Wormit et al.

Music Therapy in Geriatric Care

A practical guide

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Alexander F. Wormit • Thomas K. Hillecke •
Dorothee von Moreau • Carsten Diener

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A practical guide

In collaboration with Biljana Coutinho, Linda Ibanez, Michael Keßler and Sebastian Woytinnek.

With a foreword by Lutz Neugebauer

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Translation by Rebecca E. Hames and André Giannacopoulos

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Prof. Dr. *Alexander F. Wormit* teaches clinical music therapy and heads the Bachelor's degree course in music therapy at the SRH University Heidelberg (UAS).

Prof. Dr. *Thomas K. Hillecke* is Vice Dean at the Faculty of Therapeutic Sciences, teaches clinical psychology and heads the Master's degree courses in music therapy and dance and movement therapy at the SRH University Heidelberg (UAS).

Prof. Dr. *Dorothee von Moreau* is Dean of Studies at the Faculty of Therapeutic Sciences and head of the Teaching Clinic for Music Therapy and Dance and Movement Therapy at the SRH University Heidelberg (UAS).

Prof. Dr. *Carsten Diener* is Prorector for research and practice transfer at the SRH University Heidelberg (UAS) and heads the Bachelor's degree course in psychology within the Faculty of Applied Psychology.

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1 Foreword

By Lutz Neugebauer

In recent decades, music as therapy has proven to be an innovative approach for people with special needs. This approach to treatment shows its strengths where words reach their limits. Examples include work with people who have intellectual or linguistic limitations originating from congenital or acquired disabilities or that develop due to degenerative processes, neurological disorders or age-related limitations. Even in cases where people have experienced unspeakable suffering, traumatisation through war, fleeing unsafe environments, violence or abuse, music therapy offers plausible and simple approaches.

The group of patients referenced in this book will include people in the last phase of their lives, when verbal approaches reach their limits. Sometimes these individuals no longer understand what the others are saying, they can no longer articulate themselves, perhaps they no longer share the same reality as us. Music — which we know from experience and can prove through research — can reach these people; beyond both the word and rational understanding.

This broadens our view once again. It draws our attention to the fact that, in our description of those being cared for, we also describe our limits; and the increasing desire to understand and overcome these limits — at least for the moment. Music is capable of this.

Richard von Weizsäcker (1994) says, in an essay on music, that it does not adhere to boundaries. Perhaps that is exactly why music is suitable as therapy. The forgotten can become present, the unsaid audible, the inaccessible recognisable. Loneliness can be overcome through shared activities.

Music is created from two elements, impression and expression. In contrast to verbal interaction, which is always reciprocal, i. e. alternating, ideally related to each other and running one after the other, music offers the possibility of synchronous and simultaneous communication. Impression and expression merge when the people acting together meet in the music. It wants to communicate nothing, nothing but itself. It always unfolds temporally and thus offers possibilities (e. g. to give temporally non-oriented people a frame of reference that makes orientation possible again).

However, music only becomes part of music therapy when it is related to a diagnosis, enabling new insights or showing ways of alleviating, overcoming or

avoiding suffering. In order to move from meaningful leisure activities or cultural participation to music therapy, there is a requirement of good and relevant training, cooperation within institutions and recognition that music therapy is a special approach to helping special people. There is also a need for recognition on the part of underwriting agencies and institutions providing care, and, not least of all a legal safeguarding of the profession.

The results of the Music Therapy 360° project (hereby referred to as *Musiktherapie 360°*), which form the basis of this book, can contribute to this need for recognition and safeguarding. Many colleagues will recognise themselves and their daily practice in the scenarios described here.

Witten, December 2019 Prof. Dr. Lutz Neugebauer

2 Introduction to the guide

By Thomas K. Hillecke & Alexander F. Wormit

This practice guide is a result of the project *Musiktherapie 360° – Innovative Concept for the Establishment of Modularised Music Therapeutic Interventions for the Enhancement of the Quality of Life of Patients, Relatives and Nursing Staff within the framework of the funding line Social Innovations for Quality of Life in Old Age (Soziale Innovationen für Lebensqualität im Alter – SILQUA-FH) funded by the Federal Ministry of Education and Research* (BMBF Programme SILQUA FH 2015).

There is no need to underline the fact that the quality of life of older populations is one of the most pressing challenges in our ageing societies. It is noteworthy that music therapy receives special attention through the funding of the BMBF. This may come as a surprise from the point of view of those music therapists all over the world who are comprehensively involved in providing care for the elderly. At times, this commitment is not truly perceived by the outside world, by the elderly themselves, their relatives, the gerontological disciplines or the health care system. The aim of this project was therefore to systematically record the internationally available findings and to develop them further for practical use. This process resulted in the creation of functional *Modules* that music therapists can utilise in their practices, thus providing a music therapy system from which older people, their relatives and the nursing staff working in this field can benefit. In addition, it was necessary to create transparency regarding the potential of music therapy.

No other study has investigated the integration of music therapy interventions and their implementation in institutions for the care of the elderly as systematically as the *Musiktherapie 360°* project. This project thus enriches the research landscape with its specific approach to module development and its attempt to compile an adequate description of possible music therapy interventions (which other sources often described inaccurately and heterogeneously) for practice, from which patients, relatives and nursing staff can benefit.

The reader can explore individual chapters in the sense of professional articles, or allow themselves to be guided systematically by their own interests. These options resulted in the following logic for the structure:

Chapter 3 describes the groups of people found in geriatric settings.

Chapter 4 addresses the scientific perspectives of music therapy with elderly people. The more recent evidence as well as possible general and effect factors of music therapy are discussed.

Chapter 5 focuses on the music therapist. What training prerequisites, basic music therapy stances, musical and practical therapy skills and knowledge must be available in order to work successfully as a music therapist in the field of geriatrics?

Chapter 6 presents the music therapy intervention module catalogue. This was derived from literature as part of the project Musiktherapie 360° in which music therapy services were systematically summarised, modularly conceived and partly tested in practice at cooperating institutions, depending on requirements.

Chapter 7 systematically summarises the quantitative and qualitative empirical evaluative results of the project Musiktherapie 360° and discusses conclusions regarding music therapy with the elderly, while taking into account the perspectives of patients, relatives and nursing staff.

Chapter 8 summarises the book chapters and provides an outlook.

The project and author team hope that music therapists and other gerontological specialists will benefit from the practice guidelines and that they will be able to create transparency regarding the potential of music therapy, especially with older people and their relatives. We also hope that our practice guide will be considered by funding agencies, institutions and administrations for the care of the elderly, so that music therapy can be a more strongly implemented practice in the future.

Finally, we would like to express our sincere thanks to all those involved, the patients and nursing home residents, their relatives, the nursing staff, the management of the facilities, the SRH University of Applied Sciences Heidelberg and, last but not least, the Federal Ministry of Education and Research (BMBF) for their support.

For reasons of clarity, the male form was chosen in the text. Nevertheless, the information refers to members of all possible genders. The authors also opted for a uniform use of the term patient. This always includes residents in residential homes and nursing homes. Finally, as music is an integral part of music therapy, all song examples will remain in the original German. Music used as part of the Musiktherapie 360° project consisted of traditional folk music, popular music from the early 1900s and hymns.

3 People in geriatric settings

By Dorothee von Moreau & Michael Keßler

The geriatric setting in residential homes and nursing homes, senior citizens' day care facilities, specialist hospitals and rehabilitation clinics includes senior citizens with illnesses and illness-related limitations, specialist staff such as nurses and specialist therapists, social workers, pastoral workers, doctors, and also the relatives of the patients, volunteers, everyday companions and housekeepers. Some of these groups of people will be described in more detail below with their respective individual challenges and needs and the possibilities for interdisciplinary cooperation.

3.1 The patient

The patient is typically 70 years and older. Because of the higher life expectancy of women, the proportion of female residents is often considerably higher. From the age of 80 onwards, seniors are particularly vulnerable to the onset of illness due to the risk of complications and their resulting conditions, the risk of chronic illness, and the increased risk of loss of both autonomy and of the ability to engage in self-help practices (Neubart, et al., 2015).

However, according to the German Society of Geriatrics, the German Society of Gerontology and Geriatrics and the Geriatrics Association (BV Geriatrics), *geriatric-related multimorbidity* is more important than biological age. This stage is reached as soon as at least three relevant diseases such as hypertension, fat metabolism disorders, stroke, pneumonia, osteoporosis, bone fractures, atrial fibrillation, Parkinson's disease, delirium, dementia, incontinence, sleep disorders or certain tumour diseases (Neubart, 2015) present simultaneously.

Frequently, those affected believe that the consequences of the disease compromise their quality of life to a greater extent than the disease itself does. The International Classification of Impairments, Disabilities and Handicaps (ICIDH) describes here a so-called *cascade model*: a disease (e. g. brain tumour) causes damage (e. g. paralysis), which leads to disruptions in everyday abilities (e. g. inability to walk) resulting in a participation disorder (e. g. no possibility to attend a social afternoon for senior citizens). Neubart (2015) cites disruptions in mobility,

daily activities and communication as well as problems in the processing of *disease as capability* disruptions, which can have a particularly limiting effect on the quality of life of geriatric patients. Preserving or improving quality of life is currently an important criterion for the evaluation of therapeutic interventions in geriatrics, as many chronic diseases cannot be cured or treated as aggressively in old age (Dichter et al., 2011; Dröes et al., 2006).

The following sections describe the most common age-related diseases and their effects on those affected in more detail.

Figure 3.1: In old age, maintaining quality of life is of great importance.

3.1.1 The dementia patient

Dementia (F00-F03) is manifested by disorders of cortical functions in memory, thinking, orientation, perception, arithmetic, learning, language and judgment. Cognitive deficits can also affect emotional regulation, social behaviour and motivation. Dementia can occur in neurodegenerative diseases such as Alzheimer's disease, cerebrovascular disorders (e.g. vascular dementia), as well as other primary or secondary brain diseases. Tumours, hematomas or other spatial events can also be associated with dementia (DIMDI, 2018). Mixed forms are not uncommon. Depending on the type of dementia, there are different presentations of dementia. The classification into severity levels has therefore proven to be valid across the various forms of progression (Möller et al., 2015).