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Reaching the Socially Isolated Person with Alzheimer's Disease Through Group Music Therapy - A Case Report

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Abstract

The purpose of this report is to present a case on John, an 82 year old man with Alzheimer's disease, who resides in a dementia specific unit of a nursing home. People with dementia who require institutional care are often at risk of social isolation, due to the regressive nature of the disease, and the potential of developing behavioural disturbances. This case story demonstrates how group music therapy can be individually tailored to meet the needs of people with dementia who are socially isolated as a result of behavioural challenges, including aggressive and agitating behaviours, and therefore improve the quality of the person's life.

"John"

John is an 82-year-old man who has resided in a single room on a dementia specific unit at a nursing home since his admission in 1992. John was born and educated at an inner city suburb in Brisbane. He left school to work on a farm before moving to Mackay and becoming a butcher. John married before World War II and had 4 children. During the war he served 4 years overseas. Sometime after this he returned to Brisbane with his family and set up a butcher's shop. John's wife passed away in the 1970s and he later married a woman who worked in the shop. John retired from his shop and took up the hobbies growing roses and listening to records. His wife described that John became more withdrawn and isolated as his frustration with his memory difficulties in early dementia became evident.

John was admitted to the nursing home because his wife could no longer care for him in a safe environment. John has probable Alzheimer's Disease, epilepsy and hypertension. He is hard of hearing and complains of back and knee pain. John is obese as a result of being unable to control his eating. He takes medication for pain relief, epilepsy and agitation. John spends the majority of his days lying on his bed, only leaving his room in search of food. John does not interact with others and has been observed to become angry and aggressive if anyone attempts to socialize with him. John's case history suggests that he has always been a person who prefers his own company. John's wife and one son visit briefly once weekly. This is the only social contact he has from outside the nursing home.

Dementia

Dementia is an umbrella term given to a family of diseases that have a similar group of symptoms characterised by cognitive and behavioural deficits and the permanent and degenerative quality of the brain damage (Cavanaugh, 1990). Alzheimer's disease is the most

common form of dementia (Rybash, Roodin & Santrock, 1991). It is a progressive, degenerative disease that attacks the brain and results in impaired memory, thinking and behaviour (Rybash et al., 1991).

"Behavioural disturbance is a critical and understudied aspect of Alzheimer's Disease. Alzheimer's Disease is not just a disease of the memory. It is a disease characterised by significant and devastating behavioural impairments" (Teri, Rabins, Whitehorse, Berg, Reisberg, Sunderland, Eichelman & Phelps, 1992, p.86). Resultant behaviours can lead to staff developing negative feelings towards the person (Goldsmith,1996).

Workers in aged care have the daunting task of caring for sufferers of a progressive disease for which there is no known cause, cure or formal treatment modalities. Functional declines due to the inevitable progression of the disease coupled with behavioural challenges isolates the person from their social environment. Treatment therefore necessarily focuses on alleviating distressing antisocial behaviours, hence contributing towards improving the quality of life and decreasing stress to the person and caregivers alike (Brotons & Pickett-Cooper, 1996).

Kitwood (1992; 1993) argued that we need to see the person with dementia as a whole and develop a sense of *personhood*. He stated that dementia is the result of a complex interaction between the person's personality, their physical health, life history, social psychology and their neurological impairment (Kitwood, 1993). These factors combine to make a person who they are, hence the concept of personhood (Kitwood, 1993). To concentrate on one of these only without proper regard to the others is to treat the person as less than a whole person (Goldsmith, 1996). Although it is recognised that we need to see people as individuals, it is not always easy to provide individualised services (Goldsmith,1996, pp.35).

Music therapists are in the unique position of being able to offer individualised and person-centred treatment to people with Alzheimer's Disease. Music therapy has been widely used to promote social behaviours and reduce isolation for people with dementia (Aldridge, 1996; Christie, 1992 & 1995; Lord & Garner, 1993; Smith-Marchese, 1994; Bright, 1972). Music invites social opportunities that can foster and reinforce meaningful interactions (Bright, 1988). Clair & Bernstein (1990) commented that music may be one of the only media through which social interaction with others occurs in meaningful ways for people with dementia.

Music Therapy to Decrease John's Social Isolation

John was not initially referred to music therapy as it was reported "don't bother with him, he only leaves his room for meals and then fights with others." The music therapist however decided to assess work with John based on this information since the music therapy programme had been initiated on the dementia unit to increase social opportunities for all residents. An initial meeting revealed that John had a previous enjoyment of music with no formal training. He was able to relate that his favourite songs were "Pretend" and "Anytime". John had a good long-term memory and demonstrated the ability to recall past information.

The initial meeting and subsequent assessment established that John was a lonely man, who had regressed into isolation as his disease progressed. He had severely impaired short-term memory and became frustrated easily. He was a confused man but still demonstrated a level of awareness and some insight, though his reasoning ability was impaired.

Interactions with other residents and staff almost invariably resulted in John becoming aggressive, raising his voice and striking out at others. He often made unrealistic demands on others, and refused to have some care needs attended to.

A study on behaviours deemed "difficult to manage" found that staff rated physical aggression toward fellow patients and staff as the most stressful behaviours encountered in working with people with dementia (Bright, 1986). This was evident in this case as John's aggression resulted in him being unpopular with both staff and residents.

Upon completion of the assessment, it was established that John had social and emotional needs and behavioural challenges that could be addressed through group music therapy, since a positive, supportive and non-threatening sociable environment could be fostered in music therapy sessions. John was invited to a music therapy group and he agreed to "give it a go." From this day in August 1994 he has attended music therapy groups on a nearly daily basis.

Quarterly evaluations indicate that John's program has been effective in meeting his social and emotional needs and helping to minimise challenging behaviours. His program and goals have been altered slightly over the years to reflect his ongoing needs.

In August 1999 his treatment program goals were:

1. To increase opportunities for appropriate social interaction with others
2. To decrease episodes of social isolation
3. To increase feelings of motivation
4. To increase levels of cognitive stimulation
5. To minimize feelings of agitation and the resultant behaviours
6. To improve John's quality of life

These goals were met through John's daily inclusion in group music therapy. This included recommended attendance in an afternoon Music Therapy Stimulation Session four times a week, and an evening Music Appreciation Session, conducted by the Music Therapist at least once weekly. Stimulation sessions were conducted at 3.00 p.m. Monday to Friday and held in a music room located on the dementia specific unit. Group sizes varied from 6 - 9, averaging 8 people. Bright (1988) documented that small group sizes were most effective when working with people with dementia (Brotons, Koger & Pickett-Cooper, 1997); and that ward work was advantageous as group members remained in their familiar surroundings and were therefore more likely to be relaxed. The group was conducted at this time because it was identifiedas a difficult time of the day, with the onset on Sundowners, and staff changeover. Music Appreciation Sessions were conducted at 6.00 p.m. Monday to Friday and held in the dining room of the dementia specific unit. Group sizes vary from 10 - 15, averaging 12. This time was chosen to provide residents with an opportunity to participate in a quiet but social experience after dinner in preparation for bed.

Over the course of 5 years, John participated actively and sociably in all group activities each day unless sick. During sessions he would greet people and participate through guessing tunes; singing loudly; clapping his hands to the music, whistling favourite tunes and helping to choose relevant songs to sing. He would play the auto harp and then complain of the effort. Music therapy remained the only time when John would exercise through playing instruments and dancing voluntarily. John participated in general discussions and conversations on various topics. He reminisced and shared stories of life events. When playing quiz games John participated at his turn but also helped other people to choose cards and answers in a supportive and friendly manner. John always requested the song "Pretend" and participated in singing the farewell song, before complaining that music had finished "too soon."

John's level of social interaction during and after music therapy remained higher than non-music therapy times. A study on the relationship between music participation and social behaviours of people with Alzheimer's Diseases showed a 24 % increase in social behaviours and a 14 % decrease in nonsocial behaviours, with all subjects responding to individualised music activity with increased social interaction after music sessions (Pollack & Nomazi, 1992). Sambandham and Schirm (1995) also reported significantly higher levels of social interaction amongst subjects after music sessions.

Music therapy has played an integral role in reducing social isolation and increasing social interaction for John hence improving the quality of his life. Music therapy has been unique in meeting these needs as he continually declines opportunities to attend other activities. Despite nearly daily attendance in music therapy, John still declines invitations to recreation activities most days. These activities include concerts, bingo, skittles, scrabble, card games, word quizzes, videos, news, craft and gardening groups, concerts and church.

Statistics taken over two 3 month periods in 1996 and 1999 show consistently higher attendance in music therapy groups, despite the inevitable progression of his disease. Music therapy research has identified that people with dementia will often sit for longer periods of time during music therapy sessions than other forms of therapy including reading and discussion sessions (Olderog-Millard & Smith, 1989; Fitgerald-Cloutier, 1993; Greone, 1993). This is evident in attendance at music therapy sessions and the fact that John would remain seated for the duration of the sessions.

Group music therapy represented a time that John could interact in socially acceptable ways with his peers and enjoy being a part of a meaningful and rewarding activity. John's social participation precluded the aggressive and/or agitating behaviours that were often evident in his interactions outside of music therapy. A study on agitating behaviours found the subjects with Alzheimer's Disease were significantly less agitated during and after music therapy sessions compared to before (Brotons & Pickett-Cooper, 1996). Hanser and Clair (1995) also reported in

a case study less aggressive and more social behaviours in a client upon conclusion of a music therapy program.

The success of John's program and his continual refusal to attend other activities including concerts has led to the question why is music therapy a successful treatment modality for this man? It is considered that the success of this program is due to several factors, the most important being that John's music therapy program is an individualised program that has been designed and implemented to meet his specific needs at a level where he is comfortable and will always experience success. Music therapy has provided a means to reach out to this man and improve the quality of his life by reducing episodes of inappropriate behaviours and social isolation. Music therapy groups focus on his abilities to sing, recall stories and interact musically, hence providing non-confrontational ways for him to interact verbally and socially with his peers. These groups are the only opportunity he has to socialise with his peers in acceptable and appropriate ways.

As dementia becomes more prevalent in our society, there will be a greater necessity to provide specialist care which encompass the person's holistic needs, hence the introduction of treatments that focus on the needs of people with dementia, such as music therapy, must be more readily accepted. We must see the person behind the disease (Kitwood, 1993) and provide individualized services that are flexible, specialized and person centred (Goldsmith,1996, p.35). These people deserve the best that we can offer as a society, the best we can provide that is specific to meeting their unique needs as people, people who have dementia.

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