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Journeying with Olivia: Bricolage as a Framework for Understanding Music Therapy in Paediatric Oncology

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Introduction

This essay is my contribution to the discourse on the value of the music therapist in the paediatric oncology setting, extending what is already known, and presenting a new framework for the work. I first presented these ideas in a paper at the World Congress of Music Therapy in Brisbane 2005, where I used the term "bricolage" to mean "something that is made or put together with whatever materials happen to be available" (Microsoft MSN, 2006). Since that conference, I have also used the concept as a way of helping to define brief interventions with clients in paediatric oncology when lecturing music therapy students at The University of Melbourne. This framework helps me to explain the diverse range of devices that are available to the music therapist in this setting, and to illustrate the journeys or stories that are constructed or created in therapy.

... there is nothing that music therapy "really is." Instead the discourses that surround and produce it are the constructive materials of the ever changing stories we tell to ourselves and others about what we do, how we do it, and most importantly why we do it ... (Ansdell, 2003, p. 152).

What is most important to the bricolage framework is that there are unique historical and emergent elements to each patient's journey and each moment of meeting with each patient is unique.

Being in the moment, while holding the past and anticipating the future.

Olivia's Story

Olivia was 5 years old when she first became unwell and had to visit the hospital to have lots of tests. She was diagnosed with Acute Lymphatic Leukemia, and shortly after began the first of many courses of intense chemotherapy that included fasting for a lumbar puncture under anaesthetic. She became quite sick on this first course of chemo, feeling nauseous, weak, tired, and irritable. She went home, to be readmitted weeks later for another lumbar puncture under anaesthetic in the day surgery unit and another course of chemotherapy on the ward. Her hair started to fall out, and she felt even worse.

This regime of chemotherapy and lumbar punctures continued for some months. As well, she continued regular visits to her oncologist in the outpatient clinic. Eventually as her treatment became less intense, Olivia's hair started to grow back and she returned to school. She still had to go back to hospital for lumbar

punctures and bone marrow aspirates and oncologist visits but these became fewer as time went on.

Two years after that first diagnosis Olivia came to the hospital for a bone marrow aspiration and was diagnosed "all-clear." She was now officially in remission. Then she only had to come to visit her oncologist every few months for the next year. Finally, when she had been in remission for a period of time, she didn't have to return to the hospital ever again.

The end.

That's not really the end of Olivia's story of course, as Olivia is still alive and well and going to school and I'm sure living a very full and interesting life. But it is the end of the story of the journey of the patient called Olivia in her context as a cancer patient. For those of you who work in Oncology this might be a familiar story - many patients go through similar treatment regimes and experiences. And in fact, the story I have told you could be any patients' story - for I haven't really told you about Olivia.

I know lots of important facts about Olivia. She loves the teddy bears called Beanie Kids, and has a whole set of them at her house. She loves blowing bubbles, playing the duck castanets - 5 little ducks is her favourite song- and she also knows the words to every Wiggles song. She has an older sister, a younger brother and a dog.

I know all these things because I met Olivia on her very first day at the hospital and waved goodbye to her on her last visit there. I saw her while she was waiting for many of her outpatient appointments. I waited with her for almost every one of her lumbar punctures. I visited her during nearly all of her inpatient admissions.

I also occasionally bumped into her informally in the hospital cafeteria, in the elevators and around the corridors of the hospital when she came in for check-ups and other tests. I came to know Olivia and the story of her particular journey as a cancer patient quite well.

My Story

My history, or my story, as a music therapist, includes my training as a music therapist and my prior experience as a music therapist before working for the past 16 years at the Royal Children's Hospital Melbourne. In that 16 years I have worked as a clinician across almost all areas of the hospital including Haematology Oncology, and my clinical focus is now almost exclusively in this area. This focus has led me to continually update my knowledge and inform myself about the work that is being done around the world in music therapy in this field. This acquired knowledge is also part of my "history."

What I know from the literature is that music therapy is an established intervention in the overall paediatric oncology context. From the initial diagnosis and throughout the course of the disease, music therapy is a service that supports many of the physical and psychosocial needs of the patient. It has been shown to be effective preoperatively, during procedures, during bone marrow transplants and other types of hospital admissions. (Hadley, 1996; Wang et al, 2002) The music therapist can remain involved with the paediatric patient and family throughout the entire health care process in treatment or rehabilitation, to cure or end of life.

Flexibility seems to be a common theme in the literature. There are many variables to consider and patient needs vary throughout treatment (Lane, 1993). Flexibility enables the therapist to modify musical elements to match the pace and mood of each hospitalised child (Robb, 2003). It has been noted that hospital music therapists follow, inspire and support the individual patient, in good or difficult periods, and let the patients' current situation determine what is possible (Aasgaard, 2002). Having a flexible, non-prescriptive music therapy approach enables the therapist to listen to the child and family without pre-set goals (O'Neill, 2003).

My history also includes my personal journey in the 14 years I have been at the hospital. This has included having two children of my own and having supervision with a psychotherapist. This has all contributed to the type of person I am today. I am not the same person I was when I started out working in pediatric oncology.

David Aldridge tells a story that encapsulates how the self changes and I find this to be a good illustration of how experience, and contexts can change the way something is done. He heard Annie Sophie Mutter playing the Beethoven Violin Concerto as part of the WDR series from Cologne. In comparing this performance to an earlier one that she had performed with Karayan

he noted that this was almost an entirely different piece of music. The tempo was slower and the timbre of her playing had changed - the tones had much more variety. In the Karayan version she was much younger and the tones were cleaner, perhaps more naïve. In her later rendition, there was the sounds of a much more experienced musician bringing a more mature performance. But both were in different contexts, with different orchestras and different conductors. (Aldridge, 2000)

My experience and knowledge - the "historical element", and the changing context in which I work - the "emerging element", impact on the way I get things done. I believe the key is that the music therapist who works in these settings needs to blend historical and emerging elements. By historical I mean the accumulation of clinical and life experiences, knowledge, skills in a variety of methods and techniques, understanding, familiarity with the context and practice wisdom. Emerging elements are an increasing awareness of the child: their personality, likes and dislikes, what is emerging from the child in the moment, their responses to their immediate context, the therapist's responses and what is happening in the immediate context, or environment. These historical and the emerging elements are blended by the music therapist, to form "bricolage".

Being in the moment...while holding the past...
anticipating the future and what the possibilities might be.

I find that bricolage is not the easiest term to explain, perhaps a little like music therapy! Bricolage is from French popular speech meaning "something that is made or put together with whatever materials happen to be available" (MSN Microsoft, 2006). I was introduced to this term by my colleague Helen Shoemark who had read about bricolage in McLeod's (2001) qualitative research text. In this book, McLeod refers to Denzin and Lincoln's description of the "researcher -as -bricoleur":

. . . who uses the tools of his or her methodological trade, deploying whatever strategies, methods or empirical materials as are at hand...If new tools have to be invented, or pieced together, then the researcher will do this. The choice of which tools to use, which research practices to employ is not set in advance....(but depends upon) what is available in the context, and what the researcher can do in that setting. (p. 25).

In addition, the achievement of a satisfactory bricolage depends on prior mastery of previously existing concepts and methods. Prior mastery of existing concepts and methods is the "historical", and deploying whatever is available in the context is the "emergent". This is bricolage to my understanding.

Conville (1997) talks about bricolage in relationships. He contrasts the bricoleur with the engineer. The engineer plans carefully and works hard to assemble the materials required for each particular project. The bricoleur by contrast uses whatever oddments are lying about. With the engineer, it is all about the historical, planning carefully, making sure all the materials are correct and going ahead as planned. There is no "emergent" - nothing is left to chance. The bricoleur however, uses the historical and the emergent, is more flexible and more open to responding to emerging elements.

The Bigger Picture

The context in which the journey of the paediatric oncology patient happens is the Children's Cancer Centre. The centre is not a physical space, it is a centre in administration only. It exists within the Royal Children's Hospital in Melbourne and consists of teams of nurses, doctors, pharmacists, researchers, therapists, social workers and other allied health professionals. All of these staff work in usually only one physical location of the Children's Cancer Centre. The cancer patient is seen and treated at several different locations within the Royal Children's Hospital which itself consists of several different buildings. For example, because the child requires an anesthetic for their Lumbar punctures and Bone Marrow Aspirates these take place in the Day Surgery Unit operating theatres in one building with one team. Outpatient appointments and day chemotherapy areas are in a second building, again with different staff; the inpatient ward is in a third building with yet another team of staff members, all contributing to the patient's treatment. Some staff, such as social workers, do see the patients in several of the areas, but I am the only member of staff who regularly sees the patients in every location.

Like other patients, Olivia was treated in the various locations of Children's Cancer Centre. And I saw regularly Olivia in all of these locations: day surgery unit, outpatients, day chemotherapy, and inpatient ward. I also incidentally saw her in the elevator and the hospital cafeteria.

Whenever I met Olivia there was an historical and emergent element to our meeting. I held the history of Olivia, the little girl. I knew about her, and it was Olivia I interacted with, not merely the patient. We were both different people, in different contexts each time we met, but what was consistent was our shared history as a dyad across those different contexts. To Olivia I stood for something positive -something exclusively joyful and playful that reached out to her as Olivia the child not merely the patient. There were particular songs for instance with particular details that may have seemed insignificant to others, but to her, they were important details. She liked the song Bugs and Beetles by Mr Whiskers, an Australian children's entertainer. She would act the song out using small percussion instruments as the beetles. The song is actually about 5 beetles, but Olivia always insisted on having 8 beetles. This became our special song together, a song that we played each time we met. The song was the same, but the contexts were different each time. Depending on where we were and what was happening at the time, how Olivia was feeling, the song might be played differently, or used to achieve various aims, but it was exclusively Olivia's version with 8 beetles that was used. This was something I learned I would be able to use each time we met.

With Olivia, I did not know when I first met her how often in the overall course of her treatment I would see her, or even how long her treatment would continue. It was safe to assume though that we would meet many times. Our meetings were sometimes fleeting - 5 minutes before a lumbar puncture in day surgery unit; or longer formal sessions - on the inpatient ward, maybe for 45 minutes; or indeed an impromptu 90 second meeting in the cafeteria. What kind of intervention should I design for an impromptu meeting like that in the cafeteria? The assumption in the literature is that music therapy consists of stand-alone episodes of care: focused, planned music therapy sessions. "Therapy might be what we think it is, it may not be." (Ansdell, 2003, p. 156)

Informal meetings, such as those in the cafeteria, involved Olivia spotting me and seeking me out. This was an informal meeting - seemingly insignificant but again, it was about her seeking to be identified as Olivia - someone with a history, a story, other than that of being merely a patient. In those brief meetings I am holding our past interactions, knowledge of Olivia and my own previous experiences of moments of meeting like this with other patients in the cafeteria, knowing these could be as important as our more formal sessions. What is possible in this context is informed by those historical elements, and then what happens is informed by what is emerging from the current context.

Cancer patients go to the Day Surgery Unit many times in the course of their treatment to have a bone marrow aspirate or lumbar puncture under anaesthetic. The children are often anxious, they have fasted therefore are hungry and often irritable because of this. Often the first treatment the child receives in this Unit will most likely confirm a provisional cancer diagnosis. The child is in the waiting area with their parents and is quite anxious. I have no history with these new patients, but I do have many similar experiences like this in my history to draw upon to know what is possible. And there will be emerging elements from the child and the context to inform what happens. I do something different every single time: as reported earlier in this paper the literature says the work is not prescriptive, and it depends on lots of variables. What I do in that moment with that particular child has both an historical and emergent quality: historical coming from my knowledge and experience with these situations in the past and emergent coming from the child him/herself in the moment.

When I met Olivia on her first day, I had a fair idea what might lie ahead for her, I understood and had experienced with other patients and families that first overwhelming sense of dread and anxiety of the unknown. At our first meeting in the waiting area of the bone marrow clinic, Olivia was displaying signs of withdrawal and distress. She was huddled into her mother and not engaging with the world around her. She was whimpering and could not understand why she had not been allowed to eat. Sensing that she, and her mother, needed reassuring, and to contain their anxiety, I sang songs that are well-known to 5 year olds, keeping my guitar accompaniment simple and rhythmic, the keys of each song the same, the tempo even and my voice gentle and temperate. As I sang, the mother began to rock Olivia gently back and forth, so I did not stop between the songs but kept the singing going for some time as a "holding" technique. Eventually Olivia looked out from her safe haven to check me out and when she did this I gently engaged Olivia with some duck castanets which she played herself, appearing less anxious, smiling and sitting upright on her mother's lap. Her mother was also smiling and interacting with Olivia. Our first encounter ended at that moment as Olivia was then called in to theatre to have her bone marrow aspiration.

From my experience I know that familiar pre-composed music works well when everything else is new and unfamiliar and the literature supports that. And simplicity too in this context is

important. I also know that the waiting time could be long or short and that this first encounter is vital. The literature supports the notion that the child needs to have an early positive experience of the hospital to help counteract the trauma of the long term effects of hospitalisation. So, any arranged or incidental encounters I would have with Olivia from then on would be based on the history of our having connected positively at this first encounter. Bricolage, in this example, was the blending of the historical-- my experience and informed knowledge; and the emerging-- the responses from Olivia and her mother.

After 2 years of treatment, Olivia arrived for, what hopefully would be her final treatment. There was a sense of excitement that at last she might be given the "all-clear". She and her mother were grinning from ear to ear. "This is the last one!" she told me excitedly. We shared the memories of what she had been through over the last two years and what was to come, how school was going, how her dog was and how she was going to celebrate this milestone. I didn't get the impression from them that it was all over - like many others that sense that they may be back at any point takes years to disappear completely. I felt, as I have felt many times before with others, excited for Olivia and happy that she had reached this point. But there is also a certain sense of sadness that our journey as a therapist/client dyad is over. Though I may, as I have with others, see her over the years in the corridors of the hospital when she comes back in for long-term follow up appointments. Who knows?

With Olivia, I shared a journey. I held the knowledge of her journey across the different treatment areas and witnessed the ups and downs, but held Olivia, the child, through that moment in her history. It was a moment in my history too, and I am also a different person through the experience of sharing this journey with her.

It is both a privilege and a challenge to be music therapist as bricoleur. To join children on their journeys as cancer patients means to be in the moment with them meeting their immediate and emerging needs, while holding them as a person not merely a patient throughout that journey, and creating possibilities....

Being in the moment...while holding the past...anticipating the future.

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