ABSTRACT: This article describes a music therapy program developed at a children's hospital that facilitated university student clinical placements. In developing a new practice area within the hospital, the music therapist's role supported patients in areas of pain management and psychological stress. Consideration was given to the needs of patients and referrals as defined by staff, as well as reference to the international literature and practice. Role informants from theoretical sources are outlined, short case vignettes are presented, and the role of the music therapist in pain and stress management is indicated with reference to theoretical constructs from the field of psychology and the empirical and case material appearing in the music therapy literature.

Background and Introduction

Over ten years ago I began working with children who were hospitalized with severe burn injury at the Royal Children's Hospital (RCH) in Brisbane, Australia. This came about because, as the sole lecturer and course co-ordinator for the music therapy programme at the University of Queensland, I was seeking clinical placement opportunities for music therapy students. I visited a number of facilities in Brisbane offering my clinical services in exchange for opportunities to have students undertake supervised practice alongside me. One by one nursing homes, hostels, psychiatric services and centers for adults with intellectual disability had rejected my offer of free music therapy services. I was left wondering what I would be able to do to ensure that students could have clinical training opportunities in a State with a population of 3 million, two of whom were practicing music therapists and one of whom was me, newly arrived into a blazing sub-tropical summer from the milder, temperate South.

I would like to write "I finally began this work" but as I had arrived on the 5th of January 1993 and started working at the hospital in early March, there was hardly a long lead-time for the commencement of the venture. In February, thanks to suggestions and the connections of a retired music therapist in Brisbane, Moya Evans, I presented at the Grand Rounds of the RCH, a major teaching and research hospital for the State, giving an overview of music therapy work with hospitalized children. In 1993, that consisted of a summary of the few references that I could find in the university library's newly established music therapy collection: Chetta (1981), Froehlich (1984), Loveszy (1991) and Rudenburg & Royka (1989). I give thanks for these colleagues and their writings as it gave my pitch to hospital practitioners and administrators the support of international scholarship and gave my early work some of its shape and direction.

At the conclusion of the Grand Rounds, the Clinical Nurse Consultant for the burns unit, Sandy Miller, approached me, holding my arm, looking me in the eye and said, "Please come and work with our children." So has continued a story, much indebted to the support of Sandy Miller, which has involved many wonderful music therapy colleagues, great professional opportunities for me and, I hope and trust, moments of real joy and peace for patients and their families with whom I worked.

Many more patients have benefited from the music therapists whose service followed on from my early development work which at that time included the burns unit and a general...
surgical ward; and some but not all of those names include
my published colleagues Jeanette Kennelly, Barbara Daveson,
Vicky Abad, Karen Brien-Elliott, and others, who have worked
in a range of other contexts within the hospital including on-
cology, rehabilitation and neonatal units, as well as sharing
and eventually taking over my clinical role in the burns and
general surgical units.

When I started at the hospital, my prior professional expe-
rience had involved adults with mental disorders and older
adults with dementia. Theoretically, I was strongly influenced
from psychodynamically informed music therapy; however,
closer to the time that I moved to Brisbane, I had become
interested in the literature on stress and coping. I had also
undertaken community-based work with people from non-En-
glish speaking backgrounds diagnosed with dementia, I had
music therapy student and professional experience with de-
velopmentally disabled children, and I had supervised a range
of student placements including external supervision of stu-
dents on placement in a child development unit at a hospital
in Melbourne.

Although lacking direct clinical experience with hospital-
ized children, I was ready to learn and was open to the pos-
sibility that I could develop the skills needed to be available
to patients and their families. Throughout most of the period
of this work from 1993 that finished with the patient, Keri (see
Edwards, 1999a), I attended regular individual psychoanalytic
psychotherapy and also, for some of that period, received pro-
fessional supervision from an outstanding children’s therapist
in Brisbane.

Although I hope that the work described by me in the pa-
pers I have written and presented appears logical, organized
and professional, I often experienced the early work as un-
predictable. It was the capacity to hold some very difficult and
anxiety provoking situations that helped the work of music
therapy to grow and expand at the hospital. I also did not find
it easy to write the papers that later appeared about this work;
however, writing helped me to expand and reflect upon what
I was experiencing and finding out about this work. Without
the support, encouragement and written feedback from Kate
Giller and Clare O’Callaghan, particularly for my initial pa-
pers, I would have found it more difficult to have been pub-
lished on this topic.

The Role of the Music Therapist as Learner Rather
than Expert

I have held the belief for a long time that we are the most
use to our patients when we are prepared to learn from them;

both what they need and what it is we are able to offer to
them in their current situation. While the research and the-
oretical literature has always been a useful informant for me,
I have not been able to use it in what could be described as
a prescriptive way in this work. It has been essential to listen
to patients and their stories and to think carefully about their
needs and then to consider the best response one might be
able to make.

As I found my way in the work with children at RCH, Bris-
bane, I spent many frequent meetings with staff asking what
it was they thought was needed in the burns unit. It was this
couragement of staff that helped me define my role and
assisted in opening up some areas of practice that otherwise
could have remained closed.

Interestingly, initially some staff thought that a music ther-
apist might be able to sing and play to entertain children and
their families while they sat in the waiting room during out-
patient visits. Others wanted music therapy to provide psy-
chological support for patients in isolation. Still others wanted
children to receive music therapy during longer procedures
and others thought it might be a way to help families with the
experience of burn injury and treatment for a loved one. I gave
staff a chance to tell me what they thought a music therapist’s
role could be, but I also worked to inform them about what
music therapy was and how it had been used in other hos-
pitals for the benefit of patients and their families.

Describing and Defining Music Therapy for Hospitalized
Children and Looking at the Role of Others in Similar Work

In my early work, I was so grateful for the advice and sup-
port I received from Beth Dun in Melbourne. When Jeanette
Kennelly started working at the hospital as a research assistant
with me in 1995, although I had written various submissions
and articles about music therapy, I began to think through the
ways in which music therapy could be defined and described
in the work that we were doing.

In this medical setting, emphasizing the critical interaction
and relationship between the music therapist and the patient
as important often gave rise to responses of incredulity when
presenting to a wider audience than the team. It had to be
emphasised frequently that this is the domain in which the
observations, experiences, and interpretations within music
therapy occur.

While many of the questions integral to music therapy with
children in the hospital also concern the role of music in the
process, it may not be possible to separate the effects of the
presence of the music therapist from what we might think of
as the effects of the music. In this way, the approach taken by
music therapists within a medical context does not always fit
within a medical model of evidence and treatment. This is

2 I tutored in a subject Human Development for Social Work Practice, co-
ordinated by Professor Dorothy Scott in Social Work, at University of Mel-
bourne in 1991 & 1992 that exposed me to a broad range of theoretical
perspectives in relation to stress and coping. I also completed two subjects,
Family Theory and Group Work Theory in that Social Work Department in
1990.

2 Professor Giller was the invited Guest Professor for the Humanities at The
University of Queensland for six weeks in 1997.

4 Elsewhere I have discussed this perspective with reference to the writings
of Patrick Casement that I began reading at the suggestion of Robin Howat
around 1995. See Edwards columns in “Voices”, www.voices.no
partly because music therapy is not a treatment intervention dealing with the primary pathology. Rather, the music therapist works with the consequences of the reasons for the child's admission to hospital whether from illness or injury.

While many of the questions integral to music therapy with children in the hospital also concern the role of music in the process, it may not be possible to separate the effects of the presence of the music therapist from what we might think of as the effects of the music.

The music therapist has a role to discover and work with the existing musical capacities and interests of the patient. Using these discoveries and giving consideration to ways that this might help the patient to develop better coping capacities to maximize their psychological strengths is important. As most children have had music exposure through nursery songs, school music programs and their family experiences, it can be assumed that almost all children have had positive music experiences and many have well-established musical preferences and interests from an early age. The child’s existing experience with music can be used by the music therapist as a starting point for building a relationship with the patient.

Music therapists working with hospitalized children have an important role as observers of the children's responses and interpretation of these responses to guide and inform their interventions, but also to provide information to the multidisciplinary team. It was often possible for me to offer a perspective to the team as to how a child was feeling following remarks made during sessions or by changes in the child's choice of song material or ways of playing.

For the work that emerged at the RCH in Brisbane, the following definition began to be used, based on Bruscia (1998, p. 20):

Music therapy provided in a children's hospital is a systematic process of intervention in which the therapist uses music in the context of a relationship between the therapist and the patient to promote well-being in the patient. Music therapy interventions support and assist the child in any or all of the following ways: to promote adaptive coping, to reduce pain or distress, and to increase and promote cognitive and/or physical development; this can include work within a family-centered model of care.

While my own development of a working definition that my colleagues and I could use to describe and explain our work was important, there were already music therapists working in this area. Therefore, apart from my ability to define the work, I also worked to make connections, particularly in the first two years when apart from the presence of students, I was the only music therapist at the hospital. In the first year, I visited the Royal Children's Hospital in Melbourne where Beth Dun had started her work a couple of years earlier. This was invaluable in helping me to frame approaches to patients. In addition, I spent a few weeks in the USA in early 1994 that included a visit to Shriner's Burns Institute in Galveston Texas. Sheri Robb welcomed me and offered helpful insights into burns work there.

It is not possible to thank all the people I met and who allowed me to view their work, or helped me to find excellent practitioners to meet and observe in various visits; however, it is important that in the work of my own role formation and identity in this work that was new for me, I took the trouble to observe and develop links with existing practice. In addition, the literature, what music therapists have said about what they do, has inspired and informed so much of what has been embedded in my ongoing thinking, research and clinical work. I would encourage colleagues who are embarking on new initiatives not to leave out any of these steps.

Theoretical Informants for Role Definition

As I sought to develop an approach to the work that was responsive to and consistent with the work of the team in treating children with burn injury, two aspects of psychological theory informed the refinement of my role in this work. Two primary roles that emerged were in management of psychological distress and in pain management for children with severe burn injury. These roles will be discussed below with brief reference to developmental theory that also has had a place in assisting my understanding of the contribution of music therapy to the support and management of children with burn injury. The wider literature of music therapy with children in hospital will be referenced since some of the themes in assisting children who have a range of illnesses and injuries are congruent with the role of the music therapist in working with children with burn injury. The work of music therapists with neonates and infants will not be referenced since my clinical experience has not included this age range.

A Role in Managing Children's Psychological Distress

Improving children's capacity for coping with the demands of treatment as well as other psychological components of the hospitalization experience is an important role for the music therapists in this field. It has been conceptualized that “improved coping with the pain of medical procedures aids the overall management of the illness” (Smith, Barabasz & Barabasz, 1996, p. 187). Thus, in assisting the child with management of pain or anxiety associated with procedures, the therapist is not only concerned with altering the child's experience during the procedure, but also aims to produce a better outcome overall for the child in managing their hospital/medical experiences.
I have found theories of stress, coping and adaptation useful in being able to identify and attending to the needs of children who were receiving care for burn injury. As I became more fluent in the theoretical constructs surrounding this work from the field of psychology, I felt more able to promote a role for myself and colleagues that followed, where I was able to support the goals of the team for individual patients who were manifesting signs of distress or were at risk of ongoing difficulties. I adapted the ideas from these theories to consider ways in which children's existing musical experiences could be harnessed to offer a greater range of supports for children.

Two particular theoretical perspectives to stress that were used to inform a role for music therapy at the hospital are discussed below; Lazarus and Folkman (1984) and Aldwin (1994) and I have discussed these at greater length elsewhere (Edwards, 1999b). Psychological stress, whether experienced by adults or children, has been defined as “a relationship between the person and the environment that is appraised by the person as taxing or exceeding his or her resources and endangering his or her well-being” (Lazarus & Folkman, 1984, p. 21). The individual's appraisal, that is, his or her interpretation of the meaning or perceived threat of the experience, is the primary element at play in a stress response. It may not be appropriate to apply external criteria generalized from others experience to indicate the importance and meaning of the event (Lazarus & Folkman, 1984).

Aldwin (1994) developed a transactional approach to stress modelling. She identified the current paradigmatic crisis in psychology as a shift from reductionism (the scientific linear causal model) to transactionism; the idea that relationships between variables can be multifaceted, and that the investigation of human experience is better pursued with a range of potential and perceived complexities in view.

Aldwin proposed three dimensions of the stress experience:

1. The strain experienced, which has emotional and physiological dimensions,
2. The stressor, including the type of stress and its temporal dimensions, and
3. The transaction between these dimensions, including the person's cognitive appraisal of the stress and the perceived intensity of the stress that contribute to their responses. That is, “the person, the situation and coping mutually affect each other in a process that evolves over time.” (Aldwin, 1994, p. 85)

I consider that the music therapist has a role in eliciting the patient's experience and helping the patient to name and express feelings about situations and events relating to hospitalization, injury and illness in order to facilitate coping. This is not, however, a license for music therapists to encourage children to describe traumatic events as some kind of misguided attempt at catharsis. The work more productively involves reference to here and now events and circumstances, helping the patient to express and incorporate their frustrations, disappointments, anger and fears.

This can be observed in a short case vignette of work with a nine year old boy in isolation and his mother (Edwards, 1998). The first verse of the song (p. 24) described the boy's feeling of being tired (he used the word 'weary') and of wishing to be able to play cricket with his brothers. The second verse written by both the boy and his mother, not printed in the final version of the article, was as follows:

- When I'm feeling sad
  We go and ring up Dad
  I just tell him about it
  Then I don't feel so bad.

While the lyrics simply convey a message about coping with a difficult situation, it can be argued that the role of the music therapist is not to presume the feelings or reactions of patients and their families but rather to provide opportunities for the expression and clarification of these feelings and coping strategies.

While it is relatively apparent when a child is having difficulties with adjustment to their hospitalization through such responses as not speaking or only speaking to particular people, refusing play opportunities, mobilizing at a lower level than their ability and demonstrating flat or low affect, the team might consider that “Successful adjustment is achieved when the child demonstrates skills in communication, play and perception consistent with skill levels prior to the injury, and when the child demonstrates verbalizations, interactions and other social skills as appropriate to chronological age and temperament” (Edwards, 1998, p. 22). The music therapist, therefore, has a role to understand from the perspective of the family, whether the child is interacting within their pre-hospital norms for communication and other behavior.

In researching children's reactions to hospitalization, a number of studies have sought to identify the factors that can contribute to fluctuations in stress response. Jay, Ozolins, Elliot & Caldwell (1983) for example found that for children with cancer coming into hospital for painful procedures, the age of the child, the number of previous medical procedures experienced, and parental anxiety in relation to the treatment were the main predictors of distressed behaviour in the child.

Other studies have investigated populations of hospitalized or ill patients in order to study effects on a particular group of hospital experiences and treatment. For example, differences have been found in the ways acutely ill and chronically ill children appraise stress (Bossert, 1994). Chronically ill children appraised intrusive events as more stressful, and acutely ill children appraised physical symptoms as more stressful. Children who had high trait anxiety (that is the anxiety that is part of individual temperament or personality, not situational anxiety) were more likely to appraise hospitalization as stressful. Gender was not significant (Bossert, 1994). Therefore, the
individual's inherent traits interact with their environmental situation, providing a complex picture of interactions.

Within the domain of clinical practice, the music therapist's role is important in helping to clarify what it is individual children are experiencing or finding stressful about their hospitalization rather than using generalized evidence to predict which aspects of treatment will be difficult for certain children. The role of the therapist is to assist the child's integration and management of these experiences as well as to communicate relevant aspects of the child's emotional state to the team.

As an example, I was asked to see a boy, seven years of age in one of the isolation rooms in the burns unit. He had contracted an infection and his ongoing treatment was to be delayed until the infection was cleared. I gowned up in the anteroom between the corridor and his room, and prepared the keyboard (which included covering it with two big sheets of plastic taped around). He had been told who I was and why I would be coming to see him, so I had a brief discussion with him about music therapy and what might be possible in our time together. When I suggested writing a song he was delighted and we decided to start writing some lyrics and add the melody later. He wanted the song to be about himself. We wrote the first line as 'My name is ——' and then I offered 'and I am . . .' and he said 'a person'. I was able to take this information back to the team with regards to how he was perhaps feeling his isolation as acutely depersonalising and needed more opportunities for interaction and support including ongoing music therapy sessions.

Music therapy practitioners can have a key role to assist children to manage their reactions to hospital and treatment (Daveson, 1999; Edwards, 1999b; Kennelly, 1999). Music therapy interventions within this setting have been described as addressing children's needs for comfort, support and self-expression (Dun, 1993; Robb, 1996).

Robb (1996) described the work of song writing as beneficial to facilitate burn patients capacity to cope with their hospitalization and treatment. In terms of the components of stress being managed for children in working with songs she noted that '... there has been a tendency within the medical community to place physical and emotional stressors in separate categories, it is becoming more widely understood and accepted that psychological and physiological components of health cannot be separated' (p. 31 & 32).

The role of the music therapist in supporting and containing children's anxiety reactions when preparing for or when experiencing medical procedures is a crucial area in this context. Children's fearful responses to procedures in the hospital setting are sometimes termed "procedural anxiety" or "anticipatory anxiety". Some authors have described this as "conditioned fear" (for example, Smith et al., 1996); that is, the child's repeated experience of this event contributes to a reaction of fear irrespective of the exact nature of the procedure, its level of intrusiveness, or its consequences.

The qualified music therapist's role is to assess and alleviate anxiety reactions through a process of providing children with opportunities to express feelings, receive support for these feelings and to have the opportunity for creative fun and play (Dun, 1993; Froehlich, 1984). Clinical reports and outcomes of empirical studies have considered that the music therapist, as a person not associated with the medical treatment or procedures, can provide an additional comforting presence to calm and support the patient during medical procedures where music, whether improvised or pre-composed, is played live by the therapist (Chetta, 1981; Cowan, 1991; Dun, 1995; Edwards, 1995, 1998; Lane, 1993). The use of music has been described in management of anxiety prior to surgery (Albridge, 1993; Robb, Nichols, Rutan, Bishop, & Parker, 1995) and to help in the management of anxiety resulting from isolation for infection control (Brodsky, 1989).

The use of children's own songs, whether improvised, parodied from existing songs, or co-composed with the therapist, as a means to express, process and work with difficult material for hospitalized children has now received extensive attention in the published literature (Aasgaard, 2001; Abad, 2003; Edwards, 1998; Hadley, 1996; Kennelly, 1999; Kennelly, 2001; Ledger, 2001; Turry, 1999; Turry & Turry, 1999). This important and growing body of writing about this way of working with patients helps to develop and promote the role of music therapy for children who are hospitalized. As we, both as individual practitioners and also as practitioners who consult with and guide each other, commit to uncovering and explicating the details and procedures of our work, our role as creative arts professionals assisting children to deal with and manage difficult experiences is strengthened (Daveson & Kennelly, 2000; Kennelly & Brien-Elliott, 2001).

A Role for the Music Therapist in Assisting in Pain Management

Key informants for practice interventions to contribute to pain management are psychological theories of pain experience and the role of music in decreasing pain (Han, 1998; O'Callaghan, 1996). For the music therapist, understanding pain reactions of the patient and providing effective interventions to support other therapeutic interventions for pain management (for example, pharmacological) need constant refinement and updating in this work.

The music therapist can have an effective role in contributing to decreases in the pain status of the patient. With regards to pain experience, it is not simply a matter of addressing the individual child's psychosocial needs or taking up a humanitarian position in working to reduce pain in the pediatric patient. As P.J. McGrath has noted in a review of research studies, there is excellent evidence for the role of pain reduction in improving total health outcomes in children (P.J. McGrath, 1996, p. 63). Therefore, the music therapist is concerned to not only reduce anxiety, pain, and discomfort during
procedures, but also to provide clinical interventions that ultimately contribute to the overall health outcomes of patients.

A study I have often cited to both describe how music therapy is used and the outcomes that are possible is by Malone (1996) who observed the frequency and degree of behavioral distress in 20 patients aged seven years or younger who received music therapy during a needle insertion. The music therapy intervention consisted of the therapist (Malone) singing nursery and childhood songs to patients during these procedures. Significantly fewer signs of distress were observed in children who were in the music treatment group as against the control group who received no music. This study indicated that music therapy had a positive impact on the children, family members, and the health workers administering the treatment.

Singing and music listening are strategies well documented by music therapists for use in assisting children who are in pain (Daveson, 2001; Edwards, 1994; Han, 1998; Loewy, 2001; Turry, 1997). This work has included description of attendance of the music therapist during burn treatment procedures (Daveson, 1999; Edwards, 1994; Edwards, 1995) and other medical procedures (Malone, 1996; Turry, 1997). Music therapists have also described the use of techniques such as counting down to the injection or other control techniques that can assist in addition to the use of musical materials (Loewy, MacGregor, Richards & Rodriguez, 1997).

There is evidence to support the role of the music therapist in helping patients feel less anxious in the preparation phase prior to surgery (Robb et al., 1995). Twenty patients between the ages of eight years and twenty years who were awaiting reconstructive surgery received either the music assisted relaxation (treatment condition) or the usual preparation for surgery (control). Results indicated significant reduction in measures of anxiety on the State portion of STAIC for the treatment condition however no differences in physiological response were indicated for either group (Robb et al., 1995).

Music therapists are, however, required to be cautious regarding their use of music in pain management. Two important considerations have been proposed in the use of such distraction techniques. The first is that distraction is considered to be best conceptualised as a coping strategy. That is, pain may become more tolerable but may not be less severe in intensity (McCaffery & Wong, 1993). Concerns have been raised that if clinicians observe a child to become co-operative that this behaviour could be erroneously interpreted as a reduction in pain so that pharmacological interventions of benefit might be inappropriately withdrawn (McCaffery & Wong, 1993).

In some of the early work at RCH, staff had previously used music whether from the radio or tapes in the background during procedures, and it was important to differentiate the role that I would have in offering music during procedures. I was aware that some research had shown that music listening does offer benefits when used by non-music therapists (for example, Fowler-Kerry & Ramsay-Lander, 1990) and that children can be encouraged by non-music therapy professionals to use music listening to place pain at “the periphery of awareness” (McCaffery & Wong, 1993, p. 312–313).

Early on in this work I sometimes felt quite challenged by my colleagues’ discussion with me of the music listening they offered to children, especially when it was presented to me as a reason not to include me in a treatment procedure for a child. In retrospect, however, I feel that colleagues wanted to offer children something good during difficult procedures (that must be acknowledged can also be difficult for staff) and, when there was no music therapist, music was seen to have intrinsic properties of usefulness and support which in turn prepared staff to accept that what I offered might also be useful.

The role of the music therapist in pain management is to consider the ways in which they might be able to understand, as best they can, the circumstances of the patient’s experience with an openness to the possibility that the way the patient felt or behaved yesterday may not be indicative of their feeling state today. Malone’s study (Malone, 1996) shows that with simple, reliable observation techniques, information regarding changes relevant to music therapy can be obtained and the emerging wealth of case literature indicates that music therapy may be beneficial in assisting children to feel supported during treatment procedures that involve painful or distressing aspects.

The Contribution of Developmental Theory

As stated earlier, developmental theory assisted my conceptualization of the needs of children and the ways I might develop a role in responding to these needs. Children are in a constant process of development; in cognitive, physical and emotional domains. The experience of illness or injury, hospitalization and treatment impacts and intertwines with this process for each child.

A developmental model proposes that the child’s developmental stage and developmental needs can both inform the practice interventions of the music therapist, and be impacted by the interventions of the music therapist. Aspects of children’s behavior and experience within the context of hospitalization are referenced to developmental theory by the music therapist working with children who are hospitalized (Barrickman, 1989; Robb, 1999). In addition, some music therapists (e.g. Kennelly, 2000) have outlined a role for the music therapist in assisting in hospital based developmental programs for children and infants whose hospitalization has limited their attainment of developmental milestones.

The developmental approach recognizes that children are continually learning, developing, and adapting in their interaction with their environment. This theoretical knowledge about children’s approach to new situations can be used to assist understanding of how children’s age and developmental stage might influence the way they react in particular contexts,
as well as to inform the approach taken in offering music therapy.

Piagetian theory has been proposed as useful to conceptualizing the child's cognitive development in relation to health care (Gaffney, 1993) as well as in music therapy with hospitalized children (Robb, 1999). This developmental approach in the children's hospital context recognizes that "children actively construct their own views of the world and assign their own meanings to events rather than passively assimilate an increasing degree of information with age" (Gaffney, 1993, p. 75).

As an example of children developing their own understanding of what is happening around them, a four and a half year old patient I was seeing would refer to the psychiatrist as the "worry doctor". I suggest that he was aware that this doctor mainly talked with him and perhaps asked him questions such as "Is anything worrying you at the moment?" This same patient, after I exclaimed, "Wow, that's healed so well" about his skin when bandages were removed before a procedure, asked me, "How would you know?" I think this child had a capacity to organize all of the hospital professionals into categories, placing me in the category of someone who knew about songs but not about skin, and perhaps I have to confess to knowing as little about skin as it was possible to know in that context.

Lansdown (1996) considered that the difficulty in understanding what children know about their hospitalization and treatment may not lie in limitations to their understanding but rather, sometimes, children's verbal expressive limitations resulting in "... adults' inability accurately to discern what [children] ... think" (Lansdown, 1996, p. 43). The role of the music therapist is often to provide credence to the child's perspective as personal, unique, and appropriate rather than using preconceived expectations as to how the child will respond.

Following the earliest sensory motor stage, Piaget's following three stages of development are Preoperational, Concrete operational and Formal operational. In the preoperational stage, nominally from age 2–6 years, Gaffney proposed that children are more passive and reliant on others to cope for them. She concluded that children at this stage benefit from the presence of a supportive parent while in the hospital setting. Children in this stage have been noted to use single word descriptors with "simple sensory aspects—sore, hurting, bad, small, big" (Gaffney, 1993, p. 82) to describe pain experience. It is therefore suggested that clinicians should use questions such as "Show me where it hurts" rather than "Tell me about your pain" (Gaffney, 1993, p. 82).

In the concrete operational stage the child becomes more active in their understanding of pain, understanding that pain is "something you feel rather than something you have" (Gaffney, 1993, p. 83). The child broadens their understanding to include affective components of pain, for example feeling sad or worried. The music therapist can therefore expand upon this by using songs and improvisation opportunities around feelings and help children to express and identify feeling dimensions of pain experience.

In the formal operational stage, the capacity for introspection and abstraction emerges (Gaffney, 1993, p. 83). In this stage, the child can understand psychological aspects of their pain experience, rather than only the physical aspects.

In the work of the music therapist in the children's hospital setting, this information can be used to help understand the needs of the child in relation to developmental stage and to prepare and plan music therapy interventions and supports that are appropriate to the cognitive stage of the child. For example, children in the concrete operations stage may be given quite structured, achievement-oriented opportunities within music therapy sessions, for example learning an ostinato pattern to play on a melodic instrument during the singing of a favourite song.

During a supervisory session, one of the music therapy students explained to me that this idea was used when working with a young patient around the age of the concrete operational stage who was upset about her father not being able to visit. The student music therapist asked, "How long is it until your father will come and visit?" instead of a question incorporating the child's feelings around the anticipation of the visit. This allowed the child to answer the question and continue talking about the experience rather than a direct feelings question that may have interrupted the flow of discussion around the father's absence.

This is not to imply children at this age cannot manage discussions of feelings, but rather that the therapist must be considerate of the way these feelings might most usefully be elicited.

Developmental theory has been an important informant in developing a role for the music therapist at the hospital. It is not possible to view this theory discretely from the other role informants in this work. In addition, there are important contributions theoretical discussions of musical stages of development that also became useful in the music therapy program to understanding interaction between musical development and other developmental domains (for example, Briggs, 1991; Loewy, 1995).

The Integration of These Roles

The following is an example of the ways in which the music therapist has a role to support pain management objectives of the team, to acknowledge and manage children's distress, and to facilitate coping by considering developmental factors.

In a previous description of a single session (Edwards, 1995), a parody of the Beatles' song "I get by with a little help from my friends" assisted Ivan, a boy of twelve years with burn injury, to participate in a treatment procedure. In previous weeks of treatment the boy had been described as cooperative, however, his protest at this procedure towards the end of his stay in hospital perhaps suggests that the anxious...
anticipation of procedures might be tinged with perhaps too much prior knowledge of what the procedure involves and a response of "treatment fatigue". In the paper published on the session with Ivan, music was described as acting as a "bridge" to facilitate a transition from anxiety to calm; as he stopped protesting and participated in the procedure when I continued to sing and play. A key learning moment for me in the case though was that the next day when I approached Ivan, he did not want to participate in music therapy. I realised that the day before he had needed something to help him feel supported and psychologically capable of undergoing the procedure, and the next day he did not. Developmentally he had seemed much younger than twelve years on the day of the treatment procedure before whereas the next day he seemed a confident, twelve year old, able to manage more independently.

This early case was important for me in being able to conceptualize and work further with single session interventions, which are at times unavoidable. Ideally, the music therapy session is set in advance and this did occur with greater frequency in the hospital, and it happens more readily with established programs.

Conclusion

It is important that music therapists continue to examine, develop, and promote their role within the care of the hospitalized child. This writing has, for convenience, outlined discrete roles for the music therapist; however, when responding to a referral, all of this knowledge and experience is brought into play and integrated in making the best work possible to assist the child. It is not possible to think of the child in pain as devoid of a psychological component to their experience; by the same token it is not always possible to tell if a child who is distressed is experiencing physical pain or not and the techniques and responses used in music therapy are sometimes indistinguishable between these contexts.

The needs of children receiving care in a hospital and the role of the music therapist in addressing these needs are clearly open to further consideration through research, debate, and ongoing thoughtful reflection. My own reflections presented in this article have certainly not been comprehensive of the many models of practice available to the hospital based music therapist, however they do represent the cornerstones of early stages of the development of ideas around this particular program.

As a music therapist who spent many years supporting hospitalized children and their families in times of difficulty, I suggest that the role of the music therapist is emergent and responsive rather than defined and certain in each and every circumstance of attending a procedure, working with at the bedside or during a regular, scheduled session.

Music therapists working with hospitalized children may find aspects of psychological theory useful to inform and deepen their understanding of the work, however, they may also explore other informants relevant to the context and culture in which they practice. In re-reading the literature for this paper, I was aware that our writing about the work has included important reference to clinical outcomes, but perhaps it is a challenge for us to consider how to further integrate the way we use our own countertransference responses into our writing about this work so as to provide further opportunities to reflect on the ways the therapist uses self and self-experience to inform and guide responses to the patient. In addition, while the imperative of evidence based practice is powerful, at least in the present climate internationally (Edwards, 2002), we must remember that human experience has always included the singing of songs and the telling of stories and will continue to do so whether or not there is evidence to point to these behaviors as contributors to clinical outcomes.

References


