A Resource-Oriented And Relationship Based Music Therapy Approach For Persons Living With Dementia

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A Thesis

in

The Department

of

Creative Arts Therapies

Presented in Partial Fulfillment of the Requirements

for the Degree of Master of Arts (Creative Arts Therapies, Music Therapy Option)

Concordia University

Montreal, Quebec, Canada

April, 2017

CONCORDIA UNIVERSITY

School of Graduate Studies

This is to certify that the thesis prepared

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Entitled: A Resource-Oriented and Relationship Based Music Therapy Approach for Persons Living with Dementia

and submitted in partial fulfillment of the requirements for the degree of

Master of Arts (Creative Arts Therapies, Music Therapy Option)

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ABSTRACT

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The purpose of this research was to make a case for how a wide range of needs of persons living with dementia can be addressed within a person-centered music therapy approach that emphasizes therapeutic relationship as a core component. Philosophical inquiry was used to explore models of music therapy that either currently emphasize or have the potential to emphasize person-centred, relationship-based care for the dementia population. A review of the literature revealed that although current models do exist, there is a lack of publications in recent years to support their use. An emergent music therapy approach, Resource-Oriented Music Therapy (Rolvsjord, 2010), was selected for reconceptualization within a dementia care context. To assess the suitability of this approach, medical literature was reviewed to determine the physical, psychological/emotional, and social needs of persons living with dementia. The key concepts of Resource-Oriented Music Therapy were reviewed to formulate an argument for how this music therapy approach can suitably address each domain of need for the dementia population. Implications for further research on how person-centred, relationship-based music therapy approaches may be applied to dementia care, implications for how current music therapy professionals may adapt their practice to provide care within this framework, as well as implications for advocacy of the dementia population presented by this research are explored. This philosophical inquiry may serve as a resource for clinicians, researchers, and students toward enhancing awareness and understanding of how a person-centred, relationship-based approach may be beneficial to their work with persons living with dementia.

Acknowledgements

There are many people in my life who through offering a myriad of support made this research possible. I would like first to thank my family and most especially my parents Cynthia and Ian Ross for their unwavering, unconditional support of my academic trajectory and for encouraging me to pursue graduate studies in this field. My love and gratitude for you is unlimited. To Liz and Lindsay Gordon and to Andie Veljkovic and Peter Salat, I thank you for your unbelievable generosity and hospitality that made it possible to devote my fullest energy to my research. To Ben Callaghan, I thank you for your love that anchored me from the first draft to the final edits.

I must also acknowledge the academic community at Concordia University. To Laurel Young, thank you for sharing your brilliance and passion for the field with me. This project was in the most competent of hands with you as my advisor and I am grateful for your dedication to my work. To each of my professors, thank you for your commitment to my learning and for making the profession of music therapy seem bigger, brighter, and more full of possibility every day. To my cohort, I cannot wait to see where life takes each of you. You were each an honour to work with and the definition of grace under pressure. Thank you for your indomitable levity and good humour at every step of our adventure together.

This thesis is dedicated to my mentor and dear friend, Trish MacAulay, for her years of commitment to improving the lives of persons living with dementia, for showing me my path in this field, and for her unlimited compassion for each individual she works with.

Table of Contents

Acknowledgements iv
List of Tables vii
Chapter 1. Introduction 1
Significance and Rationale 1
Statement of Purpose 5
Research Questions 6
Key Terms 6
Chapter Outline 7
Chapter 2. Methodology 8
Design 8
Materials 9
Data Collection Procedures 9
Data Analysis Procedures 10
Chapter 3. Results 12
Overview of Current Music Therapy Models/Approaches for PLWD 12
Needs of Persons Living With Dementia 14
Physical needs. 14
Psychological and emotional needs. 15
Social needs. 16
Resource-Oriented Music Therapy 17
Overview of the approach. 17
Reconceptualising Key Concepts of ROMT within Dementia Care Contexts 18
Resource-oriented music therapy involves the nurturing of strengths, resources, and potentials. 18
Resource-oriented music therapy involves collaboration rather than intervention. 19
Resource-oriented music therapy views the individual within their context. 20
In resource-oriented music therapy, music is seen as a resource. 22
Summary. 22
How ROMT Meets the Identified Needs of PLWD 25
Physical Needs. 25
Psychological and Emotional Needs. 26

Social Needs 27
Chapter 4: Discussion 30
Limitations 30
Implications for Research 31
Implications for Practice 31
Implications for Advocacy 32

List of Tables

Table 1. Current Music Therapy Approaches/Models Being Used in Dementia Care.....13

Table 2. Key Concepts of ROMT Applied to Dementia Care……...24

Table 3. Overview of How ROMT can Meet Identified Needs of PLWD……....29

Chapter 1. Introduction

Significance and Rationale

As medicine continues to advance and the average human lifespan increases, it is anticipated that the prevalence of Alzheimer's disease and other causes of dementia will undergo a rapid global increase from the estimated 46.8 million people living with dementia in 2015 to approximately 131.5 million people by 2050. These statistics suggest a near doubling of dementia every 20 years, assuming no cure is found (Alzheimer's Disease International, 2015; Sosa-Ortiz, Acosta-Castillo, & Prince, 2012). This prediction is accompanied by incredible personal and financial cost, not only for afflicted individuals and their families, but to society at large. An estimated $818 billion (USD) was spent globally on dementia in 2015 alone (Alzheimer's Disease International, 2015). While a cure is sought, Alzheimer's Disease International cites public education and awareness about dementia as well as the development of initiatives to increase quality of life for those afflicted as core aims of its organization (Alzheimer's Disease International, 2014).

Sosa-Ortiz et al. (2012) define dementia as:

> a syndrome caused by different disorders that affect cerebral structures and functions, causing progressive deterioration of memory, other mental functions and behavior. The ability to perform everyday activities is impaired, compromising autonomy and capacity for independent living, giving rise to dependence and needs for care. Dementia can be a devastating disorder for those who experience it, for their caregivers, their families and society as a whole (p. 600).

Symptoms commonly associated with dementia may include: wandering and getting lost, personality changes, increased memory loss and confusion, problems recognizing family and friends, inability to learn new things, difficulty carrying out multistep tasks such as getting dressed, problems coping with new situations, paranoia, and impulsive behavior ("About Alzheimer's Disease," 2017). As an individual's dementia advances, she/he is also susceptible to increased delusions, hallucinations, and aggression (Lyketsos et al., 2011).

Current literature suggests that pharmacological intervention, including the use of antipsychotics, antidepressants, and anticonvulsants, is moderately effective in treating the behavioural and psychological symptoms of the disease (BPSD) although there are health risks associated with the prolonged use of antipsychotics. Potentially deleterious complications of long-term antipsychotic use may include "cerebrovascular accidents and an increased risk of mortality" (Seitz et al., 2012). It is therefore necessary to seek alternative therapies to aid in the management of BPSD. This idea is also supported by current literature, which indicates a need for: (a) a non-exclusive focus on biomedical approaches, (b) psychosocial intervention as a primary course of action, (c) the incorporation of person-centered approaches (i.e., those that take the individuals' expressed or implied wishes into account), and (d) increased interdisciplinary collaboration (Azermai, 2015; Cankurtaran, 2014; Kaplan & Andersen, 2013; Portacolone, Berridge, K Johnson, & Schicktanz, 2014). Overall, these writings indicate that non-pharmacological interventions are a crucial component of treatment for persons living with dementia (PLWD) due to their ability to foster meaningful experiences and alliances that support quality of life in ways that medication alone cannot address. Furthermore, dementia can result in social isolation, which in turn can exacerbate the BPSD (Grand, Caspar, & MacDonald, 2011). Therefore, it seems logical that interventions being used or developed to address the BPSD should also try and account for this factor.

Although the frequency and consistency of use is unknown, there are many non-pharmacological interventions that may be employed with PLWD. Such interventions may include cognitive interventions, pet therapy, social activity, physical activity, reminiscence therapy, validation therapy, music therapy, massage, and therapeutic touch (Cankurtaran, 2014). It is important to note that all of these interventions involve direct social contact between caregiver and care receiver and therefore have the potential to incorporate an individualized person-centred approach.

> A central feature of person-centered care is the recognition that all human life is grounded in relationships, and that individuals with dementia need an enriched social environment that fosters opportunities for personal growth while compensating for their

cognitive and functional impairments (Grand et al., 2011, "Person-centred care for BPSD", para. 1.).

I (the current author) am a music therapist who completed my 1000-hour pre-professional internship in 2013 in a long-term care centre situated in a Canadian teaching hospital. During my internship, I found that many aspects of person-centered care resonated with my evolving clinical approach. I believed that the value of my clinical work lay not only in the application of music therapy interventions in and of themselves, but also in the therapeutic relationships that I was able to develop with individuals through sharing meaningful music experiences. Residents who could not form explicit memories of our music therapy sessions seemed to form an implicit therapeutic alliance with me over the course of our time together. One example of this includes my experience of working with a gentleman, diagnosed with dementia, who lived at my internship facility. Upon my arrival to this individual's room to offer a music therapy session, he would often greet me by saying "Oh, it's you with the guitar! I feel better already… the music makes me well again. Let's play!" Under other circumstances this resident often displayed debilitating BPSD, including wandering, anxiety, confusion, and agitation that regularly escalated into aggressive behaviour toward nursing staff and other residents. His fixation on wanting to return home and be with his family also led to great psychological distress. However, during our music therapy sessions, these BPSD were virtually non-existent. By playing music together and reminiscing about his past as a jazz musician, this individual was able to feel an enhanced sense of self, have constructive social interactions with me, and feel more comfortable, safe, and oriented in his current context. This experience (along with others like it) motivated my deep interest in trying to better understand the full potential that music therapy could have with this extraordinary population of individuals- who in the face of great challenges still seemed capable of so much if given the right opportunities.

When attending inter-professional rounds and observing various clinical programs offered at my internship facility, I noticed that treatments for PLWD often focused on the use of pharmacological and/or other "in the moment" interventions such as re-direction of attention to manage symptoms of anxiety or agitation after they emerged. Sometimes, my own clinical work

followed a similar approach. For example, I would periodically be paged by nursing staff or the unit physician to use music therapy interventions to treat the gentleman mentioned above after his BPSD had escalated. While this may have been a necessary response, it seemed to me to be incomplete as a primary or exclusive treatment approach. I wondered if there was a way to be more proactive. Given what I had been experiencing in my internship, I believed that music therapy had a unique and important contribution to make in this area. I wondered if a person-centered approach to music therapy could address unmet needs and identify resources/potentials of PLWD, which in turn would help maintain or improve their quality of life to a point where distressing symptoms could actually be lessened or prevented before they emerged.

Recent literature identifies the use of music and music therapy as being important components of dementia care (McDermott, Crellin, Ridder, & Orrell, 2013; Pavlicevic et al., 2015; Raglio et al., 2012). This may be due in part to the fact that neuroscience research findings have indicated that the music functions of the brain often remain intact as other abilities deteriorate (McDermott, Orrell, & Ridder, 2014; Raglio et al., 2012; Sacks, 2008; Simmons-Stern, Budson, & Ally, 2010; Ueda, Suzukamo, Sato, & Izumi, 2013). However, my review of the literature revealed that most current studies focus on the use of music (Hara, 2011b; Wyatt, 2015) or music therapy (Hsu, Flowerdew, Parker, Fachner, & Odell-Miller, 2015; Ueda et al., 2013; Whear et al., 2014) to provide short term treatment of behavioural and psychological symptoms of dementia with little attention being placed on symptom prevention, person-centered care, and/or the role of therapeutic relationship. The absence of this latter component is especially surprising given that therapeutic relationship is a core element of widely accepted definitions of music therapy (Bruscia, 2014) and plays a central role in several established models/approaches to practice e.g., Creative Music Therapy (Nordoff, Robbins, & Marcus, 2007), Community Music Therapy (Pavlicevic & Ansdell, 2004), and Ecological Music Therapy (Stige, 2002). The literature also indicates that while music therapy seems to be making a positive impact in the lives of PLWD, there are often significant limitations in the research being conducted (Wall & Duffy, 2010).

Public awareness of the potential for the use of music with PLWD has also increased due in part to a 2014 American documentary film entitled 'Alive Inside' (Rossato-Bennett, McDougald, Scully, Regina, & Rossato-Bennet, Michael, 2014). A YouTube clip from this documentary that went viral (with 2,123,600 views as of November 30, 2016; Music & Memory, Inc., 2016) shows a gentleman with dementia move from a withdrawn state to an animated way of being after he hears music delivered via an iPod. This has resulted in the formation of a non-profit organization called Music and Memory© which promotes the use of personalized music listening programs delivered via iPods for PLWD ("Music & Memory," 2016). While these programs may have quality of life benefits for some PLWD, there is no scientific evidence to indicate that these benefits are generalizable to the population as a whole and in fact the use of music delivered via a personal listening device may sometimes be contraindicated (Clements-Cortes, Pearson, & Chang, 2015; Young & Foster, 2016) . Furthermore, there appears to be both an implicit (i.e., assumed) and explicit (i.e., expressed outright) focus on using iPod music listening programs to address the BPSD, which is quite different from person-centered and relationship-focused music therapy approaches cited above.

Statement of Purpose

Current literature in the field, including the publications outlined above, in addition to my own professional experience, indicate that pharmacological treatments alone are inadequate to address the full spectrum of needs of PLWD. A person-centered approach that takes individuals' needs for being in relationships (i.e., constructive, meaningful interactions with others) and their personal resources and/or potentials into account could have a significant positive impact on quality of life and perhaps even prevent, delay, and/or lessen distressing symptoms. Several models of music therapy intervention are framed within individualized person-centered/relationship-based approaches but current literature does not indicate that they are consistently being used with this population. It is my opinion that sporadic and/or symptom-driven use of music or music therapy is overly simplistic in approach and limited in scope. Given the projected increase in incidence of dementia and the increased amount of time that people are living with this condition, it is essential to develop strategies that maximize individuals' potential

for living well given a diagnosis of dementia. Therefore, the purpose of this philosophical inquiry is to make a case for how a wide range of needs of PLWD can be addressed within a person-centered music therapy approach that emphasizes therapeutic relationship as a core component.

Research Questions

The primary research question was: Why is a person-centered, resource-oriented music therapy approach that emphasizes therapeutic relationship as a core component an ideal way to conceptualize music therapy practice in dementia care contexts?

Subsidiary research questions were: (a) According to the literature, what music therapy approaches are currently being used in dementia care? (b) What are the needs of PLWD?, and (c) How can a person-centered, resource-oriented music therapy approach that emphasizes therapeutic relationship as a core component address these needs?

Key Terms

The American Alzheimer's Association defines *dementia* as:

> An overall term that describes a wide range of symptoms associated with a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities. Alzheimer's disease accounts for 60 to 80 percent of cases ("What Is Dementia?", 2017).

See also Sosa-Ortiz et al.'s (2012) definition cited on p. 1 of this thesis.

Person-centred therapy emphasizes individuals' strengths and abilities as opposed to a more exclusive focus on the pathological elements of illness. It takes into account the individual's explicit or implied personal wishes and needs for optimal wellbeing. *Person-centered music therapy* realizes this idea within a music therapy context.

Therapeutic relationship can be defined as "the feelings and attitudes that therapist and client have toward one another and how these are expressed" (Norcross, 2010, "Abstract", para. 1). In music therapy and other helping professions, it is thought that a constructive therapeutic relationship will result in positive change for the client (i.e., help her/him achieve therapeutic goals; (Bruscia, 2014).

Dementia care contexts may include home, hospital, day program, and long-term care milieus where PLWD receive various kinds of support. The context in which a PLWD is situated may affect the level or type of care that she/he receives. The role of the music therapist (and other health professionals) may vary according to the dementia care context and/or the employment situation (e.g., full time, part time, permanent position, contract position, etc. (Young, 2013).

Chapter Outline

This research has been organized into four chapters. Chapter 1 describes the significance, rationale, and purpose of the inquiry. Research questions are presented and key terms are defined. Chapter 2 describes why philosophical inquiry was deemed as an appropriate methodology for this research. Data collection and analysis procedures are also outlined. Chapter 3 presents the results. Chapter 4 presents limitations of the study, implications for research and practice, and a discussion of the need for advocacy.

Chapter 2. Methodology

Design

Philosophical inquiry was deemed to be a suitable methodology to address the research question. Stige & Strand (2016) a music therapist and philosopher of science respectively, described the merit of such an approach through stating:

> Philosophical questions about the good life and how to live it are part of the subject matter itself of music therapy. Music therapy research is not just a descriptive enterprise. It has a purpose, namely to support and develop music therapy to the benefit of human individuals, their communities, and society in general ("Music Therapy Philosophy", para. 4).

This methodology provided a means to examine the needs of PLWD and then systematically organize and present ideas on how a person-centered, relationship-based music therapy approach could address these needs (Stige & Strand, 2016). Using this methodology, I formed an argument to support my position that the current scope of music therapy practice (as represented in the literature) could be expanded or changed to better meet the full scope of needs of PLWD. Trustworthiness of the inquiry was addressed through regular academic advisement with my supervisor, peer consultation, and critical examination of scholarly writings (Shenton, 2004). This allowed me to form a philosophical position that maintained both ethical integrity and practical relevance.

In order to focus the scope of the inquiry and to accommodate the time frame of a Master's thesis, several delimitations were imposed. No participants were included in this research. Publications used as sources of data were delimited to those from the last 6 years (from January 2010 to January 2016). It was important to use recent publications in order for the results to be relevant to the current situation of PLWD. Some literature published prior to 2010 was used to provide context in Chapters 1 and 4, but this literature was not included in the analysis. Although much has been published on the use of music with PLWD at large, I only included literature that focused specifically on the use of music therapy with PLWD (i.e., a credentialed music therapist was involved). Finally, although various person-centered models of music

therapy exist, I chose Rolvsjord's (2010) Resource-Oriented Music Therapy (ROMT) approach as the framework within which to discuss how a person-centered music therapy approach that emphasizes therapeutic relationship as a core component might be conceptualized for PLWD. I made this choice for several reasons. First, the ROMT approach directly resonated with my clinical philosophy. It focuses on nurturing an individual's strengths, resources, and potentials within a care context that emphasizes collaborative therapeutic relationships. Based on my personal experience, I also believed that this philosophy would likely resonate with many other music therapists who work with PLWD and therefore, the results of this research would be directly relevant to their practice. Finally, from a theoretical perspective, ROMT seems well-suited to accommodate the changing needs of PLWD throughout all stages of their disease as it focuses on "here and now" potentials and emphasizes PLWD's fundamental human needs for social belonging and interpersonal connection. Although ROMT has been conceptualized for use in various mental health contexts (Gold et al., 2013; Gold et al., 2005; Rolvsjord, 2010; Rolvsjord & Stige, 2015; Solli, Rolvsjord, & Borg, 2013), the literature does not indicate that it has been conceptualized for use with PLWD. It was my hope that this research would help to fill this gap and provide the framework for a practical approach that music therapists could easily apply to practice.

Materials

As noted above, scholarly literature published between January 2010 and January 2016 served as the main source of data for this inquiry. This included qualitative and/or quantitative articles from peer reviewed journals, case reviews, and books/chapters related to the thesis questions. Other materials included a laptop computer.

Data Collection Procedures

To guide my data collection process, I used Creswell's (2013) suggestions on how to gather relevant literature. I searched online databases including PubMed and Google Scholar as well as Concordia University's online database, Concordia CLUES. I created two separate key word lists following the identification and clarification of the research topic. To discern the current needs of PLWD, I created a keyword search that included the words: dementia,

neurocognitive disorder, Alzheimer's, symptom management, and/or quality of life. This search resulted in 54 publications found in PubMed, 7,720 publications found in Google Scholar, and 2 publications found in Concordia CLUES that fell within the targeted dates (see delimitations above). The resulting publications from each database were reviewed for relevance to the research topic and 14 publications were included in this text as they were deemed suitable to provide a current, comprehensive representation of the needs of PLWD.

A second keyword list to discern current music therapy practices for PLWD included the words: music therapy, dementia, neurocognitive disorder, Alzheimer's, relationship, behavioural and psychological symptoms, and person-centred care. This search resulted in 0 publications found in PubMed, 58 publications found in Google Scholar, and 1 publication found in Concordia CLUES that fell within the targeted dates. The resulting publications from each database were reviewed for relevance to the research topic and 12 of these publications were included in this text as they were deemed suitable to provide a current, comprehensive representation of published music therapy practices for PLWD. I also reviewed online music therapy journals including *Voices: A World Forum for Music Therapy*, the *Canadian Journal of Music Therapy*, the *American Journal of Music Therapy*, the *Nordic Journal of Music Therapy*, the *British Journal of Music Therapy*, and the *Australian Journal of Music Therapy.* This resulted in 3 additional articles for a total number of 15 publications on current music therapy practices for PLWD.

Finally, in order to choose an approach which resonated with my beliefs, I reviewed various well-known person-centered music therapy models/approaches including Community Music Therapy (Pavlicevic & Ansdell), Creative Music Therapy (Nordoff & Robbins), and Ecological Music Therapy (Stige) and ultimately chose to use Rolvsjord's Resource-Oriented Music Therapy approach (Gold et al., 2005, 2013, Rolvsjord, 2006, 2010, 2010; Rolvsjord & Stige, 2015; Solli et al., 2013) for reasons cited above.

Data Analysis Procedures

I reviewed the 14 publications that I found in relation to the needs of PLWD. I extracted identified needs and relevant information and organized it under three categories: physical needs,

psychological and emotional needs, and social needs. I then reviewed the 15 publications that I found in relation to current music therapy practices being used with PLWD. I organized the essential components of these practices into a table to give readers a sense of what is and is not being addressed according to this literature. Finally, using Rolvsjord's (2010) book and other articles that provided additional context on ROMT (Gold et al., 2005, 2013; Rolvsjord, 2006; Rolvsjord & Stige, 2015; Schwabe, 2005; Solli et al., 2013), I created a summary description of this approach and then identified how key elements of this approach could be conceptualized within a dementia care context (in general) and address a broad spectrum of identified needs for PLWD. The ways in which my perspectives either aligned with the results or evolved over the course of the study are addressed in the Discussion chapter.

Chapter 3. Results

Overview of Current Music Therapy Models/Approaches for PLWD

As noted in Chapter 1, recent literature contains little evidence to indicate that person-centered music therapy models/approaches are being used frequently or consistently for PLWD. The following table provides an integrated summary of current music therapy approaches/models according to the 15 publications that I reviewed. The information in Table 1 is meant to provide the reader with an overview of current music therapy approaches being utilized in dementia care contexts (according to the literature). This emphasizes the need for the current study in that it highlights a lack of focus on client-centered, resource oriented, relationship-based music therapy approaches for PLWD.

Table 1

Current Music Therapy Approaches/Models Being Used in Dementia Care Contexts

Music Therapy Model/Approach	Implied/Expressed Theoretical/Philosophical Foundations	Goals/Needs Addressed	Role of Therapeutic Relationship	Sources
Behaviour and Symptom Management	Behavioural	Reduce BPSD, including anxiety and agitation	Minimal emphasis on developing therapeutic relationship	Cerejeira, Lagarto, & Mukaetova-Ladinska, 2012; Hsu et al., 2015; Jutkowitz et al., 2016; Kales, Gitlin, & Lyketsos, 2015; Raglio, 2013; Raglio et al., 2012; Ridder, Stige, Qvale, & Gold, 2013; Seitz et al., 2012; Ueda et al., 2013; Whear et al., 2014
Creative Music Therapy	Humanistic/client centred, music centred	Opportunity for non-verbal communication, enhance mood, enhance engagement	Focus on developing relationship between client and therapist, client and musical processes	Cheong et al., 2016; Pavlicevic et al., 2015
Community Music Therapy	Humanistic/client centred, ecological, recreational	Enhance interpersonal connectedness, foster sense of belonging to a social system/community, enhance quality of life	Strong emphasis on interpersonal connection, building community relationships	Dennis & Rickson, 2014; Schrag, 2015
Ecological Music Therapy	Humanistic/client centred, ecological, recreational	Enhance interpersonal connectedness, foster healthy social environment	Strong emphasis on interpersonal connection, building community relationships	Hara, 2011

Needs of Persons Living With Dementia

Physical needs. There are several physical symptoms associated with moderate to advanced dementia that create daily challenges to quality of life in addition to taxing psychological wellbeing. These symptoms may include pain, dyspnoea (difficulty breathing), pressure sores as a result of extended periods in bed or wheelchair, agitation, difficulty with appetite and eating problems in addition to damaged verbal/communication ability (Lyketsos et al., 2011; Sampson, Burns, & Richards, 2011). Prolonged physical discomfort may exacerbate anxiety and agitation and increase the BPSD such as screaming, restlessness, wandering, culturally-inappropriate behaviours, sexual disinhibition, hoarding, and cursing (Cankurtaran, 2014). Current research also suggests that physical conditions associated with aging such as problems with eyesight and hearing may also receive inadequate diagnosis and treatment in PLWD, further compromising overall quality of life (Cadieux, Garcia, & Patrick, 2013).

PLWD in institutionalized care are also at high risk for lack of positive sensory stimulation, including non-clinical touch. The sensory need to initiate contact such as touching or hugging others and to receive such contact in return endures throughout the human lifespan and may not be accessible within an institution if PLWD do not have access to friends, family, or touch-oriented programs such as pet therapy (Nicholls, Chang, Johnson, & Edenborough, 2013). Over time, this lack of positive sensory stimulation can also have deleterious effects to the psychological and emotional needs of PLWD by increasing feelings of depression and isolation.

Psychological and emotional needs. Given the prevalence of psychological distress as a primary symptom of dementia, the psychological and emotional needs of this population are profound. Despite this, research suggests that there is a lack of support to help individuals manage psychological conditions such as depression and anxiety (Cadieux et al., 2013). Other psychological and emotional symptoms of persons living with dementia that require support may include apathy, personality changes, hallucinations and delusions, misidentification syndromes, sundowning (i.e., increased agitation that occurs later in the day), elation, and negativism (Alzheimer's Association, 2014; Cadieux et al., 2013; Cankurtaran, 2014; Cerejeira et al., 2012; Sorbi et al., 2012).

The psychological and emotional symptoms of PLWD may be exacerbated by elements of institutionalized care, where shortages in staffing may prevent PLWD from receiving the psychological support they need, especially in these contexts. A 2012 British study found that due to understaffing, health care providers felt unable to offer:

> Personalised, patient-centred care that provided for patients' social and emotional needs. In some instances, this had implications for residents' independence and choice and control over what they would like to do every day, and in some cases it seems that basic needs are not being met ("Royal College of Nursing," 2012, p. 15).

Diminished autonomy due to lack of social support must also be considered when evaluating the psychological and emotional needs of this population. PLWD also have an enduring psychological need to retain a sense of self and self-esteem as abilities decline. As dementia progresses, self-concept is shaken due to changes in cognition and how PLWD perceive themselves, as well as being aware of changes in how other individuals perceive them (Gennip et al., 2016).

Social needs. As PLWD experience cognitive decline, their social vulnerability increases and they are at risk for social withdrawal (Hugo & Ganguli, 2014). As the process of dementia gradually increases disinhibition, individuals' ability to conduct themselves within "social and cultural norms and restrain inner feelings such as sexual drives" (Cerejeira et al., 2012, "Disturbances in Motor Function", para. 2) is impaired, creating further challenges in relating to others in socially appropriate and meaningful ways. Current research suggests that in particular, a "lack of stimulating daytime activities and social company" (Cadieux et al., 2013, p. 723) are important social needs that are not consistently realized for this population in health care. The literature also reflects that PLWD experience an unmet need for feelings of normalcy and meaningful relationship (Miranda-Castillo, Woods, & Orrell, 2013). In addition, PLWD may also have social needs that are specific to their cultural background. Such cultural needs may include (but are not limited to) race, ethnicity, needs of specific age cohort, religion, social class, gender identity and expression, and sexual orientation (Young, 2013, "Multicultural Considerations", para. 1). As communicative skills and cognition decline, these cultural needs may be unrealized due to a limited ability of PLWD to express their presence and/or significance, potentially leading to psychological distress and/or further losses in sense of self and community.

Rolvsjord (2010) speaks to the social challenges posed by institutionalization:

> When illness strikes, it is not only the effects of the illness itself that threaten our health, but also the implications of the illness on our total life situation. When mental illness leads to hospitalization, this is often related to stigmatization, and it also disturbs or hinders our participation in social activities that usually contribute to our sense of health and quality of life (p. 68).

Even though Rolvsjord is not speaking to the institutional situation of PLWD directly, I believe the statement applies as PLWD are at great risk for the concerns of stigmatization and disturbed social participation Rolvsjord raises. PLWD are in crucial need of both social acceptance and being included and encouraged to participate in social activity.

Resource-Oriented Music Therapy

Overview of the approach. Resource-oriented music therapy (ROMT) was developed by Norwegian music therapist Randi Rolvsjord although the seeds of the approach began to emerge in the context of an international collaborative research project that she was part of between 2004 and 2008. In order to develop a theoretical framework and approach that focuses on "noticing, acknowledging, and making use of the client's resources through the fostering of a collaborative relationship" (Rolvsjord, 2010, p. 66), Rolvsjord drew from theories of empowerment philosophy, the common factors approach, positive psychology, and musicology. By combining her clinical experiences with these theories, Rolvsjord sought to create an approach that speaks to the unique potential opportunities that music therapists have to actively recognize and utilize the strengths of their clients: "we have so many possibilities to see and to make use of the client's resources, as the musical interaction allows clients to unfold and show us their musical and relational strengths" (p. 67). In addition to intermusical relationships, ROMT also strongly emphasizes the interpersonal relationships that can develop through music, as Rolvsjord states: "music may help us to move toward more egalitarian relationships, as we let ourselves be engaged with the music together with our clients" (p. 67).

In her 2010 publication, "Resource Oriented Music Therapy in Mental Health Care", Rolvsjord outlines the four central concepts of ROMT: "(1) resource-oriented music therapy involves the nurturing of strengths, resources, and potentials; (2) resource-oriented music therapy involves collaboration [i.e., through relationship] rather than intervention; (3) resource-oriented music therapy views the individual within their context; and (4) in resource-oriented music therapy, music is seen as a resource" (p. 74). Given my position (outlined in Chapter 1) that person-centered, relationship-based approaches are essential in helping PLWD to reach their full potential for living well, it seems that the ROMT concepts are well suited for re-conceptualization within dementia care contexts. The following two sections of this chapter will focus on this task.

Reconceptualising Key Concepts of ROMT within Dementia Care Contexts

Resource-oriented music therapy involves the nurturing of strengths, resources, and potentials. In ROMT, the client's resources are the centre of attention. As noted in Chapter 1, PLWD very often have preserved musical abilities even up to the end stages of their disease. McDermott et al., (2014) stated: "The effects of music go beyond the reduction of behavioural and psychological symptoms. Individual preference of music is preserved throughout the process of dementia."("Conclusion", para. 1). Sustaining musical and interpersonal connectedness could help PLWD to feel more in touch with their own identity and at the same time help others to see or acknowledge their identities beyond the confines of their disease. Nurturing this musical strength through shared music experiences may enable social participation and foster social relationship. Rolvsjord (2010) indicates that "social relationships are emphasized as important health resources in relation to both social support and social capital" (p. 68).

Rolvsjord (2010) also emphasizes the importance of nurturing individuals' innate resources as a means of strengthening feelings of resilience throughout the disease process. It is therefore possible to suggest that using consistent and knowledgeable approaches to fostering each PLWD's musical potential could strengthen individuals' intuitive feelings of resilience, which could act as a buffer against the emergence of BPSD. By considering the person (i.e., their identity) and their musical strengths first rather than the pathology, the PLWD is empowered to have the best quality of life possible within the boundaries of their current context.

Rolvsjord (2010) states:

> Resources are seen as an essential part of the focus of therapy at every stage of the therapy: in other words, they should be a significant part of the assessments, of the therapeutic collaborations, and of the evaluation of the therapy (p. 67).

In practice, the resource-oriented music therapist must therefore investigate what these strengths, resources, and potentials are and do so in collaboration with the client as much as possible. Given the progressive cognitive challenges of PLWD, assessment and re-assessment is required to help each individual to connect and reconnect with their own resources. Although assessment should include information related to life history and past music preferences supplemented by

caregivers and family when possible, the music therapist must also try and assess the individual's current identity, needs, and wishes. If an individual does not identify with music that was previously important, the music therapist should continue to try and determine what connects with them in their current context. Following the initial and ongoing assessments of musical strengths, resources, and potentials, the work of the music therapist is to structure appropriate and engaging musical opportunities and experiences for each PLWD that help to maintain and heighten their particular musical potentials.

Resource-oriented music therapy involves collaboration rather than intervention. In her work, Rolvsjord (2010) emphasizes the value of collaboration on the therapeutic experience of the client: "In order to be empowered in the relationship, people need to contribute to as well as benefit from relationships" (p. 71). She stresses the importance of collaboration further by describing the potential gaps left by non-collaborative treatment: "Even in a therapeutic relationship, mutuality has to involve more than a one-way emphatic response from the therapist to the client. Mutuality involves a person-to-person responsive relationship in which both client and therapist are directly and personally involved" (p. 70).

This central focus of resource-oriented music therapy may be well-reconceptualised for PLWD, a population for whom working together with others is an integral aspect of maintaining wellbeing and quality of life. Current literature addresses the importance of collaborative therapeutic relationships as a means of promoting feelings of wellbeing and equality: "all human life is grounded in relationships, and individuals with dementia need an enriched social environment that fosters opportunities for personal growth while compensating for their cognitive and functional impairments" (Grand et al., 2011, p. 139).

A music therapist working with PLWD through this lens would consider adapting interventions to support collaboration with individuals throughout all stages of dementia. Given that communication deficits are often present in later stages of dementia, a music therapist would ideally have concrete background information on the individual which they would combine with context and in the moment observations/intuition to collaborate with PLWD and determine what the individual implicitly or explicitly needs/wants. The music therapist could integrate visual

aids (e.g., flashcards, images, song titles) to encourage gestural responses such as pointing, head-nodding, and/or vocal reaction to participate in decision-making processes. The music therapist may also support collaboration during music therapy sessions by providing options for mutual instrument playing that PLWD may accept/decline/engage with either verbally or gesturally. Ultimately, thorough assessment and re-assessment is required to determine how to provide opportunities for PLWD to collaborate in their therapy sessions as dementia progresses and to adapt interventions in ways that appropriately support their ability for mutual involvement.

Resource-oriented music therapy views the individual within their context. Rolvsjord describes traditional care models as being overly focused on: "a concept of pathology as something that resides solely in the individual… [obscuring] the interpersonal, structural, societal, and cultural aspects of the problems" (Rolvsjord, 2010, p. 71). To overlook the surroundings of PLWD living in an institutionalized setting would be to overlook their reality. Similarly, to look only upon the pathology of a PLWD would be a limited lens through which to view their total life situation. ROMT's key principle of viewing an individual within their context would address PLWD's need to feel valued as members of a community. In an article on Community Music Therapy in a hospital dementia care ward, Dennis and Rickson (2014) use community music therapists' Pavlicevic and Ansdells' (2004) idea of the "ripple" effect where "music therapy can move an isolated person towards the community, and bring the community toward the individual" ("Discussion", para. 1). In their study, Dennis and Rickson also discovered that "investigating music therapy to aid in relationships between people with dementia and their family members was found to be valuable in fostering a sense of community between residents, family members, and carestaff" ("Abstract", para. 1).

Rolvsjord's approach also promotes the idea that contributing to a community is necessary for maintaining quality of life:

> Happiness is related not so much to economy and material welfare as to aspects of social relationship and possibilities to use our strengths… empowerment philosophy somehow bridges the gap, or at least aspires to bridge the gap, between therapy and society (p. 72).

Within dementia care, Rolvsjord's focus on context would draw PLWD from states of isolation to a position of social-connectivity through supporting PLWD's enduring needs to participate in their community in gratifying ways. Resource-oriented music therapists can support contextual wellbeing in PLWD by facilitating open group music therapy sessions as appropriate that include family and/or care staff. In addition to providing PLWD with opportunities to engage in meaningful shared experiences with their community, group music therapy would also offer family and care staff the opportunity to learn resources and strengths of PLWD they might not have observed otherwise. Care personnel's awareness of their patient's resources could translate to enhanced understanding of PLWD by their care community and increased efforts to provide opportunities for residents to contribute their resources outside of music therapy sessions as well.

In resource-oriented music therapy, music is seen as a resource. In a ROMT approach, the concept of resources refers not only to an individual's personal strengths, but also to those resources to which she/he has access. Thus, music as a health resource must be understood both individually (e.g., musical preferences, competencies, etc.) and socially (e.g., engaging with the medium and with others through the medium). "Music has certain qualities that represent potentials that can only be actualized through human engagement with music" (Rolvsjord, 2010, p. 73). As noted in Chapter 1, research indicates that the music functions of the brain, including music memory, appear to remain largely intact during the otherwise neurologically devastating progression of dementia. By viewing music as a resource, music therapists may work with PLWD to address communicative, social and relationship challenges (Peretz, 1996; Peretz & Coltheart, 2003; York 1994; Young, 2013). For example, PLWD may use music rather than words to express emotions, ideas, and/or needs. Active music making can serve as a form of communication or socialization. The music therapist may use music to facilitate interactions between PLWD and their families, care teams, and communities. It can help to maintain or create meaningful human relationships.

Summary. Ultimately, a resource-oriented approach to music therapy may be understood as both person-centred and relationship-focused in its philosophy. Person-centred care is concerned with seeing PLWD as individuals foremost and taking their needs and wishes into account, a stance Rolvsjord (2010) illustrates:

> The task of the therapist is not to decide what the right therapeutic intervention is, and to execute that intervention, but to help the client become involved and motivated and to help her or him to actively use the therapy (p. 175).

Rolvsjord continuously emphasizes the importance of therapeutic relationship through stating that:

> A good collaborative relationship seems to be directly related to change, growth, and developmental processes… both participants are actively involved in the process of assessment, in deciding the goal for the therapy, and in finding a way to work toward problem-solving, development, or other goals (p. 175).

This approach to care could provide a valuable opportunity to support increased independence and decision-making processes in PLWD, promoting positive feelings of self-esteem and autonomy. The information in Table 2 is meant to provide the reader with an overview an “at a glance” summary of the four central foci of the ROMT approach and how that might be reconceptualised within the specific context of dementia care.

Table 2
Key Concepts of ROMT Applied to Dementia Care

Concept	Goal(s)	Relevance for PLWD	Implications for Practice
Nurturing individual and contextual strengths, resources, and potentials (SRP).	Acknowledge, stimulate, and develop SRP.	Throughout dementia, music functions are usually neurologically intact.	Clinical assessment to determine musical SRPs; personalized music experiences are structured accordingly.
Collaboration rather than intervention.	Actively participate in one's own personal well-being, including decision-making processes.	PLWD have a voice in their care; PLWD have the opportunity to contribute in mutual, egalitarian relationships.	Adapt MT interventions according to observed responses as verbal functioning declines.
Views the individual within her/his context.	Connect an individual to his/her community	Diminish social isolation by involving PLWD in their community	Provide access to music experiences based on identified SRP; motivates PLWD to engage with others through group and community MT sessions
Music is seen as a resource.	Use music in ways that enhance health and quality of life.	Music is a non-verbal method of communication for PLWD; musical ability and enjoyment are often neurologically preserved.	Encourage musical dialogue, provide opportunities for PLWD to listen/play/engage with preferred music to address various quality of life domains.

How ROMT Meets the Identified Needs of PLWD

Although the previous section touches upon how a ROMT approach meets the needs of PLWD, it is not comprehensive. The purpose of this section is to present all of the needs of PLWD that were identified earlier on in this chapter, and provide hypothetical concrete examples of how music therapy experiences realized within an ROMT approach might address these needs.

Physical needs. Rolvsjord (2010) states: "participation in decision-making and social support is related to a reduction in psychological and somatic symptoms and a reduction in perceived stress levels" (p. 69). Through offering PLWD the opportunity to actively express and make decisions in whatever ways that they can, ROMT may help to alleviate discomfort related to physical symptoms including pain, dyspnoea, pressure sores, agitation, and appetite challenges. Because this care approach uses musical collaboration as a primary medium, ROMT may also remove communication barriers posed by damaged verbal ability through providing an alternate method of transmitting and receiving messages.

Rolvsjord (2010) also states that: "engagement with something that is not related to illness or treatment can play an important role in the total health situation" (p. 74). The opportunities for meaningful interpersonal experiences that ROMT offers such as participating in a music café or choir could address unmet needs for social relationship and in doing so potentially alleviate symptoms such as anxiety and agitation as well as redirect other BPSD mentioned above (screaming, restlessness, wandering, culturally inappropriate behaviours, sexual disinhibition, hoarding, and cursing). Through regular collaboration between music therapists and PLWD, other health concerns such as eyesight and hearing may be monitored through gaging responses to visual and auditory stimuli.

Psychological and emotional needs. ROMT encourages involving client resources such as how individuals involve music in their everyday life as well as "instrumental skills, knowledge of a repertoire of songs, and singing ability" (Rolvsjord, 2010, p. 68) as a means of boosting feelings of wellbeing. Using activities such as these could provide an effective approach toward addressing symptoms of psychological distress such as depression, anxiety, apathy, personality changes, hallucinations and delusions, misidentification syndromes, sundowning, elation, and negativism. Rolvsjord (2010) suggests that this is due to the emphasis on strong collaborative relationship, which she states is "directly related to change, growth, and developmental processes" (p. 69). Rolvsjord also speaks to the power of using resources to bolster resilience when addressing psychological needs:

> Resources can be connected to the prevention of mental health problems and illness in a diversity of ways, as well as to the ability to cope with stressors and illness. "Resilience" is a concept that refers to the individual's ability to tolerate stress and comprises such aspects as hardiness and power of resistance (p. 68).

PLWD who have access to structured music programs that are tailored to their resources (e.g. a singing group that uses participants' preferred music) may also experience a reduction in psychological symptoms exacerbated by institutionalized care. Participation in familiar musical activities surrounding familiar musical skills developed in partnership between the PLWD and the music therapist may increase feelings of autonomy, sense of self, self-esteem, and self-concept. By making musical resources available to PLWD, a music therapist who operates from a resource-oriented approach also gives individuals the means to actively participate in managing their own psychological health outside the music therapy room. Maximizing access to musical resources might include ensuring that PLWD have access to music technology for personal music listening or encouraging health care personnel and volunteers to remind residents of any other musical resources such as instruments (e.g. a unit piano). To ensure quality assurance, music therapists would provide their facility with detailed instructions on how, when, and why to use music resources/activities if they (the music therapists) are not present. Music therapists may

also consider offering educational in services to staff and family members. Rolvsjord (2010) describes the benefits of maximising resources further:

> From research into people's use of music in daily life, it is, clearly demonstrated that people engage with music in ways that are related to health and quality of life. They use music to regulate their emotions, to regulate their activity. They use music to construct their identities, to assist feelings of embodiment, or as an aid for social ordering and social relationships (p. 74).

This idea is easily applicable to PLWD. Even if a PLWD has lost touch with their musical identity, a music therapist may assist in identifying their musical resources. Once this is accomplished, a music therapist can readily help PLWD achieve the benefits Rolvsjord states above. The psychological merits of using music as a resource are potentially profound and should be taken into account when considering the psychological and emotional needs of PLWD.

Social needs. ROMT offers PLWD access to shared social activities, such as music-making with the music therapist or in a therapeutic group, where they are able to make use of and contribute musical abilities that are largely unaffected by their disease process. This may foster empowerment that transcends the therapeutic arena by increasing PLWD's desire for social interaction overall. Participating in ROMT could lessen feelings of social withdrawal, while supporting safe and appropriate social behaviours by using the music activity as a social cue for PLWD. By developing a therapeutic relationship over the common ground of shared musical ability, ROMT addresses PLWD's needs for stimulating activity and social company by emphasizing a democratic participation, characterized by "equal rights to influence decisions… both the therapist and the client are engaged" (Rolvsjord, 2010, p. 72). Meaningful relationship is established through a collaboration-focused therapeutic alliance that encourages PLWD to contribute an active voice toward their treatment. Experiencing the opportunity to collaborate empowers PLWD within the relationship and would bolster feelings of normalcy and efficacy as they exercise their unique skills and musical ideas with the music therapist and other residents.

ROMT also accounts for impairments in cognition by giving those without the ability to speak coherently or understand spoken or written language access to preserved abilities for

musical expression and appreciation, thus lessening the risk of social isolation. Even if a PLWD is unable to recognize or identify objects or perform motor activities, they may still implicitly or explicitly indicate their wishes to have access to musical activities including music listening, music-making with others, and/or to receive comfort through shared social interaction from a music therapist. Because dementia impairs neurologic ability to think abstractly, make sound judgments, and plan and carry out complex tasks, it is imperative to consider the value of music as a neurologically intact function. Music remains a resource for most PLWD and ROMT is directly concerned with maximizing the therapeutic potential of this resource.

For PLWD, the ROMT approach to music therapy signifies an outlet, a place to actively express emotional states and participate in a meaningful, shared social activity using preserved musical ability and identity as an anchor. Because an individual's musical identity will be shaped and influenced by PLWD's lived experiences, shared activities and musical programs can be co-developed between PLWD and the music therapist to support multicultural needs (Young, 2013, "Multicultural Considerations", para. 2). In practice, such culturally-based activities might include creating listening groups specific to religion, having an LGBT choir, creating singing groups that focus on music specific to certain decades, or facilitating song-writing workshops that explore personal content and/or life themes of individuals. By making music experiences available that take into account PLWD's social and cultural needs in a manner that encourages participation and inclusion, PLWD are primed to experience feelings of social success and acceptance.

Ultimately, I believe that a ROMT approach provides a person-centred, relationship-based care strategy to address the needs of PLWD in a way that can help to maximize quality of life for them and subsequently, their loved ones. Table 3 provides an "at a glance" summary of a ROMT approach to addressing the identified needs of PLWD.

Table 3
Overview of how ROMT can Meet Identified Needs of PLWD

Area of Need	Associated Symptoms	ROMT Approach
Physical	Pain, dyspnoea, pressure sores, appetite/eating problems, agitation, anxiety	Focus on musical collaboration, encourages expression of physical needs and/or helps MT identify strategies for management; musical engagement may decrease perception of physical pain or prevent/reduce physical symptoms
Psychological/ Emotional	Depression, anxiety, hallucinations, delusions, misidentification syndromes, sundowning, elation, negativism	Emphasis on collaborative musical relationship may develop resilience, which may help PLWD cope with psychological/emotional stressors; use of musical resources may improve mood and overall quality of life
Social	Social isolation, lack of stimulating daytime activities/social company, lack of feelings of normalcy/meaningful relationships	Mutuality, equality, and participation in therapeutic music alliance may foster social bonding for PLWD; focus on music experiences that engage/empower may decrease social isolation

Chapter 4: Discussion

In summary, the literature indicates that although PLWD are in need of person-centred, non-pharmacological interventions, recent music and music therapy research has largely focused on managing the BPSD. However, as the music-related functions of the brain often remain neurologically intact (or less affected than many other functions) throughout the disease process, music may be viewed as a resource that can help to address the physical, psychological/emotional, and social needs prevalent in PLWD. Knowledgeable and personalized use of music provided within the context of a therapeutic relationship may even help to prevent symptoms before they occur. This philosophical inquiry used Rolvsjord's (2010) Resource-Oriented Music Therapy approach (originally conceived for the benefit of mental health patients) to create the foundation for a music therapy approach tailored to the specific needs of PLWD's that seeks to maximize their overall quality of life.

The purpose of the present chapter is to present implications of the results for research and practice, as well as to discuss the need for advocacy for approaches such as the one suggested by this research. Limitations of the study are also presented.

Limitations

Limitations of the present study must be considered. I, (the current author), am a first time researcher and although I do believe that my results are credible, the suggested approach lays the foundation for a model that could be further clarified. Another limitation is the hypothetical nature of the results; because there were no participants involved in the research, there is no clinical evidence that documents the efficacy or appropriateness of using this approach for PLWD. Finally, my personal perspectives are based mostly on my 6-month pre-professional internship. Further clinical experiences with PLWD would likely help me to further refine this approach.

I also had some assumptions, which could be considered as limitations, which may have inadvertently affected how I interpreted and presented the results. Based on my personal experiences, I assumed that a resource-oriented approach to music therapy would be beneficial for PLWD. Secondly, I assumed that much of the music therapy professional community would

agree with this approach and are, or would be willing, to incorporate it into their practice. Lastly (also based on my experience), I assumed there would be obstacles in the current health care system that could limit the implementation of this approach.

Implications for Research

This study was a preliminary attempt to explore the implications of Resource-Oriented Music Therapy adapted to a person centered, relationship-based approach for PLWD. Further research is required to understand how this approach may be conceptualized in "real life" dementia care contexts. In addition to clarifying the parameters of the music therapy-based experiences needed to address identified needs and prevent symptoms, the approach needs to be examined in research studies that involve PLWD and other relevant stakeholders (e.g., family members, health care workers and administrators, etc.).

As previously noted, the literature indicated a lack of current music therapy research regarding person-centred music therapy approaches at large including creative, community, and ecological approaches. While I chose to examine Resource-Oriented Music Therapy as an approach for PLWD, these other approaches may also offer valuable perspectives. My results indicate that further research is required, focused on examining the potential for integrating such diverse perspectives on person-centered therapeutic approaches for PLWD. Implications of this future research may expand what is known about providing care for PLWD and refine the scope of practice for music therapists. While recent music therapy literature does demonstrate that there are some music therapists currently working with PLWD who see the benefits of practicing within a person-centered, relationship-based approach, there is a lack of current clinical research that emphasizes the philosophical importance and concrete outcomes of doing so. Further qualitative and quantitative studies would be needed to help translate these clinical aims into practice.

Implications for Practice

This study has also implications for practice. By examining an approach to music therapy that had not previously been conceptualized within the context of this population, this study sought to clarify, expand, and/or change the scope of practice for music therapists who currently

work in dementia care. This research also advocates for a less exclusive focus on a biomedical approach in favour of a more balanced approach to care. Rolvsjord's (2010) Resource-Oriented Music Therapy approach helped me to articulate my intuitive clinical approach and professional values. This research effort will inform and improve my current and future practice. I believe that this may be the case for other music therapy professionals who work with this population. It is imperative that we as health care professionals expand our focus from *what* care we provide, to *how* we provide that care, ensuring that the services rendered are optimal. It is my hope that this thesis will help music therapists to articulate and/or validate their current practices and/or provide them with information that they need to shift or expand their current approach.

Implications for Advocacy

This study is congruous with the aims of Alzheimer's Disease International (2012) who in recent years have been advocating more overtly for the rights of PLWD. They support implementation of policies at all levels of government, calling for: "awareness raising [that] focuses on the general public, as well as families and healthcare professionals, to improve their understanding of dementia and to change attitudes and practices" (Wortmann, 2012, "Alzheimer's Disease International", para. 4). As members of society, I believe we have an ongoing responsibility to care for our most vulnerable individuals. When working with PLWD, we have the responsibility to affect change in our current care systems and continuously strive toward reaching the most beneficial, dignifying, and compassionate approaches available.

This philosophical inquiry is, at its most basic elements, a call for action. By exploring how a ROMT approach originally designed for mental health contexts could be reconceptualised for PLWD, I hope to offer guidance and information to music therapists who are advocating for a more humanistic, preventative, and holistic approach to practice. Because music is such an important resource for PLWD, providing physical, psychological/emotional, and social benefits well beyond mere "pleasant distractions", this study is advocating for more full-time music therapy positions in dementia care contexts. It is possible that a ROMT approach could reduce the need for pharmacological interventions and/or address unmet physical, psychological/emotional, and social needs of PLWD.

In the four years following my clinical internship, upon re-entering academia and subsequently collaborating with peers and professors, I met many music therapists who felt the same way about their work with PLWD. We wondered: how do we name the gap in dementia care, and more importantly, how do we fill it? I hope that this thesis is a preliminary step toward addressing both of these questions.

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