

Music Therapy and Dementia in an Urban Koorie Community¹

Beth Fogerty

For some Aboriginal people, city living—and to some extent rural living—is an existence that is separate, yet shared with non-Aboriginal Australia. It is a life in which their being, their Aboriginality, is considered to be lost by some non-Aboriginal Australians. At the same time, elements which parallel Australian culture are also denied. This creates a situation in which the culture of the Australian Aboriginal peoples, whether urban or rural, has its ties to the past, as well as its present culture, overlooked by the hegemonic Australian culture.

Consequently, urban living has brought new challenges and experiences. Once combined with a fight for identity as a person—and as a nation—these stresses place an individual under personal and outside scrutiny. This inspection influences daily living and interactions with both Aboriginal and non-Aboriginal Australians, and forms the basis for Aboriginal health care systems throughout Australia. These stresses influence an Aboriginal person's identity and being. Recognising these stresses and the Aboriginal approach to health care creates a model for Western health care providers who work with Aboriginal people. Consequently, each must be addressed within the music therapy setting to provide appropriate and high-quality care. To illustrate the music therapy process, this paper reflects on music therapy sessions with a group of Koorie Elders who have an actual or probable diagnosis of dementia. Before addressing music therapy and dementia, it is important to define some terms which carry infinite meanings, and discuss the health needs and aged care services available for Koorie Elders.

Koorie: Koorie refers to the Aboriginal peoples of Victoria.²

Urban: Urban does not reflect upon the Aboriginality of an individual, but is used as a distinction between living in the cities (urban), in the country (rural) and in the out stations (remote).

¹ I thank the Elders with whom I worked for their friendship, knowledge, trust and participation in the music therapy sessions. I also thank all the staff and Koorie people who shared their knowledge and love of music with me. Without their support and assistance, this work could not have been accomplished.

² Larry Walsh, *Still Here* (Highpoint City, Vic.: Melbourne's Living Cultural Museum of the West, 1996) 7.

Culture: Culture includes not only values and beliefs, but the way an individual experiences and relates to the world.³

Stresses in Urban Living

Working within an urban Koorie community may present challenges in dealing with intrapsychic identity conflict.⁴ This conflict has both primary and secondary features. In primary identity conflict, an individual internalises and represses the conflicting values between Aboriginal and non-Aboriginal society, and thus is able to function in the situation. In contrast, an individual who has secondary identity conflict experiences discord between pro-Aboriginal expectations and mainstream Australian expectations and values. This individual is unable to internalise and resolve the disparity between Aboriginal and non-Aboriginal values. As a result, inner turmoil and a question about identity are experienced. Moreover, an inability to resolve secondary identity conflict may result in psychological problems.

Stresses that cause identity conflict for urban Koorie people may be categorised into four main divisions:

A. *Prejudices in society*

Koorie people are faced with stereotypes on a daily basis. Non-Aboriginal Australia has frequently not recognised people of Koorie descent who physically resemble non-Aboriginal Australians. Though reconciliation is changing these value judgements, it takes time to erase stereotypes which were taught and enforced in society. Some examples as stated by Aboriginal people are:

- 1) It is believed that Aboriginal peoples of the south-east [Koorie people] have lost their culture and their land.⁵
- 2) There are no Aboriginal people living in Victoria. The real Aboriginal people live elsewhere in Australia.⁶
- 3) Aborigines of mixed descent are not 'real'.⁷

B. *Non-Aboriginal helper expectations*

The administration of health services is a culturally-embedded phenomenon. In instances where the helper is not sensitive to the patient's culture, the patient loses faith in the helper, and the helper-patient relationship is destroyed.⁸ Four common examples are:

³ Christine L. Fry, 'Emics and Age: Age Differentiation and Cognitive Anthropological Strategies,' *New Methods for Old Age Research*, ed. Christine L. Fry and Jennie Keith (South Hadley, Mass.: Bergin & Garvey, 1986) 107.

⁴ Patricia Dudgeon and Darlene Oxenham, *The Complexity of Aboriginal Diversity: Identity and Kindredness* (St Lucia, Qld: University of Queensland Aboriginal and Torres Strait Islanders Study Unit, 1990) 5-7.

⁵ Ian Anderson, 'Towards a Koori Healing Practice,' *Voices From the Land*, ed. M. Yunupingu (Sydney: ABC Books, 1994) 33.

⁶ Aldo Massola, *The Aborigines of South-Eastern Australia as They Were* (Melbourne: Heinemann, 1971) 2.

⁷ Christopher Anderson and David S. Trigger, 'Black Alternatives in Australia,' *Social Alternatives* 2.2 (1981): 2.

⁸ Peter Hill, 'Aboriginal Culture and the Doctor-Patient Relationship,' *Australian Family Physician* 23 (1994): 29-32; Cindy Shannon, 'Social and Cultural Differences Affect Medical Treatment,' *Australian Family Physician* 23 (1994): 33-35.

1) Private consultations:

Privacy, a product of individualism, is valued in Western health care. In community oriented societies, like Koorie society, consultation is not a private endeavour. Consequently, consultations should be open to family and friends, as defined by the patient.

2) Maintaining a formal consultation:

A formal consultation impedes the opportunity to learn about a patient. In addition, the health care provider becomes 'an expert.' As a consequence, the patient is not understood in relation to the illness, or as an individual. In order to gain trust and compliance with medical procedures, consultation needs to focus on the individual. This emphasis on the patient in turn relaxes the consultation atmosphere, enabling the health care provider to learn about external factors which may contribute to the immediate health concern.

3) A diagnosis of health and illness (physical over spiritual):

In Western health care, labels create a separation between the individual and the illness by categorising people into identifiable problem groups. This policy does not reflect on environmental influences, nor does it emphasise the relationship between physical and spiritual life, elements central to Koorie values.

4) Expecting a direct response to a question:

Koorie people respond best to questions that are open ended and allow an unlimited time for response. This process enables the helper to learn about the individual as a person, and may provide answers to unasked questions.⁹

C. Aboriginal expectations

Koorie peoples expect that their needs will be culturally met with the same quality of care as non-Aboriginal people.

D. Family and community expectations

The Aboriginal peoples value close kinship bonds, sharing, and communal living and decision-making.¹⁰ Adherence to Western care models and life-styles with an emphasis on individuality, privacy and competition is in striking contrast to the values embedded within Aboriginal family life. These differences are exacerbated when Western care models are exclusively followed. Nevertheless, urban Koorie people have responded to Western situations. This change created unique urban communities, each united by its Aboriginality.¹¹

Aged Care Services for Koorie peoples in Victoria

There are few resources and facilities available for ageing Aboriginal peoples throughout Australia.¹² Though the government recognises Aboriginal people as a community with distinct

⁹ These instances are only a few examples of how Western models of care conflict with the values and norms of Koorie life. It is also important to remember that each individual is different, thus these explanations may only be considered as working guidelines for health care providers.

¹⁰ Shannon, 'Social and Cultural Differences Affect Medical Treatment' 34.

¹¹ Marcia Langton, 'Urbanizing Aborigines: The Social Scientists' "Great Deception", / *Social Alternatives* 2 (1981): 17.

¹² See Ian Anderson, Fay Carter and J. Stewart, 'Aboriginal Elderly,' *Culture Care Kit*, ed. Residential Care Rights Advocacy Services (Melbourne: Printmode, 1995).

cultural needs, the services are provided within a Western medical model. That model is not adjusted for the specific needs and beliefs of the Aboriginal people.¹³ This is seen in the services provided within the state of Victoria. Victoria is divided into eighteen aged care service regions (see Table 1). Only three of these services have Aboriginal liaison workers on staff. Another four have an Aboriginal training program. While it may appear that services are available for Koorie Elders, only 38.39 per cent of the regions provide Koorie specific aged care programs and assessments.¹⁴ Four regions have ethnic liaison workers. While not specific to Koorie culture, these individuals are trained to interpret cultural differences, an advantage for Koorie Elders when no specific services are available to them. As a result, aged care services for Koorie Elders are dependant upon the initiatives of the individual facilities. An example of these special services is seen in the North West region.

Table 1: Aged Care Regions in Victoria¹⁵

Region (rural)	Services Provided	Region (urban)	Services Provided
Ballarat	—	Bundoora	—
Bendigo	Aboriginal Co-operative and culture training	Caulfield	—
Geelong	Aboriginal Co-operative and culture training	Eastern (Melb.)	Ethnic Liaison workers
Gippsland	Ethnic Liaison workers	Heidelberg	Ethnic Liaison workers
Kingston	Aboriginal Liaison workers	Henry Pride	—
Mildura	Aboriginal Co-operative and culture training	Mt. Eliza	Ethnic Liaison workers
Mooroopna	Aboriginal Liaison workers	North West (Melb.)	Aboriginal Liaison Workers
Wangaratta	—	Victoria Parade	Aboriginal Co-operative and culture training and Ethnic Liaison workers
Warrnambool	—	Western (Melb.)	—

North West

Melbourne's North West region has one of the few urban Koorie hostel and day care centres. The centre was established to provide care for the Elders after two Elders died in the community, one in a mainstream nursing home and the other alone at home.¹⁶ Michele Gallagher, a personal care attendant, explained that care at the centre follows a home-like model. She stated:

¹³ Neil Croll and Selina Griffin, 'The Koori Conundrum: Helping to Develop Strategic Plans for Health Services,' *A Fair Go for Rural Health: Forward Together: 2nd National Rural Health Conference* (Armidale, NSW: University of New England, 1993).

¹⁴ Department of Human Services and Health, *National Register: Aged Care Assessment Teams* (Canberra, 1997).

¹⁵ This chart is compiled from information regarding each aged care region in Victoria, as stated in the Commonwealth Department of Human Services and Health, *National Register: Aged Care Assessment Teams*.

¹⁶ Sophie Miller, 'Aboriginal Community Elders Service,' *Ngariaty: Koories Talkin*, eds. Julie Andrews, Ian Anderson and Wayne Atkinson (Bundoora, Vic.: La Trobe University, 1993) 86.

You don't worry about who was in charge or not you just do it. You know, if they want a smoke you give them a smoke. If they want a cup of tea you make them a cup of tea. Then take them outside, brush their hair or give them a shave... Basically when you work, like I worked tonight, everybody just helps everybody.¹⁷

At the day centre and hostel this family-like atmosphere incorporates aspects of Koorie culture. The facility has a cultural centre that operates a cultural awareness program. In addition, residents participate in activities such as making tissue box covers, picture frames and baskets (the straw for which is grown around the centre), rock painting, exercises and bingo.¹⁸

Culturally appropriate care is also reflected in the presentation of music therapy sessions. Not only do the sessions reflect the culture of the centre, but they illustrate the importance of sensitivity to the identity conflicts and urbanisation stresses.

Music Therapy with Koorie Elders

Little is known about music therapy and its benefit for Koorie people. We do know, however, that for Koorie people music is a large factor in their lives. It reinforces the link to their rich culture. One Elder illustrated this, stating, 'Music is our life.'¹⁹ Through music, Koorie people have been able to maintain the strong link to culture, despite being forcibly separated from their land and families.

Robin Ryan, an ethnomusicologist, has studied the sociomusical practice of the Koorie people in Melbourne and found that British and American folk tunes and hymns such as *Swanee River*, *Old Black Joe* and *Coming in on a Wing and a Prayer* were the most popular types of songs.²⁰ She noted that the Koorie Elders maintained their vocal music traditions, with particular emphasis on natural harmonies, to this day. Within this vocal tradition, lyrics carried the purposes of telling a story, entertaining and passing on information.²¹ Ryan defines purpose and musical preferences in four key lyric themes: identity (Country-Western, folk), politics (folk, calypso), heritage (traditional tribal, Country-Western, folk) and interactions (rock, jazz, 50s/60s, hymns).

Based on these purposes and musical preferences, it is no surprise that few examples of traditional tribal Victorian Koorie songs exist today. Many Koorie songs either reflected non-Koorie traditions that were favoured and developed by the Koorie people as their own, or the songs of non-Koorie origin sung by Koorie peoples.²² It is apparent that urban living and mission life influenced the music known and preferred by the Elders. Though this music may appear to follow non-Koorie traditions, it has a separate creative identity.²³ Besides becoming

¹⁷ Michele Gallagher, 'Hostel Staff Worker,' *Ngariaty: Koories Talkin'* 89.

¹⁸ Miller, 'Aboriginal Community Elders Service' 88.

¹⁹ A. Iaulcone, Personal communication, October 1996.

²⁰ Robin Ann Ryan, *Koori Sociomusical Practice in Melbourne Since 1988*, MA thesis, Monash University, 1992.

²¹ Marcus Breen, *Our Place Our Music: Aboriginal Music*, Australian Popular Music in Perspective 2 (Canberra: Aboriginal Studies Press, 1988) 92.

²² Tamsin Donaldson, 'Making a Song (and Dance) in South-Eastern Australia,' *Songs of Aboriginal Australia*, ed. Margaret Clunies Ross, Tamsin Donaldson and Stephen A. Wild (Sydney: University of Sydney, 1987) 14-42.

²³ C. Sullivan, 'Non-tribal Dance Music and Song: From First Contact to Citizen Rights,' *Australian Aboriginal Studies* 1 (1988): 64.

part of the Koorie song repertoire, singing hymns in the Koorie language was a means of preserving their language in a living form. This was done despite being forbidden to speak in their native languages.

In many ways, this use of music parallels music therapy, 'using musical experiences and the relationships that develop through them as dynamic forces of change.'²⁴ This is emphasised in Renate Marek's work in an Aboriginal community in the West Kimberley region, which found that music therapy promoted interactions among the Aboriginal people.²⁵ In this setting, music therapy was a means (language) that generated personal links in the community. This change came through the use of music and musical activities, which promoted individual pride and dignity in one's Aboriginal cultural values, and thus emphasised the individual's cultural role.

There is limited music therapy literature available on working with indigenous peoples. Joseph Moreno established the process of ethnomusic therapy, where a music therapist enters the culture of the client to provide therapeutic interventions.²⁶ Carolyn Kenny took an ethnomusicological approach in her work with Native American Indians.²⁷ While both Moreno and Kenny depicted foundations for music therapy intercultural work, M.M.D. Wexler discussed music therapy interventions with Cibecue White Mountain Apaches.²⁸ He discussed the importance of consultation with the Elders and incorporating Apache traditions into music therapy. However, the music therapy implementation and analysis followed Western methodologies, an element which may have limited the apparent benefits of the grief counselling that Wexler described in his project.

To address Koorie culture and the individual needs of each Elder, consultation needs to occur with the staff through all aspects of the music therapy session design, implementation and evaluation. Consultation with Koorie communities is a requirement for research, and entails meeting with the medical staff to discuss each aspect of the music therapy session and program.²⁹ In the project this paper discusses, staff members were involved in each session, and suggestions were followed up with other Koorie organisations in the area. Thus it was possible for the music, instruments and music therapy format to reflect the needs of the Koorie people. As a consequence, each session, while maintaining the same foundation, was adjusted for each Elder and situation.

²⁴ Kenneth Bruscia, *Defining Music Therapy* (Phoenixville, PA: Barcelona, 1989) 47.

²⁵ Renate Marek, 'A Music Therapy Pilot Project with a Largely Aboriginal Population in the West Kimberley,' Unpublished paper, 1995. Other information regarding Aboriginal peoples and music therapy is limited to Catherine Ellis' statement that Aboriginal peoples use music as therapy. Catherine Ellis, *Aboriginal Music Education for Living* (St Lucia, Qld: University of Queensland Press, 1985) 29-31.

²⁶ Joseph Moreno discusses ethnomusic therapy through his work with native healers in India, Brazil, Africa and Peru. See J. Moreno, 'Multicultural Music Therapy: The World Music Connection,' *Journal of Music Therapy* 25.1 (1988): 17-27; J. Moreno, 'Ethnomusic Therapy: An Interdisciplinary Approach to Music and Healing,' *The Arts in Psychotherapy* 22.4 (1995): 329-338.

²⁷ Carolyn B. Kenny, *The Mythic Artery: The Magic of Music Therapy* (Atascadero, CA: Ridgeview, 1982).

²⁸ M. M. D. Wexler, 'The Use of Song in Grief Therapy with Cibecue White Mountain Apaches,' *Music Therapy Perspectives* 7 (1989): 63-66.

²⁹ National Health and Medical Research Council, *Guidelines on Ethical Matters in Aboriginal and Torres Strait Islander Health and Research* (Canberra: NH&MRC, 1991).

Planning the Music Therapy Session

Designing music therapy sessions for Koorie Elders in this project drew upon several key elements. Each of these elements dictated one aspect of the music therapy session. Once combined, the following aspects formed the basis for the entire music therapy session, philosophy and practice:

- a relaxed family structure
- the Elders' direction of the music therapy sessions
- the music therapist's participant role as guided by the Elders
- the Elders' implicit right to refuse an activity or session
- a respect for silences
- culturally sensitive activities.

Consultation with the Koorie peoples was essential to the success of the music therapy sessions. In this project consultation occurred with current staff, local Koorie organisations and individuals who had previously worked with Koorie people. Several aspects of the music therapy session were discussed, including musical styles, instruments and activities. In addition, as the music therapist, I learned about the culture of the organisation and, most importantly, how staff interacted with the Elders. During consultation the music therapist was interviewed and assessed for sincerity, purpose, abilities, sensitivity, a willingness to learn and an openness to new ideas.

In this manner, consultation provided the initial establishment of rapport between the music therapist and the Koorie Elders. From this point on, the music therapist drew upon Koorie resources in relation to her own abilities and skills. Included in this process was an understanding and awareness of both sets of cultural norms (Koorie and non-Koorie). This awareness was furthered by evaluations conducted with the Director of Nursing (DON) after each session. The activity presentation and the music therapist's interventions were discussed in order to establish a positive and beneficial music therapy program for the Elders. Once the values were defined, the music therapist and the Koorie people formed a new group culture based on each other's strengths and abilities. The resulting culture was neither Koorie nor non-Koorie, but contained elements of both in a unique working relationship.

Music Therapy with Koorie Elders who are Diagnosed with Dementia or Probable Dementia

The music therapy literature stresses a structured therapist-run session for individuals with dementia.³⁰ This approach generally encompasses a variety of activities. Those most widely advocated are rhythmic improvisation,³¹ movement (free with scarves or structured, therapist-

³⁰ Melissa Brotons and Patty Pickett-Cooper, 'The Effects of Music Therapy Intervention on Agitation Behaviours of Alzheimer's Disease Patients,' *Journal of Music Therapy* 33.1 (1996): 2-18; Alicia Ann Clair, 'Music Therapy for a Severely Regressed Person with a Probable Diagnosis of Alzheimer's Disease,' *Case Studies in Music Therapy*, ed. Kenneth Bruscia (Philadelphia, PA: Barcelona, 1991) 571-80; Alicia Ann Clair and Barry Bernstein, 'A Comparison of Singing, Vibrotactile and Nonvibrotactile Instrumental Playing Responses in Severely Regressed Persons with Dementia of the Alzheimer's type,' *Journal of Music Therapy* 27.3 (1990): 119-25.

³¹ Alicia Ann Clair, Barry Bernstein and Gary Johnson, 'Rhythm Playing Characteristics in Persons with Severe Dementia including those with Probable Alzheimer's Type,' *Journal of Music Therapy* 32.2 (1995): 113-31; Natalie Hanson, Kate Gfeller, George Woodworth, Elizabeth A. Swanson and L. Garand, 'A Comparison of the Effectiveness of Differing Types and Difficulty of Music Activities in Programming for Older Adults with Alzheimer's Disease and Related Disorders,' *Journal of Music Therapy* 33.2 (1996): 93-123.

led exercises)³² and, when the above activities are not effective, singing.³³ To provide culturally appropriate sessions for Koorie Elders with dementia, these music therapy activities and structural foundations needed to be assessed.

In the project discussed in this paper, a music therapy program was developed over six weeks of music therapy sessions with three Koorie Elders who lived in an urban metropolitan area. The purpose was to see if music therapy was beneficial in increasing interactions for Elders who had dementia. Focusing on this group addressed the gap in urban Koorie aged care services.

Unlike other music therapy settings, all the music therapy activities, music and instruments used in the sessions were selected and devised with the DON. Once the music therapy session began, the activities, music and the music therapist's participation were directed by the Elders, and evaluated for their efficacy by the DON. Nevertheless, the session progression was dependent upon how the music therapist interpreted and responded to the Elders' initiatives. This was seen in the music and instruments available, the activities introduced and interpersonal communication styles.

Music

Though the preferred music in these music therapy sessions was country-western songs and British and American war tunes, other works such as hymns, rock-and-roll, folk songs and traditional music were also available (see Table 2). Limiting the song choices to one musical style would have stereotyped the Elders' choices, diminishing their control over the sessions.

Table 2: Examples of Songs Played During the Music Therapy Sessions

Amazing Grace	Lean on Me
Country Roads	Memphis Tennessee
Daisy Daisy (Bicycle Built for Two)	Moonlight Bay
Danny Boy	My Old Kentucky Home
Help	Oh You Beautiful Doll
Hey Jude	Old Black Joe
Home on the Range	Old Folks at Home (Swanee River)
House of the Rising Sun	Red River Valley
How Great Thou Art	This Land is Your Land
I'm Forever Blowing Bubbles	What a Wonderful World
It's a Long Way to Tipperary	When Irish Eyes are Smiling
Jamaica Farewell	Yesterday
Kansas City	You are my Sunshine

³² Brotons and Pickett-Cooper, 'The Effects of Music Therapy Intervention' 2-18; Alicia Ann Clair, *Therapeutic Uses of Music with Older Adults* (Baltimore, MD: Health Professions Press, 1996); Hanson, et al., 'A Comparison of the Effectiveness' 93-123.

³³ Melissa Brotons and Patty Pickett-Cooper, 'Preferences of Alzheimer's Disease Patients for Music Activities: Dance/movement, Games, and Composition/improvisation,' *Journal of Music Therapy* 31.3 (1994): 220-233; Alicia Ann Clair, 'The Effect of Singing on Alert Responses in Persons with Late Stage Dementia,' *Journal of Music Therapy* 33.4 (1996): 234-247; Clair and Bernstein, 'A Comparison of Singing, Vibrotactile and Nonvibrotactile Instrumental Playing Responses' 119-125.

Instruments

The instruments used for improvisation (music-making) were selected after discussions with the staff and other Aboriginal organisations. Besides the guitar and piano, clapsticks (claves), maracas, rainsticks, bells and shakers were recommended for use in the project. As with the songs, the instruments available included both traditional (didgeridoo and gum leaves) and Western instruments. Though the didgeridoo is not originally from south-eastern Australia, it has become part of Koorie culture. Still, like the gum leaves, not every Elder is able to play the didgeridoo. Thus recordings should be available when live music cannot be offered.

Music activities

As selected by the centre staff, three different music therapy activities (movement, improvisation and relaxation) were explored in the project. Each activity was introduced with singing.

Movement

Music and movement in a group setting can foster interpersonal communication for individuals with dementia. Two common music therapy approaches to movement were explored: balloons and free movement with scarves. In working with Koorie Elders, the effectiveness of music and movement was related to the familiarity and practical uses the Elders had with each task. Music therapy movement tasks, such as free movement with scarves, in which each Elder instigates and follows peer movements, and physical games (passing a balloon) were met with different responses. For example, as passing a balloon to music was a familiar activity, the Elders automatically passed the balloon to each other and imitated different movements (such as swirling the balloon and rolling the balloon before passing it to a peer). This familiarity enabled the Elders to participate in the activity without any intervention from the music therapist. In contrast, free movement with scarves—a prop that holds practical everyday uses—relied on the music therapist's facilitation of the group. The resultant activities reflected every day uses such as wiping mouths or noses, and commenting on the scarves' colours.

Improvisation

Rhythmic improvisation is highly valued in music therapy for stimulating involvement for individuals with dementia. In this setting, rhythmic improvisation emphasised the intrinsic use of rhythm by the Koorie peoples. Individual moods and the timing of the session influenced this activity. The improvisation passed through three main stages of development, based upon the formation of each Elder's group role and activity initiatives.

Stage 1: Inquisitive

The instruments were selected, but after a brief playing time were placed either on the participant's lap or back in the instrument bags.

Stage 2: Exploration

Interactions occurred for brief periods of time. These interactions included playing on the same instrument and the initiation of pauses in the playing time.

Stage 3: Musical Dialogue

The participants began to take turns and respond to each other's rests and dynamics through a process of leading and following.

Relaxation

In music therapy practice, relaxation generally involves a structured and directed method of Progressive Relaxation Exercises. This approach is not recommended for individuals with dementia. However, it was provided in this project as the DON believed that music relaxation was a way to decrease the Elders' agitation levels. Despite this belief, the Koorie Elders in this project did not respond to the exercises. Instead they initiated participation in improvisation, singing songs and group discussions. While Progressive Relaxation activities were not effective, a decrease of agitation from the beginning of the session to the end illustrated that the music therapy session in its entirety was considered a relaxing experience.

Interactions

Through a family-focused music therapy approach, Elders with a diagnosis of dementia were able to fulfil their cultural roles and maintain dignity and autonomy. The interactions took one of two approaches, supportive or encouraging. A supportive interaction was where the Elders assisted their peers to hold instruments, or changed activities to match peer moods. In contrast, the encouraging interactions included verbal praise and nodding or smiling at peers. These interactions were influenced by environmental conditions such as:

- the location of the group
- the involvement of Elders outside the group
- the involvement of staff
- the mood of the individual group members.

Other elements that influenced the success of the music therapy sessions were the music therapist's awareness of distance, time, touch and praise.

Cultural Considerations for the Music Therapist

Distance

A key component of the music therapy groups was the awareness of personal space and appropriate distancing. This was best established through the group members themselves, as it maintained the Elders' control of the session. As the music therapist became aware of the group and its interactions, her role in the group was defined in relation to the Elders' needs and wants. Without this awareness and understanding, the Elders' roles could not be strengthened. As a consequence, the Elders lost interest and the activities became ineffective.

Time

Session timing was integral to the activity success, and was based upon the Elders' moods, activity preferences and schedules. As a result, time became continual, with each activity based on the Elders present. This promoted a flexible session format in which the Elders could leave and arrive at any time, take breaks for tea or smoking, and discussions could ensue. In addition, this use of time promoted a relaxed family-like session where each activity was important and not burdened by the constraints of time.

Touch

Touch and its application are culturally bound values. The acceptance of touch was relative to each Elder, but was not appropriate until rapport was established. Despite this, agitation may ensue in relation to touch even when a good rapport exists between the Elder and the music

therapist. Rather than initiating touch, the music therapist based touch upon the initiatives made by the Elder. Nevertheless, it was appropriate to assist an Elder with holding instruments, provided that the activity was selected by the Elder.

Praise

Since praise is an integral aspect of Western music therapy practice, it mandated attention. Praise was relevant to each Elder's specific personality and group role. For some Elders this meant verbal praise, while others required non-verbal praise such as smiles and nodding. At the same time, it was important to praise the entire group of Elders. Through combining these two forms of praise, the Elder was recognised for his or her individual role while a cohesive group experience was maintained.

Summary

In reflecting on these music therapy issues in an urban Koorie nursing home setting, it was apparent that music was a beneficial activity for maintaining the close family ties held between the Elders. However, it was much more than the music therapy experience that benefited the Elders. Their direction and teaching provided a way to pass on knowledge through music, an element that has been and continues to be an integral part of their lives. It was the awareness and openness of the music therapist that enabled the Elders to benefit from the music therapy activities. Without an understanding of the stresses and conflicts faced by the Elders, and a willingness to learn from the Koorie peoples, music therapy would have been ineffective.

Music is an expression of beliefs and a way of life. Through a culture-sensitive approach to music therapy, dignity and autonomy can be maintained in conjunction with Koorie values. As Marika, an Aboriginal Elder, stated in 1978:

There is no real distinction for us between art and life; art is the expression of our beliefs, it upholds the laws by which we live, and is an important element in the way in which we relate to the physical world around us. It is an integral part of our lives.³⁴

Thus, music therapy is a natural extension of Koorie culture and health. Each activity, whether singing, improvisation or movement, enables Koorie Elders with dementia to maintain their cultural role as providers of knowledge.

³⁴ Quoted in Henrietta Fourmile, 'Aboriginal Arts in Relation to Multiculturalism,' *Culture, Difference and the Arts*, ed. Sneja Gunew and Fazal Rizvi (St Leonards, NSW: Allen & Unwin, 1994) 76.