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## **Dementia: When music is the only way in – An emergency intervention**

### **Abstract**

Music cannot only provide comfort and reduce agitation associated with dementia, but can also generate connections between all who are present. This article describes an 'emergency' music intervention conducted by the author during doctoral fieldwork, which illustrates how music was used as a medium for connection and comfort with a highly agitated person with advanced dementia. This experience provides strong support for increasing the training of musicians towards providing music for people living with dementia – particularly when other nonpharmaceutical methods are not proving effective.

**Keywords:** communication, care home residents, dementia, Alzheimer's disease, music, palliative care

### **Background**

Music holds the possibility of effectively capturing and sustaining the engagement of all listeners – even those who are in a highly disturbed or anxious state (Aragon, Farris, & Byers, 2002; Sacks, 2007). This paper describes an 'emergency' music intervention I was requested to conduct for a person whose dementia sometimes took him to a very dark place. At the time of this intervention, I was conducting fieldwork for my PhD (Garabedian, 2014; Garabedian & Kelly, 2018). On this particular day, having exhausted all previously successful ways of connecting with Robert (pseudonym), the care home manager telephoned me with an urgent request that I come and play music for Robert. An accomplished amateur musician, with a keen affinity for music, we had created a good bond with one another. I quickly arrived at the care home to find Robert pacing the corridor, unshaven and red-eyed from a lack of sleep. Staff explained that no one had been able to

get close enough to Robert to provide crucial care. It was hoped that as Robert was especially fond of music, my playing the cello for him could successfully connect with and engage him – thus providing a way out of his current state and eventually to being approached and cared for by staff. I greeted Robert and invited him to come listen to me play music for him in his bedroom – to which he readily assented. Quickly unpacking my cello, Robert perched himself on the edge of his bed, tightly holding onto his ‘mouthy’ (harmonica). After a brief chat, I began playing fast-paced, upbeat Scottish and popular tunes. I chose this type of music because I was well aware that my only hope for capturing his attention was through ‘entrainment’ – playing music matching his current agitated state (Khalfa, Roy, Rainville, Dalla Bella, & Peretz, 2008). Almost as soon as I began playing the cello, Robert was robustly tapping his feet and thumb while nodding his head along with the music. We interacted with one another in this manner for some time, with only a brief break while his keyworker ‘Sharon’ came in and offered him some juice and ‘crispies’ (cereal). Resuming my playing of fast-paced upbeat music, Robert recommenced engaging with both me and the music (robustly tapping his feet, nodding his head, and sporadically singing along), while intermittently drinking juice and taking small bites of cereal. Between tunes, I gently cajoled Robert to eat a bit more cereal – to which he happily complied. Once I felt that Robert and I had become fully connected through the fast paced music I was playing, I began gradually reducing the music’s pace; aiming to gradually calm Robert. Although Robert did slow-down his foot tapping, and even briefly closed his eyes in alignment with the slowing pace of the music, whenever there was a momentary break in the music, he reverted to vigorous foot tapping while energetically rapping his spoon on the side of his cereal bowl.

After over an hour of my playing music for Robert, he appeared to be considerably calmer, so I quietly packed-up and began to pack my car. However, coming back inside just a few moments later, I again found Robert pacing the corridor. He was saying things such as, ‘I know what you’re doing!’ – ‘I’ll get you!’ and threatening to ‘beat me’ etc. His

expression made it evident that Robert was not actually seeing nor speaking to me; rather, he seemed to be addressing someone or something outside of present time – perhaps related to a distant and presumably unpleasant memory. Equally, I was aware that I was standing very near to him and that his actions were not at that time predictable; I chose to hold my ground, calmly suggesting he re-join me in his room to listen to some more music – which he readily accepted. I quickly re-unpacked my cello and resumed playing fast music – which Robert again instantaneously engaged with by tapping his feet, humming along, and maintaining eye-contact. However, his jaw remained notably clenched. We continued in this manner for some time. Evelyn (the care home manager) quietly entered the room accompanied by his regular doctor, who stood in the doorway watching Robert interacting with the music and myself, gradually growing calmer as I played successively slower-paced music. I eventually took a short break to allow the doctor to ask Robert a few questions and to examine his tongue. Evelyn later informed me that this doctor, who was quite familiar with Robert's circumstances, had been tremendously moved by what she had witnessed, saying that although she had read about the potential benefits of music particularly for people with dementia, this was the first time she had directly observed them.

I commenced playing fast-paced music for Robert once his doctor had left – and he again tapped his feet along with the music. However, he was now also frenetically rubbing his hands, which is a recognised sign of agitation (Cohen-Mansfield, 1997). Evelyn soon returned and sat beside Robert on his bed, joining him in a 'sing-song' while I continued playing fast-paced and upbeat tunes. Robert gradually grew calmer alongside the gradual slowing-down of the pace and mood of the music; indeed, he became peaceful enough that his long-time keyworker felt able to sit beside him to feed him and provide the care he needed. Nearly three-hours after I had initially began playing music for Robert, I left him smiling, happily partaking of food and receiving much needed care from his long-time keyworker – with a feeling of relief and gratitude that Robert was at least for the moment in more peace.

Evelyn said of this intervention:

“. . . a phone call that I gave you because staff were finding it very problematic to actually calm this person down . . . when you came in and went into his room – and it was a brave thing that you did, because not everybody could have gone into that room where that gentleman was at that precise moment in time. When you walked into that room, what he gained from the music that you gave him, and that you played, brought him back to down where he lives in here. Rather than the place that he was experiencing, which was very frightening . . . and one in which we couldn't bring him out of. But you managed through music . . .”

Robert's passion for music is epitomised by his instantaneous embodied engagement with to the music I played for him – despite his high state of distracted agitation and exhaustion. The music seemed to restore his calm. Music was perhaps the only means of reaching and connecting with Robert at that moment in time. I feel extremely gratified knowing that, through my cello, I was able afford Robert some respite – a 'haven' where music was able to call him back into the present. This unplanned 'emergency' intervention provides rare and vivid insight into the capacity for music to reach and improve the circumstances of an especially agitated person with quite advanced dementia (Cohen-Mansfield, 2013; Raglio et al., 2012; Ueda, Suzukamo, Sato, & Izumi, 2013). This experience also illustrates how music can fulfil Kitwood's (1997) basic human needs for *occupation* (with the music); *inclusion* (with me and as well as others who shared the music with him); *identity* (derived from familiar Scottish music); *comfort* (derived from familiar Scottish music); and *attachment* (the familiar Scottish music likely helped draw him back into his real life).

Music can reach and connect with persons who may not be reached by more conventional methods (e.g. verbal communication). All that is required of the recipient is some level of hearing and a willingness to receive the music being played; all that is

required of the person(s) providing the music is training and prior experience working within this specific population. Medical and care home professionals who work most closely with people living with dementia are beginning to recognise music's potential for helping especially people with advanced dementia to have a better quality of life through engagement and connection. This emergency intervention highlights the need for further research towards fostering this emergent relationship between medical professionals and trained music practitioners/therapists, towards increasing inclusion of music within acute and chronic institutional and domiciliary dementia care.

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