 27 telephone interview participants comprised 16 care setting managers, six senior members of staff, two activities co-ordinators, two care homeowners and one administrator. No personal details were requested but it was noted by the researcher that all participants were women.

6.1.5 Questionnaire survey sample

Eighteen care settings were represented in the questionnaire survey: nine residential homes, five with Elderly Mentally Infirm (EMI) care status; one nursing home with EMI status; three-day care centres, two with EMI care status; and five mixed care settings.

Table 6.4 Care categories and funding sources of care settings that contributed to questionnaire survey data

Ques. Survey Site Codes	Nursing Home	Residential Home	Assessment Rehabilitation Centre	Day Care Centre	Emi Care Status	Number of Clients	Main Funding Stream
QA		X		X	X	44	Local Authority
QB				X	X	40	Local Authority & Age Concern
QC			X	X	X	65	Hospital NHS Trust
QD	X	X			X	39	Private
QE		X				6	Private
QF		X			X	11	Private
QG		X				22	Private
QH		X			X	24	Private
QJ		X			X	28	Private
QK		X				32	Private
QL		X	X		X	30	Local Authority
QM	X	X			X	64	Private
QN		X			X	20	Private
QP				X	X	60	Local Authority
QQ		X			X	35	Private
QR	X				X	24	Private
QS		X				24	Private
QT				X		Not Known	Age Concern England

Table 6.4 gives details of the settings care categories, their overall client numbers and their main source of funding. In terms of the latter, the sample represented the current trend of funding arrangements in the UK, as discussed in chapter two, in which around 70% (n = 12) were privately owned and the remainder were split between local authorities and/or NHS Trusts.

Questionnaire (Q) research site	Town Centre	Suburb	Rural	Sites located within the 116 highest deprived wards and their ranking (1 = most deprived)
QA		x		116
QB	x			26
QC	x			76
QD	x			7
QG		x		7
QN		x		29
QQ			x	87

According to National Indices of Deprivation (2004), at the outset of data collection seven participating care settings were located within the top 116 deprived wards in the country (Table. 6.5).

Questionnaire survey respondents were asked to give their sex, age and details appertaining to their working environment and their length of service. Out of 97 respondents, 87 were women.

		Number	Percentage
Valid	Under 25	9	8.1
	25-34	15	13.5
	35-44	25	22.5
	45-54	39	35.1
	55 and over	23	20.7
	Total	111	100
Missing		1	
Total		112	

Table 6.6 shows that over half of overall respondents were aged between 35 and 54 (57% n = 64). Just over one fifth (20.7% n = 23) were 55 and over, 13.5% (n = 15) were 25 to 34 and 8 % (n = 9) under 25.

Table 6.7 Category of workplace			
		Number	Percentage
Valid	Residential Care home	21	20
	Residential EMI	24	22.9
	Nursing Home	6	5.7
	Nursing EMI	8	7.6
	Day Care	13	12.4
	Mixed	33	31.4
	Total	105	100
Missing	9	7	
Total		112	

In terms of category of workplace, Table 6.7 shows that 20% (n = 21) of respondents worked in a residential care home, 22.9% (n = 24) worked in a residential care home with EMI care status, 5.7% (n = 6) worked in a nursing home, 7.6% (n = 8) worked in a nursing home with EMI care status, 12.4% (n = 13) worked in a day care centre and 31% (n = 33) worked in a mixed care setting. Seven participants did not provide the relevant data.

Table 6.8 Questionnaire survey respondents' years of service in care settings			
		Number	Percentage
Valid	Less than a year	5	4.5
	1-2 years	12	10.9
	3-5 years	27	24.5
	6-10 years	23	20.9
	More than 10 years	42	38.2
	Total	110	100
Missing	9	3	
Total		112	

Table 6.8 shows that 4.5% (n = 5) of respondents had worked in care settings for less than a year, 10.9% (n = 12) for one to two years, 24.5% (n = 27) for three to five years, 20.9% (n = 23) for six to 10 years and 38.2% (n = 42) for more than 10 years. Two participants did not provide the relevant data.

Focus group site codes	Care staff working in care settings		Others		Total
	No. of Registered Nurses (RGN)	No. of Care-assistants (CA)	No. of other care staff		
Fg1		2			2
Fg2		2	1 (Manager)		3
Fg3		3			3
Fg4		3			3
Fg5		1	1 (Home Owner)		2
Fg6	1	3			4
Fg7			1 (Manager)		1
Fg8		2	1 (Caretaker)		3
Fg9		1	1 (Manager) 1 (Administrator)		3
Fg10		2			2
Fg11		1	1 (Manager) 1 (Administrator)		3
Fg12	2				2
Fg13	2	1			3
Fg14		3			3
Fg15		2			2
Fg16				8 Trainee music practitioners	8
Fg17	1 (retired)	1 (CA/music student)		1 Informal carer	3
Fg18				5 older community members	5
Fg19				2 medical practitioners 1 Social Worker	3
Total	6	28	7	17	59

1.6 Focus group discussion sample

A total of 59 participants took part in 19 focus group discussions. Table 6.9 shows the composition of each group. Overall, these were: 41 care staff, which comprised six registered nurses, 28 care-assistants, four managers, two administrators, one caretaker, two healthcare professionals and a social worker; eight trainee music practitioners; five older community members; one informal carer.

Cultural mix of focus group participants

Of the participants who offered information about their ethnic origins, 25 were British. Twenty of these had predominantly spent their childhood years in the South of England, four in the North and one in the Midlands. Five participants were from the Philippines, none of whom had spent more than two years in the UK. Three participants had spent a large part of their childhood in Ireland and one each in Australia, India, Nepal, Nigeria, Malta, Scotland, South Africa and Thailand. The characteristics of their childhood settings were also mixed, with eight participants coming from a city or large town, 20 from suburban settings, 13 from rural settings and one (Nigerian national) from a township. Although not generalisable elsewhere in the country, this reflected the cultural mix of staff currently working in the catchment area of the study.

6.1.7 Face-to-face interviews

Six face-to-face interviews took place with one informal carer, one registered care home manager and four music practitioners. One music practitioner had focused on work in care settings for three years. Another had recently left her long-term job as a registered nurse and care manager for older people with a local authority, to work as a full-time music practitioner. The other two music practitioners had both worked in care settings for a approximately one year and had assisted in a training course for care-givers to use music in the workplace.

6.1.8 Participant Observations

Participant observation (PO) sessions involved two music practitioners and one trainee music practitioner, 15 care staff, which comprised two managers, nine care assistants, an NVQ trainer, two catering staff and an administrator, and 22 clients from care settings. (NB. Three care assistants and six clients took part in both PO2 and PO3).

Setting	Activity being observed	Music practitioner (MP) leading the session and accompaniment type	Nos. of clients present	Numbers and working role of staff observed
PO1 24 bedded residential unit	One of a three or four-weekly interactive music activity session. Singing old-time songs using word sheet, playing percussion instruments to recorded music, movement to music and listening to relaxation music	MP 1 with recorded backing tracks	12	7 1x Manager 4 x Care Assistants 2 x Catering staff 1x NVQ Trainer
PO2 Day care unit within a mixed-care setting	As PO1	MP 1 with recorded backing tracks	8	6 1 x Manager 5 x Care Assistants
PO3 EMI unit in mixed care setting	One of a weekly performance-based interactive music activity. Clients singing along to popular reminiscence songs (no word sheets).	MP 5 with acoustic guitar	6	6 1x Administrator 5 x Care Assistants

Table 6.10 shows that PO1 one took place in a 24 bedded residential setting and PO2 and PO3 took place in the same mixed care setting, PO2 in the day care unit and PO3 in the 36 bedded EMI residential care unit. The table also shows the type of music activity and numbers of people taking part in each. PO1 and PO2, which were led by Music Practitioner 1 were highly interactive sessions based on a prescribed programme of singing old-time songs, playing percussion instruments, movement to music and listening to relaxation music. All activities were accompanied by a pre-recorded CD. Participant observation 3, which was led by Music Practitioner 5, was a performance-based programme of old-time popular songs, with opportunities for clients to sing along. Songs were accompanied by the music practitioner playing the guitar.

6.2 Changes to proposed procedures

6.2.1 Telephone interviews

Difficulties in accessing participants for telephone interviews were those anticipated. The two most commonly encountered problems related to unexpected staffing problems, whereby the participant was needed to help with care duties, and the participant being absent at the time of the researcher's call. A few discussions were delayed and seven of the originally proposed 35 were abandoned because of unresolved difficulties in accessing relevant staff.

6.2.2 Questionnaire survey

Problems occurring with the questionnaire survey centred on very poor initial response rates. In response to this, after the first batch, the questionnaire design was changed to cover one folded A3 sheet, rather than 4 x A4 sheets, to give the appearance of a more manageable document. In addition, a reduction in the number of homes from 27 to 20 enabled the researcher to personally visit the *gate keeper* of each home to deliver and collect questionnaires and to reassure potential respondents, via the *gate keeper*, of the confidential and subjective nature of the questionnaire. Overall, 112 people, out of a proposed 240, responded to the questionnaire survey. This was a response rate of 46.6%. It was felt by the researcher that the care setting sample still fairly represented the characteristics of care provision currently available in the UK.

6.2.3. Focus group discussions

The proposed 10 focus group discussions rose to 19, due to the small number of participants available at one time for each discussion. Problems in accessing staff largely related to unexpected occurrences in the setting and staff shortages. For example, two discussion dates at Site Fg8 needed to be rescheduled due to staff sickness. The manager at Site Fg13, in which six members of staff had elected to take part, requested two separate discussion sessions to resolve issues of high care dependency for clients on the day. One proposed site withdrew after staff were unavoidably detained on three consecutive attempts. At site Fg7 unexpected care needs meant that only one member of staff was available out of a proposed four. As annual leave for staff during the proceeding period

prevented satisfactory re-scheduling arrangements, an interview was conducted with the one member of staff in place of a focus group discussion.

6.2.4 Face-to-face interviews

One interview, of the proposed five, with music practitioners failed to take place because of difficulty in arranging a mutually suitable time. The researcher felt that the data gathered from the participants provided a fair representation of the experiences of music practitioners working in care settings.

6.2.5 Participant observations

One observation session out of the proposed five was cancelled due to rescheduling of the music session scheduled to be observed. Another failed to take place because four clients out of six chosen by staff to take part in the music activity on the day had not been informed of about the research in advance, nor did they appear able to give any form of informed consent.

6.3 Musical activities in care settings

The first stage of data collection aimed to ascertain that music activities took place in the research sample. An understanding of the number and characteristics of these activities aimed lay a foundation for investigation into staff perceptions of their value and impact. Objectives A and B addressed the enquiry.

Results Objective A

Objective A: To examine the numbers and types of live musical activities carried out by visiting musicians in care settings was addressed through telephone interviews and focus group discussions. Together this represented the views of staff from 27 care settings.

Figure 6.11 Objective A: main themes and emergent sub themes

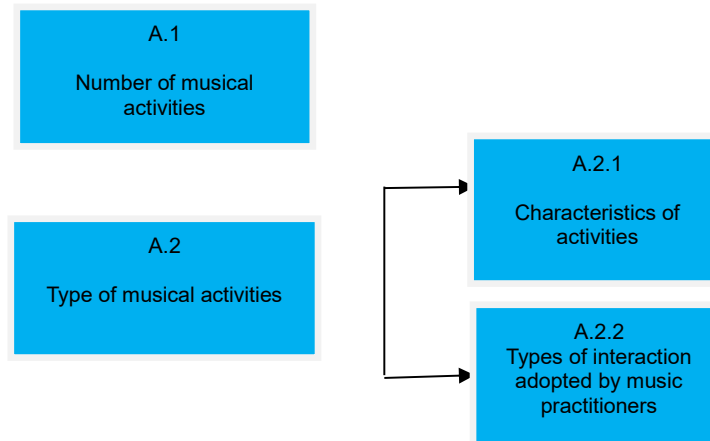


Figure 6.11 shows that the two main themes, that is the numbers of activities and the types of activities were analysed separately. The latter comprised the characteristics of the activities and the types of interaction adopted by music practitioners.

A.1 Number of musical activities

Of the 27 care settings, all had engaged a visiting musician(s) during the year preceding the study.

Figure 6 12 Frequency of live music activities in the setting sample

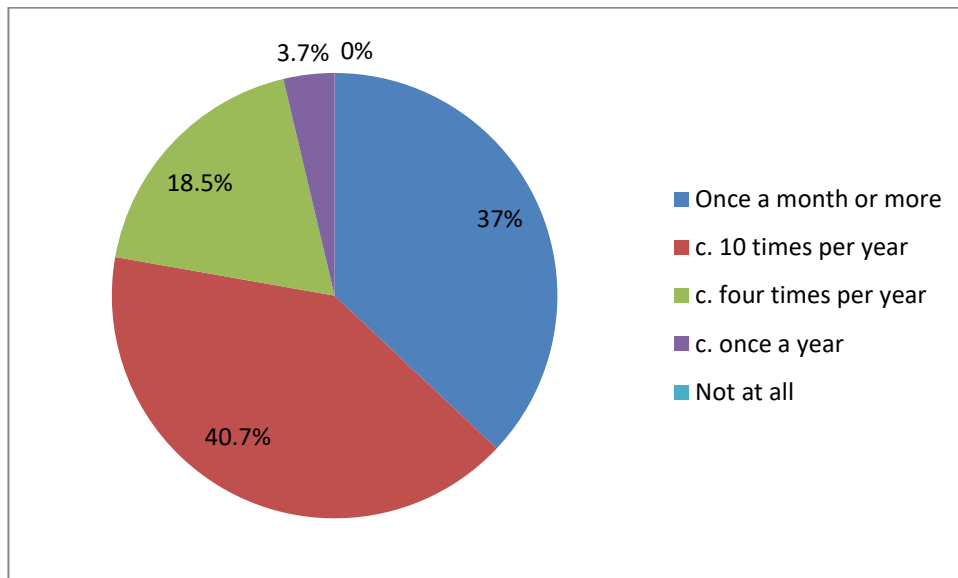


Figure 6.12 shows the frequency of music activities in the sample. Table 6.13 shows that: 37% (n = 10) of the sample had engaged a musician about once a month or more; 40.7% (n = 11) had engaged a musician up to 10 times a year; 18.5% (n = 5) up to four times; 3.7% (n = 1) had engaged musicians approximately once a year.

	Once a month or more		c. 10 times per year		c. 4 times year		c. once a year e.g. Christmas/Easter or special events		Not at all
	n	%	n	%	n	%	n	%	
Residential care homes 44.4% (n = 12)	3	11.1	6	22.2	2	7.4	1	3.7	
Nursing care and mixed care settings 40.7% (n = 10)	3	11.1	4	14.8	3	14.8			
Day care settings 18.5% (n = 5)	4	14.8	1	3.7					
Total (n = 27)	10	37	11	40.7	5	18.5	1	3.7	

The table also shows how frequently care settings had engaged with a visiting musician according to their care category. Of the 12 residential care settings, three had engaged visiting musicians once a month or more, six had engaged visiting musicians around ten times a year, two, around four times a year and one had engaged a visiting musician once. Of the ten nursing and mixed care settings, three had engaged visiting musicians once a month or more, four around ten times a year and three, around four times a year. Four day care settings had engaged with visiting musicians once a month or more and one had engaged visiting musicians around ten times a year. In the former, the frequency level included a series of twelve, monthly activities organised and provided free of cost to each of the four day centres by the Sing For Your Life Ltd. In focus group discussions, three of the centre managers said that this level was not the norm. Although clients often elected to invite a visiting musician or musicians at times throughout the year, this is not usually at regular intervals.

About a third of other focus group participants, from residential and nursing care settings indicated a mixed number of activities that were sometimes difficult to quantify.

Care Assistant 1 - *"We have a music-man every couple of weeks and we have that lady come down and they get up, have a sing-song..."*

Care Assistant 2 - *"We have [name of musician]. And whose that other bloke comes in? We have two don't we?"*

Researcher - *"How often does he come?"*

Care Assistant 2 - *"Once a month'. I think. And there's someone who comes in and plays the organ; comes in about three times a year."*

(Fg8)

A.2 Types of musical activities

The types of activities included solo and ensemble performances by professional or amateur musicians, in which the client group took on a passive audience role, and interactive sessions led by musicians, or music practitioners who were not necessarily professional performers but facilitated interactive music activities. The latter tended to be referred to by staff as 'music therapists' but it was interesting to note that none, out the three music practitioners who were referred to in this way, were qualified therapists.

A.2.1 Characteristics of activities

About half of settings reported a mixture of music activities, the characteristics of which varied. Some involved performance-focused events with a solo professional or amateur performer or a group of performers, such as a choir or instrumental ensemble, or interactive events led by one or more professional or amateur musicians. All activities tended to focus on singing but sometimes included playing percussion instruments, movement or dance, relaxation and/or shared listening experiences.

The most common type of activity, reported to take place in more than four fifths of settings, was a solo singer, self-accompanied on a guitar or electronic keyboard or organ, or accompanied by electronic backing tracks. Such activities tended to focus on musical material that was familiar to clients, as illustrated in the following quote.

"Well most of the stuff the music man plays is stuff that they knew back in the war years. The 30s, 40s, 50s. One or two more up to date."

(Senior Care Assistant: Fg3)

The next most common type of activities, reported to take place in about a third of settings, were duos or small groups of adult singers and/or children's school choirs. The adult groups were either accompanied by a keyboard or they sang *a capella* (unaccompanied). When involving adult performers, these activities tended to include songs that were largely familiar to clients. By contrast, children's choirs tended to perform songs that were mostly unfamiliar, apart from at Christmas, when traditional carols were usually sung. Staff from two settings reported infrequent opera performances with one, or a small group of singers. Least common were groups of instrumentalists. Staff from one setting reported occasional activities with a trio or small group of jazz musicians. Staff from two settings had once engaged a string quartet and a brass ensemble respectively.

A.2.3 Types of interaction

The most common type of interaction was predominantly performance orientated, in which musicians sang old-time, popular songs to clients. There was often a strong expectation that clients would sing along during familiar songs and in a few cases, word

sheets were handed out. Some focus group participants' comments highlighted the common use of electronic equipment to accompany singers and to guide session processes, as illustrated in the following comments.

"The Music-Man! He comes in and plays and people sing along... with a keyboard and synthesiser and backing tracks that he plays along to. He doesn't sing."

(Care Assistant: Fg10)

Care Assistant - *"We have a music-man every couple of weeks and we have that lady come down and they get up, have a sing-song."*

Researcher - *"What does she do, does play the piano?"*

Care Assistant - *"No, she's got a machine with old songs and she's got a mike. And sometimes she gets them [clients] singing into it."*

(Fg1)

"In the other place where I worked which is mental health, every now and again we used to have the music man; country and western singing. It was really nice; he'd go around to everyone with the microphone."

(Senior Care Assistant: Fg6)

"She [musician] comes in every three weeks. They bang instruments, she does it with paper plates, they sing ...and sit quietly and listen to something soothing. She brings it all with her, a CD player with all of it on."

(Registered Nurse: Fg15).

A few participants reported that their clients were less likely to join in activities with groups of musicians, such as choirs, and were least likely overall to join in during more highbrow music activities, such as the opera. Participants from six settings reported highly interactive musical sessions which involved a musician facilitating client-centred activities. Two models were described, both of which had little element of performance on the part of the musician but rather focused on clients singing, playing percussion instruments, conducting, moving to music and sharing music-listening exercises. Three day care centre managers reported that this type of interactive session was of particular value for people living with dementia. One manager felt that 'shaking rattles' and actively engaging in singing could stimulate people living with dementia, whereas people with high levels of cognition may feel patronised.

In answer to objective A, the study found that the majority of musical activities were carried out by solo musicians, rather than a group of musicians, on average, around ten times per year. Most commonly, these were characterised by a performance style approach, in which clients were often invited to sing along to familiar songs. Very few participants reported engaging instrumental ensembles or singers who performed music outside the popular genre.

Results Objective B

B.1 Funding mechanisms for live musical activities

Objective B: To compare the funding mechanisms for live musical activities taking place in the sample of care homes and day centres, was addressed through telephone interviews, focus group discussions and face-to face-interviews.

Figure 6.14 Objective B: main themes and emergent sub themes

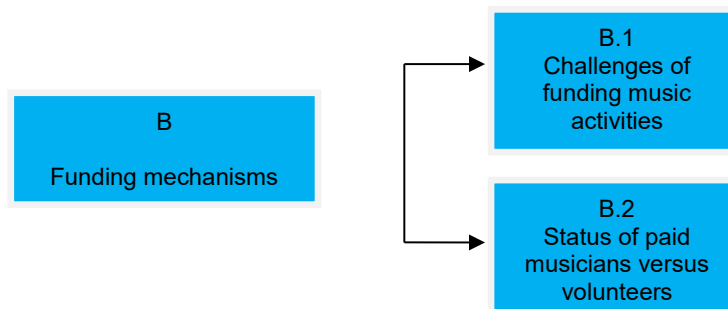


Figure 6.14 shows that two sub themes emerged from the analysis. These were the challenges of funding and sustaining musical activities and the status of paid musicians versus volunteers.

The funding for musical activities in care settings came from three main sources. These were internally funded commissions, externally funded services and voluntary services.

Internally funded commissions

Most commonly, care settings paid for the services of musicians, most often from an 'activities fund', which was variably allocated month by month by the setting's funders or owners or generated through fund-raising events. These processes were frequently

organised by a designated member of staff, such as an activities co-ordinator.

Externally funded services

Some visiting musicians were funded by external funding generated by a third-sector organisation, for example, Sing for your Life ⁴, which provides regular interactive music programmes for older people, including those living with dementia. These programmes are free at the point of delivery. Staff from one setting also reported an occasional donation from a single benefactor.

Voluntary services

Commonly reported amongst the sample was the utilisation of visiting musicians who provided their time and resources free of charge. This applied to individuals and groups of musicians, such as choirs, including children's school choirs.

Figure 6.15 Funding mechanisms for visiting musicians

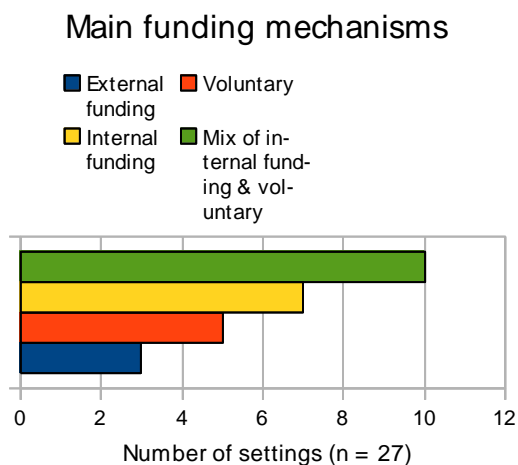


Figure 6.15 shows the distribution of main funding mechanisms amongst the 27 research settings. Overall, ten settings mainly provided a mix of internally funded and volunteered music activities, seven mainly funded activities themselves, five mainly utilised volunteer musicians and three utilised externally funded musicians.

⁴ Sing for your Life Ltd. is a not-for-profit third sector organisation that provides music activities for older people.

B.1.1 Challenges of funding music activities

Of the ten settings reporting the highest level of music activities, that is more than once a month, three mainly funded activities from internal funding and three mainly utilised external funding. The remaining four used an equal mix of internal funding and volunteer-led activities. This showed a fairly equal distribution of funding mechanisms, but the figures take into account the provision of externally funded, monthly ‘Silver Song Club’ activities, which were taking place in three of the research settings at the time of data gathering. According to many focus group participants this type of external funding for activities was not the norm, although one setting reported actively seeking funded projects via a relationship with their neighbouring university. This had enabled two music and drama projects in the preceding year, and links to business and arts organisations.

The challenges of raising funds and sustaining activities were raised at least four-fifths by focus group participants. The following exchange illustrates this, and the staff’s perceptions of the monetary value placed on music activities for clients compared to activities such as attending the hairdresser.

Senior Care Assistant - *"We can't put much on really [commissioned music activities] – it's all about money. We used to have someone; a chap who played guitar. He was great....but he's not been for a long time. "*

Care Assistant - *"Relatives think it's all paid for but it's not; we have to fund-raise for everything."*

Senior Care Assistant - *"I don't see why the residents shouldn't pay something towards it. They pay to have their hair done 'cos it makes them feel better, so why not pay for music."*

Care Assistant - *"We always have someone [musician] at Christmas and the children come at Easter and we might get someone in between.... but not that often. They love the children but people don't realize we have to raise the money ourselves."*

Senior Care Assistant - *"We all have a good time when someone comes; so if they [clients] all paid a £1 or even 50p we'd have enough for something."*

(Fg1)

These comments mirrored views expressed by three music practitioners during face-to-face interviews. One stated that she had only ever provided services in settings where the

activities were paid for by the settings themselves. Two music practitioners reported providing a free taster session of activities to care settings with view to the setting commissioning, and paying for, regular ongoing activities. Both practitioners highlighted the common practice of settings not commissioning any further activities or doing so for a limited period only. Music Practitioner 1 reported that in her experiences about quarter of care setting managers emphasised funding pressures that inhibited regular commissioning of music activities. The managers also highlighted the difficulty of providing a range of activities to suit all of their clients within a limited budget.

The issue of managers valuing music as a supportive mechanism for well-being was also raised by Music Practitioners 3 and 4 in the following quotes.

"Any sort of activity like that or any sort of art activity, not just music, it all kind of costs a lot of money, and if they don't see it as important enough, or if they just don't have the funding for it then it's not going to happen frequently."

(Music Practitioner 4)

"What would be ideal would be for any sort of therapy, music or art, or any therapy available to be completely free for the care home. But then obviously the therapists would need to be possibly funded by council or government. But I sense that there is a lack of faith maybe in alternative therapy from maybe government. So that's probably why there's little funding for those sorts of things."

(Music Practitioner 3)

Music Practitioner 3 went on to give her perception of medical model dominance that remains evident in care settings. She suggested that 'non-scientific interventions' continue to struggle for credence. This mind set, she believed, places music and other therapeutic interventions in the realms of pleasant recreational 'add-ons', rather than being seriously considered 'treatments for depression and distress' and as such, hinder policy decisions on funding.

B.1.2 Status of paid musicians versus volunteers

Participants in two focus groups implied that paid musicians and volunteer musicians may be viewed differently. For example, when asked by the researcher how a regular visiting musician is funded, a care setting administrator said, 'Oh, no he's just a volunteer'. Other references to volunteer musicians were also prefaced with 'just' or 'only'.

Participants from one of the focus groups raised issues of musical integrity. They talked about a volunteer musician whose musical standard was 'Okay', and which 'kept [the clients] happy' but they added that care homes in general could not afford to pay for top quality musicians. However, it is interesting to note that no other participants critiqued the standard of musical activities in their care settings.

In answer to objective B, funding mechanisms for music activities in settings over the year prior to the study included internal funding from the settings themselves, external funding and voluntary services. Most commonly, activities were funded through a mix of internal funding and by engaging the voluntary services of musicians.

6.4 Staff's personal histories and attitudes related to music

The aim of investigating staff personal histories and attitudes related to music was to gain insight into factors that may influence their perceptions and behaviours around music in their workplace. The generic term 'music' was deliberately used by the researcher to elicit participants' own definitions. This could have related to active experiences with live music, such as singing or playing an instrument, passive experiences, such as attending concerts or other musical events, or interactive or passive experiences to recorded music. Any of these activities could also relate to group or singular experiences. This aim was addressed by objective C and D.

Results Objective C

Objective C: To examine staff experiences of music in childhood was addressed through focus group discussions.

Figure 6.16 Objective C: main themes and emergent sub themes

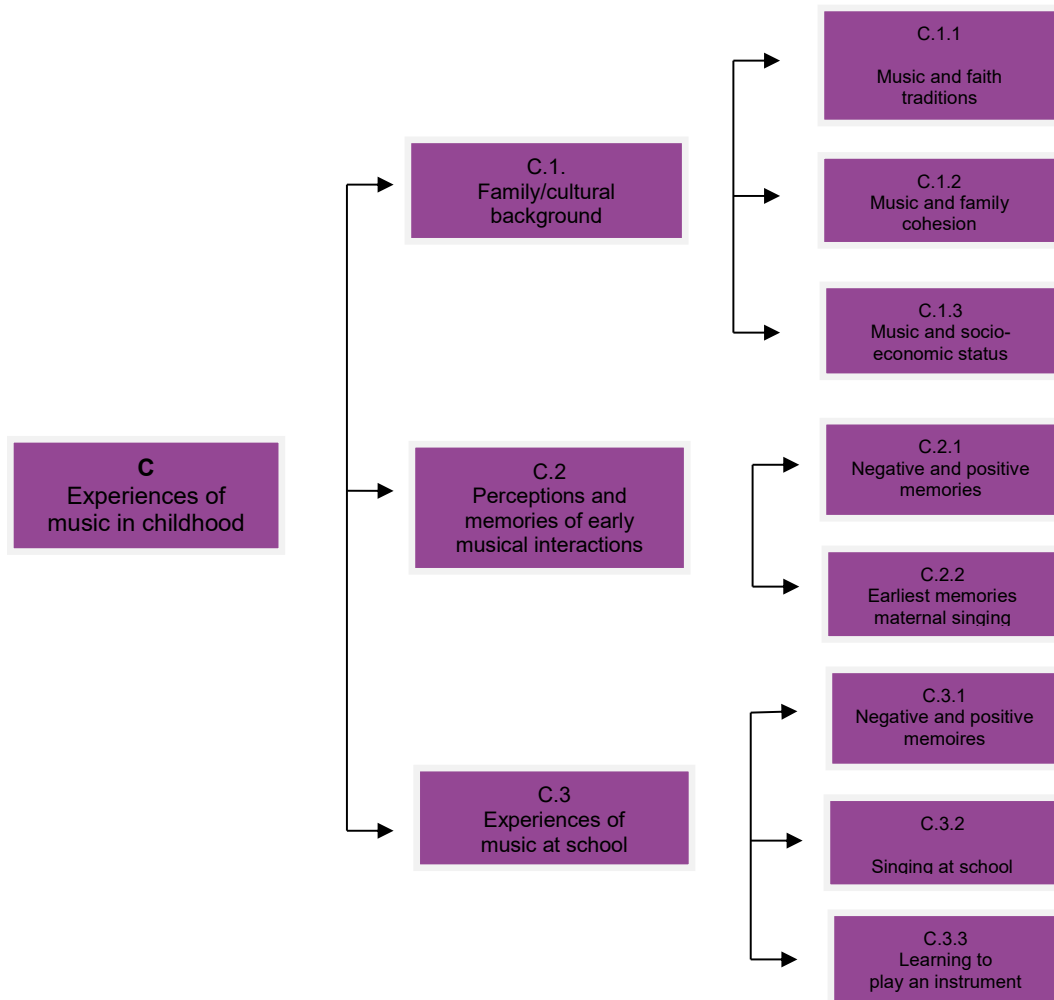


Figure 6.16 shows that three main sub themes emerged from the analysis. These were family and cultural background, perceptions and memories of early musical interactions and experiences of music in school.

C.1 Cultural and Family background

Around two thirds of the focus groups discussed music's role in, or as a reflection of national and family cultures. Collectively, participants who were brought up in the UK

expressed varied levels and types of interactions with music as a cultural experience. Although around half of this group of participants reported engaging with culturally grounded music at some level, the remainder reported having had little experience with music *per se*. Participants from the Philippines, Thailand, Nepal, Africa and Australia, however reported a belief that music as a cultural experience was generally more consistently embedded into their day to day lives, when compared to UK-born participants.

Amongst the whole focus group sample, a few references were made to cultural relationships with the Western Classical Tradition. References made by UK-born participants tended to relate tensions between musical genres traditionally associated with the Western Classical Tradition and those outside it. Terms describing music from the former genre included 'classical' 'high-brow', 'la-di-da music' and 'proper music'. Some comments raised issues of perceived elitism around this type of music.

"And ballet of course - I do remember dancing to Chopin or Beethoven with my sister. She [mother] didn't mind that but she would never have modern music on."

(Informal carer: Fg17)

"Oh ...yes, my mother was furious when I played 'Take That' on the piano – not good - but I loved it. She went mad because I never practised my grades. Anyway... she thought it was rubbish, not proper music."

(Trainee Music Practitioner: Fg16)

Not all references to the Western Classical Tradition came from participants who had spent their childhoods in Western countries. Four participants from the Philippines reported learning 'English music' on the piano, singing 'English songs' and attending 'English classical' orchestral concerts.

C.1.1 Music and faith traditions

Several focus groups explored the perceived benefits of music that is embedded into faith cultures. All three participants in one focus group agreed that 'devotional music' was uplifting (Fg6).

This concept, and the term 'devotional music', re-occurred in another discussion.

Researcher- *"So if you were to have a horrible day at work, when you go home, would you put on some music that would calm you down?"*

Care Assistant 1- *"Yes, really. I would like to listen to devotional songs at that time."*

Care Assistant 2 - *"Devotional, yes me too. Negro soul, soul music to the Negro. ...All sort of, as she said, devotion music to God and that. It's very real."*

(Fg15)

Another two participants referred to a sense of 'feeling good' associated with singing hymns and choruses in church or when hearing 'church music'. The concept of devotional music creating a sense of community cohesion was also raised.

Registered Nurse 1 - *"Christian songs, hymns, songs, any kind of songs really...Yeah, we sing at church', it's good to sing with everyone."*

Registered Nurse 2 - *"It's like a family; a big family with everyone looking out for each other."*

(Fg13)

A change in community singing brought about by changes in faith practices was raised by two focus groups. One discussion was prompted by a participant's account of a visit to a church service in Pretoria, South Africa, whilst on holiday. The participant was invited to join in with apparently spontaneous, congregation-initiated singing, clapping and dancing during the service, which invoked a sense of unity despite the cultural and language differences.

Registered Nurse - *"Well that doesn't happen in England now that people have stopped going to church. Other than, well...that's the thing isn't it. I go to London on Sundays and I just love it. I drive past the bus stops and they're all dressed in turbans and their Sunday regalia. They look beautiful, and they're all off to church."*

Informal Carer - *"It's just such a celebration; every service. I can just imagine the fun they have. It'll be all about singing, celebration and singing. What is that about? Is it really about God or is it about the community, the celebration?"*

Registered Nurse - *"It is just uplifting - and to hear all of that. It's all about all of it really."*

(Fg17)

Researcher - *"Do you think that your culture [the Philippines] is more musically active than here [UK]?"*

Care Assistant 1 - *"It's... like in Britain they used to go to church every Sunday and sing a song. Prayer is like singing but in my country if you visit a monastery or a temple you sing a prayer but nowadays people are getting so lazy they don't go to the temples. Before all countries used to sing a prayer for God but now they haven't got time. Just with their friends they sing a song but it's not so much."*

(Fg3)

C.1.2 Music and family cohesion

Over three quarters of participants had memories of music as a mechanism for eliciting a sense of cohesion within their family life.

Researcher - *"Where did you grow up?"*

Registered Manager - *"Farthing Common I grew up, out near Lyminge along Stone Street [rural]."*

Researcher - *"Do you think that had a bearing on music at home?"*

Registered Manager - *"Cos we used to live in the middle of nowhere, we used to do a lot of walking. It was two miles to the nearest bus stop and my Mum and I used to sing and dance down to the bus stop".*

(Fg9)

*"Well [music] was part of our family, very much so. My father played the piano accordion. We'd sing along to **Sing Something Simple**. We used to have good hour or so playing on, with spoons... anything."*

(Senior Care Assistant: Fg12)

One focus group of English-born participants, who had previously reported that music did not generally feature in their young lives, discussed how historically faith-based practices shaped family behaviour. They spoke of the importance of the Sunday ritual which included listening to music on the radio collectively as a family after attending church and whilst the women of the house prepared the main meal of the week. The group suggested that being together as a family during the week was often inhibited by fathers' work patterns. Work-free Sundays were therefore a time to share in family life and listening to music was something that the whole family could do together.

Around a third of other participants remembered collectively listening to musical radio programmes as a family. Music as a family experience frequently centred on accessibility.

Researcher - [To A] *"Did you have much in the way of music in the home?"*

Administrator - *"We always had **Radio Two** on. I've got an older sister and brother so **Top of the Pops** was always highlight of the week and on Sunday the **Top Twenty** was on. And Ed Stewpot".*

Researcher - *"So would you all listen to that - the whole family?"*

Administrator - *"Well it would be on so we could all hear it."*

Registered Manager - *"I know that the first piece of furniture my Mum and Dad bought was a radiogram."*

(Fg9)

Around a fifth of focus groups discussed their perceptions of changing social attitudes towards children and young people since the 1970s and 80s, which largely centred on increased levels of autonomy and choice relating to access to music.

Researcher - *"When I was little we had a radiogram. So you could only hear music in one place that everyone tended listened to."*

Registered Nurse - *"That's because of choice. You hadn't the choice of what your parents wanted to listen to, which would be what ever. You wouldn't be going up and changing it."*

Researcher - *"Why is it different now do you think?"*

Registered Nurse - *"Yes, well, children are more demanding now, well, people demand more choice. When I was a teenager, my brother and I... he'd be listening to **Bob Dylan** or whatever and I'd be listening to **Bay City Rollers** or that sort of thing. But when we were very young, it was always my mother's choice."*

(Fg17)

Administrator - *"And of course Sunday in the evening, you had **Radio Luxembourg**, when we were teenagers. You could tune it on the radio."*

Registered Manager - *"I remember the pirate radio stations. **Caroline** and all those....."*

Administrator - *"You'd get your top thirty on **Luxembourg** and all that."*

Researcher - *"So that was a younger channel?"*

Administrator - *"Oh, yes. But we couldn't have it loud. It was better when mum and dad were out."*

(Fg2)

A small number of focus groups also discussed social changes relating to the growth of technology. A positive benefit to family cohesion was thought to be the in-car stereo systems, which one focus group agreed encouraged family-singing during long car journeys. Largely, however, technology was thought to have shifted the experience of music as a family activity, to an individualised activity.

Researcher - *"So when you were young, did you just have one piece of equipment and all sit around it?"*

Administrator - *"Yes, but I don't really remember it being played very much to be honest. I don't remember us doing anything musical jointly to be honest. I know when we were young we had record players and I'd spend a lot of time in my room playing records."*

Researcher - *"Oh, did you. That's quite common now isn't it, for kids to have their own music playing .[equipment]."*

Registered Manager - *"Oh, we had our own as well. Every week my Mum used to buy us a single on Friday."*

Care Assistant - *"So does that in a way...; that kind of isolate music, once you're in your own room. Which of course now you've even got your earphones in your iPod. It can be much more of an individual activity..."*

Administrator - *"Oh yes."*

Care Assistant - *"Laptops...that seems to have taken over kid's lives these days. They download it all now and put it on their MP3s."*

(Fg9)

C.1.3 Music reflecting socio-economic status

Around half of the focus groups discussed the relationship between musical practices and socio-economic status. Most commonly this centred on access to commercial music.

"My parents listened to a lot of music and we had loads of records as opposed to a lot of our mates didn't. A lot of my mates didn't even have record players. Lots of people didn't have things like that."

(Registered Manager: Fg12)

*"You won't remember but they used to have lots of music in factories. They played **Music While You Work**. It was on at dinner time; everyone stopped to have their dinner and listened at the same time."*

(Senior Care Assistant: Fg1)

Administrator - *"I also think television brought music in didn't it. If you had one... the variety show. **The Black and White Minstrel Show**, I know it's not PC now but people used to enjoy it and they sung all sorts of music didn't they."*

Registered Manager - *"And for the younger ones – **Ready Steady Go**."*

Administrator - *"And **Juke Box Jury**."*

Registered Manager - *"You know, which was great if you didn't have access to music and you couldn't go out and buy it because you didn't have the money. Now every child has their own CD player, you know, earphones."*

Administrator - *"When I was a child you didn't have all those things because they weren't around. And the fact that you couldn't afford to have them."*

(Fg2)

Two participants highlighted issues of the affordability of formal music lessons. One referred to taking trumpet lessons at school, which was enabled only by the school subsidising the fee, and the other reported having had free violin lessons at school, which she had to give up once the funding had ceased.

C.2 Perceptions and memories of early musical interaction

A few participants had strong memories of very early musical interactions. Those reported appeared to have had a profound effect on the narrators.

C.2.1 Negative and positive memories

Two participants illustrated negative memories of music interactions in childhood. In the following exchange the participants referred to musical performances at nursery school and Sunday school, respectively, in which they remember feeling humiliated or overwhelmed.

Researcher - *"Do you remember any music before you went to school?"*

Care Assistant - *"Not at home. At nursery. I think that was playing games and singing. But I do remember having a tea towel on my head and being a shepherd and being told that an angel is much better. My sister had blond hair and she got to be Mary."*

Registered Nurse - *"Well, I was terrified. I got to be Angel Gabriel and I fainted and hit my head on a radiator. I'd practised my song every day but I was carried off with my foil-covered cardboard wings all crumpled up and my angel gown wrapped round my knickers!"*

Researcher - *"Did that affect you later on?"*

Registered Nurse - *"D'you know, it's probably the single most relevant reason for my utter fear of singing in public – now I come to think of it."*

(Fg13)

One participant described tensions in the family around taste and tolerance for music, which may have shaped her perceptions of musical performance.

Informal Carer - *"My father was very musical. I remember when I was very small him listening to classical music and my mother coming in and saying 'Right, we'll have that noise off'. Or he'd go to play the piano and she'd say 'I've got a headache, stop it!'. She was always stopping it."*

Researcher - *"Do you think that affected the way you felt about music later?"*

Informal Carer - *"I'm not sure. But I hated performing anything."*

(Fg17)

Positive memories mainly centred on music as a vehicle for building confidence and self-esteem. This was commonly associated with parental interactions and encouragement to sing and perform within the family.

The following passage, which was taken from the researcher's written notes during a face-to-face interview, illustrates this point.

The eldest of seven children, Ann has a lively and engaging personality. As such she took a lead role in organising and activating creative interactions, such as dance, plays and singing, for herself and her six siblings. Although she undertook piano lessons briefly and enjoyed hearing her mother play the piano by ear, Ann believes that her eagerness to engage with music and creative art in the care home stems not from any formal musical experience but from the overarching self-confidence to simply "try things out". This developed during her young years and was considerably nurtured by her parents' encouragement

(Registered Manager: Fg7)

Two participants raised the nature/nurture argument by implying that personal characteristics, rather than the presence of a supportive environment, determines a willingness to perform.

Researcher - *"You made spontaneous music at home?"*

Care Assistant - *"Yes, My family aren't really musical. But it was just spontaneous, me and [my sister] just started singing. But my little sister she would do it on her own but she wouldn't just start singing in the car. Like me. But me and [my sister] were a bit more confident with it. We'd just start singing; play around with hair brushes and things."*

(Fg12)

"We'd all be at home doing girly things. We'd just start singing along to music. Really out of tune and badly. But just making music in our way. But I'm really shy to sing now. I will, at work, but I won't start it."

(Music Student/Part-time Care Assistant: Fg17)

C.2.2 Earliest memories of maternal singing

Three or four participants expressed a belief that their willingness to sing with clients in the workplace stems from their experience of their mother's singing to them (maternal singing) at an early age. One care assistant reported 'feeling happy' when hearing her mother singing 'hit parade songs of the sixties'. Another participant, who reported singing and dancing with her children at home, believed that the influence came from her own mother singing and dancing with she and her siblings. The following exchange demonstrated a pattern of maternal singing through three generations.

Researcher - *"So music is actually quite important to you?"*

Registered Nurse - *"Very important."*

Researcher - *"Where do you think that came from?"*

Registered Nurse - *"I have a three week old grand-daughter; as soon as I held her I sang a song that my mother used to sing to me."*

Researcher - *"What's the song?"*

Registered Nurse - *"It's (sings) 'Oh you are a mucky kid, dirty as a dustbin lid'- d'you know it?"*

Researcher - *"Oh yes."*

Registered Nurse - *"My mum used to sing it around the house. I sing it to [granddaughter] now and it calms her; I don't know if it's because I'm calm."*

Researcher - *"Is that when you're holding her?"*

Registered Nurse - *"Yeah, yeah, oh she'll get used to me singing; it's just that music is ...you know."*

Researcher - *"Does her mum sing; your daughter, does she sing?"*

Registered Nurse - *"Oh yeah."*

Researcher - *"So there's still a strong singing connection between you all?"*

Registered Nurse - *"Oh yeah, very strong'."*

(Fg6)

C.3 Experiences of music at school

Over three-quarters of focus group participants discussed their experiences of music at school. The experiences included negative and positive memories, singing at school and learning an instrument.

C.3.1 Negative and positive memories of music at school

Around a quarter of participants had negative memories of music at school. These memories tended to relate to classroom music lessons at secondary school. Comments such as, 'just sitting listening to boring records of orchestras' and 'messaging about on triangles' implied a general disinterest and were illustrative of the expressed unpopularity of school music lessons.

Around half of the participants referred to memories of music in school in a positive way. The following comments showed how early experiences of music at school may have underpinned a life-long interest.

"I loved being part of a group doing music. I suppose I was a show-off. And I'm still showing off on stage now."

(Registered Nurse: Fg17)

"We did music all the time. And country dancing. We had all that music. I love country music even now."

(Administrator: Fg9)

Very few participants reported being involved in school musical shows and/or productions but those who did regarded them positively. Whilst many participants had memories of a predominant genre of music at school, such as learning about Beethoven's Fifth Symphony, or singing mostly folk songs, one participant appeared to normalise the inclusion of both popular music genres and music from the Western Classical Tradition, into formal music education. She said:

*"Also we did a lot of musicals. Every year there would be a musical. **Pirates of Penzance, Noyes Fludde, Oliver**, you know that sort of thing. Yes great fun... the **Hallelujah Chorus**, you know, the things that schools do."*

(Registered Nurse: Fg17)

C.3.2 Singing in school

The reported level of singing in schools amongst participants was varied with some remembering a lot of singing and others remembering very little. All five participants from the Philippines reported frequently singing in the classroom and as a whole-school activity. They talked about regularly participating in school singing competitions and singing at annual events where they performed national and other songs.

"When I was at school [in the Philippines], every day we were singing. And every Friday we had to practice dancing - and obviously we were singing then...Every parents day at that time we practice a culture song and an English song, written by my head teacher."

(Care Assistant: Fg4)

A participant from Australia also reported singing as a regular and popular feature in Australian schools during her childhood. Apart from one participant's traumatic junior-school memory of having to stand in turn and sing a solo to the whole class, most comments made about singing at school in the UK, related to belonging to a choir. Memories of how choirs were set up and the joining criteria varied. One participant referred to the compulsory nature of this activity and the punishment of 'lost liberties for three weeks' for non-attendance (Informal carer: Fg17). Some participants remembered age-related or audition-led criteria for joining the school choir. The following comment related to these issues and highlighted the contrasting nature of the participant's experience of music at primary and secondary school.

Researcher - *"Were you at a local school?"*

Senior Care Assistant - *"Yeah, but I don't remember anything more than shaking tambourines and bells and things like that in music lessons at primary school but at secondary school it was a lot more serious. I mean you had to join the choir, you HAD to join the choir, in year seven and you were released in year eight if they decided you didn't have a decent voice, or you didn't pay attention."*

(Fg12)

The issue of peer influence was raised by a small number of participants, whereby people belonging to the school choir encouraged friends to join. Many comments related to judgements of standard. Many participants claimed that they would not have been allowed to sing in the school choir, or that they had attempted and failed an audition, or were withdrawn after joining. A few participants reported being asked to mime during performances.

C.3.3 Learning to play an instrument at school

Over half of the participants from the UK had memories of instrumental experiences at school. Most often these related to learning to play the recorder. There seemed, amongst participants, some level of affection around these memories, with many remembering learnt tunes, such as 'Go and Tell Aunt Nancy', and 'London's Burning'. Some tried to remember the recorder fingering and two participants delivered sung renditions. Whilst the recorder appeared to be the most common instrument to be taught in UK schools, the more commonly learnt instrument at school amongst participants from the Philippines

was the piano. One also learned to play the *bandurria*, a twelve stringed, mandolin-like instrument.

Most of the participants who learned to play the recorder elected to join the school recorder club and some learned during class lessons. A small number reported choosing to learn other instruments that was offered as an option at school. Three participants briefly elected to join the school orchestra and were given a choice of instruments to learn and one elected to join the guitar club. A small number of comments demonstrated that choice of instrument was sometimes undertaken by teachers.

"At school I played the recorder as well and because I had the widest hand-span I was given the tenor."

(Administrator: Fg9)

"I was given the triangle, the smallest instrument for the smallest child!"

(Registered Nurse: Fg17)

"I learned the trumpet: I wanted to play the clarinet but so many other girls were playing it; I thought I'd play trumpet."

(Care Assistant: Fg5)

Researcher - *"Did you have your own violin?"*

Administrator - *"No, the school's violin. There was a music teacher who was into violins. That's why I got it."*

(Fg2)

A very few participants commented on gender-related issues. One participant said ' I wanted to play something else but they only had trumpets, which the boys got, so I played recorder'. Two participants described going against the trend. One said:

"We had assemblies where groups would come in and try to promote instruments for students to take up... they did girl/boy auditions. They tried girls on the high instruments and boys on the low instruments. I didn't go because I didn't want to put myself forward. And then my Mum told me to go the next day. That was the boys' audition day but I tried on the trombone and I got a few notes out!"

(Music Student/part time Care Assistant: Fg17)

A few comments demonstrated the effect of marginalisation associated with individual instrumental lessons undertaken at school. One participant reported that lessons at lunch time isolated her from her peers. Another described a sense of embarrassment at having to walk out of the classroom during ordinary lessons to attend her weekly trombone lesson, and another took a different route home when she was carrying her guitar case to avoid ridicule from neighbouring children.

Of the very few focus group participants from care settings who had had private instrumental lessons outside school, most reported negative experiences. These ranged from teachers appearing disinterested or being absent, to a teacher hitting a participant with a cane in the event of errors. The latter participant reported that on one occasion she jumped out of a window to avoid corporal punishment. Another recounted her fear of a private piano tutor.

"Every time you'd walk past his house you'd hear this wonderful music thundering out. Obviously, we were an interruption. I suppose he had to teach to survive. He was very, very scary. Terrifying really."

(Informal Carer: Fg17)

In answer to objective C, the study found that memories of music in early life often related to music embedded into national, cultural and faith practices. Some social practices reported upon appeared to encourage family-orientated interactions, which are less common today than historically. These were often influenced by economic resources relating to access to music and appear may also to relate to macro cultures and practices round music *per se*. A few participants remembered very early music interactions, such as pre-school musical events and maternal singing. These appeared to impact either positively or negatively on their relationship with music in adult life. This also applied to memories of music at school, in which positive memories tended to be associated with learning to play the recorder at primary school and negative memories tended to be associated with music lessons and choir singing at secondary school.

Results Objective D

Perceptions of the value of music in the personal lives of care staff

Objective D: to investigate staff perceptions of the value of music in their personal lives was addressed through the questionnaire survey and focus group discussions.

Figure 6.17 Objective D: main themes and emergent sub themes

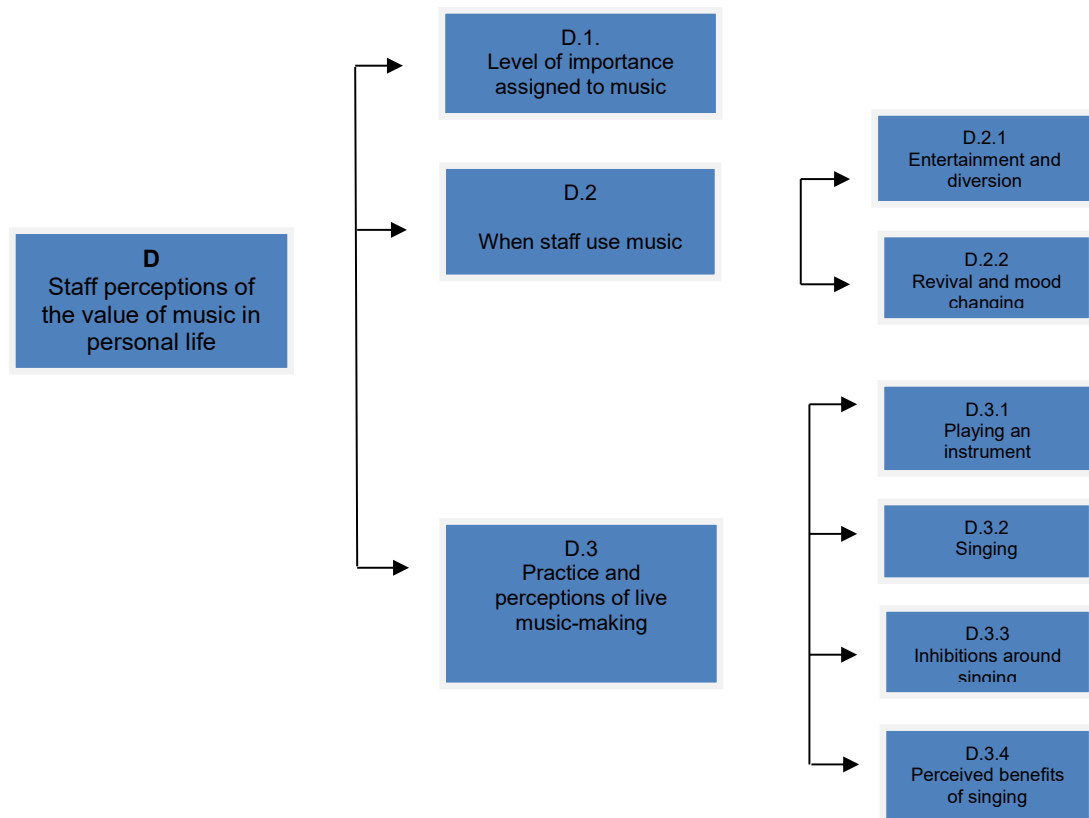


Figure 6.17 shows that three sub themes emerged from the analysis. These were the level of importance that staff assigned to music in their personal lives, when and how staff used music in their personal lives and the practice and perceptions of live music-making.

D.1 Level of importance assigned to music in personal life

Some questions on the questionnaire survey investigated how important music was for staff in their personal lives.

	Number replying	Number and percentage agreeing	
		n	%
Music can help me feel good about myself	108	99	91.7
Taking time to listen music is important	109	71	65.1
I listen to background music a lot of the time	112	100	89
Music is of little importance in my life	111	21	20
Sometimes music is important sometimes not	107	87	81.3

Table 6.18 shows that the majority of questionnaire survey respondents rated the value of music highly in their everyday personal life. Sixty five percent of respondents (n = 71) agreed with the statement, 'Taking time to listen to music is important' and 89% (n = 100) agreed with the statement 'I listen to background music a lot of the time'. Nearly 92% of respondents (n = 99) agreed with the statement, 'Music can help me feel good about myself'. This data corresponded to the negatively posed question, 'Music is of little importance in my life', with which 20% of respondents (n = 21) agreed.

The data was supported by focus group participants, nearly all of whom reported music's importance and omnipresence in their personal lives. On a scale of one to ten, with one being low, 87% of participants rated the importance of music between 5 and 10, with an average of eight.

D.2 When staff use music in everyday life

The questionnaire survey data showed a range of situations when staff were likely to use music. Over two-thirds (65 % n = 71) of staff agreed with the statement, 'Taking time to sit down and listen to music is important to me' agreed, and 89% (n = 100) agreed with the statement 'I like to have music in the background while I'm doing other things'.

I use music:	Number and percentage agreeing		Main mood engendering/reflecting mechanisms (Based on model by Saarikallio and Erklila 2007)
	n	%	
On journeys	108	96.4	Entertainment; Diversion
Doing housework	94	83.9	Entertainment; Diversion
To exercise to	61	54.5	Revival; Diversion
To relax to	81	72.3	Diversion; Solace; Revival
To help me feel calm	69	61.6	Diversion; Solace; Revival; discharge
To uplift me	75	67	Discharge; Revival; Strong sensation
To give me energy	58	51.8	Revival; Strong sensation
To help me concentrate	41	36.6	Revival; Mental work
When feeling happy	89	79.5	Entertainment; Strong sensation
When feeling sad	78	69.6	Solace; Discharge; Diversion; Strong sensation; Mental work

Table 6.19 shows how many staff used music in a number of day-to-day situations, such as on journeys, doing housework and to exercise to, and to affect or reflect mental states, such as to help them feel relaxed or when feeling happy. Data was analysed into two subheadings: music used as a mechanism for entertainment and/or diversion, and music used as a revival and mood changing mechanism.

D.2.1 Entertainment and diversion

Ninety six percent (n = 108) reported using music 'on journeys'. Eighty-three percent (n = 94) reported using music whilst undertaking domestic chores and 54% (n = 61) used music during exercise. A high number of focus group participants indicated similar usage. Most reported using music on car journeys. A few, mostly younger participants, reported frequent use of personal music equipment. One said, 'I always have it [iPod], all the time, at home, on the bus, shopping'. Most participants reported playing recorded music at home in the background for a lot of the time. Illustrative reasons given for using music in this way were: 'It entertains you; something to listen to'; 'It's something in the background'; 'I don't like it quiet'. However, one participant said, 'I never have music on. Gets on my nerves', and another reported that putting on music at home would not occur to her.

D.2. Revival or mood changing

Of the 108 participants responding to the statement, 'Listening to music can help me to feel good about myself', over nine-tenths (91.7% n = 99) agreed. Around two-thirds (67% n = 75) reported using music to help uplift them and over half (51% n = 58) used music to help give them energy. Almost three-quarters (72% n = 81) used music to relax to and just under two-thirds (61% n = 69) reported using music to help them feel calm. More than three-quarters (79% n = 89) reported using music when feeling happy and over two-thirds (69.6%, n = 78) used music when sad. Around a third of respondents (36% n = 41) used music to help them concentrate.

These findings were confirmed in focus group discussions with most participants reporting music's capacity to lift their spirits and/or to reflect mood. Very many comments related to the frequent use of music to induce a relaxed or cheerful state. More than half of the participants could identify a song or music that 'always' invoke a specific physiological response to emotion, such as tears or 'goose pimples'.

D.3 Live music-making

Activity	Number replying	Number and percentage engaging in activity	
		n	%
I enjoy going to hear live music	109	89	81.7
I play a musical instrument regularly in a group	107	6	5.4
I sing regularly in a choir	107	8	7.1

Data from the questionnaire survey showed the numbers of staff who enjoyed engaging in live and pro-active musical activities. Table 6.20 shows that four-fifths (81.7% n = 89) of respondents enjoyed attending live music events. This level was endorsed by focus group participants, where over three-quarters reported enjoying live music events, such as pub gigs, concerts by prominent popular-music celebrities and, occasionally, musical productions, either in the West-end of London or a local amateur production. However, a caveat to their regularly attending these events was limited monetary and time resources.

Table 6.20 also shows that although a high number of respondents reported music's value in supporting their quality of life, very few engaged with regular, live music making, that is singing or playing an instrument. Just over 5 % (n = 6) reported playing an instrument regularly in an organised group and 7.1% (n = 8) reported singing regularly in a choir. Most focus group participants offered a view on live music-making. Data was analysed into three topics, the challenges of playing an instrument, inhibitors to singing and the perceived benefits of singing.

D.3.1 Playing an instrument

Four focus group participants reported that they still played a musical instrument; two played a guitar, one played the flute and one the trombone. The latter, who worked as a part time care-assistant but was also a music degree undergraduate, played in formal performance settings. One of the guitar players reported playing at church to accompany hymns and choruses. The remaining two played at home, usually alone and for their own amusement. Apart from the music student, none were currently taking lessons, nor intended to in the future.

Around an eighth of participants expressed some level of disappointment at having discontinued instrumental lessons in childhood. This was often attributed to loss of interest due to perceived lack of potential, the challenge of maintaining the payment of fees or meeting the cost of increased fees, and/or a sense of peer pressure. Three of four participants regretted not having learnt an instrument but expressed no motivation to learn in adulthood whilst four expressed an interest in starting or re-starting instrumental lessons. However, most felt limited in terms of time to practice and, therefore, their ability to reach any reasonable standard.

D.3.2. Singing

Activity	Number replying	Number and percentage engaging in activity	
		n	%
I like to sing in private	111	80	71

Table 6.21 shows that amongst questionnaire survey respondents, 71% (n = 80) liked to sing in private. This data was endorsed by many focus group participants.

Figure 6.22 Focus group participants' reported levels of singing

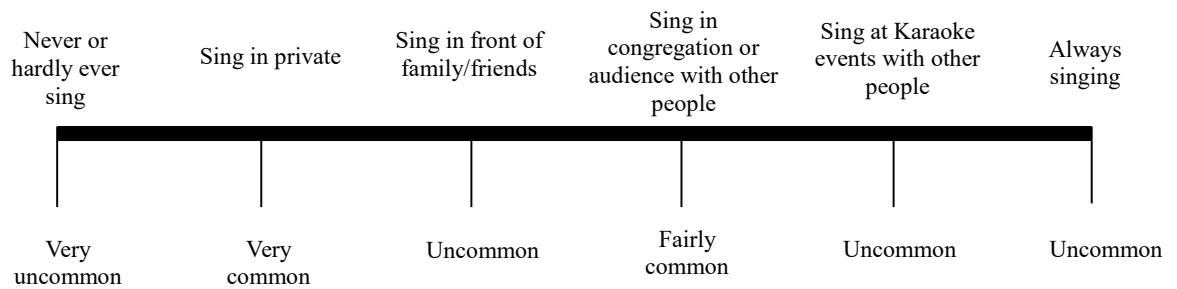


Figure 6.22 shows the reported levels of singing amongst focus group participants. Apart from a very few who reported rarely or never singing, around nine-tenths reported singing in private at some time, usually at home or in the car. Less than a quarter of the British-born participants reported singing in front of family members. One very occasionally sang in 'family sing-songs' involving her father and children and the rest regularly sang with their children along to CDs or the radio playing at home or in the car. The exchange below between the researcher and two Philippine-born participants implied a cultural difference.

Researcher – (To Care Assistant 2) *"Did you sing at home?"*

Care Assistant 2 - *"Yes, like in our house, in our country, we used to sing with the family very much."*

Care Assistant 1 - *"When we get together again we always sing."*

Researcher - *"Do you do that now?"*

Care Assistant 2 - *"Yes when we have a small party we are singing, songs from our country."* (Fg3)

Another participant referred to the culture of social music-making in Ireland.

Researcher - *"Is the family very musical too?"*

Registered Nurse - *"We just sang, you know, we used to have real Irish get together, you know."*

(Fg6)

A few participants reported singing with non-family groups. Around a quarter reported 'usually singing' as part of a congregation at, for example, a family wedding and/or in audience-participation activities at, for example, their children's school Christmas celebrations. Less than a quarter of participants reported having sung at Karaoke events, mostly as a one off, usually with at least one other person. One participant reported singing regularly in a church choir, and two sang in amateur operatic and dramatic society performances. One of these participants also regularly sang solos. Fewer than a fifth of participants reported singing as a prevalent part of life, using comments such as 'I'm always singing' 'I sing all the time', 'I sing a lot at home and in the car and at work'. One participant said 'I sing when I don't even realizing I'm singing. It's just such a part of my life'.

D.3.3 Inhibitions around singing

Discussions on inhibitions around singing were often centred on contextualisation. A few participants reported that they would sing to their young children, regardless of their perceived quality of their singing voice.

Researcher - *"You don't like the sound [of your voice]? Isn't that a shame because I bet your kids loved hearing you sing?"*

Registered Manager - *"Oh, they don't mind now. My little boy might say, "Oh, Mum shut up"... but I don't care what they think at home."*

Researcher - *"How old is your little boy."*

Registered Manager - *"He's eight."*

Researcher - *"So you're uninhibited at home?"*

Registered Manager - *"Oh yeah."*

(Fg9)

About half of the participants agreed that they could probably be persuaded by friends to sing at a Karaoke event after the consumption of at least one alcoholic drink. However, the following exchange is illustrative of the mixed response from participants to the suggestion by the researcher of a singing *soirée* with friends.

Researcher - *"If someone invited you to an evening soirée of singing at their house, your friends, say - would you go?"*

(Laughter)

Care Assistant - *"No!"*

Registered Manager - *"I don't think..."*

Administrator - *"It depends who it was, probably if I knew the people."*

Care Assistant - *"It's silly though isn't it. You get up and sing Karaoke in front of complete strangers, but you won't go for an evening singing with people you know."*

(Fg2)

Many participants made self-judgements about the quality of their singing voice. No participant claimed to have a good singing voice. More than half stated either a complete inability to sing, or to have a voice that embarrassed them and inhibited their singing in public. Many participants made derogatory remarks about their singing voice, with analogies to 'killing/strangling the cat' and 'caterwauling'. One participant said that he never sings because he 'wouldn't risk it – it would clear the room'. One participant who regularly sang solos on stage was also self-deprecating about the quality of her voice, saying, 'They [audience] have to put up with me screeching away'.

The following exchange illustrates the combined factors discussed above. These included a desire amongst many participants to sing *per se*, inhibitions associated with singing in front of others and self-judgement of the quality of one's singing voice.

Registered Manager - *"Well, I suppose that unless you're really.... have a voice that you feel you can ..., which is a shame really because everyone likes to sing. I sing away in my car. I know people are laughing as they go passed. I can't sing. I'd love to be able to. I'd like to know I had a nice enough voice to stand up and sing in front of people... I love the X-Factor and I think, I'd love to be able to sing."*

Administrator - *"I wouldn't mind singing in a group. Like at church."*

Care Assistant- *"Yeah, that's alright."*

Researcher - (to Registered Manager) *"Would you sing in a group?"*

Registered Manager - *"No, because I can't sing!"*

Administrator - *"We went to the wedding on Saturday and I like hymns. I'd sing hymns at primary school but to hear my voice. I was miming it because can't stand my voice."*

Registered Manager - *"If you sing hymns, I can hear myself not being able to sing them."*

(Fg9)

Around a third of participants talked about the origins of their inhibitions. Occasionally these related to ridicule from within the family. One comment demonstrated a family culture that was being replicated between generations.

"They're [children] not self-conscious at all. My eldest does that. She sounds awful but she's really going for it. So I shout upstairs to her "Meeoowww" and she says "Don't care!" My mum done that to me."

(Care Assistant: Fg12)

Often, negative feedback related to experiences of singing at school. These were variably shaped by the behaviour of teachers and/or other children. Several participants remembered being reprimanded by teachers for singing badly, or being asked to mime at concerts or, in the case of one participant, to leave the school choir. One participant recounted an experience that involved a peer pupil.

"I remember when I was 9 or 10, and a boy at school told me I got a flat singing voice and I have never forgotten that. And I don't like singing loud, not even now."

(Registered Nurse: Fg13)

One focus group discussed the origins of rating the quality of singing, pointing out that before starting school all children are usually encouraged to sing.

Registered Manager - *"Where does that come from then. You don't see children at nurseries being told to "shut up", do you?"*

Care Assistant - *"No, it's because they don't expect toddlers to sing properly. Some can. I bet Charlotte Church knew she could sing when she was this high. But you know if you can sing when you go to school because everyone tells you."*

(Fg11)

D.3.4 Perceived benefits of singing

One comment showed how family cultures can nurture singing in small children.

"Yes, and my little girl she makes up her own songs. I used to when I was young. It's funny when you look back at your childhood. She walks round the garden and I say "What you doing" and she says "I'm just making up a song" and I think, ah, I used to do that."

(Care Assistant: Fg5)

In general, participants agreed that singing can underpin a sense of enhanced well-being.

One participant spoke of the 'passion' of singing saying, 'I love singing, it's keeps me alive!' A number of participants referred to the value of singing as a shared activity to create social bonding.

*'It's brilliant. When you... mmm everybody's singing at the top of their lungs - and no one cares. It takes you back – **Amarillo, Delilah**. Everyone's friends. You just have a great night out'.*

(Care Assistant: Fg1)

The issue of social bonding amongst staff appeared important. At least a half of the focus group participants indicated that they spent social time together. Many staff interacted using affectionate banter. One participant expressed a bond with a colleague, whom she believed had helped raise her levels of self-confidence through informal counselling and support. One focus group of four care assistants discussed how they would care for each other in old age. They suggested a communal living arrangement in which each would carry out jobs that they were best suited to. This was done in a very jovial manner but all

four expressed a desire not to live long enough to need nursing home care.

Many focus groups participants referred to 'feeling good', when singing, both physical and mentally. The first exchange below also acknowledged inhibitions.

Registered Nurse - *"[Singing] makes you feel good, I think it's all one way that you can get rid of everything. Just by singing you take in deeper breaths. So instantly you just relieve all that stress and you stand up straight, cos you have to get the air in."*

Researcher - *"Does it matter what you're singing?"*

Registered Nurse - *"No not really but it matters where, or who's listening, because you feel self-conscious then you don't do it properly', you don't really open up'."*

Senior Care Assistant - *"It's so physical, the act of singing."*

Care Assistant - *"I think it is really; it's good for the soul."*

Registered Nurse - *"It's just good for the soul. It gets every bit of you. It gets your toes tapping or your fingers tapping it just wakens you, doesn't it - just brings you to life."*

(Fg13)

One focus group highlighted singing as a mechanism for supporting or reflecting mood.

Registered Nurse - *"Everyone says to me, Ann says to me 'How can you sing when you're stressed?' but I do, I sing all the time."*

Senior Care Assistant - *"Yeah, I do too but if I don't want anyone to talk to me I sing; if I'm singing you can't speak to me can you... when I'm stressed, I sing faster songs."*

Registered Nurse - *"Oh no, I sing to calm me down."*

Care Assistant 1 - *[to SCA] "I think you're easier to approach when your singing; that's when I like approaching you."*

Researcher - *"How interesting; so she's more approachable when she's singing?"*

Care Assistant 1 - *"Yeah."*

Registered Nurse - *"Yet to me, I know she's not if she's singing ... if she's singing a happy song she's alright but if she's singing [sings forcefully] **It's a Long way to Tipperary**, I know she's not!"*

Researcher - *"So the song you chose reflects your mood?"*

Registered Nurse - *"Oh, Yeah."*

(Fg6)

In answer to objective D the study found that most participants regarded music as important in their personal lives. Most referred to engagement with popular and commercial music. No references were made in relation to regular engagement with 'art' music. Participants used music variably as a recreation, to reflect and/or alter mood and to support a sense of well-being. Most participants enjoyed hearing live music but very few regularly took an active part in live music-making. Although the majority liked to sing in private, and a few felt comfortable singing in front of their family members, or at Karaoke events, a range of inhibitions generally limited participants' enjoyment of singing where they may be overheard by others. No participants claimed to have a good singing voice. However, most participants believed that singing can enhance well-being.

6.5 Practices and perceptions of staff relating to music in care settings

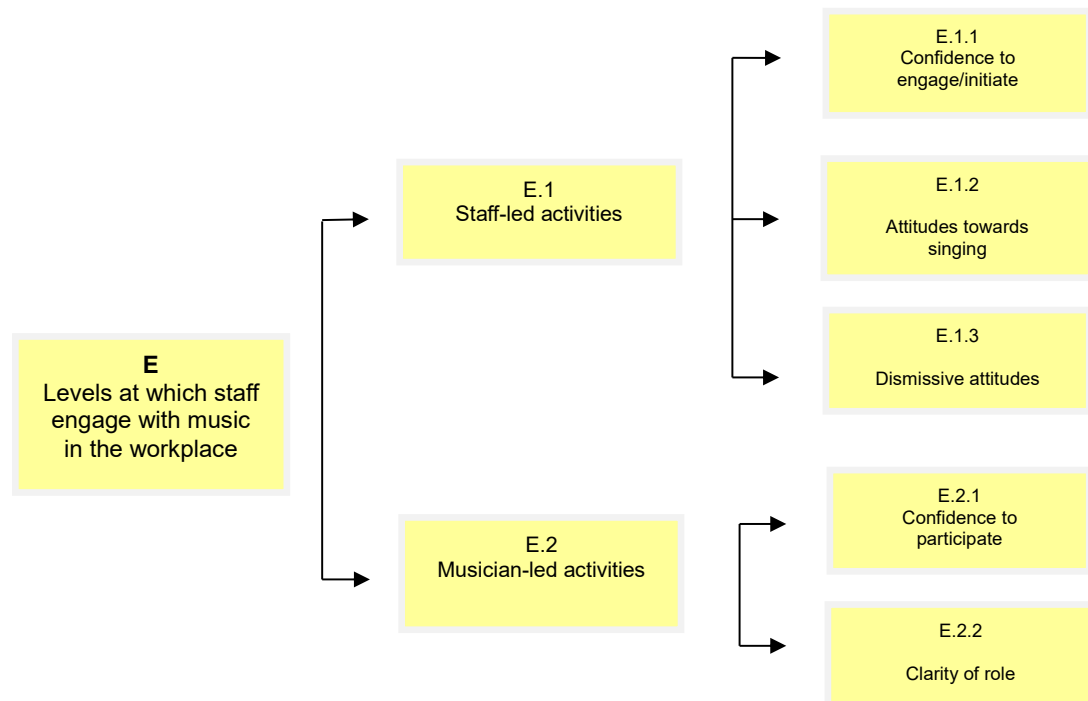
The purpose of investigating staff practices and perceptions of music in care settings was to ascertain any relationship between these and staff perceptions of music in their personal life. The investigation was addressed by objectives E, F, G, H, J and L.

Results Objective E

Levels at which staff engage with music in the workplace

Objective E: to investigate the level at which staff engage with music in the workplace, was addressed through the questionnaire survey, focus group discussions, face to face interviews and participant observations.

Figure 6.23: Objective E: main themes and emergent sub themes



Two themes emerged from the data relating to staff-led activities and activities led by visiting musicians. Figure 6.23 also shows the emergent sub themes. These related to issues of staff confidence to engage and/or initiate staff-led activities, staff attitudes

towards singing, and the presence of dismissive attitudes to musical interactions. In terms of musician-led activities, the sub-themes related to staff confidence to participate and clarity of role.

	Number and percentage taking part in staff-led activities		Number and percentage taking part in musician-led activities	
	n	%	n	%
None	59	54.1	38	34.2
A few times	33	30.3	42	37.8
Quite often	8	7.3	18	16.2
Very often	9	8.3	13	11.7
Missing	3	2.7	1	0.9

E.1 Staff-led music activities

Table 6.24 shows that more questionnaire survey respondents reported having engaged with visiting musicians that in staff-led music activities. More than half (54.1% n = 59) reported having never engaged in staff-led activities and just under a third (30.3% n = 33) had engaged ‘a few times’. Less than one-tenth reported having engaged ‘quite often’ (7.3% n = 8) or ‘frequently’ (8.3% n = 9). However, discussion in focus groups revealed some ambiguity around the term 'staff-led music'. Most commonly participants' understanding of the term was the provision of CDs, the radio or television to which clients may listen, and/or performance/interactive activities modelled on music activities facilitated by visiting musicians.

Table 6.25 Organised and spontaneous staff-led music activities in care settings			
	Activity	For whom/how many clients	Reported frequency and duration
Common organised activities	Playing recorded music i.e. CD players/CDs, radio and television in communal areas at set times of day	All clients using communal areas	Usually daily: Ongoing
Less common organised activities	Staff-led interactive singing and dancing sessions to recorded music	Large self-selecting groups and staff-selected clients	Usually weekly: For approx. 6 months whilst facilitating staff was in post
	Musical Bingo	Large self-selecting groups	Periodically: approx. every 3 /4 months and weekly for 4/5 weeks
	Staff-led interactive music sessions: communal singing, playing percussion instruments to popular recorded music, seated chair dances, listening to client-chosen songs/music, either live (performed by staff) or on a CD.	Large groups of self-selecting and staff-selected clients	Approx. 3-monthly For two years whilst facilitating staff worked at the care home
	Playing recorded music during individual care-giving activity (i.e. preparing client for bed)	One individual client	When client appeared distressed, usually each evening: For approx 8 months, for duration of client's residency.
	Pantomimes and performances by staff	Large groups of clients	Annual event in two settings: Ongoing
Common spontaneous activities	Playing recorded music in communal areas	All clients using communal area	Varied frequency: Ongoing
Less common spontaneous activities:	Playing recorded music during individual care-giving activity (i.e. preparing client for bed)	One individual client	Varied frequency: Ongoing
	Staff-led singing and dancing along to background music with clients as a shared recreation.	Usually a small group or one individual client	Varied frequency: Ongoing
Uncommon spontaneous activities:	Staff-led <i>a capella</i> singing with clients during day to day care-giving duties	Usually a small group or one individual client	Varied frequency: Ongoing

On further exploration with focus group participants other models of staff-led music activities appeared more prevalent than apparent from the questionnaire data. Table 6.25 shows the range of activities divided into two main modes of delivery, the delivery of organised music activities and the delivery of spontaneous music activities. The activities collectively encompassed: background recorded music; foreground recorded music; communal singing; the use of percussion instruments, dancing and rhythmic movement; staff performances. These activities variously involved staff interacting with one client at a time or with a number of clients simultaneously.

The most commonly organised activity was the placement of audio equipment, CD players, the radio or television in communal areas. Most focus groups participants reported that playing music on this equipment was the most frequent musical activity, usually occurring daily, most often in the communal lounge area. The following exchange was illustrative of a flexibility and willingness amongst staff to engage clients in this way and the acknowledgement of music's capacity to affect mood and behaviour.

Registered nurse - *"But you know when they [clients] need something to pep them up. We put on music they like."*

Care Assistant - *"As well though, we have it on if it's a bit tense because of something...someone's having a bad day or something. You just gauge it really and chose the right music."*

(Fg13)

Another relatively common organised activity was musical bingo. Staff from three care settings reported using a commercial musical-bingo pack. Two used the pack on average every three or four months and one had held sessions weekly for three or four weeks.

A very few participants reported spontaneously using recorded music during individual specific care-giving activities but participants from two settings described using music as a care intervention. Staff from one of the settings had played specifically chosen recorded music whilst preparing a distressed client for bed. This was an integral part of the client's care plan and was usually administered on a nightly basis for around eight months (the duration of the client's residency). Staff from the other setting had used a similar intervention with a client 'sometimes', when it was perceived to be helpful.

Staff from only one care setting reported using recorded music for weekly organised singing and dancing sessions. One other focus group reported staff-led sessions of live, communal singing and playing percussion instruments that occurred around three times a year in their setting. However, in general, these staff-led models of activity were reported as highly uncommon. Their delivery had relied on certain members of staff initiating and facilitating sessions and, therefore, only took place whilst these members of staff were on duty and employed at the individual settings.

One focus group reported a staff-led annual pantomime, and another a staff-led variety show performed by staff for their clients.

Spontaneous incidents of staff-initiated music activity centred largely on singing, either to recorded music or *a capella* (unaccompanied). This involved staff singing and dancing with clients along to music that happened to be playing in the background, and/or spontaneous *a capella* singing to, and with clients, either individually or in small groups. These incidents, which tended to be short in duration, usually involving no more than a small part of a song, were difficult to quantify in terms of frequency. Although around half of the focus groups reported spontaneous music activities taking place in their settings, estimations of the frequency with which they occurred ranged fairly equally from 'most days', to 'sometimes' or 'every week or so'.

E.1.1 Staff confidence to participate in or initiate staff-led activities

Levels of confidence amongst focus group participants to participate or initiate staff-led music activities appeared to some extent to be activity-dependent. Some staff would sing along to a pop song, whilst others were happy to dance with clients. The two focus group participants, who had described the staff-led pantomime and variety show performances, pointed out that staff were variably confident to take on specific roles. Some would take on prominent or minor performance activities, whilst others would help with non-performance activities, such as props or costume-making. Some would decline to take any active part.

Figure 6.26: Staff-reported confidence levels with organised music activities

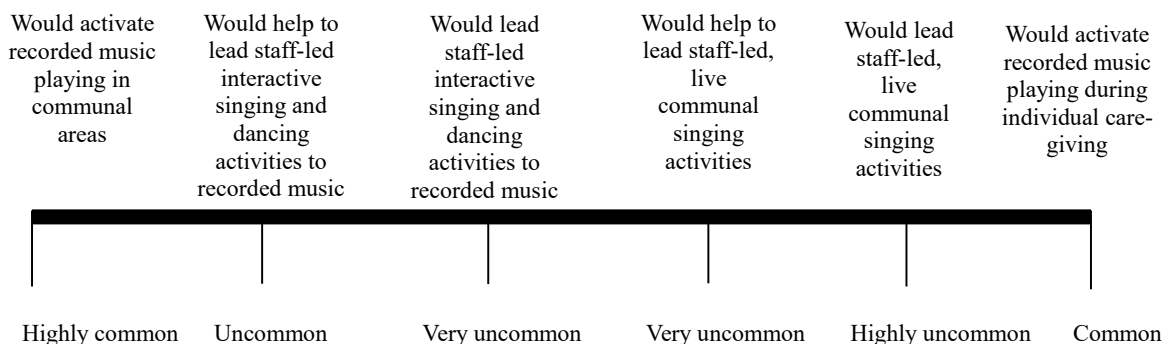


Figure 6.26 shows that most participants felt confident in activating recorded music in communal areas and more than half would activate music during individual care-giving activities. Less than a fifth of participants felt confident enough to lead interactive singing and dancing activities to recorded music but around a quarter would *help* to lead them. Participants generally reported the least confidence in helping to lead, or in leading live, communal singing activities.

E.1.2 Staff attitudes to singing

Confidence to lead spontaneous music activities largely centred on confidence to sing *per se*.

Figure 6.27 Staff-reported confidence levels with spontaneous music activities

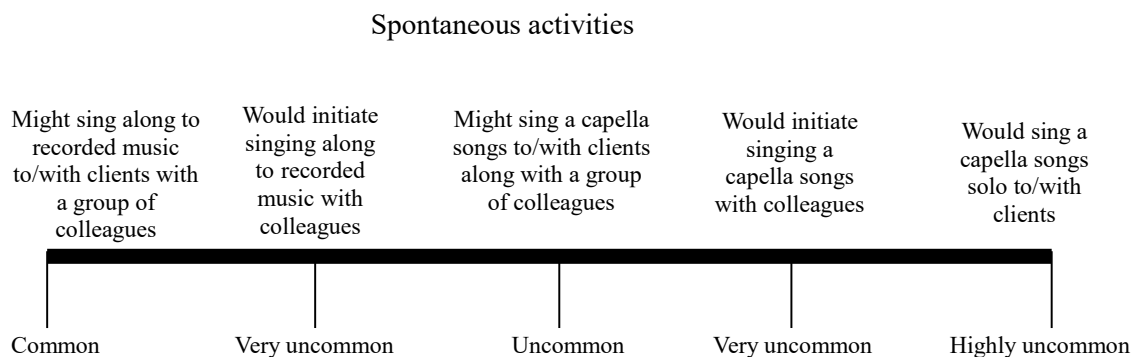


Figure 6.27 illustrates how confident participants felt about leading spontaneous activities involving singing. More than half of participants reported that they might sing along to recorded music together with colleagues but fewer than five reported feeling confident enough to initiate such activities. Fewer than a quarter of participants reported that they might sing *a capella* songs with a group of colleagues but very few would initiate this activity. Participants generally reported least confidence in singing solos to, or with the people in their care. However, one participant said that she would sing to/with individual clients in private, providing none of her colleagues could overhear.

Approximately a quarter of participants adamantly rejected the suggestion of singing in the workplace.

Researcher - *"If someone said to you "Would you just go and sing to that patient please""?"*

Registered Manager - *"I'd read to them. I couldn't sing. I'd do anything with them but sing."*

Researcher - *"So that's quite daunting, the idea of being asked to sing?"*

Registered Manager - *"To sing, oh! YES."*

(Fg2)

Declining to sing was mostly rationalised on the grounds of lack of skill, which was expressed by participants by comments such as 'I'm tone deaf', 'I can't sing' and 'Don't ask me to sing, 'cos I'm rubbish.' One participant gave her perspective of colleagues' concerns.

"I can see so many negative faces if I think of nursing, "Are we going to have to do singing, I can't sing, I'm not a performer!". The carers whatever, you know it's out of their realm at present, they're not naturally going to do that, unless you're a performer. You couldn't imagine a lot of carers doing that."

(Registered Nurse: Fg17)

The following exchange and comment provide a view of colleagues' lack of confidence.

Researcher - *"So some of the staff aren't so comfortable about singing. What's that to do with do you think?"*

Registered Nurse - *"It's a personal thing. They might say, 'Oh, I'm going down the other end [withdraw]."*

Care Assistant - *"Some of them [staff] have never done it though; they've never tried it. Too scared. Too shy"*

(Fg13)

"She [colleague] says she can't [sing] but she can, when she thinks no one's listening there."

(Care Assistant: Fg15)

Four participants from one focus group agreed that *personality* was the primary determinate in staff-engagement in activities in the workplace, over and above

perceptions of ability. The group suggested that staff with confident personalities would sing and join in with activities without worrying about their ability, whilst shy staff would decline, even when they could sing well. This was born out by a registered manager who reported one member of her staff having formal academic qualifications in fine art and another having a diploma in singing. Despite significant expertise in their specialist fields, neither felt able to transfer these skills to the workplace. The manager expressed the need to understand staff and the pressures that may be under in their personal and professional lives. The manager reported that *all* staff have skills, many of which are not immediately apparent, and these need nurturing in order for staff to maximise their potential.

There was often a sense that, regardless of staff experience around music in their personal lives, music-making in the workplace was perceived differently. The following exchange between the researcher and two participants, who were also experienced musicians and performers and skilled in leading interactive music sessions in the workplace, showed their need to differentiate their music-leader role from their professional care role. The exchange also indicated their belief that staff were not generally seen as the beneficiaries of music in care settings.

Registered Nurse - *"When we put on some musical activities periodically in the Nursing Home, neither of us felt comfortable doing it with our uniforms on. We had to be a different person, change into our civvies before we were comfortable to perform a song, if we were singing a duet or something. That was true wasn't it? We as 'singing nurses' weren't really comfortable. The other thing was that I was much more conscious of what my colleagues would say. Like [colleague] she's going to think I sound really silly. But I wouldn't have been worried about the clients so much."*

Care Assistant/Music Student - *"Yes, because you were entertaining them [clients] and you weren't entertaining staff."*

Researcher - *"So we see that differently?"*

Registered Nurse - *"I'm sure that would be it... And yet it was a platform for them [staff] because we did stand up and get them to do things with us."*

Researcher - *"You're obviously very accomplished musicians, so you'd feel self-conscious because of the other staff?"*

Care Assistant/Music Student - *"Yes."*

(Fg17)

Three participants suggested that the initiation/activation of music activities should be assigned to an activity's coordinator, rather than to care staff. The group agreed that this caused problems in care settings that do not employ the former. However, more than half of the participants believed that, in theory, music for clients should be an integral part of holistic care and was therefore partly the responsibility of the care-giver.

E.1.3 Dismissive attitudes

There also emerged a tendency amongst participants to dismiss or trivialise staff engagement with music activities, illustrated by the use of terms such as 'playing the fool' and 'muck(ing) about', in relation to staff music-making in their workplace.

Senior Care Assistant - *"You have to play the fool to keep them happy and laughing, ' specially if there's a bit of a tension."*

Researcher - *"So you have a sort of performance mask in a way?"*

Care Assistant – *"Yeah."*

Senior Care Assistant – *"Mmm, oh yeah."*

Care Assistant - *"You have to for the residents really... I can act an idiot and jump about and muck about, but at home ..."*

Senior Care Assistant - *"Well even if we've just got music on just in here [dining area] we jump about across the floor, then we have them laughing."*

Care Assistant – *"I'm not a very confident person but sometimes you have to act the fool to get them going"* (Fg12)

Researcher - *"Do the clients enjoy that [staff singing and dancing together] do you think?"*

Care Assistant 1 – *"Yes."*

Care Assistant 2 - *"Yes they do, they enjoy it don't they. It gives them a laugh, whether we're making fools of ourselves or whatever. They sometimes give you a funny look but it gives them a laugh, it helps their day or whatever."*

Senior Care Assistant - *"Yeah, they do enjoy it. It gets them chatting. Even if it's - "ooh look at that silly woman", it gets them chatting. Like [client] and I have a little tete a tete. When I start singing, she'll say something like "ooh somebody stood on the cat"*

(Fg6)

Interestingly, the term 'acting the fool' was also used by Music Practitioner I, to illustrate her approach to encouraging clients to engage at the outset of a music session.

Two participants agreed that it might 'not be right' for care home owners to join in with singing. The reason given centered on the potential for music to be seen as a frivolous activity, which could jeopardize very senior staff's authority. One focus group of three participants suggested that singing should be avoided in care settings when an older person is in an end-of-life situation.

Attitudes towards music-making were discussed in two focus groups in reference to the pantomime and variety show performances by staff. Participants agreed that the comedy nature of these activities defused the need for high quality skills, which in turn encouraged staff to take part. The groups also agreed that reticent staff were buoyed by the more confident staff.

E.2 Musician-led activities

One-third (33.3% n = 37) of questionnaire survey respondents reported never having engaged in music sessions with visiting musicians. Thirty seven percent (n = 42) had engaged 'a few times' and 16.2% (n = 18) had engaged 'quite often'. Just over a tenth, (11.7% n = 13) reported frequent engagement with visiting musicians.

Reasons for these statistics were discussed in more than half of the focus groups. The groups collectively suggested that the term 'musician-led activities' was understood by staff to include adults' and children's singing groups and solo musical performances, and interactive music activities led by community music-practitioners. Amongst those commenting on this topic, around three-quarters reported associated enjoyment. Some of this enjoyment related to the pleasure of staff seeing the positive effects on the people for whom they cared. For around a quarter of these participants this observed enjoyment, and the desire to encourage greater participation amongst their clients, was a motivator for joining in themselves. However, active participation in musician-led activities appeared generally limited.

E.2.1 Staff confidence to participate in musician-led activities

Table 6.28 Potential for embarrassment							
	Number replying	Number and percentage agreeing		Number and percentage not sure		Number and percentage disagreeing	
		n	%	n	%	n	%
It can be embarrassing if visiting musicians ask staff to join in	108	41	38	19	17.6	48	44.4

Table 6.28 shows that just over a third (38%) of questionnaire survey respondents agreed with the statement, 'It can be embarrassing if visiting musicians ask staff to join in'. Just under a fifth (17.6%) disagreed, and just under half (44.4%) were unsure. At least half of the focus group participants offered a view on this topic, which tended to centre on issues of confidence. Many of the issues arising around musician-led activities mirrored those in staff-led activities. Whilst a few participants reported feeling confident to *always* take part in musician-led sing-along sessions, more than half agreed that they might do so only if other staff joined in and providing the songs were familiar.

The theme of shyness emerged in a number of other exchanges. Whereas several participants reported that they might participate in music activities with colleagues, they also expressed perceived inhibitions for themselves and their colleagues to do so in front of a lesser known musician.

One participant said:

"Well, I'm a very self-conscious person. I open up to [colleague] quite a lot. Whereas, like music. I'd rather be here listening to music with the residents and have a joke and muck about with the other carers."

(Care Assistant 1: Fg12)

In addition to issues of confidence, other conjecture for staff choosing not to take part centred on a disinterest in music *per se*. One care assistant put this succinctly:

"They don't like music, they aren't outgoing. They don't sing, or they won't have go at making a fool of themselves in front of people."

(Care Assistant 2: Fg12)

Around a quarter of participants highlighted concerns about feeling exposed during musician-led activities, using terms such as '[avoiding] the limelight', 'being put on the spot' and 'being shown up'. The following exchanges were illustrative of a common desire amongst participants to avoid feeling focused upon. It also emphasised the issue of perceived skill in singing.

Researcher - *"Did you say he [musician] tries to get the staff ...[to join in]?"*

Senior Care Assistant - *"He hasn't succeeded in that one."*

Care Assistant - *"No, he won't! I'm tone deaf."*

(Fg12)

Care Assistant - *"I'll sing, yeah, but I don't sing loud."*

Senior Care Assistant - *"No we're all a bit mike-shy. We sing along without the mike!"*

(Fg8)

Observation question	Participant observation (PO) site		
	PO1 Interactive, backing tracks, percussion, singing, movement, listening	PO2 Interactive, backing tracks, percussion, singing, movement, listening	PO3 Performance-based, guitar accompaniment, clients singing along to reminiscence songs
Was a member/members of staff seated amongst clients at the beginning of the session?	NO	YES (CA)	NO
Did they stay throughout the session?	N/A	NO – left after 40 minutes having been summoned	N/A
Was a member/members of staff standing in the room but away from the central action?	YES	YES –	NO
Did they stay throughout the session?	NO - CA1 stood in doorway watching, on four occasions, remaining for between 1 to 3 minutes	NO - two or three staff stood together in the doorway at times for various durations	N/A
Did a member of staff enter the activity space during the session?	YES – CA2 to escort agitated client out of the room	YES – collected a bell shaker from MPs box and played it	YES – to collect client for treatment
Did staff sing?	NO	YES – spontaneously initiated 'My Old Man'.	N/A

(PO – Participant Observation; CA – Care Assistant; MP – Music Practitioner)

Levels at which staff took part in musician-led activities were recorded in the three participant observations (PO) of musician-practitioner led activity sessions. Table 6.29 shows staff interaction levels during each session. Apart from one care assistant, who was present in PO2 for around 40 minutes until summoned by another member of staff, no other staff appeared to intend to take an interactive part in the sessions. However, in PO1 and PO2, some staff did stand in the room but away from the central action, usually standing in, or near the doorway. No staff stayed for the duration of any session. One member of staff entered the activity space during PO1 to escort an apparently agitated client out of the room, and one entered the space during PO2 to participate musically. On this occasion, the staff member walked into the space in an exaggerated rhythmic fashion at the end of an activity in which clients had sung a medley of old-time songs. She collected a shaker from the music practitioner's box and sang the first two lines of the song 'My Old Man said Follow the Van'.

In a face-to-face interview, Music Practitioner 1 offered a view that staff often appear to enjoy her sessions. However, she observed that staff tended to join in more when grouped together.

"In some places the staff clearly enjoy having a bit of jolly music and being able to shake a tambourine for their own enjoyment and you know - completely separate from the residents."

(Music Practitioner 1)

E.2.2 Clarity of role

For some focus group participants, uncertainty around their role in musician-led activities appeared to create some tension.

"Most of them [musicians] encourage residents to join in... Well, when he's singing away you don't know if you should join in, even if some of them [clients] are. He don't give us the words, does he? So you don't really..."

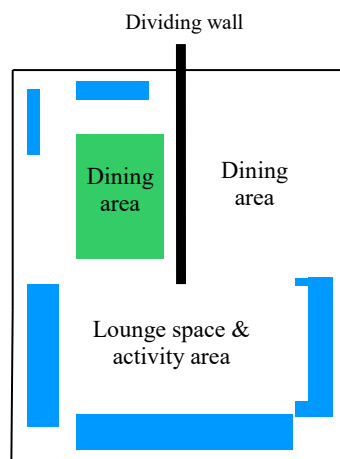
(Care Assistant 1: Fg15)

"Well, it's not really for staff. The other lady, she's very good, she leaps about and gets them all rattling things, but staff don't go in, not really; sometimes."

(Care Assistant 2: Fg15)

Evidence of these tensions was apparent in the participant observations. Participant observation 1 took place in the lounge area of a residential care setting. The lounge was part of a three-section open-plan space.

Figure 6.30: Participant observation 1: Room layout



(Green area - table used for staff training; Blue areas – seating for clients)

Figure 6.30 shows how the space was divided. Chairs were set out in rows around the perimeter of the rooms. No one was present in the dining area but three members of staff, who were apparently engaged in a training discussion, were seated at a table in the second lounge area.

During the session, the music practitioner made no reference to a care assistant who appeared at the open entrance into the activity area on four occasions, remaining there, apparently watching the activities for some minutes. On one occasion, the music practitioner directly passed the care assistant by as she handed out shakers to clients. No interaction took place between the music practitioner and the training group of staff. In general, each party appeared to retain a role that had no real impact on the role of the other. This was other than, at times, negatively, for example, when the raised voices of staff taking part in the training session interfered with a relaxation activity led by the music practitioner.

The second participant observation took place in a lounge in day care unit within a mixed care setting.

Figure 6.31: Participant observation 2 room layout

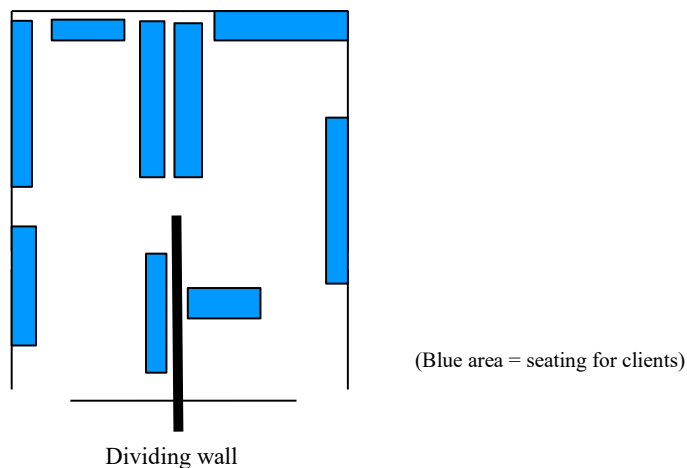


Figure 6.31 shows the room layout. Four members of staff were observed taking part in this session, three on the periphery and one in the centre of the activity. The latter was an apparently shy care assistant who was seated between clients at the beginning of the

session. The music practitioner made no reference to the care assistant. When a neighbouring client appeared to have difficulty understanding the music practitioner's offer of a bell shaker, no interaction occurred between the care assistant and the music practitioner. The music practitioner did not offer the care assistant an instrument or a word sheet during the session, either on behalf of a client, or for the care assistant herself. A group of two or three staff appeared in the doorway of the activity room on several occasions, remaining for various durations. They interacted briefly with one another, and with clients seated close to the door, by dancing and singing together. They did not interact with the music practitioner. The music practitioner made little reference to the member of staff who fully entered the activity area and began to sing 'My old Man said Follow the Van'. When the music practitioner said pleasantly, 'Oh, she's off!' and continued to hand out word sheets for other songs, the member of staff stopped singing, spoke briefly to a client and then left the room.

Although there appeared an aspiration amongst some staff to participate in music activity sessions, these collective observations illustrated tensions in terms of their expected role.

The issue of role was expressed from a wider perspective by two focus group participants who talked about the challenge of balancing their professional role with human-to-human connections. One said:

"I know we are here to work, but when she [client] was dying, I had her in my arms and was singing our song. It broke my heart, 'cos she was my princess."
(Care Assistant: Fg6).

In answer to objective E, fewer than half of the questionnaire survey respondents reported having never engaged in staff-led music activities and just over a third had never engaged in musician-led activities. In terms of the former, some ambiguity arose over the definition of staff-led music activities. There emerged in the focus group discussions examples of a whole range of short, spontaneous singing and movement interactions that may not have been interpreted by survey respondents as 'staff-led music activities'.

Confidence to participate or initiate staff-led activities was activity-dependent. Whilst most participants would initiate recorded background music, the more the activity required live interaction, the less confident most participants became. Very few reported the confidence to lead live singing activities. Most participants believed that they were, in theory, partly responsible for including music in care-giving to promote the holistic well-being for their clients, but most felt that staff who were specifically employed to promote activities were better qualified/experienced to on this role.

Staff participation in musician-led activities seemed generally limited. Some focus group participants posited possible reasons. These largely centred on how staff judged the quality of their singing voice and a lack of clarity in terms of their role in these activities.

Results Objective F

Staff perceptions of the value of music in their care setting

Objective F: to investigate staff perceptions of the value of music in their care setting was addressed through the questionnaire survey, focus group discussions and face-to-face interviews.

Figure 6.32: Objective F: main themes and emergent sub themes

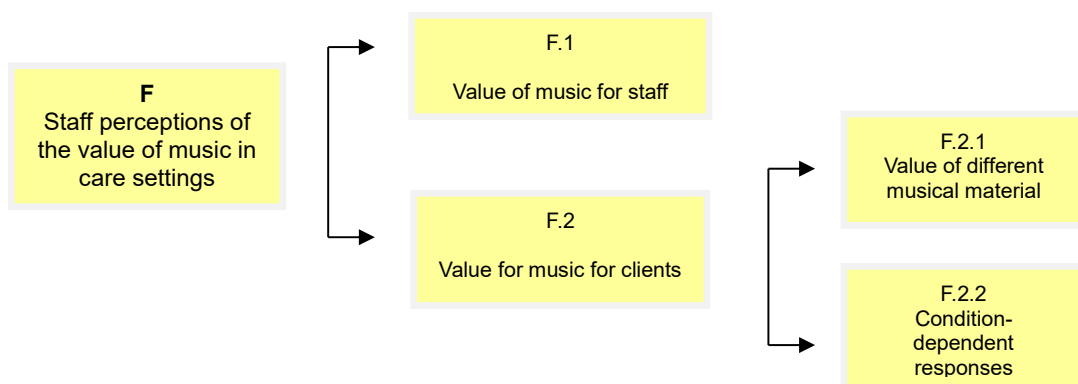


Figure 6.32 shows that themes emerging from the data on staff perceptions of the value of music related to impact on staff themselves and for their clients.

F.1 Value of music for staff

Results from the questionnaire survey showed that 6.4% (n = 7) agreed with the statement, 'Music in the [care] home would annoy more staff than it pleases'. Around half of the focus group participants offered a view on the value of music for staff. Most agreed that its presence can be an important factor in maintaining staff morale but that this was largely based on the staff benefiting from music primarily designed for clients. Three focus groups highlighted the positive effect of playing music that spans the taste of both staff and clients. They referred specifically to having the radio tuned to Capital Radio in communal areas, playing recorded Irish folk and Latin American dance music and playing certain types of 'cheerful' music. The following exchange illustrated the notion of mutual benefit and a cyclical pattern of well-being.

Researcher - *"What [music] would you put on [in communal areas]?"*

Care Assistant 1 - *"**Boyzone** is good; it's cheerful music, they [clients] like it and the staff feel cheerful when they come in and it's on. It makes it better for them [clients] because the staff feel happy."*

Registered Nurse - *"Yes. Obviously, that makes for a much nicer work environment. If the clients are happy then you feel that you can achieve something."*

Care Assistant 2 - *"Exactly yeah. The other way round as well, like if you're happy it makes them happy. And then it's a happy home so...."*

(Fg13)

Issues of mutual value were highlighted specifically in reference to staff-performance activities, as in the pantomime and variety show. Participants who engaged in these activities reported high levels of benefit for both themselves and their clients.

The potential for negative responses from staff to music in their care settings was brought up by a small number of participants. These included the clashing of musical tastes. One participant expressed annoyance at having to repeatedly listen to World War II songs playing in the clients' lounge, in which staff also took their breaks. Another negative response centred on the timing of activities creating practical difficulties.

One focus group of four discussed what they would like to hear when older. Their taste was varied, ranging from jazz to country music and rock music. All four participants could identify a favourite piece of music that induced an emotional response, such as crying, laughing or feeling 'goose pimply'. However, some of these favoured pieces others found annoying. In this discussion, each of the participants expressed the desire avoid getting 'old enough' to have to listen to someone else's choice of music, or not to be in control of when and for how long it is played. They agreed that the use of personal audio equipment to provide individual choices might be a preferred option.

F.2 Value of music for clients

Most focus group discussions that focused on the value of music in the workplace did so from the perspective of its value for clients, rather than for staff.

	Number replying	Number and percentage agreeing		Number and percentage not sure		Numbers and percentage disagreeing	
		n	%	n	%	n	%
Music in the home does not make any particular difference to clients	106	10	9.4	18	17	78	73.6
Music in care settings can improve clients' overall quality of life	108	88	81.5		-	20	18.5

Results from the questionnaire survey showed that 9.4% of respondents (n = 10) agreed with the statement, 'Music in the home does not make any particular difference to clients' and 81.5% (n = 88) agreed with the statement, 'Music in care settings can improve clients' overall quality of life' (Table 6.33). These results corresponded to focus group discussions in which the majority of participants agreed that music was a valuable mechanism for supporting the well-being of clients. Many participants made overarching statements, such as 'They all love it', and 'Music is good for everyone'. Others were more circumspect, acknowledging client's various relationships with music.

The questionnaire survey investigated staff perceptions of the value of activities led by visiting musicians versus staff-led activities.

	Number replying	Number and percentage agreeing		Number and percentage not sure		Number and percentage disagreeing	
		n	%	n	%	n	%
Clients prefer music activities led by visiting musicians rather than staff-led activities	109	43	39.4	33	30.3	33	30.3
Clients prefer staff-led activities rather than music activities led by visiting musicians	109	10	9.20	46	42.2	53	48.6
Clients prefer to join in rather than just listen	109	66	60.00	29	26.60	14	12.80

Table 6.34 shows that responses to the statement, 'Most clients seem to prefer music with visiting musicians rather than staff-led sessions', were mixed, with 39.4% (n = 43) of respondents agreeing, 33.3% (n = 33) 'not sure' and 33.3% (n = 33) disagreeing. However, very few respondents (9.2% n = 10) agreed that clients preferred music activities led by staff. In terms of preferences for passive listening activities compared with interactive activities, 60% (n = 66) of respondents agreed with the statement, 'Clients prefer to join in rather than just listen'.

Around a fifth of the focus groups offered a view on these findings. There was a general tendency for participants to associate live, interactive music with visiting musicians because of their apparent belief in musicians' expertise. Most participants considered these interactions to be more beneficial to clients than recorded music, which was generally considered the remit of staff. However, a small number of participants pointed out that staff-led recorded music activities may be more beneficial at times because of the number of clients who may benefit at one time and because the unfamiliar presence of a visiting musician and a subsequent change to the normal routine, could cause distress in some clients. The exchanges below were illustrative of these issues.

Researcher - *"Do they [clients] enjoy the music man?"*

Senior Care Assistant - *"They're happy. The majority. Very few of them don't*

like it and we have the advantage of having two lounges here so if, for instance we have the music-man coming on Thursday afternoon, we have a selected group coming in here to listen and some come from upstairs."

Researcher - *"Do they elect to come in?"*

Senior Care Assistant - *"Oh yes. They know the music-man is coming in and we now know, having looked after them for some time, who likes music and who doesn't... We've one or two who can actually look forward to it. They set their calendar. [Client], in particular. And one lady's daughter comes in specially for it too."*

(Fg12)

Care Assistant - *"Some of them [clients] don't like it. Like [client], she always agitated when people come in."*

(Fg6)

Two focus groups discussed factors that may inhibit clients' enjoyment of musician-led activities. These included negative feelings around playing percussion instruments, due to shyness and/or a sense of being infantilised. In addition, some participants felt that some clients may feel manipulated into singing in order to conform to social pleasantries. Comments made by some participants from the older people's focus group illustrated these issues.

Older Community Member - *"No thanks. I feel daft doing the rattle things. You're alright but we did that at school."*

Older Community Member - *"We HAD to sing at school, everyday, to "'cleanse the soul'". And got the cane if you didn't do it loud enough or did it out of tune. That's why I don't do singing now. Don't get me wrong... I love this [community, musician-led activity] I'm happy to just sit here and listen."*

(Fg18)

F.2.1 Value of different musical material

Around two-thirds of the focus group participants gave their views on the value of different types of musical material for clients. Many participants reported that the choice of musical material generally used by visiting musicians tended to be from around the same two or three eras, with an emphasis on music from around World War II. This was also commonly reflected in the choice of recorded music in staff-initiated activities. Other music to be considered by participants as popular with clients were ballads from the 1930's, 1940s, 1950s and 1960s, dance band music, Scottish or Irish dance music and

songs from traditional musical shows, such as Oklahoma and Carousel.

The perceived importance of playing familiar music was frequently raised. In rationalising the apparent benefits of World War II music, references were commonly made to long-term, or childhood memories and the symbolism of comradeship.

Care Assistant 1 - *"Sometimes we turn on the music after dinner."*

Researcher - *"How do you choose the music?"*

Care Assistant 3 - *"We do...like for them, because they're all dementia. We play the music that they know. If we put on music that is not familiar they don't listen. Sometimes we put on music that is not familiar and they do like this (hands over eyes) they cover their eyes, but when we play wartime songs, they love that music."*

Care Assistant 1 - *'They all like the war songs.'*

(Fg8)

It was interesting to note that, in order to familiarise themselves with popular World War II songs, all of the Philippine-born care-givers in one care setting carried post cards on which were written the lyrics.

Most participants emphasised the perceived value of familiar songs a very small number, advocated the use of unfamiliar songs. One focus group suggested that songs for clients need not be confined to the *'usual old songs'*, providing new songs have certain characteristics, such as *'it's quiet, has a good tune and is sort of the same all the way through'*. One exchange showed how opportunities were taken to introduce unfamiliar music.

Researcher - (To CA1) *"So do you sing in the home?"*

Care Assistant 1 - *"Yeah, I sing".*

Researcher *"What do you sing?"*

Care Assistant 1 - *"Modern songs."*

Care Assistant 2 - *"Reggae!"* (laughter)

Registered Nurse – *"R 'n B - that's what really does it."*

Care Assistant 1 - *"You wouldn't know anything I sing; American songs more than British."*

Researcher - *"Would the clients join in?"*

Care Assistant 1 - *"They wouldn't know it... but it's still... Sometimes they join in the rhythm even though they don't know it."*

Senior Care Assistant - *"I put a song in their heads; I repeat the same song until I get a reaction."*

Researcher - *"Oh do you? So people learn it?"*

Senior Care Assistant - *"Oh, they look at me sometimes; they think first of all, 'What is she doing'? So then I sing it a second time and one person may join in and then I sing it for the third or fourth or fifth time then you get five or six people joining in. Then of course once the song is stuck in someone's head they just keep singing it."*

(Fg6)

Participants in two other focus groups referred to specific music practitioner-led activities that involved clients improvising with percussion instruments and singing. The common consensus was that these activities may have the potential to engage clients in a way that engaging with familiar music cannot achieve but the benefits were not immediately obvious. However, most participants expressed perceived limitations for clients with profound cognitive impairment, believing them incapable or less able to contribute to this type of activity.

F.2.2 Condition-dependant responses

Many focus group participants believed in the positive value of music for most clients at some level, irrespective of their morbid conditions and the stages of those conditions. A few however, referred to stage-related disabilities that could limit the value of music for some clients. One participant referred to one client for whom she perceived *"Nothing gets through"* and another suggested that music on the radio, television or CD player would *"make no difference"* to some clients who do not communicate. One participant believed that music would not *"make sense"* to clients with very late stage dementia and another said *"Well, some of the clients are like sense-less. Like they don't have a reaction to music or a musician."*

In answer to objective F, the value of music for staff in care settings was generally thought to be a bi-product of music activities set up for clients. However, participants who had engaged in performing to clients, that is a staff pantomime and a variety show, felt that this form of activity was of particular value to staff as well as to clients. Although there was some ambiguity in how survey respondents compared client preferences to musician-led activities versus staff-led activities, most agreed that clients gained more benefit from live, interactive music than passive listening. Most focus group participants agreed that music was of value to most clients, but a few highlighted their perceptions of limitations for clients with profound cognitive impairment.

Results Objective G

Staff perceptions of the impact of music on clients

Objective G: To examine staff perceptions of the impact of music on their clients was addressed through the questionnaire survey and focus group discussions.

Figure 6.35: Objective G: main theme and emergent sub themes

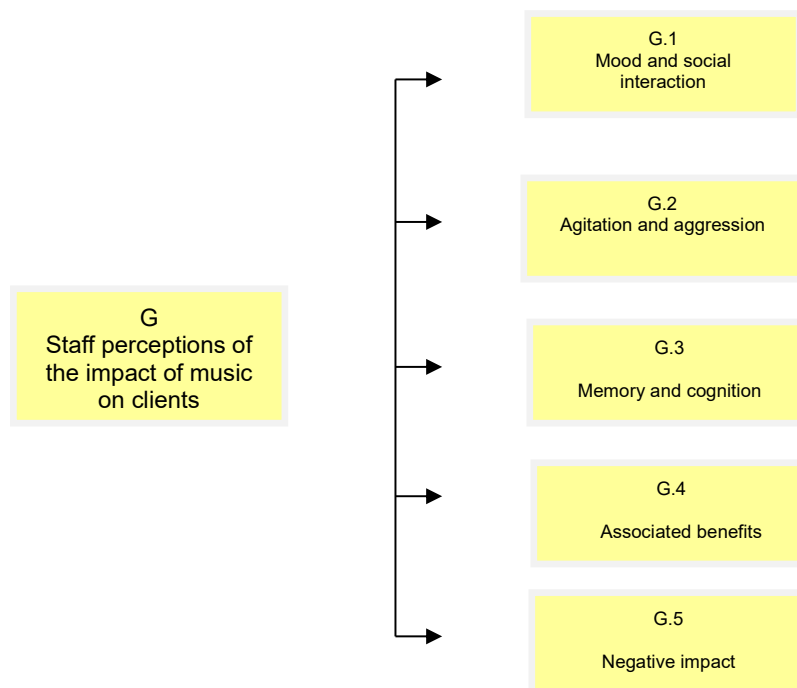


Figure 6.35 shows that five themes emerged from the data relating to mood and social interaction, agitation and aggression, memory and cognition, associated benefits of music and negative impact.

The impact of music on quality of life.

		Number replying	Number and percentage agreeing		Number and percentage not sure		Number and percentage disagreeing	
			n	%	n	%	n	%
Overall quality of life	Music can help improve overall quality of life	108	88	81.5	-	-	20	18.5
	Clients would benefit from daily music	109	95	87.2	10	9.2	4	3.7
Mood and social interaction	Live music does lift the mood of clients for some afterwards	109	99	90.8	6	5.5	4	3.7
	Live music does not affect mood of client	106	38	35.8	25	23.6	43	38.4
	Music can help clients communicate better	108	57	52.6	-	-	51	47.2
	Music can help clients and staff relate better	107	60	53.6	-	-	47	43.5
	Music can help clients relate better with family	108	48	44.4	-	-	60	55.6
Aggression and agitation	Music can help clients express feelings	109	87	79.8	-	-	22	20.2
Memory and cognition	Music can give insights into clients' abilities	107	77	72	-	-	30	28
	Music can help clients remember	108	66	61.1	-	-	42	38.9
Associated benefits	Music can help clients move better	108	76	70.4	-	-	32	29.6

Table 6.36 shows the questionnaire survey results of staff perceptions of the role of music to affect a number of quality of life indicators. Over four-fifths of respondents (81.5%) agreed with the overarching statement, 'Music in the home would help improve clients' overall quality of life' and nearly nine-tenths (87.2%) agreed with the statement, 'Clients would benefit from daily music. In terms of music's capacity to impact on mood and social interaction, nine-tenths (90.8%) also agreed that 'Live music does lift the mood of

clients'. Around half agreed with the statements, 'Music can help clients communicate better', and 'Music can help clients and staff relate better', and just under half (44.4%) agreed with the statement, 'Music can help clients relate better to their family'. Four-fifths (79.8%) of respondents agreed with the statement, 'Music can help clients express feelings'. In terms of music's capacity to aid memory and cognition, nearly two-thirds (61.1%) agreed with the statement, 'Music can help clients remember'. Just under four-fifths (72%) agreed with the statements, 'Music can give insight into clients abilities'. Relating to associated benefits of music, around four-fifths (70.4%) also agreed with the statement, 'Music can help clients move better'. Each of the themes above were explored and elaborated upon in focus group discussions.

G.1.1 Mood and social interaction

Around three-quarters of focus groups discussed music-induced mood improvement as a pre-cursor to heightened social interaction for clients. One care setting administrator contrasted the responses of clients sitting in the lounge during no activity, where she observed most were asleep, to the motivated responses of clients during music activity sessions.

Administrator - "Oh yeah, as you see in here [no music] they're sitting in here falling asleep. We have a music-man every couple of weeks and we have that lady come down and they get up, have a sing-song, and they enjoy it; keeps them motivated, they need something... Yeah, they're happy."

CA - 'Yeah, it makes them happy, because then they want to join in.'

(Fg15)

Two care assistants highlighted the potential for music activities to engage clients socially.

"I've actually seen one woman, she would never mix in, she would stand against the wall, she was so thin and she'd never mix in, but as soon as we started the music and started dancing she would come up and all the others would come and we'd all start waltzing, waltzing around. We could all waltz with each other. And that's how...they were brilliant."

(Care Assistant: Fg5)

'They just come out of their shell; they become people instead of this quiet person, suddenly they're laughing; they're joking, they even want to get up and have a dance... I want to get up and go over there; I want to dance with her; she's dancing, can I get up? And she does.'

(Care Assistant 2: Fg3)

'I just think music is... well you see those people [clients] sitting in there, bless them, you have someone who's been confused all day, doesn't know where she's going, doesn't know what's happening and you bring music in she knows this music, she knows this song and she becomes part of the community; she's not wandering around, she's not lost; she's part of this environment and it's so lovely to see. I think we should have music every day.'

(Registered Nurse: Fg6)

The words, 'enjoy/enjoyment' and 'happy/happiness' were frequently used by focus group participants to describe the effect of music on clients. A few focus groups reported improved mood amongst clients associated with anticipation of a music activities and a positive residual effect. One exchange highlighted the potential for music activities to provide a focus for the week.

Researcher - *"Do they look forward to the music man coming. Do you think it makes any difference to their day, if you were to tell them he was coming?"*

Registered Nurse - *"A lot of them said they really liked it; they enjoyed it. Ann was saying today she enjoyed yesterday's [activity]."*

Care Assistant - *"It does actually... You can see the difference in her excitement. Her face lights up, her whole face lights up. When you say the music-man is coming you see her face light up."*

Researcher - *"So she has remembered that from yesterday?"*

Registered Nurse - *"Yes, she told me this morning when I went into her that she enjoyed yesterday."*

Care Assistant - *"And Jim's still talking about it. He told night staff all about it. He saw friends from his other home."*

Registered Nurse - *"That's right, it's like a little meeting point where people gather have a sing, have a dance, have a chat."*

(Fg6)

Two focus groups referred to depression amongst clients, which was considered a primary de-motivator for social interaction. Both groups believed that depression in care settings is often the result of clients having too little opportunity to express their emotions. The following exchange illustrated cathartic experiences for two clients, one with moderate

dementia and another with severe dementia-related *dysphasia* (difficulty with speech).

Registered Nurse - (To Informal Carer, referring to caring for her spouse) *"Yes, when I took [your husband] out and 'Abide with Me' came on and I looked across at him and oh, floods of tears."*

Informal Carer - *"Really... I never ever saw him cry."*

Registered Nurse - *"Yes, it was Aled Jones I think and we had the CD on and I look across – not just tears, they were rolling."*

Care Assistant - *"... but one lady who is really quiet, but she likes to try to escape and doesn't really say anything. She just says 'Ticket' mostly. But as soon as they [brass quartet] started playing, as you described, loads of tears just coming. I looked across, obviously just bringing back loads of memories. I sat with her. She was very happy to stay and listen, but it all came out in tears because she can't really talk about it."*

(Fg17)

G.1.2 Agitation and aggression

In addition to music's potential to change mood and to induce cathartic responses, around a third of focus group participants commented music's effect on levels of agitation and aggression amongst clients. One informal carer reported highly significant improvements to her husband's levels of agitation once engaged with music, stating, *"The difference it made to my husband was fantastic."* Other comments related to the calming influence of background music in communal areas, background music as a therapeutic tool to calm an agitated client during washing and music used at mealtimes. The following comments were illustrative of the varying outcomes, which ranged from positive effect to a neutral or negative effect.

Researcher - *"So, do you think that music is helpful for people with agitation?"*

Care Assistant 1 - *"Some of them, I think so, but some of them are just confused."*

Care Assistant 2 - *"Actually in our experience, for some when there is agitation they will calm down, not all; it varies."*

Registered Nurse – *"Some of them don't like it. Like Ann, she's always agitated when people come in. But that's no different, she's always agitated."*

(Fg3)

Researcher - *"Why does music calm clients, do you think?"*

Senior Care Assistant – *"I don't actually think there's an answer to that honestly."*

Just people who do enjoy music, who listen to music are that much happier, that much calmer, I mean we have one or two that after the sessions they can be very agitated."

(Fg12)

G.1.3 Music, memory and cognition

Apart from focus group participants offering no specific answer to the question, 'Why do clients enjoy music?', the most common response centred on eliciting memories. The following comment was illustrative of many participants' views on the value of music as a reminiscence tool.

'The other thing is that it always takes you back somewhere. You know, you hear a song and you're instantly back where you first heard it; whether it was your husband or your very first boyfriend or you heard it as a kid at school, you know it takes you instantly back doesn't it and then you reminisce, then they want to talk, they want to tell you what they are remembering. I think that's also what it's good for. I think it's good for everything. I love it.'

(Care Assistant: Fg4)

An emphasis on World War II songs re-occurred in terms of reminiscence. Participants explained their perspective on the value in terms of the music's ability to trigger long memory. This was thought to be associated with childhood memories during the common experience of the war. This latter point was sometimes paralleled with affectionate memories of that staff have of their own musical memories in childhood.

A number of comments indicated perceptions of a link between with music-induced memory and cognitive exercise for clients. A small number of participants expressed an interest in clients' abilities to remember the words of songs even when their memory usually appears severely hampered. They used words, such as 'amazing' and 'incredible' to describe their reactions. The following exchange was illustrative of suggestions that songs can be used as a positive cognitive stimulant.

Researcher- *"What is it about music do you think?"*

Home owner - *"Oh, their memories, their times, their memories, that they were good. That's what I'm trying to, sort of, put across to you. Because they have wonderful memories and they can use their brains on that."*

(Fg5)

G.1.4. Associated benefits

Many participants automatically associated music with dance or movement, as if the two activities were synonymous. This was illustrated by responses to the question, 'Do you have much music in the home?' to which one participant answered, *“Yes, we had armchair aerobics the other day”*. Other responses included, *“Oh yeah, they love music, they love to dance”*; *“They love having a little jig”*, and, *“I'm always singing and dancing”*. The comment, *“It must be comforting, because surely everyone has been sung to as a child or baby”*, related to rocking a client whilst singing.

Other associated benefits around music were discussed theoretically. One focus group concurred that music in the background whilst administering hand massage to clients could add overall therapeutic value. One participant said, *“It would make them feel calmer”*. No participating group reported using multi-sensory interventions involving auditory, olfactory and sensory stimulation. One focus group doubted the value of frequently-administered multi-sensory experiences for clients because of the potential for habituation, which the commentators believed would quickly lead to boredom and/or agitated behaviour.

G.1.5 Negative impact

	Number responding	Number and percentage agreeing		Number and percentage not sure		Number and percentage disagreeing	
		n	%	n	%	n	%
Music would annoy most clients	109	10	9.2	-	-	99	90.8
Music could upset clients	108	57	52.8	-	-	51	47.2
Music would upset routine	109	12	11	-	-	97	89

Table 6.36 shows that over 9.2% (n = 10) of questionnaire survey respondents agreed with the statement ‘Music in the home would annoy more clients than it pleases’ and over half (52.8% n = 57) agreed that ‘Music could upset clients’. Eleven percent (n = 12) agreed that music would upset the home's routine. A small number of focus group participants posited reasons for these results. Potential to upset clients centred on songs

invoking sad memories and distress caused by changes to room layout/seating arrangements in the event of visiting musicians. The presence of unfamiliar people and/or musical paraphernalia and the loss of ability to sing were also put forward as possible distress-inducing for some clients. One discussion group expressed the potential for music to annoy clients by staff misjudging their musical taste or by overwhelming them with too much extraneous noise.

The following focus group exchange referred to the perceived challenges of staff-led singing, suggesting that this activity is challenging to administer and could impact negatively on some clients.

Researcher - *"What about, for people who feel comfortable with it, actually singing. So the carer would be singing. Would that work?"*

Registered Nurse 2 - *"Think it's very difficult."*

Registered Nurse 1 - *"Yes, it's the time factor."*

Care Assistant - *"You need to constantly need to reassure them all the time; you know; we're doing this; washing you here; we're putting on this or the other."*

Registered Nurse 2 - *"Also it would be a new thing; so instantly they would be, "Oh, what is that?""*

Care Assistant - *"It would be like someone else being in their room; a lot of them need a one to one and a lot of them would think there was someone else in their room and they'd want to know who that was."*

(Fg13)

One focus group of four participants suggested an impropriety in singing relating professional status. They suggested that care setting owners singing in the workplace might be interpreted by junior staff as frivolous behaviour and therefore serve to jeopardise the former's authority. The group also felt that singing at certain times when reverence is required, such as in end-of-life situations, might be inappropriate.

In answer to objective G, more than two-thirds of the questionnaire respondents and focus group participants believed that music could improve clients' moods, levels of social interaction and memory and cognition levels. Over half also believed that music could

reduce levels of agitation and aggression but around one-tenth indicated intransigence towards agitation and aggression in some clients for whom they believed no type intervention to be affective. Around half of participants also believed that music could 'upset' clients. This centred on evoking sad memories and on changes to routine when preparing for a visiting musician. In terms of staff singing to clients during care-giving, the unusual nature of the interaction and potential for over-stimulation were given as potential reasons for causing clients distress.

Results Objective H

Staff perceptions of the practicalities of including music in their care settings

Objective H: To investigate staff perceptions of the practicalities of including music in their care settings was addressed through the questionnaire survey and focus group discussions.

Figure 6.38 Objective H: main themes and emergent sub themes

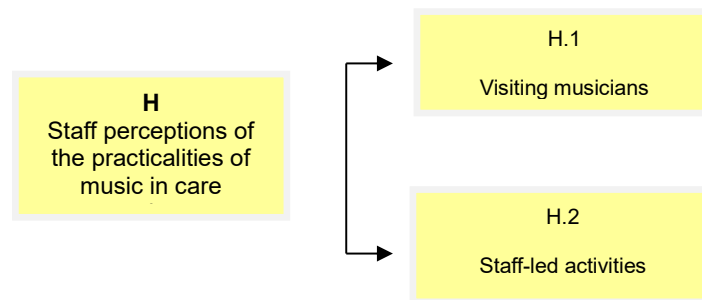


Figure 6.38 shows that two themes emerged from the data. These were staff perceptions of the practicalities of visiting musicians and practicalities around staff-led activities.

H.1 Practicalities of including visiting musicians in care settings

	Number responding	Numbers and valid percentage agreeing		Numbers and valid percentage not sure		Numbers and valid percentage disagreeing	
		n	%	n	%	n	%
		Music in the home would annoy more staff than it pleases	109	7	6.4	-	-

Although the majority of questionnaire survey responses on the value of music for clients were positive, Table 6.39 shows that a small minority (6.4% n = 7) of questionnaire survey respondents agreed with the statement 'Music in the [care] home would annoy more staff than it pleases'. Participants from three focus groups offered a view on this. One group attributed annoyance around music to the timing and location of sessions with visiting musicians. These were often just after lunch. In this case, staff highlighted problems of 'slow-eaters', who staff may be helping, which had potential to delay the start of a session, or to disrupt the client to such an extent as to impede his/her nutritional intake. Another problem related to the practicalities of organising clients for sessions at a time when hand-over meetings with all staff usually took place and/or whilst staff were trying to attend to the normal post-lunch needs of their clients, such as toileting or preparing them for a rest in their rooms.

H.2 Practicalities of including staff-led music activities in care settings

Timing and time factors were also discussed by participants, in relation to staff-led music activities.

A discussion on the optimum timing for activities, in which the researcher brought up the *sundowning* phenomenon, illustrated that staff might not view music as a priority in terms of care interventions.

Researcher - *"Do you know the 'sundowning' phenomenon? When people with confusion get worse when the sun goes down...."*

Care Assistant 3 - *"Yeah, we notice that, don't we?"*

Researcher - *"Do you think music activities at that time might help. Stop them being restless?"*

Care Assistant 2 - *"No, not really. It's time. Everything is time."*

Care Assistant 3 - *"Specially at teatime."*

(FgK)

Around three-quarters of participants reported that, apart from activating recorded music, fitting other music activities into their day-to-day work was challenging. The few participants who reported frequently initiating singing with clients, tended to agree that this was the most practical way of using music. In disagreement, one participant felt that singing in this way would distract her and colleagues from their work.

In answer to objective H, staff who commented on the practicalities of music in care settings raised a small number of potentially inhibiting factors. These largely centred on the timing of activity sessions led by visiting musicians, and time factors associated with staff availability for both musician-led activities and staff-led activities.

Results Objective J

Staff attitudes towards music-related training.

Objective J: To investigate staff attitudes to music-related training was addressed through the questionnaire survey and focus group discussions.

Figure 6.40: Objective J: main themes and emergent sub themes

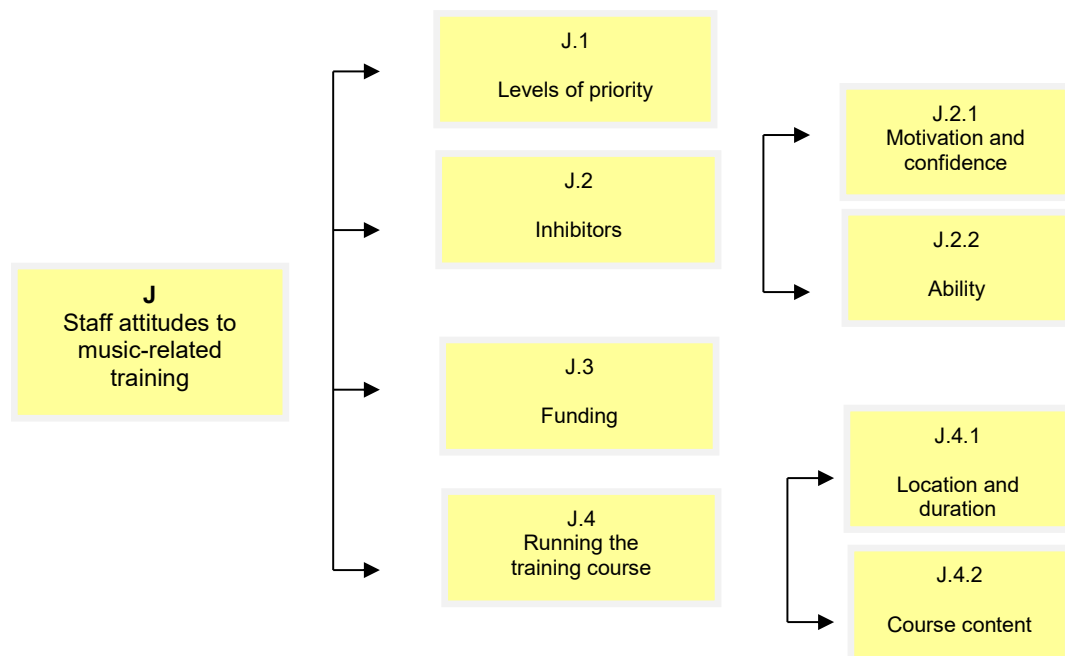


Figure 6.40 shows that four themes emerged from the data on staff attitudes towards music-related training. These were levels of priority, motivation, funding and training-course characteristics.

	Number responding	Number and valid percentage agreeing		Number and valid percentage not sure		Number and valid percentage disagreeing	
		n	%	n	%	n	%
I would use music more if training was available	105	61	58.1	29	27.6	15	14.3

Table 6.41 shows that 58.1% (n = 61) of questionnaire survey respondents agreed with the statement, 'I would personally use music more with clients if some form of training was available'. Just over a quarter (27.6% n = 29) were unsure and 14.3% (n =15) disagreed. Seven people did not provide the relevant data. This was the highest missing value in the questionnaire survey.

J.1 Levels of priority

Around half of the focus groups discussed the notion of music-related training in care settings. Eight participants in three focus groups were asked how they would rate the level of priority of training for care staff to use music with their clients, using a scale of one to ten, where one is low.

Participant	Rating out of 10	Participant	Rating out of 10
Care Assistant 1: Fg6	3	Care Assistant 1: Fg8	4
Care Assistant 2: Fg6	8	Care Assistant 2: Fg8	5
Care Assistant 3: Fg6	2	Care Assistant 1: Fg13	5
Registered Nurse: Fg6	7	Care Assistant 2: Fg13	7

Table 6.42 shows that five out of eight participants rated the level of priority at five or less, two rated it at seven and one at eight. It was interesting to note that the registered nurses all gave a rating of five or above and, apart from one care assistant, who gave a rating of eight, all others gave a rating of five or less.

Accompanying comments from some of the participants who rated prioritising music related training seven or above, appeared to illustrate an embrace of music not only as an integral part of holistic care-giving but also in terms of supporting their own development and well-being. The following comments illustrate attitudes from three highest raters.

"Yeah definitely, because it could be. I mean you think it would just be such a little part of it but it's not, then that can be taken into the workplace. I mean a lot of girls [care-staff] and nurses think, yeah, what's that got to do with our jobs, but it's got a hell of a lot to do with it."

(Care Assistant 2: Fg13)

"Yeah. Anything to help the residents; yeah if it helps them, then I'm all for it."

(Care Assistant: 2: Fg6)

"I think I would, yeah. Because it would be a skill that I could take with me to another job, so it's not necessarily for dementia or residential whatever... It's a skill for life..."

(Registered Nurse: Fg 6)

J.2 Perceived inhibitors to music-related training

Some of the low raters highlighted a number of inhibitors to music-related training. The most commonly expressed centred on low levels of staffing in care settings, as illustrated by the following two comments. One who rated music-related training at two out of ten said:

"We have training for other things but that's compulsory, like manual handling and hygiene but the problem is if someone's off sick or a resident is playing up; we can't leave the floor then"

(Care Assistant 3: Fg6)

Another, who rated the training at five out of ten, pointed out the potential for staff to have to engage in extra duties in order to free them to attend training courses:

"We have to come in before [training days] and get the clients up and washed and breakfast by 10 o'clock, then we can go on the course."

(Care Assistant 1: Fg13)

The last comment also referred to the challenges for care settings to uphold mandatory training. When asked if music-related training would be prioritised, many participants disagreed.

Registered Manager - *"I wouldn't put it in with mandatory training".*

Senior Care Assistant - *"No, I don't think it would. Because at the moment there are an awful lot of courses that we have to go on. I've got three in three weeks and I'm doing an NVQ."* (Fg2)

"We get five days training, we have to do five days, but sometimes we can't do it because there aren't the staff."

(Senior Care Assistant: Fg9)

Researcher - *"Do you think it [music relate training] would be something that would be prioritised?"*

Care Assistant 3 – *"No I don't think it would be. We've got, at the moment, most people are either just beginning to start an NVQ course or are in the middle of an NVQ course."*

Care Assistant 2 – *"And I'm starting a course on, we're starting a course on Thursday aren't we, Infection Control."*

Care Assistant 3 – *"And then we have the regular updates on fire...So I really...mmm."*

Researcher - *"So that kind of saturates the time available?"*

ALL - *"Yes."*

(Fg8)

J.2.1 Motivation and confidence

A number of personal issues were also raised by participants in relation music-related training for staff. Some pointed out that a few staff are reluctant to attend training of any form. One care home manager suggested that this occurs partly because staff are not offered any financial incentive linked to training. Even though staff are paid for their time, staff shortages often mean that they attend training on their normal days off. It was suggested that this can clash with family and personal commitments and for some, a second part-time job.

A few comments illustrated that lack of confidence can impact of staff willingness to engage in training. Four participants indicated that they would attend training with well-known colleagues but not alone. Issues of confidence and motivation to attend training courses arose in around a quarter of focus groups. One registered manager suggested that a group generates its own level of motivation. She had observed that if a strong personality in a group of colleagues appears unmotivated, others will follow suit. The participant reported that motivating staff was one of the greatest challenges in her role as manager.

J.2.2. Ability

In terms of music-related training, the following comment illustrated a common concern amongst at least a quarter of the participants:

“Yes, I’m sure it [music-related] training could be fitted in. But I don’t have to sing though do I?”

(Registered Manager: Fg2)

It emerged that a reluctance to agree to take part in principle may often centre on participants' pre-conceptions about their musical abilities. One manager agreed that training was a good idea, but only for staff who could sing or who were musical. Another participant suggested that training could be confined to activities coordinators, as they are more used to working with art media. Participants in one focus group pointed out that limited academic ability or language issues may inhibit learning ability.

J.3 Funding for music-related training

Two focus groups raised issues of funding for training. One manager's comment illustrated general concerns about how training was paid for, both in terms of the course itself and in remunerating staff for their time. The manager explained funding for the five mandatory training days for staff is built into the setting's training budget but funding for other training courses is not readily available. Participants from one focus group concurred with one another that large care organisations are more likely to have the resources to fund training, compared to small independent settings.

J.4 Running training courses

All of the focus groups contributing to the discussion on music-related training offered views on how they should be run. Three main themes emerged relating to location, duration and course content.

J.4.1 Location and duration

Most commonly, participants suggested that in-house training was preferential for a number of reasons. Firstly, attendant staff could easily return to care duties in the event of some unforeseen occurrence. Secondly, potential travel problems, specifically in rural areas, were limited. Thirdly, it was commonly suggested amongst participants that training in familiar surroundings, with known colleagues was likely to boost staff engagement.

Around a fifth of participants offered views on the most convenient duration of training courses. One said, *“It needs to be an attainable target”*. In general, the notion of day-long training sessions was not popular due to the challenges of organising staff-cover and the necessary intensity of teaching. The general preference amongst commentators was short sessions of no more than three hours, to run over no more than a six-week period. One focus group suggested avoiding the high summer months due to staff vacations and the high percentage of staff who have children on holiday from school, and winter months when clients are more likely to have additional care needs.

J.4.2 Course content

A small number of participants had either asked a visiting musician for a recording of their material and/or song word-sheets or expressed a desire to have these resources. This was generally thought to be a good way of helping staff to use music in their settings with clients. Other suggestions about the content of training included training on how to use percussion instruments and one group suggested some theoretical perspectives on why music is good for people. This was thought to help underpin staff understanding of its value, and therefore to encourage engagement. One focus group suggested that training needing to relate to the needs of their individual clients and the environment in which

they work. The following exchange referred to a number of issues including the duration of a training course, the relevance of the training and the perceived need for student support to continue periodically after the end of a course.

Registered Manager - *"...So shorter hours. Then they think about that and go back to it the next week."*

Administrator - *"And that gives people the opportunity to bring up issues as it goes along. You know, that the course has suggested doing something and they've tried it and it doesn't work or something."*

Registered Manager - *"I think there should be an opportunity for support. Not necessarily coming into the home but maybe a telephone call if they need it."*

(Fg11)

In answer to objective J, just over half of the questionnaire survey respondents agreed that they would use music more if training were available. Over half of the focus group participants offered an opinion on why this may be the case. The most common reason related to low staffing levels in care settings, which was also reported to impact on fitting in mandatory and NVQ training. Other inhibitors related to poor motivation and confidence amongst staff and perceived lack of musical ability. The challenges of funding training were also raised. Suggestions from participants about the optimum structure for training courses included in-house training, short sessions, some theory but with specific practical application, and adequate student support.

6.6 The experience of using music with people with dementia

This investigation was based on the experiences of music practitioners. The aim was to gain insight into how music practitioners define the benefits and challenges of using music in a care context. The investigation was addressed by objectives K and L.

Results Objective K

The experience of music practitioners

Objective K: To investigate the experience of music practitioners working in care settings was addressed through focus group discussion with trainee music practitioners,

face-to-face interviews with experienced music practitioners, and participant observations.

Figure 6.43 Objective K: main themes and emergent sub themes

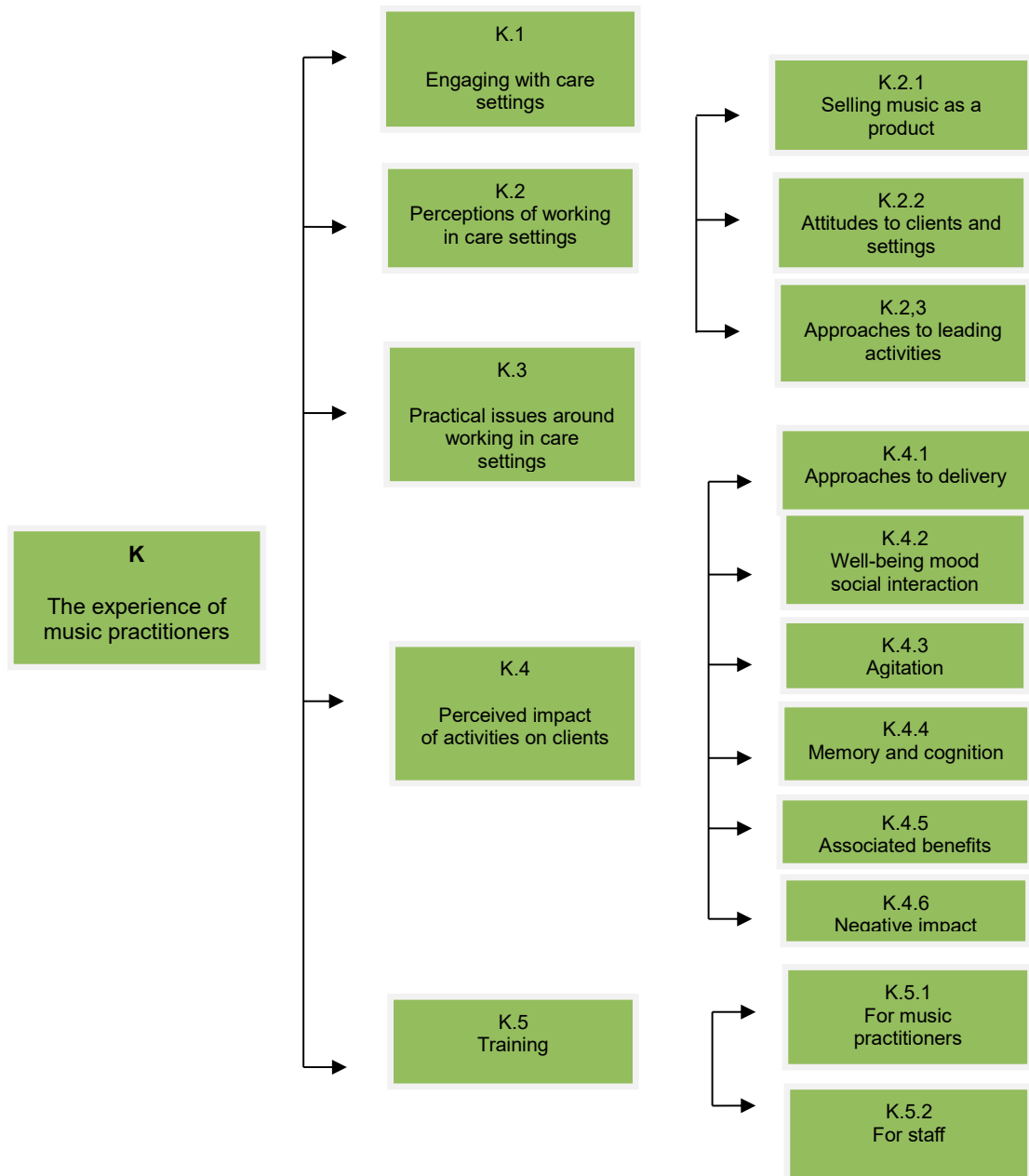


Figure 6.43 shows that the data was analysed into five main themes. These were engaging with care settings, perceptions of working in care settings, practical issues around working in care settings, perceptions of the impact of music on clients and perceptions of training for music practitioners and for staff.

K.1 Engaging with care settings

The experiences of all music practitioners around engaging with care settings were similar. Although a manager from one care setting had contacted Music Practitioner 1 to request a taster session of activities, all other contacts were reported to have been initiated by the music practitioners.

Most managers indicated a keenness to engage practitioners for regular music activities. Music Practitioner 2 suggested that this keenness stemmed from various recent government policies for care settings to provide a range of appropriate activities for their clients. Music Practitioner 2 believed that managers are often grateful for a chance contact from practitioners because it enabled them to 'tick boxes' in terms of legislative requirements around activity provision. Music Practitioner 2 highlighted the paucity of systematic information on services available for people in care settings and the practitioners providing them. This appeared to inhibit effective communication between the agencies involved.

K.2 Perceptions of working in care settings

K.2.1 Selling music activities as a product or service

Music Practitioners 3 and 4 perceived themselves as salesmen with a product or service to sell. In expressing the ease with which she approached this task, Music Practitioner 3 reflected the attitudes of all four music practitioners and their commitment to the value of their product.

*"In a way it is selling it to them, but believing in it as I do, I do sell it to people. It doesn't feel in any way as though it's some sort of... Using the word selling means there's a monetary aspect, which there is but as far as promoting it and expressing my faith in it as a therapy, I would feel very happy to do that. Knowing that it does work, I'm motivated to share music, to share singing, which is very positive. And that's concrete because it affects **me** so much."*

(Music Practitioner 3)

Music Practitioner 4, however, reported feeling uncomfortable in the role of 'salesman' and being affected by settings' responses to his offering music services. Negative responses to 'cold calling' from care settings' staff had in the past dampened his

enthusiasm for seeking work in this way. Music Practitioner 3 believes that these negative responses reflect a limited understanding amongst staff of the benefits of music for people in care settings. The quote below, which illustrates this point, also demonstrated broader tensions associated with quantifying the value arts-based services *per se*

Music Practitioner 3 - *"It's more than a product. I'd say. It's such a varied thing. It's almost intangible the sort of thing we deliver to people. In terms of if being a sellable thing, it makes it seem...The idea of selling anything doesn't particularly conjure up positive connotations."*

Researcher - *"What about if it were commissioned in a different way. If you didn't have to sell it, as it were?"*

Music Practitioner 3 - *"Yeah, yeah, definitely. If it was a more of an expected thing. If it was more taken for granted, if you didn't have to sell it to people, it would be a much more pleasant task, I think. If you add money into the equation it can always be a bit of an awkward thing, especially with arts of any type."*

(Music Practitioner 3)

K.2.2 Perceptions and attitudes towards clients and settings

Music Practitioners, 2, 3 and 4 gave a view of their perceptions and attitudes towards care settings and older people. Music Practitioner 2, who was also a registered nurse, observed that her extensive work with older people gave her insight and understanding relating to the needs of frail older people, and in care settings' routines and systems. The practitioner gave an account of a new assistant being 'put off' during her first music session by a distressed client's apparently aggressive behaviour towards staff and other clients. Music Practitioner 3 had also spent some time in care homes as a child due to two family members working in these settings. She had begun assisting with music sessions in her mid-teens. When asked what she remembered about starting to work as a music practitioner in these settings, her responses centred on her personal levels of confidence and musical ability rather than issues around spending time with clients. She did, however, highlight difficulties that might arise for music practitioners who are new to this field of work. The practitioner held responsible the culture of isolating older people and people living with disabilities in the UK *per se*. This topic was also raised by Music Practitioner 4 who reported feeling 'discomfort' when first working in care settings. He described his feelings using the terms '*out of my comfort zone*' and '*shocking*' and related this to his own limited exposure to older people living with disabilities and broader cultural issues.

"Everyone is separated from it. I liken it to mental health institutions and places like that. And again, it's sort of people who aren't 'normal', in inverted comas, are kept away from us so we don't have to focus on it or think about it really. It's a weird societal sort of shunning. Sort of modernday asylums. It means it's very much not in the front of people's minds. And obviously when you do go and see it, it's concentrated in terms of lots of people suffering from mental and cognitive failures, so it does come as a big shock."

(Music Practitioner 4)

K.2.3 Approaches to leading activities

In terms of the music practitioner's approaches to leading music activities, two differing models emerged. Music Practitioners 1 and 2 reported a 'performance' approach, which they felt was essential to generate the energy for delivering engaging activities. Practitioner 1 referred to her sessions as being '*an entertainment on top of anything else*', in which she prioritised '*getting people to smile and feel good*'. Referring to the desirable personal credentials for work in care settings Practitioner 1 said:

"[It's] very like a performance, well for me it is.... I think they [organisation engaging music practitioners] reject quite a lot of people at the first stage and they are looking for extrovert people who like to perform... I think that's what they say that they are looking for because if you don't put the initial energy in then you are never going to get the thing off the ground..."

(Music Practitioner 1)

Music Practitioners 3 and 4 described a different model. Whereas Music Practitioners 1 and 2, reported the use of mostly familiar songs and music within a pre-planned programme that was more or less structured, Music Practitioners 3 and 4 included an interactive entertainment element but their primary focus was on live improvisation with clients using percussion instruments and their voices. Practitioner 4 described this as '*standing back*' in order to enable clients to potentially flourish. The following quote illustrated the expectations associated with the latter type of activity.

*"It needs to **feel** casual. You don't go there with any preconceptions as to what you're going to achieve so, achieving anything as a sort of unit is always a good accomplishment. I mean you do find sometimes that improvising with some groups something will happen that is incredible whereas sometimes it might not quite get off the ground but then that's the same with anyone, even if you're working with professional musicians, sometimes it just won't work..."*

(Music Practitioner 4)

It was interesting to note that both Music Practitioners 1 and 4 used the term '*get/getting it off the ground*', but whereas Music Practitioner 1 regarded this as central to a successful session, Music Practitioner 4 suggested that failure to do so can be an acceptable aspect of a session's exploratory process. These expectations also appeared to affect how music practitioners judged the success of a session. All four reported perceived successes and failures in terms of personally feeling good about sessions. Music Practitioner 1 and 2 reported that feeling good about sessions was generally associated with clients appearing to enjoy themselves. In the focus group of trainee music practitioners, one participant related the motivation for working in this field to an overarching need amongst musicians to be appreciated as performers.

"There's just something innately pleasurable about making people happy. But I mean we're all musicians and we all use music to get some sort of response and usually a positive response and I think that's just something... you know, if we didn't want that to happen then we wouldn't bother being musicians in the first place."

(Trainee Music Practitioner 3: Fg16)

Music Practitioner 3 and 4 acknowledged the positive impact of seeing clients smiling and engaging in up-beat music activities and enjoying reminiscences. However, 'feeling good' about sessions tended to relate more to a sense that clients had gained from developing something creative for themselves. This could be measured by exuberant engagement but equally by embodied concentration and subtle or overt interactions with the music practitioner and/or others in the group.

Music Practitioner 1 referred to the challenges of working with '*an audience*' who do not always have the capacity to relay their feelings. She referred to vulnerability and personal sense of ill-being when confronted with low level reactions from clients.

"You know, if you are not feeling on top form and you walk into the residents lounge, and there they all are, you know, classic thing, lined up round the... watching a TV...and the light's gone out behind their eyes and you say, 'Hello! I've come to do music!' and they may look up or they may not and so... And you hope at that point that two or three will say, 'Oh great!' and if you've got even one person in a group who you can react with initially, it might be for good or bad... I'd rather have somebody who's a heckler, who's actually rather anti than have a whole room where they're all sitting completely passive."

(Music Practitioner 1)

A further factor to affect music practitioners related to perceived tensions between activities based on entertainment and psychotherapeutic activities. Referring to an incident where a client left a session having been apparently angered by a choice of song, the trainee music practitioner focus group discussed the boundaries between these types of activities and speculated on practitioners' sensing loss of control in the latter.

Trainee Music Practitioner 5 – *"I mean it's no good to have people blowing up all over the place but maybe if they could be allowed to do that sometimes it will be overall quite good."*

Researcher - *"Do you think that could be in any way explored and achieved through musical activity?"*

Trainee Music Practitioner 3 - *"Like primal scream therapy or something? Could do."*

Researcher - *"...I'm just thinking in the context of what you do and your experiences, so far."*

Trainee Music Practitioner 3 - *"It's hard to say really, I think it would be something that I wouldn't particularly want to explore because I don't like seeing people get distressed and stuff like that but.."*

Trainee Music Practitioner 5 – *"It would have to be very controlled wouldn't it, very controlled."*

Trainee Music Practitioner 3 – *"Maybe if given on a one to one basis but with a group it could be..."*

Researcher – *"So would you see... sorry, what were you going to say?"*

Trainee Music Practitioner - *"...mayhem."*

Researcher - *"Mayhem. Erm. So, would you see that as the music therapist's domain?"*

Trainee Music Practitioner 3 – *"Err, I dunno."*

Trainee Music Practitioner 5 – *"No."*

Trainee Music Practitioner 6 - *"It could be a bit of both."*

Trainee Music Practitioner 3 – *"I think it would say it was more towards music therapists because I don't think I'd enjoy seeing people get upset when you don't need to upset them when they're perfectly happy to, sort of, sing."*

(Fg16)

Music Practitioner 1 referred to her model of activities as having 'therapeutic properties'. She suggested that delivering this type of activity did not require music therapy training but rather relied upon an intuitive relationship with clients.

K.3 Practical issues around working in care settings

All four music practitioners felt that working in care settings had some advantages and some disadvantages in terms of practicalities. Advantages related to the availability of a working space, in which issues of access and health and safety had already been addressed, and client uptake largely being the responsibility of the individual settings. This was contrasted with activities in community settings, in which music practitioners could be responsible for organising a suitable space and generating a client group week by week. The common fixed-fee arrangement, in which music practitioner's fees were fixed at the point of commission, and were not usually number-dependent, was also pointed out as an advantage.

All 12 music practitioners and trainee music practitioners who took part in focus groups reported that the organisation of clients and spaces in which activities take place was considerably varied from setting to setting and sometimes from session to session. The variation ranged from clients being seated and ready when the music practitioner arrived to the music practitioners waiting, or helping to organise clients, for up to 30 minutes after the session's proposed start time. Suggested reasons for delays included weight of work for staff, unforeseen care emergencies and the planned session being overlooked/not prioritised by staff. In terms of space, problems had arisen in dual-purpose spaces in which the previous activity, often lunch in a dining area, was incomplete and where furniture needed moving. However, Music Practitioner 4 suggested that taking part in organising clients for music session could be positive in terms of creating a bond with staff.

Music Practitioner 4 - "Again, that [level of pre-session organisation] does vary as well because sometimes it seems we can be walking into a ready-made setting but on other occasions it can take a long time to sort of round people up, sometimes it seems that people are completely unaware that we are there in the first place. But then either way, it's no sort of complaint, it's nice to just be able to mould into the structure of the care home and to... just to be there anyway, regardless of who's ready and who's organised and who's..."

Researcher - *"So, do you see your role includes helping to get the room and the people there?"*

Music Practitioner 4 - *"Yeah, yeah."*

Researcher - *"So it's very much sort of integrative thing with the care staff."*

Music Practitioner 4 - *"Yes, yeah, yeah. We definitely become a, all be it short lived, a kind of unit I think."*

(Music Practitioner 4)

One highlighted disadvantage to working as a music practitioner in care settings was the isolated nature of the work. This centred on practical issues, such as help with organising sessions/transporting and setting up equipment, rather than any psychological issues. Music Practitioner 1 also felt that working alone occasionally limited the value of activities for clients.

"I mean I try and sort of jolly people along but there's only one of me. If you have to physically be getting hold of somebody's hand and helping them in that way then there's a limit to how much you can do within the group. I mean I always feel that probably there's more potential there than I ever achieve because it's a limited time, there's only one of me and there's a lot more of them."

(Music Practitioner 1)

K.4 Perceived impact of activities on clients

All four music practitioners and around half of the trainee music practitioners believed that music activities supported the well-being of clients. One trainee music practitioner highlighted the potential for bias for this prevalent view amongst musicians. A few related the positive value to the common paucity of other activities in care settings, saying *'It's definitely better than nothing'*, and *'Well, they just sit there looking at the walls for hours otherwise'*.

K.4.1 Approaches to delivering activities

All the music practitioners and trainee music practitioners reported a personal passion for music, which translated to a belief in the art form as a medium for inducing well-being amongst clients. Music Practitioner 1 illustrated this with her reference to music being *'a sort of sonic vitamin C'*.

The trainee music practitioners' focus group discussed the role of music from the widest perspective in terms of innate human associations. Participants referred to the earth's natural rhythm of the rising and falling of the sun, the natural pitched sounds of the wind blowing through trees, birdsong and the rhythms of the human heart beat and of walking. They related the presence of natural musical sound and the omnipresence of symbolic musical sounds encountered in everyday life, such as the bell heralding the end of school lessons, the warning sound of car horns and the pitched tones of a Pelican crossing, to the power of music to affect lives. Music Practitioner 1 referred to this phenomenon as *'the magic of music'*. She also highlighted the immediacy of music to affect reactions, which she believed occurred less in other activities.

The following exchange illustrated the commitment of the trainee music practitioners to use music for positive effect on clients and their perceptions of the value of other arts media.

Trainee Music Practitioner 5 - *"... when you go there [care setting] you're actually; you're doing something which is more than taking an exam or getting a... you're actually trying to affect the life of someone which is, which, to me seems a lot more relevant and important."*

Trainee Music Practitioner 2 - *"It's almost like the music's not really important, it's what we're doing with it and sort of the relationships you build up with the people there."*

Researcher - *"Could you do something similar with a different media, could you do it without music?"*

Trainee Music Practitioner 2 - *"You could do it with like, just art as well."*

Researcher - *"Would it have the same effect?"*

Trainee Music Practitioner 1 and 3 - *"No."*

Trainee Music Practitioner 8 - *"Well it won't have the same effect."*

Trainee Music Practitioner 2 - *"Not necessarily a bad different effect, just a different effect."*

Trainee Music Practitioner 8 - *"It's just different, it's the same with all alternative therapy."*

Trainee Music Practitioner 4 - *"But we've all got voices, it's practically a lot easier as well isn't it?"*

(Fg16)

In terms of the value of types of musical material, each music practitioner believed in the positive value of using familiar music to induce a sense of communion and to provide opportunities for reminiscence. The following quote illustrated common perceptions amongst the music practitioners of the value of 'old time music' and music from World War II, and the need to address clients' individuality.

*"I think it does depend very much on the person and their background and their environment. It does concern me sometimes because I go in and generally speaking, I go in with old time sing a long, songs from the second world war etc. and I've gone in and done little bits of research for myself asking what type of music that they like and umm, cos I don't think all of them do like to hear, 'I do Like to be Beside the Seaside' every week. But some of them do. And some of them that have never really been into popular music only really liked classical. They don't have a string quartet going in and entertain them. I've never heard of that. I'd like to think it does happen but to have that taste catered for, I think is unusual. So I do tend to ask them, 'Does anyone like classical music and I'll play you something like **Fur Elise**, because it's not everybody's taste."*

(Music Practitioner 2)

Music Practitioner 1 reported using a range of different genres of music, including recorded popular and classical music to which clients are invited to play percussion instruments, move, sing along to and listen to. This inevitably includes music with which some clients are unfamiliar. Music Practitioner 2 also reported using some unfamiliar music in her sessions. The choice might be a more up to date song, such as I Like to Teach the World to Sing. The criteria for inclusion are '*happy lyrics and a catchy tune*', described as '*something that has a positive feel*'. This effect was evident in the second participant observation (PO3), when an unfamiliar song, I Like the Flowers, I Like the Daffodils, which had these characteristics, appeared to induce heightened engagement with clients' clapping and playing their instruments enthusiastically and a few attempted to sing the words with the music practitioner.

The song also related to Music Practitioner 4's reference to deep-rooted cultural connections with the natural harmonic series. The so-called cycle of fifths, on which the song's harmonic basis is grounded, reflects the order in which the ear hears the subtle overtones of a base note. Music Practitioner 4 also pointed out that harmonies based on the root, the fourth and the fifth note of a Western scale, which encompass this phenomenon, are ubiquitous in popular songs and music. Music Practitioner 4 reported

deliberately using these harmonic structures to trigger a positive response in improvised activities.

"[In an improvised piece] I would very much simplify an accompaniment down to, if we're playing in C it would be a basic accompaniment in C Major with simple chord progressions sort of I – IV – V sort of standard sort of things like that. That's because it's quite simple, fits in with the tuned percussion they're playing and also is quite familiar to the clients."

(Music Practitioner 4)

K.4.2 Well-being, mood and social interaction

Many comments around the value of music for clients related to music practitioner's observations of its capacity to improve well-being and mood and to elicit social interaction. Common words and phrases used to convey this affect were *'it makes people feel happy/good'*, *'it uplifts people/it gives people a lift'*. A number of explanations for a sense of well-being were suggested. Three music practitioner's suggested that offering clients control during sessions, such as inviting them to choose songs or to facilitate activities such as conducting, related to sense of empowerment. Music Practitioner 1 also highlighted the potential for clients to feel validated in activities which entail the music practitioner following or copying clients' actions.

The focus group of trainee music practitioner gave an example of an empowering activity, in which clients took a productive rather a submissive role. In this, clients took on the role of assessors during the trainee's assessed practice sessions and were asked to give their opinions about how the trainees presented an activity.

"Maybe the fact that they know that it's a chance for us to practice and that's quite empowering, maybe that's something we should make a bit more of."

(Trainee Music Practitioner 5:Fg 16)

Trainee music practitioner 3 compared productive activity with fitness activity concluding that both are equally valid in terms of prolonging life. Music Practitioner 3 referred to empowering clients to engage in creative pursuits. She stated that human beings are naturally creative and that enabling clients to pursue creative instincts through music is *'incredibly important'* in terms of *'easing the distress of their predicament...'*. Music Practitioners 3 and 4 believed that this was particularly relevant in free

improvisation activities. Although probably alien to begin with, these activities were thought to have the potential to engage clients in a more rounded way than in reminiscence activities.

Many focus group participants commented on the relationship between an improved sense of well-being through music and heightened social interaction. Examples of manifest changes amongst clients during music activity sessions were talking and laughing with one another.

Trainee Music Practitioner 4 - "I think the music always provides like a topic of conversation for them between each other and they always seem to talk about that, but also when you involve activities which they're interacting with each other like maybe clapping together or something or making a rhythm together, or maybe they're in groups like with the chime bars, then it kind of, they talk to each other on their team or maybe with the flags as well or something like that they, erm, that helps them to interact with each other."

Trainee Music Practitioner 3 - "Yeah they do don't they, split them off into teams like into four groups, they'll sort of natter amongst those groups which they might not have done before you put them into four groups."

(Fg16)

Heightened social interaction was evident in all participant observation sessions when compared to social interaction prior to the sessions. In PO2, three clients who appeared non-communicative during verbal interactions before the session interacted during music activities at some level. This ranged from smiling with the music practitioner to swaying to the music. One client was inspired to recount a personal story from their past.

The musical responses across all of the participant observations ranged from a client in PO1 tapping a finger in time to Radetzky March, to a client in PO3 frequently dancing and waving both arms, or playing the claves robustly to accompany every song.

Music Practitioner 1 reported one client with apparently profound cognitive impairment whose eye contact had increased over time. Other notable changes reported by Music Practitioner 2 had happened over time. These were increased client to client musical interaction, for example, synchronizing their beats on percussion instruments, and increased client to music practitioner verbal interaction.

K.4.3 Agitation

A few comments related to music's capacity to address agitated behaviour amongst clients. Two music practitioners referred to staff reports of normally agitated clients responding well to music activity sessions. Music Practitioner 4 reported a client whose repetitive upper body movements appeared to abate during 'lullaby type' songs. However, Music Practitioner 4 also noticed that for some clients, the presence of the 'unknown faces' of music practitioners, appeared to increase agitation. Music Practitioner 1 pointed out that music itself can sometimes exacerbate agitation, although she felt that agitation associated with cognitive impairment was often improved by sharing familiar songs.

During the first participant observation the researcher noted that the apparently agitated repetitive verbalisation of one client appeared to be unaffected by any of the activities. In the same session, during a quiet listening exercise the conversation between staff in an adjacent open plan area became motivated and loud in volume. Apparently in response, one client rose from her chair, appearing anxious.

K.4.4 Memory and cognition

The theme of music improving memory and cognition was not uncommon. The following quote is illustrative of the views of all four music practitioners, in terms of music's capacity to elicit memories.

"Everybody's got some sort of connection with music and some experience through their life and music just tends to be... it's not just about reminiscence but it just does make you... put you into a certain place, doesn't it? And it can be different places it can put you"

(Music Practitioner 2)

The benefits of music on memory tended to centre on linking people to their past and drawing people together who had shared similar life experiences, most notably, experiences of World War II. Music Practitioner 1 particularly referred to the value of singing to invoke memories, suggesting that her sessions '*...would be a lot poorer without singing*'. This viewpoint was based on the added dimension of song lyrics, which Practitioner 1 believed triggered more vivid memories. Music Practitioners 1 and 2

referred to the positive benefit of memory stimulation leading to cathartic experience. The following quote illustrated issues of music practitioners' dealing with types of responses when they occurred in group settings.

"I don't see it as bad, I think it's better to have the memory and to realise that you've got... rather than to be sitting there in this fog of nothingness, I think to have any sort of emotion and engagement with life and remembering your husband, you know, one lady was sitting in floods of tears in an Elvis Presley number, 'I Can't Help Falling in Love With You', and I just sort of put a hand on her while we were singing, but I carried on, because the rest of the group were enjoying, then when I had a chance I said, 'That had lots of memories for you didn't it?' and she said, 'Oh yes, my husband used to sing that to me.' And I said, 'Oh what a lovely memory to have!' To me, I hope to her, it was better that she had that memory and was able to think about it again rather than just trying to forget it all."

(Music Practitioner 1)

In addition to recognising music as a vehicle for emotional expression, Music Practitioners 1 and 3 commented on music's capacity to affect cognitive functioning. Music Practitioner 1 suggested that, in addition to awakening memories, another key benefit to music, over and above other therapeutic media, was its impact on the brain. Music Practitioner 3 suggested that working with improvised music can have '*a positive benefit on cognitive well-being*'. This theme also occurred amongst trainee music practitioners, who used the terms '*stimulus to the brain*' and '*sound works on the brain*', in relation to the benefits of music activities.

K.4.5 Associated benefits

Music Practitioner 1 and 2 both suggested that observing clients taking part in music activities can give staff and other clients beneficial insight into their lives. This was demonstrated in PO1 when, triggered by the song *Singing in the Rain*, a client recounted her experience as a young teacher taking a group of students to London on a photography trip in the rain. Music Practitioner 1 suggested:

"I think it gives the other residents a little bit more of an insight and knowledge of the person telling the story and they are able to see them in, perhaps, a more positive light. Yeah, just get to know them a bit better."

(Music Practitioner 1)

Three of the music practitioners highlighted the value of coming to activity sessions without any pre-conceptions of clients' abilities. They implied that staff stereotyping clients according to their perceived abilities, can inhibit a client's potential to develop.

"And I think the staff have, they put labels on people, or, "She wouldn't know the answer to that." "She won't hold a maraca." And I just work from the premise that they do all want to be there, that they are all capable of joining in and they would all like to engage in some sort of way and I do, I think, get people engaging in ways that surprise the staff sometimes."

(Music Practitioner 1)

Comments made by Music Practitioners 1 2 and 4 relating to music activity inevitably involving physical movement of some type, reflected those made by staff. In particular, the practitioners talked about music stimulating swaying, tapping and dancing.

K.4.6 Negative impact

In discussing the negative impact of music on clients in care settings, the music practitioners tended to focus on musical taste. The trainee music practitioners also referred to variations in taste for music *per se* and acknowledged that some people do not like music at all. Music Practitioners 1 and 3 raised the challenging issue of choosing generically appropriate music. Taste was discussed in terms of eras, genres, instrumentation, specific songs and artists, tempo and volume. The latter was observed to annoy/agitate clients if either too loud or too quiet.

K.5 Training

K.5.1 Training for music practitioners

Apart from one music practitioner, who had attended two preliminary training sessions provided by the organisation for which she worked, no others reported having had specific training to work in care settings. All four, however, had attended some form of training workshops for musicians working in the community. Each reported that whilst these workshops were beneficial, they would value the opportunity for more training and to regularly engage with other practitioners working in care settings. When asked what they would hope to achieve all said they would value sharing material and delivery approaches. Music Practitioner 4 suggested that a greater theoretical understanding of music's affect

'from a scientific point of view' would be of considerable interest and, he believed such knowledge would enhance her practice.

About three-quarters of the trainee music practitioners, who had experienced community-music practice placements in care settings as part of their music degree programme, reported the positive value of observing experienced practitioners and the opportunity to practice delivery amongst a group of informed clients.

K.5.2 Potential for music practitioners to train staff

When asked to comment on the potential for music practitioners to train staff to use music in the workplace, all four music practitioners agreed that this may be possible at some level. Music Practitioner 2 suggested that training for staff would be highly feasible but in order to incentivise staff this would need to be coupled with teaching some level of neurological and social theory that underpins the benefits of music. Music Practitioner 3 and 4, who had been previously involved in training for care staff to use music in their everyday practice, believed that empowering staff in this way has potential to improve the quality of their lives as well as the lives of the people for whom they care. Both Music Practitioner 3 and 4 posited views relating to staff perceptions and attitudes towards this type of training.

Music Practitioner 4 - *"My perception of it is their obvious reluctance to engage in such a kind of well what's seen as a very, frivolous past time, well..."*

Researcher - *"So this is training specifically for care staff to use music?"*

Music Practitioner 4 - *"But then again ...on the other hand, there have been people who have been so enamoured with it, and have really enjoyed the course which has been, essentially the course is teaching carers, well sort of advising carers how to use music and how music is very, can be very therapeutic. So it depends, I mean it does depend on the person really"*

(Music Practitioner 4)

"There's a fair amount of scepticism as to the benefit of [music-related training], or at least to start with, I think some, I've noticed the change in some care staff who kind of almost get won over by the concept."

(Music Practitioner 3)

One care setting manager suggested that, given adequate time, support and encouragement, many of her staff could become valuable facilitators in music, arts and crafts activities. Music Practitioner 1 also reported having observed a few members of staff, who, due to their gregarious nature, would, she believed, be highly suitable to train to use a model of music activity based on the use of backing tracks. Music Practitioner 1 highlighted the potential difficulties of funding such training, which she believed would require a specialist trainer to work extensively with staff. Music Practitioner 1 also posited the view that the novelty value of music practitioners visiting care settings adds a positive dimension to activity sessions that would be lost in staff-facilitated activities.

In answer to objective K, factors that affect the experiences of music practitioners and trainee music practitioners were multi-faceted. Most believed that most people in charge of care settings advocated the regular use of music to support the quality of their clients' lives. However, difficulty with financing these activities was thought often to be seen by care setting staff as insurmountable. This factor was thought to underpin the challenge identified by music practitioners of maintaining a positive approach in initially engaging with care settings when staff responded negatively.

The practitioners' reports of perceived challenges of working with clients with physical and cognitive disabilities were thought to relate to wider societal issues of isolating people with disabilities *per se*.

Two main approaches to delivering activities were described. Both centred on interactivity but one was modeled on a quasi-music-hall style of activity with a main performer and audience participation, the other a quasi-music therapy approach in which the practitioners encouraged musical exploration and creative expression through improvisation. In the performance approach success tended to be measured by how happy clients appeared to be. In the improvisational approach, success tended to be measured by how creatively expressive the clients had been.

A not uncommon theme was the potential for music practitioners to feel vulnerable when faced with cathartic responses from clients. This also raised questions about the definition

of therapeutic music compared with music therapy. The approaches described here indicated a spectrum that spans, at one extreme, entertainment, and at the other psychotherapeutic treatment.

Music practitioners' attitudes towards helping staff prepare clients for sessions, varied. This ranged from no expectations on the part of the practitioner to help organise clients and activity spaces, to practitioners deliberately building in time for pre-session help. Practitioners who engaged in the latter regarded the activity as an important bonding mechanism between staff, clients and music practitioners.

When discussing what underpins the value of music for clients, music practitioners variably discussed innate human connections to music and the strong association between familiar harmonic structures embedded into popular music and natural harmonics. This association was thought to underpin a sense of well-being, to elicit greater levels of social interaction, to address agitation in some clients, to aid memory and cognition and to give insight into the lives and abilities of clients.

Most trainee music practitioners commended training opportunities to work in care settings. The majority of music practitioners reported little engagement or knowledge of training to work in care settings. All regarded training as a desirable facility but issues of funding were raised as a potential inhibitor. All music practitioners believed that training staff to deliver music activities was feasible at some level, but issues of staff-willingness, practicalities and funding were raised as potential inhibitors.

Results Objective L

The relationship between music practitioners and staff

Objective L: To examine the relationship between music practitioners and staff when working in care settings was addressed through focus group discussion with trainee music practitioners, face-to-face interviews with experienced music practitioners, and participant observations.

Figure 6.44: Objective L: main themes and emergent sub themes

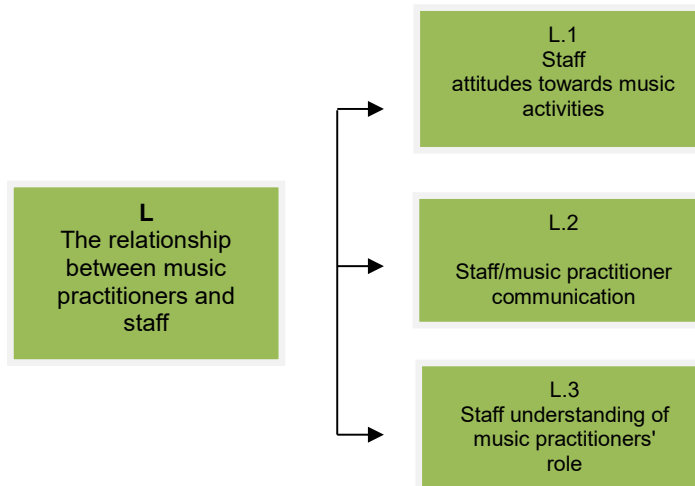


Figure 6.44 shows that data was analysed into two themes, music practitioners' perceptions of staff attitudes towards music activities, and staff/music practitioner communication.

L.1 Music practitioners' perceptions of staff attitudes towards music activities

All four music practitioners suggested that their relationships with staff were coloured by the way in which staff viewed music activities. Music Practitioners 1, 3 and 4 believed that most staff advocated music practitioner-led activities, based on their positive their value for clients. However, certain attitudes and practical issues inhibited these activities from being fully embraced as an integral part of care-giving. Music Practitioners 4 suggested that this may stem from the idea that music is considered amongst staff to be a '*...frivolous past time*'. Music Practitioners 1 suggested that few staff viewed activities as anything more than just 'fun', but she acknowledged that their knowledge base did not enable them to quantify this at any meaningful level.

"[Staff think] this [music activity] is fun, and maybe looking at it they think that's all it is but it actually is having a far more, far deeper effect and is a lot more serious and is something that they should be taking seriously on behalf of their residents, and that I often feel doesn't happen..."

(Music Practitioner 1)

Although Music Practitioner 4 felt that staff were more inclined to regard music activities as a *'nice little bit of entertainment'*, rather than an important therapeutic intervention, he also pointed out that in his experience, there was no common reaction from staff. The practitioner had also experienced anomalies in the reactions, whereby staff who appeared very positive on most occasions, could appear unenthusiastic and even irritable on others. Music Practitioner 4 associated this with stresses and strains of care work in which a certain set of circumstances can result in a planned music session creating tensions for staff.

Music Practitioner 4 also acknowledged that sometimes, *'you get a sense that you're sort of disrupting the day's duties'*. The following quote was illustrative of this and other comments by all four music practitioners, suggesting that negative responses from staff are often associated with clashes to routine.

"Some [staff] see it as, "Actually I want to be serving tea and if I don't serve tea now I can't them fit in the other things." Or, "It's time to start the toilet run before lunch." Or whatever, and so I'm just getting in the way of their routine. They don't see it as, "Well isn't this wonderful for the residents, this is something really positive for them I must allow this to happen and slightly adjust my working routine in order to fit this in."

(Music Practitioner 1)

L.2 Staff and music practitioner communication

Music Practitioner 1 and 2 suggested that tensions may occur due to poor communication between management and staff working on the 'coal-face' within care settings. Both practitioners reported that not infrequently, junior members of staff had appeared unaware of the arrangements made for music activity sessions. This was particularly evident when the commissioning member of staff was either away or busy at the time of the music practitioner's arrival. Both practitioners reported their protocol for engaging with a care setting, which included a face-to-face discussion with a senior member of staff about their mutual needs, expectations and the purpose and content of activity sessions. This was usually undertaken with the settings manager or owner. Music Practitioner 2 highlighted the challenges for the person in charge to devolve information down to *all* staff in care settings where many are part-time and some work very occasionally. Music Practitioner 1 suggested that more robust communication with more staff from each setting may be of

mutual benefit. This was followed by the caveat that dialogue with staff about clients' conditions might lead to unhelpful preconceptions on the part of music practitioners that may in some way limit some clients' potential.

Music Practitioner 4 highlighted that the same problems that can create an apparent unhelpfulness amongst staff, can also affect how staff receive and interact with music practitioners. All four music practitioners reported experiencing various types of reception from staff. This ranged from staff being welcoming and highly helpful with preparations for, and during activity sessions, to staff appearing indifferent or even rude and unhelpful. However, Music Practitioner 2 reported that in her experience all care setting staff were friendly, even though their levels of interaction had varied considerably.

Observation question	Participant observation site and music practitioner		
	Site – PO1 Music Practitioner 1	Site – PO2 Music Practitioner 1	Site – PO3 Trainee Music Practitioner
Who answered the door?	Care assistant	Manager	Automatic door release
Did the person on charge come to speak to MP?	NO	YES	NO
Did staff speak to the MP during the setting -up process?	YES- two catering staff	YES – manager and two care assistants	YES – two care assistants, sought by MP to help organise clients
Was MP offered any form of refreshment?	NO	NO	NO

MP – Music Practitioner; PO – Participant observation

Table 6.45 shows the results of the participant observation questions relating to staff communication with the music practitioner on arrival. In the first participant observation (PO1), in general, both the staff and the music practitioner appeared to engage in friendly but limited and superficial interaction. The observation took place in a residential care setting that the practitioner had visited twice before. A care assistant who opened the

door to the music practitioner offered a brief, pleasant-sounding greeting, commenting on the amount of equipment that the practitioner had, which comprised a large box on a trolley and a large rucksack. Neither party appeared to have any expectations of receiving or offering help with manoeuvring the equipment. The setting's manager, who appeared preoccupied and hurried, and a care assistant passed by without talking to the music practitioner. The practitioner was not escorted to by a member of staff to the dining room in which the activity session was due to take place, and in which most participating clients were already seated. Two catering staff, who were clearing the lunch tables, responded to the music practitioner's greeting and there ensued a short congenial conversation about how soon they would vacate the space. A care assistant escorted two further clients into the dining room whilst the music practitioner prepared for the session. Neither made any reference to the other, rather appearing to focus their attention on the clients.

In a face to face interview, the music practitioner confirmed that, in her experience, this type of reception was common.

"Somebody will let me in the door and I'll explain who I am and they'll say, "Oh fine, yes, go through there." And that's it. And they are clearly, you know, feel that I should just be getting on with it."

(Music Practitioner1)

The second observation, PO2, which also involved Music Practitioner 1, showed how staff reception can differ from setting to setting. This observation took place in a setting where the practitioner had been leading music activities on a three or four-weekly basis for approximately six months. The music practitioner was greeted at the door by the setting's manager, despite it having an automatic door release to enable unmanned access. The manager offered to help carry the practitioner's equipment, which again comprised a large box on a trolley and a large rucksack. The practitioner and a passing member of staff greeted each other, the latter referring to the music practitioner by name. Once reaching the lounge in which activities were due to take place, a pleasant-sounding conversation took place between the music practitioner, the manager and two other members of staff, who were already in the room with clients. The staff members appeared keen to help organise clients for the session and the manager and music practitioner discussed the level

of help the latter might need with setting up her equipment. At the end of the session, no staff were present whilst the music practitioner gathered together her equipment. She visited the manager's office to collect her fee and was greeted pleasantly by the administrator. The manager and music practitioner discussed a specific client referring to her high level of interaction during the session. They confirmed the date of the next session, whilst walking together towards the main door.

In the third participant observation session, PO3, interaction between staff and the music practitioner appeared strained. The observation took place in a same setting as PO2, in which the Music Practitioner 5 had co-led music activities regularly during the preceding three months. On this occasion, Music Practitioner 5 was let into the setting via an automatic door release. An administrative member of staff who was seated in the office with the door open did not appear to react to the practitioner's arrival until he initiated a short dialogue about where the session was due to take place. The music practitioner was not escorted by a member of staff to the allocated room. In the corridor, a passing member of staff smiled and politely declined the music practitioner's invitation to join in with the pending activity session. The music practitioner also invited another three members of staff whom he passed in the corridor. This was done in a jovial manner with further encouragement when staff reported that other duties would prevent their attendance. On reaching the dining room, no clients were present, and the tables and chairs were positioned around tables as if for dining. The music practitioner had some difficulty in locating staff to ask for their help to organise clients and the furniture for the session. Gathering clients together, which was eventually undertaken by two care assistants, the music practitioner and the researcher, took approximately twenty minutes. During this time, the music practitioner 5 and the researcher also stacked the dining tables around the edge of the room. The care assistants appeared unenthusiastic. One suggested that many clients who normally took part were either unwell, resting, or in one case, 'being disruptive'. The music practitioner suggested that the latter client, whom he later reported normally enjoyed the music sessions, would be better occupied if she attended. When the care assistants did not appear to respond, the practitioner sought advice from the setting's manager, who agreed that the client should take part. One of the care assistants appeared annoyed. Neither moved to collect the client from the residential wing of the setting. This

was eventually undertaken by the researcher. No staff were present during the activity session. At the end of the session the music practitioner asked the researcher to find a member of staff to escort clients back to the main lounge.

Music Practitioner 3 and 4, who mostly delivered activities designed for staff and clients, believed that developing a relationship with staff was important to maximise the value of activities for the well-being of both staff and clients. Both aspired to communicate the inclusive nature of their activities with as many staff as possible but Music Practitioner 1 pointed out that this was rarely achievable in care settings, due to the number of staff in any one setting and their shift patterns.

L.3 Perceptions of staff understanding of music practitioners' role

Certain ambiguities appeared to arise equally for music practitioners and for staff in terms of their respective roles in music sessions. The first of these appeared to centre on music practitioners' perceptions of how staff view music activities in their care setting.

Music Practitioners 1 and 2 stated that in their experience the role of the music practitioner is not always understood by staff. Both suggested that some staff can view music activity sessions as a 'sitting' service, whereby music practitioners oversee clients' safety allowing staff to pursue other duties.

"Well yes, there's ...different types of carer reactions that I get. On one extreme, you've got the ones who think, "Great! An hour off! So I can go and do whatever, my paperwork or whatever else it is I'm supposed to be doing and I don't have to worry because they're all being entertained and they're fine."

(Music Practitioner 1)

Music Practitioners 1, 2 and 4 suggested that this perception can lead to staff disrespecting or trivialising the activities themselves.

"It's not completely stress free because sometimes it can be quite challenging, some of the homes I do get a little bit upset that while the activity is going on, other things are [going on] but there seems to be very little respect that the residents are listening and wanting to join in and you've got members of staff or visitors and they're chatting away..."

(Music Practitioner 2)

This was illustrated in PO3, when a client who appeared to have interacted very little, began to mirror the researcher's hand movements during the song *Blowing in the Wind*. The client smiled and maintained eye contact with the researcher, appearing to gain focus. At that moment a care assistant opened the door noisily, walked across the room, telling the researcher that the client was due to have her dressing changed. Whilst the music practitioner continued to sing, the care assistant needed to shout to make herself heard by the client. In this case, in addition to the staff member appearing to have prioritised the physical care of the client, her behaviour also indicated little respect for the music practitioner leading the session, or the activity itself. Music Practitioner 1 highlighted other staff behaviour that indicated limited regard for the value of activities. These included staff serving hot beverages during a session, laying cutlery noisily on dining tables in the same room, and staff vacuuming floors in immediately adjacent rooms, or talking loudly.

Music Practitioners 1 and 2 stated that their activities were not generally designed for staff, although both welcomed staff participation at an appropriate level. Both pointed out that inappropriate levels of involvement can cause disruption to the proposed flow.

"..there can be carers who try to get too involved and that is as much of a problem for me and actually in some ways can be more of a problem..than the ones who don't engage at all..."

(Music Practitioner 2)

"... where they [clients] are supposed to be sitting quietly and listening to maybe a classical piece, or just a more reflective piece, I might have asked them to be thinking about their breathing, or you know, meditation themed things. And a member of staff will come bowling up grab a tambourine and say, "Come on! Join in!" And not really knowing how the thing is supposed to be working and that actually is the thing that annoys me most, I'd rather they weren't there at all than come and do that!"

(Music Practitioner 1)

Music Practitioner 1 believed these actions to be grounded in good motives but lack of clarity in terms of staff role presented some problems. This most often occurred due to staff misunderstanding the purpose of an activity, most commonly because they were absent for large parts of the session.

In answer to objective L, the relationship between music practitioners and staff varied considerably from setting to setting and sometimes from session to session. In addition to apparent tensions for some staff around preparing clients and spaces for music activities, some staff appeared to have a neutral or negative attitude towards the activity itself. The latter appeared to be partly associated with poor inter-staff communication between the commissioning member of staff and other members of staff who work directly with clients, and poor communication between staff and the music practitioner in general.

Additional findings

A number of additional findings, which were not specifically sought at the outset of this study, arose from the analysis of data. These included: i) the attitudes of some participants towards age and ageing, ii) the perceptions amongst some participants of dementia-focused services, iii) the way in which staff in the sample interacted with people in their care, vi) the way in which staff in the sample expressed their understanding of the term person-centred care, and, v) the apparent importance of informal social networks amongst staff in the sample. These findings are referred to in the Discussion chapter (Chapter Seven), where they help to explain certain perceptions, attitudes and practices.

Chapter Seven:

Discussion and Conclusions

The aim of the study was to examine the perceptions and experiences of care staff who might use music with people living with dementia. The emphasis was on the perceptions and experiences of care-givers because these are the people delivering most of the day-to-day care for those living with dementia (Dalley and Denniss 2001).

Whilst no literature was found on the specific subject of this study, the literature review revealed nine papers were most relevant to the investigation. These relate to applications of music in care settings in which staff are the central players. The first six, Clair (1996), Gotell, Brown and Eckman (2000, 2002, 2003, 2009) and Perry (2005) focused on the impact of live, staff-led music interventions for clients living with dementia. Chatterton (2009) focused on the effects of non-music therapists, including staff, singing with people living with dementia. The remaining two studies, Berger (2003) and Rose *et al.* (2008), explored music as a tool to develop models of reflective practice, whereby music interventions become the catalyst for developing care-givers' confidence and capacity for new levels of enquiry and more meaningful interactions with the people for whom they care. The authors of all nine studies commented briefly on how staff may feel about engaging in live music-making activities in their workplace. However, the issue of staff willingness and comfort to engage in these activities was only very briefly referred to. The findings of this study therefore represent an original contribution to research.

7.1 The context of the present study

In order to better understand the underpinning philosophical and psychological approaches to using music in care settings, the literature was viewed from four main perspectives. These were: i) the context in which people live with dementia in the UK today, which focused on demographic predications of longevity and the associated economic and social impact of the rising number of people living with dementia; ii) the development and challenges of reaching/maintaining high standards of care that encompass holistic well-being as a primary goal; iii) the origins, bio-physiology and neurology of music and the socio-musical practices over time that may relate to care-

givers' relationship with it today; iv) the impact and relevance of music in caring for people living with dementia.

7.2 Research questions

The study set out to answer four broad questions, which were summed up in the aim. These were:

1. What level and nature of musical activities are currently provided by visiting musicians in care settings for people living with dementia?
2. How are musical interventions perceived and their impact understood?
3. How do staff feel about training to develop skills to use music in care-giving?
4. How might musical interventions relate to wider perspectives of care-giving and the health and well-being of both staff and the people for whom they care?

To explore the factors that may underpin answers to the four questions, eleven objectives were identified. These were divided into four main themes: i) musical activities in care settings; ii) staff personal histories and attitudes relating to music; iii) staff perceptions of music in care settings; iv) the experience of using music with people living with dementia. These four themes provide the headings for this discussion.

7.3 Music activities in care settings

The study investigated musical activities in care settings through two objectives:

A: To examine the numbers and types of live musical activities taking place in a sample of care settings

B: To compare the funding mechanisms for live musical activities taking place in a sample of care settings

The enquiry began with telephone interviews with care staff from the sample of settings to ascertain the presence, number and types of musical activities that took place with visiting musicians during the previous year, and the funding methods. Focus group discussions with care staff and trainee music practitioners and face-to-face interviews with music practitioners were used to gather further data on these topics, and on the rationale and challenges of commissioning musical activities.

The results showed that musical activities had taken place in all of settings in the sample with variations in frequency of between once a year to more than once a month. The latter frequency was the most common. However, this result may have been misleading because three of the five day-care settings had received 12 x monthly music activity sessions during the study period which were provided free at the point of delivery by the charity Sing For Your Life Ltd. The managers of the settings in receipt of these activities reported that the free delivery of regular monthly sessions was not generally the norm.

The most common types of activities were performances by musicians, or music-hall style activities which were led variably by musicians or music practitioners, who were not necessarily performers but experienced workshop leaders. It was noted that staff tended to differentiate the two by using terms such as '*the music man/lady*' or '*music therapists*', or '*the music therapy lady*'. However, none of the four experienced music practitioners involved in this study were qualified music therapists, even though staff referred to a three as such. This implies an assumption on the part of staff which may be grounded in their observations of the style of the activities.

The main characteristic of the most prevalent activity, the music-hall style activity, was audience participation. Staff reported that the older people in their care were often invited to sing along in these activities to popular and familiar songs. The choice of material, which was most often popular songs from the 1930s, 1940s, 1950s and 1960s, was generally up-beat and fun in nature. This may relate to the literature that historically equates music-hall, which largely attracted people from the working class, with socio-political manoeuvres to encourage optimistic escapism and a diversion from social inequality (Middleton 1990; Bailey 2004). The older people's reactions to these activities, which, in the participant observations session, often included highly visual representations of enjoyment such as smiling, singing, foot-tapping, may have reinforced the impression that they were appealing to the widest range of people.

Perceptions of enjoyment also appeared to be the main reason for staff in the sample to commission the activities repeatedly. By contrast, the few staff who had commissioned musical activities outside the popular music genre, which had included a sung performance of operatic arias and a performance by a string quartet, noted that these

activities tended to elicit very few, or no, physical reactions from the older people. This was generally interpreted as disinterest. However, the literature points out that enjoyment relating to inner contentment through music may be less visually obvious (Small 1998). Diminutive, or absent visual evidence of enjoyment may also relate to contextually dependent patterns of social behaviour in Western cultures, such as sitting very still and quietly throughout an orchestral concert of classical music, for example. It may be the case that some of these behaviours are less familiar to some care staff and, consequently, are not fully appreciated.

The narrow choice of musical activities, that is, mostly popular music-hall style activities, may also imply an assumption on the part of commissioners about their clients' musical tastes and how they were formed. The literature suggests that people's musical experiences and subsequent practices are significantly grounded in their cultural and socio-economic histories (Tagg 1986; Small 1998; Bailey 2004). In this case, the most commonly commissioned activities may not be relevant to some older people living in care settings at all in terms of their previous experiences.

Whilst the material presented by the musicians may not have been the first choice of some of the older people, because of its ubiquity in their younger lives it may nevertheless take on a personal meaning by providing a narrative relationship to their lived experiences, albeit perhaps peripherally. In view of the literature that highlights the value of using familiar music with people living with dementia (Pollack and Namazi 1992; Lord and Garner 1993; Gerdner 2000; Son, Therrien, and Whall 2002) this appears to be positive practice. There may also be some value in cohabitants of an institution using familiar music to express themselves as a collective. However, willingness to conform to any form of activity may indicate the phenomenon of institutionalisation (McCarney, *et al.* 2007), particularly if the activity is far removed from a person's historical experiences and cultures. This raises the potential for music activities to compound institutionalisation, rather than to liberate people from it.

The telephone interview participants were also asked to give information on how musical activities were funded. Frequent comments from commissioning personnel indicated tensions between the desire to engage musicians and the ability to pay. At least nine-tenths

of staff from the sample had commissioned solo musician/music practitioners rather than groups of musicians. Whilst no statistics on the numbers of musicians working in care settings and their patterns of work were found in the literature, the common pattern shown in this study may relate to the level of available monetary resources. Most commonly, musicians were either paid for by care settings' internal resources or they were volunteers. No staff member in the study reported regular allocation of funding for music activities specifically, rather funding tended to be drawn from an 'activities fund', and the nature of activities varied. This indicates that although music is viewed as a positive activity, it does not necessarily take precedence over other activities.

It was interesting to note that only six or seven staff out of 59 focus group participants commented on the quality of services provided by either paid or voluntary musicians. No participant referred to any musician being asked to attend an audition, but one participant had not re-commissioned a musician owing the perceived poor quality of his service. In the infrequent case of paid musicians providing a free taster session for staff to judge the suitability of their services, the criteria for re-commissioning depended first and foremost on the affordability of the service.

An apparently relaxed attitude about the standard of music activities may illustrate three points. Firstly, it may indicate that some staff are undiscerning about the quality of musical services on offer. This may reflect a limited exposure to live musical activities *per se*, or it may relate to a paucity of relevant information. Although one music practitioner had provided written information on the process of her music sessions and the theory that underpinned them, and one organisation claimed to be delivering evidence-based services, references to scientific studies were brief with inadequate source information. This made it difficult for commissioners to investigate the evidence in more detail, which resulted in their engaging musicians/practitioners who had provided little or no theoretical validation for their services. The second point concerned institutional expectations whereby the calibre of musical events in care settings may not be expected to come under rigorous scrutiny. These two points highlight the recommendations in the literature for training staff to better understand music-related interventions (Clair 1996; Brotons, Koger and Pickett-Cooper 1997; Gotell *et al.* 2000, 2002, 2003, 2009; Sixsmith and Gibson 2007). To this end, Brotons *et al.* (1997) advocated a collaborative

relationship between music therapists who specialise in the field of dementia and care staff who might like to include music in their care-giving. The third point related to the broader social elements of music activities. This was illustrated by the comment of one commissioning manager who always welcomed any musician to entertain clients, whether paid or unpaid, because it enabled important social interactions from people outside the setting. This indicates that the social interaction was considered as significant as the musical content, and therefore the quality of the latter may have been less of a focus than in other situations.

In answer to the investigation of music activities in care settings, the study found that, although varied in frequency, music-hall style activities were the most common in the sample of care settings. The challenges of delivering a range of music activities to address a wide spectrum of quality of life issues for people living in the care settings appeared to centre not only on funding limitations but also on the availability of information for staff who commissioned the activities.

7.4 Staff personal histories and attitudes relating to music

The study investigated staff personal histories and attitudes relating to music through two objectives:

C: To examine staff experiences of music in childhood

D: To investigate staff perceptions of the value of music in their personal lives

The objectives were explored through a questionnaire survey and focus group discussions with care staff. Findings showed that staff engagement with music in childhood was embedded in cultural, social and family influences and experiences of music at school. Experiences of singing in and outside of school were also specifically highlighted as important. These collective experiences appeared to have had variable influences on staff perceptions of the current value of music in their personal lives.

7.4.1 Cultural, social and family influences relating to music

More than three-quarters of participants referred to the powerful impact of live music-making experiences in their young lives. Most of the study's participants were children

between 1940 and 1990 when popular music and music-listening became increasingly available through mass-media (Tagg 1982; Scott 1990; Longhurst 2007). Much of this music centred on uncomplicated melodic sequencing, simple harmonic foundations and time signatures, and simple repetitive forms, such as binary form (A, B, A; e.g. chorus-verse-chorus) (Tagg 1982; Scott 1990). It was notable that only 3% (n = 2) of the British-born participants reported high levels of familiarity with non-popular music genres compared with all of the Philippine-born participants (n= 5) who, in addition to enjoying popular music also reported learning to play music by composers such as Mozart and Beethoven. Although the numbers involved are far too small to generalise, this implies that the Philippine-born participants had access to music that involved more complex structural and harmonic underpinning, which tended to be less popular to a mass audience in the UK (Adorno 1973).

Findings in the study centring on music and faith reflected the legacy of music within Christian doctrine that was identified by Turner (1993) and Boyce-Tillman (2001). The tradition of a day free from work on Sundays, for example, enabled participants and their families to listen to popular music on the radio or radiogram together and all participants remembered singing Christian hymns at school. However, it was interesting to compare the different experiences between the participants from England and those from Ireland, Nigeria, Nepal, the Philippines, South Africa and Thailand. In the latter, faith-orientated music activities with the wider community and with families in and outside the church, appeared to be far more prevalent. In view of the wide-spread collapse of faith as a dominant influence in England from the mid twentieth-century (Parsons 1951; Boyce-Tillman 2007), this finding is likely to bring up some comparisons between the church-based music activities of care-givers today and those of the older people for whom they care.

Around three-quarters of participants identified the growth of technology as the primary change in their musical behaviour and choices of music during their teen years. The advent of portable audio equipment enabled an increase in the participants listening to music as an isolated activity. This led to higher levels of autonomy and choice (North, Hargreaves and Hargreaves 2004; Bull 2005). Around a third of participants also remembered choosing to listen to radio stations that targeted young people, such as Radio

Caroline. Participants in one focus group suggested that these changing practices emphasised a growing generation-related schism of musical tastes between parents and their children. This issue was thought to transfer to care-settings, in which younger members of staff and the older people in their care may find difficulty in enjoying the same music.

Around six or seven participants gave vivid accounts of very early childhood memories. These centred on live music-making experiences and tended to be extreme, either highly negative or highly positive. Positive memories tended to be associated with mothers singing to participants in very early childhood. Staff used terms such as 'feeling happy/calm', to illustrate a sense of well-being associated with hearing their mother's singing. One theory that might explain positive responses to maternal singing is the *adaptation* theory, which links singing and music-making to the survival of the human species (e.g. Darwin 1871; Blacking 1973; Cross 1992; Miller 2000; Sloboda and Juslin 2002; Huron 2003; Sloboda 2007; Levitin 2008). Other theories include: i) the *exaptation* theory; which positions music as a consequence of cultural and evolutionary trait development (Pinker 1997); ii) the musical genome theory, which rationalises the relationship between music and human-beings in terms of a genetic predisposition (e.g. Trainor and Trehub 1992; Parncutt 2007; Trehub 2003; Hauser and McDermott 2003). These theories may strengthen the rationale for using music in care settings for people living with dementia because they imply an innate relationship between human-beings and music that is not necessarily dependant on higher cognitive functioning.

Two participants recounted memories of embarrassing experiences whilst performing in nativity plays at nursery school. These were reported by the narrators as having shaped their attitudes towards musical performance in adult life. This supports the potential for early musical experiences to engender life-long feelings and behaviours around music-making (Welch 2000; Bannan 2000; Richards and Durrant 2003; Pitts 2008) and may relate to the level at which staff are willing to engage with music in adulthood.

7.4.2 Staff experiences of music at school

Whilst only few participants remembered very much about pre-school musical experiences, the comments of about three-quarters supported the literature that observes

the potential impact of people's experiences of music education at school in later life (Welch 2000; O'Neill and Green 2001; Walker 2001; Coll and Finney 2007).

Positive memories of music at school, which were referred to by over half of the British-born focus group participants, tended to be associated with learning to play the recorder at primary school. This was often affectionately referred to and tunes which participants had learnt were frequently well-remembered. Those referred to reflect the standardised structures and simple repetitive forms commonly found in popular/folk music (Scott 1990). These positive experiences for participants may support a taste for popular music in later life.

With the exception of one participant, who was an undergraduate studying music and working as a part-time care-giver, no participant had engaged in advanced instrumental or voice training. Five or six participants remembered learning to play an instrument as an extra curricula activity in childhood, but this mostly occurred for a limited period. One reason given for the short duration was the family's financial limitations. The challenge of families paying for music tuition was highlighted by participants in three focus groups and in the literature (Drummond 1999; O'Neill and Green 2001).

Another reason given by participants for their stopping extra-curricular instrumental lessons was disinterest, particularly in their teen years. Both the literature and the commenting participants identified decreasing engagement with music as they progressed through the education system (DES 1978; Paynter 1982). Reasons identified in the literature were reflected by at least half of the participants who reported that music at secondary school had had little social or educational relevance to them personally (Davidson and Smith 1997; Johnson 2004).

A small number of participants reported being deterred by their secondary school's emphasis on high-brow music, music theory and skill-excellence, believing these foci to relate only to certain students. This supported Walker's (2001) observation that priority was, and arguably continues to be given to students who demonstrate musical aptitude and instrumental skill and who use these to strive for educational accolades.

At least four-fifths of focus group participants claimed that they were not musical. Amongst this group, their reported lack of musicality appeared to centre wholly on their perceived lack of instrumental or singing skill. However, Bentley (1966) suggested that the definition of musicality is grounded in institutional judgements, which shapes teachers' attitudes and methods of teaching. Very few participants reported opportunities to explore their musicality creatively for its own sake at school, although Paynter (1996) and Coll and Finney (2007) and Bannan (2000) highlight the importance of nurturing creativity to engender musical confidence amongst school students, which may also transfer to other areas of confidence in later life.

7.4.3 Staff perceptions of the value of music in their personal lives

The absence of creative opportunities in music education may have played a central part in the way in which participants engaged with music in their personal lives. Although claiming to be non-musical, over nine-tenths of British-born focus group participants reported engaging with music at a high level. However, they defined 'music' in terms of listening to music, rather than engaging with live music-making activities. Their general preference tended to centre on popular, commercially generated music, such as pop and rock, rhythm and blues, country and folk music. Despite a change in popular culture, which meant easier access to a huge diversity of musical genres at the end of the twentieth century (Meyer, 1994; Emmerson 2001), very few participants routinely elected to purchase or listen to music linked with the Western Classical Tradition or to tune their radios to BBC Radio Three or Classic FM, for example.

A sense of elitism associated with this music was demonstrated by participants' using descriptive terms such as '*proper music*', '*high brow*' and '*la di da* [music]'. The compartmentalisation of different genres of music and the belief that certain genres are inaccessible appeared to be linked to social conditioning and experiences of music in childhood and maintained by the experiences that presented themselves in later life (Walker 2001). The common tendency for staff to feel comfortable with popular music in care settings today may reflect their relationship with it in childhood and in later life.

Over nine-tenths of questionnaire respondents agreed that music could help them feel good about themselves. The results showed that favourite, familiar music was variably used by respondents recreationally or as entertainment, to reflect and/or alter mood and

to physically energise. These findings supported theoretical perspectives of the purpose of music in human existence which variably focused on music's ability to elicit pleasure (e.g. Pinker 1997; Stefano *et al.* 2004), to reaffirm deeply ingrained patterns of self and a sense of safety and security (Hargreaves, and North 1999; Berger 2003) and to reflect emotional states and affect emotional changes (e.g. Sloboda and Juslin 2001; Sloboda 2001).

Participants from four focus groups identified songs or music that always induced emotional reactions leading to, for example, laughter, tears, rising '*hairs on the back of the neck*' and/or '*goose-pimples*'. These affects relate to research by Sloboda (1991; 1998), Panksepp (1995), Sloboda and Juslin (2001), Panksepp and Bernatsky (2002) and Stefano *et al.* (2004), who collectively describe the intrinsic effect of certain musical structures from a neuro-physiological perspective. In particular, the researchers refer the effect of emotions relating to key changes, syncopated rhythms, grace notes and falling melodic lines. Although the focus group participants did not express knowledge of research that underpins their experiences, the experience itself appeared to cement their belief in music's power to positively affect emotion for them personally. The capacity for music to support the well-being of staff in these ways indicates its potentially wider value in the context of care-giving environments. This relates to the nine most relevant studies found in the literature (Clair 1996; Berger 2003; Gotell, Brown and Eckman 2000, 2002, 2003, 2009; Perry 2005; Rose *et al.* 2008; Chatterton 2009), which nominally highlight a various applications of music to support the well-being of staff in addition to the people being cared-for.

7.4.4 Singing

The concept of staff singing as a care intervention, as examined by Clair (1996), Gotell *et al.* (2000, 2002, 2003, 2009) and Perry (2005) and Chatterton (2009), is largely dependent on their willingness to sing. There may be a range of influencing factors that support staff singing, which centre on cultural and family experiences in young life.

In the current study, more than nine-tenths of the British-born participants related the phrase 'music in childhood' to listening to music. However, whereas all of the Philippine-born staff and the staff from Ireland, Nepal, Nigeria, South Africa and Thailand related to this, they also equally referred to it in terms of singing with their family group. This factor

may lead to variable attitudes amongst staff towards singing with/to the people for whom they care, which may be culture dependent.

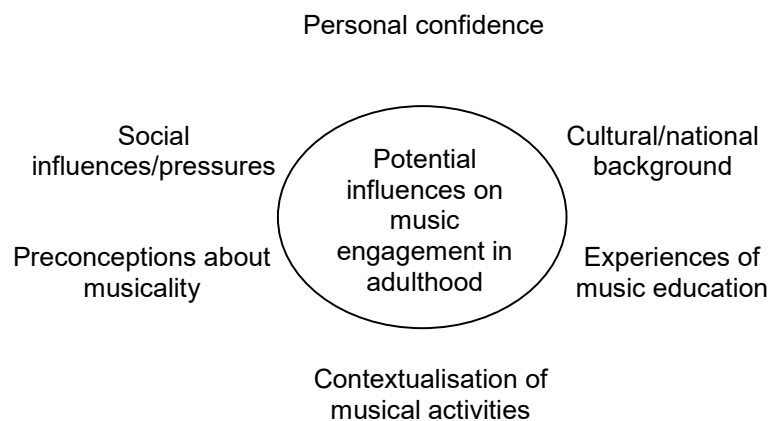
Most participants, regardless of their nationality, believed that singing could enhance a personal sense of well-being. Just under three-quarters of respondents and around nine-tenths of focus group participants enjoyed singing in private. Descriptions used to illustrate the effect, such as 'makes you feel good'; concurred with studies that reported positive psycho-dynamic benefits associated with singing (Clift and Hancox 2001; Clift *et al.* 2008) and bio-physiological changes associated with supporting mood, memory and the immune system (Grape *et al.* 2003; Beck *et al.* 2000 and Kreutz *et al.* 2004).

However, for the British-born participants, well-being associated with singing did not often transfer to sharing singing activities. Over three-quarters worried about singing in situations where they may be overheard. This appeared to relate predominantly to self-perceptions of poor singing skill. It was interesting to note that no participant of any nationality claimed to have a good singing voice, yet the participants from Ireland, Nepal, Nigeria, the Philippines, South African and Thailand reported enjoying singing regularly with family and friends, regardless of their perceived abilities. This finding may be associated with a national/cultural reticence or tendency to promote, or even acknowledge, inherent talent or ability (Siebenaler 2008), or it may be grounded in the level at which national institutions dictate judgements of singing ability.

In the current study, insecurity around singing amongst British-born participants was often associated with ridicule from family members/friends or negative behaviour, such as fierceness of singing/choir teachers/leaders at school. This latter point reflects the literature which identified potentially life-long influences of teachers' behaviour towards pupils' singing at school (Welch's 2000; Turton and Durrant 2002; Pitts 2008). However, some participants in the current study who had not enjoyed singing at school, did enjoy singing as an adult, and vice versa. Three participants suggested that a confident personality could overcome negative experiences and underpin enjoyment to sing in later life. This supports Turton and Durrant's and Pitts' observations that good or bad experiences at school need not consistently colour attitudes towards singing in adult life in either direction.

In the current study, participants' willingness to sing also appeared to be determined by context. The findings showed that 71% of 111 questionnaire respondents liked to sing in private. This was higher than in Turton and Durrant's (2002) study in which under half (40%) of the sample of 60, reported singing alone. However, some findings in both studies corresponded. For example, around a quarter of participants in both studies reported singing congregational hymns at church weddings and around quarter expressed willingness to sing at Karaoke events. Very few in either study sang either with/to their children or in amateur dramatic societies. These findings illustrate the variable attitudes that people have towards singing in different contexts.

Fig. 7.1 Influences on music engagement in adulthood



In answer to the investigation of staff personal histories and attitudes relating to music, some significant musico-social changes over the last half decade are likely to have affected the way in which staff and their clients each relate to, and engage in music. The musical experiences of staff in childhood appeared to have influenced their engagement with music personally in their adult life to some extent but this was not consistent. Figure 7.1 shows the six main factors that were raised by participants as influential in relation to their willingness to engage in music, particularly singing in their adult life. These were: cultural/national background; music education experiences; the context in which music occurs; preconceptions about the definition of/their own musicality; social influences and pressures; levels of personal confidence.

7.5 Staff perceptions of music and music related training in care settings

The investigation into staff perceptions of music in care settings and their views on music-related training was addressed through five objectives. These were:

E: To investigate the levels at which staff engage in music in their workplace

F: To investigate staff perceptions of the value of music in their care setting

G: To examine staff perceptions of the impact of music on their clients

H: To investigate staff perceptions of the practicalities of including music in their care settings

J: To investigate staff attitudes towards music-related training

The objectives were explored through the questionnaire survey and focus group discussions. Findings showed that a number of factors appeared to influence staff perceptions of music in care settings. These centred on: singing in the context of care settings; the levels at which staff usually engaged with music in their workplace; staff perceptions of the value and impact of music for people living with dementia; staff perceptions of the practicalities of including music in their care settings; staff attitudes towards music-related training.

7.5.1 Singing in the context of care settings

This finding relates most significantly to the literature on singing as a care intervention (Clair 1996; Gotell *et al.* 2000, 2002, 2003, 2009; Perry 2005; Chatterton 2009). Most focus group participants advocated singing in the context of their workplace in principle but the levels at which they engaged in singing personally varied considerably. This ranged from about a quarter adamantly rejecting the notion of singing at work to two participants' regularly leading singing sessions with the people in their care.

Most of the participants' objections to singing at work centred on their self-perceived lack of singing ability. The participants' emphasis on the quality of singing rather than the emotional connection it might engender, may relate to the long-term effects of Plato's doctrine of excellence and the tendency for music education to de-prioritise the aesthetic

qualities of music in favour of the pursuit of excellence (McCarthy and Globe 2002; Reimer 2003; Johnson 2004). It may also relate to the current-day omnipresence of institutional judgements of musicality (Bentley 1966; Bannan 2000; Reijnders, Rooijackers and Van Zoonan 2007; Walker 2007), and the technological advances that mean people who engage with singing today by listening to recordings, do so in the context of highly-produced and artificially polished singing performances (Emmerson 2001; Walker 2007).

Four or five participants referred to context-related issues in which singing might be seen as improper or frivolous, such as in end-of-life care situations, or when practical care-giving needs to take priority. The same participants believed that the authority of care-setting owners might be jeopardised if they were to sing in the workplace. Two registered nurses reported leading singing sessions in their workplace but only when dressed in civilian clothes. This implies a need for clarity in terms of how staff-led singing activities are classified. If considered entertainment rather than a therapeutic intervention, as described by Gotell *et al.* (2000, 2002, 2003, 2009), then staff may believe it to be tangential to their care-giving role.

7.5.2 Staff engagement in music activities

The investigation of staff engagement in music activities was sought from two perspectives, their engagement in staff-led activities and their engagement with musician-led activities. More than half of the questionnaire respondents (54.1%) reported that had never engaged in staff-led music activities. However, further investigation with focus group participants revealed that the term 'staff-led activities' was ambiguous. Further discussions revealed a range of organised staff-led activities, such as musical bingo, and spontaneous activities, such as singing with/to clients and/or initiating rhythmic-movement or dancing. These interactions, which relate to the concept of integrating singing into care processes (e.g. Clair 1996; Perry 2005; Gotell *et al.* 2000, 2002, 2003, 2009; Chatterton 2009), were usually short in duration, not general across all settings and appeared to depend upon the enthusiasm of key members of staff to activate the initiatives.

Just over a third of questionnaire respondents reported having never engaged in 'musician-led activities'. In discussion with focus groups the term 'musician-led activities' was understood to include adults' and children's singing groups, solo musical performances and/or interactive music activities led by community music-practitioners.

The study showed that around nine-tenths of staff appeared particularly uncertain about their role during music practitioner-led activities. This was apparent by staff standing at the periphery of the room, often by the door, and their lack of consistent interaction with the older people or the music practitioner. This uncertainty of role may relate to perceptions amongst staff that music is a specialist activity and is, therefore, tangential to their care-giving role. It may also indicate the need for greater levels of communication between staff and the music-practitioner.

7.5.3 Staff perceptions of the value and impact of music in their care setting

In the main, participants appeared to regard the value of music activities in their settings in relation to the people in their care and not themselves. More than half of the focus group participants reported that their enjoyment was associated the apparent pleasure that the older people experienced. This may underpin the reasons why staff distance themselves from musician/music practitioner-led activities.

The value of music to affect psychological and emotional well-being was discussed by more than four-fifths of focus group participants who had observed one or more changes in the behaviour of the people for whom they care. The identified changes included improvements in mood and social interaction (e.g. Cevasco and Grant 2006; Tadaka and Kanagawa 2007), better emotional expression and higher levels of communication (Sherratt, Thornton and Hatton 2004), improved memory stimulation (e.g. Son, Therrien, and Whall 2002) and reduced agitation. However, five or six participants reported a belief that when agitation is associated with the late stages of dementia, no intervention is likely to be effective. This may relate to the literature that showed various effects of music on different types of agitation/aggression Goddaer and Abraham's (1994) and different stages of dementia (Clair and Bernstein 1990; Clair, Bernstein and Johnson 1995; Brotons 2000).

Although the observations of participants in the current study appeared to accurately reflect the research evidence on the value of music for people living with dementia, none reported an awareness of any specific study or studies. This may imply a need for better and more accessible information for staff.

Whilst over nine-tenths of participants agreed that music in some form was of value to most clients, a small number suggested that its value may be limited for older people with profound cognitive impairment. This was judged on an apparent lack of response and/or the desire to avoid over-stimulation. No participant commented on the potential value of different types of musical interaction with different clients, as identified in the literature. Again, this may indicate the need for better information for staff.

7.5.4 Staff attitudes towards music-related training

The Department of Health's most recent policy document on dementia care (DH 2009) has emphasised the importance of including therapeutic arts in models of care. However, the mechanisms to implement and sustain therapeutic arts in these settings are not made clear. It may therefore be reasonable to strongly recommend training and supporting the care staff who spend the most time with people living with dementia in care homes to use the arts therapeutically. Issues found in the current study that relate to training staff to engage with music in this context may contribute to the wider picture pertaining to the DH's proposal relating to arts in general.

Over half of the questionnaire respondents (58 %) answered 'Yes' to the question, "Would you use music more if training were available?". This meant that just under half answered 'No' or 'Not sure'. Around two-thirds of focus group participants gave their opinions on this response. Some of these opinions related to overarching issues of training *per se*.

At least half of focus group participants reported having undergone, or were planning to undergo, a range of mandatory and professional-development training courses. Such training was met with varying levels of enthusiasm. Although most participants reported being empowered by most, but not all, training opportunities, more than three-quarters had experienced some level of practical and/or personal barriers to training. The first of these barriers centred on poor staffing levels. Although the literature provided policy-

level benchmarks for staffing levels (Laing (2002), participants in the current study highlighted the frequent challenges that arose around staff sickness and the difficulty of anticipating changes to the intensity of clients' care needs. To address problems of adequate staffing levels during mandatory and other training, some staff were asked to attend training sessions on their days off. This practice appeared to engender some resentment amongst staff, which in turn led to negativity about the training from the outset.

Around a quarter of participants referred to the difficulties of balancing family and other personal commitments and one participant highlighted the likelihood that some part-time staff might also have a second job. These issues concurred with Bruce's (2004) and Marshall's (2006) observation that the success of any training programme is largely dependent upon senior staff understanding the personal and professional pressures and commitments of their staff.

A further barrier to training, which was identified by around a fifth of participants, related to low levels of confidence. At least half of the participants in the study reported struggling with confidence when faced with completing written coursework for an NVQ programme. This may relate to the literature on the motivation of care-assistants who choose the work because of the appeal of its task-orientation nature and the absence of academic measures of achievement (Bruce 2004). However, recent changes have meant that care-givers are increasingly required to engage in academic-style learning at some level. This may create tensions for some care-giver which implies a more flexible approach to training may be needed. In her theoretical perspective, Berger (2003) focuses the concept of musical creativity and improvisation and its synergy with successful relationships between staff and the people for whom they care. Rose *et al.* (2008) illustrate how Berger's theory can be applied in their music-centred training for dementia-care staff to explore reflective practice.

Approximately half of the focus group participants identified three key barriers that related specifically to music-related training. These were: i) a perceived lack of musical skill amongst staff, ii) an uncertainty of what such training might entail and, iii) a lack of clarity about its impact on the people in their care. In addition, a small number of

participants suggested that, in the context of limited financial resources for continued professional development for staff *per se*, the topic of music was unlikely to be prioritised. The identification of these barriers provided insight into staff perceptions of their potential role, their expectations of how music may be delivered therapeutically and its intended outcome. The barrier concerning lack of musical skill indicated a preconception about the musical qualities needed to facilitate or share music activities. This may have been grounded in participants' observations of musicians performing and/or music practitioners leading music-hall style activities. These may be roles to which most participants felt they could not aspire.

Difficulties for staff to imagine the role they might take as non-music specialists may have centred on what they recognised as a valuable therapeutic activity. It was interesting to note that staff generally under-acknowledged the level of staff-led interactions that took place in their care settings. Activities such as staff listening to recorded music with a client, or exploring a life narrative through musical reminiscence, as described by Batt-Rawden (2006), rocking or swaying clients, or singing or humming in one-to-one care situations, as explored by Gotell *et al.* (2000, 2002; 2003, 2009), Gerdner (2005) and Perry (2005), all constituted meaningful music activities yet these were not necessarily recognised by staff as such.

The investigation into staff perceptions of music and music related training in care settings showed that whilst staff generally advocated the use of music in their care setting to benefit the people for whom they care, they did not necessarily expect to benefit from the activities themselves. More than two-thirds of staff did not feel equipped to initiate music activities in the workplace that went beyond facilitating background music. However, there was evidence of a number of valuable staff-initiated music activities that staff did not recognise as being of therapeutic value. This implied that staff may not recognise the presence of latent musicality, thus the potential for this to be nurtured through training was not acknowledged. This factor, and general issues of staff confidence, staffing levels, timetabling and funding, appeared to negatively influence staff welcoming music-related training.

7.6 Music Practitioners' experiences of using music with people living with dementia

The study investigated the experiences of music practitioners using music with people living with dementia through two objectives:

K: To investigate the experiences and perceptions of music practitioners working in care settings

L: To examine the relationship between music practitioners and staff when working in care settings

The objectives were explored through a focus group discussion with trainee music practitioners, face-to-face interviews with experienced music practitioners and participant observations of music activity sessions. Findings highlighted key factors to affect music practitioners' experiences. These were commissioning processes, the challenges of working with people living with dementia, the music practitioners' perceptions of the impact of music on people living with dementia, and the relationship between the music practitioners and staff.

7.6.1. Commissioning processes

The study showed that the music practitioners perceived some level of challenge to working in care settings from the point of access. All of the experienced and trainee practitioners believed that the majority of care staff advocated the regular use of music to support the quality of life of the people in their care. However, in all but one instance, contact between care settings and the music practitioners was initiated by the practitioners. This may indicate a paucity of information for care staff or an expectation on the part of staff, and/or the music practitioners, that marketing music activities is the responsibility of the latter.

The concept of 'selling' music as a commodity elicited some difficulty for at least half of the music practitioners and trainees. All five of the experienced practitioners reported that funding was often a barrier to staff commissioning music activities. Over two-thirds of the music practitioners and trainee practitioners believed that their services would be

readily welcomed if music interventions were seen as part of mainstream care, and funded, or partly funded, by local authorities or the NHS. This highlights the wider question of the value placed on arts in healthcare in general. It also highlights issues raised in the literature around models of care for people living with dementia and the priorities within those models (e.g. Kitwood and Brendin 1992; Kitwood 1997; Bender 2003; Balfour 2007).

7.6.2. The challenges of working with people living with dementia

Three out of the four music practitioners referred to the difficulties of working with older people who live cognitive disabilities. Factors identified as difficult to manage included the apparent distress of some people, some of the environments in which they lived, physical appearance and behaviours that did not reflect the norm, and difficult-to-gauge responses to the practitioner/music activities. Two practitioners associated this with the social exclusion of older people living with dementia (e.g. Kitwood 1997; Langdon *et al.* 2007), which meant that they were initially unused to spending time with individuals who appear different and manifest these types of behaviours. This may also reflect the wider societal issues of ageism and stereotyping older people, as discussed in the literature (e.g. Cuddy and Fiske 2002; Seabrook 2003; ACE 2005). The presence of socially constructed discourses on these issues continues to challenge overarching changes to exclusion.

One practitioner believed that some musicians would reject work in care settings because it is not well respected amongst other professional musicians. This observation, which was also illustrated by one staff member who suggested that care settings cannot usually afford to engage 'high-quality' musicians, may also engender neutral or negative attitudes amongst staff towards musicians working in these settings. This may indicate a need for professionalising the work of musicians and music practitioners working in this field.

7.6.3 The impact of music activities on people living with dementia

Interviews with the experienced music practitioners revealed two distinctly different approaches to delivering activities. The differences importantly highlight two main applications of interactive music activities in the care of people living with dementia. The first, the music-hall/performance approach, relates to a range of studies in which the focus of value is on the person living with dementia (e.g. Clair and Bernstein 1990; Goddaer

and Abraham 1994; Clair *et al.* 1995; Brotons 2000; Son *et al.* 2002; Sherratt *et al.* 2004; Cevasco and Grant 2006; Tadaka and Kanagawa 2007). In the current study, the success of these activities tended to be measured by the music practitioners in terms of how happy participants appeared to be. The second approach relates to the further-reaching impact of music on staff as well as the people for whom they care (Berger 2003; Rose *et al.* 2008). This approach represents a quasi psycho-therapeutic intervention, in which the practitioners used musical improvisation to affect some level of change. The success of this approach was measured by the music practitioners in terms of expressive exchanges that occurred between individuals and the group as a whole. Reflecting the model of music interaction described by Rose *et al.* (2008), this second style of delivery, which includes staff as a norm, aimed to encourage creativity and non-hierarchical communication between people living with dementia and their care-givers. The approach is grounded in a culture of care, first described by Kitwood (1997), in which relationships between care-givers and the cared-for are reflective and person-centred. This model also highlighted one of the ways in which staff can engage in practical music-making to develop their creative and reflective skills and, in doing so, may benefit their own quality of life (e.g. Clair 1996; Brotons, Koger and Pickett-Cooper 1997; Gotell *et al.* 2000; 2002; 2003; 2009; Sixsmith and Gibson 2007).

It was interesting to note that the two music practitioners, who tended to focus on the older people *and* staff sharing improvisation activities, used the preparation for an activity session as to develop a relationship with staff. Whilst these practitioners had an expectation to help to prepare the room and gather clients, the practitioners who facilitated music-hall style activities did not have the same expectations. This may reflect the psychology associated with the different styles of delivery, whereby the audience and the setting for a music-hall style activity would not normally be the responsibility of the performer. It may also reflect a different concept of the role of the music practitioner as performer, as apparent in the music-hall style approach, and as facilitator, as apparent in the improvisation approach. This indicates that some music practitioners are applying therapeutic elements to their practice and may benefit from working more closely with music therapists (e.g. www.nordoff-robbins.org.uk).

7.6.4 Music practitioners' perceptions of the impact of activities on clients

In the current study, the trainee music practitioners attributed the benefits of music for people living with dementia to the probable presence of a musical blueprint in the brain. The trainees concurred that rhythmic and melodic elements that occur in nature underpin musicality in all human beings, which, importantly, is not necessarily dependent on cognitive function. This discussion related to the literature that argued variably for and against a genetic musical blueprint (Darwin 1871; Blacking 1973; Cross 1992; Sloboda 1994; Pinker 1997; Trehub 2000; Miller 2000; Tramo 2001; Huron 2003; Morely 2003; Trehub 2003; Parncutt 2007).

The trainee practitioners also reiterated the strong association between familiar harmonic structures embedded into Western popular music and related this to the natural harmonic series. This is the order in which the ear unconsciously hears the subtle overtones of one single note. The observation related to the improvisational delivery approach of two of the music practitioners, the basis of which was grounded in harmonic sounds created by these overtones. The association between natural overtones and popular music may also provide another explanation as to its popularity amongst staff in their personal lives and in the workplace.

It was interesting to note that around two thirds of the music practitioners and trainee practitioners collectively expressed a desire to avoid cathartic responses from the older people. Most acknowledged the potentially positive value of cathartic experiences but, whilst one practitioner described her practiced responses to music-induced tears, the remainder felt ill-equipped to deal with sad emotions.

The issue of dealing with emotional responses may relate to the experience of music practitioners and their training opportunities. Most of the trainee music practitioners commended the training opportunities that had been provided for them as part of their music degree programme. The training included the observation of at least two experienced music practitioners and mentored practice placements in care settings. This process enabled the trainee practitioners to observe the relationships between the practitioners and staff in the settings, the practitioners' delivery approach and material and their interaction style with the older people. However, the experienced music practitioners

themselves had undergone little or no formal training to work in these settings. With the exception of one practitioner, who had engaged in a training day for new franchisees of a company that specialises in the provision of music services in care settings, the other practitioners reported no knowledge of training opportunities to support their practice.

The notion of music practitioners helping to train staff to undertake a more active role in delivering music activities may be dependent on the practitioners' perceived and relevant skills-base. Three of the music practitioners and about half of the staff in focus group discussions agreed with the idea in principle. However, in addition to issues of staff-willingness, practicalities and funding being raised by both parties as potential inhibitors, two practitioners stated that they would appreciate training to support them to take on this role.

7.6.5 The relationship between music practitioners and staff

The study aimed to provide an understanding of the relationships between music practitioners and care staff. The results showed that these relationships varied considerably from setting to setting and sometimes from session to session. One of the compounding factors appeared to centre on the practical issue of time for staff to prepare the older people and the allocated space. A small number of focus group participants reported that this was particularly stressful they, as the staff responsible for these tasks, had been unaware of the pending session until the music practitioner's arrival. On these occasions, the omission of senior staff to communicate the planned activity may indicate that other elements of care were prioritised. This highlights issues of the value placed on different care-giving mechanisms, which may relate to the challenges of changing cultures of care for people living with dementia (e.g. Kitwood and Brendin 2004).

The music practitioners also believed that staff attitudes towards the activity affected the relationship between the two parties. Three music practitioners believed that staff would be more receptive to music activities if they understood the philosophical underpinning and its value for the people in their care. Two practitioners, who had been involved in training care staff to use music in their settings, remarked that an overview of current research on the psychological and physiological benefits of music interventions appeared to encourage staff to support the work of music practitioners in their care settings.

The study showed that the tensions identified in relationships between music practitioners and staff appeared to centre on poor communication and the impression that music activities are not usually prioritised as a primary care need. The problems that ensued appeared to impact on staff attitudes towards commissioning music activities, their awareness of the role of the music practitioner and the role of music in the context of care settings. The paucity of communication also appeared to affect the practitioners' awareness of the challenges that staff may face in their day-to-day work. This issue also appeared to impede the potential for the two parties to work together in a shared learning capacity, even though representatives from both expressed an interest to do so.

7.6 Additional findings

7.6.1 Attitudes toward ageing

The additional findings in this study, which were not specifically sought at the outset, may provide some background information to aid an understanding of the overall findings. These included references from participants which related to the literature, including the likelihood of their developing dementia (Comas-Herrera, Wittenberg, Pickard *et al.* 2003; Ferri, Prince, Brayne *et al.* 2005; Dementia UK 2007) and the concept of their being a burden on younger people in older age (Miller *et al.* 2003; Seabrook 2003; Mental Health Foundation and Alzheimer's Society 2008). The fact that these references were very few might indicate that the participants did not generally relate to themselves to getting old. This may be a mechanism that staff adopt to protect against facing the possible consequences of ageing, which confront them on a daily on basis, but it may also have the effect of limiting empathy for the people in their care.

7.6.2 Dementia-focused service and training

A second additional finding related to staff perceptions of dementia-focused services. Their reports of clients with complex co-morbidity residing in the whole range of care categories, including people with moderate dementia living in non-EMI residential settings, highlighted the challenges that staff often face. It also reflected Ford's (1998) argument for adequately staffed mixed care establishments. There was also a discussion on the true value of dementia care training. In contrast to advocates of robust training and education in this field (e.g Hawkins 2008), a few staff believed it to be superfluous. This

observation was grounded in the belief that intuition and intimate knowledge of a person living with dementia underpins good quality care. This may indicate a refined and innate ability for caring well, or it may otherwise indicate an unawareness of the highly specialised and complex skills needed to affect good care.

7.6.3 Staff interactions with people in their care

The researcher's observations of staff interactions with people in their care reflected a range of care models. Although about two-thirds of focus group participants referred to their clients the way in that indicated some sense of hierarchy, most of the interactions witnessed in the participant observation sessions indicated an affectionate and demonstrative relationship. Staff frequently used teasing banter and affectionate hugging and touching and appeared largely to respond in some way to any person in their care who displayed an apparent need or distress. These interactions appeared to reflect psychosocial and/or interactionist models of care that were highlighted in the literature (Engel 1980; Antonovsky 1984; Seadhouse 1986 and 1997; MacPherson 1993; Earle 2007). However, a number of comments from focus group participants also indicated a loyalty to task-based and biomedical care orientations. Examples included the non-scheduling of recreational activities on 'bath afternoons' and the removal of an older person from a music activity, which she appeared to be enjoying, in order to change her leg-wound dressing. It may be argued that staff who feel comfortable using these approaches to care could find the concept of a more creative approach, as explored by Berger (2003) and *Rose et al.* (2008), challenging.

Whilst most staff in the current study appeared willingly to interact with their clients, a small number seemed detached, and two appeared off-hand in their responses to clients. This may relate to the detachment-strategies theory, in which staff withdraw emotionally to protect themselves from the emotional intensity of the work (Lloyd 2009), and to reduce the potential for care-giver 'burn out' (Todd and Watts 2005; Hawkins 2008). This may underpin reluctance on the part of staff to engage in potentially emotive relationships with the people for whom they care, such as those that might be induced through music.

7.6.4 An understanding of person-centred care

Between a fifth and a quarter of focus group participants used the term 'person-centred care' but this appeared to relate to enabling better choices for clients associated with, for example, when to rise from, and retire to bed and when and what to eat. In terms of choice of activities, most of the study's participants reported that the people in their care always had a choice of activities. However, the range of activities seemed fairly limited, standardised group activities that often took place on set days and times. Regular, organised activities may address a range of the needs of people living with dementia, but they may also fail to adequately address the care directives laid out in The National Minimum Standards for Care Homes for Older People (DH 2001). These state *every* person should be able to achieve self-actualisation through individualised and relevant occupation and social networks.

Two participants reported that the undertaking of unusual activities for one or a small group of clients depended on the recruitment volunteers. This highlighted Iliffe *et al.*'s (2006) observation that the delivery of non-pharmacological interventions to benefit the well-being of every client creates some challenges and is not yet automatic in older people's care settings. These points indicate a need for more research which focuses on identifying support needs for individual staff to deliver person-centred care for the people in their care.

Around a fifth of participants referred to time-limitations which prohibited the reading details of clients' histories and preferences or engaging in long conversations with families or friends. About the same number of participants referred directly to a specific life-experience of one or more of the people for whom they cared but the relationship between the two parties generally appeared to relate to the present day. This could lead to the important life narratives of people living with dementia being disassociated from their current life-situation (Aldridge 2000; Hughes 2001; Killick and Allan 2001). According to the literature, this situation threatens to jeopardize a person's sense of self (Parfit 1984; Gallagher 2000) and can centralise a person in their present (ill) health status (Wade and Halligan 2004).

These issues may raise questions about the apparently limited choices of music activities, which may not necessarily relate to people's life narratives. It also highlights the potential for live improvisational music activities to acknowledge presence in the 'here and now', which is critical for people living with dementia.

7.6.5 Informal social networks amongst staff

Evidence of strong informal social networks amongst staff were apparent in the current study. Over three-quarters of focus group participants appeared to communicate between themselves through affectionate banter and teasing and around a quarter reported that social activities with their work colleagues were an important part of their lives. This related to Lloyd's (2009) observations, in which she recognised that strong social bonds between staff gave them a sense of support. It may be argued that this occurs strongly amongst care-staff because of their need to address the emotional strain of working in care settings and, in some cases, because of inadequate support from employers. These factors may highlight a need for more robust formal forms of support for staff and the importance of encouraging staff social networks to flourish. The latter may be assisted through shared music activities.

7.7 Limitations of the study

The validity of any research is dependent upon the researcher's choice of questions and the methods chosen to address those questions, the people chosen to take part in the study and the way in which they are invited, the researcher's personal approach to collecting the data, the way in which the researcher sorts and analysis the data and the way in which he/she chooses to report the results. The main characteristic of these processes is the researcher's choice. In the current study a number of strategies were implemented to ensure highly informed choices and to guard against assumptions and biases.

The choice of questions in this study was motivated by the researcher's considerable experience of working in a nursing capacity with care staff during music activities in care settings for people living with dementia. This experience regularly raised questions about a whole range of issues that appeared to affect people's experiences of these activities. In addition, a detailed review of the relevant literature and consultation with colleagues and other healthcare professionals informed the final research questions.

The choice of methods to address these questions was underpinned by the researcher's understanding of research paradigms in social science and the veracity of each method to draw out the most truthful data. This was informed by a wide scope of reading. It was also accepted that the researcher's nursing experiences and personal confidence to gain the data through the methods influenced the choice.

7.7.1 Reflection on the methods

Sampling

The methods chosen to address the questions in this study were successful for three reasons. Firstly, they largely met the objectives of the study. Secondly, the question framework/schedule within each method, which no participant appeared to have difficulty understanding, focused the participants and the researcher on the desired questions. Thirdly, and importantly, participants seemed to enjoy taking part in the study. However, reflection on the methods revealed a number of shortfalls which should be addressed in future studies in this area of research.

The *purposive* sampling technique used in this study was successful in terms of gaining a wide range of perceptions, opinions and experiences from care staff who may have experienced music in some form in their workplace. However, a number of limiting factors were identified. Firstly, the sample was relatively small (193 participants). The second limiting factor centred on how the researcher identified the sample. Fifteen settings were deliberately targeted because they were known by the researcher to have engaged in music activities. Whilst the researcher could not anticipate which, or if staff from these settings had engaged in these activities, it was likely that most had had *some* experience, even if peripheral. The technique of approaching settings chosen from randomly selected pages in the County Council's Nursing and Residential Home Registry aimed to balance this potential issue of bias, as some staff may not have engaged with music at all. However, although the attitudes and opinions of participating staff could not be anticipated, their agreement to take part in the study implied an interest in the topic. In view of the small sample size and the likely scenario of staff with little or no interest declining to take part, any form of generalisation was made impossible. In order to better represent the general population, further research in this area would benefit from a considerably larger sample and *randomised* sampling.

Collecting the data

Data relating to the number, type and funding mechanisms for music activities in care settings was gained by telephone interviews and focus group discussions. The method, which enabled person-to-person conversations, was chosen for several reasons. Firstly, the researcher was confident with telephone conversations. Secondly, it was a convenient way to gather information. Thirdly, it enabled the researcher to develop a relationship with the participants who would become important *gate-keepers* in the study's subsequent data-gathering processes.

The qualitative nature of data and its analysis gave some insight into the processes of commissioning and funding music activities and allowed for some conjecture about motivation behind the commissioning patterns. However, the inferences made are arguably weakened by the absence of quantitative data to support the analysis of the qualitative data. This might have been addressed by including the topics in the questionnaire survey. In order to gain a more robust picture of music activities in care settings, future research might include a nationally distributed postal questionnaire survey.

The investigation into staff personal histories and attitudes relating to music in adulthood was also limited because of a shortcoming in the questionnaire survey. The purpose of the investigation was to examine the potential for personal histories to affect attitudes in adulthood and to assess the potential for these attitudes to transfer to the workplace. However, the questions only addressed staff's current engagement with music. Although the topics were explored in focus group discussions, no quantitative correlations could be analysed to ascertain any consistent relationship. Future questionnaire designs should address this shortfall.

The study revealed some interesting cultural differences in terms of care staff attitudes to music. However, only a small minority of participants represented non-UK cultures. The non-UK participants were only identified in the focus group discussions because the questionnaire survey omitted to ask for the ethnic origin of respondents.

To ascertain the presence or absence of generalisable cultural differences, future research should incorporate a wider geographical scope that represents a broader multi-cultural population.

A further limitation of the study may have occurred due to the deliberate use of the generic term 'music' in the questionnaire survey. The purpose was to elicit from study participants their own definition of 'music'. However, whilst this could be discussed and clarified in interviews and focus group discussions, lack of clarification in the questionnaire survey may have resulted in some false answers. For example, without clarification, in the question, 'Taking time to sit down and listen to music is important to me', 'music' may have been interpreted as only live or only recorded music. This issue also particularly related to Question 6, which asked, 'If regular music sessions were available for clients to join in, what effects do you think this would have? (Tick 'agree', 'disagree' or 'not sure')'. In this case respondents' answers would have been guided entirely by their own definition of a 'music session'. It is recommended that the wording of future questionnaires clarify the meaning of 'music'.

A number of limitations were identified in relation to the method of focus group discussions. Out of 19 focus groups only one comprised a heterogeneous group of individuals, a care assistant, who was also an undergraduate reading music, a retired dementia care specialist nurse and an informal carer, each of whom were unfamiliar with the other. In this group, the discussion was broader and bore much fruitful data, than the homogenous groups of care staff. The study may have benefited further from engaging more of the former, rather than groups of staff whose familiarity with one another and established social and professional hierarchies may have influenced individuals' responses in some way.

A further limitation related to the number of participant observation sessions undertaken in the study. Whilst the perspectives of 13 music practitioners and trainee music practitioners gave a fairly broad view of their perceptions and of practices, the limited number of participant observations ($n = 3$) with only two different practitioners provided too narrow a perspective on the correlation between what practitioners said in face-to-face interviews and the way they behaved in practice. It is recommended therefore, that

future research should include a minimum of four participant observation sessions with four different music practitioners.

7.7.2 Validity of the findings

The validity of any research is diminished if the responses of participants are not truthful. In the current study, in addition to the relevance of the research questions and the calibre of the design, the researcher's techniques in facilitating data collection underpinned the validity of responses.

On listening to the audio recordings of focus group discussions and face-to-face interviews, the researcher's prompts were often statements to which participants responded. When these statements, which had an upward inflection as if a question when spoken, were transcribed to the written page, they appeared to be blunt statements. This illustrates the complex issue of how participants might have interpreted these prompts and how they responded to them. The researcher sought clarity in participants' responses by carefully observing their non-verbal actions and reiterating their verbal responses, sometimes *verbatim* and sometimes paraphrased. This was motivated by a strong desire to demonstrate to the participant that their input was valuable. However, despite the researcher's caution, it is accepted that at times bias influenced the vocal inflection of repeated comments and/or the words chosen for paraphrasing. In choosing a qualitative method that involves face-to-face human communication the researcher has the benefit of human contact and his or her communication instincts. Because these instincts, and those of the co-communicator, also determine the way in which information is exchanged and interpreted, there must always be a compromise in which the researcher seeks to minimise, but nevertheless acknowledge, the presence of bias.

Another threat to validity in any face-to-face communication is the potential for people to exaggerate and/or to fantasise. This happens for a number of reasons and it is incumbent upon the researcher to put people at their ease in order to minimise untruthful responses. However, some factors may be difficult to overcome. For example, in the current study there was some evidence of professional and social hierarchy and a few participants appeared to lack the confidence to disagree with others. The researcher sought to address these and other similar challenges, but it was accepted that this was not always successful.

The inevitable presence of bias emphasises the need for researcher integrity in analysing the data accordingly. In this study, strategies to avoid an overly narrow or assumptive analysis included the researcher reading a wide range of literature on analytic processes and the highly systematic process of analysis which was based on an established method (see p. Chapter 5 p. 177). However, the collective factors highlighted above illustrate the inevitability of some contamination of data. This will occur by virtue of the researcher's and participants' humanity. It was accepted that in the final analysis, the findings only occurred within the limitations of the study's questions and objectives, the types of questions asked and the way in which they were posed, and the researcher's analysis and interpretation of data. Therefore, the potential for the findings to represent the 'whole truth' is unlikely. In this case, the findings should be considered a limited view of the participants' experiences and insights.

7.8 Conclusions

The following conclusions were reached at the final stage of the study.

Question 1: 'What level and nature of musical activities are currently provided by visiting musicians in care settings for people living with dementia?'

The investigation of music in the sample of care settings raised some far-reaching issues. The activities in general reflected two main types of interaction; performances by musicians and music-hall style interactive activities which were facilitated by musicians and music practitioners. The most common genre of music, by far was popular music. The visually expressed enjoyment of clients to these activities appeared to prompt repeated commissioning by staff. In addition to the effect of the generally up-beat and cheerful music chosen for these activities, this enjoyment may have related to the power of institutionalisation, in which people living with dementia valued taking part in musico-social activities in their care environment, with material that they could relate to at some level. However, whilst it was likely that the songs and music were familiar to most of the older people in the settings, they may not have been explicitly relevant to some of their personal histories at all. This implies a limitation the way in which these activities might support the well-being of people living in care settings. It may, therefore, be the case that both care staff and music practitioners would appreciate information on the wider therapeutic uses of music and the opportunities to apply these in care settings. This might

be modelled on training initiatives such as those offered by the specialist organisation 'Lost Chord' (www.lost-chord.org.uk), music therapy organisations (e.g. www.nordoff-robbins.org.uk) and Higher Education institutions (e.g. Vella-Burrows 2009)

The study also showed that staff opinions of the standard of musical activities centred largely on their expectations of activities in care settings. That very few staff commented on the standard indicated either that, in their experience, all musicians and music practitioners provided adequate or good services, or that the issue of standard was not scrutinised. In the case of the latter, the value placed on music services in the context of caring for people living with dementia may need some investigation.

The challenge of raising funds for music activities also highlighted wider contextual and social issues. Limited funding for music activities, which was generally provided by care settings' internal resources, appeared to have driven some commissioning patterns. This included irregular or infrequent activities or the regular engagement of musicians who provided their services voluntarily. This factor may highlight the value placed on the arts in healthcare in general, which currently is rarely perceived as funding priority. Despite suggestions that music activities should be funded by local authorities/social services and/or NHS Trusts, or by clients themselves, none of the study's participants reported lobbying for change. This implies that, whilst reporting dissatisfaction with funding levels for music activities in care settings, the study's participants were not motivated sufficiently to prioritise action to precipitate change.

These concluding points suggest that staff may appreciate information on the potential for a wide scope of applied music activities to support QOL for people living with dementia. It also suggests a need for champions to motivate informed changes in attitudes towards music activities in care settings and the funding of these activities.

Question 2: 'How are musical interventions perceived and their impact understood?'

The common practice of staff engaging with popular music in their personal lives may help to explain the strong allegiance to the wide-spread use of popular music the sample of care settings. Around four-fifths of focus group participants reported perceptions of value of popular music for the people in their care, specifically its capacity to support

mood, memory, communication and to reduce levels of agitation. This appeared to be wholly experiential and based on staff's observations as no participant reported an awareness of any theoretical or empirical evidence.

Even though participants appeared unaware of the body of literature that focuses on the benefits of music for the people living with dementia, at least half expressed observations that reflected evidence in the literature. There also appeared to be a relationship between the reports in the literature on the theory of innate musical competences and participants' observations of responses to music that do not appear to demand any specific level of cognitive function. The perception amongst participants that people living with dementia often benefited from music may be grounded in their observations, but it may also imply a refined intuition about the therapeutic properties of music which relate to an innate musical understanding.

However, the way in which people living with dementia expressed the impact of music appeared to effect staff opinions of value. A very small number of staff expressed a view that their clients may experience non-visual responses to music, which were nevertheless meaningful. Sitting still and listening to music, for example, was acknowledged as potentially positive but the staff highlighted the difficulty of ascertaining effect in people who are unresponsive generally.

The difficulty of identifying the value of responses was also highlighted in relation to tears elicited by music. This may help to also explain why most staff and at least half of the music practitioners tried to avoid using music that made clients cry. This issue might indicate limited strategies for dealing with cathartic experiences, which in turn may highlight professional issues in which people caring for others living with dementia are increasingly required to explore psychotherapeutic paradigms of care. None of the study's participants expressed an awareness of research in this field, or on music-related therapeutic approaches, other than on a very superficial level.

Each of the concluding points in this section strengthen the concept of providing staff with information about the different applications of music and its impact and information on research about music's broader therapeutic benefits. The points also indicate that

music practitioners may appreciate this information. The final point indicates a need for better communication between staff and music practitioners and a greater mutual understanding of their respective challenges and intentions.

Question 3: 'How do staff feel about training to develop skills to use music in care-giving?'

Whilst more than half (58.1%) of questionnaire survey respondents agreed that they would use music more if training were available, a number of inhibiting factors were highlighted. These included general institutional challenges to training staff who work in dementia care, professional issues relating to the role of care staff in music interventions, and issues of staff confidence to engage in training *per se*, and in music-related training specifically.

Staff levels of self-confidence to engage in music-related training appeared to centre on a number of factors. These included: the influences of macro and micro cultures relating to music attitudes and behaviours, which impacted on the musical experiences of staff in their young life; experiences of music education and singing at school; institutional and social constructs that influence self-perceived musical ability.

The study showed a willingness amongst at least half of the staff to undergo in-house training with visiting music practitioners. However, this may be dependent on music practitioners' own opportunities for training to take on this role.

These concluding points highlight the challenges of administering music-related training and indicate the probable need for fully informed pre-training support and information for staff who may wish to apply music to their practice. It also suggests a possible training collaboration in which music practitioners may help to train care staff but this appeared to be dependent upon training opportunities for the former.

Question 4: 'How might musical interventions relate to wider perspectives of care-giving and the health and well-being of both staff and the people for whom they care?'

The concept of utilising music as a support mechanism for people living with dementia was generally understood by participants to be positive. The perceived value of music to support the well-being of staff was less clearly expressed. In this sense, staff did not

expect to directly benefit from music activities in the workplace on either a personal or professional level. However, there appears to be a strong rationale for music interventions that deliberately target the well-being of staff and the people for whom they care. This is premised on the high levels at which staff use of music to support their well-being in their personal lives.

The use of music as a catalyst for developing confidence and for exploring the creative skills of staff appeared largely to be an alien concept amongst the participants. Opportunities for staff to engage in learning processes in which they explore and express their creativity through music were not the norm. This may reflect the culture of the healthcare industry limits the value it places on the use of music, and the arts in general, as primary tools to explore and develop creative thinking in care-giving. Arguments for using music in this way emanate from the theories on the origins of music, the ubiquitous and apparently innate relationship between music and human-beings and its potential capacity to support cognitive, emotional and physical development.

The challenges of organising clients for activities with visiting musicians or music practitioners sometimes presented difficulties for staff. This occasionally resulted in tensions between staff and the music practitioner during music activity sessions appeared to centre on poor communication. Staff appeared unsure of the role that they should take and the music practitioners' expectations of staff were generally not expressed. This appeared to highlight a clash of disciplines, which, since the dominance of the biomedical model in healthcare, traditionally do not meld. However, in principle, both staff and music practitioners generally accepted the proposition of working more closely together. This may present a model which goes some way to bridge the identified barriers between the two disciplines.

The concluding points in this section firstly present a justification of resources for music interventions to simultaneously support the well-being and personal development of people living with dementia and their care-givers. Secondly, collaboration between staff and music practitioners may yield a valuable transfer of skills.

7.9 Recommendations and opportunities for further research

Recommendations relating to the four research questions are inter-connected and will be addressed accordingly.

Recommendation 1

The development of a systematic and comprehensive information service for care settings to identify and choose music practitioner's who work in their locality. This information may be in the form of an easy-to-access local database which could also highlight music practitioners' musical and professional credentials and experiences. Such a resource could enable commissioning staff to make more informed choices in respect of the individual needs of the people for whom they care.

Recommendation 2

The development of some form of registration for music practitioners. This could act as a quality indicator for commissioning staff and might raise the professional credibility of the practitioners.

Recommendation 3

An information database for care staff linking them to relevant academic papers relating to music and the complex psycho-social issues and neurophysiology associated with people living with dementia. In communicating this knowledge, the credibility of music activities as valuable care interventions may be better understood. This may also impact positively staff attitude towards the work of the music practitioners and the fee that they charge for their services.

Recommendation 4

The provision of appropriately conceived in-house education programmes for staff to develop an understanding of the wider benefits of music activities and their own musical skills. Such programmes should ideally be accredited through a Further or Higher educational institution in order to maximise credibility. The potential for sustainability should be built into the programme design so that newly acquired knowledge and skills can be transferred between staff members and/or other care settings. This may relate to existing courses run by, for example, 'Lost Chord' (www.lost-chord.org.uk), Nordoff-

Robbins (www.nordoff-robbins.org.uk) and Canterbury Christ Church University (Vella-Burrows 2009).

Recommendation 5

The creation of *music-care practitioners*, a new layer of professionals who have both a nursing/care qualification or experience and experience of using music as a therapeutic activity. These professionals would straddle the work of music practitioners and music therapists. By working directly with staff in their usual day-to-day care-giving duties, opportunities would be created for staff to see how the theory and practice of therapeutic music activities can be applied to individual care circumstances. This recommendation includes a feasibility study to identify relevantly qualified/experienced individuals and their level of interest in taking on this role.

Recommendation 6

The continuation and national development of cross-agency initiatives between care settings/organisations and Higher Education establishments, which are delivered at no cost to the care settings. Current initiatives emphasise shared learning which combines the skills, knowledge and experiences of established music practitioners with university students and care staff who collectively deliver music activities that have relevance to the well-being of people living with dementia and for staff. This relates to, for example, the University of Southampton's 'Music in Care Homes' project delivered in partnership with Southampton City Council, Southampton Primary Care Trust and Canterbury Christ Church University, and Canterbury Christ Church University's 'Music Arts and Health' programme delivered in partnership with Abbeyfield Kent Society and Age Concern Herne Bay.

Recommendation 7

The inclusion of creative arts initiatives as an educational tool *as a rule* in dementia care training programmes. This recommendation aims to address deep-seated influences that may prevent staff from engaging in much-needed creative practices in this field of care work. The concept will require of staff a broadened view of their care-giving role, which may include bringing music into the workplace to develop creative and reflective care-giving. The model of training should reflect the maxim of organisations such as *Creative*

Partnerships UK (www.creative-partnerships.com), which attribute raised self-esteem and higher levels of analysis and synthesis of information to school students' engaging in new dimensions of creative expression.

Recommendation 8

The development of models of staff-led music interactions that do not focus on staff singing. Some training programmes, such as the programme offered at the University of Sweden (Gotell *et al.* 2009), may support some staff to sing more with/to the people for whom they care. However, it is unlikely that all staff will overcome long-standing inhibitions or wish to engage in singing in this context. In this case, it is recommended that staff should be enabled to use other methods of musical engagement. Examples of models that use alternative musical interactions to develop meaningful relationships have included Professor Kari Batt-Rawden's life story narrative project (Batt-Rawden 2006) and Trish Vella-Burrows' 'Music 4 Wellbeing' project, which facilitates in-house training and a resource pack for staff to deliver a range of non-singing music activities with people living with dementia

Recommendation 9

The development of opportunities for staff to engage in in-house live music-making activities. This might be in the form of a recorder club (identified in the study as generally popular in childhood), or a choir or guitar/ukulele club, for example. The facilitation of such clubs could be the responsibility of *music-care practitioners* (see above, Recommendation 4). In addition to addressing the identified need for staff to develop strong social networks with work colleagues, the clubs could provide an important platform for creative endeavour, progressive learning and a sense of achievement. These achievements could be demonstrated informally in shared music/sing-a-long sessions with the people for whom participants care. Some staff may also enjoy an opportunity to engage in a theatre or drama event with a performance for their cared-for. This type of activity, which was also identified in the study as engendering very high levels of inter-staff/client bonding, reflects the work of 'Ladder to the Moon Theatre Company' (www.laddertothe moon.co.uk), practitioners from which work with staff and people living with dementia in their care settings.

Recommendation 10

The development of the relationships between musicians and music practitioners and care staff for three key reasons: i) to improve mutual understanding and respect for the challenges each face in their work, ii) to facilitate clarity in terms of the role staff might take in musician/music practitioner-led activities, and iii) to facilitate the possibility of shared learning experiences. To address issues of time pressures for staff, staff/music practitioner interactions might occur immediately before/after an activity session and/or during preparation and activation. The recommendation includes a proposal that music practitioners might provide some level of training and/or support for staff to facilitate group music activities in their care setting. This might range from practical support, such as sign-posting staff to resources such as backing track CDs and/or word sheets, to the provision of information on the theory and philosophy that underpins their practice, and training/supporting staff to facilitate similar activities. An example of an applied model that relates to this recommendation is the work of 'Music for Life', practitioners from which work directly with people living with dementia and their care-givers (Rose *et al.* 2008)

Recommendation 11

To develop opportunities for musicians and music practitioners who work in the field to interact. A peer-forum, which might take the form of a social internet site or face-to-face meetings, could provide important opportunities for practitioners to share their experiences. In addition to providing social support for practitioners who usually work in isolation, the forum might include links to relevant literature other educational support and information on practice development.

7.9.1 Opportunities for further research

A reflection on the methods and validity of this study helped to identify its shortcomings and the opportunities to address these and other identified issues in future research on this topic. The study also provided opportunities for research on other wider issues that arose as a consequence of the study. Recommendations include:

- A more ambitious repeat of this study with a considerably larger, randomly selected sample from a broader geographical area with multi-cultural demographics, in order to better represent the general population. This might include a nationally distributed postal questionnaire survey that:
 - investigates the scope and types of musical activities taking place in care settings across the country
 - includes a question on the ethnic origin of respondents to evaluate culturally-dependant patterns
 - better defines the term ‘music’ to gain more explicit understanding of staff perceptions and experiences of their musical experiences in out of the workplace
 - includes questions that would make possible a correlation between staff’s childhood musical experiences and their attitudes towards music in the workplace
 - examines in more detail attitudes towards music-related training and perceived inhibitions to training
- An international study to explore care staff perspectives of music for people living with dementia from several different cultural perspectives.
- A robustly designed study on the effects of music activities specifically identified in this study on people living with dementia to develop an evidence base to which staff and music practitioners can refer.
- An audit of education and training courses for staff caring for people with dementia that use music as a catalyst for nurturing confidence and creative/reflective care-giving.

- A collaborative study with arts/music practitioners/organisations on the general value that staff place on arts interventions in care settings for people living with dementia and their perceptions of the potential role they may take in delivering them in the future.
- A robustly designed study on the impact of drama/theatre activities in care settings (e.g. the work of 'Ladder to the Moon'), from the perspective of staff.
- A collaborative study with music educationalists on the opportunities that children have to engage in creative/expressive music-making in primary and secondary schools today and their perceived impact of value.

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Appendix 1



Canterbury Christ Church
University College

Music and Elderly Care: Research questionnaire

The aim of the questionnaire is to see how staff members in residential and day care establishments view musical activities for older people.

Information about You (Please tick the appropriate box)

Sex	Male	Female
-----	------	--------

Age	Under 25	25-34	35-44	45-54	Over 55
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How long have you been working with older people?	Less than a year	1-2 yrs	3-5 yrs	6-10 yrs	More than 10 yrs
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Current place of work	
-----------------------	--

1. What does music mean to you personally? (Tick boxes as appropriate)

	Yes	No
I like to have music playing (radio/CDs etc) in the background while I am doing other things	<input type="checkbox"/>	<input type="checkbox"/>
Taking time to sit down and listen to music is important to me	<input type="checkbox"/>	<input type="checkbox"/>
Listening to music can help me to feel good about myself	<input type="checkbox"/>	<input type="checkbox"/>
Sometimes music is important; sometimes it's not, depending on how I'm feeling and what I'm doing.	<input type="checkbox"/>	<input type="checkbox"/>
Music is of little importance in my life	<input type="checkbox"/>	<input type="checkbox"/>
I like to sing in private (e.g. in the shower or the car)	<input type="checkbox"/>	<input type="checkbox"/>
I play a musical instrument/sing regularly in an organized group.	<input type="checkbox"/>	<input type="checkbox"/>
I sing in a choir or group	<input type="checkbox"/>	<input type="checkbox"/>
I enjoy going to hear live music (in a pub or a concert)	<input type="checkbox"/>	<input type="checkbox"/>

2. Do you sometimes use music personally in any of the following ways? (Tick boxes that apply to you)

To exercise to	<input type="checkbox"/>	To help me feel calm	<input type="checkbox"/>
On journeys	<input type="checkbox"/>	To help me concentrate	<input type="checkbox"/>
While doing housework	<input type="checkbox"/>	To relax to	<input type="checkbox"/>
When I'm feeling sad	<input type="checkbox"/>	To give me energy	<input type="checkbox"/>
When I'm feeling happy	<input type="checkbox"/>	To help uplift me	<input type="checkbox"/>

3. Have you been involved in, or been present at, music sessions run by visiting musicians while you have worked with elderly clients? (Please tick appropriate box)

No	A few times	Quite often	Very often
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Have you been involved in, or been present at, music sessions run by staff while you have worked with elderly clients? (Please tick appropriate box)

No	A few times	Quite often	Very often
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Here are some statements about music sessions and how clients might respond to them. Do you agree or disagree with them?

	Agree	Disagree	Not Sure
Live music with clients is OK but it does not affect their mood and/or behaviour long-term	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Live music at work usually lifts the mood of most clients during and for some time afterwards	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most clients would benefit from some form of music everyday.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would personally use music more with clients, if some form of training was available for staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Music in the home does not make any particular difference to clients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most clients seem to prefer live music if they are invited to join in, rather than just listening.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most clients seem to prefer music with visiting musicians rather than staff led sessions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Most clients seem to prefer music led by familiar staff, rather than visiting musicians.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It can be embarrassing if visiting musicians ask staff to join in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Telephone interview guide

Appendix 3

	Once a month or more	c. 10 times per year	c. 4 times year	c. once a year Christmas/Easter/special events	Not at all	Funding SF = Self funded V = Volunteer Ex = External M = Mix
Type of setting						
Residential care homes						
Nursing care homes and mixed care						
Day care						
Total						

Date/site	Comments

Cont.

Focus Group question guide and related objectives									Appendix 3
	<i>A and B Numbers types and funding mechanisms for live musical activities</i>	<i>C: Staff experiences of music in childhood</i>	<i>D: Staff perceptions of the value of music in their personal lives</i>	<i>E: Levels at which staff engage in music in their workplace</i>	<i>F and G Staff perceptions of the value and impact of music in their care setting</i>	<i>H: Staff perceptions of the practicalities of music in their care settings</i>	<i>J: Staff attitudes towards music- related training</i>	<i>K: Experiences and perceptions of music practitioners working in care settings</i>	<i>L: Relation- ships between music practitioners and staff</i>
1.What do you remember about music at home and at school when you were young?		x							
2. Can you tell how important music is to you now?			x	x	x				
3. How do you use music and what are the effects it has on you?	x		x	x	x				
4 How often do musicians come into the home?	x				x				
5.Do you know how the activities are paid for?	x				x				
6. What sort of involvement do you have with music and your clients?				x	x	x			x

Face-to-Face interview question guide

Appendix 4

Question	Addressing objective:
1. What sort of personality do you think is suited to this type of work?	K
2. In what way do you think music is important for clients living with dementia?	K, L
3. Do you think music has a role in helping to build and/or maintain relationships between carers and the cared-for? If so how?	
4. How do carers react to you?	
5. How do carers react to the music sessions?	
6. What do you enjoy about working in this field?	
7. What are the disadvantages of the work?	
8. In your experience, what specialist training is available for practitioners? Can you comment on training you may have been involved with?	
9. What do you think of the idea of music practitioners training staff to use music with their clients?	

[Type text]

Appendix 5

Participant Observations grid

Observation framework
Part 1
Setting code -----
MP code -----Date/time/duration
Description of the event
Participants and their role
Cont.
Part 2

[Type text]

1. Who answered the home's door?
2. Did the person on charge come to speak to CMP?
3. Was the room/space dedicated to the proposed music session used for this purpose only?
4. Were clients ready and waiting?
5. Did CPM ask staff to bring a specific client/clients?
5. Did staff help the CMP with setting up her equipment?
6. Did staff speak to the CMP during this process?
7. Was CMP offered any form of refreshment?
8. Was a member/members of staff seated amongst clients at the beginning of the session?
9. Did they stay throughout the session?
10. Was a member/members of staff standing in the room but away from the central action?
11. Did they stay throughout the session?
12. Did CMP ask staff to help to give instruments to clients?
13. Did staff initiate helping to give out instruments to clients?
14. Did CPM give staff an instrument?
15. Did CMP ask staff to help clients to use instruments?
16. Did staff use instruments themselves?
17. Did CPM give staff song sheets?
18. Did CMP verbally or non-verbally invite staff to join in with singing?
19. Did staff sing with or without an obvious invitation?

Reflections and personal responses

Appendix 6

Sidney De Haan Research Centre for Arts & Health
11, Church St, Folkestone, Kent. CT20 1SE

Ref. TVB Tel. 01303 220870
Email pkv2@canterbury.ac.uk

Dear All,

Invitation to complete a questionnaire to help with a research project about music in homes and day care centres.

Who am I?

My name is Trish Vella-Burrows. I am a nurse and practicing musician with an interest in how music might benefit older people and people caring for them. I am seeking helpers in a research project looking at what care-staff think of current musical activities offered to residential/nursing homes and day care centres and how they feel about music personally.

How can you help?

Each helper will receive a questionnaire to complete. It will ask questions such as:

Example questions:

Do you enjoy singing?

Does having music around help you at work?

Do you enjoy listening to live music in a pub or at a concert?

Do your clients prefer live or recorded music?

Could music help your clients communicate?

The full questionnaire will take approximately 10 mins to complete.

Version 1.3

PTO

What is the questionnaire for?

The project is part of a postgraduate research degree. The aim is to inform people working in social health and welfare services about current musical activity and what effects it has on clients and staff.

Your answers and comments are confidential. You will not be asked to give your name or any other personal details. Any subsequent reports, written or spoken, will only give overarching details and will not use personal or establishment names.

What happens next?

I will send some questionnaires to your home/centre within a week or so. Participation is entirely voluntary. You do not have to take part. If you would like to, please hand any completed questionnaires to the person in charge and I will collect them.

If you would like any help with filling in the questionnaire, or if you need it in different format e.g. another language, larger font etc, please let me know by contacting me on either of the two numbers below or by email.

Thank you for your attention. I look forward to hearing from you.

**Trish Vella-Burrows - Mobile phone no. 07790 263762
- Landline phone no. 01304 365646
- Email: pkv2@canterbury.ac.uk**

Appendix 7



Sidney De Haan Research Centre for Arts & Health
11, Church St, Folkestone, Kent. CT20 1SE

Invitation to help with a research project by talking about how music might affect you and the people you care for

Dear All,

Who am I?

My name is Trish Vella-Burrows. I am a nurse and practicing musician working with older people and people caring for them.

Why am I writing to you?

As a research student, I am seeking voluntary helpers for a research project exploring the effect of music in carers and the people that they care for.

How can you help?

I would like to visit your care home to talk to you and your colleague as a group. I would like to hear about musical memories from your childhood and what music means to you today in your personal life and working life. **I would like to use a mini disc recorder to record your comments to help me remember them later.**

Why do I need this information?

Music in care settings appears to be popular for many older people, particularly those living with dementia. However, the type of music, its frequency/regularity, how it is delivered and by whom appears to be affected by a number of factors. I would like to understand these factors and to identify others, with your help, to see if there may be ways in which music could be delivered differently to benefit both clients and staff.

Who will see your comments?

Other researchers and health care workers may like to see the results but your comments will be kept anonymous. You will not be asked to give any personal details.

**Please contact me if you would like any other information
Tel. 01303 220870 or email pkv2@canterbury.ac.uk**

Appendix 8



Sidney De Haan Research Centre for Arts & Health
11, Church St, Folkestone, Kent. CT20 1SE

Invitation to help with a research project

Dear All,

Who am I?

My name is Trish Vella-Burrows. I am a nurse and practicing musician working with older people and people caring for them.

Why am I writing to you?

As a research student, I am seeking voluntary helpers for a research project exploring current musical activity in the community.

How can you help?

If you agree, I would like to visit two of your musical activity sessions atto observe how sessions are run and what impact they have on everyone involved.

What exactly will I be doing in the sessions?

With your permission, I would like to join in with the session to see how it feels.

What do you have to do?

Nothing! Just turn up to the session as usual. I need to ask you to sign a form giving me permission to observe the group, but after that, the session will run as usual.

Who is it for?

Other researchers and health care workers may like to know about the research but all participants will remain anonymous.

**Please contact me if you would like any other information
Tel. 01303 220870 or email pkv2@canterbury.ac.uk**



Appendix 9

CONSENT FORM to take part in focus group discussions

Study Number:

Participant Identification Number for this study

Title of Project: Music and Elderly Care

Name of Researcher: Trish Vella-Burrows

Please initial box

1. I confirm that I have read and understand the information sheet dated (version) for the above study and have had the opportunity to ask questions

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason

3. I understand that protocols of anonymity will be adhered to in terms of reporting findings

4. I agree to the discussion being audio recorded

5.

Name of Participant

Date

Signature

.....	
Name of Person taking consent	Date
Signature	
Researcher's name	Date
Signature	



Appendix 10

CONSENT FORM to take part in face-to-face interviews

Study Number:

Participant Identification Number for this study

Title of Project: Music and Elderly Care

Name of Researcher: Trish Vella-Burrows

Please initial box

1. I confirm that I have read and understand the information sheet dated (version) for the above study and have had the opportunity to ask questions

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason

3. I understand that protocols of anonymity will be adhered to in terms of reporting findings

4. I agree to the discussion being audio recorded

5.

Name of Participant

Date

Signature

.....

Name of Person taking consent	Date
Signature	
Researcher's name	Date
Signature	



Appendix 11

CONSENT FORM to take part in an observation session

Study Number:

Participant Identification Number for this study

Title of Project: Music and Elderly Care

Name of Researcher: Trish Vella-Burrows

Please initial box

1. I confirm that I have read and understand the information sheet dated (version) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and I can still attend music sessions without prejudice.

3. I understand that I will remain anonymous at all times and findings will only be published without using my name.

5. I agree to take part in the above study.

Name of Participant

Date

Signature

.....	
Name of Person taking consent	Date
Signature	
Researcher's name	Date
Signature	
Witness/parent/legal guardian	Date
Signature	