

# Listening Amidst the Chaos: Music and Recreation Group Therapy in Acute-Care

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## Abstract

A brief term music and recreation therapy group on a general medicine acute-care unit at Sunnybrook and Women's College Health Sciences Centre (SWCHSC) Toronto is presented. Acute care settings are often filled with noises, busy hallways, unfamiliar faces, and upsetting news. This paper will describe how a music and recreation group was started in an acute care setting and will examine whether brief creative intervention is a worthwhile service in an acute care setting.

## Introduction

Accompanied by his wife, Mr. Smith, an elderly man has been taken to emergency by ambulance. He has had a stroke and fell getting out of bed late at night. His wife sits in the emergency waiting area for hours to hear if her husband is all right. She is finally told that he has regained consciousness and is going to be transferred to an acute care bed where he will stay while he is treated for his injuries and helped to recover. She stays another hour waiting for someone to push his bed to acute care. She holds her husband's hand and tries to comfort him but he appears to be confused and only looks at her with a blank stare. He is finally transferred to a general medicine acute care unit. His wife follows him up to the unit to make sure she knows where he will be. She watches the nursing staff take vital signs and helps to settle him into his new bed. She is told to go home now and get some rest. In the morning the patient wakes to the sound of his roommate hollering for help. He is frightened and has no recollection of where he is. He reaches out for his wife but his hand hits the bedrail. He is suddenly aware of more sounds: beeping monitors, voices over the intercom, foot steps in the hallway, more hollering from the bed across from him, a loud beeping from his IV drip. Then suddenly a face peers down at him. "Oh, good! You're awake Mr. Smith. Let me fix your IV, you've rolled onto the line." The face has rolled him over, he feels pain and is now looking at a wall. "Who is this person and what is she talking about?" he wonders. He is pulled back onto his back and his bed makes a buzzing sound as it rises into a sitting position. A meal tray is placed in front of him and the nurse leaves the room. With a foggy mind, he reaches for what looks like a glass of water but his arm will not cooperate. Panicked, he tries again with no success; his arm will not budge. Frightened, he tries to call out for his wife: "Mary!!!" His voice is muffled and weak. For ten minutes he calls for her with no response. Confused and crying he lies in his bed. Finally, a nurse comes and explains that his wife will be in later. She encourages him to eat with his left hand and then leaves quickly to help another patient.

Note: This story is meant to paint a picture of the emotional experience of a patient in acute care. While some might find the above description to describe nurses as being cold or uncaring, this is not the case. In acute care hospital units nurses are expected to provide care to many patients at a time and attend to their immediate physical needs. Of course this account is not reflective of all patients' experiences.

Here begins Mr and Mrs. Smiths journey. Their lives will never be the same. Mr. Smith's stroke has left him with right side paralysis. His fall has fractured his hip and given him a good bump on the head that will need to be examined for any damage that could have been caused. He will need rehabilitation and then a long term care bed. Until a bed becomes available the hospital will be his home. He may never see his house again. While in the hospital Mr. Smith will experience much loss. He will lose motivation, feel depressed, develop anxiety about how this is going to affect his wife and family, and he will withdraw. Several days following his admission the unit social worker calls the music therapist and leaves a referral explaining Mr. Smith's current condition. Mr. and Mrs. Smith are introduced to the music therapist. She tells them about a music and recreation group called "Music and Memories" that will be taking place tomorrow on his unit. Mr. Smith appears to be reluctant to leave his room but agrees to consider it. The

next day the music therapist reminds him that it is okay to simply come and listen to the music and conversation. With this reminder he allows the music therapist to push his wheelchair down the hall toward the sounds of soft jazz music and voices in a room at the end of the hall; Mrs. Smith follows closely. Here begins another journey for Mr. Smith and Mrs. Smith. One of self-expression, feelings of enjoyment and comfort, increased motivation, and decreased anxiety.

This paper will look at a unique group called "Music and Memories" that was initiated by a music therapist and a recreation therapist within the general medicine acute care units of SWCHSC. The development and implementation will be described including some case studies. Finally, some questions will be raised regarding the validity and efficacy of brief intervention within such settings. Before beginning, a short discussion of where this work fits into previous research is presented.

### **Locating Brief Therapeutic Intervention in Research**

To locate brief creative therapy in the literature a working definition of brief therapy in the acute care context was needed. For our purposes, brief creative group intervention involved the establishment of a group that was to receive creative music and recreation therapy for as little as a single session. Thus, "brief" was defined as patients attending as few as one group session.

An initial search in music, and recreation therapy literature resulted in very little research looking specifically at the use of brief group intervention. Much has been written on music therapy in palliative care, which is by nature, usually brief. However, the majority of this work is not written from a group intervention perspective lending it difficult to generalize to the brief work done in acute care. When focussing on research in psychotherapy and counselling, some work surfaced, however, definitions and models of brief intervention were missing. There appeared to be varying degrees to which therapists, psychologists and counsellors defined the length of brief intervention, but these definitions did not fit the criteria of only one or two group sessions.

Tom Plach (1996) provides eight guidelines for planning and implementing group sessions involving music. While this model may be helpful for planning a set number of sessions for a set group of people within a specific population it lacks appreciation for the therapist working in a setting where the group composition will be potentially different each week. Plach's guideline number three states that the amount of structure contained in group activities is contingent upon the level of functioning of the group and its individual members. For the therapist working in a fast paced acute setting this guideline is difficult to plan for. Some group members may have only just been introduced to the therapist leaving no time for assessing functioning levels. Assessments were sometimes conducted in the moment and one had to be ready to alter and plan sessions in the moment. In other guidelines he suggests things such as the participation level of the leader, group responses, communication of observations, and how to integrate and explore new insights. While all are valid and useful statements regarding group sessions in music therapy, the guidelines do not account for the group who has been spontaneously formed. It is the application of guidelines and models like Plach's to brief creative interventions that would aid development of programs in acute hospital settings.

### **Setting the Stage: General Medicine Acute Care at SWCHSC**

The following is an overview of the hospital's philosophy of care, the acute care environment, and the types of patients found on acute care units.

#### **Sunnybrook's Philosophy**

SWCHSC embraces a patient focused care philosophy. This places control and trust in the patients and their families allowing them to be empowered:

Patient-centred care means that staff at SWCHSC will work together to create a hospital where all persons feel valued and respected. As staff of SWCHSC, we will:

listen to people and pay attention to the things patients say are important to their health and life; respect patients, residents, and families as partners in care; refrain from judging and labelling people and we will not try to control or manipulate their choices. We will take actions that address the patient's priorities, needs and concerns. It is our belief that clients/patients are the best judges of quality of care and therefore, we will consistently seek input from individuals and families about their views and recommendations for improvement in care and service at SWCHSC. We will formally document patient and family perspectives, wishes and evaluations.

-Staff Manual 2002-2005

**General Medicine Acute Care Units:** From emergency, patients requiring diagnosis and interim are sent to one of four acute care general medicine units. Their stay might be one day to several months averaging approximately 2 weeks. Each unit has a large allied health team of physiotherapists, occupational therapists, social workers, dieticians, speech pathologists, and pharmacists. There is one, part time music therapist to cover all four units. As SWCHSC is a teaching hospital, the medical team is made up of doctors with residents and interns. These medical teams change as often as every month, adding to patient and family confusion of who is looking after them. There is also a large team of nurses, nursing students and personal service associates (PSA's).

**Types of Patients** – As a first stop, the general medicine acute care units consist of patients with a variety of health issues: patients in transition, stroke and other heart conditions, a fall at home, failure to cope/sudden decline in health, new cancer diagnosis, diabetes complications, respiratory illness, severe flu/fever symptoms (note: infectious diseases involve isolation), seizures, injuries from accidents, illness related to substance abuse, and new diagnoses of dementia.

**The Environment:** General medicine acute care units are busy places! There are as few as 12 and as many as 22 rooms per unit, with each room having one, two, or three patients. All but one of the units has a room that is kept as either a quiet area or common lounge area for patients and families to use. There is little privacy unless the patient has a private room, but these are usually reserved for patients with infectious diseases to provide the needed isolation for infection prevention controls and precautions. Hallways and rooms are almost always filled with noise and many faces. There is very limited access to the outdoors and patients are usually not able to leave the unit without accompaniment. While nurses provide high quality care they are usually too busy to provide much care beyond immediate physical needs.

This type of environment, at times, was busy, noisy, changing, crowded, open, and chaotic. One had to be flexible to deal with interruptions and ever changing schedules. To function effectively in such an environment required patience, flexibility, creative problem solving, and a good sense of humour!

### **Music and Recreation Therapy in Acute Care**

**A Brief History:** Music and Recreation Therapists first started working in acute care when there was an "acute care transition unit". Patients admitted to the transition unit, D4, were waiting for placements in long term care, reactivation, or rehabilitation. These were mainly elderly patients. The average length of stay was anywhere from 1 week to more than a month. Initially, a recreation therapist was hired to improve quality of life for these patients. In 1999 a 6-week pilot project was implemented to introduce music therapy. The recreation therapist felt that patients who could not communicate or were unable to get out of bed were being missed by what recreation therapy could offer. The results of this pilot project were presented to the head of the Division of General Medicine, the Director of General Medicine, the Patient Care Manager, and the Clinical Nurse Specialist. Unfortunately funding was not made available until October 2001 when the Lea Reichmann fund enabled the hiring of a music therapist to provide services one day per week. The intent was to target elderly patients who had longer stays on this specialized unit and to provide them with creative therapy and programming designed to improve their health and overall quality of life while they make difficult life transitions. However, everything changed with the SARS epidemic in 2003, when the transition unit became the "SARS" unit. Following the

outbreak Sunnybrook's general medicine units underwent much change and repositioning. Transition patients were dispersed among other general medicine units and the transition unit was not put back into place.

As mentioned earlier, music therapy is provided through external funding. Each year a report and proposal is resubmitted for further funding and possible expansion of the position. Since 2001 the funding from this source has grown to a three day per week part time position. Initially the funding was allocated for the music therapist to specifically target elderly, frail patients in transition. Due to the aforementioned circumstances and changes with regards to the transition unit it became extremely difficult to seek out patients in transition. Referrals are now from all four general medicine units and they are put into priority based on those who fit the criteria frail/elderly/transition being placed at the top of the list and, when there is room, seeing other referrals. Most referrals target patients experiencing isolation, depression, anxiety, palliative needs, and difficult behaviours such as aggression.

### **Listening and Identifying a Need: The development of "Music and Memories"**

**Identifying a Need:** Davies and Richards (2002) argue that human beings have basic needs that stem from childhood: the need to be heard, understood, and shared with. When these needs are fulfilled we experience the feelings of possibility and hope. In an acute care setting it is difficult to combat feelings of anxiety, depression, loneliness and isolation when patients are in bed and surrounded by distractions such as roommates and the constant movement of people in and out of the room.

The music and recreation therapists discussed the possibility of working together to develop a creative group intervention that would address isolation and promote socialization. Initially the music and recreation therapists wondered if it was possible to run a regular, weekly group in such an ever changing setting. It was decided that a relaxed and flexible approach that would bring patients out of their rooms and promote sharing and interaction would be the most welcoming for the patients. The group was named "Music and Memories" and it was advertised as a casual open gathering for patients and their families to attend. The initial goals for Music and Memories were to give patients a reason to leave their beds and their rooms and engage with other patients, family members, and staff in a creative, reflective, and expressive manner. Through the support of the co-therapists it was hoped that these patients would feel welcome to create music, share stories and memories, be with others, and be recognized and heard.

**Team Involvement:** Support from the entire hospital unit team was an essential component to test-driving and running the Music and Memories group. Whenever possible, both therapists spoke with team members including allied health, nurses, students, doctors, and support workers such as PSA's and maintenance to ensure that they understood the purpose of this group and to let them know how they could go about referring a patient to this group. Support workers and nurses were often called upon to help transport patients to and from the groups making them a very valuable resource. Nurses needed to be on board with scheduling on the day of the group to help ensure that those who were to attend would be up, ready, and available during that time. Posters on the door contained contact information for both therapists in the hopes that those who were curious would contact the therapists and ask questions. It was most gratifying when new faces on the unit would stop to listen and then seek out the music or recreation therapist following the group to ask what it was all about. Having the support of the entire team was necessary and helpful in getting this group off the ground. Maintaining continued support involved keeping up with the changing teams, meaning that the therapists were always prepared to explain and promote Music and Memories.

**Family Involvement:** Families were encouraged to attend the group and to participate. The groups often provided a safe place for family members to interact and discuss what was happening around them. Families were able to share memories together and tell stories to the group. Palmer (2001) writes about work with older adult patients and the many benefits that come with having family members present in group sessions. She cites improved communication, acceptance of new health conditions, and more enjoyable visits. It was hoped that Music and Memories would allow families to see their loved one interacting, expressing themselves, out of bed, and smiling and enjoying themselves. Feedback from families demonstrated this group was a wonderful source of support for family members.

**Referrals:** Referrals for the group were accepted from staff, family members, and patients themselves. Most referrals came from social work and nursing. The maximum number of patients accepted for this group was six. While referrals for this group were welcomed at any time, they usually did not come until the day of the group. Receiving last minute referrals was yet another reason why flexibility of the therapists was so important. In a situation where there had been no new referrals for the group the music and/or recreation therapist did some investigative work of their own. This usually took the form of asking a social worker to look over the list of patients and make recommendations based on whom they were seeing. Having to go to the units and ask for referrals was something that was hard to adjust to, but extremely necessary. Being the only music therapist and the only recreation therapist in acute care made it difficult to meet everyone from all four units and keep up with the changing medical teams. Expecting these unit teams to remember what we had to offer was not realistic. Rather, the reality was that we needed to remind people directly through voice mail, email, or in person. "We have a group coming up on Tuesday, do you have any new referrals?" became our slogan.

**Session Format:** Together, the therapists brainstormed ideas for structuring a group that would meet the needs of such a diverse population. There were varied ages, diagnoses, cultures, and backgrounds to consider. The group needed to be flexible enough to allow patients to guide the way, but structured enough to lead a group comfortably and in a non-threatening manner. Music therapy offers so many modes of musical expression from improvisation to singing familiar songs. However, in this type of setting such interventions may have proven to be quite threatening. When working for such a short period of time with adult and elderly persons such musical freedom could very likely create much fear and anxiety (Davies & Richards, 2002). They further explain that the relationship between an adult/elderly client and the younger therapist brings dynamics that may cause discomfort and put up blocks between client/patient and therapist. Providing a comfortable and open environment was the main goal. The groups were designed to meet the needs of the patients in the moment being flexible in nature and allowing the participants to control the level to which they participated.

A collection of session themes and plans were developed prior to the first session, and these usually started each session. However, from that point on if a patient moved away from that theme, the therapists were prepared to be flexible and follow that lead. According to Plach (1996), using musical ideas provides a safe and common starting ground from which discussion and group work can then emerge. As the weeks progressed, the co-therapists developed a "theme bank" that was drawn upon from week to week. Musically, each theme had a list of pre-selected songs from a variety of time periods and cultures. The recreation therapist drew upon her resources to add poetry, pictures, props, decorations, and other sensory objects to complement and facilitate the chosen theme. Please see Appendix 1 for an example of a session theme and plan.

**Role of each Therapist:** Each therapist brought a unique background and skill base to the sessions. Adding secondary mediums to creative groups can both add more structure and create flexibility in what the co-therapists have to use as tools (Plach, 1996). Specifically, the music therapist brought her knowledge of song repertoire and instrument use while the recreation therapist brought her many resources (eg: pictures, trivia, props, decorations etc.) in to help support and facilitate an enjoyable and flexible group experience.

The use of two therapists provided a unique team approach to meeting the patient's needs. Depending on what was happening in the moment, either therapist would take initiative to observe and help group members. For example, if a group member had said something quietly that the recreation therapist heard while the music therapist was responding to another patient, she acknowledged the patient to ensure that his/her thoughts were brought to the group. Similarly, if a patient became agitated or uncomfortable while the recreation therapist was reading a short story, the music therapist would be sure to check in with that patient and help to meet their needs. The co-therapists naturally lead and observed, listened and discussed, and interacted or intervened when needed. Durham (2002) discusses the importance of being able to evaluate group sessions and share observations and feelings with co-therapists from other disciplines (specifically occupational therapy and speech therapy). She feels it is invaluable to be able to make sense of each person's individual experiences the group. Co-leading for Music and Memories was

a practical necessity for safety and environmental reasons, but having another professional to share, observe, and discuss with was invaluable.

### **Listening to Patients, Families, and Staff: Case studies and feedback**

The following short case studies are intended to give the reader a picture, an idea, as to the type of patients who participated in the Music and Memories group. You will read about four patients: the long stay patient, Allan, who has called his bed in Sunnybrook home for over two years; John, admitted to hospital when his health suddenly declined due to cancer and was declared palliative upon admission; finally, Harry and Mr. Z, two short stay patients, one with liver problems the other beginning cancer treatment, both waiting to be well enough to head home.

#### **The Long Term Patient:**

Allan has been living in Sunnybrook for two years and counting. He is an elderly Jewish man with a wonderful sense of humour. Following an accident he is now dependent on a respirator to breathe which means that long term care homes will not take him and he must wait for a chronic care bed in another hospital. That wait has gone on for two years. He cannot speak and is completely dependant on nurses and personal caregivers to do all activities of daily living. His limbs are very stiff and hard for him to control. However, Allan has a remarkable sense of humour and functions at a high level cognitively. This is not realized by many of the doctors and health care professionals who come into his life for a brief time. After witnessing Allan participate in the Music and Memories group many staff members comment that they had no idea of Allan's capabilities. Music and Memories added greatly to this patient's quality of life. His personal care giver made sure that on Tuesdays he was ready to be up out of bed and in his wheelchair in time for them to make it to the afternoon group. It was something he looked forward to each week. It was an opportunity for him to meet and interact with new people. It was a safe environment for him to express himself; usually through music. It was a unique way to meet his emotional, social, and spiritual needs. Communicating through hand gestures and facial expressions he was always the first to wave and smile to greet new faces.

#### **The Palliative Patient:**

John always had a large crew of family members by his side. An elderly man, he was admitted to acute care after a sudden decline in health due to meta-static cancer. He quickly became palliative while in acute care and his family came from all over Canada to be with him. The wait for a bed on the palliative care unit was quite long. He was referred to music therapy by social work and the music therapist suggested that he and any family members might wish to attend the Tuesday afternoon Music and Memories group. That afternoon three of his family members attended a group, but no John! John's close friend, his sister, and his granddaughter each found themselves a seat and joined in with the singing. They shared stories and memories of family, including many stories about John. They listened to others, shared in music, and shook hands with other patients at the end of the group. The following week, John was up in a wheelchair and was ready to give the group a try. His sister and brother-in-law attended the group with him. The group theme was "travel". Songs of places around the world were shared, instruments played and photos of familiar tourist destinations were shared. John spoke very little. He smiled at the stories his sister shared and nodded in agreement of wonderful trips he had taken in the past. When asked by the music therapist if there was any place in particular that was his favourite place to visit he looked around the group and said "The only place I would love to go to right now is my home." The group immediately validated these feelings and John expressed that all his travels and trips were lovely, but that at this point in his life the best place he could think of is home. The music therapist offered songs about "home" and the group discussed family and feelings of home. In a large review of literature dealing with music, spirituality and health Lipe (2002) cites an article by West (1994) which cautions that therapists must be aware of the need for sessions to "serve as a container or support for the expression of feelings rather than as a stimulant for working through psychological issues." While West is referring to sessions specifically for persons at end of life stages, this also applies to the patients attending Music and Memories sessions. These sessions aimed to provide a safe and supportive environment for patients to express themselves and, in this case, it appeared to open a new doorway of communication between John and his close family members. This group session perhaps allowed him to

safely tell them what he was really feeling. Following the group John and his family stayed to look once more at the pictures of places around the world. Together they collected pictures of places they had visited: Rome, Paris, Egypt...they sat listening to soft recorded jazz music and shared some quiet memories together.

### **The Short Stay Patient:**

Harry and Mr. Z were roommates on an acute care unit. Both were only to be in hospital for a short time. Harry was recovering from a liver related illness caused by alcoholism and Mr. Z. needed care when he became sick while receiving radiation treatment for cancer. Harry was middle aged and Mr. Z quite a bit older. Both men were enthusiastic about attending a Music and Memories group, but neither was feeling up to leaving their beds. Since there was only one other person interested in the group on this day, the group was moved to their room! Prior to the group the music therapist met with them briefly to assess their musical preferences and get a brief impression of how they were doing medically on that day. Both men, as well as the third party who joined them, expressed a love of theatre and entertainment. The music therapist quickly gathered some music theatre favourites. Both men sang, played instruments, looked over photos of popular shows (old and new!) and laughed together. While the room was quite crowded with the group members and therapists the air seemed to lighten and mood quickly lifted. After an hour of sharing and singing the music therapist attempted, as planned, to choose an appropriate song to end with. This idea was met with much protest from the group members: "Must we stop now???" "Surely we could sing a couple more before you go?" And so the music continued. Harry and Mr. Z. both expressed much thanks and positive feedback following the group. Harry felt his mood had been lightened while Mr. Z. simply said he felt great and that it was nice to have some interaction and fun.

### **Feedback:**

Patients and family members were asked two things when they participated in this group: first, if they would sign a consent form for the possible use of their face in a picture, and second, if they would like to fill out a feedback form. The feedback forms were not intended to be formal research questionnaires, rather, they were to provide a general understanding of how the group was doing and if it was meeting a need in this setting. The results of these forms as well as patient comments can be found in Appendix 2. Overall the only negative comments expressed were that they wished it could be offered every day or that the session had been too short.

A variety of staff members from the unit where the group took place, D4, were asked if they would fill out a quick questionnaire about the Music and Memories group. Again, this was not intended to be a formal research questionnaire. Team members were asked to give their impressions, thoughts, feedback, and any additional feedback that they might have received from patients, family members, or other staff. A variety of staff were given a form to fill out: a resource nurse, the unit manager, two social workers, a nurse, a PSA, and a personal care provider. Please see Appendix 3 for these comments and results.

### **Conclusion and Recommendations**

The pilot sessions of Music and Memories were deemed a success by the co-therapists, the general medicine teams, and the patients and families. In a setting where so much emphasis is placed on physical well being a group of this type paved the way for the realization that emotional and spiritual needs are essential to one's overall treatment and experience. People receiving treatments in hospital must cope with many confusing issues surrounding their care. Richards and Davies (2002) point out that music can help understand feelings, and make sense of things in the midst of confusing and chaotic surroundings. These general medicine acute care units contained chaotic surroundings while demanding patients to make life changing decisions. With the help of music therapists, music can certainly find a constructive place within this whirlwind. Recently there has been a trend in health care toward "treating the whole person", not just their illness and creative group intervention can be a big step toward fulfilling this philosophy.

Thus, if music and other creative therapies are to be offered in hospital settings, specifically acute care settings, we must strive to show that brief interventions are effective and valuable. As mentioned earlier, the literature on brief creative therapy is scarce and mainly concentrated within psychotherapeutic practice. Even here, there seems to be conflicting views on its usefulness and effectiveness. For example, Immonen (2001) argues that the brevity of brief interventions is unacceptable. She further

states that therapists must be involved consistently over a long enough period of time to work through changes or developments that might have been initiated through the therapeutic process, raising questions of the ethics of brief interventions. She argues that one must consider the "harm factor" that she feels is likely to be caused within a brief therapy model. On the other hand, Smith (2002) sees the benefits of brief therapy provided that the patient has the resources and a safe place to continue their journey after the intervention. Similarly, Ingram (2003) comments that "in brief work the therapist cannot waver in his belief that time limited therapy can provide a complete and healing experience, often not despite the brevity, but because of it" (p.530). Perhaps brief intervention provides an experience that is valuable and useful because it addresses the reality of hospital settings. With bed shortages and budget cuts maybe therapeutic approaches that focus on an acute care perspective will allow creative arts therapies to respond to the limits hospitals and treatment centres are faced with.

In the 1980's, as discussed by Rowland (2003), there was still a need in the psychotherapy field to provide defined theoretical structures and treatment models for brief intervention. As the field of music therapy grows it needs to incorporate different models along the way that will allow music therapist's access to more and more settings such as short-term hospital units. A common denominator for brief intervention is needed to start the ball rolling in this area.

The purpose of this paper was to look at a new group utilizing music and recreation therapy within a unique setting and to begin a dialogue about the potential place of creative arts therapies in acute, short-term settings. In our present health care environment where funding is limited and being cut back each year it is so very important to remember and remind others of the importance of quality of life and patient focussed care. It is important for us to use research to show that patients do benefit from creative therapeutic interventions. We must share with each other the roads we have created, the stories of the people we have met and worked with, and then we must develop ways to bring these stories to other health care professionals. It is by learning and sharing that we will grow as a field.

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## Appendix 1

**Summertime**

- \* Recorded music to play while patients wait  
Suggestions: The Mills Brothers, The Beach Boys
- \* Hello Song
- \* *Getting to Know You*
  - encourage clapping or toe tapping
- \* Intro the theme
  - *In The Good Old Summertime*
- \* Props:-picnic basket
  - pictures of beaches and summertime activities
  - beach towel, sunscreen, sunglasses
  - ocean drum
- \* Songs:
  - In the shade of the old apple tree
  - Up the lazy river
  - Surfin' USA
  - Sunny Side of the Street
  - Under the Boardwalk
- \* Summer Evening Songs:
  - In The Cool Cool Cool of the Evening
  - By the Light of the Silvery Moon
  - Sail Along Silvery Moon
- \*Good-Bye:
  - So Long It's Been Good To Know Ya
  - Good-night ladies

NOTE: Session plans are to provide ideas for themes and do not dictate the direction of a session.

## Appendix 2

Patient and family feedback (six forms were completed)

1. How did you feel following the group?

Relaxed	6	100%
Paid attention to	3	50%
Respected	1	17%
Happy	4	67%
Supported	2	33%
Good	6	100%
Content	3	50%

2. Being a part of a group made me feel:

Included	6	100%
"Listened to"	1	17%
Confident	2	33%
Supported	2	33%
Comfortable	4	67%
Respected	1	17%

3. Was the group a positive part of your day?

Yes	6	100%
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4. What aspect of the group did you enjoy the most?

Singing	3	50%
Everything	2	33%
Voice, guitar playing and choice of song	1	17%
Discussing travel	1	17%

What aspect of the group did you enjoy the least?

Nothing	5	83%
Too short	1	17%

5. Did you find this group to be worthwhile?

Yes	6	100%
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Additional Comments:

"It brought music back to my ears!"

"It took me out of the hospital mood!"

"It made me so much more happy to go home at last!"

"We were sharing feelings"

(The group) "makes me happy to be with other patients, in a group"

## Appendix 3

Feedback from General Medicine staff:

Seven General Medicine staff of various professions were asked to complete a short questionnaire:

1) Please rate how valuable you perceived this group to be:

1	2	3	4	5
not valuable			(14%)	extremely valuable (86%)

2) Was this group a positive addition to D4 and General Medicine?

1	2	3	4	5
strongly disagree			(14%)	strongly agree (86%)

**Comments:**

**Patient Care Manager:** Whenever a session is taking place, I have noticed a light hearted spirit in the staff. Somehow the music heard by the staff creates a more relaxing atmosphere. For myself, I found listening to the music helps me deal with the complex and sometimes very difficult aspects of my role. The music allows me to approach these difficult tasks in a more positive manner. I have heard positive comments from family members, stating how they too become relaxed after seeing their relative distracted from their discomfort and pain. Patients appear to be brought together by the music, it definitely is an effective therapy.

**PSA:** I think this group should be continued.

**Resource Nurse:** It was noted that patients who were restless and confused responded well to the therapy. During the sessions they were able to create their own rhythm and music.

**Social Worker:** This provides an essential service which improves patient quality of life and overall outcomes while in hospital.

**Nurse:** Music and recreation therapy should be continued. There was a positive reaction from patients and family noted. Excellent job!

**Personal Care Provider:** The music and recreation therapy group is useful for my patient's social life. Meeting new people and playing music with them builds his confidence and he always looks forward to the next meeting. Useful for relaxation and stress reduction as well.

**Social Work:** Patients were motivated to get up and attend the group. It gave a purpose to the day and a break from medical tests. The group is a positive experience for our patients and families to reflect upon their life transitions (not being able to return home, changes in health, loved ones being separated.)