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Child-Parent Wellbeing in a Paediatric Ward

The Role of Music Therapy in Supporting Children and Their Parents Facing the Challenge of Hospitalisation

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Abstract

This report, based on clinical practice on a children's ward in New Zealand, examines the role of short-term music therapy in supporting children and their parents[1] facing the difficulties of hospitalisation. It endeavours to explore three questions. How might music therapy support hospitalised children? How can it support parents of hospitalised children? Is it important/valuable for music therapists working in a paediatric ward to involve parent(s) in music therapy sessions? Three hospitalised children (aged 11 months, 5 and 7 years), who were accompanied by a parent, participated in a single individual music therapy session. From the clinical notes, semi-structured interviews with the children's parents and a staff member, and my own reflective journal it was indicated that music therapy supported the psychosocial needs of the paediatric patients and their parents in many ways. For the children music therapy: 1) promoted normalisation; and 2) provided emotional/psychological support. For parents, it: 1) elicited positive changes in mood; 2) reduced anxiety; and 3) supported parental learning/parenting. Furthermore, the findings suggested that the wellbeing of the parent-child relationship can be supported during music therapy. The importance of parental involvement varied for each case, and highlighted different views between therapist, staff member and parents regarding this. Factors that may determine parental involvement and the benefits of both parental presence and absence during sessions were elicited. The report suggests that music therapy has the potential positively to support paediatric wards in New Zealand to provide an environment that is responsive to the psychosocial needs of hospitalised children and their parents.

Introduction

This report[2] explores the perspectives of parents, staff and therapist on their experience of short-term music therapy with hospitalised children. It is based in the paediatric ward of a general hospital in New Zealand where I worked as a music therapy student. I was at the facility for one day a week and in most cases patients were not admitted long enough to receive more than one session. As a result music therapy sessions were designed to achieve meaningful outcomes in a single session.

It is well accepted that hospitalised children can face many challenges during an admission (Petrillo & Sanger, 1980; Skipper & Leonard, 1968). The situation may become stressful for the child (Harbeck-Weber & McKee, 1995; Skipper & Leonard, 1968). Stress and anxiety may be caused by multiple stressors: pain, discomfort, the unfamiliar environment, immobility, separation from family members, disruption of typical routines, and loss of control (Harbeck-Weber & McKee, 1995; Petrillo & Sanger, 1980; Siegel & Conte, 2001). This stress may result in physiological changes (for example, elevated blood pressure, raised temperature, loss of appetite) and changes in behaviour (for example, restlessness, disturbed sleep, withdrawal).

These physiological and behavioural changes can be detrimental for patients as they may hinder and delay the recovery of the physical and emotional health of the child (Harbeck-Weber & McKee, 1995; Skipper & Leonard, 1968).

There is a significant body of literature regarding the benefits of music therapy for hospitalised children. Some potential benefits/outcomes of music therapy for hospitalised children outlined in the literature were: assisting children in attaining normal developmental milestones (Kennelly, 2000; Gfeller, 1999); providing a channel through which children can identify and express their emotions/feelings triggered by hospitalisation (Brodsky, 1989; McDonnell, 1983; Perez, 1989); helping patients re-establish a sense of control (Pfaff, Smith, & Gowan, 1989; Robb, 2000; Sheridan & McFerran, 2004); assisting pain management/distraction technique during painful procedures (Edwards, 1999a; Malone, 1996; Pfaff et al., 1989); Decreasing pre-operative anxiety and anxiety during procedures (Aldridge, 1993; Chetta, 1981; Malone, 1996; Micci, 1984; Robb, 2000; Whipple, 2003); and it may have a positive impact on the wellbeing of the child (Barrera, Rykov, & Doyle, 2002).

The majority of the literature pertaining to music therapy and hospitalised children is from international authors. However, New Zealand researchers/authors Brooks and O'Rourke (2002) developed a resource booklet, based on the findings of their action based research in 1998, which described the use of music therapy in paediatric wards and palliative care. In this booklet they discuss the findings from a survey they conducted in New Zealand hospitals in 2000. Out of the 16 hospitals who replied to the survey, in which paediatric and oncology services were targeted, only two indicated that they would employ a music therapist. One of the reasons given for this negative response was a lack of knowledge about music therapy, highlighting the need for more awareness, and demonstration, of the benefits of music therapy in a New Zealand context. At the time of this report there were no qualified music therapists working in paediatric wards in New Zealand hospitals.

Parents themselves are often challenged by the stress created by the child's hospitalisation (Hunsberger, 2000; McDonald, 2006; Shooter, 2002; Tiedeman, 1997). The stress of parents, and strategies to reduce it, is of particular interest to those working with hospitalised children, as parental stress may affect the child in two ways. The first is that the parent's stress may be communicated and transferred to the child (Skipper & Leonard, 1968). This transfer has been termed "emotional contagion," meaning that children can "catch" their parents emotions and vice versa (Hatfield, Cacioppo, & Rapson, 1994). Links have been made between the level of parental anxiety and the anxiety the hospitalised child experiences (Skipper & Leonard, 1968; Hagglof, 1999; Jay, Ozolins, Elliot & Caldwell, 1983). Secondly, parental stress may interfere with the parent's ability to provide positive support and meet the emotional needs of their child (McDonald, 2006; Skipper & Leonard, 1968).

There is a paucity of literature that examines how music therapy can support parents of hospitalised children. However, case examples by Whipple (2003) and McDonnell (1984), suggested that the intervention assisted not only hospitalised children, but also parents in managing their own anxiety/stress. The current report (where the ward concerned had a philosophy of family centred care) therefore took the opportunity to consider parental needs and involvement and to address this gap in literature.

Questions

While undergoing my clinical placement on the children's ward I developed a particular interest in the role of music therapy in supporting the child and parent as a unit. During my initial weeks on the ward I realised the difficulties some parents were experiencing, however I was not clear on my role in supporting parents. Thus raising the question, how can music therapy support parents? I did not want to leave the parent passive or an observer, or deprive the child of the parent's support, replacing it with my support, during music therapy sessions. Therefore, it was often appropriate to include parents in music therapy sessions. The high number of parents present during sessions provoked many questions. Such as, what do parents and children gain from parental involvement, and is it important?

These professional concerns and the study of literature led to the development of the following questions:

1. How might music therapy support children facing the challenge of hospitalisation?
2. How can music therapy support parents of hospitalised children?
3. Is it important/valuable for music therapists working in a paediatric ward to involve parent (s) in music therapy sessions?

Aims

1. To gain greater understanding of the role of music therapy in supporting parents of hospitalised children.
2. To improve patient care.
3. To foster knowledge of the role of music therapy, and the benefits incorporating music therapy, in New Zealand paediatric wards.
4. To add to the body of music therapy literature for hospitalised children.

Gaining a Close Look at tha Clinical Work

I was particularly interested to look closely at the clinical work and to gain insight from a range of perspectives as I felt this could genuinely inform my practice. Therefore the following steps were taken:

1. Three hospitalised children of varying ages participated in individual music therapy sessions, from which I wrote very detailed clinical notes.
2. The parents of the children and a staff member participated in a semi-structured interview
3. I kept a journal to record my own personal thoughts, feelings, reactions, and concerns about any aspect of the work

Cases Examined

Sam's story

Sam was 11 months old, with a diagnosis of mild heart failure and viral gastroenteritis. He had been in an isolation room for 10 days and had become very irritable, partly due to the lack of stimulation encountered in isolation rooms. His mother noted that he had been having a bad morning before his second session, and commented on his low mood and lethargy. Staff also felt that exposing Sam to a positive experience while he was in hospital was important, as he required further operations and admissions. His mother (Anna) accompanied him to the music therapy session and at a later time engaged in an interview.

Joshua's story

Joshua was 7 years old with a diagnosis of drop attack seizures. Joshua was referred because his interaction and communication had regressed while he was in hospital. When Joshua is unwell he sometimes finds it difficult to communicate verbally and can get frustrated when this happens. His medical notes stated that he was unresponsive at times, but was more interactive between drop seizures. His father (Steve) accompanied him to the session and at a later time engaged in an interview.

Logan's story

Logan was five years old with a diagnosis of Friedreich's ataxia (an inherited degenerative disease effecting the muscles and heart) with cardiac involvement. His mother noted that he was not very happy about his return to hospital. Some physical restraints, such as a lot of bed rest, had been imposed on him since his last admission due to his condition, which had been difficult for him as he likes to be active. Also, staff had noted some concerns about how his mother was coping with Logan's new diagnosis and the stress of the situation. His mother (Mary) accompanied him to the music therapy session and at a later time engaged in an interview.

Staff member interviewed

Kim, a play specialist on the ward, engaged in an interview about the music therapy service on the ward. She was familiar with the music therapy service and had witnessed/been involved in some sessions.

Music therapy intervention

The music therapy sessions were tailored to the child's developmental level, needs, musical preferences and to accommodate different levels of parental involvement. Parents were welcome to participate and were offered instruments to join in, however, their level of involvement was their choice. The sessions involved interactive music making. Improvisation, singing and playing familiar songs, lyric substitution (changing the lyrics to a pre-composed song), were mainly employed. A variety of tuned and untuned percussion instruments and a guitar were made available. The sessions took place in an isolation room on the ward and were 30-40 minutes in duration. The report is based on one single session for each child. Typically

this is the case with most patients, as they are usually not in hospital long enough to receive more sessions (I was only at the facility for one day a week).

Findings and Discussion

1) How can music therapy support hospitalised children?

Normalisation

Promoting normalisation to provide comfort and reduce stress

When children are hospitalised they are faced with an unfamiliar environment and disruptions in normal routines. This can create stress and frustration in children (Barrickman, 1989; Gfeller, 1999). The findings from the interviews and clinical notes suggest that music therapy can provide a sense of normality for the children in a number of ways. Firstly, it was elicited that music was perceived as an appropriate/powerful tool, as it is a typical childhood experience. Parent C[3] noted how children are familiar with music due to being exposed to it at kindergarten and at school, and the staff member described it as a "safe" and "familiar" medium for children. Secondly, the use of familiar songs (for example, Logan's favourite Elvis songs were used in the session) was seen to provide a link between home and hospital for the children, thus bringing some familiarity into the environment and aiding normalisation.

The staff member looked favourably on the children being able to "make noise" during sessions, seeing it as a good outlet for them:

> [It's] quite a nice outlet for a lot of the kids, banging on the drums as hard as they can, and...not having to be quiet and shouting if...that's part of the music.

Due to hospital being much quieter than normal environments, making noise/music was considered to help normalise the experience. She also mentioned the joy she witnessed children getting from being able to do this. However, this may be seen as disturbing for other patients and needs to be carefully considered and monitored.

Normalisation to promote development

Children are in constant process of developing social, motor, and cognitive skills (Edwards, 1999b). This constant process of development may be interrupted or delayed due to the unstimulating hospital environment (Gfeller, 1999; Kennelly, 2000; Robb, 2000). By normalising the environment, cognitive, motor, and social development can occur and be supported (Schwankovsky & Guthrie, 1982). The findings from this project suggest several ways in which a child's development may be supported by music therapy. The most prominent of these was music therapy aiding the learning/cognitive growth of the child. Parents A, C and the staff member discussed the learning gained in sessions. For example, the staff member commented that:

> Another thing children benefit from during sessions is listening to what others are doing and being patient...quite often when there's a group session you know you say to them that they have to listen to the other instruments and make sure that other people have opportunities and things like that, and that is a really good skill that the kids need to have in hospital, that they are aware of other people around them and that, that other kids have needs and that they have to be patient and wait their turns sometimes. So it's teaching them all those things as well.

Language development and communication skills may also be supported. The clinical notes indicated that music therapy encouraged Sam to vocalise and explore vocal sounds, thus supporting language development. Also, for Joshua, both the interview and clinical notes indicated that the session encouraged and assisted both verbal and non-verbal communication. This was significant as his ability to communicate had regressed during his admission due to his seizures. His father stated:

> When you would sing "Jingle Bells" and then he would say "hey", some of that at the beginning was a little bit delayed but as he got into the swing of things...it was more in time.

The physical movement opportunities, which support motor development, from playing instruments were also highlighted by parent B, the staff member and clinical notes of Sam. The staff member commented that:

> It gives them opportunities to move around physically, rather than be static, in their beds [during sessions]. So for some kids it's giving kind of some physio

> opportunities really to be able to move muscles and those types of things.

Lastly, the staff member suggested that music therapy can provide opportunities for social interaction, which is a normalising activity. This finding of how music therapy can promote cognitive, language, physical, and social development, through normalising the environment, is supported by preceding music therapy literature. This literature provides descriptive information on how music therapy can assist hospitalised children attain normal developmental milestones (Barrickman, 1989; Gfeller, 1999; kennelly, 2000; Marley, 1996).

Emotional/psychological support

Emotional expression

Music therapy can provide a channel through which children can express their emotions (Brodsky, 1989; McDonnell, 1983; Perez, 1989). This was highlighted in this project also in the clinical notes and interviews. For example, the staff member stated that:

> I think they get an opportunity to express themselves and to have a voice with all the music writing that you do. Quite often kids in hospital don't have a voice, and so it provides them with an opportunity to be able to...tell people what they feel...think, and what they've experienced. And...it can be whatever they want it to be...they don't think oh I have to be nice or I have to say the right thing they can say whatever they want to say.

Decreasing anxiety

Previous research has ascertained that music therapy can reduce the anxiety children may experience before surgery (Aldridge, 1993; Chetta, 1981) and during medical procedures (Malone, 1996; Micci, 1984). In this project, the anxiety Sam experienced whenever his mother left him (he initially cried when his mother left a couple of times during the session) was alleviated by music. His mother commented that music was able to settle him when she left, whereas a nurse holding him would not. The staff member made the observation that the children were generally more relaxed after the sessions.

Opportunities for choice and control

Music therapy can help provide a sense of control (Pfaff et al., 1989; Robb, 2000; Sheridan & McFerran, 2004). Two of the children in this report appeared to be supported in this way. The clinical notes indicated that due to the opportunities given to Joshua and Logan for choice and control they became more directive and took more control towards the end of their session. For example, Logan said, "play sad now" toward the end of his session. I followed and supported such initiatives. This active role lies in contrast to the passive role patients play in the hospital environment.

Distraction

Distraction is a cognitive coping strategy (Kleiber, 2001), therefore it is a technique to help stabilise/enhance emotional wellbeing. Live music is an effective distraction technique for children undergoing painful procedures (Edwards, 1999a; Malone, 1996; Pfaff et al., 1989). The findings in this project suggest that music can help distract children from other noxious stimuli. For example, music distracted Sam while his mother administered the medication he disliked receiving. The staff member described how music therapy can help distract children with eczema from scratching, and parent C noted how it generally distracted/diverted Logan's attention from the hospital environment. This diversion for Logan seemed to provide a shift in focus from his difficulties and physical restraints.

Mastery and success

Parent B suggested that Joshua could achieve and be successful during the session, thus potentially increasing his sense of mastery and success. This fulfilment is important as prior to the session, Joshua was having difficulty with fundamental tasks, due to the effect his seizures had on his bodily movements. Increased feelings of success may lead to an increase in self-esteem (Pehler, 2001).

Fun and enjoyment – positive change in mood

From the interviews, the one theme found which applied to all three children was that they experienced fun and enjoyment. Parents felt that fun was a significant and important aspect of the sessions. Parent B stated that:

> Fun is really important because...it helps with the positive outlook...I think that can't be discounted...It [music therapy] is something that makes hospital fun,

because it's not a great place to be really.

All parents mentioned this numerous times and expressed gratitude for their child's laughter and smiles. For example, an important outcome of the session for parent A was: "seeing him so happy for the first time smiling".

The staff member also noted this aspect of the sessions. As experiencing fun can evoke positive feelings, this may have been a key aspect of the session that contributed to Sam and Joshua's positive change in mood, which were noted in both the clinical notes and interviews. The quantitative results from Barrera, Rykov, and Doyle (2002) found a marked improvement in hospitalised children's ratings of their feelings post music therapy ($p<.01$).

I reflected about this finding further when I was asked one day by a child what it was that I did for a job. I explained that I played music with children who are in hospital to help them feel better. He contemplated this for awhile then replied with, "so you are a clown who uses music". This view through the eyes of a 6-year-old child captured simply the essential aspect of fun that the parents and staff member highlighted. The idea of being a clown using music implies that a non-threatening person (the clown/music therapist) uses music to achieve fun/enjoyment. As the parents and staff member appeared to so strongly value the fun element of sessions, music therapists could embrace the delightful idea of being "a clown that uses music".

"You played to his noises" – (what do music therapists do to support children?)

It was interesting that parents made observations on how the sessions were conducted to support their child and recognised how this was different to other music groups. The following were noticed:

- The music therapy student was musically responsive to the child's contributions and responses. For example, parent A stated that, "I tell you what I did love about that session was that when he did make noises you played to his noises and I had never hear that before. Rather than we just play songs when you go to play group".
- Activities were adjusted and focused on the child's abilities - what they could do. For example, parent C stated, "you would do something then see what he did and you would maybe adapt it to what he could do".
- The session was individually tailored by using activities/music the child was interested in.

These parents observed something at the very heart of music therapy, a child centred way of working, and noticed the interaction that evolved from this; "you did something then he did something" (parent B). Underlying the work of music therapists is the premise that sessions are always adjusted to the individual child's strengths, weaknesses, responses, and with attention to their unique personality (Wigram, Pedersen, & Bonde, 2002).

2) How can music therapy support parents of hospitalised children?

The interviews suggested a variety of ways in which music therapy can provide support to parents. All parents found the music therapy session beneficial in some way. The clinical notes did not reveal as much as the interviews, however they support the interview findings.

Positive changes in mood

The staff member pointed out that parents get to see their children happy and witness positive changes during music therapy sessions. It seems to be important for parents to witness this, as it appears that positive changes in a child's mood can positively affect the parent's mood. For parents A and C, seeing their children happy as a result of music therapy made the situation easier for them and made them feel happier themselves. Parent A commented that:

> Seeing him so happy for the first time, smiling and...participating...as much as a baby can...made it a lot easier for me. It was actually I suppose quite therapeutic for me as well.

Parent C stated that:

> What pleased me was that when you were doing that game or just having fun with a instrument...and he was just laughing, and I just thought oh god it's just so nice to hear him laugh, cos ...children in hospital actually (sighs-outward breath) you know it's, it's not always that easy so it's very nice to hear him laugh and just to know he's having a nice time and it just makes me feel happy.

Parents may also experience fun. Parent B felt that it was fun to be involved and the staff

member observed how parents enjoy sessions. It appears that for parents, seeing their child happy and/or experiencing fun and enjoyment themselves may elicit positive feelings and improve mood.

Reducing anxiety

The findings suggest that music therapy can help parents feel less anxious and aid relaxation. Parent A described how the session helped lessen her worries and anxieties:

> it [music therapy] made a serious situation a lot lighter...it took away the worry...hospital can be so serious when your children are sick. And I was just so grateful for those sessions because it made [the hospital] a nice place to be...

The staff member discussed two ways music therapy may help parents relax; firstly by being actively involved in the session or alternatively by having a break while their child is engaged in a session. It was discovered that music therapy provided a good time for some parents to leave their children. It was difficult for parent A to leave her child as he would become upset when she did, but knowing that he settled well with music made it easier for her to leave and tend to her own needs. Parent C was in need of a break and asked to read her book during the session. She stated that:

> Today I felt like reading my book and just switching off a bit...and that was nice to have some time where I wasn't having to entertain him, cos that's the other role of a parent in hospital with a child...you notice with particularly with one and two year olds, that age group the parents walk them around the halls all the time because they wont sit down. You can't really tell a one year old to stay still on the bed, they are just on the move so the parents are on kind of constant vigil, so it's nice if you had something like [music therapy] it would be very nice just for the parents to sit back and go ahh

Three research articles were found, within the confines of this report, that highlighted how music therapy sessions for hospitalised children can relieve parental anxiety (Barrera et al., 2002; McDonnell, 1984; Whipple, 2003).

Supporting parental learning/parenting

It appears that parental learning can be supported by music therapy. Parent A made many comments on what she had learnt from the music therapy session. She gained understanding of how her child responds to music and his ability to learn through music, which instigated her to pursue other music groups her child could attend outside of hospital. Likewise, the staff member felt that it was a good teaching and modelling session for parents:

> A lot of the parents that we see don't sometimes have the experience or the knowledge to play with their kids, or to do something positive with their kids. So I think for them to be involved in the music session as well gives them some ideas about what they can also do at home, and how they can maybe use music to calm their child or distract their child and so it's a good teaching and modelling session for the parents without them even knowing that.

This outcome is encouraging as it shows that music therapy may continue to have an effect after the life of the session. This positive outcome is vividly illustrated with an entry from my journal. In response to having visited parent A five months after the interview to check the interpretations of the interview with her, I wrote in my journal:

> Parent A said that because she witnessed her sons responses during the sessions she sings to him now because she knows it can help settle him. She had also bought him a child's keyboard for Christmas after discovering his enjoyment in creating sounds. It was lovely to see them play around with music together while I was there and the impact only two sessions had on this mother.

McKenzie and Hammlett (2005) and Abad and Edwards (2004) described music therapy programme's for families with infants/preschool aged children. These studies suggested that music therapy sessions provided additional ideas for parenting strategies and helped to extend parents repertoire of skills in relating to their children through interactive play.

Parents may also gain insight and learn more about their child by seeing them in a different situation. Parent B raised the point that music therapy helped him to assess his child's condition and wellbeing, particularly his physical ability and verbal responsiveness. From this, Parent B commented that:

> From my point of view I do have a bit more confidence in his condition now

because I saw him do those various activities.

As Jacobowitz (1992) asserts, the healthy aspects of the child can become apparent to parents during a music therapy session. This appeared to give optimism to parent B.

An important aspect of music therapy is the concept of "being with" our clients. It seems that music therapy can help parents "be with" their child. Parent A described how she was lost in the chaos of trying to manage the situation but that the session helped her to stop and pay attention to her child.

3) The use of music therapy to support the wellbeing of the parent-child unit/relationship

It was suggested from the clinical notes and the interview with the staff member that music therapy may help support the parent-child relationship, thus demonstrating another way sessions can positively support parents and children. Sessions involving parents seemed to provide a joint positive experience for parent and child. Many positive parent-child interactions were noted in the clinical notes and the staff member observed that sessions helped parents to positively engage and interact with their children:

> ...you encourage parents to be involved especially with the babies...for some parents who have had problems...in attaching with their child...the music and the way that you've run the session has provided a relaxed non-threatening environment for them to be able to engage with their child in a positive way...where...our staff on the children's ward haven't been able to get the parents...involved...little things like even being able to pick them up. You can come in...and suddenly the parents are singing with their child and playing musical instruments and...wanting to interact with their child...that is massive.

Her comments support the notion that music therapy provides a "non-threatening"/non judgemental environment for parents to interact with their child:

> I find it really amazing that...they've been quite self conscious with staff...they think that they are being judged with how they are feeding, how they are holding...but they can sing and laugh and dance around the room playing musical instruments.

This finding is important for two reasons: firstly because illness not only impacts the affected child but can have a negative impact on the relationship and influence the interactions of the parent and child (Siegel & Conte, 2001) and secondly parent-child interaction can influence the degree of coping and crises the family experiences (Hagglof, 1999). Literature suggests that parental involvement in music therapy with hospitalised infants can support infant-parent interactions and nurture the parent-infant relationship/bond (Lenz & Moreau, 2004; Shoemark, 2004; Whipple, 2000; Zimmer, 2004).

4) Is it important/valuable for music therapists to involve parents in music therapy sessions?

The findings regarding the importance/value of involving parents in music therapy sessions were inconsistent and multifaceted. The clinical notes and staff member interview indicated that it can be really valuable to involve parents, if the parent was not in need of a break. The findings from the parent interviews were conflicting. All parents felt that it was not particularly important that they were present or involved during the session, however, they described benefits from being there (these have been discussed above). With the exception of music therapy providing a time for a break, the benefits parents described resulted from their presence.

In each case discussed, the importance/value of parental involvement was different. Additionally, parents B and C suggested that the necessity of parental involvement would depend on the individual child and parent, thus illustrating that each parent-child unit has differing needs and must be independently considered by the music therapist.

It seems that it can be important that parents have the flexibility both to be involved and to choose to leave during a session. For example, parent A was able to leave but participated when she was present. She liked having this control and flexibility over her involvement. This flexibility enabled her to reap the benefits from both her break and involvement.

This project highlighted some underlying factors that may determine the involvement of a parent and its importance. These were:

- Whether the parent was in need of a break. This was a primary factor.
- The personality of the child. All parents felt that parental involvement was not important

because their child was not shy/were extroverted and would have participated regardless.

- Parental issues. The staff member raised that in cases where there are issues with the parents, that may negatively impact the session, parental involvement would not be suitable. At the time of her interview there were a couple of mental and physical child abuse cases on the ward.
- Confidentiality of songwriting. The staff member felt that it is sometimes not appropriate to involve parents in sessions when songwriting is employed, as it may hinder the child from being open and honest about their feelings.

In determining the importance of parental involvement for a patient, it is helpful to understand what a child and parent can gain from both parental presence and absence. The findings in this report suggested the following:

Possible positive outcomes from parental involvement during sessions

- Support the parent-child relationship by: providing a joint positive experience, increasing positive interactions, and supporting parent-child bond.
- Support the parent by: aiding parental learning, helping them to focus on the child, witnessing their child's abilities/the healthy child, witnessing their child having fun may positively effect their own mood, providing positive stimulation, reducing their anxiety.
- Support the child by: receiving parental support during session, may help them to feel safe/comfortable, the parent may act as a human resource for the child (for example, suggesting songs that the child likes at home).

Possible positive outcomes from parental absence during sessions

- Benefit parents by: providing a time for them to have a break, relax, tend to their own needs, and re-charge.
- Benefit children by: allowing them to be open and honest as they may have to consider what they say in-front of their parent, encourage independence.

Determining parental involvement can be complicated further when what is beneficial for the parent may not appear to be as beneficial for the child. This was demonstrated in the clinical notes of case A and C. It appeared that both parents needed some time away from their child (they both left for around10-15 minutes during the session) but both children seemed to react adversely to this separation. One child cried and the other was concerned that his mother could not hear his music. These responses demonstrated the children's want and need for their parent's presence/support. The ways of dealing with such situations are intricate and subtle. Encouraging parents to be involved when they can for their child, making them feel comfortable to leave their child when they need to, and supporting the child if the parent needs to leave, need to be attained and balanced in such circumstances to support both parent and child.

Conclusion

The findings in this report suggest that music therapy can help paediatric wards to provide an environment that is responsive to the psychosocial needs of hospitalised children and their parents. In this project, music therapy supported the children and parents in a variety of ways. For children, the benefits were categorised under: 1) promoting normalisation; and 2) providing emotional/psychological support. For parents, the benefits were categorised under: 1) eliciting positive changes in mood; 2) reducing anxiety; and 3) supporting parental learning/parenting. The wellbeing of the parent-child relationship also appeared to be supported by music therapy. It seems that the importance of parental involvement depends on many factors and is different for each child-parent dyad.

As family-centred care is standard practice in New Zealand paediatric wards, increasing the awareness of the role of music therapy to support parents and the parent-child unit is crucial. This report has contributed towards filling an existing gap in the music therapy literature.

Engaging in this reflective study has increased my own practice wisdom. I have noted particularly a shift in my own practice from a predominantly child focus to a more child-parent focus during the course of my work.

It is hoped the discoveries from this project will encourage music therapy to be utilised in New Zealand paediatric wards. As one parent wrote in response to checking the findings from their interview, "I hope they listen to what you and 'we' are saying and take it up in hospitals." In

conclusion, the participants' perceptions on short-term music therapy indicate that it may have an important role in meeting the psychosocial needs of hospitalised children and their parents, thus supporting the development of music therapy services in New Zealand paediatric wards.

Acknowledgements

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Notes

[1] 1 Throughout this paper, 'parent' should be taken to mean primary caregiver.

[2] 1 This report is based on a study that was conducted as part of the requirements for the Master of Music Therapy programme at the New Zealand School of Music. Ethical approval was sought and gained from the New Zealand central region Health and Disability Ethics Committee (Ref No: CEN/06/07/063).

[3] 3 To clearly show who's perspective is being discussed and their role (parent or staff member), and to limit the confusion caused by using many names, the participants will be referred to as the following in this section:

- Anna, (Sam's mother), will be referred to as - parent A
- Steve, (Joshua's father), will be referred to as - parent B
- Mary, (Logan's mother), will be referred to as – parent C
- Kim will be referred to as – staff member

The children's pseudonyms will be used when referring to the children. These are written in the brackets above.

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