the attention of the patient.[34]

In this chapter, however, we are not concerned with the total effect of music but rather with the effect of rhythm. We must therefore turn to examples which show that states of self-forgetful musical satisfaction may be produced largely by the movement and rhythm of music. Psychological experiments have demonstrated that rhythm is the important factor in the recognition of music. Composers have long been aware of this fact, and it is possible to point out many symphonic and operatic passages in which composers have expected an audience to recall a previously stated theme when its rhythm alone was played. A particularly good example occurs in Act I of Wagner's *Die Walküre*. Hunding enters his house as the orchestra announces his theme. He threatens Siegmund, who has taken shelter there, with death on the following morning. As Siegmund prepares to sleep, there is a shadowy and menacing recall of the Hunding theme, now reduced to a purely rhythmic drum figure.

It is not unreasonable to assume, therefore, that the rhythmic element plays an important and sometimes dominant part in the pleasure taken in music and in the intense concentration which is the result of attentive and interested listening. It may further be assumed that the rhythmic factor is more important in proportion as the listener is inexperienced or lacking in musical capacity. We know that such listeners generally prefer rapid and rhythmic music, "something with some life to it," to slower and more lyric selections. Everyday experience gives abundant indication of this. As the musical endowment or the experience of the listener increases, the other factors, melody, harmony, tone color assume an increased importance. Such considerations are of obvious importance to those who employ music for listening, whether for therapeutic or for purely recreational ends.

It is also possible to show in a more definite fashion that the listener may on occasion concentrate on the rhythmic factor. Such situations will occur when actual rhythmic bodily movement is imagined or is actually present. We may experience this at three levels. At the first level, where the subject is himself the dancer, we have already shown that absorption in the dance may reach the point of selfhypnosis. Even in social dancing it is probable that the phrase "the intoxication of the dance " so often employed in one form or another, is more than a conventional expression. Admittedly the elements of social pleasure, flirtation or courtship, pleasurable surroundings, and many other factors reinforce the rhythmic factor. Nevertheless, rhythm, together with its expression in rhythmic motion, makes the dance what it is. At the second level, the creator of dances may be completely absorbed in imagining rhythmic movement. No documents show this more clearly than the autobiography of Isadora Duncan. In a particularly striking passage she speaks of the images which filled her imagination:

> I so ardently hoped to create an orchestra of dancers that, in my imagination, they already existed, and in the golden lights of the stage I saw the white supple forms of my companions; sinewy arms, tossing heads, vibrant bodies, swift limbs environed me.[35]

Finally, the part which rhythm plays at the third level in the satisfactions which the spectator or auditor derives when he is neither participant nor creator is less tangible though not less important. Here the evidence derived from the dance itself seems less important because the pleasure experienced by the spectator is complex in nature. The physical beauty of the dancer, literary and dramatic elements suggested by costume, accessories, or story, all play their part in addition to the movement of the music and the rhythmic response of the dancer. Nevertheless, the muscular responses of the listener and their emotional concomitants obviously form an important part of the audience reaction both to music and to the dance. Data derived from tests of audience reaction to music, like those conducted by Esther L. Gatewood, suggest the importance of rhythm in determining audience response.[36]

It would seem, therefore, that the vital fact concerning music is the emotional reaction of the listener and his intense preoccupation with the music. This will probably remain the crucial point both in music and in its application in music therapy. In this emotional reaction, rhythm clearly plays an important role; but much more scientific study is needed to determine more exactly just what this role is.

34 Edward Podolsky, M.D., *The Doctor Prescribes Music* (New York, 1939) ch. VI.
35 Kirstein, *op. cit.* 269.
36 Max Schoen, *The Effects of Music* (New York, 1927), ch. V. *passim.*

Assessment in Music Therapy with Clients Suffering from Dementia

Niseema Marie Munk-Madsen

Introduction

"Music therapy for demented people with behaviour disturbances Kridthuset, Gentofte Municipality's Residential Home for Elderly People". This was the title of a project, which I conducted in 2000 and completed with the publication of a report (Munk-Madsen, 2001a). This project was made possible with financial support from Marie Dubronn Hoff Fund. The report describes the background, methodologies and results of the project. In addition, there is an appendix with case studies of 10 individual musical therapies. In connection to the above-mentioned project I have developed an assessment model to systematise the observations in music therapy with people suffering from dementia. I am hereby describing the model's structure and application.

A music therapy assessment protocol with demented clients must in most situations, stretch over a minimum of 3-4 sessions. Objectives of such an assessment could be:

- to find out the client's resources
- to pinpoint the problem areas and try out possibilities to help the consequential emerging drawbacks
- to try out possibilities to compensate the reduced or lost functions
- to find music therapy techniques that can be applied in a long term musical therapy progress or in a daily nursing situation.

It is also possible that music therapy assessment could be integrated as part of the diagnostic process. However, I have no personal experience in this aspect.

The assessment model presented here is meant to be used by the practising music therapist, partly as a kind of "inner reminder" during a music therapy session, partly as a structure for memorandum after the sessions. It can be used when qualitative observation/description of both the client and the music therapy process is desired. The characterisations in the model should, for instance, help to describe the character of a condition or activity, its quality, coherence, transformation, as well as the clients' reactions. This kind of descriptive assessment can also be used to identify areas where quantitative observation is desired. An example could be to research prevalence of eye contact during singing in comparison with during interview. Therefore, video recording or the participation of an outside observer is necessary.

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Annotations to the model

Table 1 presents the six sections and the basic questions of the assessment model.

The assessment model is divided into 6 sections which will be briefly commented upon here.

1. Musical Activities

The first section deals with the demented client's participation in the activities of the music therapy session. The musical sphere is the music therapist's most important means of observation and intervention. When working with people suffering from dementia, a flexible attitude to the profession and methodology of music therapy is essential. Since individuality is a prominent trait for people with dementia, such flexibility is crucial in order to reach an alliance with the client. A good approach is to use music that the clients know from their earlier days. It is therefore important to be able to draw on material from various musical genres. The music therapist should examine during which activities the client is able to participate actively, and where he/she shows the strongest motivation. In addition; what resources have been revealed, how is the musical material being used, and what is the character of the music?

Listening experiences and tactile sensations are important for patients with advanced dementia as well as for clients who do not want to or are not able to play/sing. It is of course also important to be aware of how the different activities affect the client or affect the interaction. Often, it is seen that people with dementia are missing the ability to build musical structure and melodic forms. On the other hand, the ability to be part of a musical structure that is already known or is created by the music therapist is well preserved, just like a good sense of rhythmic pulse can be preserved for a long time. The clients' ability to play/sing and take part in a musical interaction can be influenced by the physical proximity of the music therapist. I have experienced that many clients can only play when they share the music instrument with the therapist.

2. Motor Activities and Quality

This section deals with the functions that are almost always being affected by dementia. Muscular

1. MUSICAL ACTIVITIES
Is the client active in:
Movement? Song/verbal sound? Playing of instruments/ improvisation?
Does the client thereby show:
Flow? Variation? Congruity in interplay? Initiative? Fantasy?
How does this appear? In which context? How does the client react?
Does the client engage in:
Listening? Reception of tactile stimulation?
How does this appear? In which context? How does the client react?
2. MOTOR ACTIVITIES AND QUALITY
The client's use of:
Fine motor skills? Gross motor skills? Facial expression? Voice in speech and singing?
How does this appear? In which context? How does the client react?
3. EMOTIONAL LEVEL
The client's emotional response:
Flat/appropriate/unstable?
How is the client's mood?
Feelings of anxiety or fear/security?
4. COGNITION AND MENTAL ACTIVITY
How does the client function with accordance to:
Verbal language? Memory (recalling/recognising)? Reminiscence (memoirs being brought in focus)? Sense of orientation? Learning?
5. ATTENTION AND CONTACT
How is the client's energy level:
Drowsy/attentive/agitated?
How does the client response to different types of stimulation/approach:
Verbal? Physical? Musical? Eye contact? (E.g. does not respond/does react/does reply/initiates contact)
6. THE CLIENT'S COMMENTS/REACTIONS TO THE MUSIC THERAPY SESSION
Verbal comments to:
Activities? Togetherness? The session as a whole? Others?
Non-verbal comments/reactions, e.g.:
Voice change? Bodily reaction? etc.

Table 1: *The assessment model.*

stiffness, shivering, dull facial expression, and reduced walking ability are usual symptoms. Even though the brain damage that causes these symptoms cannot be cured, the motor skills can be stimulated and in some cases can be maintained or even rehabilitated. This is of course significant for the clients' opportunities for development and thus their self-esteem and quality of life. In music therapy with people with dementia, movement and touching often become important elements. The therapy can eventually include musical activities, which can be used as a tool in rehabilitation or maintenance of motor skills. In these cases the role of music will often be to motivate and to provide the rhythmical and dynamic framework for physical movement. Motor skills can also be affected indirectly by the emotionally stimulating aspect of the music.

3. Emotional Level

The clients' emotional level during music therapy is in focus in the third section. Musical experiences can evoke emotions in those demented clients who seemed emotionally lifeless. They show also that, despite their illness, sharing and integrating emotional experiences is possible and essential. To those that are emotionally unstable, musical activities can probably be arranged in such a way that the clients' emotional expression can be framed within the context of musical communication without disturbing or destroying the contact. In addition, music therapy can have an immediate uplifting effect on the client's mood and can eventually affect feelings of restlessness, anxiety, anger, etc.

4. Cognition and Mental Activity

Reduction of cognitive/mental function is the theme of section 4. Problems in these areas (foremost reduced memory) are the primary reason to make the diagnosis of dementia. The magnitude of the problems is depended on the type of dementia, how advanced the illness is and the personality, resources and weaknesses of the affected person. Here, the interest is to investigate what kind of functions can be stimulated in music therapy and if, through musical means, there are ways to access hidden/forgotten resources, such as memories/ reminiscence.

Reminiscence can be both verbal and musical (Munk-Madsen, 2001b). Music from the client's lifetime can help to retain or regain a fading sense of identity and can be means to create connection between past and present. The client can, through music of his/her own life, be present in the common room of the music therapy session, though he/she cannot narrate and mark his/her presence in conversation. As regards to the verbal language, it is stimulated through conversation and song in music therapy. Yet also through the musical parameters which, according to my opinion, are indeed the "raw material" of our language.

5. Attention and Contact

Concerning the clients' attention level, one must be aware that many people with dementia are being treated with psychoactive drugs and that the effects and side effects of the medicine can have a great influence on the person's functions. Many are being treated with medicine, which has a subduing effect on anxiety, aggression and restlessness, but unfortunately as a frequent side effect it makes the person drowsy (in some cases very drowsy). It has often been observed that music therapy has a stimulating effect on clients' attention, and it can also have a balancing effect on the energy level. The last-mentioned effect is often seen with agitated conditions.

The attention span of demented people is quite narrow. It is often said that they "withdraw into their own world". However, it is my opinion that such a move is absolutely involuntary. In music therapy, most of my demented clients have showed a big "hunger" for contact and closeness of a fellow human being. It is therefore important to find those activities and types of stimulation that brings out responses from the client, and thus serves as a key to a shared sphere of experience.

6. The Clients' Comments/Reactions to the Music Therapy Session

In research on dementia it is very rarely seen that the patients' own voices are being searched for (Swane, 1996). In a music therapy assessment process, the clients' own comments and responses are an important signal. As a consequence of the dementia, it is difficult or impossible for the client to maintain and refer experiences and progressions.

The music therapist must therefore constantly be aware of not just verbal comments, but also non-verbal responses during activities and interventions. The atmosphere whereupon a therapy session is finished, can in some situations give obvious signals about clients' appreciation of the music therapy.

Conclusion

The presented model of assessment considers all fields that might have interest in a general assessment of a person suffering from dementia, this is its greatest advantage (force?). In the use of the model, many non-musical aspects will be described. Therefore some of the collected data will be accessible also for people representing other professions. Furthermore the functions that are mentioned in the model will usually be examined in assessments made by doctors and other therapists in addition. It will therefore be easy to compare findings, reactions and effects of different treatments/therapies.

In the first assessment sessions all the sections of the model should be investigated and described thoroughly. When used in a consecutive evaluation of a music therapy progress, it will most often happen that the therapy enfolds around themes within a few sections. In such a case it is natural to concentrate observations and descriptions here. Section 1 is always important though, since the music is the basic material when the music therapist observes, describes, interprets and evaluates. It is therefore desirable to develop this section further towards a greater degree of particularity and precision. The presented model is developed on the basis of the work of only one music-therapist. This must be considered as a weakness. An improvement of section 1 in the assessment model would require the possibility of drawing on experiences of many music therapists working with people with dementia. Hopefully this will be possible when, as I believe, the use of music therapy in dementia care is going to grow considerably in the Nordic countries within the coming decade.

There are still only very few Danish music therapists engaged in this area. There is however in these years a great interest in renewal and inspiration, especially about activities for people with dementia. Care for the increasing number of fellow citizens suffering from dementia is a challenge to many professional groups. It is my experience that music therapy has some very good contributions in the form of stimulation, communication, and fellowship that consider demented people's needs and possibilities. Music therapy work can focus on the non-verbal, the sensory and the emotional aspects of demented people to enable them to participate for a long time, maybe even until the end of their lifetime.

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Layers of Meaning

Dorit Amir interviewed by Brynjulf Stige

Introduction

This interview is the fourth in a series of interviews focusing upon the question of meaning in music therapy. Previously published texts are: '"I have to wait for the moment that I'm doing the music to figure out what the meaning is"' (Michele Forinash, 9(1), 2000), 'The Nature of Meaning in Music Therapy' (Kenneth Bruscia, 9(2), 2000), and 'Music, Meaning, and Experience as Therapy' (Kenneth Aigen, 10(1), 2001). Our intention is to stimulate dialogues and reflections on this important issue, and readers are welcome to submit comments in our Discussion Forum on our web-site: http://www.hisf.no/njmt
This particular interview with Dorit Amir was given at New York University Thursday November 4, 1999. The transcript has been read and revised by Amir before publication.

The Existential View

BS: *I want you to speak about your ideas about music and meaning in music therapy. If I ask questions which make you understand that I have different views from you, my idea is not to have an argument which you or I shall win, but to illuminate your way of thinking. I am not now searching for one way of thinking but for what your perspective is.*

DA: Let me start by saying that in general I believe that every human being finds her own meaning, or gives her own meaning to the things that she does or perceives. Now, there are factors that influence the particular meaning given by the individual: cultural factors, environmental factors, historical factors and so on. If we take historical factors as an example, we can see three layers that can give meaning to the individual's experience: the personal history of the individual (including her family), the history of her nation, and the history of the world and world's events.

So, if I move now to music therapy, my role as a therapist is to try to understand my client's life-history as qualifications of her being in the world. My goal is to help my client find meaning in her life. I can help her find meaning in the music she just played, in a song she sang or brought to the therapy session. I can help her discover meaning in her dreams, associations, images and words. I am concerned with what the existentialists call "dasein" – the existence of this particular being who is with me in the music therapy room.

So, this is an intrapersonal meaning. By that I mean that it is a subjective, inner experience of the grasping of what other things in the world mean to the person. How she relates to a piece of music, to her thoughts, associations, images, to nature and so on. But there is also the interpersonal. I like what Rollo May (1986) says about it. He says that animals have an environment, but human beings have a world. World has the structure of meaning that is created by the interrelationship of the people in it. Relationship involves mutual awareness of both client and therapist. So, if we look at a piece of music that is being created by both my client and I, the meaning that each one of us will give to this improvisation is mutually affected by the encounter.

Meaning is also context and time related. Here is an example from my own personal life. When I got married, our wedding song was the song "One, I love you" from the movie Nashville. Ever since, this song has had a particular meaning for me. But the meaning has changed throughout time. During my marriage, whenever I heard this song, it automatically evoked feelings of joy and happiness. Later on, it became a painful reminder and a symbol of what

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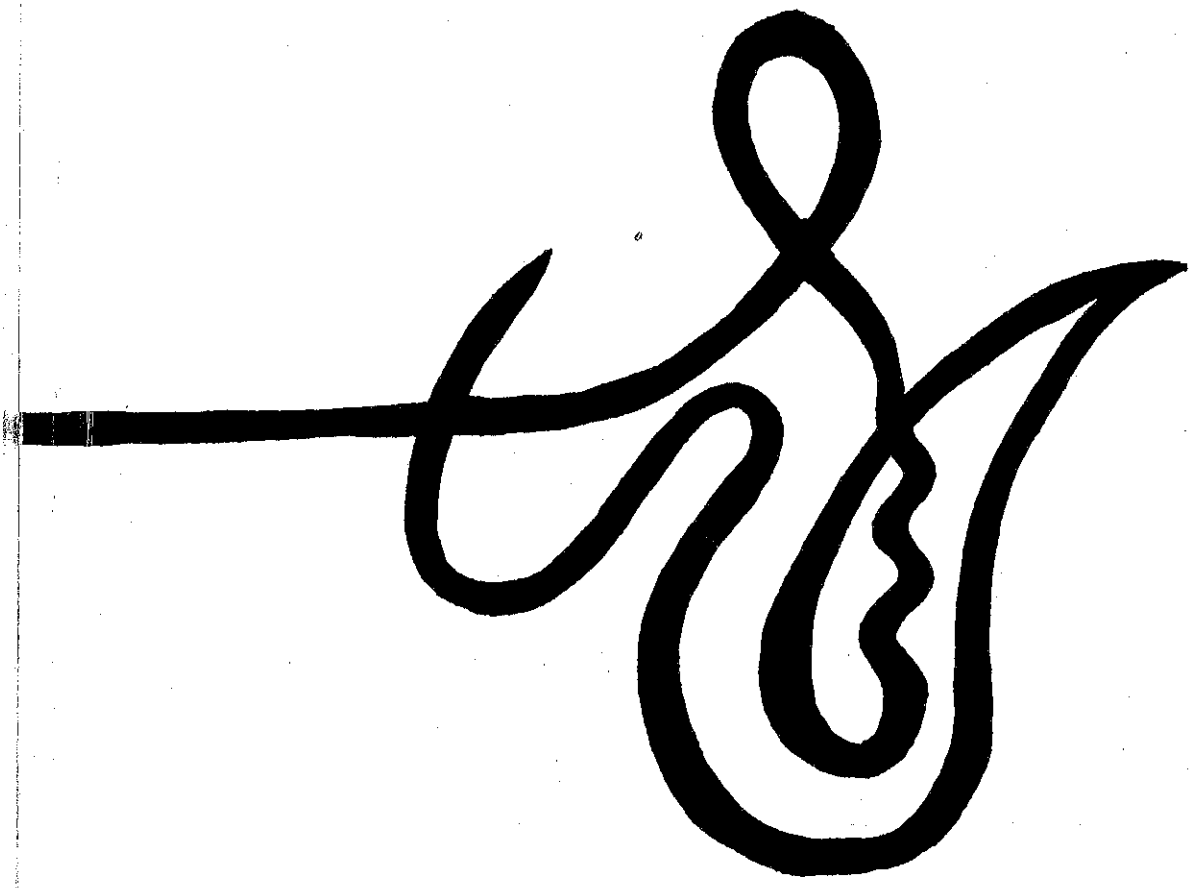

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