Assessment in Music Therapy with Clients Suffering from Dementia

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Introduction

"Music therapy for demented people with behaviour disturbances Kridhhuset, 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 Dabrowski 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 5-4 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 process 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 qualitative 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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Nordic Journal of Music Therapy, 2001, 1(2)
1. **MUSICAL ACTIVITIES**

Is the client active in:
- Movement? Song/verbal sound? Playing of instruments/improvisation?
- Does the client thereby show:
  - How does this apply? In which context? How does the client react?
  - Does the client engage in:
    - Listening? Reception of tactile stimulation?
    - How does this apply? 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 apply? In which context? How does the client react?

3. **EMOTIONAL LEVEL**

The client’s emotional response:
- Flat/irrelevant/inexpressible?
- 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/recreating)?
- Reminiscence (memories being brought in focus)? Sense of orientation? Learning?

5. **ATTENTION AND CONTACT**

How is the client’s energy level:
- Verbal/physical?
- How does the client respond to different types of stimulation/approach:
  - Verbal? Physical? Musical? Eye contact? (E.g. does not respond/does not respond/does reply/initiates contact)

6. **THE CLIENT’S COMMENTS/REACTIONS TO THE MUSIC THERAPY SESSION**

Verbal comments to:
- Activities? Togetherness? The session or a whole? Others?
- Non-verbal comments/reactions, e.g.:
  - Voice change? Body reaction?

Table 1: The assessment model.

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**Nordic Journal of Music Therapy, 2001, 10(2)**

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

In research on dementia it is rarely seen that the patient's own voices are being searched for (Svendby, 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 in which 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 program, 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.

References

Munk-Madsen, Niseema Marie (2001a). Musikterapi til demente med adfærdssværrelser, Genotrope Kommunes plejehjem, Kribsklasse Centret, Kommune, Omsorgsafdelingen, DK