Music in Hospitals: Anatomy of a Process

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Declaration

I declare that this thesis consists entirely of my own work, except where explicitly stated to the contrary. The thesis fits within the prescribed word limit of 100,000 words, excluding the Appendices.

[Signature]
Acknowledgments

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Abstract

The research engages with the increasing interest in the application of music in community health contexts. Previous research has tended to have a singular focus (such as on the effects of selected music on individual patients in a clinical setting) and to under-represent the role of the musician. Accordingly, the thesis sought to understand the nature, process and impact of live music in a hospital context from the perspectives of each group of stakeholders (musicians, patients, carers, medical staff and administrators). An initial web-based survey of music in hospitals led to a preliminary observational and interview study of eight musicians working in hospitals for a leading UK charity. The emergent data from these two sources was juxtaposed iteratively with related research literatures to explore the perceived reasons for musical intervention in clinical settings and the reported effects on the different groups of participants. The main fieldwork phase was a month-long qualitative study of a group of nine musicians in an Italian paediatric hospital, selected because it was relatively unique in offering a sustained programme of forty-five hours of music each week across the year for its patients. The fieldwork embraced observations of 55 musical interventions with 162 children (totalling 36 hours and 40 minutes) using a specially designed observation schedule, supplemented by video recordings and 68 interviews with members drawn from each participant group (musicians, patients, carers, medical staff and administrators). Subsequent thematic analyses - informed by grounded theory and systematic content analysis using Atlas.ti software - suggest that provision is generally valued by participants and, overall, having a positive impact on patients and hospital environment. Nevertheless, the Italian data suggest that there are also perceived negatives in such multi-faceted provision, related to the choice and variability of repertoire, musicians' relative status, available monitoring and support, and the often stressful nature of the work. Implications for policy and practice are discussed.
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Part 1. Setting the research context
Chapter 1. Introduction

1.1 The context for this research: My personal experience as a ‘musician in hospital’.

'Anna, 3 years old and affected by Down syndrome and now also by leukaemia, had to undergo bone marrow aspiration'. When she had previously heard music in the clinic, she had always been very responsive and so, together with her mother and the doctors, we decided to play music during the aspiration to see if it could moderate her pain. I started playing guitar and singing to her when she was still in her room with her mother prior to treatment. I played relaxing songs and lullabies that she and her mother already knew and, even though she was aware of what would soon happen (one hour before the aspiration, nurses used to rub a special anaesthetic cream in the patient’s back), she seemed to be quite relaxed and enjoying the music. When the time for aspiration came, I went with her and her medical team into the operating theatre, continuing to play the guitar and,

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1 Bone marrow aspiration treatment consists of inserting a special needle into a bone that contains marrow and withdrawing the marrow by suction or by coring out a sample. (http://www.medicinenet.com/bone_marrow/article.htm, retrieved on 27 July 2008).
according to her mood, humming or singing. Although I could see that she was very frightened, she was still listening to me and she was not crying. I continued to play throughout the treatment, during which she continued to listen to me. Doctors said that she was relaxed and that the aspiration had been faster and easier.’ (C. Preti: Case study notes, February 2002).

Figure 1.2 Music in hospitals: Music in the ward

‘Antonio, 14 years, loved an Italian pop group called ‘883’ and, whenever I walked into the room, the first thing that he used to do was to ask for their songs. Most of the nurses got to know some of the refrains very well, as Antonio used to play the songs endlessly on CD. Nurses and doctors used to make fun of his musical ‘obsession’, but whenever I was in his room, his enthusiasm attracted other children and they often moved into his room with their parents to sing with us. I remember these moments as extremely enjoyable and liberating for children, parents and myself. We were all singing together, sometimes changing the words to make the lyrics sound ridiculous; Antonio played along with us, always smiling and giving space to other children’s musical choices as well. I have often left his room with a feeling that the mood in the ward had changed and that something positive had happened.’ (C. Preti: Case study notes, February 2002).

Anna and Antonio are among those children who experienced a ‘musical hospitalization’ in the Meyer paediatric hospital, in Florence where I have worked as a professional musician for five
years. In both cases, music seemed to be an effective tool to reduce pain, anxiety and stress connected to the hospitalization process and to create musical interactions between children, parents and nurses within the hospital setting. Although the initial focus might be described as 'therapeutic', the overall experience would seem to integrate educational elements and support musical development, as well as fun (Preti & Welch, 2004).

The photographs above point up a variety of interactions that take place when music is played in the hospital. In Figure 1.1, the child patient is engaging with the musician whilst the parent looks on and encourages her musical participation. In Figure 1.2, a nurse is holding a child whilst they listen to the music, doctors standing behind and joining in as part of the collective experience, parents looking at their child with smiles on most of the faces (Figure 1.2). The atmosphere could be described at least as ‘different’ from what might be expected by looking at a customary snapshot of a hospital ward. Even if some of the children are receiving their treatments, they still seem to be able to engage with the music alongside the parents and nurses. The ability of the musician to create a trusting and safe environment where they play and sing together with the children is a valuable occasion for the all the participants to break the hospital routine and to forget, just for a brief time, where they are and why.

Music, in this context, appears to bring together groups of people that are in the hospital for a variety of different purposes. It can be interpreted as a positive distraction, as sheer entertainment. But besides the social engagement that music promotes in such a setting, there are some important ‘therapeutic’ effects which contribute to calming and relaxing both participants and the environment itself, as a result. These effects have been widely documented in the literature. The vast majority of the studies (see Chapters 2, 3 and 4) focus on the measurement of single variables such as pain, anxiety, stress and their relative decrease after a musical intervention. A less consistent number of researches have focussed on the analysis of the social dynamics that take place in a hospital setting whilst live music is played. In fact, even though music may be used primarily as a form of distraction for the patients (children), other people are directly or indirectly involved in this process, such as carers, doctors and nurses. The effects that music has on the children interact and become interwoven with the effects that music has on those adults present and vice verse. Different interactions are important variables arising within the musical process.

The interest in this research derives from my personal experience as a musician involved in a relatively unique project in the oncology ward of the Meyer paediatric hospital, a renowned specialist hospital for children in Florence.

The project Musica in Ospedale (music in hospital) has been funded by a charity, the Fondazione Livia Benini, since 1996, as part of a wider programme on the control of pain in children, based both on pharmacological and non-pharmacological techniques to reduce pain, stress and anxiety in the hospitalized child (Fondazione Livia Benini, 1990). The music programme was initially limited to the hospital's oncology ward. At the time of its inception, the
oncology ward was relatively isolated from the rest of the hospital in a depressing physical environment. Because of the nature of the illnesses involved, children would spend a lot of time in the ward undergoing treatments. Positive distractions were, therefore, seen by members of the hospital medical team as essential in order to break the rhythm of the hospital routine and to foster, and in some cases rebuild, emotional relationships, both between the children and their parents and also with the clinical environment.

Before the project started, the Fondazione Livia Benini supported the specialist training of a musician in Paris with Musique et Santé, a French association that had been undertaking musical projects within paediatric hospitals in France since the early 1980s. This musician then trained, in turn, two other musicians (including me), neither of whom had experience of music therapy per se, but both of whom had teaching experience. Together, we focussed on the development of a range of musical interventions and activities that included playing songs with guitar and simple percussion accompaniment.

The locations in which music activities and interventions took place were spread throughout the oncology ward and included: rooms for single/double occupancy, isolation rooms, the ‘day hospital’ and a large communal waiting room. In the ward there were an average of 40 children that kept returning for treatments and periodic checks. Consequently, the musicians got to know them all very well. The structure of the musical interventions was designed to be flexible. The musicians played five days a week and some weekends, if none of the additional voluntary associations were available for the weekend duty. Each of the musicians had a fixed day and a fixed time in the morning, afternoon or evening. However, within these periods, there were no fixed limitations of time for the musical activity. An intervention could be short, such as five minutes, or much longer, such as an hour, depending on the particular conditions of the children. The duration of the intervention depended also on the attitude of parents and carers because if they were tired or under pressure, music could easily be perceived as confusion. Every fortnight the musicians met to plan the programme for the following two weeks. Sometimes, the ward’s psychologist joined the meeting to offer suggestions for particular musical approaches for individual patients.

In this context, music ranged from being used as a means of distraction, an enjoyable social interlude, without any predetermined therapeutic goals, to something more specific that was focused on the needs of particular patients, carers and medical staff at a moment in time, such as in Anna’s case above. Thinking back on those experiences, it seemed that the team of musicians drew on their extensive craft knowledge to take important variables into account in the design of the musical provision. In retrospect, it suggests that these variables included (most notably) the age and sex of the children; their socio-cultural background; the nature of their illnesses (the presence of pain, motorial, and/or psychological conditions); the intervention context (such as group size, time of day and specific hospital location); the degree to which the
choice of music was familiar; their experience of previous musical interventions (often linked with age) and the carers’ ability to respond and interact with the musicians and the children.

Throughout, the use of music was professional in its approach, notwithstanding the lack of formally qualified music therapists or psychotherapists with a musical background being employed in the project (and contrary to the different trends evident in customary music therapy: cf. Bunt, Pike & Wren, 1987; Bunt 1997). In Florence, children were placed ‘in control’ of the musical intervention and they decided whether they wanted it (or not) and for how long the musical activity should last. This central patient-derived organisational feature represents one of the main differences between the approach taken by Musica in Ospedale compared with much traditional music therapy. Nevertheless, in common with music therapy, the ‘music in hospital’ programme embraces Pavlicevic’s view (1985: 157) that ‘the essence of the therapeutic musical relationship is its quality: the more trusting, reciprocal and creatively free it is, the more stress and change it will have to undergo, and the more profound the healing will be.’

Throughout the years since 1995, doctors and nurses, as well as children and parents, have reported the positive effects of music in this setting in the creation of a friendly, distractive and relaxing atmosphere. One measure of the project’s success is that, from 2003, financial support has shifted from the original Foundation to the hospital itself and the musical provision has now been extended to embrace the whole hospital.

My personal experience as a working musician in a hospital was the starting point for the research. I was interested as to whether my own experience was relatively unique and whether there was any evidence to suggest that the provision of music in hospitals was a clearly understood phenomenon. Consequently, my research journey (organised in this thesis into four ‘Parts’) has embraced (1) an initial exploration of similar provisions in other hospitals (as evidenced through the web-based survey and the interviews with musicians working in this field in the UK), (2) a review of related literature, (3) extended fieldwork in the Florentine setting as a researcher rather than practitioner and (4) a reflective synthesis of these different evidence bases. The text that follows contains chapters that are organised under these four main headings. The overarching foci for the research and the methods adopted are summarized in Table 1.1 and reviewed in the section that follows.
1.2 Research aim, related questions, and chosen methodology

The overarching aim of this doctoral study is to understand more clearly the nature of music provision in a hospital setting, and the perceptions of its effects through an exploration of previous research as reported in diverse literatures and new empirical data.

Two main research questions are addressed, each with a subsidiary question:

1. What happens when live music occurs in a hospital context? What are the possible characteristics of an 'effective' musical intervention?
2. What is the value of offering a musical programme in a hospital setting? Who benefits (if at all) from the musical intervention?

1.2.1 What happens when live music occurs in a hospital context? What are the characteristics of an ‘effective’ musical intervention?

In order to answer question 1, the research process began with an exploratory web-based search of the provision of music in hospitals as advertised by the hospitals or by the organizations managing musical events in hospitals. The aim was to develop a clearer view of what counted as a musical intervention in such settings, and whether there was a univocal emerging view amongst the reviewed programmes. The emergent data, allied to my own experience in Italy, suggested that some of the charities and associations offered a formal preparation to prospective musicians. Consequently, I became interested in finding out more about the musical and personal characteristics that were perceived to be essential in order to become a ‘musician in hospital’.

I then searched for an organization that was similar to the one that I had worked for in Italy, but I was unable to find a similar musical programme in the UK. The closest example that I was able to find was represented by the established UK-based charity Music in Hospitals, although the activities of the charity were primarily focused on offering musical concert-type performances, rather than interactive musical activities with individual patients. I investigated

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2 By ‘intervention’ is meant a live music session that musicians perform in the hospital. The term is specifically used to indicate the musical activity taking place in the paediatric hospital in Florence where the main fieldwork occurred.
whether the charity had explicit criteria to identify a successful ‘musician in hospital’. From a preliminary analysis of their promotional videos and brochures, their musicians appeared to have a role in which they were engaging with the audience at different levels other than the purely musical. The audition process, alongside data from two interviews with the Chief Executive, provided insights into the somewhat unspecified criteria that the charity used when seeking to select their prospective musicians. However, subsequent interviews with practising musicians who worked for the charity provided a different insight with respect to the intended outcomes of their musical activity in the hospital. Their comments focused on how the role embraced both personal and professional aspects, with implications in relation to their identities as ‘musician in hospital’, including evidence of their moral values and personal rewards from playing in such a setting (see Chapter 2, section 2.3).

Moreover, by observing the interaction between the interview panel and the musicians (during the audition process), and from the interviews with the musicians, it emerged that crucial elements for the reported and observed success of the musical performance were the interaction between the musician and the audience, and the audience’s response to the music. It appeared that music in hospitals, at least for these particular musicians, was more of a collective process, involving a shared experience between the musician, the ‘audience’ and the hospital staff, rather than ‘just’ a musical performance. Their comments resonated with my experiences in the Italian hospital, although the formal and musical details of the two activities (in the UK and Italy) were different. For example, in the UK the focus was usually a one-off concert-type performance either in a nursing home or in a hospital setting, where the musician dressed up formally for the concert. In contrast, in Italy the musical programme was seen as a regular set of interventions in a paediatric hospital, six days a week, where the same musicians performed according to a formal timetable.

The case study of the UK charity Music in Hospitals, together with my personal experience as ‘musician in hospital’, and the information from the web-based survey about the music in hospitals programmes constituted the starting point of the research. The literature reviews followed (see Part 2 and Table 1.1) as more information was needed about any previous studies concerning music and the hospitalization process (such as from the perspective of the children, their carers and the hospital staff) in order to ensure that the doctoral research had a credible and situated academic basis and was subsequently able to demonstrate a clear contribution to knowledge.
Table 1.1 Overview of the links between research questions, methodologies, research progress and design of the thesis

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The literature reviews revealed that in none of the literature sources, nor in discussion with the UK musicians, was there any evidence that explained the actual processes and inherent interactions that take place over time when music is provided in a hospital context. Consequently, it was necessary to undertake a period of extended fieldwork in the Florentine hospital in order to record moment-by-moment action and interaction between the musicians and the other people in the hospital (see Part 3, Chapter 5 for more details of the actual research methodology employed). The choice of Florence was justified both by my extended knowledge of the hospital setting and by the kind of ‘regular’ musical activity taking place there. Also, my familiarity with the cultural context was considered to be an advantage in understanding the musical and other-than-musical interactions among musicians and the ‘audience’, not least because I was working in my mother tongue.

1.2.2 What is the value of offering a musical programme in a hospital setting? Who benefits (if at all) from the musical intervention?

In order to answer question 2, concerning the possible value of offering a musical programme in a hospital setting - including its benefits to participants - evidence was drawn from both (i) literature sources and (ii) a synthesis of the experiences of various participants involved in music in hospitals programmes, from the UK and Italy fieldworks. These sets of evidence are collated in the concluding section of the thesis, Part 4, Chapter 8 and conclusions.

To summarize, Chapter 1, sets the context for the research, introducing the Florentine project and the initial difficulties of undertaking fieldwork in the UK. Chapter 2 deals with the identities and motivations of musicians who play for the UK Charity Music in Hospitals as well as a web-based survey of existing provisions for music in hospitals. Chapter 3 is a literature review of the effects of hospitalization on children and their families. Chapter 4 presents a review of the significance of music in human lives and music's adaptive value to contextualize the impact of music on hospitalized children. Chapter 5 introduces the main fieldwork (in the Meyer paediatric hospital in Florence, Italy) and illustrates the research design. Chapter 6 reports the analysis of the fieldwork collected from the musicians playing in the Meyer paediatric hospital in Florence, while Chapter 7 reports the analysis for the children, their carers, the hospital staff and the administrators involved in managing the project in the Meyer hospital. Chapter 8 is the discussion chapter followed by conclusions and recommendations. Table 1.1 outlines how these chapters address the research questions of the thesis.
Chapter 2. Identities and motivations of musicians who play in hospitals: Fieldwork, literature and synthesis

2.1 Introduction

This chapter reports two empirical studies: (i) a web-based survey of existing 'music in hospital' activities exploring the nature of associations promoting such activities and (ii) initial exploratory fieldwork in the form of an in-depth case study of the UK-based charity Music in Hospitals and eight of its musicians, outlining their musical and personal backgrounds as well as their motivations, attitudes and expectations. The chapter presents evidence to suggest that a musician playing in a hospital is an emerging professional figure and, at present, under-researched.

Previous research in the fields of music therapy and music medicine indicates that music can be an effective means of decreasing the perception of pain among hospitalised children (Chetta 1981; Froehlich 1984; Curtis 1986; Aldridge 1993). The majority of this evidence, however, focuses on the child/patient without taking into account the role of the musician and the interactions, social and otherwise, that stem from the musical process. This bias in reporting is mainly due to the fact that, in these studies, music is perceived as something that stands in its own right without being too much connected with the role of the players. But music in the hospital appears to be a multifaceted process, involving not only the music played and the patients who are listening, together with their carers and medical staff, but also the performers (Daveson 2001). For example, through their performance, musicians play a leading role in the communication of emotion, fostering an emotional response in the listeners (Gabrielsson, 2001; Juslin, 2001; Miell et al., 2005). Consequently, it may be that much of the success of such live musical interventions depends on the player’s ability to interact positively with the children/patients, whilst also responding meaningfully to the hospital environment. Despite the fact that there are quite a number of studies on musician’s personalities (Kemp, 1996; Parnicut, 2002; Davidson, 2004; Pitts, 2005), the particular category of ‘musician in hospital’ appear to be under-researched and under-theorised.

Of the limited previous research, what it is known about these musicians is that they frequently do not have a music therapy background and that their stated purpose within the
hospital is primarily to entertain children, carers and staff (Lindsay 1995). They do not necessarily play regularly in hospitals, for this is not their main employment, but they are not employed on a voluntary basis either. Moreover, musicians in hospitals make up a fairly new occupational group, with the result that we do not know very much about particular practical aspects of their work, least of all if their activities are generalizable.

As explained previously, the literature available has not been sufficiently focussed on this professional group to enable an initial portrait of musicians who play in hospitals. Accordingly, two studies have been conducted in order to address the lack of research and to explore: (i) a sample of associations and charities involved in the organization of ‘music in hospital’ performances, their motivations and different approaches in undertaking what could be described as a ‘philanthropic’ activity; (ii) the different approaches of such organizations towards the necessity of a specific training of musicians prior to their actual employment and consequently the selection criteria adopted in selecting participant musicians; and (iii) personal and professional identities, motivations and beliefs of a sample of freelance musicians who play in hospitals. All the documents were collated for textual analysis using Atlas.ti (version 5) (Atlas.ti 2005), a qualitative data analysis package for textual and video data. What follows is a methodological description of both studies and a discussion of the findings in relation to the three questions posed at the beginning of the chapter.

2.2 Web-based analysis of music in hospitals programmes

The first study was a web-based search that was conducted in order to draw an initial map of the organizations involved in providing musical activities in hospitals. The main aims were to gather a general perspective on: (a) existing musical activities across different hospitals; b) the nature of a sample of associations involved in providing music in hospitals activities.

In reporting the history of ‘The Bing Music Series’ at Stanford Hospital and Clinics, Clawson observes that ‘although hospitals rarely provide a formalized programme, music has been used in therapeutic settings in America for almost 200 years’ (http://news-service.stanford.edu/news/2001/march21/bing.html, retrieved on 23 August, 2008). The majority of musical interventions analysed, though, seems to have started relatively recently around 2000. In the era of ‘hospital excellence’ - where health care structures are experiencing a progressive privatization and consequently patients with the means are able to choose where to be treated on the basis of the perceived quality and variety of services provided by different
hospitals - musical interventions appears to have become a form of luxury accessory that hospitals tend to advertise on their websites and on various brochures as a distinctive activity (see section 2.2.1). Therefore, an initial hypothesis was that those hospitals who did not advertise such activities were either unlikely to have the necessary funding to run them or did not value this type of provision.

Music programmes were selected as a result of a key-word search run through Google which included the following combinations: 'music in hospital', 'music in hospitals', 'hospital music', 'hospital with music', 'musicians children hospital', 'children's hospital music', 'children hospital bedside music', 'music programme children hospital', 'music intervention children hospital', 'healing music children hospital', 'bedside music healing children hospital.' The results considered were those listed within the first 10 pages. The methodology presents clear and considerable limitations due both to the nature of the database (primarily US based that listed web sites on how often they get searched) and the use of English key-words that restricted the search mainly to United States and United Kingdom. This was not considered to be a crucial issue, as the aim of the investigation was more to gather a general sense of the kind of organizations that provided musical activities in paediatric hospitals (where possible) and the nature of such activities, rather than to carry out a comprehensive survey. Music programmes from France and Italy were also included as personally experienced by the researcher.

The total number of organizations reviewed was 39 (see Appendix A). Of these, 27 were hospitals hosting music programmes, eight associations providing music services in hospitals, and three specific training programmes available for aspiring musicians in hospitals. Hospitals were mainly based in US (18) and UK (5), two were from mainland Europe (2) and one from Australia (1). Associations and programme were represented both in Europe (7) and in US (4).

**Music in hospitals programmes**

Hospitals programmes were analysed according to:

- Nature of the programme (which had to be a music programme, even though several programmes applied the label 'music therapy' to indicate a music programme);
- Frequency of the musical intervention;
- Kind of musicians employed (professional or volunteer, trained or not trained);
- Variety of music(s) and instruments employed in the programme;
- Start date of the programme;
- Definition of the service as advertised in the web page.

Associations were analysed according to:

- Their stated aims;
• Activities offered;
• Selection criteria to employ musicians;
• Structure of their training.

2.2.1 Analysis of outcomes of music in hospitals programmes

There are four main typologies of musical interventions emerging from the selection of hospitals analysed.

(1) Bedside music

The first typology embraces 'bedside music' which is a regular, long-term, intervention either sponsored by the hospital or privately funded. Musicians 'make rounds' in the hospital, performing in some of the rooms, mainly on a one-to-one basis. The frequency of such interventions varies from six days a week (Stanford Hospital & Clinics, Ospedale Pediatrico Meyer, Italy) to five days (Thomas Jefferson University Hospital, Pennsylvania; El Camino Hospital Mountain View, CA; C.S Children Hospital, Michigan) to two days (University of New Mexico Hospital; Hopital de Saint Nazaire, France), and 'on request' mode (University of Rochester Medical Centre, NY; Flagstaff Medical Center, Arizona). Although their web sites state that they host a 'regular' music programme, most hospitals do not specify the frequency (Beth Israel, NY; Rady Children's Hospital, San Diego; Our Lady of Lourdes Medical Center, NJ; Golisano Children's Hospital, NY).

Musicians performing in such programmes are often: (i) certified music practitioners (ranging from music therapists, musicians for healing and transition programme (MHTP), and trained musicians in special programmes (see below)); (ii) voluntary musicians, such as professional musicians – like Una O'Donovan, former principal harpist of the Royal Philharmonic Orchestra in London and now volunteer musician at Cedars-Sinai as part of the Medical Center's 'Music for Healing' programme – or musicians from the community, as in Beth Israel, NY; (iii) professional musicians, as in the enlightened and resourceful Healing Arts Program at El Camino Hospital, CA, where seven semi-professional musicians are employed on a five-days-a-week basis in the 'Music as Medicine' programme, playing a variety of instruments and music, ranging from Latin and jazz to Celtic music to classical Spanish guitar and solo harp. The fact that the hospital is located in Mountain View, Google's headquarters, might induce
speculation about a flourishing fund raising activity that, being ‘tax deductible’, represents a privileged philanthropic activity for a variety of companies.

The modalities of bedside musical interventions embrace three main activities: (i) music performance at bedside on a one-to-one basis (Paige’s Music Programme at Children Memorial Hospital, Chicago; Golisano Children’s Hospital, NY; Stanford Hospital & Clinics; Cedars-Sinai, NY; Beth Israel, NY; University of Rochester Medical Centre, NY); (ii) interactive music, by giving young patients drums and little percussion instruments to join a music group (Ospedale Pediatrico Meyer, Florence; Musique à l’hôpital, de Saint Nazaire); and, (iii) in few cases, where a music therapist is involved in the programme, writing song lyrics to help children express fears and anxieties due to hospitalization (Children Memorial Hospital, Chicago; Children’s Hospital Boston).

The musical instruments employed in such activities are mainly guitar and voice (8) and harp (5), although the majority of hospitals are rather vague about the musical details of their programmes. Music ranges from familiar popular music (Musique à l’hôpital, de Saint Nazaire; Ospedale Pediatrico Meyer, Florence; University of Rochester Medical Centre, NY; Beth Israel, NY), folk music and American songs (Stanford Hospital & Clinics), Jazz, Rock, Classical (Northwest Hospital, North Seattle; Pembroke Hospital, MA; Maria Fareri Children’s Hospital, NY), to a more ethnic selection, such as the work of Sundiata Kata at Rady Children’s Hospital, San Diego, where a variety of instruments gathered from all over the world are used to ‘educate the patients with stories and let them play the instruments’ ([http://www.chsd.org/body.cfm?td=89](http://www.chsd.org/body.cfm?td=89)).

(2) Regular concerts in common spaces

Concerts usually take place in one of these areas: outpatient area, lobby, corridors, hospital atrium, auditorium. The frequency of the concerts varies from twice a week, like in the prestigious ‘Bing Concert Series’ at Stanford Hospital and Clinics, to once a week (Guy’s and St Thomas’, London), to monthly sessions (Pembroke Hospital, MA), to one week a year, as in the ‘Host music appreciation week’ at Northwest Hospital, North Seattle and to unspecified ‘regular’ sessions (Maria Fareri Children’s Hospital, NY). Concerts are usually targeted for patients, families and hospital staff.

Concert musicians are often (i) professional musicians coordinated by the hospital itself. In several cases, where funding is enough to guarantee a regular running of the concerts, hospitals establish a music programme coordinator responsible for the artistic programme (Stanford Hospital & Clinics; Guy’s and St Thomas’, London); (ii) music students from prestigious music schools, such as the Manhattan School of Music and Harvard students (Mihnue, that through their outreach programmes performs regularly in hospitals and nursing homes (Maria Fareri Children’s Hospital, NY; C.S. Mott Children’s Hospital, Michigan).
The selection of music ranges from classical music to a more mixed selection, including world music, country, pop, jazz. In some cases – where music seems to be given a relevant role – the hospitals have a grand piano in the lobby, like in the Maria Fareri Children’s Hospital and Stanford Hospital and Clinics.

(3) Special music events
These events are typically hosted in common spaces, their frequency is irregular and depend on the availability of funding. Special events often take the shape of (i) concerts organized by charities (see below) who employ musicians trained for this particular purpose. During such performances musicians communicate and engage with the audience through a broad range of music genres and sometimes through verbal interaction, introducing a piece and talking with the audience; (ii) specific projects, organized by either charities or hospitals themselves, involving musicians from established orchestras, like in the case of the Royal Hospital for Sick Children in Glasgow where musicians from the Royal Scottish National Orchestra hold performances and workshop for both children and staff, on an unspecified basis, or at Great Ormond Street Children’s Hospital in London, where a permanent creative project is hosted in partnership with the City of London Sinfonia every year for two weeks.

(4) Artist-in-residence programme
These programmes are usually sponsored by private foundations or charities that support an artist to be in a hospital for a fixed period of time to develop their work with children and to collaborate with hospital staff. Artists are often poets, sculptors, visual artists and musicians. Among the various hospitals hosting this programme, two hospitals have been found to have implemented such a programme with a music artist: Children Memorial Hospital, Chicago and Children’s Hospital, Los Angeles. In both cases, musical activities range from music workshops where children learn how to build and play musical instruments, to sessions where they write and record songs, to a one-to-one interaction at bedside where the musicians play for the child in a more intimate situation.
2.2.2 The nature of a sample of associations involved in providing music in hospital activities

Eight associations providing music services in hospitals, and three specific training programmes for musician in hospitals were analysed according to:

(1) Stated aims;
(2) Activities offered;
(3) Selection criteria to employ musicians;
(4) Structure of the training.

(1) Stated aims

Associations, charities and organizations involved in the provision of musical activities in hospital settings are keen to advertise their mission statements in order to be clearly identifiable among the numerous charities operating in hospitals. These organizations seem to have a common aim which is ‘to help people access the joy of live music’ as stated in the Live Music Now! web site (www.livemusicnow.org retrieved April 16th 2007) and ‘to improve the quality of life of adults and children with all kinds of illness and disability through the joy and therapeutic benefits of live music’ (www.music-in-hospitals.org.uk). The therapeutic potential of music and live music in particular, is acknowledged by each association. The musical experience provided is commonly defined as ‘exhilarating, educational and therapeutic’ (ibid) and it is considered a vehicle to ‘help aid the healing process, physical, mental and spiritual’ (www.musicforallseasons.org). Music is reported to ‘help calm patients, alleviate pain and help lift symptoms of depression’ (www.musiciansoncall.org) through the communication skills of their musicians using their high degree of musicianship.

For some organizations, such as Live Music Now! and Minuet, one of the stated priorities is to provide musicians with an occasion to develop professionally by performing in different settings. Despite not being mentioned extensively, this seems to be a relevant aspect in the life of all associations, as musicians are one of the main ingredients of such activities, even though it is not clear the extent to which organizations themselves impact – or are interested to do so – on the training of their musicians.

The idea that a musical intervention has to ‘bring out the person that is behind the patient’ (www.music-in-hospitals.org.uk) is also a central aim shared by most associations. Music becomes a powerful tool for distraction and patients ‘for a brief time, can transcend being in a healthcare facility’ (ibid), and ‘fulfil their innermost needs as human beings and thus facilitate the healing process’ (https://www.hcs.harvard.edu/~mihnuet/). The distractive element is part of a broader educational outcome, as the presence of an artist in the hospital becomes an
opportunity for privileged encounters with artistic creations, not only for the young patients, but also for their carers and hospital staff. The hospital setting turns into a cultural venue where music helps to foster ‘new expression and communication opportunities during a hospitalization’ (www.musique-sante.com).

According to these organizations, musical interventions in therapeutic settings become simultaneously a therapeutic and educational process that soothes calms, distracts and culturally enriches the patients and the people that they are surrounded by.

(2) Activities offered

There are three different kinds of musical activities:

1. concerts (including bedside / in-room performance);
2. established music programmes running on a regular basis;
3. artist-in-residence programmes;

These activities are live music interventions that often take the shape of ‘interactive’ concerts where a high degree of musicianship is combined with the musicians’ interpersonal skills, acting as a facilitator in the communication process between music and the audience, and between different members of the audience themselves. This specific kind of musical intervention seems to be the core activity of most associations as the funding available is not sufficient to allow differentiated programmes to happen in the same venue on a more regular basis, the likely ambition for any organization.

The reality of a lack of funding appears to be one of the main challenges that organizations have to confront and, in the majority of cases, concerts in hospitals become isolated events except where a continuity is guaranteed by alternative source of funding (as happens in Florence where the paediatric hospital itself has supplied the necessary subsidy to support a musical programme on a daily base).

The Project Playback Programme, organized by Musicians On Call represents an interesting variation to the concert-like approach as it gives patients the chance to have their original music recorded and produced. Special software enables patients to compose their own songs and work with volunteer professionals who provide guidance in the writing and recording process.

In the case of the French association Musique et Sante, the musical activity is associated with a training activity for musicians that include musical and pedagogical techniques to work specifically in healthcare environments. This training has been developed across Europe through the creation of an European network of associations promoting music in hospital activities as a regular intervention in hospital settings and simultaneously, the specific training of ‘musicians in hospital’ as a new professional figure
Some associations such as Musique et Sante and Snow City Arts, promote artistic residencies programmes where renowned composers and musicians are hosted in the hospital for a given period.

(3) Selection criteria in the employment of musicians

The recruitment of musicians tends to follow an audition process. Usually, musicians approach the organization and are encouraged to submit a curriculum vitae and a CD of a sample of music that they perform. If the selection of music is perceived as interesting enough, they are invited for an audition. The general criteria sought in a musician are reported to be: high level of musicianship, a varied and suitable choice of music, good presentation skills and an ability to establish a rapport with the audience. In one case (Live Music Now), priority is given to young musicians (the maximum age for application is 27 for instrumentalist and 30 for singers). Freelance musicians are employed on the basis of the concerts for which they are considered to be most suitable (mainly on the basis of their repertoire). On average, the number of concerts performed by each musician, or group, is reported to range from 12 to 20 a year.

(4) Structure of the training

Music in hospitals appear to be a fast growing area of activity and there is a general interest from different organizations, including music therapy organizations and conservatories, to set up specific training programmes (as exemplified in the current debate within music therapy associations about the needs to establish a ‘medical music therapy’ degree in order to be competitive and to fill the gap in the ‘music in hospitals setting’ area; cf. Standley, 2005). This debate originated in France where, since 1984, nine Universities have established an undergraduate diploma called ‘DUMI’, Diplôme Universitaire de Musicien Intervenant, that is focussed on a more general musical training, including a pedagogical curriculum to allow musicians to work in kindergartens, primary schools and to collaborate with institution within the community (http://www.up.univmrs.fr/document.php?pagendx=1469&project=cfmi, circulaire n°84-220, 25 June 1984).

The University of Strasbourg, together with Musique et Santé, has refined the DUMI curriculum, establishing the first university degree focused on the training of musicians playing in a hospital setting (DUMIS: Diplôme Universitaire de musicien intervenant en milieu de la santé). The training takes place across one year, resembling a UK PGCE course, with 264 hours of theory and practical courses, 100 hours of independent work, 96 hours of stage within designated structures and 90 hours of stage within similar structures in a different European

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1 PGCE stands for ‘Post Graduate Certificate of Education’.
country (http://musims.fr/, retrieved 3/08/07). The teaching embraces seven units: 1) music tools (repertoire, musical objects, musical environment); 2) musical intervention in a therapeutic setting (musical intervention for children, carers, elderly people, staff, evaluation criteria, managing a project); 3) relational tools (focused on hospitalized children and their carers, elderly people in a nursing home and their carers, the hospital staff); 4) the organization of health structures (rules and functioning, rules and regulations for staff, relevant policies); 5) observation and related methodologies; 6) analysis of existing European projects; 7) communication (non verbal communication; European language). This is an example of an integrated programme that includes musical topics, hands-on practice, a theoretical insight of the ‘audience’ and of the mechanisms regulating the hospital environment and, finally, an awareness of evaluation methodologies to self monitor the musical activity.

A very different kind of preparation is offered to musicians by charities and associations running ‘music in hospital’ performances. In such cases, the training becomes a rapid way of testing the awareness of musicians with respect to some sensitivity issues related to the settings where they will perform, rather than a more pedagogical occasion (which would need consistent funding and an appropriate organization). The training often takes the shape of a basic introductory session with a consequent monitoring support offered by former musicians or, alternatively, members of the association. Monitoring is undertaken through observation of performances, feedback and report from participants staff after each performance, development of self-evaluation skills for musicians and visual documentations of events (such as pictures of the event) (Lindsay, 1995; ‘training’ and ‘monitoring’ section in www.livemusicnow.org; http://www.musicforallseasons.org/mus_network.html and private correspondence with the Development Manager; http://www.music-in-hospitals.org.uk/musicians_howtoapply.htm and private correspondence with the Chief Executive).

2.3 A case study of the UK-based Music in Hospitals charity and a selection of its musicians

The second study is a research that focuses on the UK charity Music in Hospitals and its musicians². An initial search was conducted to discover if there were any England-based projects where musicians without music therapy qualifications were playing on a regular basis in hospital settings, but there was no evidence of specific initiatives of this sort. The closest project was carried out by the charity Music in Hospitals, a well-known and long-established charity that,

² This section draws on the research reported in Preti (2004).
since 1946, had organised concert for hospitalised people. Contacts were made with the Chief Executive of the charity and she agreed to have a conversation with the researcher about organizational aspects of the charity. She subsequently provided contacts with eight musicians who were often asked to play in paediatric hospitals, each of whom was interviewed. Opportunity was also taken to observe the Charity's auditions process for the selection of new musicians. This provided insights into the selection criteria that the charity was using.

The fieldwork embraced three components: (i) in-depth interviews with eight musicians who were regularly employed to perform in a hospital context; (ii) two interviews with the Chief executive of a leading charity in the field; (iii) observation of an audition process for the selection of musicians to perform on behalf of the same leading charity. The data set, therefore, included: interview transcripts, observation notes and associated documentation.

This qualitative study was focused on acquiring a better understanding of the motivations, perceptions and personal and professional backgrounds of a small number of musicians who had chosen to play in the hospital. Data relevant to addressing this aim were obtained using two methods of empirical enquiry: semi-structured interviews and observations, in each instance complemented by relevant documentation, including brochures and leaflets produced by the charity and application forms completed by the musicians. These methods underpinned both an investigation of the work of the eight musicians in hospitals and a case study of the charity that employs them.

The use of semi-structured interviews, with open-ended questions, was motivated by the need to have a flexible method to elicit data on personal issues (Cohen & Manion, 1994). To that extent, it contributes to the realisation of new data about an under-investigated occupational group. Additionally, the technique is a convenient and cost-effective way of engaging with those involved (Kvale, 1996: 102). Structured interviewing is also an appropriate methodology when it comes to the study of a work-group or a special category (Robson, 2002: 271). As Arksey and Knight (1999: 32) stress, interviews allow respondents and researchers to follow up ideas and ask for clarifications or further elaborations, thus fostering a degree of trust between interviewer and interviewed which, in turn, adds to the quality and authenticity of the data collected. Informants can answer the questions in terms of what they regard as important and choose what to say about a particular topic, and how much. Moreover, according to Brenner (1985: 3), qualitative interviews ‘focus on the informants’ understandings, rather than checking the accuracy of the interviewers’ account’, an outcome that is not easily achieved using the questionnaire method for example.

Visual observations were recorded in the form of note taking as video and audio recording were not allowed. My approach was ‘unobtrusive’ and ‘informal’ (Robson, 2002: 313).
2.3.1 The case study data and their collection

Interviews

Two different kinds of interviews were conducted:
(1) in-depth interviews with the Chief Executive of the charity *Music in Hospitals*; and
(2) with eight musicians:
   a. four face-to-face interviews; and
   b. four telephone interviews.

The Chief Executive, DG, was the first person that was contacted after discovering the existence of the charity. An informal conversation took place over the phone and another at the time of the first visit. On each occasion the intention was to get a general idea about the work of the charity, whilst checking if the organization was suited to the aims of the research. DG agreed to be interviewed formally about practical and ethical aspects of the charity. Prior to this interview, she was sent the schedule of questions as well as a copy of the BERA ethical guidelines for research. She gave permission for the interview to be audio-recorded.

Subsequently, DG facilitated contacts with a selection of musicians that were employed by the charity and who regularly played in children’s hospital wards. To keep her fully informed of the research intentions, she was sent a copy of the planned interview questions for the musicians. DG then wrote to each of them, explaining the purposes of the study - asking for their collaboration, after which personal contact was made by the researcher. Not all these potential respondents were resident in London. Therefore, for pragmatic reasons, a decision was made to conduct face-to-face interviews only with those who lived in the capital. With the other respondents, telephone interviews were conducted. In the case of all the musicians that were interviewed and the Chief Executive, transcripts of the interviews were offered to be made available for their comments. In the event, none of the respondents took up this offer, though they were also promised summative copies of the overall findings once the study was completed.

Observations

Twenty-two auditions of musicians seeking to become involved with the *Music in Hospitals* charity were observed. Such auditions usually take place twice a year and they were a useful means by which to learn more about the selection criteria adopted by the charity in the recruitment of its musicians. Auditions took place at the Royal Academy of Music, over one day. The venue was selected because one of the members of the panel was employed there as a
Professor of Musical Communication. The rest of the panel was made up of the Chief Executive, administrative members of the charity (senior administrator, concerts administrator and administrative assistant) and one of its Trustees. Also present was the Chair of the charity’s fundraising group and an experienced musician who had been playing with the charity for many years.

Each audition lasted approximately twenty minutes. Applicants performed in different formations: solo, duo, trio and quartet. They were required to sing four songs from different repertoires, treating the interview panel as a hypothetical hospital audience. After each performance, the panel discussed the musical and communication abilities of the applicant, deciding, it seemed, relatively quickly if they were suitable for the job, as if it was something that they could almost ‘feel. It seemed that experience of many different auditions in the past had provided them with an extended ‘craft knowledge’ (Lindsay, 1995) of likely suitability.

Documents

The following documents were collected:

(1) documents related to the aims and activity of the charity itself; and
(2) documentation specific to the musicians attending the audition.

The first group of documents included the ‘Guidelines’ for musicians, published by the charity and handed out to all the performers who are accepted after the selection process. Different material such as ‘Newsletters’ and ‘information sheets’ were also collected as they were also usually distributed to applicants. This material was of particular interest as it outlined an ‘ideal’ profile of musicians that the charity were looking for, providing insights into its understanding of what it considered to be appropriate musical interventions in a hospital setting.

Application forms from the participants taking part in the auditions constituted the bulk of documentation about the applicants themselves. Although 22 such forms comprised this part of the data set, the number of actual individual applicants was higher, standing at 38. The difference in these figures is explained by the fact that just eight of these people were individual applications, the rest being from musicians who were either part of a duo, trio or quartet.

Their forms are rich depositories of information about the educational backgrounds of the performers, including their previous musical experience. They also provide data about what kind of musical performances applicants considered to be especially relevant to hospital settings, taking the form of an outline imaginary programme of activity. The application forms also required each musician to describe their personal strengths in relation to the work that they would be expected to undertake in the hospital, assessing themselves both on a personal and musical level.
2.3.2 How case study data were managed and analysed

Interviews

An interpretative approach as theorised by Smith and his colleagues (1999) was undertaken which identifies four main steps in the analytical process: 1) making an interview transcription; 2) analysis of a single transcript; 3) looking for connections within the transcript; and 4) constructing a master list of themes. All the documents were collated for textual analysis using *Atlas.ti* (version 5) (Atlas.ti 2005).

Observations

In the course of observing the auditions, notes were made, embracing all aspects of what went on, from how the performers walked into and departed from the room, to what they performed in it, including their interactions with each other and with members of the interview panel. So, whilst the observations tended to be ‘unstructured’, in the sense that the researcher noticed and recorded a diverse range of things in the setting, an implicit set of coding categories created an embedded structure in the notes. These audition categories were three-fold:

1. How the performer(s) entered the room;
2. Playing and performance qualities;
3. Interactions:
   a) amongst the musicians themselves (when more than one);
   b) between the musician(s) and the panel;

Each category was examined from the perceived musician’s point of view, noting their reactions to the situation and their engagement with the music, whilst communicating with the panel, and from the panel’s perspective, notably their perceptions of each musician’s performance. In this way, it was possible to use the observations to isolate some of the variables that *Music in Hospitals* members believed to be the appropriate ingredients for a successful performer.

Documents

As previously mentioned, two kinds of documents were collected: (i) those about the organization of the charity; and (ii) the application forms completed by musicians participating in the auditions that were observed.
Each set of documents was analysed in a similar way as the interview transcripts, with a view to identifying common themes. In addition, special attention was devoted to locating text, notably key words and phrases that provide an insight into the perceptions of the applicants, of what they believe constituted an appropriate performance in a hospital setting. This was not a difficult undertaking, to the extent that each applicant was required on their application to write a short statement about themselves as musicians and to outline an imaginary programme of musical activity that they considered matching their view of what they would perform in a hospital if given the opportunity. All participants gave their consent to the use of their application forms in this study.

The documents produced by the charity itself, all of which were sent to each applicant in advance of their audition, also carried messages about what it is considered an appropriate musical performance in the hospital. As with the performers, these were noted down in the form of key words and phrases, which were cross-checked (as a form of triangulation) with those recorded in the analysis of their forms of application.

2.3.3 The outcomes of the case study of the charity and its musicians

2.3.3.1 The Charity as a nested case study

An account of the history of the charity, from its origins until 1992, is provided by Sylvia Lindsay, in her book *A Song Bird for the Heart* (1995). Because of the author’s close involvement with the charity, both as a performer and subsequently as its Director, this history is likely to be a very sympathetic one. Nonetheless, it provides interesting insights into how one of the Charity’s leading figures conceive the role of music in hospital settings and how the organization has developed, including successfully addressing recurring financial difficulties which at times have threatened its continuing existence.

*MUSIC IN HOSPITALS* was founded in 1948 by Sheila McCreery. Her desire for its creation derived from a previous involvement with the *Entertainments National Services Association* (ENSA), an organisation that provided live concerts in UK’s military hospitals during the period of the last world war. After its closure, the provision of live music ceased to be organised and it became dependant on the availability of charitable associations.

The charity started on a voluntary basis, with little financial backing. However, Sheila McCreery was very successful in creating social and cultural networks of people who gave their
name and support to the charity. This assisted her efforts subsequently to obtain grant aid from the Arts Council which, initially, underwrote relevant musical consultancies. This financial support was renewed in the years that followed, persisting until today. In 1948, the aims and objectives of *Music in Hospitals* were set down as follows:

> ‘to organise and provide regular series of concerts of music of high quality, to assist in organising lectures, meetings of gramophone clubs, etc. in hospitals; to assist hospitals in experimental work on the value of music therapy for individuals or for groups; to encourage patients on leaving hospital to continue their interest in music and to keep them in touch with musical circles near their homes.’

(Lindsay, 1995: 20)

The educational, social and therapeutic aspects of the charity's work are prominent, being linked with the idea of 'high quality' music and a wish to foster musical interests in the patients, encouraging them to follow these up once out of the hospital. Additionally, the charity's experimental work on the value of music as therapy was stressed. These aims have remained broadly the same throughout the decades to the present days, the only distinction being that music therapy was not included in the activity of the charity. This choice was not a straightforward one as, until it became a registered charity in 1955, the identity of the *Council for Music in Hospitals* (the original name of the charity) was not so well defined. Because of financial difficulties, there had been several attempts to merge the charity with the *Association for Music Therapy*, so that, in the 1960s, its Officers and Executive Committee included a Music Therapy Sub-Committee, and one of its members was Juliette Alvin, a leading pioneer in the field of Music Therapy. The interaction between the two associations did not last for very long, however, with each body creating their own distinctive identity as that decade drew to a close. *The Council for Music in Hospitals* stated clearly in its aims that it was not going to provide music therapy interventions as such, but only music performances which it saw, then as now, as being therapeutic themselves.

### 2.3.3.2 The choice of music: A survival issue

The musical performances promoted by the charity were strictly 'classical', with musicians playing from a stage. The formal aspect of the performance was never questioned, even though reports from several hospitals suggested that a more informal programme with a popular selection of music would have been equally and sometimes more welcomed (Lindsay, 1995).
Reports suggested also that increased communication between musicians and patients and greater flexibility in the sorts of programmes offered would be more suitable for hospital settings (Lindsay, 1995: 41).

The charity found these suggestions difficult to respond to positively, especially during the 50s and 60s, when 'high quality' music coincided entirely with Western classical (art) music. Indeed, the choice of the programmes offered frequently reflected the somewhat high-brow musical tastes of individual Medical Superintendents, and there was an element of class complacency in offering such musical programme that would have been difficult to eradicate without changing the middle class nature of the charity.

Classical music became the main feature of the charity, an aspect of its work that was reproduced and reinforced by an audition process that gave it priority. Indeed, the charity noted the identity and sought the assistance of internationally acclaimed musicians, such as Robert Sutherland, Maria Callas’s accompanist, and the singer, Gordon Honey. It also did the same for individuals that featured in the programmes offered by the Wigmore Hall. In such ways, the charity consolidated its reputation for providing high quality musical interventions in hospitals, despite these being restricted to performances of just one kind of music.

The charity’s stress on classical music went largely unquestioned until the end of the 1960s, at which point significant cultural changes, including some that challenged traditional aesthetic values, forced it to rethink its position. Its stance was increasingly undermined as well by the hospitals themselves, many of which urged it to include popular music programmes alongside its classical ones. A significant decline in the number of concerts taking place in such hospitals only added to the charity’s difficulties, which were further compounded by ones of a severe financial nature. It was clear to everyone concerned that changes were needed if the charity was to survive – changes in what it offered, and changes in how it funded itself. In 1971, Sylvia Lindsay inherited responsibility for directing the charity, setting in motion a process of reconstruction including giving fundraising a central role. The way that concerts were delivered was also changed substantially, symbolised by the adoption of a new motto for the charity: ‘a professional performance, presented in an informal manner’ (Lindsay, 1995: 53). All these changes reshaped the reported image and role of the charity, both of which have remained, until today, much the same.

2.3.3.3 An ideal musician

The success of the charity has been connected with the ability of its musicians to foster a ‘positive atmosphere’ in the hospital setting. From the success of a musical performance
depends the positive evaluation of the hospital staff and, therefore, future requests for concerts. As DG emphasises in her interviews, 'word of mouth' is the main source of publicity for the charity. This implies that the best promotion is the performance itself.

Both Sylvia Lindsay, in her history of the charity, and DG in her interviews, identify a number of characteristics that musicians must possess if they are to succeed in their work in hospitals. According to the charity, musicians should develop a 'special perception', enabling them to respond sensitively to every situation in the hospital. They should, for example, be aware of the abilities and disabilities of those represented in the audience and able flexibly to adapt their programmes accordingly. The understanding of the patients' problems should prepare them for the possible reactions which are not necessarily a reflection of their own performance or of the music played. The ability to relate empathically to the patients, providing a programme that articulates sensitively with their circumstances, is also emphasised, as is the requirement to try to involve everyone in the performance, encouraging patient participation, including satisfying their musical requests. According to Sylvia Lindsay, the ideal performer in a hospital setting should be:

'a superb artist; extrovert and imperturbable; having a tremendous gift for communication; imaginative and sensitive, with a vast repertoire, a good memory, the ability to project great warmth, and unfailing sense of humour.' (Lindsay: 133)

This description is a very significant one, for it makes clear the charity's position that being a good musician, whilst a necessary condition, is not sufficient to be a successful performer in a hospital. Also required are social skills that foster a close rapport between musician and patient. In order to be able to offer a 'standardised' performance that ensures it is branded in a similar way, and also to help musicians reflect on a number of variables connected to their performance in hospitals, a booklet of *Practical Guidelines* (Council for Music in Hospitals, undated) has been produced by the charity. This identifies different aspects of performing in a hospital setting, offering practical suggestions about how best to interact with patients. Whilst some of these suggestions are commonsense ones, it is noticeable that the patients' perspectives are always stressed above everything else. Suggestions about the importance of being on time ('Punctuality'), for example, draw attention to the fact that not all patients are physically capable of remaining seated, even for a short period, stressing the need for musicians to take into account the physical arrangements of the room in which they are performing, requiring them to adjust it in such ways as to make it easy for them to circulate among the patients. Other practical suggestions focus on the performance itself. 'Visual Aspect', for example, includes advice about appearance (*please dress up in colourful clothes, whatever time of the day*); 'Introduction' is about first encounters (*always commence a concert by introducing yourself and fellow musician*); 'Setting the Scene' addresses questions of ethos (*Aim to create a relaxed, happy, informal atmosphere in which the patient can...*)
enjoy a professional performance); ‘Involvement’ is about creating interest (a brief demonstration of what the instrument can do is always appreciated); whilst ‘Communication’ is centrally concerned with breaking down barriers (The printed page is a real barrier to communication, please perform without music, wherever is possible; you are then free to move among your audience, using all your communication skills such as touch and eye contact). In the last section of the Guidelines there are suggestions about how to deal with the hospital staff and patients’ reactions. Being welcomed by the staff is seen as ‘vital’ for the success of the performance, as they are perceived to be very supportive once they recognise the benefit for their patients.

2.3.3.4 An example of the selection process

Applications

The charity’s auditions are not public. They ‘pre-select’ musicians on the basis of initial telephone conversations, inviting those who seem to be suitable for a formal audition. The charity does not advertise auditions and musicians get to know about them through the web site or more often, ‘word of mouth’, as was the case for each of the people that were interviewed as part of this research. In any event, like other applicants who had heard about the charity, these respondents already represented a self-selected group inasmuch as they already had had previous experience of playing music in hospitals or similar locations.

According to DG, some musicians are put off from applying to be auditioned by the charity’s requirement that they must perform their musical selection entirely from memory. She suggested that some musicians find this very difficult, especially those classical trained and who are more used to reading from a score. Musicians are asked to play four songs from different repertoires and to introduce each one to panel members as if they were in front of a hospital audience. They are not briefed beforehand about the audition. The only guidelines that they receive being those found on the application form itself, where it states that they should give examples of items that they would like to include in an imaginary Music in Hospitals concert, bearing in mind the huge age-range and different pathologies of the people to whom they are likely to be asked to perform. The implication for this requirement is clear enough: applicants are expected to be able to manage a wide repertoire and to mix different genres. The application form also includes a special note for singers, in bold, which says “please ensure that you sing in ENGLISH or WELSH as appropriate”, suggesting that auditions are restricted only to those with appropriate competency in these language-speaking groups, an inference confirmed in the application forms and by the musicians interviewed. In practice, musicians attending for audition come from all over England, Wales and Northern Ireland and, if successful, will play in
hospitals located in the area from which they come. *Music in Hospitals* has a Scottish branch that deals with events in that area and this explains the geographical exclusion in the above quote.

The application form consists of two sheets of paper, each A4 size. In the first section of the form, applicants are required to give details about their age, the instruments that they play and about the place and the date of their musical training or other study. In the second section they have to (i) give a brief account of their previous work related experience; (ii) list a selection of the repertoire that they would include in a hospital programme of their own; and, (iii) finally, describe their personal and musical strengths in relation to the work that they have so far undertaken in hospitals.

Five aspects of the applications were explored in this research analysis, each providing data that, together, offer a preliminary portrait of the musicians:

1. **Age range**
2. **Gender**
3. **Educational background**
4. **Previous experience**
5. **Philosophies, aspirations and motivations.**

Applicants (N=38) were drawn from a wide age range, with the oldest being aged 64, and the youngest 21. No clear pattern, however, emerges from these data, inasmuch as there are almost as many applicants in the under-40 age group (N=17) as who are over-40 (N=19). Whilst more women than men feature in this sample of applicants (women = 22; men = 16), there is no evidence to suggest that this is any way significant to the extent that the charity does not promote itself as an organisation that has any gender preferences or biases.

The data on the educational backgrounds of the applicants, however, are more striking. Almost all (90%) are music graduates, with nearly one-half (just over 40%) obtaining their first degrees at one of the country's leading specialist university colleges of music, such as the Royal College of Music, the Royal Academy of Music or the Guildhall School of Music and Drama. Whilst many of the applications (whether group or individual) contain a singing element (15 out of 22), the range of musical instruments played by individual applicants is interestingly diverse, taking in the clarinet, harp, piano, percussion, flute and the accordion. Importantly, applicants coincide very much in terms of the musical work that they have undertaken previously in settings that are relevant to the charity's purposes. Thus, in a section on the application form where they are asked to list 'relevant performing experience', almost all of them either have worked, or presently do work, in hospitals or nursing and residential homes.

The philosophies, aspirations and motivations of the applicants, as reflected in the personal statements that they made on their application forms show differences in emphasis. Three themes emerge from these statements. First, we learn a great deal from them about
significant earlier life experiences that have prompted applicants to want to play music in hospitals. A recurring principle here is the idea of paying off a moral debt or sharing an advantage. Thus, typically, one applicant writes about himself as follows:

'I am enthusiastic about music and hope that my enthusiasm can be shared with others who may need it and to whom it can make a difference.'

Whilst another states:

'I am conscious of the fantastic (musical) opportunities (I have)... been given and thus always tries to give back something to the community and so share (my) talent.'

This same moral tendency is reflected too in the statement made by a group of musical applicants:

'We want to bring happiness to people who (unlike themselves) have little or no access to live music.'

Second, we discover an equal amount of emphasis concerning applicants’ personal philosophies about the therapeutic and other emotional effects of music. Evident here are strongly felt views about the power of music to heal and to help, occasionally infused by sentiments that have a religious flavour. Examples of this tendency are reflected in the following extracts, each of which is abstracted from separate application forms:

'We firmly believe in the power of classical music to communicate emotion and to engender a positive response in thought and feeling.'

'I believe that music is the universal language of the soul and can carry tremendous healing energy.'

'I have a strong belief in the restorative and equalising power of music.'

Finally, the applicants write equally enthusiastically about the abilities that they have to translate such philosophies into action, in each case exemplifying a good understanding of the qualities needed to be an effective musician in a hospital setting. This is notably evident in what they write about the importance of being good communicators, with one applicant, typically, stating that he is
‘able to connect individually with most people in a group setting and to build up a good rapport with any audience, using eye-contact, touch and humour, as well as displaying empathy and compassion.’

Others, again typically, point up the importance of always being enthusiastic and, when the situation demands it, of being humorous as well:

‘I’m passionate about singing and performing, and I think audiences respond well to my enthusiastic love of music.’

‘I have a great sense of humour, with an equally great sense of fun, which usually comes through in my performances.’

‘My programmes are guaranteed to put a spring in your step!!.’

‘I am keen to whip up a sense of fun and enjoyment.’

Lastly, and no less significantly, a number of applicants point up the ability that they have to perform in ways that pacify and calm:

‘I can bring... beauty, hope and peace into (patient’s) mind.’

‘I am able to bring peace... and gentleness to any group of listeners.’

**Auditions**

Auditions usually take place twice a year and are held at the Royal Academy of Music in central London, a venue that is associated with musical professionalism and classical music in particular. It is a venue that many people may find intimidating, especially those without a formal classical training, and living outside the capital. Access to the Academy and to the audition room is also extremely difficult, a feature of the building that one could anticipate compounding the nervous state of any applicant who had not previously studied there or in a similar higher education context.

The audition room itself is very large and bright, commanding an excellent view onto Regent’s Park. It is a space, moreover, that communicates to any one that enters it a sense of high status, a feeling confirmed by a RAM Professor and prominent and influential member of the panel, who described it to the researcher as ‘a very privileged room.’ The audition schedule was very tight. There were 22 individuals/groups to audition and the room was booked for less
than 8 hours. Each applicant had only 15 minutes to enter the room, set up their instruments, introduce their pieces, and perform.

The observation analysis of what took place is divided into three aspects of the audition process:

1. How the performer(s) entered the room;
2. Their playing and performance qualities;
3. Interactions:
   a) between the musicians themselves (when more than one);
   b) between the musician(s) and the panel;

The moment in which the applicants enter the room is perceived to be crucial. DG, commenting on the performance of one group, remarked that she takes very much into account her 'first impression' of applicants. This is communicated initially by the manner in which they walk into the audition room. If they are relaxed and confident about themselves and their musical and communications skills, this is immediately translated into a body language that makes the panel relaxed and at ease. In such a way, applicants engage with the panel before starting the musical aspects of the audition. The panel responds to their body language, being positively predisposed to listen attentively to what is played. Almost all the performers introduced their music with a small presentation. This too was rated as very important by the panel in reaching their overall evaluation of individual applicants. Also how applicants were dressed contributed to the first impression. Musicians had been asked to dress for the audition as they would like to look in a hospital setting.

Their musical choices can be divided into five main genres: classical, jazz, pop, folk and children's songs. The instrumental groups played mainly classical and jazz, whilst the singers tended to concentrate on pop, folk and children's songs. The music played was all very familiar and drawn from the English tradition. Songs like 'Bye Bye Blackbird', 'On the Sunny Side of the Street', and 'My Grandfather’s Clock' were sung along by the panel who clapped in time as well. Beatles' songs also featured prominently, as well as contributions from musicals. In case the group had selected unknown songs, the panel encouraged them to demonstrate more familiar items, explaining that the aim of the charity is 'to relate to people through their music.' This advice was given fairly often, especially with classical music groups who sometimes had quite an elitist choice of repertoire. DG made clear that they should be prepared to drop some Elgar in favour of 'Happy Birthday', if needed.

Applicants were encouraged to choose a 'welcoming song' and a 'goodbye song' as the means of framing their performance. Most of them sung an English military - flavoured song, such as 'We'll Meet Again', or the famous Charlie Chaplin, 'Smile', both extremely sad, despite their positive lyrics. However, the panel encouraged each musician to avoid playing such songs
in hospitals as they were deemed to be too emotionally charged, which might not set the right tone at the end of a performance.

The variations in dynamic contrasts between musicians were evaluated as the audition preceded, the panel trying always to suggest alternative combinations in order to bring variety into the performance. ‘Variety’ was a key word, being mentioned in almost every audition. The panel made clear that the combination of two musicians that were strictly playing their instruments, or singing in the same way, would have quickly produced the same kind of sound, thus easily branding the whole concert independently from the programme that they were performing. Therefore, the panel often invited the members of group applicants to play different instruments, and to change the order of their songs, and (in some ways) broke the intended rhythm of their performance.

Musicians made efforts to interact with the panel, sometimes through eye contact, but also through the shaking of hands and walking around the room, even bending on their knees to sing at the same height of the panel members, all of whom were seated. For some, this was spontaneously easy to achieve, for others it was clearly an unnatural thing for them to do. On one occasion, when the song being performed was particularly cheerful, DG improvised a little dance, involving other members of the panel, in order to test the applicants’ reaction. This approach, however, did not always work. Where musicians were intimidated by the panel, this friendly attitude frightened them further, and on one or two cases appeared to led to some embarrassment on their part.

The panel's decision about the outcome of the audition was nearly always reached, at least implicitly, as the applicant performed. Members of the panel, for example, made significant eye contact with one another as each audition proceeded, in the course of which they communicated their impressions of what was going on. It was rare for subsequent deliberation to last very long, with panel members nearly always reaching a unanimous decision about the suitability of a particular applicant within minutes of them leaving the room. Communication and musical skills were the main features under discussion; interestingly without either one being given the highest priority. Each performer was expected to achieve a certain standard in both communication and musical skills. Some good musical performers were, therefore, rejected, and some not very good performing musicians accepted. As a long time Music in Hospitals performer and member of the panel, one commented, ‘some fantastic musicians would die [in a hospital environment], and some not fantastic musicians would flourish. That’s what is so unique about this whole process.’
2.3.3.5 The musician’s perspectives

The research process also enabled attention to be drawn to the perspectives and experiences of a small group of performers (N=8) who were regularly engaged in giving concerts for the *Music in Hospitals* charity, of whom each was interviewed as part of the research. Table 2.1 below (*Music in Hospitals* interviewees) provides summary background information about these respondents, including their ages, backgrounds, qualifications and previous experience. With the exception of one of these people (Tom), all the others had many years involvement with the charity, in three cases (Hugh, Ann and Helen) lasting more than twenty years. Despite the sometimes huge differences in the numbers of years of involvement in the charity between these people and those applying to work for it - some of whose profiles featured in earlier discussion - a significant degree of congruence is evident in the perspectives that they all have about how they view the significance of performing music in hospitals and about the skills needed to do this well.

<table>
<thead>
<tr>
<th>Musicians</th>
<th>Gender</th>
<th>Age group</th>
<th>Musical Qualifications</th>
<th>Instruments played</th>
<th>Types of music played</th>
<th>Professional musician</th>
<th>Teaching experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hugh</td>
<td>M</td>
<td>50/60</td>
<td>Self taught</td>
<td>Guitar and voice</td>
<td>All sorts of music</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ann</td>
<td>F</td>
<td>40/50</td>
<td>EALCM A-level music</td>
<td>Singer</td>
<td>All sorts of music</td>
<td>Yes</td>
<td>Some</td>
</tr>
<tr>
<td>Tom</td>
<td>M</td>
<td>50/60</td>
<td>Self taught</td>
<td>Guitar and voice</td>
<td>Popular, jazz and folk</td>
<td>Don't know</td>
<td>Yes</td>
</tr>
<tr>
<td>John</td>
<td>M</td>
<td>30/40</td>
<td>Graduate at RAM</td>
<td>Piano</td>
<td>All sorts of music</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>May</td>
<td>F</td>
<td>20/30</td>
<td>BMUS (hons)</td>
<td>Singer</td>
<td>Popular, jazz and folk</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Louis</td>
<td>M</td>
<td>30/40</td>
<td>GRSM (p)</td>
<td>Guitar and base guitar</td>
<td>Popular, jazz and folk</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Helen</td>
<td>F</td>
<td>30/40</td>
<td>GRSM,LAEM</td>
<td>Harp and voice</td>
<td>Popular, jazz and folk</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lana</td>
<td>F</td>
<td>20/30</td>
<td>Self taught</td>
<td>Guitar and voice</td>
<td>Popular, jazz and folk</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Additionally, motives for wanting to undertake this type of work frequently converge. The discussion below begins by examining these.

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3 The names of the musicians are fictitious.
Motivations

In earlier discussion, a highlight was the degree to which many of those musicians seeking to work for the charity were motivated to do so by strong moral reasons (e.g. 'sharing an advantage'; 'paying back a debt'). Similar drives were evident in the data provided by the more experienced respondents. Tom was a typical and good example of this, remarking during the interview that he 'wanted to do some good.' Similarly, Ann felt a strong compulsion to want to please patients through music by enhancing their enjoyment of life. Others said much the same, adding, not surprisingly, that they found the work 'very rewarding' (May) as a result.

On the other hand, some of the respondents simultaneously reported, confessed even, more self-centred reasons for wanting to work for the charity, which coincided with a wish to use such employment as a means of obtaining regular opportunities to perform in public. This tendency was especially evident in Helen’s transcription that reports her saying:

‘If I am brutally honest, originally it was an opportunity to get the experience of performing straight out of college.’

It is also apparent in Louis’s interview, where the confessional ‘honesty’ word features similarly and significantly:

‘If I am entirely honest, my motivation (initially) was to find a way to earn a living playing music rather than teaching. A lot of my peers (after graduating) became part-time teachers to supplement their performing. The result is that such teaching takes over… and I didn’t want that to happen to me. By working for the charity I am always performing, which means I am able to say that I am full-time musician. That was really the motivation at the outset, as well as a feeling that working for the charity would develop me musically via performing.’

Louis’s negative attitude about teaching, however, is contrasted in Tom’s transcription, where we learn that he was first attracted to the idea of working for the charity as a result of his positive teaching experiences in a special school whose pupils ‘liked (my) music very much.’ Unlike in the case of Louis, these experiences provided Tom with both the confidence and motivation to want to do similar work on another, bigger, ‘stage.’

Philosophies

The more experienced musicians that were interviewed shared with their less experienced counterparts various views about the importance of musical performance in hospitals. Tom is a
typical example. Like most of the applicants interviewed at the Royal Academy, he was convinced of the therapeutic potential of what he did when he sung and played his guitar in a hospital ward, as this extract from his transcript demonstrates:

CP: ‘When you are in the hospital, do you feel as if you are doing something else other than playing?’
Tom: ‘Oh, yes, definitely! I think it is close to therapy really. It’s a form of cheering them up. For some you are also probably doing an educational job, because for certain people, like those whose speech might not be that good now, and who have trouble making sense, what I do results in them singing entire songs. I have had members of staff coming up to me saying, ‘Gosh, that’s the most she/he has said for a long time! It’s as if the music has triggered some part of their brain which isn’t working.’

Helen, on the other hand, was not as convinced of such outcomes:

‘I can’t pretend to do anything more therapeutic than enabling people to enjoy themselves. Because it’s not my role.’

Her somewhat extreme view here, however, does not feature in any of the other transcripts, though it is important to stress that none of the interviewed musicians said that they performed in ways that were designed to have specific therapeutic effects, which was the position of the charity itself.

It will be recalled that several of the applicants whose data were analysed earlier partly defined their ‘philosophy’ of playing in hospitals using religious terms. This tendency is apparent also among some of the experienced interviewed musicians. Take John’s conception of the spiritual value of what he did that extended not only to the people he played for, but to himself as well:

‘There have been many times... when [during the course of playing the piano] I totally appreciate what God has given me, because my life is ‘normal’ compared to the patients’, some of whom struggle to stand, and have difficulties going to the toilet. That touches you... [playing in a hospital] makes you review your own perspectives on the world as a human being and as a musician.’

John’s views here are the product of his Christian beliefs; Louis’s, which were similar in nature, derive from his interest in Buddhist conceptions of the Good Life:
‘When I perform in the hospital, I don’t just feel like a musician. Rather, I feel like a fully integrated member of a special community. As a result, I feel I am doing something that’s very ‘real.’ I am interested in Buddhist philosophy. Some of its literature says that to achieve peace and harmony in your life you need to have a job that helps to expand your mind and to think very positively about the world. Making music in a hospital is like that, for it links to the feeling that the world is a nice place.’

This sense of both being in the world and being in harmony with it through playing in the hospital is also present in Ann’s transcript, which at one point reports these words:

‘I think music enables you to achieve an extraordinary intimacy with people you don’t know very well. It’s like a conduit, helping you to get very close to people… I think there is a mystical aspect to it all as well; for communication through music is more powerful to me than just communication.’

Hugh, sharing this view, invokes, like John, a specifically Christian set of categories:

‘I think you have to love people as part of your work. And an audience recognises this. It knows when you feel this about them, and its help them to relax. Love in this case comes from my Christian faith, which helps me to reach out to people.’

Skills

Hugh’s reference to ‘reaching out’ in the last quotation leads into a consideration of the skills that the sample of experienced musicians in hospitals believe to be essential to the creation of a successful performance in such a setting. What they believe about this aspect of the process articulates fully with the sentiments expressed by the audition candidates whose application forms were analysed in the previous section and whose behaviours in this connection were literally played out in front of the researcher during their interview performances at the Royal Academy.

The importance of successfully making initial and maintaining personal contact subsequently with individual members of the hospital audience through the use of specific non-musical skills was mentioned by all of them, albeit with varying degrees of emphasis. For example Hugh observes that
‘... there is more to this work than the power of the music I play; it’s also about making good eye-contact and making friendship [...] remembering people’s names... so as to make them feel special.’

Similarly, ‘May’ states significantly that

‘good personal skills are as important as good musical skills.’

Being flexible in what one chooses to perform is also highlighted by several of respondents. ‘Ann’ speaks for most of them when she says

‘I always have a plan, but it’s never a rule, for I drop things as the moment dictates, pick up something else, take on extra music, and encourage requests.’

‘John’ concurs, remarking that he often

‘has to be spontaneous in a fashion that might be quite shocking to other musicians that are very organised and controlled.’

Both he and May also stress, like other members of the sample, the importance of having a sense of humour, and of being able to interact with patients in familiar, joking sorts of ways that make the performer ‘an entertainer as much as a musician’ (May). Perhaps it is unsurprising that Tom concludes his interview by saying that ‘it’s really not a job to do if you take yourself too seriously.’ All, moreover, recognise that this ability was additional to being able to make music well. So, whilst clearly some music as performed is amusing in itself, all respondents were conscious of the added-value that comes from having a performing personality that was friendly, engaging and entertaining.

The possession of such a personality does not always follow naturally from being able to play an instrument or sing a song well. As Ann said, ‘some people don’t have good communication skills.’ Others agreed, drawing attention to the fact that, whilst they thought that some performers were innately equipped socially, others were likely to need specific skills training to develop themselves in this aspect of their role as ‘musician in hospital’. In making such a case, several respondents (notably Helen, John and Louis) expressed strong views about the form that this training should take, which all converged on the proposal that it should eschew theory in favour of practical guidance drawn from the experience of musicians whose performances in the hospital have been positively evaluated. Thus, Louis, who first admitted that he was ‘not sure what training in this area should be like’, went on to plead that it should be provided by people like himself who took on the responsibility of sharing with less experienced
musicians the ways of interacting with a hospital audience that had proved successful in their own case.

2.4 Discussion and other empirical studies

Both sets of studies provide evidence that one of the prime intentions of the provision of music in hospitals is to use its sonic-features to elicit particular emotional responses, such as to calm, excite, smooth, and uplift (Preti & Welch 2004). Sonic features can also deflect attention from clinical experiences by the use of slow/fast tempi, changing pitches and familiar timbres (Gabrielsson, 1999; Juslin, 2001). A review of the specific literature about sonic effects supports the impression that music can have a positive effect on hospitalised people, although there is an ongoing debate in relation to the adopted methodologies (see discussion in section 4.3.1). However, the underlying explanations for such effects have not been explored systematically. Most of the work published about these matters has focused more on recognition of emotion rather than on the induction of emotion or emotional response to music (Blood & Zatorre, 2001; Juslin, 2001; Gabrielsson, 2003). Even though there is not a wide body of research in the field, there is anecdotal evidence to support the positive effects of music on hospitalised people and this seems to be strong enough to generate a considerable amount of such programmes and to contribute to the birth of new associations involved in such provisions, as well as to create a new professional figure of the musician playing in the hospital.

Activities offered as part of the ‘music in hospital’ umbrella range from ‘bedside’ music, a specific one-to-one intervention, to general concerts, to specific artist-in-residence programmes. The general aim of all these programmes is openly therapeutic and educational and, in some cases, such as the charity Live Music Now, the programme focus is also on creating new opportunities for musicians to perform in a variety of settings.

In the case of each type of musical interventions, either bedside music or a concert or an artist-in-residence programme, the effectiveness of music is likely to be based on the development of a close relationship between the musician(s) and the audience/patient(s). The underpinning intention for the music in this context is to facilitate communication between the patient and the musician, such that each tunes into the other’s emotional state. The interaction has different degrees of intensity based on (i) the nature of the intervention (bedside or concert), (ii) the willingness of both patient and musician to participate and get involved in the event and (iii) an appropriate, and hence, effective choice of music in bringing about different emotion.

Music becomes a strong means of reciprocal communication between musician and patient. As Gabrielsson (1999) explains, the emotional intention underpinning music is one that
In his analysis of how a performer communicates emotions to the listeners, Juslin (2001; 2005) suggests that music is conceived as a part of a communication system in which 'composers code musical ideas in notation, performers recode from the notation to musical signal, and listeners recode from the acoustic signal to ideas' (Juslin, 2001: 309). As a direct consequence of this system of 'multiple translations', opportunities for music performances are seen to induce performers to look for what music should really express to the listeners.

Interpretation, therefore, involves some personal reflection concerning the search for different meanings within the music itself. Music in this case becomes a 'structure' to interpret. The same music can be performed in different ways and the type of performance 'may affect the listener's impression of the music in profound ways' (Juslin, 2001: 310). As Juslin (2005) emphasises, the performer's expressive intention influences almost every aspect of the performance. The mechanisms of musical communication involve the use of codes employed by performers and listeners. One important code is that arising from the five 'basic emotions' (happiness, sadness, anger, fear, love/tenderness). There are often correspondences between these emotions, the expression marks of musical scores (allegro, allegretto, teneramente, dolente, furioso) and expressive cues, such as 'tempo, sound level, timing, intonation, articulation, timbre, vibrato, tone attacks, tone decays, and pauses' (Juslin, 2001: 316). The variability of these expressive cues through the performance is believed to be a crucial element in the communicative process. Within this process, the intentionality of the message results in changes within the musical structures affecting musical features such as 'tempo, timing, amplitude/dynamics, intonation, timbre, tone onset and offset, vibrato' (Gabrielsson, 1999: 48). In the case of musicians who play in hospitals, musical communication is often associated with other forms of communication involving body language, embracing facial as well as physical expressions. Juslin (2005: 102 – 104) identifies five main theoretical mechanisms that help to explain how music may arouse emotions. These are: 1) Musical Expectancy, according to which emotions are induced when expectations are interrupted (Meyer, 1956); 2) Mood Contagion, when emotions are transmitted through facial or vocal expression, as the voice-like aspects of music have been hypothesized to induce arousal through a reaction of a neural module that leads to mimic the perceived emotion internally (Juslin & Laukka, 2003: 802); 3) Arousal Potential, when the listener reacts to the 'inherent arousal potential of more general stimulus characteristics, such as its complexity, ambiguity and familiarity' (Juslin, 2005: 103); 4) Association, when there is an established Association between the music and non musical factors related to emotion, such as specific places and events (Gabrielsson, 2001); 5) Mental imagery, when music helps to shape a variety of mental images.
(Bonny & Savary, 1973). After presenting a brief condensed summary of each of them, Juslin concludes that ‘there is no single theoretical mechanism that can account for all instances of musically induced emotion’ (Juslin, 2005: 104), but that instead, a multi component model is needed in order to investigate different psychological mechanisms at different level of processing. He suggests that this model has not yet been developed, but that a possible model should incorporate different psychological mechanism as well an investigation of the social context in which musical emotion take place, an area neglected by research on expression, perception and induction of emotion.

The emotion-related dynamics of a musical performance are crucial variables to understand both the single participant and the dynamics developing from their interaction. Juslin (2001) suggests that communication of emotions in music performance reflects two factors: brain programmes and social learning. With regards to ‘brain programmes’, there is a reported similarity between vocal and musical expression of emotions – as it has been suggested that they are both processed asymmetrically, with a predominance in the same brain hemisphere (the right, and in the main brain centres) (Thurman, 2000; Peretz, 2001; Welch, 2001). As far as the social learning is concerned, it is assumed that certain aspects of music performance depend on cultural influences.

In a hospital setting, communication and processing of emotion involves quite a number of additional variables, including the presence of pain, fear of dying, stress arising from long hospitalisation, as well as changes in family dynamics, parental interactions with the child’s fears and their own anguish. The relationship that the musician establishes with the child is very rarely a ‘one-to-one’ because many other people surround the child and, in some ways, take part in the musical intervention. The environment itself presents a challenge for the musicians as there is a constant need to monitor the emotional aspects of the session and to recalibrate the choice of music. The mood of a session can change rather quickly as many variables are involved, such as interruptions by ward nurses, doctors, physiotherapists, as well as the challenge of the general sound environment (e.g. television, telephones, loud sounds from the chemotherapy machines). Therefore, as Munro (1984: 36) comments, ‘to create an environment conducive to intimate music experience [...] constitutes another challenge for the musicians’ which has to take into account the physical and emotional state of the child and their carers, as well as be aware of the environmental factors that will be likely to impact on their musical activity. These factors are likely to impact on both bedside performance and concert-like performance. The artist-in-residence programme is a different kind of intervention as music making in this case becomes a collective activity in which children are encouraged to participate within a structured framework. Participation and involvement of patients, carers and hospital staff are the focus of most musical interventions and they are actively sought through different choices, such as appropriate music to facilitate a joining-in, sing-a-long, kind of participation and the distribution of little percussion instruments to accompany the musicians.
According to Council (2003), making art can be a powerful vehicle for rebuilding the medical patient’s sense of well-being. The combination of familiar materials and a facilitator, or a therapist, can reassure the ill children about their own sense of worthiness. The artistic process can empower the child to express feelings that words would fail to express (Bunt & Marston-Wyld, 1995), either because the child’s vocabulary does not match the experience, or because the ill child feels they must protect the adults around from their own feelings (Bluebond-Langner, 1978; Bailey, 1984; Daveson, 2001). Snyder et al. (1997: 400-401) theorize that ‘children who think hopefully can imagine and embrace goals related to the successful treatment of their physical problems [...] children with health problems need to focus upon new goals, find alternative ways to do things, and muster the mental energy to begin and continue treatment regimens.’

The literature agrees that creating art is a vehicle for self expression and that illness arouses the need for creative expression as a means of coping (Petrillo, 1980). The creative process helps the child to shift ‘from being a passive victim of a disease into being an active partner in the work of getting well’ (Council, 2003: 213). Kazak (2006) suggest that the supportive intervention, both during and after treatment, can diminish the traumatic effects of treatment and help patients to cope better with the hospital experience. These views are broadly supported across the music medicine and music therapy literature (Bailey, 1984; Ryan, 1989; Stevens, 1990; Standley 1992; Malone, 1996; Sabo & Michael, 1996) and from the practice of an increasingly growing number of paediatric hospitals where inductions prior to any intervention have become part of the hospital routine (see the Child Life Program in Chapter 3). This new practice has been endorsed by the results of studies which suggest that children who received education about their medication and encouragement to take responsibility in their administration were more likely to increase their compliance with medical procedures (Richardson, Shelton, Krailo & Levine, 1990).

2.4.1 The choice of music

For musicians who play in hospitals, the choice of music is a crucial variable to determine the success of their intervention. There are no fixed ‘rules’ in this choice. Any ‘rules’ probably arise from previous experience ("craft knowledge"), the psycho-acoustic features of the selected music combined with the level of pain in children, their ethnicity and socio-musical background, the particular moment in time, the environment and the carers’ mood, among the possible variables.
In one sense, music in this environment 'allows a person to access experience of emotions that are somehow already on the agenda for that person' (Sloboda, 1992: 35) and this might explain why the same song does not always produce the same emotional responses.

Most of the literature reports that the choice of music for experimental interventions is usually self-selected by the patients. The studies generally do not comment on this aspect, but it seems to be quite relevant that the choice of the therapist is often oriented towards music that is familiar to the patients. In the hospital context, perhaps such choices would undermine the idea of music as a 'universal language' (Cook, 1986; Stevens, 1990: 1046), in the sense of all music having a common sonic foundation within the constraints of a particular cultural context, and suggests the need to seek different, more differentiated and nuanced explanations.

The choice of music in a hospital setting depends on different variables. Musical behaviour has been defined by Welch (2000: 3) as the interface between three generative elements 'namely (i) the overall nature and individual developmental history of our human anatomy/physiology, (ii) socio-cultural context, and (iii) music (however defined).' This implies that characteristics like personality traits, language, culture, educational influences, are all relevant in musical choice. It also means that music is likely to become more effective if these characteristics are addressed somewhat consciously in the musical choice. As Hanser (1985: 199) comments: 'selection of the right single piece or musical sampling is crucial to the success of the experiment.' However, a definition of what counts as 'relaxing' music is difficult to reach.

Stratton and Zalanowski (1984) found a significant correlation between the degree of relaxation and liking for the music. O'Callaghan and Colegrove (1998) report that most of the hospitalised cancer patients refused music therapy when the music therapist did not elicit their music preferences. In the study by Micci (1984), adolescents undergoing cardiac catheterisation generally requested mild rock music for relaxation and some of them asked for hard rock, even if afterwards they felt that it would not be relaxing in the operating theatre. Davis and Thaut (1989: 184) found that the criteria for the selection of music to reduce anxiety or increase relaxation seemed to include some factors such as 'preference, familiarity, cultural context, past experiences, and perception of elements of the music such as structure, tempo and dynamics.' Therefore, they supported (ibid) the importance of 'considering [a] client's unique musical preferences and background' when selecting music. Similarly, Standley (1992) asked patients undergoing chemotherapy to choose their favourite piece of relaxing music in order to reduce nausea. Patients selected music from a wide range of genres. It seems paradoxical that new age music, usually considered as 'relaxing' by definition, was 'quickly rejected upon hearing' (1992: 34). Standley claims that 'the specific piece of music utilised in clinical procedures is not as important as are the Associations which have been developed by the individual patient with the selection' (ibid). Therefore, it is important that music - in order to be more effective in a hospital setting - may need to be selected by patients because this may elicit associated positive emotional memories, with likelihood that such a recollection might improve the sense of well-

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being and heighten the musical experience. Standley (1995; 1986) found also that live music administered by a music therapist had a greater effect than recorded music.

From what has emerged so far, the musical identity of both patient and musician seems to be central to the process of communication. The musician needs to speak the musical language of the child and the musical intervention would likely benefit from an adequate and appealing choice of music. One of the main intentions of the music provision is to promote a sense of musical empowerment in their clients, to enable the client groups to have an increased sense of agency in their engagement with music that is both 'therapeutic' and 'educational' (Prokofiev, 1994). Although musical activities are focused on the needs of particular patients and the adults that support them, such 'goal-directed individual and group actions' (Engerstrom, 2001) are also reflexive and expansive in that there is always the possibility that the diverse elements of provision (in music, settings, performers and clients) will facilitate new learning, whether musical, social, intra-personal or a combination of these.

2.5 Chapter summary and overall conclusions

To summarize, three main findings emerge from this chapter:

(1) Music in hospitals is a structured activity that is increasing in a number of hospitals across the US and Europe, shifting from a voluntary engagement by both charities and musicians to one that is more formalized. As an activity, it tends to comprise four sets of interventions: bedside music; regular concerts in common spaces; special musical events and artist-in-residence programmes. The nature of the activity, as stated in the aims of charities and associations involved in the provision of music in hospitals, is described as therapeutic and educational. The therapeutic aspects of the intervention are attributed to the 'power of music', often described in mystical terms, and to the ability of musicians to communicate effectively through the music. An appropriate choice of repertoire is also mentioned as a criterion to predict the success of an intervention. Hospital staff and management, as well as musicians, report enthusiastically on the positive effects of music on their patients and, even though the evidence is anecdotal, it seems compelling enough to justify a relatively flourishing funding around music in hospital activities.

(2) Musicians who play in hospitals appear to constitute a new professional group (and see Chapter 6, section 6.4 and Chapter 8, section 8.2.5 for a discussion), as performing in a hospital requires a high level of professionalism which is explicitly defined by associations and charities through their stated aims and implied by their selection
criteria. For example, literature on musical communication and emotion, as well as literature adapted from existing studies on music therapists' experiences, suggest that there are relatively close professional overlaps in terms of both work values (Oppenheim 1984) and in the population with whom they work, collaborate or consult (Register 2002). The emerging profile of a 'musician in hospital' is one of a knowledgeable and skilled musician, often a professional with a classical music background, highly motivated in playing in hospital settings, often for strong moral reasons, and occasionally for religious ones.

(3) The personal and professional characteristics of musicians undertaking this profession and activity, as well as the nature of their engagement in such activities, become relevant aspects that contribute to a more general understanding of the dynamics of a musical intervention itself.

In summary, Part 1 (Chapters 1 and 2) has focused on setting the scene for the rest of the thesis by exploring aspects of current provisions for music in hospital settings. The possible underlying reasons for such provision are the focus of the next section, Part 2 (Chapters 3 and 4). In particular, it would seem that there is a need to understand more clearly the nature of the musical process and also how this is interpreted by all those involved.
Part 2. A review of other related literatures
Chapter 3. Hospitalization of children and their families: Setting the context for a musical intervention

3.1 Introduction

The chapter explores the significance of illness in relation to hospitalization and the ways that children and their families respond to such a process. The psychological impact that hospitalization frequently has on children and their families, connected with social adjustments that both child and families undergo as a consequence, will be discussed as part of a clinical context in which a musical intervention takes place. The hospital setting will be analysed as an 'interaction system' (Barakat, 2003) where children, families and nurses engage with each other in different ways according to the nature and degree of illness, perceived needs and the length of the child's hospitalization.

3.2 Children's reaction to illness and hospitalization

The psychological implications of children's hospitalizations are discussed below in the light of two major themes, each of which features prominently in the nursing and health psychology literature (e.g. Petrillo & Sanger, 1980; Turk & Kerns, 1985; Thompson, 1985; Cooper et al., 1999). The themes are:

1. Children's conceptualization and perception of illness;
2. Children's psychological reactions to hospitalization and models of their coping strategies;

An understanding of children's behaviour in relation to each theme helps to contextualise better the perception of children's reactions to hospitalization and illness, including their responses to a musical intervention designed to ameliorate any negative effects from the former. Additionally, it is proposed that an understanding of children's contextualized behaviour assists in evaluating the impact that children's reactions might have in planning and enacting such intervention.
'To understand how individuals attempt to maintain health, cope with stress, and respond to illness, attention needs to be paid to their own conceptions of these relevant constructs' (Turk & Kerns, 1985: 1).

3.2.1 Children’s conceptualization of illness in relation to their developmental stages

Since the 1940s, much research has been undertaken to understand better the emotional effect of hospitalization, surgery and chronic illness on children (e.g. Vernon et al., 1965; Blos, 1978, Thomson, 1985; Bibace & Walsh, 1981). Whilst lacking a systematic aspect, these studies have begun to establish a relationship between children’s conception of illness, health and treatment, and also the level of their cognitive development (Nagy, 1951; Nagy, 1953; Vernon et al., 1965; Schwartz, 1972).

In this connection, Bibace and Walsh (1981) plotted the development of children’s concepts of illness in line with the stages outlined in Piaget’s theory of cognitive development. In their seminal studies (1979, 1980, and 1981), they conducted a series of clinical-interviews1, involving 160 children aged between 3 and 13, in which they sought to elicit data on children’s understanding of the common cold. The children were divided along the lines of Piagetian developmental stages: prelogical, concrete logical and formal operational, with the aim of defining the categories that ‘reflect the interaction between general stages of cognitive development and particular content areas’ (1979: 288). Bibace and Walsh found that each developmental stage corresponded with a different conceptualization of illness, with the maturity of the child being the most important variable. Children between the age of 2 and 6 years old - assessed by Bibace and Walsh to be in the prelogical stage, which is characterised by an inability to distance themselves from their environment (Piaget, 1930; Schaffer, 2004) - tended to speak of illness in terms of ‘incomprension’, ‘phenomenism’ and ‘contagion’ (1979; 1980). In the case of ‘phenomenism’, the cause of illness was perceived by the child as an external concrete phenomenon like the sun or God (1980: 914), whilst explanations characterised as ‘contagion’ had to do with the proximity of the child with objects or people that had contaminated the child in some sort of ‘magical’ way (ibid).

Older children, between 7 and 10 years old - identified as being at a concrete operational stage of development - gave two main causal explanations of their illnesses, which

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1 ‘Clinical interview’ is an interview technique developed by Piaget (1930) which is primarily based on open-ended questions in order to stimulate children’s thinking process (Smith et al., 2003; Schaffer, 2004).
were 'contamination' and 'internalization.' According to Piaget (1930) (see Schaffer, 2004), in this concrete operational phase children begin to reason systematically and start differentiating between the self and the other. That is why both these types of explanations were able to identify the illness as somehow dependent on an external action or person which was negatively affecting the body. The child perceives the source of the illness as an event associated with an harmful action through which the contagion happen, like going outside in the winter without a hat as 'your head get cold — the cold would touch it — and then it would go all over your body' (Bibace & Walsh, 1980: 914).

Finally, children at a formal operational stage, around the ages of 11 or 12, were more able to differentiate between the self and the other and, therefore, capable of describing more accurately the origins of their illnesses. Their answers were clustered into 'physiological' and 'psychophysiologic' and their explanations were much more accurate in locating the source of illness within the body.

Despite its importance, Bibace and Walsh’s framework has been criticised subsequently for underestimating children’s understanding of illness. Some critics, for example, object to their overly linear approach to child development which, its critics say, fails to explain how children move from one stage to the next whilst not taking into account the impact of past experiences, culture and social environment (Nelson, 1986; Cooper et al., 1999). Among such critics, Donaldson (1978) argues that children build up a model of the world by formulating hypotheses that helps them to anticipate future events on the basis of their past experience (Smith et al., 2003: 405). In this case, children’s experience is considered to be directly influenced by the expectations that they bring to a given situation. In line with Donaldson, Turk (1985) suggested that how an individual behaves is a direct result of their definition of the situation and this largely depends on their prior experiences. Despite these criticisms, Bibace and Walsh’s stages have been widely used as a working framework in a large number of studies on the perception of illness in children and young people (e.g. Banks, 1990; Crisp et al., 1996; McQuaid et al., 2002).

In their extensive review of the literature on children’s concepts of illness, Burbach and Peterson (1986: 322) identified three main implications for medical staff. First, that an awareness about children’s conceptualization of illness might improve the services offered by paediatric health care professionals, as the awareness could target some of the children’s fears and anxieties arising from their developmental conception of illness. Second, that such knowledge could be useful if adapted to educational experiences involving illness prevention and early intervention. Third, that an understanding of children’s stages of cognitive development in relation to the way

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2 There is a recognition in other developmental literature that different kind of questions / approaches may elicit different insights (e.g. the work of Donaldson (1978) and Hughes (1986) in mathematics) concerning children’s thinking.
that they conceptualize illness is necessary for adults to enable children to be more involved in health decisions regarding different treatments options.

In everyday hospital practice, the importance of providing developmentally appropriate information about events and procedures has been accompanied by the perceived need to equip children with a positive experience about hospitalization in order to minimize the negative effects of such experience. This approach is currently adopted by the majority of pre-hospitalization programmes, including the Child Life Program, a standard programme employed by a growing number of American paediatric hospitals (American Academy of Pediatrics, 2000; http://www.childlife.org). The Child Life Program's primary focus is to render the hospital experience less intimidating through the use of developmentally appropriate play. These approaches often take the form of 'medical play', involving exploration of medical equipment to allow the child to familiarize themselves with situations perceived as threatening. The underlying theoretical framework for such interventions derives from 'self-regulation' theory (Leventhal & Johnson, 1983; Johnson et al., 1997), an information processing theory based on the idea that the provision of information to an individual who is about to undergo a stressful procedure 'will facilitate the development of a cognitive schema that is analogous to the real-life event' (Melnyk, 2000: 10). As such, the individual will be 'coached' about the experience that is about to happen, increasing their understanding, predictability and confidence about the forthcoming experience which ultimately will lead to better coping outcomes (Johnson et al., 1997).

The cooperation elicited in the child by following age appropriate explanations about medical procedures has also been evaluated as an effective means of reducing the length of hospitalization (Wolfer et al., 1988). Among other strategies to minimise distress, the Child Life Program suggests that preoperative information and preparation for hospitalization are 'crucial for the reduction of anxiety reactions and maladaptive behaviours' (Hagglof, 1999: 76). This view finds support as well in a number of studies on the nature of communication between the child and medical staff connected to the decrease of fear and anxiety prior to medical procedures (Chetta 1981; Potter & Roberts, 1984; Froehlich, 1984; Bunt & Marston-Wyld, 1995).

The psycho-educational preparation for hospitalization has also been studied in relation to the impact on the child and their families after the child's discharge from hospital. An extensive, albeit limited3, review of studies on children's post-hospital behaviour (Vernon & Thompson, 1993) suggests that 'cognitively oriented preparation' (1993: 41) is effective in reducing the negative effects of hospitalization, which often include 'sleep disturbance, regressive behaviours, apprehension or fearful behaviour' (Youngblut & Shiao, 1993: 47).

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3 The vast majority of studies that Vernon and Thompson reviewed were biased towards short-stay hospital experiences (95%).

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Vernon and Thomson (1993) also indicate that younger children (less than 6 years old) benefited less from psycho-educational preparation than older children (more than 7 years old). A possible explanation is that the selected cognitive interventions had not been planned on the needs and abilities of this particular age group, and that there might be alternative tools to carry out such interventions rather than dramatic presentations through play or verbal descriptions of medical procedures (Melnyk, 2000). Indeed, a non-verbal intervention such as music therapy has been found to be more effective in helping school-age children to verbalize their hospital experience than medical play therapy (Froehlich, 1984), indicating the possibility of alternative approaches to psycho-educational preparation to hospitalization.

Bunt and Marston-Wyld (1995) noted that, by combining counselling and improvisation on a variety of percussion instruments within a music therapy session, group 'music therapy was seen as having a unique role to play where there were feelings but not words to name them' (Bunt & Marston-Wyld, 1995:50), suggesting that sometimes the sonic features of music can be more effective than language in the communication of emotions (and see Chapter 4).

Relatedly, Vernon and Thompson (1993) pointed out that the frequency and length of the cognitive intervention preparation were crucial variables in determining the efficacy of an intervention, considering that regular interventions would be more beneficial in reducing post-hospital distressed behaviour. Intervention would, in fact, assist the child to 'integrate the hospital experience in their self-concept and personalities in a positive enduring fashion' (1993:42).

The way that children perceive their illness seems to be at least as important as the illness itself. As Rennick et al. (2002) point out, the way that children respond to hospitalization ‘may be affected less by the location of their hospital stay and more by their perception of the illness experience’ (Rennick et al., 2002:141) as is reported in a number of studies on children’s hospitalization in intensive care units (Youngblut & Shiao, 1993; Melnyk, 2000; Rennick et al., 2002; Board, 2005). For example, there is evidence that invasive procedures (such as injections) are often perceived as worse than the disease itself, and - in line with the Bibace and Walsh's thesis - that children's reaction are mediated by their cognitive development. A recurrent comment in the literature about children's hospitalization is that, for a child, fantasy can be worse than reality (Menke, 1981; Hockenberry & Bologna-Vaughan, 1985). Common reported examples include preschool children for whom illness is often perceived as a punishment for something that they have done wrong (Melnyk, 2000), or their fears that medical treatment might result in permanent body mutilations (ibid). Because ‘animism’ is a cognitive characteristic of preschool children and toddlers, children in this developmental stage also tend to attribute human characteristics to inanimate objects (such as monitors), the outcome being a generalized and uncontrolled fear about the hospital environment.

In this context, targeted preoperative interventions for children and their families seems to be effective in reducing the negative effects associated with hospitalization, as they enhance
coping strategies in both groups (Youngblut & Shiao, 1993; Melnyk, 2000), although there is an ongoing need to develop differentiated intervention for different clinical populations. As Melnyk (2000) emphasises, the majority of children in most ‘prior intervention studies’ are undergoing minor surgeries and the number of participants are often small. There are important variables that still need to be explored, such as different kind of hospitalization (critical care, repeated hospitalizations, chronic illness, difficult surgeries), together with the design of specific programmes to improve outcomes for the parents. Parents’ ability to cope with their children’s hospitalization has been suggested to be directly dependent on the effects that hospitalization will have on their children (Hagglof, 1999; Melnyk, 2000).

3.2.2 Children’s psychological reaction to hospitalization and models of their coping strategies

Hospital care and treatment by invasive procedures produces significant psychological effects in children (Hagglof, 1999; Cooper et al., 1999). The way that children and their families handle the experience of illness and hospitalization are seen to depend on two set of factors: personal and situational (Lambert, 1984; Thompson, 1985; La Montagne, 1987; Hagglof, 1999; Melnyk, 2000). The former includes the child's age, emotional and psychological development, personality type and previous hospital experience; the latter focus on the social context surrounding the child, the support received by parents, the parents’ emotional state in coping with their child's hospitalization and the family network that surrounds them.

According to the psychosocial literature on paediatric hospitalization, extensively reviewed by Thompson (1985), the child reacts to hospitalization at three different levels: immediate, post-hospital and long-term. At an immediate level, reactions include crying, resistance to treatment and emotionally charged behaviour (1985: 21) – interpreted in other literature as a child's attempt to cope with an unfamiliar situation (e.g. Rose, 1972; Shaw & Routh, 1982) – and, therefore, as a normal adaptive response that will subside once hospitalization will cease. Post hospital responses include ‘increased aggression, withdrawal, passivity, hyperactivity and decreased attention span, self-esteem, and self-confidence’ (Rennick et al., 2004: 359) and are associated with the age of the child, the degree of illness, the length of hospitalization and the exposure to a higher numbers of invasive procedures (Thompson, 1985; Rennick, 1986; Vernon & Thomson, 1993; Youngblut & Shiao, 1993; Rennick et al., 2002). Finally, long-term responses include similar behavioural changes as post-hospital symptoms, as well as post-traumatic stress, persisting after the discharge from hospital. The effects can last from ‘months and sometimes years’ (Rennick et al., 2004: 359) after the discharge and they are
mainly dependent on the severity of the illness and the number of invasive procedures undergone (ibid).

These different stages of reactions indicate that hospitalization can have a relatively permanent impact on the life of the child, and consequently, on their families as well. An understanding of the variables and the dynamics affecting a child’s reactions to hospitalization are part of the context for any musical intervention within such a setting, and are likely to impact on the nature of the musical intervention and its effectiveness.

As indicated at the beginning of this section, there are two set of factors that are connected to the experience of illness and hospitalization, embracing (i) personal and (ii) situational factors. According to the details in the literature, among (i) personal factors, age appears to be the most important determinants of upset experienced from a child following hospitalization, with children aged between 6 months and 4 years considered to be the most vulnerable group (Thompson, 1985; Rennick, 1986; Vernon & Thomson, 1993; Melnyk, 2000; Rennick et al., 2002). The child patient’s developmental conceptualization of illness associated with the actual hospitalization influences greatly the psychological reactions and will have different effects according to the age of the child. These effects are likely to range from sleep disturbance, irritability, hyperactivity and anxiety, to a delayed development of language and disrupted bodily control (Hagglof, 1999: 73). There is growing evidence that the subjective experience of illness - rather than its severity - is one of the main factors determining psychological outcomes (Ryan-Wenger, 1990; Cooper et al., 1999; Kazak et al., 2006) and, therefore, the child’s coping strategies become crucial variables in understanding the effects of stress on physical and mental health and general well-being (Pretzlik, 1997: 6).

Lazarus’s theories of stress and coping (1991, 2000) are believed to offer a valid framework to evaluate children’s responses to a stressful situation such as hospitalization. His transactional stress model (Lazarus, 1991) is based on the definition of stress as being the product of a particular relationship between the person and the environment that is perceived by the person as threatening for their well-being. As Schwarzer and Schulz, (2003: 29) points out, there are three meta-theoretical assumptions in this model: transaction, process and context. It is assumed that:

‘(a) stress occurs as a specific encounter of the person with the environment, both of them exerting a reciprocal influence on each other, (b) stress is subject to continuous change, and (c) the meaning of particular transaction is derived from the underlying context.’

Transactional in this context means that there is not only a unidirectional influence, a stimulus leading to a stress reaction, but that there is a relationship between a changing situation and an individual with all their cognitions, emotions, and actions. That implies that a stressor is not
independently stressful as such, but that the person who experiences the stressor appraises it as being either 'challenging, threatening, or harmful' (Lazarus, 1991: 56). These cognitive appraisals are a crucial component in the transactional stress model. In Lazarus' words: 'Stress is a post appraisal state' (Lazarus, 1991: 4).

According to Lazarus and Folkman (1984), stressors results from the interaction of personal variables ('Life events') and environmental variables ('Resources') (Figure 3.1). This interaction leads the subject to appraise a given situation, evaluating whether it is a potentially threatening one. Lazarus (Figure 3.1) distinguishes between two kinds of appraisals: (i) primary appraisal and (ii) secondary appraisal. The term primary appraisal refers to a person's evaluation of the severity of the stressor. As a result, a stressor can be classified as a challenge, or as a threat, and/or harm/loss (Lazarus, 1991). The perception of challenge or threat will be followed by coping attempts directed to the future. The appraisal as a harm/loss, however, is followed by efforts referring to a past event so that coping strategies for both will differ. Primary appraisals are mainly related to environmental information (that is the demands of the situation or of the person, or the aversive stimuli). Secondary appraisal is referred to a person's estimate of their own resources to cope with the stressor and it is mainly focussed on personal resources and information about the availability of a social support. After a second appraisal has occurred there is reappraisal of the stressor in the light of the available coping resources. This mechanism is conceived as a widely employed device for 'regulating stress and emotion by changing the relational meaning of what is happening' (Lazarus, 1993: 238). It is possible that there may be several stressors at the same time, but the primary appraisal of all stressors present will lead to one dominant classification so that the person can focus on a certain coping effort to deal with the most important stressor.
According to Lazarus (Schwarzer & Schulz, 2003: 29), stress is an 'active unfolding process that is composed of (i) casual antecedents, (ii) mediating processes and (iii) effects.' As represented in the 'Process model of stress and health relationship', based on the transactional stress theory by Lazarus (Figure 3.1), 'casual antecedents' are personal variables ('Resources') and environmental variables ('Life events') whose interaction leads to primary and secondary appraisals; 'Mediating processes' are referred to appraisals and coping behaviour; and 'effects' are the outcome of a stress process and coping behaviours which are likely to have significant impact on physiological changes and long-term effects on well-being ('Health Consequences').

Lazarus' model highlights the subjective perception of stress and the individual's response to it. The model also emphasizes the contextual validity of coping strategies as they depend on individual adaptation to a specific situation and they will change over time as the threats themselves will also evolve (Lazarus 1993: 236). The result of the cognitive appraisal determines the choice of appropriate coping strategies. Lazarus (1993, 2000) distinguishes between two major function of coping: problem-focused coping, and emotion-focused coping. Problem-focused coping refers to the relationship between the person and the surrounding environment and the attempts to act on the environment itself in order to change it. Emotion-focused coping refers to the person's attempt to regulate the emotions related to the stress situation. These two function of coping are part of a general coping effort and, according to Lazarus (2000: 206), 'it is the fix between thinking, wanting, emotion, action, and the environmental realities that determines whether coping is efficacious or not.' This holistic view suggests that coping is the dynamic product of different variables undergoing constant changes.
An applied model of stress/health relationship (Figure 3.2), proposes that a musical intervention in a hospital is part of a coping system which can influence the perception of social support and consequently impact on the coping mechanisms (though the links between music and emotion, cf. Juslin & Sloboda, 2001). As the psychosocial literature on paediatric hospitalization suggests (Thompson, 1985), the subjective experience of illness, rather than its severity, is what is likely to determine a child's psychological reaction to hospitalization. One of the main aims of music in a hospital is to create a sense of continuity with the child's life outside the hospital, through the use of a child-focused repertoire, in so doing, minimizing the fear of hospitalization and reducing the threat caused by the hospital as an unfriendly environment.

Figure 3.2 Adapted model of stress/health relationship, based on the transactional stress theory by Lazarus (1991)

The application of social ecology theory (Bronfenbrenner, 1979) provides an helpful framework to contextualize the hospitalization experience - in which the stress-coping model is a central component - in so far as it describes how populations can be perceived as fitting into a physical, cultural, and social environment (Lemyre & Orpana, 2002). Social ecology theory conceives the organization of the environment into dynamic systems which are integrated and that interact. Applied in paediatric psychology, this theory helps to identify the interactions related to children's illnesses, the individual child and systems that are seen as 'internal' (parent, siblings,
extended family) and those that are 'external' to the family (such as school, neighbourhood, parent workplace, health care setting).

Figure 3.3 Adapted model of Social Ecology Theory (Bronfenbrenner, 1979; Bakarat, 2003)

In an adapted model of social ecology (Barakat et al., 2003), the ill child is conceived as being at the centre of a series of concentric circles (Figure 3.3). The child's circle is nested within a larger circle that includes members of the family (parents and siblings) and the illness (type, course, prognosis, chronicity). The family is central to the social context of the child for many reasons, including the fact that most children cannot consent for medical care independently. If a concept of 'development' is added, this also implies change over time and reinforces the importance of viewing the experience of the children and families as fluid, undergoing many temporal transition.

There are three different levels: the microsystem, made up of family, fits into a functional world called the mesosystem, made up of work, neighbourhood, and organizations such as schools and hospitals. Both systems fit into a social order made up of (i) public services...
and (ii) a legal framework that defines the exosystem. These various systems influence one another.

In the present research, the social ecology model helps to contextualize a ‘music in hospital’ intervention and its participants, as they belong to a culture that is likely to determine, among other reactions, (i) the specificity of a socio-cultural reaction to illness, and (ii) the style of the musical intervention, the musical repertoire, and the emotional and physical reaction of all participants to the hospital environment.

Social ecology is a dynamically-nested system that plots the influence of determinate variables on three different subsystems: exosystem, mesosystem and microsystem. In this specific case, culture and social networks (exosystem) are seen as affecting (i) the dynamics of hospitalization (mesosystem) (e.g. different cultures would experience different kinds of hospitalization according to the country that they might live in and this would be a predictor of different kinds of reactions from peer groups, school and neighbours) and (ii) the way children and their family will react to illness (microsystem) (e.g. the concept of illness is a culturally related one, as is the perception of pain and death associated with illnesses (Kleinman, 1980)).

According to the literature, the way children react to illness is chiefly connected with (i) their cognitive development (e.g. conceptualization of illness, see section 3.1.1) and with (ii) the reaction of the parents to the new situation and their ability to adjust according to positive coping strategies (Melnyk, 2000). As Lazarus (1991, 1993, 2000) points out, the reaction to illness is also connected with the child’s ability to develop coping strategies, which is closely associated with the child’s personal resources (a product of cognitive development and family interactions). Lazarus’ model of transactional stress offers a temporal explanation of how appraisals and coping reactions originate and develop in relation to illness. These events are influenced by three main factors: 1) first reaction to illness (impact, duration, predictability, controllability); 2) evaluation of the personal resources available to cope with the situation; 3) social support available.

### 3.3 The dynamic of hospitalization

From what has been outlined so far it appears that a child’s illness is characterised by a complex system of personal and environmental interactions that become predictors of coping strategies that can significantly impact on health behaviours. Within the hypothesised ‘microsystem’, the child and family generates interactions that will impact on the choice of the child’s coping strategies in order to adjust to the illness (e.g. Turk & Kerns, 1985).
The relationship between child and parents become central to the process of illness and hospitalization (see Figure 3.4). The variables that are likely to influence this process are part of an interaction that is constantly evolving, affecting both the relationship between the child and the parents, as well as the family as a unit. These changes are likely to impact on the child’s choice of coping strategies, which are ultimately predictive of health outcomes (Ryan-Wenger, 1990; Lazarus, 2000).

The research literature suggests that one of the main factors determining a child’s reactions to illness is the way that the family responds to their illness. As Turk and Kerns emphasises (1985: 2) ‘the family is the major context in which illness occurs and health is maintained’ and medical illness, especially if it is a chronic one, is believed to require adaptation by every member of the family (Council, 2003: 216). The importance of family interactions is stressed across the medical literature as it is a well-documented predictor of the child’s adaptation to illness and treatments (Anthony & Koupersnik, 1973; Petrillo & Sanger, 1980; Thompson, 1985; Turk & Kerns, 1985; Roberts & Wallander, 1992; Darbyshire, 1994). Melnyk (2000), for example, reports that the emotional state of the parents and the quality of parental support are among the variables that most influence children’s adaptation to hospitalization. Researches indicate a significant correlation between children’s coping styles and mother’s ability to parent effectively during hospitalization (Jacobson et al., 1990). Moreover, it has been suggested that anxious mothers tend to have highly distressed children during and after hospitalization, as anxiety is seen to inhibit parenting styles and mothers are ‘less likely to fulfil their protective, nurturing, and decision-making roles’ (Melnyk, 2000: 6). Among the factors that are likely to influence parents’ coping strategies in dealing with their children’s hospitalization is the support received from the family network, together with the culture the family belongs to (Turk & Kerns, 1985; Roberts & Wallander, 1992; Cooper et al., 1999). Both the characteristics of the social network and wider cultures are part of the hypothesised exosystem, the external system that embraces the interaction between child and family, and, at a different level, the local hospital context which is seen to be where the microsystem (child and family) and the exosystem (societal and cultural expectations) meet the hypothesised mesosystem in a particular locality.

Family has been defined as a ‘system’ in so far as the events that affect one family member tends to exert an influence on other family members as well (Roberts & Wallander, 1992). The way each member will cope with a threatening situation is likely to impact on the other family members’ reactions and coping strategies.

A systems approach to human development considers the way that relationships within the family and between the family and social environment influence individual development and family functioning. Systems theory is based on principles that apply to all kinds of systems, including business and industry, community organizations schools and families. These principles are helpful in understanding how families function and how families and communities interact.
(Schaffer, 2004). Systems theory (Minuchin, 1988) stresses the following characteristics (Schaffer, 2004: 206):

1. **Wholeness:** One part of the system cannot be understood in isolation from the other parts. Children cannot be understood outside the context of their families. Any description of a child has to consider the two-way patterns of interaction within that child's family and between the family and its social environment;

2. **Integrity of Subsystems:** All systems are made up of subsystems. The families' subsystems include spousal subsystem, parent-child subsystems and sibling subsystems. A family's roles and functions are defined by its subsystems (Fine 1992);

3. **Circularity of influence:** Every member of a system influences every other member in a circular chain reaction. A family system is constantly changing as children develop;

4. **Stability and change:** In order to maintain stability, systems are resistant to changes. When this is not possible, the system as a whole has to change and adjust to outside influences, even if they affect only one member of the family. This property has been defined as 'family homeostasis' (Turk & Kerns, 1985: 7). In this context, illness is regarded as fulfilling a stabilizing function in the family as 'the sick child becomes the focus of attention and thus may serve to prevent marital conflict' (ibid). As Schaffer (ibid) comments, from a system perspective, the family can be seen as the integration of (i) individual members and (ii) their relationships with each other (Figure 3.4).

Figure 3.4 The family and its subsystems (Schaffer, 2004: 206)

In everyday practice, the importance of the family for hospitalized children has been officially recognized and coded by the American Academy of Pediatrics (2003). In a policy statement entitled 'Organizational principles to Guide and define the Child Health Care System and/or Improve the
Family-centered care is an approach to health care that shapes health care policies, programmes, facility design and day-to-day interactions among patients, families, physicians, and other health care professionals. Health care professionals who practice family-centered care recognize the vital role that families play in ensuring the health and well-being of children and family members of all ages. These practitioners acknowledge that emotional, social and developmental support are integral components of health care. They respect each child and family's innate strengths and view the health care experience as an opportunity to build on these strengths and support families in their caregiving and decision-making roles. Family-centered approaches lead to better health outcomes and wiser allocation of resources as well as greater patient and family satisfaction. [...] Family-centered care is based on the understanding that the family is the child's primary source of strength and support and that the child's and family's perspectives and information are important in clinical decision making.

The Family-centered Approach is based on family systems theory which helps to contextualise the child within a systemic framework of interactions. Arguably effective interventions need to take account of these structures and to understand each family's system and how this interacts with other systems and socio-cultural influences (cf. Bronfenbrenner, 1979).

3.3.1 Reaction to hospitalization: Stages of emotional reaction to trauma as perceived by key participants

As has been reviewed so far, when hospitalization occurs, there are a series of psychological consequences for the child patient, possibly ranging from regression, sadness, separation and anxiety, to apathy or withdrawal (Youngblut & Shiao, 1993; Melnyk, 2000; Rennick et al., 2002). Any self-appraisal (as a form of metacognition) might prevent the child returning to a previous psychological state when they were healthy (Thomson, 1985; Cooper et al., 1999). This process of experiencing trauma is seen to require a series of adjustments that are physical, psychological and social. The person, either a child or an adult, may have to find new coping strategies in their approach to personal and interpersonal aspects of living. The process of adjustment has been
reported to involve a possible cause of threat from abandonment, loss of self-esteem and a reduced ability to cope with daily stress (Lee 1970; Thomson, 1985; LaMontagne, 1987).

Lee (1970), suggested that the frame to analyse an individual’s reactions to trauma needed to be contextualized in what she called ‘the cultural circuit’ of the patient (op. cit: 587) which includes both the environment and the people with which the patient interacts. Lee identified four stages of reaction to trauma: impact, retreat, acknowledgment and reconstruction. This framework has been subsequently adopted and updated in later studies that report a confirmation of its continued applicability (Walters, 1981; Krulik et al., 1987; Kaiser, 1988; Appleton, 2001; Council 2003).

For example, Appleton (2001) adapted Lee’s stages of reaction to trauma in order to identify goals and potentialities of an art therapy intervention in a hospital setting. Appleton’s analysis was mainly directed to the child’s reactions and to the therapist’s approach, whereas Lee’s initial framework was a more broadly systematic focus on the different impacts that the trauma or illness are likely to have on the child, the family and nursing staff. It may be, therefore, that a synthesis of the two models could provide a more complete framework to understand the complexity of the emotional reaction to trauma. An adaptation of Lee’s four staged process of reaction to trauma in combination with Appleton’s construct, suggests the following in relation to the key participants:

1) Impact: This is the realization that a physical change is occurring. It may occur at the time of an accident or when the level of injury is realized. This state is called ‘depersonalization’ and it is seemed to be characterised by anxiety and a patient’s inability to exert control over their own behaviour.

- **Patient:** Often the patient’s perception of what they are experiencing is clear, but the event is perceived as if it was not happening to them. The patient’s behaviour may shift from anxiety and passivity to regression and poorly controlled reactions (Youngblut & Shiao, 1993; Appleton, 2001). Some patients can also experience a sense of relief from everyday life routine (Roberts & Wallander, 1992).

- **Family:** Usually the family is brought together by the emergency event (Turk & Kerns, 1985; Cooper et al., 1999). Reactions may range from ‘quiet dread to trepidation, to generalized excitement’ (Lee, 1970: 579).

- **Nurse:** Nursing care depends on the patient’s situation, as there are two kind of basic emergencies: physical and interpersonal. In any event, the nurse is expected to deal with anxiety reactions from both patient and the family.

- **Therapist:** ‘creating continuity’ is the therapeutic goal in this phase (Appleton, 2001); during a crisis, continuity is established through therapeutic relationships and the media of the therapeutic intervention. The therapist customarily maintains an anticipated
schedule of visits to the patients. The goal is to encourage a spontaneous form of expression (Appleton 2001).

(2) **Retreat:** The level of anxiety experienced increases and the patient enters a phase called a ‘defensive phenomenon’ (Lee, 1970: 580). This stage is characterised by the patient’s attempt to return to a situation prior to the occurrence of the critical event (Schaffer, 2004). The perception of reality is likely to involve a state of denial.

- **Patient:** The emotional reaction of the patient may indicate a psychological inability to face the trauma at this point in time. As a result of the trauma, the body will have changed, either temporarily or permanently (Rossi, 1993; Pert, 1997; Rennick et al., 2002; Rennick et al., 2004). The patient will have to face these changes and deal with their meanings and implications. Behaviour which indicates denial may range from indifference to euphoria (Melnyk, 2000). The patient may find it difficult to verbalize fears and concern arising from the new condition (Potters & Roberts, 1984; Froehlich, 1984).

- **Family:** It is often the case that the family would tend to assume the same behaviour of the patient which often consists of denying the implications of the illness or traumatic event. Sometimes repressed anger emerges and is redirected at the hospital staff who are blamed for their relative’s situation (Darbyshire, 1994).

- **Nurse:** In the ‘retreat’ stage, the role of the nurse is to identify the behaviour of the patient and to inform the doctors. According to Lee (1970: 582) ‘the nurse begins where the patient is’, which means that they accept the behaviour of the patients without trying to reinforce it. Nurses also attempt to bring reality to the patients, reassuring them in a non judgmental way, by having regular conversations during medications, or their rounds. Listening skills are very considered to be very important skills in this phase, as patients might need to verbalize their own experience or associated fears (Darbyshire, 1994; Bjork et al., 2006). It is important to establish a positive relationship with both patients and their families, as a break in communication may provoke a resistance that would compromise such relationships.

- **Therapist:** ‘Building a therapeutic alliance’ is the therapeutic goal during this phase (Appleton, 2001). The therapist respects the patient’s timing in getting used to the new situation and consequently focuses on building a relationship that is therapeutic and based on trust. The process of creativity of expression seems to be more important for the patient than the competence with any given artistic media (Appleton, 2001).

(3) **Acknowledgment:** The patient faces the recognition and acceptance of their new condition. When such realization happens the individual may go into a ‘mourning period.’

- **Patient:** Changes in the body image directly influence the patient’s relationships with other people (Thompson, 1985; Cooper et al., 1999). Isolation becomes one of the
most common reactions and it is often caused by fear of being abandoned and low self-esteem (Thompson, 1985). The behaviour changes as well resulting in a more argumentative and aggressive attitude, generally towards members of the family or hospital staff (Turk, D. & Kerns, 1985; Appleton, 2001).

- **Family**: There is a mixture of different feelings in this phase, ranging from guilt and shame to anger and sadness. The overall anxiety produced by these feeling may result in an overtly solicitous attitude towards their relatives, or a more distant one (Melnyk, 2000).

- **Nurse**: Their task is to support the patient and the family during this phase of grieving and adjustments.

- **Therapist**: ‘Overcoming social stigma and isolation through mastery’ is the therapeutic goal during this phase (Appleton, 2001). As Appleton states (2001: 9) ‘art can facilitate communication between the patients and the others’ in a context where contact with peers is minimal (Bunt & Marston-Wyld, 1995). The therapist can also work as a facilitator between the patients and the family.

(4) **Reconstruction**: The mourning is now replaced by a more accepting attitude. The challenge in this phase is to reintegrate positive forces in order to induce and support a new approach to life.

- **Patient**: Mastering this phase is seen to involve three stages for the patient: 1) the acceptance of the changes that have occurred in their body and the reintegration of the new body image; 2) a reorganization of social values; 3) the adjustment to a medical procedure or a technical device. What Lee describes as ‘the reintegration of the self’ (1970: 586) at this stage is seen to be mainly physically oriented.

- **Family**: All members of the family need to re-establish a balance among themselves to cope with the altered situation (Turk & Kerns, 1985). They may also have to reorientate their interpersonal relationships with the patient (Melnyk, 2000). Counselling is often an opportunity to support the family in going back to their previous routines without delaying social activities which might have been interrupted for a long period. One of the most challenging aspects of this phase is considered to be the need to differentiate between ‘meeting and perpetuating dependency need’ (Lee, 1970: 586).

- **Nurse**: Reinforcement of the progresses and achievements made by the patients are acknowledged. The nurse helps the patient and the family to plan forward toward future goals, suggesting therapies and resources available within the community.

- **Therapist**: ‘fostering meaning’ is the therapeutic goal during this last phase. In the conclusive stage of the relationship with the patient, the therapist will try to address the patient’s concerns for the future and unresolved concerns in general (Appleton, 2001).

This adapted framework is contextualized by the various theoretical perspectives rehearsed earlier. These embraces social ecology theory which stresses the interdependency of different
level of interactions between the children, their families and hospital staff. Such interactions occur within the context of the hospital, which can also be seen as a system itself that interfaces with the wider society. The framework also highlight a multidimensional system of interactions in which participant react according to (i) the challenges presented by the situation (ii) perceived reactions of each participant involved in the hospitalization.

3.4 Chapter summary and overall conclusions

To summarize, three main concepts emerge from the literature reviewed in this chapter:

1. According to the psychosocial literature on paediatric hospitalization, children's reactions to hospitalization are determined by their conceptualization and perception of both illness and treatment. Such conceptualization is connected with the level of their cognitive development and their individual coping strategies, as the subjective experience of illness - rather than its severity – appears to be one of the main factors that are likely to determine the psychological reaction of the child. Also, the appraisal of a stressful condition, such as being ill and hospitalized, depends on the individual's assessment of the environment (in this case, the hospital) that is consequently perceived by the child as more or less threatening (Lazarus, 1991, 2000).

2. The child's reaction to the illness is characterised by a complex system of personal and environmental interactions that become predictors of coping strategies that can significantly impact on health behaviours. The reaction of the family to their child's illness is a powerful predictor of how the child will elaborate their coping strategies.

3. Music in the hospital might help the child and their families to refocus their attention on something external to the illness and, through the familiarity of the repertoire, might turn the perception of the hospital environment into a more familiar and less threatening space. Consequently, the musical intervention might constitute for the child and their family a space where they interact without the mediation of anxiety and stress elicited by the child's illness.

According to systems theory, the relational aspects that connect the family to the child are central to the process of hospitalization (Turk & Kerns, 1985). Moreover, the child's behaviour cannot be understood in isolation from other parts of the system (wholeness). These parts embrace the relationship between family members and the social environment in which they live and are also interdependent with each other in determining a child's coping strategies. Systems theory (Minuchin, 1988), in addition, stresses the idea of 'subsystems' in which members of the system influence each other in a circular reaction (integrity of subsystems; circularity of influence). Such
characteristics can be seen to be central in the interaction between social ecology and transactional stress model in so far as: (i) social ecology provides a contextual explanation of different interactions that will evolve according to the changes that will take place in one of the systems and that will consequently affect the others (exo, meso, micro); meanwhile (ii) the transactional stress model works on the basis of the changes that occur in the social ecology model and combine them in a temporal sequence to determine the origin of the process of appraisal and coping strategies, predictors of health outcomes.

In this context, the musical intervention can be regarded as a 'subsystem' in which individuals or groups of musicians perform in a hospital setting by interacting with children, their families, and medical staff.
4.1 Introduction

This chapter focuses on the ongoing debate about the origins of music, its function(s) in human lives and the related implications for a musical intervention in a hospital. The impact of music on the child appears, in fact, to be influenced by the human predisposition for music and by the culture surrounding the child and their families.

4.2 Why do human respond to music?

Archaeological evidence has established that the first musical instrument, a bone flute from Germany, dates back to approximately 36,000 years ago (Mithen, 2005: 269). Music is reported to have been part of the life of our ancestors, accompanying them in their evolution, as Mithen reconstructs in his compelling account The Singing Neanderthals (2005). But music is not only an ancient capacity, it is also a human universal, as it is common to all human societies, irrespective of their culture (Blacking, 1973; Lomax, 1977; Blacking, 1995; Nettl, 2000). Moreover, it appears that any member of any culture is able to be musical, though this capacity is realized to different degrees and in different cultural and social environments (Merriam, 1964; Cross, 2001).

The origin of music has been a puzzling question for scientists since Darwin noted in The Descent of Man (1871) that our musical abilities 'must be ranked among the most mysterious with which [humans are] endowed' (quoted in Patel, 2008: 367). Musical abilities have been compared to a cheesecake (Pinker, 1997) or, less prosaically, to the ability to make and control fire (Patel, 2008), but no definitive answer has been provided yet on a specific musical gene that might be responsible for the evolutionary transmission of music as a biological factor.

In order to address the much debated question of the origins of music, researchers have relatively recently adopted a multidisciplinary approach which brings together neuroscience, genetics, musicology, anthropology, developmental and comparative research (Wallin, 1991;

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1 For a discussion and a review on human universal in relation to specific musical features see Nettl (2000), Peretz (2006: 6-7), and Trehub (2006).
Wallin et al., 2000; Peretz & Zatorre, 2003; Peretz, 2006). There are two different positions emerging from these studies: music is an enjoyable by-product of other cognitive skills (Pinker, 1997); and music is an evolutionary adaptation (Cross, 2005). The fact that each hypothesis contains some weaknesses is, at present, a secondary concern. More important is that both positions focus on identifying survival elements within the musical domain that might have been responsible for the transmission of music throughout human evolution. The importance of music *per se* is central to the evolutionary debate which reviews and discusses primarily functions of music at a neurological, social and cultural level. Such functions represent a framework to understand and contextualize the significance and the impact that music had, and still has, on human lives, where it might have originated and in which forms. This literature also helps to clarify the role of music in relation to a number of its powerful effects, such as soothing, bonding, calming, modify arousal and attention which are central to the musical process within a hospital setting, and which appear to be grounded in an evolutionary history which has passed them on as adaptive functions.

Although there has been research on the origins of music, the question has not yet been resolved; meanwhile, music remains somehow a fascinating and mysterious means to communicate emotions. The French anthropologist Claude Levi-Strauss commented on the puzzling origins of music by observing that

> ‘Since music is the only language with the contradictory attributes of being at once intelligible and untranslatable, the musical creator is a being comparable to the gods, and music itself the supreme mystery of the science of man.’ (Levi-Strauss, 1970: 18)

### 4.2.1 Is music a by-product of other cognitive skills?

There is an increasing amount of evidence, coming primarily from research on infant musicality (Deliege & Sloboda, 1996) and neurocognitive science (Zatorre & Peretz, 2001; Peretz & Zatorre, 2003), suggesting that ‘musicality is in our birthright’ (Cross, 2001: 34). However, this notion is not in line with more general theories of the infant mind which posit that, rather than being domain general, the infant mind is endowed with either modular or domain-specific

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2 Domain general refers to empiricist theories that hypothesized learning as being driven by the operation of a few general learning devices. Prominent examples of such domain-general views include Piaget’s theory of cognitive development which predicts that cognitive maturation occurs simultaneously across different domains of knowledge (Smith et al., 2004; Schaffer, 2004).
competences (Cross, op. cit.: 35). Such competences had an adaptive value during evolution and the different cognitive faculties that developed according to different time-tables are conceived as largely independent of one another. However, many theorists (e.g. Barrow, 1995, Sperber, 1996, Pinker, 1997) consider music as having no adaptive role in human evolution and confine it to a contingent - mostly hedonic - position which is exemplified by Pinker’s iconic definition of music as ‘auditory cheesecake’. By ‘auditory cheesecake’, Pinker suggests that humans are not equipped with an evolved capacity for making or appreciating music, though humans possess evolved capacities for making and understanding meaningful sound sequences in hierarchical structures, preference for certain types of acoustic consonance, etc. In other words, following Pinker’s metaphor, we do not have an evolved preference for the taste of cheesecake, but makers of cheesecake do take advantage of our evolved preference for sugars, fats, etc. (Levitin, 2006: 248). Pinker confirms his dismissive view about the role of music by writing that

‘compared with language, vision, social reasoning, and physical know-how, music could vanish from our species and the rest of our lifestyle would be virtually unchanged. Music appears to be a pure pleasure technology, a cocktail of recreational drugs that we ingest through the ear to stimulate a mass of pleasure circuits at once’ (1997: 528).

3 Modularity of Mind is a cognitive theory proposed by Jerry Fodor (1983) according to which at least part of the mind might be composed of separate innate structures which have established evolutionarily-developed functional purposes (Thurman & Welch; 2000). Such an approach is now commonly accepted in research on musical abilities which are studied as ‘part of a distinct mental module with its own procedures and knowledge bases that are associated with dedicated and separate neural substrates’ (Peretz & Coltheart; 2003: 688).

4 Domain-specificity is a theoretical position in cognitive science (especially modern cognitive development) that argues that many aspects of cognition are supported by specialized, presumably evolutionarily specified, learning devices. The position is not far from the idea of modularity of mind, but is considered more general in that it does not necessarily entail all the assumptions of modularity proposed by Fodor (Schaffer, 2004).

5 Cognitive developmentalists argue that, rather than being domain general learners, children come equipped with domain specific capabilities, sometimes referred to as ‘core knowledge’, which allows them to break into learning within that domain. In addition, domain-specific accounts draw support from the competencies of infants, who are able to reason about things like numerosity, goal-directed behavior, and the physical properties of objects all in the first months of life (Smith et al., 2003; Schaffer, 2004). Domain-specific theorists argue that these competencies are too sophisticated to have been learned via a domain-general process like associative learning, especially over such a short time and in the presence of infant’s perceptual, attentional and motor deficits. Current proponents of domain specificity argue that evolution equipped humans (and most other species) with specific adaptations designed to overcome persistent problems in the environment.

6 The debate on the evolutionary nature of music draws on the account provided by Cross (2001: 35-37).
Pinker ignited a cross-disciplinary debate with his book *How the Mind Works* (1997: 529-39), where he argued that musical abilities are bound to the domain of language and draw on a range of mental mechanisms that originally evolved for other purposes. Pinker identifies five areas that might have contributed to the fostering of musical abilities and that, according to him, had a direct adaptive value in human evolution: language, auditory scene analysis, habitat selection, emotion, and motor control. Motor control is an area connected to actions such as walking and running that are performed more efficiently in a rhythmic mode. Despite acknowledging the link between music and movement, Pinker treats music as simply ‘tapping in’ to systems of motor control, failing to recognize the deep connection between sound and movement in music (Peretz & Coltheart; 2003). Similarly Sperber suggests that music originates by an exploitation of a cognitive capacity to ‘process complex sound patterns discriminable by pitch variation and rhythm’ (quoted by Cross, 2001: 35), a feature of primitive human communication that exhausted its function once a modern vocal tract emerged with differentiation in sound patterns.

However, the idea that human musicality latched onto the capacity for language, almost in a parasitic way, is controversial. Although there has been a consistent body of research into neurosciences, both neuropsychology and neuroimaging have produced contradictory evidences on the syntax of music and language (Patel, 2008). On the one hand, neuropsychology (Levitin, 2006) has provided well-documented cases of dissociations between musical and linguistic syntactic processing by studying the musical perception of individuals who experienced brain damage (acquired amusia) or due to a lifelong condition (congenital amusia), who did not exhibit any language disorders (aphasia). According to neuropsychologists, these cases suggest that

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7 This connection has been proved to be rather powerful, up to the point that organizers of the New York City Marathon decided to ban the use of audio players during the 2007 edition of the race, as music was considered to improve the physical performance of the athletes, promoting motivation and reducing fatigue and pain perception (Macur, 2007; Dyrlund and Wininger, 2008). Furthermore, leading researchers from Colorado University (Pacchetti et al. 2000; Thaut & McIntosh, 2006) have analysed the way rhythm communicates time-information to the brain, focussing on identifying rhythm codes in the brain that structure neural communication. According to Thaut (2005), the brain is able to read auditory rhythm into its own system with great ease. It follows that the connection between the rhythmic features of music (the beat) and movement can be successfully employed in the rehabilitation of patients with neurological disorder such as stroke, cerebral palsy, muscular dystrophy and Parkinson’s disease during physiotherapy. The ‘beat-based rhythm processing connection’ is regarded by neuroscientists as a predominant line of research ‘that could reflect evolutionary modifications to the brain for the purpose of music making’ (Patel, 2008: 402) in so far as music across different cultures exhibits a common trait in the form of a regular beat ‘that afford temporal coordination between performers and elicits a synchronized motor response form listeners’ (ibid) (Nettl, 2000). Moreover, neurological studies reveal that the human ability to synchronize movements to an external timekeeper is dissociable from the capacity to perceive and produce tonal features of music (Peretz, 2006), therefore, ‘a modular view of musical ability would suggest that metric timekeeping is a distinctive feature of the human brain, one that most likely evolved in the context of group wide music and dance rituals.’(Wallin et al., 2000: 12).

8 Syntax is defined according to Patel (2003: 674) as ‘a set of principles governing the combination of discrete structural elements (such as words and musical tones) into sequences.’
human brain is equipped with neural circuitries that deal exclusively with music. Such circuitry is not only independent of language processing, but also of the melody of language (intonation) (Peretz, 1993; Peretz, 2006). Given such independence, it is possible that a person may lack musical competence, through either some form of congenital or developmental disorder, whilst having all other faculties intact; or on the contrary, retain the music faculty in the presence of other mental dysfunction (Peretz, 2005).

Neuroimaging research, on the other hand, has pointed out that processing of musical and linguistic syntax overlaps, by showing that musical syntactic processing activates areas of the brain, such as the Broca's and Wernicke's areas which are traditionally associated with language processing (Maess et al., 2001; Koelsch, 2006). To reconcile the apparent tension between neuropsychology and neuroimaging, Patel (2003; 2008) proposes the 'shared syntactic integration resource hypothesis' (SSIRH), according to which it is possible to identify a point of convergence between modern cognitive theories of syntactic processing in both language and music. This implies that 'linguistic and musical syntax share certain syntactic processes (instantiated in overlapping frontal areas) that apply over different domain-specific syntactic representations in posterior brain regions' (2003: 679), although the two systems should be seen as 'constellations of subprocesses, some of which are shared and others not' (2008: 417). Patel maintains that there is no compelling evidence yet to suggest that music is a biological adaptation and that only developmental studies of beat-based rhythm perception and synchronization - essential for all kinds of social and cultural activities, including rituals - might cast a new light on the evolutionary perspectives of music (2008: 400), as beat induction could be the variable that has made a difference in the cognitive development of the human species (Wallin et al., 2000).

Although musical abilities are not believed to be the direct target of natural selection, Patel suggests that the choice between adaptation and 'frill' is a false dichotomy in so far as music belongs to the category of 'transformative technology' (Patel, 2008: 401), by which he means a set of technologies (such as written language, the invention of aircraft, or internet) invented by humans that have become integrated in our lives and that have changed them substantially in terms of the way that we interact or communicate as a results. Patel acknowledges the importance of music and compares it to the ability of making and controlling fire, which is a powerful image that elegantly concedes the uncertainties connected to the biological origins of music as such, but that, nonetheless, recognizes a prominent role for music in human evolution:

'Music may be a human invention, but if so, it resembles the ability to make and control fire: It is something we invented that transforms human life. Indeed, it is more remarkable than fire making in some ways, because not only is it a product of our brain's mental capacities, it also has the power to change the brain. It is thus
emblematic of our species' unique ability to change the nature of ourselves' (Patel, 2008: 412).

4.2.2 Is music an evolutionary adaptation?

This second line of thought about the origin of music supports the idea that natural selection had a direct role in shaping human musical abilities and that therefore, in the course of evolution, individuals who exhibited musical behaviour acquired some advantages over those individuals who did not. Darwin (1871) was the first who argued that music played a significant role in sexual selection, specifically in courtship behaviour.

This idea has been more recently repropose by Miller (2000) who carried out a study on female sexual preferences (Haselton & Miller, 2006) showing how creativity might have evolved at least partly as a 'good genes' indicator through mate choice. Haselton and Miller asked forty-one college students, at various stages of their menstrual cycle, to rate the attractiveness of potential mates based on two models of man outlined in written vignettes: creative but poor men vs. uncreative but rich men. The results showed that women in their peak fertility tended to prefer the creative but poor artist, both as a short term preference and in the case of forced-choice decision, suggesting that creativity might be a distinctive human trait that has evolved through mutual mate choice. The authors conclude by commenting on 'the famous sexiness of musicians [that] could be a particularly promising domain for further research' (2006: 14). Whilst the study is intriguing in its implications, the idea of music as a 'fitness indicator', selected for evolutionary purposes, has been generally dismissed by researchers as it presents several difficulties. As Patel (2008) points out, one of the main problem with this theory is that humans do not exhibit that kind of high sexual dimorphism that has been established to be a distinctive trait in sexual selection. In fact, as Huron (2001) comments, women might be impressed by a man serenading them, but they are perfectly capable of serenading a man themselves, unlike female songbirds who seem not to have a choice other than to be the passive recipient of male courtship. Another difficulty with the sexual selection hypothesis is that the use of music across cultures does not appear to be limited to courtship rituals.

Music is considered by ethnomusicologists as intrinsically 'polysemic' (Cross 2001: 32) in so far as it comprises a multiplicity of functions, references and meanings, which range from

As Huron explains (2001: 47) 'sexual selection arises once a particular genetic preference is established by the opposite sex [...]. The classic example of sexual selection is the peacock’s tail. The function of the tail is not to promote the survival of the peacock; rather, the function is to promote the survival of the peacock’s genes [...]. It remains to the female’s benefit to mate with the most colourful male if her offspring are more likely to be desired by other females who are fond of colourful tails.'
communication with the dead, to building social relations in the community. Beside the ‘sexual selection’ hypothesis, there are two main evolutionary hypotheses that are currently established as part of a bigger argument to contrast the idea of music as non adaptive: music originates as a primordial form of language; and music promotes social cohesion between members of a group. These views were articulated and collected in the ‘Origins of Music’, an edited book (Wallin, Merker, Brown, 2000) which re-established an interest on the topic by bringing together evidence from different disciplines (among others: animal studies, archaeology, anthropology, ethnomusicology, psychology), grounding such evidence within the frame of contemporary theories of evolution.

A description of both views seems to be especially relevant in so far as they hold significant implications to contextualize the function of music as a means of communication within individuals of a social group. This aspect is central to the present research on music in hospitals in so far as musical interventions tend to be mostly connoted as group activity, or in the case of a one-to-one interaction, the musical activity seems to reproduce the musical dynamics typical of a mother-infant relationship (Papousek, 1996), (see Chapter 8 for a discussion of these aspects in relation to music in hospitals practices. See also section 4.2.3 on mother/infant musical communication).

(a) Music as a primordial form of language

This hypothesis suggests that language and music evolved from the same acoustic communication system. Darwin, speculated on the idea that language might have developed from a pre-existent musical communication system, an idea that is likely to remain at a level of speculation, but that has not ceased to attract interest. More recently, both Brown (2000) and Mithen (2005) developed similar arguments.

Brown identifies a type of ancient communication system that he calls ‘Musilanguage’, a precursor of language in which meaning was conveyed not so much by the shapes of sounds as by their pitch. This is a fairly complex structural system as it examines acoustic properties of music to which Brown attributed specific properties to enable the communication system to embrace elements from both music and language (2000: 279). The basic idea is that music and language are closer than commonly maintained and fit along a spectrum rather than occupying two different, partly overlapping, areas. Music and language are considered as 'reciprocal specialization of a dual-natured precursor that used both sound emotion and sound reference in creating communication sounds' (2000: 278).
Mithen (2005), similarly, argues that what he calls the 'Hmmmm communication system' (an acronym which stands for holistic, multi-modal, manipulative, musical) was the precursor for both language and music and that music emerged from the remnants of 'Hmmmm' after language evolved. He explains the transition in these terms:

‘Compositional, referential language took over the role of information exchange so completely that ‘Hmmmm’ became a communication system almost entirely concerned with the expression of emotion and the forging of group identities, tasks at which language is relatively ineffective. Indeed, having been relieved of the need to transmit and manipulate information, ‘hmmmm’ could specialize in these roles and was free to evolve into the communication system that we now call music.’ (Mithen, 2005: 266).

Mithen offers a compelling archaeological and neuroscientific-based evidence to support his view, however, current evidence from infant studies - and specifically from (i) the rate of learning musical structures (Trainor & Trehub, 1993; 1994), (ii) critical period effects (the time frame when developmental process are more likely to occur) (Patel, 2008) and (iii) acquisition of musical abilities (Bigand, 2003; Bigand et al., 2006) - suggests that the development of musical abilities is not as strong as the development of linguistic abilities and that therefore, the hypothesis of a common origin of music and language might not be a consistent one (Patel, 2008: 374 - 376).

(b) Music promotes social cohesion and social development

‘Music is a uniquely human phenomenon, which exists only in terms of social interaction; that is, it is made by people for other people, and it is learned behaviour. It does not and cannot exist by, of, and for itself; there must always be human beings doing something to produce it. In short, music cannot be defined as a phenomenon of sound alone, for it involves the behaviour of individuals and groups of individuals, and its particular organization demands the social concurrence of people who decide what it can and cannot be.’ (Merriam, 1964: 27)

Merriam and his fellow ethnomusicologists (Blacking, 1973; Lomax, 1977; Blacking, 1995; Nettl, 2000) described the function of music as existing mainly by virtue of its social features. The idea of music promoting social bonding and fostering group cohesion has been widely researched
across disciplines and appears to be the dominant view in support of the adaptive value of 
music. Studies on infants agree that the initial step in bonding through sounds is established by 
the mother singing or using expressive speech with the newborn through a process 
denominated 'emotional contagion', described as 'the tendency to synchronize vocalization and 
movements with those of another person and, consequently, to converge emotionally' (Peretz, 
2006: 24). Music has a powerful effect on mood regulation (Thayer et al., 1996; Sloboda & 
O'Neill, 2001), suggesting that the shared use of music within a group context promotes a level 
of cooperation and a sense of bond between its members. An example of this behaviour is 
described by Blacking in his anthropological account of the Venda - a South African population 
that he studied during the 50's - who performed communal music making when the social 
situation within the community was stable and not during periods of hunger or stress. This was 
attributed by Blacking to the fact that

'consciously or unconsciously, they sense the force of separation inherent in the 
satisfaction of self-preservation, and they are driven to restore the balance with 
exceptionally cooperative and exploratory behaviour. Thus forces in culture and 
society would be expressed in humanly organized sound, because the chief 
function of music in society and culture is to promote soundly organized humanity 
by enchanting human consciousness' (Blacking, 1973: 101)

The idea that music reinforces group identity, and consequently promotes social cohesion, is 
proposed in different variations. Brown (2000) argues that music is essential to create and 
maintain group identity, as collective music making supports synchronization between members 
of the group and fosters a cooperative behaviour within the group itself and a potentially hostile 
behaviour towards the 'outsiders.' Music is also used to express and represent collective 
emotions and to preserve and pass on the identity of the group through the transmission of its 
history. For Brown music is 'a type of modulatory system acting at the group level to convey the 
reinforcement value of these activities [...] for survival' (quoted by Cross, 2001: 37). Cross 
points out that if Brown is correct in his portrayal and interpretation of music's role in the 
promotion of 'groupishness' then music might be the major contributor to the very emergence 
of human culture' (ibid).

reinforcing group identity and modulate collective behaviours. Music, he says, besides its 
capacity to entrain, allows each participant to experience a sense of 'shared intentionality.' This 
is due to music's ambiguity and 'floating intentionality' which are seen by Cross as advantageous 
characteristics of music's function for groups in so far as 'they might serve as a medium for the 
maintenance of human social flexibility' (2005: 36). In fact, the 'floating intentionality' of music,
its 'aboutness'\textsuperscript{10}, provide a space where social interactions are encouraged as the risk of conflicts is minimized by the under-specifying goals implicit in music signal, which allow individuals to interact even whilst holding to personal interpretations of goals and meanings that may actually be in conflict. Cross argues that, by providing a safe space and by characterizing itself as a safe medium, music promotes cognitive flexibility and social facility and, as a consequence, the development of mind (Cross, 2001, 2005). Cross situated the meaning and function of music within a cultural context, observing that music is not universal in its meaning, but its meaning depends on the personal history of the individual listener and to the 'situational significance that culture’s shared systems of meanings confer on that activity' (2001: 39), (cf. Bronfenbrenner, 1979). His attempt to establish a mutual relationship between biological foundations of music and cultural context is rich in cross disciplinary ideas as it is based on the view that music is polysemic and, at the same time, possesses common attributes across cultures (e.g. the capacity to entrain\textsuperscript{11} to an external stimulus like when the foot start tapping to the beat of a song) which are able to shape neurophysiological correlates as a result.

The state of 'aboutness' of music explained in socio-cultural terms by Cross is explained at a chemical level by Freeman (2000), even if not fully tested in relation to music. Freeman proposes that music (and dance) are the product of biological evolution of (i) brain chemistry and (ii) cultural evolution of behaviour, and that the very action of making music together induces new forms of behaviour due to the 'malleability that can come through the altered state' (2000: 422). This is believed to be caused by the release of oxytocin, a neuropeptide\textsuperscript{12} that is traditionally associated with pair bonding, maternal care, sexual behaviour and the ability to form normal social attachments (Insel & Young, 2001; Heinrichs et al., 2002). Recent psychological research (Kosfeld et al., 2005) suggests that oxytocin modulates the activity of cognitive neural networks, resulting in enhanced trusting behaviour. Damasio (2005: 572) commented that this finding 'points to the crucial involvement of emotional phenomena in the process leading from cognition to behaviour', a perspective that is closely involved in Freeman's

\textsuperscript{10} Cross refers to 'aboutness' (2005: 30) as an alternative term to describe the 'floating intentionality' of music and the ambiguous characteristics of music as a communicative medium. As Cross explains (2005: 30) 'the same piece of music can bear quite different meanings for performer and listener, or for two different listeners; it might even bear multiple disparate meanings for a single listener or participant at a particular time [...]; it [music] can be thought of as gathering meaning from the context within which it happens and in turn contributing meaning to those context'.

\textsuperscript{11} Entrainment in this case is used by Cross and others to describes a process whereby two rhythmic processes 'interact with each other in such a way that they adjust towards and eventually 'lock' in to a common phase and/or periodicity' (Clayton et al., 2005: 3).

\textsuperscript{12} Neuropeptides are tiny bits of protein that consist of strings of amino acids. Scientists have found neuropeptide receptors throughout the nervous system, and Pert's research (1997) has shown that the immune system also produces its own. This has led to the view that the brain and the nervous, endocrine, and immune systems are interlocked in a "psychoimmunoendocrine" network in which different parts communicates with each other and where emotions are the link between the mind and the matter (Pert, 1997).
hypothesis. For Freeman, bonding does not simply come from a release of oxytocin, but it is the group music making that induces new forms of behaviour by tapping into the participants' chemically modified state that is induced by the collective musical activity itself (related to the ancient Greek concept of catharsis).

Music has the power to induce and modulate different emotional states and these states are accompanied by release of neurohormones. The study that Kreutz et al. (2004) conducted among members of an amateur choir would seem to reinforce Freeman hypothesis, even if in this case the chemical reaction elicited by group music making was measured through different indicators, specifically cortisol (an indicator of arousal levels), and secretory immunoglobulin A (S-IgA)\textsuperscript{13}. Kreutz et al. found out that singing led to an increase in positive mood and S-IgA, but did not affect cortisol responses. These results are in line with previous findings which support the positive influence of singing on subjective emotional states and immune defence (Beck et al., 2000).

According to these hypotheses, one of the reasons why music exists and has evolved might lay in its ability to promote cohesion and cooperation at the level of a social group. This might be one of the reasons why music in the hospital appears to be effective in involving participants whilst providing a socially inclusive space. In fact, music in the hospital is most likely to happen at a group level because of the hospital design: waiting rooms, wards, single rooms (that despite the name, host at least two children and their carers). Also, there are different age groups involved, different musical backgrounds, different ethnicities, cultures and social classes, different expectations. Despite this surprising mixture, an application of the available literature suggests that music elicits positive responses, both at a social and physiological level, enhancing cohesion and promoting cooperation.

4.2.3 Early musical communication: Pre-birth and infant stages

The parental care hypothesis (Trehub & Hannon, 2006) is that human babies are 'born musical' as they enter the world with an innate predisposition for music and specific musical abilities that are crucial for establishing a bond with their mothers. This capacity for music has been defined as a 'universal disposition' (Trehub & Hannon, op.cit.: 74) because newborns, irrespective of cultures, are equipped with a set of musical abilities that are related to those of experienced

\textsuperscript{13}Kreutz et al. define S-IgA as 'a protein considered as the body's first line of defence against bacterial and viral infections of the upper respiratory pathway.' (2004: 624).
listeners, suggesting that musical abilities have a biological origin rather than a cultural one. Moreover infants and parents, across cultures, exhibit strikingly similar behaviours in relation to the early stages (preverbal phase) of communication (Deliège & Sloboda, 1996; Dissanayake, 2000; Trehub, 2001; 2003; 2003a; 2006; Hannon & Trainor, 2007).

Implications are significant for the observed musical interactions within a hospital setting in so far as the relationship between carers and child is central to supporting child’s coping strategies and levels of cooperation in response to hospitalization (cf. Chapter 3, section 3.2.2). Aspects of mother/infant interactions are, in fact, likely to be reproduced either by the musicians or by other carers, or members of staff, in the attempt to recreate a safe, soothing and familiar environment for the hospitalized child (see Chapter 8 for a discussion on the data). Furthermore, participants in the musical sessions are endowed with a musical heritage that was transmitted to them by their own mother and, therefore, they all have experienced aspects of musical communication in their own infancy, so that the dynamics of musical communication are common traits for everyone involved.

It is relevant to observe that when research refers to music in relation to mother/baby interactions, they mainly refer to singing or different forms of vocalizations, as the vocal sound is the medium through which communication is most likely to take place at this stage.

Since the final trimester of pregnancy, when the auditory system is usually developed, maternal voice is transmitted through body tissues and bones so that the fetus is able to perceive it ‘significantly better’ (Lacanuet, 1996: 7) than other external sounds and therefore able to recognize it and to start creating a first level of bonding with the mother. As Welch (2006) points out, the final trimester is also the period when the fetus develops key functional elements of its nervous, endocrine and immune systems for the processing of affective states and this affect the emotional communication with the mother:

‘as a consequence, a mother’s vocalization with its own concurrent emotional correlate is likely to produce a related neuro-endocrine reaction in her developing child […]. The filtering interfacing of the maternal and fetal blood-streams allows the fetus to experience the mother’s endocrine-related emotional state concurrently with her vocal pitch contours. Feelings of maternal pleasure, joy, anxiety or distress will be reflected in her vocal contours and her underlying emotional state. Given that singing (to herself, listening to the radio, in the car, with others) is usually regarded as a ‘pleasurable’ activity, this will be reflected in a ‘positive body state’ (Damasio, 1994) that is related to the endocrine system’s secretion of particular neuropeptides, such as b-endorphine, into the bloodstream (Thurman, 2000). Her musical pleasure (expressed vocally and hormonally) will be communicated to her fetus.’ (Welch, 2006: 246)

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Consequently it is argued that the child enters the world with a ‘basic emotional capital’ (Welch, 2006: 247) that has been encoded by the neonates through the mother’s acoustic and affective experience and this heritage will shape infant’s subsequent emotional responses to sounds (Deliège & Sloboda, 1996). Studies on newborns support this view, reporting that infants enter the world having already learnt to distinguish sounds of their cultural environment and to express preferences. Among related findings, it has been reported that newborns prefer a story read by their mother during the last 6 weeks of pregnancy to a new story (De Casper & Spence, 1986), their native language to a foreign language (Mehler et al., 1988; Moon et al., 1993), a tune that the mother had listened regularly throughout her pregnancy to a novel one (Hepper, 1991). In other words infants are rather ‘conservative’ in their sounds’ preferences and seem to prefer what is familiar to them.

Sandra Trehub and her colleagues have conducted landmark research in the field of music perception in babies, and their findings suggest that young infants are able to perceive significant structural and affective features of musical sounds, irrespective of their socio-cultural environment as they seems to be equipped with an innate predisposition to structure and organize elements of auditory pattern in an adult-like way (Trehub et al., 1997; Trehub, 2001; Trehub, 2003). These abilities are evident in early development and include the preferences towards consonant intervals, an affinity for regular beats and multisensory interactions between movement and auditory rhythm (Hannon & Trainor, 2007: 467). Hannon and Trainor (2007) propose that musical enculturation is based on these early musical abilities which form the foundation of musical learning. Passive exposure to a specific musical systems will then modify the brain structures to allow enculturation to take place and, finally, formal musical training will impact on the neural encoding of musical structure ‘enhancing musical performance, music reading and explicit knowledge of the musical structure, as well as domain-general effects on attention and executive functioning, which can affect linguistic and mathematical development’ (ibid).

The interaction between infant and caregiver is a feature common to every culture and caregivers across cultures exhibit similar behaviours when they interact with their babies, either singing or speaking (Trehub & Schellenberg, 1995; Papousek M., 1996; Trehub & Trainor, 1998; Trehub, 2003a), with musical features seeming to be predominant elements during this phase of preverbal vocal communication (Papousek M., 1996; Trehub, 2003a).

Throughout the world, maternal singing to the preverbal child is characterized by the use of lullabies and play songs, a special genre of music which shares ‘simple pitch contours,

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14 In this case the tune was the musical theme of the mother’s favourite Australian television series, Neighbours.

15 Newborns were tested using the ‘nonnutritive-sucking-paradigm’ (Patel, 2008: 382) a method that records auditory preferences bases on the rate of sucking on an artificial nipple (Pouthas, 1996: 117).
repetition and narrow pitch range' (Trehub, 2003: 671). Other relevant features associated with singing to infants include ‘the use of raised pitch level, decreased tempo and an emotive voice quality’ (Trehub, 2003a: 9). Trehub and her colleagues points out that expressive features of the ‘maternal style’ are also evident when other members of the family, like fathers and siblings, interact with the infant (Trehub et al., 1994; Trehub et al., 1997; O’Neill et al., 2001). The maternal repertoire of songs is limited and highly ritualized (Trehub & Trainor, 1998). Newborns exhibit significant preferences for such rituals by listening significantly longer to an audio recording of infant-directed singing (a song in a maternal style performed by mothers of other infants) than to typical informal singing (the same song, sung in a non-maternal way) (Trainor, 1996) and greater attention to higher than lower-pitched version of the same song (Trainor & Zacharias, 1998). Maternal singing is attractive to infants and has an ‘hypnotic’ effect, as evidenced by Nakata and Trehub (2004). They showed 6-months-old infants an audiovisual presentation of their own mother (i) singing and (ii) speaking, discovering that infants demonstrated longer attention and significant reduction in body movements during their mother singing episode. Measuring the cortisol level in infant saliva before and after the mother sung or spoke to them, Shenfield, Nakata and Trehub (2003) found out that cortisol level dropped significantly after both stimuli, but stayed low for a longer period after infant-directed song then after infant-directed speech. As Trehub observes (2003: 11)

‘maternal music seems to be an effective means of optimizing infant mood […]. It appears that some forms of music, maternal singing in particular, modulate arousal levels in healthy, non-distressed infants, as they do for distressed newborns in intensive care units. There are indications, moreover, that maternal singing is a more effective regulator of arousal than is maternal speech.’

Music therapy and music medicine findings support Trehub’s view about the soothing effects of music associated with maternal singing, and more in general with familiar/preferred music (Standley & Moore, 1995). In the light of these findings, implications for the choice of repertoire (and associated performance styles) within the context of music in hospitals are significant, as there seems to be precise musical features to which the infants respond, arising as the product of prenatal learning and associations.

To reinforce the hypothesis of infants’ biological predisposition for the sonic organization of sound as music, research has pointed out that musical features (especially melodic contour) exert also a prominent role in maternal speech, especially in the stage of preverbal communication (Papousek, [M], 1996) suggesting that early stages of communication are based on musical interaction even when it is speaking-based. Hanus Papousek has furthermore suggested that musical elements, due to their flexibility in expressing different meanings – the ‘floating intentionality’ of the musical message identified by Cross – ‘pave the
way to linguistic capacities earlier than phonetic elements.' (Papousek, [H] 1996: 43). What the literature commonly refers to as 'mothoresp' or 'parentese' (Dissanayake, 2000) is defined as proper language that exhibits 'striking cross cultural universalities in the forms and functions of musical elements included in pre-verbal parent-infant interchanges' (Papousek, [M], 1996: 92). Such functions are identified in the raising of average pitch, which ranges from seven semitones to two octaves; the slowing down of the tempo of speech; longer pauses; with speech being characterized by more rhythmical and short, segmented phrases (Fernald & Simon, 1984). The rise in pitch is believed to help the infant to distinguish auditory stimulation directed to them from background noise and this feature is both present in carers' speech and singing (Trehub, 2003; 2006).

The functional significance of infant-directed melodic elements in speech has been attributed to the mother's need to modulate the infant's arousal and attention states (Papousek, 1996: 94). Mothers' respond to infant's feedback signals on a moment-to-moment basis. They intuitively tune into infants' feedback signals of 'attention, arousal, readiness to interact, boredom or exhaustion and help in regulating transitions to and maintenance of either optimal states of alert wakefulness or states of recovery in restful sleep' (ibid). Arguably, mothers behave in a very similar way to musicians in hospitals, responding to the infant signals with appropriate soothing or alerting interventions. Even though referring to speech, Mechthild Papousek writes about 'melodies' that become 'longer, flatter and lower in range and level of pitch' (ibid) - when the mother aims to reduce the intensity of the stimulus, hence relaxing the baby - and to 'shorter, steeper, and higher in level and range of fundamental frequency' when the mother responds to infants' passivity and inattentiveness.

Beside the vocal communication, there is another element present in infant-caregiver interactions which is invariant across cultures and this involves the indivisibility of music and movement. Papousek (1996: 100) notes that communication between mother and infant is not only vocal, but comprises a rich set of multimodal sensory stimulations that include tactile ('stroking, patting, tapping, pokin'), kinaesthetic ('moving infants hands or feet') and visual information ('head nodding, head shaking'). These stimuli are synchronized with the vocal ones so that infant direct speech is often transmitted through a variety of modalities that do not comprise the auditory modality alone (ibid). As will be discussed in Chapters 7 and 8, these features - typical of early interaction between carers and infants, but also typical of the musical structure and musical interaction - represent an integral part of the techniques employed by the observed group of musicians playing in the hospital.
4.3 Music as a process

4.3.1 The effectiveness of music within a therapeutic setting

Over the past three decades there has been a growing number of researches on the psychological and physiological effects of music associated with illness and medical treatments (Wolfe, 1978; Chetta, 1981; Micci, 1984; Froehlich, 1984; Ryan, 1989; Brodsky, 1989; Thaut, 1990; Standley & Hanser, 1995; Malone, 1996; Daveson, 2001; Aldridge, 2002; Longhi & Pickett, 2008; Sarkamo et al., 2008). These studies have been largely conducted by music therapists and hospital staff, each group reflecting their professional focus.

Dileo (2008) stresses the importance of distinguishing between music interventions administered by health care professionals (music medicine) and those implemented by music therapists, as the latter are argued to be more effective than the former (Dileo & Bradt 2005). If so, this might be attributed to the fact that music therapists usually tailor their interventions to meet patients’ perceived specific needs and to engage in active musical interactions with patients whilst employing a systematic therapeutic process that includes assessment, treatment and evaluation. Whilst music medicine intervention is defined by Dileo (2008: 2) as a ‘passive listening to pre-recorded music offered by medical personnel […] [where] no systematic therapeutic process is present’, in contrast, a music therapy intervention is described as an intervention that ‘requires a trained music therapist, the presence of a therapeutic process, and the use of personally tailored music experience’ (ibid).

The music therapy community appears to evidence agreement on identifying four methods, and associated variations, through which a music therapy intervention is carried out (Aldridge, 1994; Standley & Hanser, 1995; Daveson, 2001). These embrace: 1) listening to live, improvised or pre-recorded music; 2) singing known songs, song writing and lyric substitution; 3) improvising music spontaneously using voice and/or instruments; and 4) music combined with other modalities such as movement, imagery or art. Similar activities, with the exception of listening to recorded music, are also part of what is defined as a ‘music in hospital’ intervention, including the training aspect of musicians, which are not therapists but nonetheless are selected by associations providing specific training and therefore equipped to play in hospital settings.

Music therapy research has been traditionally characterized by the use of qualitative approaches and more specifically, case studies, which are advocated in the research literature as a valid tool to provide a detailed description of a single phenomenon (Bruscia, 1995; Pothoulaki
et al., 2006). However, in recent years there has been a call for stronger evidence-based practice and the consequent employment of quantitative approaches in researching similar forms of provisions (Staricoff, 2004; Edwards, 2005; Daykin et al., 2007). This might be attributed to an emerging need of funders to establish a statistically significant link between the effectiveness of the musical intervention and the health outcomes of patients involved, in order to justify the ongoing funding of music programmes (Daykin et al., 2006; Music for Health Roundtable, 24th October 2007, RNCM Manchester, minuted meeting). It is, in fact, increasingly more common to trace this explicit link within systematic reviews where, listed among the objectives of musical interventions, appear those of ‘reducing drug consumption; shortening length of stay in the hospital; increasing job satisfaction; promoting better doctor-patient relationships; developing health practitioners empathy across gender and cultural diversity’ (Staricoff, 2004: 10) (Cepeda et al., 2006; Dileo et al., 2008). If, on the one hand, the link between health outcomes and variables that can be translated into an economic value for the hospital (e.g. shortening length of stay; reduction of drug consumption) is made clear, on the other hand, such comprehensive analysis of the objectives of music, or any other art related intervention, underline an emerging holistic approach where patients and their health are considered to be the product of an integrated systems of interactions of which music is part (Daveson, 2001; Robb, 2000; 2002).

Edwards (2005: 294) has identified four levels of evidence that have to be met within an ‘evidence based medicine’ framework for the research to be considered reliable. These levels are: 1) Evidence must be obtained from a systematic review or meta-analysis of all randomised control trials (RCT)\(^\text{16}\); 2) Evidence must be obtained from at least one properly designed randomised control trial; 3) Evidence should include all studies that have used comparative method but are not “properly designed” randomised control trials; and 4) Evidence should be obtained from case study or single subject designs, either post-test or pre-test and post-test.

Although the randomized control trial is a method widely used in health care research, its use in relation to music therapy has been questioned. O’Callaghan (2003) points out that there might be a number of methodological issues which could be inappropriate to test hypotheses about the effects of music therapy, especially in relation to children, as music therapy interventions differ from a consistent protocol in so far as they contain a degree of flexibility due both to a range of variables that are likely to affect its outcomes and the difficulty in elaborating a research design that is able to embrace most of such variables. Factors like demographic characteristics of participants (age, sex, socio-economic status), different illnesses

\(^{16}\)The RCT, frequently described as the “gold standard” for medical research, is characterised by the following features: ‘(a) patients are randomly assigned to treatment or control groups, (b) all patients who enter the trial are accounted for at its conclusion (and are analysed in the group to which they were randomly assigned; that is, they cannot be changed to the control group if for some reason they choose not to have music therapy), (c) patients and clinicians are not aware of the group to which the patient has been assigned, (d) aside from the experimental treatment, the groups are treated equally’ (Edwards, 2005: 294).
and their different stages, personality traits and related coping strategies, support of the family, types of musical interventions (active music participation, passive listening), selection of music - to mention just a few - are reported to be crucial variables, but difficult to be monitored simultaneously within a unique research design. Moreover, Harrer and Harrer (1977) observed that any response to music is individualized and it happens according to three factors: 1) the individual’s autonomic regulatory system, which is in turn affected by demographic factors and temporary conditions such as fatigue or hunger; 2) emotional reactivity, or the individual’s psychological interpretation of contingent circumstances; 3) the individual’s extra musical associations and preferences. These findings reinforce the idea that each individual has a unique biological system that reacts to a musical stimulus with a consistent physiological response and perceived psychological experience (Davis & Thaut, 1989), hence a further difficulty towards the generalization of findings.

Although the corpus of research about the effectiveness of music as a therapeutic tool has been consolidating in the last three decades, the scientific community has not reached an agreement about a possible music protocol to be introduced as part of available complementary therapies, with the result that the use of music is very much left to the discretion of enlightened (and resourceful) hospitals (see Chapter 2, sections 2.2.1 and 2.2.2). Despite the qualitative shift in adopted methodologies, there still seems not to be consistent evidence to enable researchers to generalize on the impact of music on specific groups of patients, specific illnesses, according to specifically designed musical interventions (Aldridge, 1994; Pothulaki et al., 2006), although the overall majority of studies reported within systematic reviews reports positive or not significant effects of musical interventions on hospital patients (Evans, 2001, Staricoff, 2004; Cepeda et al., 2006; Pothoulaki, 2006), with few exceptions commenting on the effects of music perceived as negative by some of the participants (O’Callaghan, 1996; Edwards, 2005).

The main limitation of these studies appears to be of a methodological nature. The conclusions of the five Cochrane’s Systematic Reviews commissioned since 2003 (Maratos et al., 2008; Cepeda et al., 2006; Gold et al., 2006; Gold et al., 2005; Vink et al., 2003) reach preliminary results regarding the effectiveness of music associated with depression, pain, autistic disorders, schizophrenia-like illnesses and dementia. Although findings from individual randomized trials support the positive effects of music on the identified variables, ‘the small number and low methodological quality [...] mean that it is not possible to be confident about its effectiveness’ (Maratos et al., 2008: 1). In this specific review, the number of studies selected was limited to five, which partly explain the authors’ comment, although in the case of the review on the use of music to reduce pain - where the number of studies reviewed amounted to fifty-one, with 3663 subjects involved - the conclusions reached were similar in stating that ‘listening to music reduces pain intensity levels and opioid requirements, but the magnitude of these benefits is small and, therefore, its clinical importance unclear’ (Cepeda et al., 2006).
Other systematic reviews, specifically about the effects of music on stress reduction, on anxiety in short-waiting periods (Hanser, 1985), and about the use of music in oncology settings (Pothoulaki et al., 2006), concord to identify the perceived lack of methodological rigour, especially in the selection of research designs, which is seen to be one of the main obstacles in the generalization of the findings. Also, a further obstacle towards the generalization of the findings seems to be the lack of follow up studies or longitudinal research to monitor the effects of music on selected variables on a broader time frame (Gold et al., 2003).

Traditionally, research on music therapy/music medicine has focused on the impact of music on specific variables and music has been shown to be effective in eliciting a number of physical and psychological responses. Although the overall evidence about the effectiveness of music therapy is not yet widely recognized because of an absence of methodological rigour, different literatures are nonetheless consistent in reporting the effects of music on a number of (i) psychological variables such as anxiousness, relaxation and depression (Biley, 2001; Chan et al., 2006) and (ii) physiological variables such as heart rate, skin conductance, blood pressure (Gomez & Danuser, 2004; Chafin et al., 2004; Iwanaga et al., 2005; Etzel et al., 2006).

Proponents of Naad Yoga (Sikh music), for example, suggest that a wide variety of emotional states can be directly influenced by specific musical patterns. These are learnt and practised by expert musicians as a mean of traditional therapy (Singh, 1993).

A published overview of related literatures suggests that the musical experience within a paediatric hospital setting is likely to embrace five main features which can also include subcategories (Preti & Welch, 2004). The primacy of any one of these features relates to their particular effects on the children in this context and on the observed/reported impacts. These five features are reviewed in the sections that follow:

(1) Interconnections between psycho-acoustic phenomena and emotional responses, related to the communication and evocation of emotions through music and the related effects that this interconnected process has on the different people involved

The literature suggests that music in the hospital context has the potential to be a form of communication that helps children to release emotions, such as turning fear and anxiety into something more positive and relaxed (Curtis, 1986; Malone, 1996 – see Preti & Welch, 2004). However, the underlying explanations for such effects have not been explored systematically, nor has the research been examined fully in theoretical terms with regard to music's inherent psycho-acoustic features (such as pitch, loudness, duration, timbre) and its social-psychological components (Hanser, 1985; Welch, 2000, 2001). Most of the work published about these matters has focused more on recognition of emotion rather than an induction of emotion or emotional response to music (Juslin & Sloboda, 2001; Gabrielsson & Juslin, 2003).

It is theorised that the musical intervention in a hospital setting is based on the development of a close relationship between the musician(s) and the child (as exemplified in the
comments from musicians in section 2.3.3.5). Assuming that the musician is sensitive and able to ‘tune in’ to the patient’s emotional state, music can become a strong means of reciprocal communication between the two of them. As Gabrielsson (1999) explains, the emotional intention underpinning music is one that works as a message, independently from the musical genre played; in this case, the choice of music cannot be disconnected from the intentions underpinning its performance and the resultant interaction between the ‘musician in hospital’ and the hospitalised child.

(2) Physical/physiological impacts, concerning the influences that music has on the physical, physiological and psychological conditions of children, and how these effects improve their hospitalization

Research in neurophysiology demonstrates a direct relationship between the nature of pain and the central nervous system in influencing processes such as ‘suggestion, attention, anticipation, anxiety’ (Wolfe, 1978: 162). This has led to various psychological and neurological approaches to the treatment of pain. Music has been considered as one of the variables that may influence pain behaviour and improve it (e.g. Curtis, 1986).

Emotional and behavioural responses to anxiety and pain present a barrier to recovery for paediatric patients, as these responses interfere with both the maintenance of healthy psychosocial stability and a decrease in patient compliance with medical staff (Cowan, 1991). Various studies demonstrate that music can reduce the perception of pain, both physically and psychologically (Curtis, op. cit.). Several, for example, show the effectiveness of music listening in reducing fear behaviours, enhancing relaxation for different medical procedures (Ryan, 1989).

All these studies recognise the effect of music on a number of variables concerning children as they are admitted to the hospital. These are anxiety, stress, pain and, more specifically, distress due to the particular treatments that children are undergoing. The measurement of the therapeutic effects of music is not always accurate because of the difficulties in establishing a precise relationship between emotional changes and the type of effect associated with music. As Hanser (1985: 201) explains, the ‘continuing challenge [in measuring physiological and psychological effects of music] is to isolate the factors responsible for any changes that occur.’ However, as the latest researches have suggested (cf. Thaut & Petersen, 2001), the development of neurological researches related to musical perception is making quantification more reliable.

(3) Therapeutic, related to the different ways/techniques of playing music in hospitals and their use according to different situations

Most of the definitions of ‘music therapy’ stress the importance of the relationship between client and therapist within a therapeutic context (Bruscia, 1998). This implies a professional and systematic use of music and, above all the acceptance of the ‘institutional’ role of the music
A therapist within the medical staff. Standley (1995) and Bunt (1997) identify six basic techniques through which music is employed in the medical context. Although none of the Florentine team was a music therapist per se, during my time there as a practitioner (see Chapter 1), we often used music in ways which accord with the practices of music therapy, some more than others. In our case music was always live music. These techniques were: passive music listening, active music participation, music and counselling, music and stimulation, music and biofeedback, music and group activity. The music-medicine literature suggests that patients should choose the music selected for the experimental intervention. The studies generally do not comment on this aspect, but it seems to be relevant that the choice of the therapists is often oriented towards music that is familiar to the patients rather than on unknown music. The choice of music to be used in the hospital depends on many variables. Musical behaviour has been defined by Welch (2000: 3) as the interface between three generative elements 'namely (i) the overall nature and individual developmental history of our human anatomy/physiology, (ii) socio-cultural context, and (iii) music (however defined).'</p>

This implies that characteristics like personality traits, language, culture, educational influences, are all relevant in musical choice. It also means that music is likely to become more effective if these characteristics are addressed somewhat consciously in the musical choice. As Hanser (1985: 199) comments: 'selection of the right single piece or musical sampling is crucial to the success of the experiment.'

(4) Social, regarding the impact of music on facilitating interpersonal processes such as interaction and verbalisation

One of the most important functions of music within a hospital may be to help children verbalize the hospital experience in order to cope with it better. Writers agree that hospitalisation and illness 'arouse the need for creative expression as a mean of coping, [and that] a child can channel pain and anxiety into creative expression' (Froehlich, 1984: 4; Brodsky, 1989), minimizing the effect of hospitalisation. For these reasons, many hospitals offer so called Child Life Program which utilise play activities to help patients to cope with the stress of hospitalisation, providing 'opportunities for normal growth and development as would exist out of the hospital' (American Academy of Pediatrics, 2000: 1156). However, there is a range of studies concerning the effectiveness of music in supporting the development of social interactions and this would support the development of a more systematic employment of music for social reasons within a hospital context. The Florentine team had observed that music works as a bridge between children, musicians, parents and medical staff and promotes positive interactions between them.

(5) Educational, concerning the (usually unintended) educational outcomes that musical provision can have for children within a hospital setting
Music in hospitals can often be an educational experience for the children involved (Bunt, 1997). Even involuntarily, children may learn songs sung by the music therapist or visiting musicians and/or they can improve their rhythmic skills by practising during improvisational sessions. All these experiences could be defined as informal way of learning.

As Green (2001, 2008) suggests ‘music learning can occur without music teaching’ (2001: 104) and there are a number of features that contribute to define this particular way of learning. In some of the cases, these practices are very similar to the ones that hospitalized children experience. From what we have observed in the Florentine context and according to Green (2001) there are at least two main educational outcomes from a regular musical intervention in a hospital setting: 1) Children learn how to play together by watching and imitating other children or the musicians who is leading the session; 2) There is a process of skill and knowledge acquisition that is both conscious and other-than conscious. Music sessions in a hospital setting appear to be an informal and relatively unstructured form of education which provides children with an opportunity to engage with and through music. Music fosters social interactions between hospitalized children, their carers and the hospital staff and supports cognitive skills such as concentration and memory as well as co-ordination.

4.4 Chapter summary and overall conclusions

The main focus of the chapter was to contextualize the role of music in human lives and its potential effectiveness in relation to a musical intervention within a hospital setting. Most of the ‘working’ features of such interventions seem to originate from ancient functions of music that are embedded in our genetic design, and nurtured by our contemporary environments, hence especially effective in eliciting a set of responses.

Even though evolutionary evidence about the ‘innateness’ of music remains controversial (Patel, 2008), research highlights the central role that music occupies in the dynamic of human evolution and in human lives in general. Music represents a privileged channel of communication between carers and infants, consistent across different cultures. Following a pre-birth form of musical enculturation, newborns enter the world already programmed to recognize sounds, express musical preferences and distinguish perceptually between basic musical features. Sounds seem to be what children react to in the first place as a consequence of their biological design.

Music has been essentially viewed as organised sounds (Sloboda, 1985) and music listening as the perception of form, or structure, in sounds (Trehub et al., 1997: 105). Infants respond to sounds and translate such acoustic information into neural activity, which then gets
transformed in auditory brainstem which is able to code different neural response properties for
different musical properties (pitch, timbre, intensity) (Peretz & Coltheart, 2003; Koelsch &
Siebel, 2005). The extraction process of auditory features is complex and not entirely
understood yet, but what is proposed by neuroscientists is that the brain groups acoustic events
following Gestalt principles such as ‘similarity, proximity and continuity’ (Koelsch & Siebel,
2005: 579) and that is how music is distinguished from other acoustic signals as it is processed in
the brain.

Why children respond to music seems to be also in need of a culturally located answer,
as music has been demonstrated to be an important element in establishing the first bond with
the mother and subsequently with other members of a social group in order to preserve group
identity or modify collective behaviour through different rituals. Music is a ‘flexible’ medium for
communicating and, at the same time, a powerful means to effect and change emotional state
(Gabrielsson, 2001). Although the biological origins of music are still not clear, research is now
almost exclusively conducted in neurological areas rather than adopting cultural perspectives,
Blacking’s vision, although perhaps dated, sounds still rather powerful and convincing in its
emphasis on the research of music as cultural expression of individuals that interact together as
part of an enriching process:

‘we can no longer study music as a thing in itself when research in
ethnomusicology makes it clear that the expression of tonal relationships in
patterns of sounds may be secondary to extra-musical relationships which the
tones represent. We may agree that music is sound that is organized into socially
accepted patterns, that music making may be regarded as a form of learned
behaviour, and that musical styles are based on what man has chosen to select
from nature as a part of cultural expression […]. But the nature from which man
has selected his musical styles is not only external to him, it includes his own
nature – his psychophysical capacities and the ways in which these have been
structured by his own experiences of interactions with people and things, which
are part of the adaptive process of maturation in culture.’ (Blacking, 1973: 25)

In summary, Part 2 has focused on the theoretical underpinnings of the structure (Chapter 3)
and effectiveness (Chapter 4) of music in hospitals by reviewing a set of cross disciplinary
literatures. The next section (Part 3) will closely analyse a music in hospitals programme in an
Italian paediatric hospital.
Part 3. The *Meyer* paediatric hospital in Florence
Chapter 5. Research design: An illustrative case study

5.1 Overall design

As stated in the thesis introduction, the overarching aim of this doctoral study is to understand more clearly the nature of music provision in a hospital setting and the perceptions of its effects through (a) an exploration of previous research as reported in diverse literatures and (b) new empirical data. With regard to the latter, the main fieldwork takes the form of a single case study focused on one hospital that was selected 'to maximise the utility of information' that was likely to be available (Flyvbjerg, 2001: 81). Within the hospital, nested case studies were identified representing each participant group as reported in the literature reviews (see Chapters 2 to 4), namely the child, the musician, the parent/carer, and the hospital staff. The chapter reports the collection of data about each of these groups within an 'information-oriented' case (Flyvbjerg, op.cit) and how data were managed and analysed. The chapters that follows (Chapter 6 and Chapter 7) provides an analysis of these data.

The two main research questions from Chapter 1 were kept in mind in the organisation and collection of the fieldwork data, each with a subsidiary question:

1) What happens when live music occurs in a hospital context? What are the possible characteristics of an 'effective' musical intervention?

2) What is the value of offering a musical programme in a hospital setting? Who benefits (if at all) from the musical intervention?

The focus of the research was exploratory and multi-focused, as numerous studies had previously investigated the influence of single variables on children's responses to music in a clinical setting, whilst a smaller proportion of research had focused on the complex set of interactions surrounding the use of music in similar environments and their dynamic impact on the overall perceived success of the intervention itself.

The research aim was, therefore, (i) to identify recurring themes and perspectives evidenced in the musical processes; (ii) to identify possible patterns among the data for each participant group; (iii) to analyse the processes of observed and reported musical interaction and its determinants, whether musical, verbal or non verbal, according to an action-reaction-interaction process between child and musician.
A flexible, exploratory design, as described by Robson (2002: 166), appeared to be the most suitable research approach because it includes fundamental characteristics as 'an evolving design, the presentation of multiple realities [...] and a focus on the participant’s views’, which were seen as particularly relevant to this research. Qualitative and analytical case studies, based on multiple methods of data collection (participant observations, field notes, interviews single and group, documentary analyses, audio and video recordings) were employed to investigate the nature of musical interventions in a particular hospital. Among the reported advantages in adopting a case study design, Cohen and Manion (1995: 123) suggest that case studies 'allow generalizations either about an instance or from an instance to a class' as their strength ‘lies in their attention to the subtlety and complexity of the case in its own right.’ This view is also shared by Yin (1994) who describes case studies as an appropriate option when the research is focused on a situation where the boundary between the phenomenon and its context are not clear. The case study approach offered the opportunity to explore complexities in the dynamics of interactions between different groups of people.

Given the selection of the particular case, the role of the researcher in the data collection process was that of an ‘insider’ having been (i) previously employed as a musician in the Musica in Ospedale programme in the oncology ward from 1998 to 2001; and (ii) having attended the one-year training course for musicians in hospitals in 2001-2002. The familiarity with the particular context appeared to be an advantage both in terms of being welcomed and facilitated in the research procedures and in terms of being trusted during the interview process. However, such a close relationship between the researcher and respondents is also considered a potential source of bias if there is a prolonged involvement with the respondents, as the researcher is likely to develop a positive or negative view of events (Robson, 2002: 172). To address this issue, the research design included triangulation of data by comparing observational and subsequent interview data and also methodological triangulation, in so far as there was a combination of qualitative and quantitative approaches (however the design was kept largely qualitative).

Given the previous employment history of the researcher at the hospital, a form of ‘participant’ observations1 were carried out according to an observation schedule (Appendix B, C and D) previously designed, and subsequently refined in the course of the fieldwork that aimed to (i) record the number and the quality of interactions happening between musicians, child and carers and (ii) to determine what kind of musical event was triggering a particular response in any of the group involved (see the discussion in Chapter 8). The observation schedule was adapted from that employed by the Structured Observation System (SOS), a data

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1 ‘Participant’ is being used here in the sense of an insider perspective concerning the nature and process of being a musician in this particular children's hospital, based on five years' previous employment in this role. The term 'participant' does not imply actual musical performance in this instance.
collection method developed to document changes in the communication behaviour of children identified with speech and language delays which takes the shape of an observation schedule with a built-in rating scale. The SOS reflects the occurrence of communication behaviour and the amount of assistance needed for behaviours that occur (Reading & Richie, 2007) and it appeared to be a dynamic way of noting changes. The adapted observation schedule, however, was more flexible in terms of not suggesting the recurrence of any kind of specific behaviour, nor specific actions, as the main aim of the observation itself was to gather a sense of behaviours (musical and non-musical) and the dynamics occurring during a music session.

The use of observations were considered a suitable method, in so far as data were collected on non-verbal behaviour and the case study observations took place over an extended period of time so that the researcher was able to develop more intimate and informal relationships with the group of participants observed (Cohen and Manion, 1995: 110). According to Maxwell (1992), there are two main threats to the validity of a flexible design and they lay in the description of the study and in its theory. In order to address these issues in relation to the description of the data (field notes and observation), each observation was audio recorded and some of these video-recorded (see below for the exact detail of data gathered in the study). Interviews with musicians, children, parents and hospital staff were fully transcribed, alongside field notes (see Appendices J to M).

Thematic analysis informed by grounded theory (Strauss & Corbin, 1990) and content analysis were performed on the four groups of data (observations, videos, interviews, field notes) with the support of Atlas.ti software (Atlas.ti 2005). Atlas.ti is a commercially available software tool that has been specially designed for the qualitative analysis of textual, graphical, audio and video data. The process of analysis was as follows:

- Observations, field notes and interviews were transcribed into Word.
- The Word files were then imported into Atlas as ‘raw’ data (see left hand side of Figure 5.1).
- The text was coded according to particular emergent features (related to the inherent focus of the textual comment and/or the application of categories/concepts from the literature) (see right hand side of Figure 5.1 and the highlighted example and coding in Figure 5.2).
- The software groups codes together and presents them (a) as a list that (b) has direct links back to the original text (see Figure 5.3).
- The list of codes can then be clustered by the user into ‘families’ of related categories (see Figure 5.4).
- A similar process was undertaken with the video data in which the raw video was imported into Atlas and coded in the same way (see Figure 5.5).
Appendix J, K, L and M provide detail of the various transcripts and coding lists. Example coding and clustering ('families') were verified by the doctoral supervisors in discussion with the author, having previously discussed extracts from the videos with participants (musicians playing in the hospital and the two hospital psychologists) and (subsequently) fellow researchers at the Institute of Education.

Figure 5.1 The screen dump shows an extracted text from an interview with a parent, recorded on audio and (for the purposes of illustration here) translated from the original Italian Word file. The coding in the right hand column is generated by the *Atlas.ti* software from researcher allocated code. The colours illustrate how the same raw text can be coded under different headings and sub-headings.
MOTHER: Yes, often enough, even though it's never enough for him as he would always have more.

MOTHER: Yes, as he always returns when he hears the music. When he is in the procedure room he hardly even exists, as the nurse watches the machine and with the music he dances, sings and doesn't worry at all. We even manage to do CAT (computed axial tomography) and various magnetic resonances without sedation, which is very unusual because children, and especially young ones, are afraid of all the noises coming from the machines. But he just gets in there and the only thing he wants is that I sit next to him and sing. When I get swayed I tend to forget the songs I usually sing. I close the door. I sing very close to his head and hold his hands, as other words I end up having a 'rash' myself, which is not exactly the best outcome!

MOTHER: Have started singing since he was a baby, as I have learnt new songs. But as general, he is an lover of the music. Whenever he watches TV, the only but he is attracted to the music, like child has a music player that he keeps pressing forward looking for a particular song. When he finds the song he smiles and starts moving. The mother sings [...]. This is a song that he has learnt from Pietro (one of the musicians). He is absolutely crazy about this song! Even when we are in the car, this is the only song he wants to listen to, even if we turn the music off. Of the ten he wants us to sing along, otherwise he gets annoyed.

Figure 5.2 The highlighted text (left) is represented by a new code (box on right in red)
Figure 5.3 The figure illustrates the original text (left) and the emergent list of codes and their occurrence (right), with a superimposed example of the connection between two quotations that belong to the same code. One quotation is highlighted (left) and numbered 6.2 (right).
Figure 5.4 The final phase of the coding process is to group codes into ‘families’ (as described by Atlas ti) under a particular overarching theme. The example above is for the theme of ‘characteristics of a successful intervention’
Figure 5.5 The process for coding video examples is very similar. Video is imported into **Atlas.ti** and stopped/started (see bottom of figure for timing) to allow particular events to be coded (see bottom left).
5.2 Ethical issues

Hospitals and children are considered sensitive areas to research. The fieldwork was, therefore, discussed in great detail and carefully planned within several doctoral supervisions. As the project needed the hospital's approval, it was not necessary to obtain internal approval from the Institute of Education's Ethics Committee, although the supervisors had approved the design on behalf of the IoE. However, it was made clear at different stages of the project, that the researcher adhered to the code of ethics approved by The British Educational Research Association (BERA)\(^2\). There were three different approvals to be obtained before starting the research: 1) from the hospital; 2) from the musicians, and 3) from children and their carers.

It was relatively straightforward to obtain approval from the hospital. The plan for the research was sent to the Research Ethics Committee that after four weeks deliberated positively about hosting the research in the Florentine paediatric hospital (Appendix E). This was both due to the fact that the ethical code about research that does not involve physical experimentation on patients is less strict in Italian hospitals, and to the fact that the research design was not perceived as an invasive one. Moreover, the hospital seemed to be keen to collaborate with a UK-based research project, led by a former employee musician who was familiar with the music programme.

An experienced psychologist from the pain control service was appointed as the researcher's personal tutor and was in charge of introducing the researcher to hospital staff, patients and their families. The mediation of an internal member of staff was an invaluable aid as it helped the researcher to be welcomed and the research itself to be valued and legitimized by the hospital. It also meant that hospital staff were aware of the presence of the researcher and were, therefore, very collaborative. The researcher was given a badge indicating her role within the hospital and the title of her research. The letter of official authorization from the hospital was often requested by nurses and doctors in different wards, especially in the first week of the fieldwork.

Musicians were contacted both through the association managing the *Musica in Ospedale* project and individually and they all agreed to participate in the study. They received a copy of the project with the attached code of ethics from the BERA where confidentiality, anonymity and the right to withdraw at any stage were guaranteed.

Due to the temporal and unpredictable nature of hospitalization and to the organization of the musical interventions, children and their carers were identified by the musicians and the hospital staff according to their individual criteria, which then become part of the research itself.

\(^2\) A copy of the BERA ethical guidelines is available for download at: [http://www.bera.ac.uk/files/2008/09/ethical.pdf](http://www.bera.ac.uk/files/2008/09/ethical.pdf)
On some occasions, musicians explained the aims of the research and asked for consent on behalf of the researcher.

A standard form supplied by the hospital was used to provide written consent which was only necessary for video material (Appendix F). The form specified the use of video material for research-related purposes, which included conferences. Individual and group interviews happened in a more informal way, under two main categories: either before or after the musical intervention or, separately at other times. In all interviews the research aims were briefly outlined and participants were verbally asked if they were willing to answer some questions in relation to music and the musical intervention experienced in the hospital. Confidentiality and anonymity in the data processing were also mentioned and a consent form was signed by all participants’ carers.

5.3 Contextual features

5.3.1 The hospital

Fieldwork took place in the Meyer paediatric hospital, in Florence, over a period of four weeks. The hospital is a renowned paediatric centre in Italy and it occupies a prominent role in the life of both the Florentine community and Tuscan region. Across many years, the hospital Charity (Fondazione Meyer) has carried out high profile fundraising campaigns, involving actors, footballers, and various personalities that have visited the hospital to associate their image to the Charity’s campaigns. Also, the hospital logo is present on several products whose proceeds are donated to the Charity, as well as being at the centre of local society and sporting events. All events are regularly broadcast by regional newspapers and televisions.

The 2005 general statistics of the Comune di Firenze (Bettucci et al., 2006: 45-49), the latest data available, gives an indication of the scale of the hospital. The hospital has 172 beds: 40 in day hospitals and 132 in wards. The total number of staff is 738, with 141 doctors, 425 nurses, 100 technicians and 72 administrators. Admissions in 2005 were 9,647. The Meyer hospital is considered to be one of the most prestigious paediatric centres in Italy and it attracts young patients from all over the country.

The hospital is part of an Italian network of clinical excellence comprising seven paediatric hospitals which are committed to operate on a ‘non-competitive base’, sharing scientific knowledge (Ministero della Salute [Ministry of Health], 2008). One of objectives of the hospitals’ confederation, besides those strictly connected to medical aspects, is the
implementation of ‘The European Association for Children in Hospitals (EACH) Charter’ (Appendix G). The charter was stipulated in 1988 in Leiden, Netherlands, and is a list of the rights for all children before, during or after a stay in the hospital. The 10 principles of the EACH Charter relate in many respects to the rights of the child in general as stipulated in the UN Convention on the Rights of the Child (UN CRC, 1989), as well as to the recognition of children's different emotional and developmental needs depending on their age. Article 1 in particular, emphasises the primacy of providing the hospitalized child with a suitable environment designed to meet their needs by stating that

‘Children shall have full opportunity for play, recreation and education suited to their age and condition and shall be in an environment designed, furnished, staffed and equipped to meet their needs’ (EACH Charter, 1988)

The hospital charity is committed to the organization of so-called ‘recreational’ activities, and has sponsored the ‘music in hospital’ programme, since 2003.

5.3.2 The project: Musica in Ospedale

The Florentine hospital was selected because of its unique musical activity, which has been running since 2003, covering 23 wards with 45 hours of music a week, performed by a team of nine musicians specifically trained by a local music association.

The genesis of the music programme dates back to 1996, when a local charity, the Fondazione Livia Benini introduced live music in the oncology ward. The programme was inspired by Philippe Bouteloup, a French musician that since the early 80's had been running music programme in French paediatric hospitals. The chief executive of the charity selected a musician from the staff of the Athenaeum Musicale Fiorentino, a local school of music. The musician – who was a piano teacher and played the guitar – was sent to Paris to attend a five day music-in-hospital training course run by Philippe Bouteluop. She then started playing in the oncology ward. The initiative was positively welcomed by children and their parents, but less by staff, who describe music as ‘distractive’ and ‘noisy’ and showed initial resistance towards the project (from the ‘storia del 7L’, http://www.fondazione-livia-benini.org, retrieved on 24 July, 2008).

During the years, the project grew to the point that in 1998 the Fondazione Livia Benini was able to sponsor live music interventions for seven days a week, both mornings and afternoons, with five musicians involved. To that point, music was limited to the oncology ward. In 2001, the charity, in collaboration with the Meyer hospital, the Athenaeum Musicale Fiorentino,
Philippe Bouteloup, and the Marc Bloch University of Strasbourg (specifically the Centre de Formation de Musicien Intervenants – centre for the training of intervening musicians) organized the first Italian training course for musicians in hospitals. The course’s aims were twofold: 1) to create a new professional figure, a ‘musician in hospital’, which could be integrated into the hospital’s everyday life through regular performance activities; and 2) to extend the music to all the hospital’s wards, which happened two years later, in 2003.

5.3.3 Theoretical underpinnings and aims of the programme

The conceptualization of the programme reflects Philippe Bouteloup’s original vision of transforming the hospital into a cultural venue that provided privileged encounters with artistic creation and live music in particular (Bouteloup, 2006). Music, according to Bouteloup, is a mean to improve the quality of hospitalization, turning a potentially ‘negative’ and, often, traumatic experience into a culturally enriched one, for all those involved (children, carers, and hospital staff). Music in the hospital becomes a cultural bridge between the hospital and the wider community surrounding the hospital itself, as music that brings that culture into the hospital breaks, as a result, the traditional idea of the hospital as an isolated environment.

The notion of ‘music’ in this case, differs from the idea of ‘therapy’ in so far as the goals of the interventions are not focused on a specific group (e.g. the patient), but targeted on the hospital population as a whole, assuming that live music generates a positive chain of reactions amongst all the participants involved, creating different opportunities to communicate and interact within the hospital and among its population (Perondi, 2005). In order to successfully integrate music in a hospital context, there are five main conditions that need to be satisfied, according to the Musique et Santé’s philosophy:

1. ‘Professional musician: Musicians are trained to musical and pedagogical techniques and are specifically trained to work in healthcare environments. They have the relational qualities and improvisation practices necessary to work environments. They work in close interaction with patients, families, and care staff.

2. Close collaboration with medical and care staff: Our projects are set up in partnership with medical and care staff. Musical workshops are integrated in the units’ projects and the musician is accompanied by a referent member of staff.
(3) Regularity of musical interventions: Musicians work in a ward on a regular basis. The musical intervention takes place in groups or at the patient's bedside according to their pathologies.

(4) Artistic residencies: Renowned composers and musicians are hosted for one-week residencies and meet a new audience in new spaces. These moments are emotionally rich and favour artistic creation.

(5) All audiences: Musique et Santé started with musical actions in paediatrics. We have now opened our projects to all ages: from neonatology to geriatrics, through adult intensive care.'


The Florentine experience has been reportedly inspired-by and modelled-on these principles, although ‘music in hospital’ is a relatively new activity/profession, whose contours are presently taking shape and whose funding principles have not been yet fully theorized, nor its training practices.

After more than ten years of commitment to the cultural development in hospitals, Musique et Santé (France), with UK and Irish partners including Arts for Health, The Royal Northern College of Music in Manchester, and Waterford Healing Arts Trust have created a European network on the theme of music, and more generally, culture in health settings. This network so far has set up the promotion and the development of music and cultural actions with partners from Italy, Romania, Bulgaria, Poland, Slovakia, Estonia, Portugal, Greece and Germany. The European network ‘culture in hospitals’ is designed to allow inter-professional exchanges on the role of music and culture in healthcare settings with the aim of giving patients access to culture, and in particular music, and with the ultimate goal to participate in the ‘humanization of hospitals’ (a key term/concept that is often used to describe the musical activity in related promotional literature) through the use of live music, by improving the welcoming, the support, and the well-being of patients.3

3 One of the likely outcomes of the European network might be that music in hospital interventions in different countries will be shaped by culturally specific approaches and that the musical influences might result in a wide variety of experiences. In this context, it seems therefore interesting to notice that the element of professional exchange is particularly stressed by Musique et Santé as both an enriching element and an occasion to monitor standards of practice.
5.4 Structure of the fieldwork

The fieldwork was structured across four consecutive weeks, preceded by three individual visits spread over three months to collect the necessary ethical approvals, make initial contacts with key respondents and to prepare the main fieldwork phase. Each of the four weeks was focused on a selected group of participants to reflect an incremental idea of coding actions that would start from the group that originated the action, the musicians, moving to the child and, subsequently, to focus on parents and hospital staff in order to generate and subsequently analyse the multiple system of interactions. Nevertheless, notwithstanding the prime focus for each week, data gathering sought to be as inclusive as possible of observations that embraced all the different groups (musicians, children, staff and parents).

**Week 1: Musicians**

The first focus group to be observed was the musicians and their activities in the hospital. The organization of the musical intervention, together with musical choices and related aspects of the musical performance were analyzed through:

- Musician responding to pre and post seven-point Likert scales on how they felt physically (i) and emotionally (ii) before and after the musical intervention;
- An observation record grid (Appendix B), which was refined during the first week as the integrated nature of the musical intervention emerged;
- A series of semi-structured interviews (Appendix H, the aid memorie of themes discussed), conducted pre and post the musical intervention, which sought to clarify links between observational data and participants' reported motives and non-musical behaviour, actions and reactions, as well as and more general themes (biographical dates, personality, beliefs). These interviews were audio recorded.
- Audio recordings of each musical intervention;
- Video recordings of the musical intervention;
- Field notes.

**Week 2: Children and musicians**

The second group to be observed were the children. Drawing on initial reflections of what had emerged in week 1, concerning the musicians' behaviour, children were observed in relation to

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4 Initially the observation grid was planned to record individual interactions in more details (Appendix D). But it soon became evident that single interactions were too short and discontinuous to be recorded on an individual grid. Hence a linear observation schedule was adopted instead (Appendix B).
their responses to the musical and non-musical actions originated during this week by the musicians. Children’s responses were analyzed through:

- Observation grids;
- Video recordings during the musical intervention, where possible;
- Informal conversations on musical preferences, hospitalization, their perception of music in the hospital, all of which were audio recorded.

Musicians’ responses continued to be monitored through:

- Pre and post seven-point Likert scales on how they felt physically (i) and emotionally (ii) before and after the musical intervention;
- Semi-structured interviews pre and post the musical interventions, related to the observed intervention and on the motivation of their musical and non-musical behaviour, actions and reactions;
- Audio recording of the musical intervention.

Week 3: Carers, children and musicians

Parents were observed alongside the children. Even if ‘carers’ and ‘children’ were divided in two separate groups, it soon appeared that the groups were symbiotically interconnected and that it was a challenging task to attribute the reaction of the child to the music or to the reaction of their parents to that music. Parents’ responses to their children’s reactions and to the music itself were analysed through:

- Observation grids;
- Interviews on their own musical preferences and of those of their child, on hospitalization and quality of time in the hospital; (Appendix I)

Children’s and musicians’ responses were analysed through the same tools used in Week 2.

Week 4: Hospital staff, carers, children and musicians

The last week was focused on the hospital staff. A selection of nurses and doctors were interviewed about their perceptions of the musical interventions, the effect on the children and on the overall environment and about their musical preferences and musical biographies (e.g. any musical instruments played). The observation grid was not used specifically for this group as the interactions between staff, the child, the musician and the parents, were sporadic although note was made across all four weeks of any specific behaviour/comments related to the adults’ (non-musicians) present. The responses of children, parents and musicians continued to be noted through the same research tools used in Week 2 and 3.

The fourth week was also dedicated to clarifying some organizational aspects of the Musica in Ospedale project. Three in-depth interviews were conducted respectively with the Chief Executive of Fondazione Meyer - responsible for the fundraising of the programme - and with two
directors of Athenaeum Musicale Fiorentino, the association that manages the work of the nine musicians in the hospital. Policy documents as well as position papers and official documentation about the programme (annual reports and archives) were also collected for analysis.

5.5 Participants in the study

The study did not have any exclusion criteria, as the aim of the research was to observe the music in a hospital as a system of interactions. It soon became clear that each day of the research, particularly for the first two weeks, was to be determined by the musicians’ schedule, which soon appeared to be more flexible than timetabled. This was frequently due to musicians’ personal reasons more than to hospital’s critical situations.

The Athenaeum Musicale Fiorentino, the association in charge of the organization of the musical interventions, provided the researcher with a copy of the monthly timetable of the nine musicians (Appendix N). The 23 wards where music was scheduled were initially grouped according to the different lengths of patient hospitalization (short, medium and long term), associated with the differentiated typology of illnesses. Musical interventions were observed to take place in five distinctive spaces: bedside; waiting rooms; treatments rooms; corridors; and staff common rooms. These spaces were subsequently clustered into three main areas: (1) waiting rooms for medical examination where children were mildly anxious but there was no likelihood of pain associated with the examination; (2) waiting rooms for invasive procedure where children were very anxious and there was pain associated with the procedure (this was because either (a) they could hear other children crying and/or (b) they were coming in regularly for their examinations), and (3) wards.

These geographical divisions were substantiated by both observations and interviews with musicians. Musicians also identified a fourth space which was constituted by the neonatal intensive care ward and the resuscitation unit. In both instances, there was no active interaction between musicians and children and, therefore, these wards were excluded from the observations.

A preliminary plan was to observe a combination of musicians in similar/different spaces, to observer whether there were any changes in the dynamic of musical interactions across different spaces and, if so, which were the perceived differences and how the differences would become interwoven with different musical approaches. This plan was largely unsuccessful in practice, due to the variable work schedule of musicians. However, the musical interventions scheduled each day consisted of an average of six hours of music a day, across different wards,
which participants reported to be a satisfactory representation of the normal working year. The average length of a musical intervention observed was approximately 40 minutes. During the four-week study period, 55 observations involving 9 musicians, 162 children and 146 carers were carried out (see Table 5.1 and Table 5.2). The observations were recorded on an observation schedule and simultaneously audio recorded. Overall, 36 hours and 40 minutes of musical interventions were observed.

Table 5.1 Observations (55) of musicians (n=9) playing in different spaces

<table>
<thead>
<tr>
<th>Hospital spaces</th>
<th>Waiting rooms (light examination)</th>
<th>Waiting rooms (procedure)</th>
<th>Wards</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Week 1</td>
<td>2</td>
<td>9</td>
<td>11</td>
<td>22</td>
</tr>
<tr>
<td>Week 2</td>
<td>6</td>
<td>6</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Week 3</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>10</td>
</tr>
<tr>
<td>Week 4</td>
<td>4</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>22</td>
<td>19</td>
<td>55</td>
</tr>
</tbody>
</table>

Table 5.2 Children (n=162) and Carers (n=146) observed as prime foci during weeks 2-4

<table>
<thead>
<tr>
<th>Age</th>
<th>Children and Carers observed</th>
<th>Sex</th>
<th>Carers present</th>
<th>Mother and Father</th>
<th>Mother and Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>m</td>
<td>f</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-2</td>
<td>17</td>
<td>33</td>
<td>22</td>
<td>53</td>
<td>34</td>
</tr>
<tr>
<td>3-6</td>
<td>8</td>
<td>13</td>
<td>7</td>
<td>14</td>
<td>17</td>
</tr>
<tr>
<td>7-10</td>
<td>7</td>
<td>11</td>
<td>22</td>
<td>25</td>
<td>19</td>
</tr>
<tr>
<td>11-15</td>
<td>2</td>
<td>22</td>
<td>92</td>
<td>70</td>
<td>81</td>
</tr>
</tbody>
</table>

The number of carers observed is less than those of children because some of the children were siblings and some other children, especially in the case of very young ones (few months old), were monitored by nurses at the time of the musical intervention. Moreover, during observations, especially in crowded waiting rooms, it was not always possible to establish the connection between children and their carers as children tended to come in the room where music was played whilst the carers were waiting in a different room.
Table 5.3 Children (n=162) and Carers (n=146) observed as prime foci during week 2-4 (percentage)

<table>
<thead>
<tr>
<th>Age</th>
<th>Sex</th>
<th>Carers present</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Mother</td>
</tr>
<tr>
<td>0-2</td>
<td></td>
<td>20%</td>
</tr>
<tr>
<td>3 - 6</td>
<td></td>
<td>57%</td>
</tr>
<tr>
<td>7 - 10</td>
<td>70%</td>
<td>25%</td>
</tr>
<tr>
<td>11 - 15</td>
<td>57%</td>
<td>43%</td>
</tr>
<tr>
<td>Total</td>
<td>20%</td>
<td>35%</td>
</tr>
</tbody>
</table>

Musicians were interviewed before and after their intervention. Most interviews occurred in the first two weeks of research as ‘musicians’ were the particular focus of those weeks (and especially Week 1). A total of 26 pre and post interviews were carried out, with the same musicians being interviewed from a minimum of twice to a maximum of five times (Table 5.4).

Table 5.4 Paired pre and post interviews with musicians

<table>
<thead>
<tr>
<th>Musicians (see Table 7.1 for details)</th>
<th>Number of paired pre and post interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1</td>
<td>4</td>
</tr>
<tr>
<td>M2</td>
<td>2</td>
</tr>
<tr>
<td>M3</td>
<td>5</td>
</tr>
<tr>
<td>M4</td>
<td>3</td>
</tr>
<tr>
<td>M5</td>
<td>2</td>
</tr>
<tr>
<td>M6</td>
<td>2</td>
</tr>
<tr>
<td>M7</td>
<td>3</td>
</tr>
<tr>
<td>M8</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>26</td>
</tr>
</tbody>
</table>

As can be seen from Table 5.2, the main age groups represented in the study are between 3 and 10 years old. Although the general statistic of the Comune di Firenze (Bettucci et al., 2006: 45-49) do not present a breakdown of data, these data are consistent with what doctors reported about the average hospitalized population (see Chapter 7, section 7.3). The age breakdown

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6 Although the hospital staff claimed that there was an annual internal statistic about numbers related to hospitalization and their details, it seemed an impossible task to get hold of such document so that in the end the general statistic of the Comune di Firenze, a public document, was adopted as a reference document. A doctor from the emergency service reported that: 'The age of the vast majority of children that come into hospital is below five years old, and then there are some children between five and ten years old, but those are mainly planned interventions. Above ten years old, is a smaller percentage. They either have chronic illnesses or more serious trauma.'
represented in Table 6.2 draws on Bibace and Walsh's (1981) idea about the development of children's conceptualization of illness (see Chapter 3, section 3.2.1). The presence of mothers as primary carers emerges clearly from Table 5.2, where mothers (N= 81+21=102) represent just over 70% of single carers accompanying the child in the hospital. When possible - mainly depending on a parent's willingness to give consent - some interventions were videoed (Table 5.5) as this was considered a more appropriate tool to support the validation and reliability of subsequent analyses of children's responses to music.

Table 5.5 Videoed Observations (n=16)

<table>
<thead>
<tr>
<th>Locations</th>
<th>Interventions videoed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting rooms (light examination)</td>
<td>6</td>
</tr>
<tr>
<td>Waiting rooms (procedure)</td>
<td>5</td>
</tr>
<tr>
<td>Wards</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
</tr>
</tbody>
</table>

The number of carers interviewed when their child was present was 22, with the majority being mothers (N= 14) (Table 5.6). Only 6 children were interviewed and, except in one case when the child was 11 years old, the interview process proved not to be a suitable tool to investigate children's perceptions about music in the hospital. The interview sample of carers was rather heterogeneous in its geographical provenience with half of the participants (N= 7) coming from Florence, and the other half coming partly within the region (N= 4) and from other parts of the country (N=3). Non-native (Italian) children were not included in the interviewed group as the language was an obvious barrier. Also, the selection of children and carers was not controlled by the researcher in so far as it was the nurse of the designated ward who had decided which children were able and willing to engage in the conversation. The majority of interviews (10 of 14) were focused on children who were undergoing extensive treatment (clarified under the heading 'Long/Repeated').

7 86% of the children observed in the musical interventions were aged between a few months to 10 years old.
Table 5.6 Children interviewed (n=14), directly (n=6*) or via carers (n=8) and carers interviewed (n=22)

<table>
<thead>
<tr>
<th>AGE</th>
<th>Where they come from</th>
<th>Sex</th>
<th>Length of hospitalization</th>
<th>Carers present</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>M</td>
<td>F</td>
<td>Long/Repeated</td>
</tr>
<tr>
<td>2,5</td>
<td>OR Sardinia</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>2,5</td>
<td>Florence</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>7*</td>
<td>OR Campania</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>13 SN*</td>
<td>Florence</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Florence</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>18 SN*</td>
<td>Florence</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>OP Livorno</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6*</td>
<td>OP Siena</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>11*</td>
<td>OR Emilia</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Florence</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 m</td>
<td>Florence</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>6,5*</td>
<td>Florence</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>13**</td>
<td>OP Siena</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>1m</td>
<td>OP Arezzo</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>

SubTotal | 9 | 5 | 10 | 4 | 14 | 4 | 4 | 4 |

Total | 14 | 22 |

SN= Special needs (e.g. cognitive delay)
* children interviewed directly
** only mother was interviewed as the child was too ill to engage in a conversation
OR = Other region
OP= Other province

A total of 20 members of staff (Table 5.7) divided into 11 nurses and 9 doctors were interviewed in the last week of the study, together with the Chief Executive of the hospital charity (Fondazione Meyer) and the Chief Executive of the Athenaeum Musicale Fiorentino and his Deputy.

Table 5.7 Hospital staff (n= 20) interviewed and locations where they are based

<table>
<thead>
<tr>
<th>Staff interviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse</td>
</tr>
<tr>
<td>11</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Departments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting rooms (light examination)</td>
</tr>
<tr>
<td>3</td>
</tr>
</tbody>
</table>

Half of the interviews were undertaken in waiting rooms, with the remained biased towards wards.
5.6 Chapter summary

The main fieldwork was undertaken over a period of four weeks in the Meyer paediatric hospital in Florence. Each of the four weeks focused on a selected group of participants. During this period 55, observations were undertaken. Observations were recorded on a specially designed observation schedule and simultaneously audio recorded. Of the 55 observations undertaken, 16 were videoed. The average length of a musical intervention observed was approximately 40 minutes. Overall, 36 hours and 40 minutes of musical activities were observed. Observations involved 9 musicians, 162 children and 146 carers. In addition, interviews were conducted with each of the 9 musicians before and after their musical intervention (a total of 26 pairs of pre and post interviews – see Table 5.4), with 14 children, either directly (n=6) or via carers (n=8) and with 22 carers and with 20 hospital staff (11 nurses and 9 doctors). Interviews were also conducted with the Chief Executive of the hospital charity (Fondazione Meyer) and the Chief Executive of the Athenaeum Musicale Fiorentino and his Deputy. Subsequently, thematic analysis informed by grounded theory (Strauss & Corbin, 1990) and content analysis were performed on the four groups of data (observations, videos, interviews, field notes) with the support of Atlas.ti software. The findings from the main fieldwork are presented in the Chapter that follows (Chapter 6).
Chapter 6. Musicians playing in the *Meyer* paediatric hospital

The group of musicians performing in the hospital consisted of nine players, three males and six females\(^1\) (see Table 6.1). Seven of these were professional musicians, playing in local orchestras and also had music teaching experience. The other two were (i) a doctor who was completing his medical training and (ii) a mother of three young children involved in voluntary work with her local church.

<table>
<thead>
<tr>
<th>Musician</th>
<th>Gender</th>
<th>Age group</th>
<th>Musical qualifications</th>
<th>Instrument played</th>
<th>Types of music played</th>
<th>Professional musician</th>
<th>Teaching experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marta</td>
<td>F</td>
<td>30/40</td>
<td>Self-taught</td>
<td>Guitar and voice</td>
<td>Children's repertoire, Pop</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Bruna</td>
<td>F</td>
<td>30/40</td>
<td>Conservatorio Diploma</td>
<td>Guitar, Oboe and voice</td>
<td>Children's repertoire, Classic</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cinzia</td>
<td>F</td>
<td>30/40</td>
<td>Conservatorio Diploma</td>
<td>Violin and voice</td>
<td>Children's repertoire, Classic</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pietro</td>
<td>M</td>
<td>40/50</td>
<td>Self-taught</td>
<td>Guitar and voice</td>
<td>Pop, Folk, Children's repertoire</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Maria</td>
<td>F</td>
<td>30/40</td>
<td>Conservatorio Diploma</td>
<td>Violin and voice</td>
<td>Children's repertoire, Classic</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Paola</td>
<td>F</td>
<td>40/50</td>
<td>Conservatorio Diploma</td>
<td>Viola and voice</td>
<td>Classic, Children's repertoire</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Luca</td>
<td>M</td>
<td>40/50</td>
<td>Conservatorio Diploma</td>
<td>Saxophone and voice</td>
<td>Children's repertoire, Jazz</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Luisa</td>
<td>F</td>
<td>40/50</td>
<td>Conservatorio Diploma</td>
<td>Flute and voice</td>
<td>Children's repertoire, Classic</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Marco*</td>
<td>M</td>
<td>40/50</td>
<td>Conservatorio Diploma</td>
<td>Sax and voice</td>
<td>n/a</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* Marco was the group coordinator. He was not observed as he never played at the scheduled time during the whole month of observations. He was interviewed in his double role of musician and coordinator.

\(^{1}\) The names of the musicians are fictitious.
As part of requirement for the role, each had to attend a one year part-time training course to be able to play in the hospital with an agreed amount of practical training. Five of the nine musicians had been playing regularly since 2003, whilst four musicians were relatively new to the work and had been playing in the hospital for just over a year, being recruited as the result of a selection of musicians from the second training course organized by the Athenaeum Musical Fiorentino in collaboration with the Meyer hospital, the local Conservatorio of music and the organization Musique et Santé. All of the musicians sang as well as played an instrument, embracing guitar (n=3), violin and viola (n=3), woodwinds (n=2) (oboe, flute) and saxophone (n=2). There was a range of musical genres represented, including popular and classical, as well as song/music specifically focused for children. None of the musicians were under the age of 30 years, and each had many years of experience on their main instrument.

6.1 Observations

The following observations-based commentary draws on 36 plus hours of observations\(^2\) of particular musical interventions complemented by subsequent Atlast.ti - based analysis of an additional 11 hours of videos of musicians working in the hospital\(^3\). Reference is made in the text to video examples that are found in the accompanying DVD (see inside back cover of thesis). Interviews with the participants musicians are analysed in the next section of the thesis (see 6.2). Three main themes emerged from the observations of the musicians playing in the hospital:

1. Code of practice (formal and informal);
2. Elements of a typical session;
3. Common musical techniques characterizing the intervention

6.1.1 Code of practice (formal and informal)

Arriving in the hospital

Every musician was expected to comply with an oral code of practice. The first expectation on arrival in the hospital was for them to sign in the attendance register held in the reception area.

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\(^2\) This is 55 observations x average length of 40 minutes = 36 hours. This number does not mirror the effective number of hours of music in the hospital across the observed month as some musicians were overlapping and their interventions could not be observed.

\(^3\) Because of the need to be mobile in the video recording, it was not possible to video and use the observation schedule at the same time.
Musicians were supposed to sign in on their arrival, noting the wards that they were to visit, and to sign off when they left, writing down the amount of hours worked on the day. In the register there was a designated column for comments about their experiences and a column for specific instructions to leave for the next musician so that others could adjust their schedule in the light of the latest events (e.g. a child or one of the medical staff requesting a musical intervention for a specific purpose).

The register had the double function of (i) exerting a sort of control on the amount of hours that each musician was playing, given that they were paid by the hour, and of (ii) exchanging information amongst musicians (e.g. asking for a piece of music that they would like to learn, leaving information about a particular child requesting a specific repertoire) as they would otherwise not have a great deal of contact between themselves.

Timetable issues: (a) Flexibility

Even though musicians operated on the basis of a fixed timetable, there was a degree of flexibility allowed, mainly because of musicians’ personal health conditions (such as having a cold or sore throat) that often restricted the range of wards that they were able to play in. This sometimes forced them to reschedule their time in the hospital. This was noted as a recurrent aspect in subsequent interviews, to the extent that the exception seemed to be represented by those musicians who actually turned up on time as scheduled on the expected day4.

The musicians’ flexibility was accepted, but perhaps more accurately, tolerated, by the Athenaeum Musicale, the association with overall responsibility for the organization of the musical activities in the hospital. Flexibility was also recognized to a certain extent by the hospital itself, although some of the staff (both nurses and doctors) in a few cases complained about an excessive degree of flexibility which had led them to perceive that the intervention was ‘unreliable’ in term of its possible use by the staff (see also Chapter 7, section 7.3) for an insight on the hospital staff’s perspectives on this theme).

Every ward had a colourful timetable framed on the wall at its entrance with the detailed weekly music plan (day, time, instrument and name of the musician). The timetable was the result of a matching between the requirements of single wards (carefully discussed between the member of the association and head nurses) and the availabilities of musicians. Although it was reported to be paramount to respect the timetable, it was also observed that, when a musician was not able to come on the designated day, they tended to make up their time, either by swapping with a colleague or turning up in the ward without a previous agreement. This

4This was mostly due to the fact that seven of the nine musicians were also music teachers and that, in June (when the fieldwork was conducted), all schools are traditionally organizing concerts before closing for a two-month summer break. Therefore, the musicians were involved with additional rehearsals which affected their hospital schedule.
behaviour, in some cases, appeared to generate in the staff, especially doctors, a sense of irritation towards some musicians, as they were not perceived as sufficiently professional in their behaviour.

(b) Rotation

The timetable appeared also to raise concerns in both musicians and hospital staff about the lack of rotation in the placement of musicians as, despite the efforts in trying to generate a turnover, the timetable essentially remained the same throughout the year. It was perceived to be too complicated to rearrange it every term, as initially planned by the association. The absence of rotation generated at least three main problems:

1. Hospital staff met the same musician (or maximum two) throughout the year and consequently, had to listen to the same repertoire - sounds and styles - for sustained periods, showing a slight intolerance which, in certain cases, turned into mild distress, as listening to a similar/child focused repertoire was reported to generate, rather than to alleviate, tension (see also section 7.3.1 for staff’s comment on the musical repertoire).

2. Musicians also perceived the above mentioned problem and reported frequent high levels of discomfort, especially those who were performing in stressful wards such as intensive care, neurosurgery and oncology; some reported that they struggled to deal emotionally with the realities of such settings (see also section 6.2.3 ‘Rotation issues’).

3. Musicians were self conscious about the limitations in their repertoire, especially those musicians playing in long-term wards or in waiting rooms where the recurrence of meeting the same child was high and the available means to surprise them musically decreased after the first few sessions. Furthermore, they reported that it was not always possible for them to update their repertoire and techniques because of the part-time nature of the work.

Changing room

Once they were in the hospital, most musicians made their way directly to the space near to where they were supposed to play. They had identified odd spaces (mostly storerooms) where they could leave their belongings, get changed and then start the musical intervention. Often they would ask a nurse for the key to lock this room and it all appeared as a consolidated routine, which implied a degree of familiarity with both staff and the environment.

Initially, musicians were allocated a changing room by the hospital, but none of them, except one, made use of this space, as it was outside the main building and as it was a rather bleak room in the basement of a semi-disused building. Also, going back to such a room after
each intervention was considered to be a waste of time. Musicians generally preferred to leave their belongings close to where they were playing.

Figure 6.1 Example of a multi pocket waistcoat

Getting ready

Getting ready before the intervention consisted of selecting a range of percussion instruments from the suitcase that the musicians were carrying, along with their main instrument. They would select the instruments according to the nature of the ward that they were visiting on the specific day and, according to average age expected in the ward and type of illnesses, they would choose appropriate shapes and sonorities. Musicians also had a specially designed waistcoat with multiple pockets to store various instruments that they handed out to children and their carers whilst playing (Figure 6.1). The waistcoat had the double function of storing some of the instruments (around 20) and keeping them separated after they had been played, before disinfecting them at the end of the session.

Entrance in the ward

Before starting the session, musicians introduced themselves to the head nurse on duty and received a brief updating on outstanding cases and on the general mood in the ward at that moment in time. There was a noticeable difference between more experienced musicians and newer ones, in so far as the latter appeared to be more scrupulous and preoccupied with following all the instructions that they still remembered from their training course. In contrast, ‘older’ musicians appeared to be more relaxed and familiar, both with the environment and in relating with staff. Nonetheless, all musicians appeared to be very scrupulous in observing sanitary regulations and they all washed their hands on arrival in the ward.
Break times

In between interventions most of the musicians appeared to be quite worn out and needed a rest and a drink (it was a rather hot June and most parts of the hospital did not have air conditioning). In a few cases, the musician would return to the dislocated room and have a longer break in there. Musicians tended to rest in-between interventions and they generally used this time to disinfect the little percussion instruments they have been handing out during the music session. They were very careful not to hand out the same instrument if it had not been disinfected.

6.1.2 Elements of a typical session

Location of musical activities and structure of a typical intervention

A standard intervention lasted approximately 40 minutes and it took place in five main types of hospital area:

Figure 6.2 Bedside (1) – for ‘bedside music’, usually there are two beds in each room
Figure 6.3 Play room (2) – a designated space for child patients to play, located in long-term wards

Figure 6.4 Waiting room (3) – a space where patients and carers were waiting for treatments

Figure 6.5 Day hospital (procedure room) (4) – a specialist space for medical interventions (e.g. blood transfusions, dialysis, chemotherapy)
Musicians operated on the basis of two simple techniques which they alternated during their sessions: a) playing for someone; b) playing with someone, where the former was generally employed at the beginning and at the end of a session, whilst the latter was most commonly used during the middle. Musical interactions occurred with single children and their carers and, more often, within a group that the musician progressively brought together whilst playing. Musicians also played for staff, generally nurses and in some rare cases (two, specifically) for/with doctors who were keen guitarists and were familiar with the repertoire that the musician was singing. In general, musicians appeared not to have specific items of repertoire associated with a type of location. The music appeared to be selected according to the physical and psychological condition of the child, irrespective of the hospital spaces.

The performance space, however, impacted on playing style such as requiring more or less dynamic change, which was also reflected in the choice of percussion instruments handed out. For example, if the situation in the ward, or waiting room, was quiet and the child was perceived to be willing to improvise with the musicians, they were more likely to use louder percussions, such as a tambourine or an ocean drum, and sing lively tunes. On the contrary, if the child was in pain and rather distressed, musicians were more likely to adopt a 'soft' approach and extract instruments such as an ocean drum, a kalimba or a rain stick.

Figure 6.6 Other common spaces (5) – such as the entrance, corridors and gardens
Independently from the musician playing, all sessions appeared to have a common structure that formed the basis for each musician's own variations according to their (i) experience, (ii) confidence and (iii) type of instrument used. The structure remained broadly the same, regardless of the different spaces in which they were playing, or the different health conditions of the young patients involved. Each intervention appeared to be organized according to the following sequence:

1. Entrance into the ward, playing a 'signature' piece;
2. Introducing the tune of a child's song (whilst physically moving towards the child);
3. Starting to sing the song;
4. Whilst singing, demonstrating to the child how to use a little percussion instrument;
5. Handing out the percussion instrument to the child;
6. Playing the same song with variations, whilst the child was playing the percussion instrument;
7. Introducing new songs (following the actions from 4 -6);
8. Closing the session by playing the 'signature' piece from the entrance, or a 'goodbye' song.

Typically, the observed detail of this sequence was as follows:

**Stage 1.** Musicians walked into the designated space, either playing the tune of the song that they had chosen to sing, or their 'signature' song which was often a well-known classical piece or, in one case, a popular song from the sixties which had been brought back to fashion by being the soundtrack of an advert for children (the Italian version of 'The lion sleeps tonight'). The musical introduction served three purposes, namely: (1) for musicians to announce themselves to the 'audience' and to signal the beginning of their musical activity; (2) to attract the children; (3) to take a few moments for a mental snapshot of the current mood in the ward, including the age and kind of children involved (e.g. health conditions; ethnicities, their body language in response to music). Overall, this allows the musicians to prepare mentally for the coming interactions (see also section 6.1.1 'Entrance in the ward' - for the rationale of musical choices whilst entering in the wards).
Stages 2 and 3. The musician sang a song focused on a single child that had been selected after their initial 'musical walk.' The selection appeared to be made on an 'instinctive' basis, selecting a child (from two or more) who was perceived to be more curious or responsive to the music. There were variations in this approach, depending on the kind of instrument played. Musicians that played the guitar and the violin tended to accompanying themselves throughout the session whilst singing; musicians that played the saxophone and flute were observed to be more flexible with the use of their instruments and to make more use of solo voice with rhythmic accompaniments, alternating this approach to an instrumental one. Their posture was typically lowered, such as on their knees, in order to establish eye contact with the child whilst singing. This first direct interaction was generally quite short (around a minute), but it became slightly longer when musicians played in rooms within a ward.

**DVD Example 1**

The musician walks down the corridor of the neurosurgery ward whilst singing a song accompanied by the guitar. She looks discreetly into each room and after few seconds she selects the room to start her intervention. In the room there are two young female patients with their parents. The door is left open so that the other children in the ward can still listen to the music and decide whether they want a more direct interaction with the musician when she will turn up to their room. Once in the room, she keeps singing, making eye contact with all the people around her. The girls (aged 10 and 11 years old) are seated on chairs. The musician kneels down to be positioned at their eye level. Then she puts the guitar on the floor and, whilst singing, she extracts a maracas from her waistcoat and directs this to one of the girls, demonstrating how to use it. Then she passes the instrument to the girl who looks amused. She continues taking out percussion instruments from her waistcoat until all the people in the room have one each. Everyone is now joining in.
Stage 4. Before the song finished, the musician was likely to extract a little percussion instrument from their waistcoat and to keep singing whilst demonstrating how to use this and its rhythmic potentialities. Subsequently, they handed it to the child, or if the child seemed intimidated, to their carers, who acted as facilitators and partners in the musical process.

DVD Example 2

The musician plays the guitar and sings a gentle song to the baby being held by a nurse. Around the baby there are other nurses and a nun. All of them have been given a little instrument that they play rhythmically, accompanying the song and encouraging the baby to look at the different instruments. The musician moves to sing very close to the baby and he mixes lyrics with onomatopoeic sounds. The baby is looking at him and also at the instruments that people are rattling around her. The heart monitor that she is connected to beeps twice and the nurse comments that the baby is getting very excited, which was one of the aims of the session, as the baby was not very responsive to external stimuli.
Stage 5. Whilst singing the song, the musician usually introduced further new instruments to either the child-patient (who was often seen to be slightly intimidated if new to the musical intervention) or to the carer, in order to reassure the child within the collective musical activity. All these actions were non-verbal and were mediated by the use of facial expressions and body language. The aim was for all participants to have a little instrument to join in and feel part of the group. They all sung the song with the percussive accompaniment.

DVD Example 3

The boy is sitting cross-legged on his bed and avoids any eye contact, looking at the floor. He does not speak Italian. The musician gives out little percussion instruments to his carers who start playing along and then, subsequently to the child. The child shakes the instrument initially in a rather disengaged way, but then he starts exploring different ways of shaking it and one senses that he becomes more engaged with the activity around him. Occasionally, he looks at the musician when the latter is not physically too close to him and, after a few minutes, his mother offers to swap instruments, to which he agrees. He then starts making quite a lot of noise on the new percussion instrument.
Stage 6. Musicians operated variations on the same song to give everyone the chance to memorize it. These techniques included mainly ‘leaving gaps in between lyrics’ and letting the child complete the missing section(s) of the song; ‘lyrics substitution’ when the musician’s approach to a well-known song was to turn the lyrics into an absurd text and to wait for a reaction from the child, such as eliciting an amused response; and musical riddles where the child had to ‘guess’ what the song was about (generally an animal).

**DVD Example 4**

The waiting room is rather busy. Children are playing around a table. The musician walks into the room singing a cheerful tune and hands out percussion instruments to all the children and carers. The attention is now focused on the musician who is acting as a musical conductor. He is making eye contact with everyone in the room, smiling, nodding his head, encouraging a particular child to engage with the music, or showing a different child how to use the percussion ‘properly.’ Children are all lined up playing their instruments and waiting for a new song to start.
Stage 7. The session continues with new songs and rhythmic improvisation on the little percussion instruments, drawing on the same rules of engagement (Stage 4 to 6).

Stage 8. Musicians often use the same song played at the beginning of the intervention to mark the closure of the session.

This structure appeared to be endorsed by the design of the training course and consolidated through the experience of individual musicians. Even though some of them performed small variations, the basic framework remained unchanged across the four weeks of observation, suggesting that it provided a secure and effective framework for the musicians.

**DVD Example 5**

The child has followed the musician into each room and she has turned into a sort of ‘assistant.’ The musician interacts with both her and another child that is in bed, singing some musical riddles accompanied by her violin. She leaves a gap at the end of each phrase to give the children a chance to answer, encouraging them to do so and providing some clues if they are struggling to guess. In doing so, she establishes a connection with the child, fostering a sense of trust. This appears to represent an emotional platform on which the musician can build a more engaging musical interaction.
Musical features

Little Percussion Instruments

An important part of the musician’s work was to improvise on the little percussion instruments. These became a means to involve different children, and their carers, as well as to foster a sense of belonging to the musical event by the action of sharing the holding of instruments. Also, the musicians showed the child how to use the instrument and - depending on the willingness of the child to get involved at that particular moment in time - they explored together different rhythmic and sonic possibilities of such instruments, performing little rhythmic improvisations so that the session often turned into an educational game where the child had the chance to have a close encounter with music and deepen their learning of how to interact through music.

Each musician had a range of approximately 20 to 35 percussion instruments that were selected for each intervention (Figure 6.7). They were expected to have a variety of interesting instruments from both a musical and a visual perspective, and were encouraged to build the instruments themselves by using recycled materials or unusual objects with a range of unusual and surprising sonic possibilities. An additional feature was that they tended to have at least two instruments of each kind to interact with the child and improvise through an imitation process.

Figure 6.7 Example of a selection of percussion instruments
In some cases they had a ‘family’ of similar instruments in order to surprise children by being able to extract more and more instruments of the same kind, like with the family of frogs (Figure 6.8).

Figure 6.8 Family of frogs

Despite the encouragement to build their own instruments, musicians appeared to use a range of purchased versions because the hand-made ones were not always as resilient and musically interesting (Figure 6.9).

Figure 6.9 Example of a commercial percussion instrument
Repertoire

The musical repertoire was similar across all the musicians. It was based on traditional songs for children, largely regional, and mainly learnt during the musicians’ training courses. This appeared to be a very precise stylistic choice whose rationale was not always clear, as some of the songs were observed to be unfamiliar to the children. Nor did they seem to appeal to all children’s tastes, as the music was strongly contextualized in a regional-folk tradition that appeared to be often extraneous to some of the children (e.g. such as those coming from different regions and outside Italy). Moreover, the choice of such a culturally specific repertoire appeared to be an attempt to recover and promote a popular musical tradition rather than to engage with children at their own musical level and taste. Furthermore, children were observed generally to engage more with musicians that adopted an interactive approach, such as in their improvisation on the little percussion instruments. On the other hand, such culturally specific repertoire sounded, at times, quite refined, and it appeared to embrace a cultural idea of ‘music in hospital’ which was not only focused on engaging with the child musically, but also to bring a cultural input into the hospital as a whole, through the ‘quality’ of the music played.

Musically, one of the most evident characteristics of the folk song-based repertoire was their repetitive patterns (like in the English song ‘The twelve days of Christmas’), whose tunes seemed easy to memorize and their incremental lyrics simple enough to be learnt in a short time. The repertoire alternated lullabies or ‘calming’ songs with more cheerful ones. One particular musician often told stories that involved touching the child’s hand, naming the different fingers across the story.

DVD Example 6

The musician asks the child if he wants to be told a story and the child agrees. She touches his hands whilst telling the story that articulates with moving her index finger across his fingers. She makes funny voices whilst doing so. The child laughs.
Only a few musicians included songs from Walt Disney's cartoons or popular songs from children's TV programmes. Whilst the musical quality of these is perhaps less interesting, they appeared, when observed, to be a more effective tool in establishing a relationship with the child (see also section 6.2.4 for musicians' view on their repertoire). Also, a sing-along effect was more likely to happen with these kinds of songs. The repertoire also comprised a minority of foreign songs, mainly English and Albanian (one of the most common minority ethnicities in the hospital population). Albanian mothers, in a few cases, were reported to have taught examples of their native songs to the musicians. Musicians occasionally played instrumental music, mainly to mark the beginning and the end of a session. In one case, a musician who was a professional viola player was encouraged by the association to play more instrumental music in open spaces (e.g. corridors, entrances, gardens) as the quality of her playing was considered to be outstanding.

Although there was a general 'sameness' about the repertoire, variation was evident on a more moment-to-moment basis in the flexible interaction of the musician with the focus child. Musicians appeared to work on the musical intention that they wanted to communicate through the song at that moment in time. Therefore, it was not strictly the breadth of repertoire that seemed to be important, but rather a range of musical modalities and improvisation techniques in so far as they allowed the musicians to respond to the need of constantly building their repertoire. Nonetheless, it was observed in more than one occasion that the musicians did make use of special songs (and related lyrics) when they wanted to elicit specific emotions. In three different situations, the same musician was observed to use the same song to facilitate the release of tension through crying. This happened exclusively with parents, especially mothers. In this case, the song was an Elton John song written for a Disney cartoon and had a rather meaningful title: 'Il cerchio della vita' ("The circle of life"). A different musician was also observed to use specific songs which often induced parents to cry. Those songs were characterized by emotionally charged lyrics rather than other musical features.

### 6.1.3 Common musical techniques characterizing the intervention

The musical techniques employed across the interventions observed appeared to be common to all the musicians. They consisted of a set of techniques shared by music education and music therapy approaches (see below). An informal pedagogical approach was evident in relation to
the use of percussion instruments\textsuperscript{5}. The musician was regularly demonstrating how to use such instruments, both practically (e.g. how to hold it and how to play it, exploring non evident ways, such contacts with different surfaces or parts of the body) and rhythmically (e.g. different rhythmic combinations) initiating a musical dialogue, by using a similar instrument. Subsequent to the demonstration, an improvised dialogue emerged that was based on four main kinds of observed musical interactions:

1. Imitation — the child played a rhythm and the musician imitated it;
2. Integration — the child played a rhythm and the musician played the same rhythm, but added a new element;
3. Opposition — the child played a rhythm and the musician played the same rhythm but in a different way (e.g. using his voice, or tapping on a furniture, or playing the same rhythm but very soft or very loud); or
4. Ignoring the rhythm that the child played to introduce a new musical idea that re-established the leading role of the musician.

When the musical interaction happened in a group context of several children at once, the musician(s) demonstrated, and then rehearsed collectively the rhythm that each child was to play to accompany the following song or their instrumental improvisation on that rhythmic base. The musicians conducted the group by giving non-verbal instructions on the dynamics (very loud and very soft) and the tempi (very fast and very slow), which sometimes translated into rather amusing body language movements and facial expressions\textsuperscript{6}. This activity usually developed into a music game that the children seemed to enjoy, as they appeared to be surprised about the fact they were playing in a music group, which was likely to be a new experience for the majority of them. Carers were likely to be involved in this stage as well and were often observed helping their child to keep the rhythm or to stay focused on the activity by encouraging them with smiles and their own direct manifestation of interest.

The musicians often showed the children their main instruments by playing a range of unexpected sounds, such as plucking the string of the violin, sliding on the strings from high notes to very low ones, bouncing on the strings or making a vibrato sound, playing a smooth legato or a harsh staccato. In the case of the string players, one of them in particular was often disassembling the bow (Figure 6.10), making wavy shapes with the bow hairs and explaining that they were horse’s hairs, which seemed a real fascination for some of the children that had never

\textsuperscript{5} The fact that all the musicians, except two, worked as music teachers in primary schools, did not seem only to be a coincidence in this respect. Their approach appeared to be influenced by their teaching background in so far as the interaction with the child was based on ‘teaching’ them informally how to do something and then building the session on that kind of interaction.

\textsuperscript{6} The musicians would lower down their knees to indicate a very soft sound, miming to be very small, and then would progressively rise from that position, until they would stand on their toes with arms wide opened, to indicate a loud sound and the progression in the middle. Their facial expressions would accompany their gestures.
had a chance to observe a violin from such a close distance. Whilst reassembling the bow, she would answer children's questions before getting back to playing. In some cases the musicians would also let the child try out their instrument (Figure 6.11), explaining how to play it.

Figure 6.10 The musician shows how to disassemble the bow to the child who is waiting for his weekly blood test

Figure 6.11 The musician teaches the child how to hold the viola

Both the flute and the saxophone players adopted a similar approach of introducing their instrument to the children through a sound exploration. The two guitarists were not professional musicians and perhaps this is why they did not 'explore' their instruments in the same way. Perhaps, also, children were more familiar with the guitar, and less interested in it.
Other informal education aspects of the music activities were also observed in the singing-related parts of the musical intervention. Observation indicated that musicians tended to adopt five main approaches, often to attract children’s attention and to elicit a sense of surprise, especially when the song that they were singing was a familiar one. These were (cf. Stage 6 reported earlier):

1. Lyrics substitution (e.g. inserting the name of the child in the song, or the actions that the child was doing at the moment);
2. Leaving silence gaps in the song and giving the child the chance to fill them;
3. Improvisation on a song’s theme (e.g. changing the lyrics by using a vocalization on the child’s name);
4. Vocal improvisation on the theme of a familiar song, which generally elicited a sense of surprise in the child who was expecting the correct words;
5. Vocal noises (e.g. strange sounds in the middle of a song, often animals’ cries or onomatopoeic sounds).

In one case, a musician was teaching a new song at the end of the session as part of her practice. This happened when she was playing in a room in the ward. She was using a rhythmic accompaniment and an imitation approach. The song was a very simple one.

Verbal and non-verbal techniques characterizing the intervention

The compulsory training course that the musicians had attended had specific indications about the use of language which was only allowed in relation to musical matters. The idea was that music had to be something extraordinary that was communicating itself through the sounds and that the musician should become a sort of disembodied figure that was only allowed to sing or play, without breaking the 'magic' of music.

Although this approach was generally adopted by the musicians throughout their practice and even though all of them observed the basic principle of not talking, differences were noted between their styles. If some of them were very restricted in the use of language - to the point that they would not even ask the children their name, unless vocalizing the question - others were more relaxed and would ask questions such as 'Do you have a favourite song?', or would make jokes whilst singing all the wrong words of a very well-know piece whilst the child was correcting them, saying phrases such as 'Ah really? Are you sure? Oh I am sorry I got this wrong!'

The musicians were generally smiling during their musical intervention, but they also often had an expression that indicated surprise (especially when extracting a percussion

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7 Course documentation acquired by the researcher who attended the first Italian training course for ‘Musicians in Hospital’ held in Florence from December 2001 to January 2002 and confirmed, subsequently, in interviews as still in use.
instrument from their waistcoat). This encouraged participation and seemed to be directed towards eliciting the child’s attention, which was done in combination with both facial expressions and other body language.

A common physical behaviour was observed across the group of participant musicians. There were five main actions that appeared to define their musical interaction:

Figure 6.12 (1) Walking around the space looking for a child to start a one-to-one interaction, whilst playing

Figure 6.13 (2) Standing up playing
Figure 6.14 (3) Kneeling down playing

Figure 6.15 (4) Singing and playing at a normal distance from the child (up to 3 metre)

Figure 6.16 (5) Singing and playing very close to the child (max. 1 metre)
**Differences between musicians**

There was a noticeable difference between the more experienced musicians - those from the first training course that had been playing regularly every week for four years (n=5) - and those from the second training course, who had just been playing for over a year (n=4). As perhaps a result of the experience and familiarity with the environment, the latter appeared less confident, more hesitant musically and emotionally in handling situations in the hospital. It was observed that, overall, they tended to spend less time focussing on a single interaction, privileging a more collective approach as this required perhaps a less intense emotional involvement. They also seemed to be more cautious with the selection of music, preferring rather 'neutral' song to more emotionally charged ones that their more experienced colleagues were noted to play.

The musicians from the second course had quite a limited repertoire that they seemed to share among themselves, with the result that they all sung very similar songs, although with their own style. Bruna, for example, who was an oboe player, often sung accompanied by percussion instruments, rarely using the guitar and hardly ever using the oboe. She would spend more time than other observed musicians in expanding her rhythmic improvisations with little percussion instruments, involving the children in such experimental activity, singing as a result an average of 5 to 8 songs during her 40 minutes intervention. A contrasting example was represented by Pietro, a very experienced musician, who was generally singing throughout his intervention, playing in between 15 to 20 songs, using the percussion instruments to involve the child in the session, but just to accompany the singing, which often turned into a sing-along session. This was possible because his repertoire was very contemporary and rich in pop songs and cartoon’s tunes with which the children were familiar. Also, he had a special energy and enthusiasm that made him very popular in the hospital. Parents would often stop him in the corridors to ask when he would come back. Marta, was also playing a repertoire rich of different songs and in order to remember them she had glued on the guitar a list of songs divided according to different categories (e.g. sad, happy, melancholic, energetic, soft, calm) (Figure 6.17).
Regardless of the experience of the musicians, and the instruments that they were playing, these two different approaches – one (Bruna) privileging the instrumental improvisation and the other (Pietro) privileging the singing - represented the main difference between the musicians. The reasons behind the different approaches seemed to be connected to the conceptualization that each musician had about the work in the hospital, as it will be clarified in the next section.

6.2 Interviews

The musicians were interviewed before and after their interventions, according to a semi-structured interview schedule which was designed to explore a set of themes. These embraced: Musicians' motivations for playing in the hospital; musicians' explanations and interpretations of the aims of their musical actions; the perceived nature of their work in the hospital; the relevant aspects of their musical intervention; and the perceived characteristics needed for a successful intervention.

Both pre-and post-interviews were conducted adopting a conversational style. Questions were formulated on the basis of the musical interventions observed. The researcher asked the musicians to explain the reasons behind some of their musical and behavioural choices that were noted during the observed sessions. The discussion that followed also covered more specific aspects of their work and some private aspects of their lives that seemed to be interwoven with their work in the hospital. The aim was not to give the musicians any impression of having an agenda, but rather letting their views about their work in the hospital emerge within a non-judgmental and non-threatening context.
Interviews were fully transcribed and analysed according to a thematic and content analysis (Strauss & Corbin, 1990). Fifty-five codes were initially derived from the transcripts (see Appendix for the interview transcript and a list of derived codes), which were then grouped into the following thematic areas:

1. Motivations to undertake the work;
2. Perceived aims of the work;
3. Perceived nature of the work;
4. Main features of a musical intervention;
5. Characteristics of a successful intervention.

### 6.2.1 Motivations to undertake the work

All musicians made a conscious effort to be interviewed before and after their sessions and they generally appeared to feel valued by the fact that a researcher was interested in understanding their work in the hospital. They operated on a daily schedule fitted with several jobs and family commitments. A sense of 'precariousness' appeared to be a common trait within the group, in so far as, except in one case, none of them had a stable occupation, despite their age which ranged between 30 and 45 years old. The work in the hospital was no exception, as the contract had always been renewed by the hospital on an annual basis and the average weekly hours of work for each musician was five (paid 19 Euros an hour, around 15 Pounds, which would only represent a small proportion of a monthly income). Even if never openly addressed by any of the musicians, one of the reasons to undertake the work in the hospital appeared to be a financial one (except in one case, where the musician held a permanent position in the main Florentine orchestra), as playing in the hospital was part of a package of different jobs that summed together constituted their living (cf. a 'portfolio career').

Amongst the main reasons reported as motivating the musicians to undertake their work in the hospital there was a moral idea of making a positive impact on people’s lives through music, which simultaneously was perceived as a rewarding and emotionally enriching experience for themselves:

Marta: ‘I play to improve people’s lives and then, indirectly, the positiveness of this objective has a beneficial return on myself. Therefore, if I am depressed,

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6 A characteristic of the life of a professional musician is that it comprises many different types of musical employment (see Creech et al. 2008).
this action becomes therapeutic; if I am nervous, I unwind, and if I am anxious, I relax.'

A musician mentioned that she had been inspired by Patch Adams, an American charismatic clown-doctor⁹, who is associated in the collective imagery with a Hollywood film portraying a sweetened version of the reality in hospitals where a clown-doctor appeared to be the real agent of change in that setting. The musician had to realize rather quickly that there was a misleading discrepancy from reality:

Maria: 'I read about the training course in the newspaper... I have always been fascinated by Patch Adams, but I wasn't sure I would have been able to face the hospital with my sensitiveness. At the beginning I was crying every time I was coming out of the hospital. I often met parents who were crying and my heart sank.'

Seven out of the nine musicians also mentioned the idea of music as being a special tool to create a 'magic bubble' where time stopped and children were able to have a break from the hospital routine:

Luisa: 'Music gives people in the hospital a moment of light-heartedness; it's a short time where they don't think about hospital. Today, there wasn't anything too serious, but sometimes it happens that someone is really ill and you manage to involve them with music and it's a magic thing because, if it only lasts for a short time, that time has been a break for them.'

One of them experienced the 'magic of music' first hand when she was in the hospital with her son. She pointed out how that experience had influenced her subsequent decision to play in the hospital, as she realized that she had a tool that she could directly use to influence a situation:

Paola: 'I was in the waiting room of the first aid station with my son and a musician arrived and started playing. The atmosphere suddenly changed... I thought it was fantastic! Everything changed with the music and it became a much more relaxing experience. After, I asked the musician if I could join him as a volunteer, but he replied with great pride that he was a

⁹Patch Adams is a promoter of the so-called 'humanistic care', a radical view of treating patients which integrates performing arts with medicine (http://www.patchadams.org/home.htm, retrieved on 21 June 2008).
professionally trained 'musician in hospital' and that I would have to attend a one-year course in order to be qualified to play. I thought about that. I am a professional musician, I play in the Maggio Musicale Fiorentino orchestra [the main orchestra in Florence], but the audience applaud the conductor, not me. I missed a direct contact with people, that is exactly what happens here and I have control on the direction of music as well.'

Moreover, playing in the hospital appeared to represent a rewarding experience for all the musicians. They felt empowered by a sense of music as being a powerful tool to impact on the lives of the hospitalized children. This feeling was explained by Bruna:

Bruna: 'Whenever I hear someone crying I always go there as it is very rewarding if you manage to calm a child down. I feel really good if I manage to do so.'

6.2.2 Perceived aims of their work

The views that musicians expressed about the perceived aims of their work in the hospital were mainly associated with the view that music helped to release emotion:

Marta: 'The musician goes into the hospital to elicit emotions, that can be positive or negative and so they can come out through music.'

It appeared that by 'release of emotion' they generally meant crying. Pietro had his own opinion about a specific technique that he was using whenever he needed to elicit crying and the underlying reasons to do that:

Pietro: 'I deliberately use a special song [Elton John's 'Circle of Life'] as I have discovered that it makes 96% of the mothers cry. I use this technique when I perceive that the mother is inhibiting the child with her tension. As they [the mothers] start crying, they usually leave the room and so I have my time with the child that can relax at that point.'

The view expressed by Pietro was, in turn, verbalised by other five musicians, suggesting that the cathartic use of music, in this case, might have had its origins in the training course. Eliciting
crying - mainly in the parents - appeared to be interpreted by the musicians as a key to opening up a relationship with the child, without the emotional barriers of the carer that were present at the moment of the musical intervention. Luisa explained this concept in more detail, through her first hand experience:

Luisa: ‘There was a young child that had just been operated on. His head had an open wound. I started playing the flute by the door and the grandmother who was with him started sobbing, like an explosion of crying. One of the motivations of the music is to give a chance to the people to release their emotions. I waited for her to calm down, still playing and then I went close to the child and I started interacting with him, as it was impossible to involve her in the interaction. She just needed some time for herself and I cut out that time for her to be on her own and not to put on a brave face in front of the child. I kept playing with the child and, when she calmed down, she joined us and told the child: ‘Have you heard what a beautiful music she plays!’ Crying is good, especially in certain situations, and she looked more relaxed afterwards.’

A therapeutic aspect of the musical intervention was also mentioned as part of the aims of ‘music in hospital’, although musicians were very cautious in describing their practice in the hospital through the word ‘therapy’. Instead, they described a generic therapeutic outcome as dependent on the sonic characteristics of music itself, rather than on any set of specific techniques. At the same time, they were conscious that music had an impact on the child, as this was explicitly recognized by the hospital staff who often requested the presence of a musician to facilitate sedations or to calm a child during a painful procedure. Pietro, dismissively conceded that:

Pietro: ‘Whenever music is used to support a therapy then it has a therapeutic aim which is to facilitate the release of anxiety, stress and depression.’

10 The Meyer Hospital has a pain control service that coordinates the musicians in case they are requested by any of the wards for special procedures in relation to the control of pain.
6.2.3 Perceived nature of the work

Risk of burnout and related causes

From the interviews emerged an image of the musicians as being constantly working and juggling complex lives. The aspect of ‘being tired’, initially noted as factual, emerged progressively as a recurring theme from the interviews with seven out of the nine musicians. Musicians were regularly reporting themselves as being physically ‘tired’, both when arriving and leaving the hospital. They were generally arriving at the hospital rushing from a previous job and, soon after the musical intervention, they would rush to the next one, conveying the impression of a rather ‘out of breath’ routine. Maria, for example, was teaching in Montepulciano two days a week where she usually stayed overnight, as it was too expensive to commute from Florence. She was also teaching in two music schools and was playing professionally in three orchestras. She was playing in two different paediatric hospitals, one of which was 20 km from Florence; she was married and had a young daughter. This was her comment when she was asked how she felt before starting her intervention in the hospital:

Maria: 'If I stop, I collapse. Tuesday and Wednesday I cannot see my daughter. I find it difficult, but one needs to work.'

Marta and Pietro reported the same feeling of being exhausted just before starting their intervention. This feeling appeared to originate both from their personal lives (e.g. having young children and juggling several jobs at the same time) and from the work in the hospital itself which was perceived as being demanding in terms of both physical and emotional engagement:

Marta: ‘Today I am worn out! Last night I haven’t slept at all. The kids have been up all night. I am exhausted.’

Pietro: ‘This morning I had two eggs and latte with biscuits. If I don’t eat properly when I play here I faint because it’s a stressful experience, both from a physical and a psychological point of view.’

The aspect of ‘being tired’, which initially appeared to be dependent on the musicians’ life styles, subsequently unravelled as being more connected to an emotional side of the musicians’ work in the hospital. Physical tiredness was a concept that the musicians employed to describe their work, which was defined in a polar way. On one hand, the work was perceived as emotionally rewarding, on the other hand it appeared to be emotionally draining, up to the point that some of the musicians needed to take a break from the hospital as they were unable to carry on:
Cinzia: 'In April I had a breakdown. I was stressed out. I couldn’t cope with coming here anymore. This job is emotionally draining. You have to pay attention to a thousand different things when you play; it is really stressful. There are a lot of children, lots of different situations. This morning was positive; there was no tension, but on other occasions, there’s a lot of tension around you. Even if the intervention goes well, it sucks a lot of energy out of you. If I have to play in the hospital for an hour or teach in school, there’s no comparison! Here, I have to give out everything and sometimes is not enough.'

Marta: ‘There are times when I arrive here in a really bad state, either because I had an argument with someone or I just got up on the wrong side of the bed and I tell myself ‘I wish I would not have to go in today.’

When the musicians reported themselves to be tired, they also reported a different reaction to the ‘crying’ that they heard in the hospital. In fact, if in general they were attracted towards a child who was crying, as representing a situation that music could have alleviated, yet when they were tired their perception changed up to the point that ‘crying’ became one of the main stressors that prevented some of them from continuing their musical activity in the hospital, even if only for a short time.

Maria: ‘After a year of playing I had to stop for a month as I couldn’t cope with it anymore. Every time I got in the hospital, I was distressed. Whenever I heard a child crying, I felt I had a block and that I simply could not go in.’

Paola: ‘There has been a period when I felt the only thing I was hearing was crying and that there was no other sound in the hospital. I found it very hard to cope with that.’

The reported tiredness was perceived to have an impact on their work in the hospital in so far as they reported a struggle, both physically and emotionally, with implications for the quality of their musical performing:

Maria: ‘My legs are hurting. I often have to be on my knees. It’s a visual thing. It’s better to have eye contact with the child and, if you are at his level, it’s easier.’
Cinzia: ‘There are times I am more tired than others and then things get harder, more dragged. I lose concentration, maybe I sing a wrong note, I play the wrong chords… if I had to do more hours, I wouldn’t be able to. This is a very demanding job, both physically and psychologically, but more psychologically.’

Pietro: ‘Being tired is also connected to how you feel inside. When my father died I was very low and I kept playing here. This is a very rewarding job, but sometimes you just cannot cope…’

Bruna: ‘Sometimes you are tired and everything hits you.’

The average length of the intervention and its repercussion on the musicians

The length of the intervention was also perceived by several musicians to be one of the causes of their ‘tiredness’. Some musicians had to play for three or four hours consecutively and, even if on the day that they seemed to cope, on the next day they reported being ‘exhausted’. One of the likely outcomes was that they tended to cancel some of their scheduled interventions, as they reported themselves to be ‘drained’ as a consequence of the previous day of work:

Paola: ‘Maybe I play for 15 minutes, and then for other bits of fragmented time, but when I get to the end of my three hours, I collapse. Before I had four hours, but I couldn’t make it and I asked if I could just do three.’

Cinzia: ‘I feel tired. A morning like this kills me physically. Psychologically I am fine.’

When asked about how they felt physically and psychologically, soon after their musical interventions, generally the musicians expressed a positive feeling, almost like being on a ‘high’, which they also translated on a Likert scale (see Chapter 6, section 6.3):

Paola: ‘Now I feel great. As soon as I finish playing it’s fine, it’s when I stop for a break that I go down.’

But when the same musician was met on the following day they were able to give a more insightful account of how the ‘high’ peak almost evolved into a negative one when the effect of adrenalin had faded out (see also section 6.3 for an explanation of the likely underlying causes):
Cinzia: ‘Yesterday, when I went back home after the intervention I slept for an hour and a half.... I was tense and emotional. When I came back home I realized that I cannot cope very well.’

Marta: ‘Today, I am tired after all the hours that I have played yesterday.’

Paola: ‘Today I’ll do a bit less, because I am tired. I have already played for two hours in a nursing home and we are playing Wagner in the theatre, so I am really tired. Last week I couldn’t make it.’

Bruna: ‘This morning I only came because I knew you were waiting for me, otherwise I would have probably stayed at home as I am very tired.’

The musicians’ busy lives, interwoven with the emotional demand of the work in the hospital, appeared to have lead univocally, at different stages (with only two exception, in both cases they were male musicians) to a minor burnout, with the likely consequence that the musicians had to take an unpaid leave from their work. As their musical activity in the hospital was part of a relatively tight monthly budget, one of the hypotheses might be that the musicians would keep working in the hospital until they reached, and probably, exceeded, a healthy psychological and physiological threshold. Moreover, musicians appeared to be provided with very few occasions to meet and to verbalize their experiences with their fellow colleagues, to release tensions, and find some kind of mutual support. All this was left to their individual resources.

Rotation issues

The perceived stress that seven out of the nine musicians reported in the interviews appeared to have one of its origins in the fixed timetable that the musicians had to comply with. The musicians had to play in the assigned wards for at least six months, even if, unofficially, it turned out that the timetable has been the same for over a year. This caused a series of repercussions for both the musicians and the staff (see section 6.1.1 (b) ‘Rotation’, for a detailed discussion). At least in two cases, the musicians explicitly asked to be moved from their designated wards after they witnessed the death of a child whilst they were playing. This episode triggered a strong emotional reaction defined by the musicians as a ‘shock’. The musicians reported not to have received any support from the association, and only some by their fellow musicians whom they met subsequently. In one case, the event experienced forced the musician to have a few months break from the hospital as she could not bring herself to play any more. She also had doubts about continuing to play in the hospital as the experience had been emotionally too disruptive for her:
Paola: 'when I came into the ward, as always I asked the nurse how was the situation on that day and she told me to start from the left side of the ward, and so I did. After few minutes I noticed a nurse crying and then a couple of parents that were holding each other, crying as well. I immediately withdrew. I didn’t expect that. At that point I was playing a cheerful tune and I felt broken. Luckily I met Luca [a musician] who is very experienced and we talked about what had just happened and I felt better.'

Moreover, it appeared quite evident that each musician had his/her own preferences when it came to playing in certain spaces:

Maria: 'I like to play where there are children. I don’t like neonatology because babies are too small to interact with or they are sleeping. Also, there is a lot of noise in that ward [heart monitors machines continuously beep].'

and an opposite account:

Cinzia: ‘I prefer neonatology because it's a quiet ward and there are not children running everywhere [she laughs]. I usually find wards less demanding, they are quieter. Waiting rooms are more trying, it’s noisier and you cannot use certain percussions instruments, you have to use different sonorities.’

The organization of the timetable was noticed to be a central issue in the overall balance between musicians’ wellbeing and their effectiveness as performers. Playing in preferred wards or waiting rooms was, in fact, reported as being an enjoyable activity and was perceived as ‘less demanding’, compared to playing in some of the assigned wards. In the light of the above comments, a possible implication might be that a rearrangement of the timetable according to the musicians’ preferences might have had a more positive impact on the musicians’ perception of stress and fatigue, as well as on the recognition of their emotional and professional effort.

Even if never openly reported, there was an underlying sense of dissatisfaction among musicians. The payment they received for their work in the hospital, for example, was not considered adequate in proportion to (i) the time needed to prepare an intervention and to (ii) the emotional time that they needed to unwind from their work in the hospital, as such experiences were reported to stay with them long after they had finished the intervention, as well as to impact on their emotional resources. Moreover,
they did not feel that the quality of their work was recognized, neither by the association, nor by the hospital staff, even if there were some exceptions among the latter (especially nurses, see section 7.3.1). The main source of reward and motivation to keep playing in the hospital was reported to come from the musical interaction with the children:

Luca: ‘I recharge when I see the children and I start playing with them.’

Luisa: ‘Almost every time I play it happens that I am exhausted physically but I get on a high psychologically.’

Coping strategies

According to the timetable, musicians were not allocated spaces for breaks in between their interventions. Even if the Chief Executive of the association appeared to be understanding of the needs of the musicians, it was difficult to organize the timetable around their needs as the timetable was the product of a fairly complex mediation between the hospital’s times, the musicians’ availabilities and the musicians’ skills to play in specific wards (evaluated by a member of the association) (see section 7.4). As a result, each musician appeared to have developed their own strategies to cope with a lack of rotation and a sometimes perceived excessive amount of hours spent in a stressful environment. If five out of the nine musicians used the time in between interventions to disinfect the little percussion instruments and somehow take a break whilst doing it, the rest of them appeared to have developed some specific musical strategies that enabled them to relax whilst playing:

Maria: ‘To feel at ease, I play songs that I have practised a lot and that I especially like, so that I both enjoy and I relax myself whilst playing.’

In particular, playing without singing, or looking for an interaction with a particular child, was reported as being a moment within the intervention where they felt more confident and in control, and therefore, they were likely to be more relaxed. Musicians also made use of the ‘instrumental’ time as a space in between interactions, when they were observing the situation around them, deciding about the next phase of the intervention:

Cinzia: ‘I feel tired. Singing continuously is rather demanding for me. If I play, I relax as that is my main job and I am in control. I often introduce the songs with the violin, without singing as I can quickly go through the lyrics whilst I am playing the introduction.’
Pietro: ‘Playing is also a way to take time and look around to see what’s happening.’

Marta: ‘If you play for four hours, towards the end you are really looking forward to finishing. At that point I prefer to play in wards where there’s not so much interaction with children and you don’t have to use percussion instruments, such as neonatology where you just sing lullabies.’

6.2.4 Main features of a musical intervention

The role of percussion instruments

Percussion instruments were generally employed by the musicians as a means of encouraging children’s participation in the musical activity and to establish a more direct and personal connection with the child through the handing out of the instruments and the consequent musical interaction:

Paola: ‘As a tendency I use percussion instruments more often, because for me it is difficult to sing in Italian [she is Japanese]. I play but not too often, because children listen but don’t participate, whilst with the percussion instruments they become protagonists and they might also be able to release some tension though their active music making. Also, they learn how to use the instruments that they can rebuild at home [she uses a selection of home made instruments built with everyday objects].’

Marta: ‘I think that if the child takes the little instrument and starts playing it, the communication has gone deeper, as that means that he trust you by taking that instrument.’

Luisa: ‘The father started singing a song in their own language whilst were improvising on the Kalimbas.’

Not all the musicians seemed to be confident with the use of percussion instruments as it required a degree of improvisation skills that not every musician felt comfortable with:
Pieter: 'Percussion instruments are used as a rhythmic accompaniment and not as we have been taught to use them, also... the level of the musical interaction depends on the age of the child. If they are too young they generally get bored pretty soon. If they are older you really need to be able to play interesting rhythms, otherwise is pathetic.'

Percussion instruments were also perceived as tools to promote music education, albeit informally and probably unintentionally, as it emerged from some of the musicians' comments. No musician in particular seemed to be aware of the educational impact or potentiality of their activities:

Luisa: 'To me is important that the children are able to learn a little song, as it is like a present I am giving them, it becomes their song and once they have learnt it they can decide whether to sing it or not once they are at home.'

Maria: 'We are not interested in the illness, we are interested in the person behind such illness and when you have a group of children that collaborate and interact with you then I try to make the most of it, organising an instrumental activity for example, with rhythmic improvisations.'

Luca: 'During an intervention I don't want to sing too many songs. I try to work on few songs, focussing on different arrangements, tempi, lyrics, to give time to the child to familiarize with the song'.

Singing and the use of musical instruments

Singing was recognized by the musicians as being a powerful tool to establish a communication with the children, especially if they were young:

Maria: 'Playing the violin is a way to relax. I don’t do that with young children. They are more attracted by the voice, the songs, and the little instruments.'

Paola: 'I need to learn how to sing [she is Japanese] because that is the best way to communicate with the child. When it happens I feel very light and I am happy.'

On the other hand, the musicians appeared to be aware of the limited use of an instrumental-classical repertoire, unless the intervention was targeted for an adult audience:
Cinzia: ‘Adults and especially staff, appreciate the solo instruments, particularly when I play classical music.’

Maria: ‘Before I used to play the violin more, maybe in corridors, as I have been taught to do. But then I got the impression that classical music was not so well received... I felt like people perceived it as sad, regardless of the pieces I was playing, therefore I changed approach.’

Paola: ‘I prefer to use percussion instruments as I enjoy them and there is an energy exchange and I feel I recharge myself emotionally. If I play I feel confident, but I don’t recharge.’

Sometimes the instrument was perceived as a sort of barrier that prevented a more direct communication with the child. In three reported cases, when the musicians were playing their main instrument, they tended to switch to ‘performing mode’, focussing more on the quality of the music rather than on the relational aspects of it.

Bruna: ‘Sometimes I think that the sound is more emotional. You can capture children’s attention with a new sound, a new shape, but adults are more attracted to the sound... for example, doctors immediately notice if you are a professional musicians as they are a category of participants that listen to music.’

Paola: ‘To attract the child’s attention I use the voice and the percussion instruments. I like having an intervention based only on musical objects. I don’t really like to play the viola because for me that is not very interesting. Any of my colleagues from the orchestra could do that, but to be able to structure an intervention based on the objects it’s different; you need to study for that.’

Bruna, an oboist, commented on how her perception of playing in the hospital changed according to the instrument that she was playing:

Bruna: ‘The guitar sustains me, as my voice is not that good. When I play the oboe, I think about playing something beautiful, as I can do that professionally as it is my instrument. I play classical pieces like ‘Summertime’ or some children’s tunes. It is different because my attention is focussed on the
In other words I am less relaxed as I am not so capable yet to use it in all its potentialities. I am less conscious of what happens around me.

In the case of Bruna and Paola, playing their own instruments was not considered as ‘relaxing’ compared to the rest of the musicians who generally used their main instrument as a way to rest and recharge after a one-to-one interaction, whilst looking at the space around them, preparing for the next interaction, both emotionally and musically.

Planning the intervention

When the musicians talked about the musical ingredients of their interventions, ‘improvisation’ emerged as a recurring theme. The musicians had to improvise constantly at different levels (both at a musical level and at a more interpersonal one when establishing a relationship with the child). It appeared that a degree of improvisation was permeating many aspects of their musical activity in the hospital, from the impromptu choice of percussion instruments - and their subsequent use in the musical interaction, either with a single child or with a group of them - to the choice of songs, to the selection of children to establish a musical dialogue. As the majority of them (seven out of nine) were classical musicians, and not used to improvisation, it might also be that these aspects added to the overall reported emotional and physical ‘tiredness’ of the job. Musicians that did not have a classical background and that were used to improvising either because they were playing jazz in more informal context (as in the case of Luca and Marco) or because they were playing within the community (as in the case of Marta and Pietro), reported less anxious comments about their preparation and their repertoire. Moreover, the flexible and unpredictable nature of the work in the hospital did not allow the musicians to have a predefined plan for the intervention, but rather, they were drawing their songs from their personal repertoire that they were constantly updating:

Cinza: ‘It is impossible to plan ahead. I have a basic repertoire, some ideas and the experience to combine them together. Sometimes I decide which songs I want to sing on that particular day. I match the percussion instruments to certain songs and so, when I give such instruments to the children, I sing those songs.’

Luisa: ‘Now I am going in the waiting room of the emergency service. I am bringing a selection of percussion instruments as the age range is wide there. I have instruments for all ages as there’s never a fixed situation. I have an idea about the age range but I never know what I am going to play.’
Bruna: ‘I prepare the songs; I have my plan and my repertoire. I have around 10 songs that I can juggle with [she is from the second training course], then it can happen that I might sing 4 or 12, depending on the situation in that particular day.’

Pietro: ‘We have some guidelines but then you have to see which situation you are in, and react to that on the spot. One has to be flexible.’

Entrance in the ward

Typically, the musicians were noticed to play a ‘signature’ piece when walking in the designated ward or waiting room. Playing the same songs was both a way to announce the beginning of the musical intervention and to make clear that they were professional musicians:

Pietro: ‘My favourite piece is a sort of ‘signature’ piece. I sing ‘the lion sleeps tonight’ so that everyone realizes that I am coming in. I like this song and everyone knows it [it has been recently used as the soundtrack of a TV advert], it has rhythm and it helps people to get in touch with music and also to be less intimidated by it. Obviously, if the situation is not the right one, I play something different.’

Cinzia: ‘To me it is important to play at the beginning of a session because people understand that I am a professional musician. When I play in a waiting room I usually play outside the door, generally three or four classical pieces so that people can listen and who is interested or curious comes out of the room to see what’s happening so that when I enter in the room I already know whom to begin a musical interaction with.’

When asked why she was playing classical music at the beginning and at the end of her intervention Cinzia replied:

Cinzia: ‘Because I think it’s relaxing. In such a context, I feel that music in the air relaxes the environment. It has never happened to me that an adolescent reacted badly to it. I play a short piece and I have always noticed a certain response to it.’
Although Cinzia’s view was shared by some of the staff and parents, there were some discordant views on the use of classical music, both among the musicians themselves, the staff and, more importantly, the children (see section 7.2.1(1)).

Different musical techniques in relation to different spaces

From the conversation with the musicians it emerged that the musical approach was perceived to change according to different spaces within the hospital. A main difference was noticed between group interaction and one-to-one interactions:

Luca: ‘I would say that there are three main areas that can influence the way we play: waiting rooms, wards, and intensive care units. In a waiting room there are different situations, for example if the room is crowded then it becomes difficult to give the little instruments to the children. If I am able to create a group interaction then I prefer that, but if not, I concentrate on a musical relationship with a single child.’

Marta: ‘In these rooms [day hospital in the oncology ward], where there’s a lot of noise, it is difficult to create individual interactions. I prefer to create a group interaction so that the noise is channelled into the music.’

Luisa: ‘Within an intervention, I usually try to relax the children through playing. I encourage them to sing a song they know like ‘Fra Martino’ [Frere Jacques] - so that I am sure everybody knows it — and then I teach them a little song. When I have this typology of group in a ward, I usually use this structure.’

Each musician appeared to be able to decode different situations in the light of their personality, individual sensitivity and previous experiences. Although there was a degree of unpredictability in the musical interactions, it also appeared that there seemed to be a sort of musical script, what they called a ‘structure’ that the musicians were following. In fact, even in the great variety of circumstances, they appeared to be able to reduce the situations they were operating, into a typology that they were familiar with and from where they were working out their musical reaction. This was particularly evident for the more experienced musicians (five out of the nine musicians have been playing in the Meyer hospital since 2003 whilst four musicians had only been playing in the hospital for over a year at the time of the fieldwork (June, 2007)).
Shortage of new repertoire

The issue of a perceived lack of new repertoire was chiefly connected to the time that the musicians needed to prepare an intervention. It was also linked to the lack of a rotation in the musicians' timetable. Playing in the same spaces was more likely to result in the same encounters, as in some waiting rooms children were coming back on a weekly basis (e.g., metabolic medicine). If, for children, listening to the same song was probably what they would have requested anyway, for the hospital staff (see section 7.3) and for the musicians this was perceived as a problem:

Pietro: 'To prepare an intervention I have to study at least for three hours every week. I find it difficult to play always the same music.'

Paola: 'Sometimes I am tired, especially when I have been playing throughout the previous day, and perhaps five hours a week are too many, especially when you keep meeting the same child again and again. I cannot change the repertoire every time.'

6.2.5 Characteristics of a successful intervention

Musicians' personal resources

The musicians were aware of the complexities of factors that constituted a musical intervention and that were likely to impact on its perceived success. At least three of them were very clear in identifying such elements, like in the case of Pietro:

Pietro: 'I think that what determine the course of an intervention is mainly: one, the intensity of the sound; two, the relevance of the repertoire; three, the relevance and the quality of the percussion instruments; and four the way I feel on that day.'

The rest of the musicians were less precise, but nonetheless, aware of the multifaceted components of their intervention. They stressed the concept that both the musician's determination and self confidence were crucial elements in predicting the outcome of their musical intervention:
Marta: 'You need a lot of things! You need the look, the determination in wanting to capture his attention. If you are hesitant the child perceives that and he generally withdraws himself. It can happen that you see a child that looks shy and maybe you timidly get close to him because you think that he doesn't want to participate or for fear of disturbing him. But maybe if you approach his parents first, the shy boy will relax and will trust you, seeing that his parents are participating in the music.'

The potential success of their intervention was also attributed to the musicians' individual abilities to decode and, consequently, to react to a situation in real time. This ability was perceived to be connected with the musicians' psychological and physiological conditions on such days:

Cinzia: 'One needs to be able to observe and decode what the children are doing, as nothing is accidental. I need to decode the children's body language and facial expression and interpret them. Through empathy and intuition, I need to interpret their needs at that moment in time and select the right music.'

Bruna: 'First impression is what counts. From the glances you understand who is interested and who is not. I should be more careful about the way I use my voice, as I tend to sing too softly and sometimes people just cannot hear me and I lose them.'

Maria: 'The success of the intervention depends on how you feel at the moment, while you are out there playing. In a short time I have to be able to realize what's happening around me. For example, earlier in that room [general paediatric ward] I realized that all children were willing to participate, so I distributed the instruments and the music was already there. But if you try to give a child an instrument and that child doesn’t do anything with it, then you give another instrument to another child who happens to be shy, then you have to be able to come up with something to bring the children together. We are the one who determine the course of the session. Then you can also be in a situation where the child is in pain and doesn’t want to participate, or where the parents are particularly anxious and just leave as soon as they see you. In those circumstances you have to respect them.'
Children's previous hospitalization experiences

The presence of pain in the child and their previous hospitalization experiences (see also section 7.1) were also mentioned among the important variables influencing the course of the musical interaction. In fact, more ‘experienced’ children were conscious about the procedures and remember the associated pain, therefore they were less willing to be distracted from their anxiety:

Luisa: ‘In this room [blood test procedure room] it all depends from the awareness that the child has about what is going to happen. It is harder to interact with children that have had a previous experience because those are more tense and anxious as they know what to expect. Children that are new to the procedure are more relaxed and it is easier to interact with them.’

Relatedly, the importance of establishing a relationship with the child before the intervention was highlighted as an important factor to contribute to the success of the interaction. Musicians reported unanimously that the music was more likely to distract the child if the relationship was established before the medical procedure as the musical interaction prevented the child from spiralling up in a state of anxiety and fear where it was difficult to reach them:

Pietro: ‘If you establish a musical interaction with the child in between five and ten minutes before the procedure begins, while he is still in the waiting room, then he will have the time to get distracted and perhaps even to relax before getting in the procedure room, instead of spiralling up in a crescendo of anxiety. It’s like when you have to go through an operation: The general aesthetic needs to kick in before they start cutting your various bits! [he laughs].’

Cinzia: ‘The child was crying, I tried to distract him but he was still crying. Even so, he was still looking at me whilst I was playing and this for me means that the relationship was going on. Therefore when the doctor finished with taking the blood sample, the child stopped crying, almost immediately and I was able to re establish a musical interaction and to distract him straight away.’

The musicians appeared to be aware of the need to approach the children at the emotional stage that they were in at that moment in time, and that only after having reached the child they could move somewhere else together, through the music. In this respect, an implicit degree of
empathy and sensitivity, even if not mentioned explicitly, appeared to be an important requisite for the musicians:

Bruna: ‘You can play any song in the way you want, either as a lullaby or in a more rhythmic way. In this ward [general paediatric] I tend to play calmer songs. If the child is agitated I play a quiet song. I personally don’t feel like playing a cheerful song if the child is crying or is nervous. If he calms down, and I manage to establish a relationship, then I can start singing something different.’

Pietro: ‘What I have experienced with children is that they tend to relax with slow rhythms and low sounds while getting stimulated by fast rhythms and high pitched sounds. What they have taught us during the training course is that if a child is too relaxed you should play something stimulating, while if the child is agitated you should play something to calm him down.’

Percussion instruments, together with the voice, were identified as a powerful tool to facilitate the establishing of a gradual relationship with the child:

Marta: ‘The percussion instruments are a tool that allows both the musician and the child to familiarize with each other and with the music. When I start singing, the child understands what’s happening and he generally relaxes. The curiosity of the child is directed on the little instruments and the voice helps to establish an emotional relationship. Voice is warmer and it is easier to communicate through the singing, especially when children are younger.’

Luisa: ‘Sometimes, if the child is angry or very distressed I have used a percussion instrument and with a loud sound or a surprise effect you might be able to distract the child from the state he is in and then take the music from there, maybe a lullaby sung in a funny way.’

Role of parents

The attitude of parents towards the musical intervention was considered to be crucial by the musicians to predict children’s reactions to music, as children were perceived to be emotionally dependent by their parents and to respond to their anxiety:
Marta: ‘According to my experience, the success to involve the child depends on the involvement of the parents. Children generally respond to the anxiety of their parents.’

Luisa: ‘If parents are willing to be involved in the interaction, then all is fine.’

Cinzia: ‘When the child was crying I decided to keep playing because the mother was singing and the child calmed down after having noticed that.’

When parents were particularly distressed, their protective attitude was reported to prevent the musicians from getting close to their child. When they managed to break the ‘wall’ that the parent had put up, musicians noticed that the music was having a calming effect on both the parent and the child, and consequently it impacted on their interaction:

Luisa: ‘After the intervention, if the child is calm, they see you as an occasion in which they can take few minutes off. But when the child is in pain, they put up a wall and then I cannot do much. I just keep playing in the corridor as music can go through all these kind of walls.’

Pietro: ‘Music is a tool that facilitates the relationship between children and their parents.’

**Familiar music and musicians’ personal musical tastes: Influence on the selection of the repertoire**

The musicians expressed diverse opinions on the impact of a specific kind of music on the overall success of their intervention. This was possibly due to the fact that they had received specific guidelines about the musical genres that they were supposed to play during the training course (as mentioned in section 6.1.2 ‘Repertoire’). The recommended repertoire included classical music and a selection of folk-regional songs, with a constant emphasis on monitoring the musical quality of the intervention. Through their experiences, six of the nine musicians reported that they had realized the importance of using a familiar repertoire, as it had proved to be more effective in involving children and their carers in the musical interaction, even if sometimes the musical quality was not as good as expected:

Pietro: ‘There is the training, but then one makes his own choice. During the course they told us not be like a jukebox, as we won’t always be able to satisfy every request. But I have noticed that meeting people’s musical
tastes increases the chance of establishing successful interactions, their qualities and their results.'

Maria: [Talking about a tune from a TV advert]: 'I know that these songs are overplayed but every child knows them and so they can sing along [...] I usually start singing and after a song or two I ask them [the children] what music do they listen to.'

The importance of using a familiar repertoire was particularly noticed for the age group of children up to eight years old:

Bruna: ‘I think it is important to play familiar music, especially for the age group up to six years old.’

Marta: ‘With children up to eight years old I usually sing the ‘animal repertoire’, a bunch of songs about animals as they really like those songs!’

Pietro: ‘Folk music is a bit boring after a while. Maybe you can use it as a lullaby. In general Disney’s songs are more familiar and there’s a better response with those.’

Playing familiar music was also connected to the issue of the time that the musicians needed to prepare an intervention. If the repertoire was targeted to adolescents or to non-Italian children, then the musicians reported that they had to spend a considerable amount of time to learn such repertoire as they realized that, especially with these two group of children and young people, ‘their’ music was like a special language which was necessary to know in order to establish a communication with them:

Bruna: ‘In this ward there are a lot of adolescents... I know few songs but the majority of my repertoire is for young children and so if I see an adolescent I often move on to the child that is around. I get anxious when I see an adolescent, because I don’t have an appropriate repertoire and the only way to involve them is through their songs.’

Paola: ‘Before the training course I detested any other kind of music but classical. Now I have to fight against the wall of pop music as children listen to this kind of music. I also need to learn some world music from Bruna.’
Luisa: ‘I played in the play room, using the toys as percussion instruments. There were two Arabic children and it’s more difficult to interact with these kids, I don’t know many Arabic songs. In these situations I tend to use vocal improvisations and the little instruments.’

Marta: ‘There was an Albanian family and I sung a song together with the mother. All Albanians know this song. I was taught it by a mother that plays the cello with Cinzia [a fellow musician].’

Not all musicians agreed with the idea of using familiar music as they did not feel at ease playing such repertoire, especially if they were coming from a ‘classical’ background:

Cinzia: ‘The point is that even if you don’t play exactly the kind of music they listen to, it’s nonetheless an experience for them. They see a musical instrument that they might have not seen before from such a close distance and they get to listen to its sounds.’

Luisa: ‘I don’t do pop music, I might have a song, but no more that that. It’s not my repertoire and it’s not my style.’

Maria: ‘I don’t really like playing pop music as I don’t think it has a great musical value.’

All musicians followed the musical guidelines that they had been given in the training course, but each of them developed their own personal approach in the selection of songs. Talking about their musical preferences, it emerged that there was a significant relationship between the music that the musicians were playing in ‘hospital’ and their musical tastes. In fact, they reported that by enjoying the music they were playing, they also felt more at ease whilst playing (as previously observed in the coping strategy section, cf. 6.2.3 Coping strategies):

Pietro: ‘You like the music that you play. When I play Bennato [an Italian song writer] I like what I am playing, it’s my music and I feel at ease with it.’

Bruna: ‘I like world music, as songs are beautiful, their rhythms, colours, sounds, and I also feel that the words that you don’t understand are magic. These songs also work for older children.’
Luca: ‘I listen to any kind of music, maybe jazz a bit more than other music, but I also listen to a lot of children’s song as this job demands a lot of updating.’

**Non verbal interaction**

The musicians identified a number of non-verbal elements that were perceived to be an integral part of their intervention, and that were likely to contribute to its outcome. The recurring concept of ‘decoding’ a situation in the shortest time possible emerged as the leading theme, subsequently connected with the view that amongst the important requisites that a ‘musician in hospital’ had to be equipped with, there were also skills like ‘empathy’, ‘intuition’ and ‘special sensitiveness’ that were informed by their previous experience in the hospital:

Pietro: ‘You need to be a good at observation and you need a lot of empathy and intuition. When you walk in a room you have to look at what people are doing and read their behaviour through their actions and decode them. At that moment in time nothing is casual: where they are, what they are doing, what kind of objects are around them, how they are dressed… nothing is casual. For example, once it happened that a child had a t-shirt with the image of a cat and then I played ‘44 gatti’ [a song about cats], and it worked so well! In that way I managed to establish a channel through which I could communicate with him. Ninety per cent it works. The needs to read the reality of the child, decode it and reproduce it through a song, I try to do this but it’s not easy. Sometimes there are very clear clues, but some other times it is not that immediate and I try to grasp them but at the same time I am careful not to be too intrusive.’

Marta: ‘When the musicians enter into the room, the first thing they see is a snapshot of a situation. In a very short time they have to realize what’s going on in there, which is something that you might get from a glance— who is crying, who is sleeping, who is playing and with what – but this is also something that requires a special sensitivity informed by our experience.’

The constant attention that the musicians needed to ‘decode’ an emotional situation and ‘translate’ it into music was reported to be a demanding feature of their work. All musicians reported that they were not allowed to relax or distract during their intervention, as the balance within the people involved in the musical interaction was very subtle.
Pietro: 'This is a very demanding job in terms of psycho-physical commitment. It's hard, it's tiring, especially from a psychological point of view because you have to establish a connection with the child, with the parent, with the staff, with what is around you, grasps the emotions around you, different moods and reprocess all this very quickly, work out all these information and select the right music.'

Bruna: 'It's mentally tiring. You have to decode non verbal behaviours that happen in few seconds.'

Cinzia: 'I find exhausting the stress of being always positive, monitoring all what's happening. You can never lose that tension, you always have to be aware of all what is happening around you and be able to decode the actions of people and react with musical ideas accordingly.'

In the case of a relationship with a non-Italian family, the non verbal behaviour was more challenging to decode:

Maria: 'I was getting close to the child and the father moved a chair so that it was in the middle of the room, but I didn’t understand if that meant that he didn’t want me to get closer to the child or if he wanted me to sit on that chair. I didn’t know what to do. I went in the room because the child was looking at me and was dancing on his bed, but his father’s behaviour was weird. If they don’t speak your language it’s difficult.'

The musicians were also aware of the importance of their physical positioning in relation to the space surrounding the child, especially if young, in order not to intimidate them. A sense of professionalism and analytical thinking, combined with long-term experience emerged from their observations of example situations. The role of the parents in facilitating the relationship with the child emerged once more:

Luca: 'There is a visual approach and a positioning approach where you look for the right distance from the child. It is better to stop further away and then gradually to come closer. We always need to check our position so that it's always at the level of the child. Especially with young children, a close distance can be intimidating. Also looking at the child directly can be sometimes intimidating. In these cases, it’s usually better to establish eye-
contact with the carer first and then to shift on the child later so that he has the time to trust the new situation.'

6.3 Musicians’ physical and psychological perception of working in the hospital

Visual analogue scales (VAS) are frequently used to assess and monitor self-reported measures, both in children and in adults. Generally, they are employed to measure pain and fear (Chapman and Kirby-Turner, 2002), but also anxiety and stress (Kindler et al., 2000). The pain control service at the Meyer hospital has adopted a six point Wong-Baker scale (1988) (Figure 6.18), which has been distributed to all the medical staff in the form of a pink bookmark, and which has also been placed in common areas of the hospital for general collection for use. This was part of a wide policy adopted by the hospital on the control of pain in hospitalized children (cf. http://www.meyer.it/notizia_2.php?IDNotizia=4807&IDCategoria=406, retrieved on 2 August, 2008).

Figure 6.18 Wong –Baker scale (1988), commonly used in the Meyer hospital for the control of pain

Therefore, the musicians were familiar with this kind of scale. Accordingly, an adapted version of the scale was used as part of the interview process before and after observed interventions. The musicians verbalized their face choices and expanded on their perceived psycho-physical conditions whilst ticking a particular face, before and after their intervention. After the first week, ‘ticking the faces’ had become a sort of ‘ritual’ and musicians were aware of what to expect before and after their session. Even if this did not seem to impact on their choice of face,
their explanations became progressively more articulated and their reflections, on both their musical actions and their individual perception of reward, fatigue and stress, more detailed.

Eight musicians were asked to self-report their perceptions on a seven point Likert scale (Figure 6.19), as this is a common measure for music education research at the Institute of Education. Twenty-six measurements were collected in paired pre and post measurements (see Chapter 5, Table 5.4). Each musician self-reported on (a) their physical state and (b) psychological state an average of three times, prior and after their observed musical sessions in the hospital. When asking them to rate their 'physical state', they were asked to make a judgment of how they felt in relation to their perception of either being tired (such as lack of sleep, or having low blood pressure, being too hot, having some kind of physical pain, etc.), neutral, or more energetic. By 'psychological state' they were asked to rate how they felt before and after their session in the hospital, in relation to stress, anxiety, relaxation, depression, etc. (see Chapter 4, section 4.3 for a literature-based distinction on the psychological and physiological effects of music).

Figure 6.19 Seven-point Likert scale, adopted in the present research

In both cases the musicians reported that the perception of how they felt physically and psychologically improved after they played in the hospital (Table 6.2, and Figures 6.20 and 6.21), with the small difference that their psychological conditions were reported to be improved slightly more than their physical ones.

A Wilcoxon Signed Ranks test was conducted to investigate whether musicians' perceptions of how they felt physically and psychologically changed after they played in the
hospital\textsuperscript{11}. Results suggest that musicians' perception of their physical condition had improved after the musical intervention ($Z = -3.00$, $N = 26$, $p = .003$). Similarly, their psychological condition also improved after they played in the hospital ($Z = -3.67$, $N = 26$, $p < .0001$). Musicians reportedly felt psychologically slightly better than how they felt physically (Table 6.2). However, these results should be interpreted with caution given the relatively small sample size.

<table>
<thead>
<tr>
<th>Musicians’ self-reported condition</th>
<th>Mean</th>
<th>SD</th>
<th>Mean difference</th>
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<tr>
<td>Physical State Pre</td>
<td>3.77</td>
<td>1.24</td>
<td>-1.35</td>
</tr>
<tr>
<td>Physical State Post</td>
<td>5.12</td>
<td>1.51</td>
<td></td>
</tr>
<tr>
<td>Psychological State Pre</td>
<td>4.15</td>
<td>1.26</td>
<td>-1.81</td>
</tr>
<tr>
<td>Psychological State Post</td>
<td>5.96</td>
<td>1.15</td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{11} A non-parametric test (Wilcoxon) was conducted instead of a paired samples t-test, due to the small sample size ($N < 30$) and as initial exploratory data analyses suggested that the data deviated from normality (the Komogorov-Smirnov test for each of the four conditions was significant at $p < 0.05$, suggesting that the data were not normally distributed – see Sig. column below).

<table>
<thead>
<tr>
<th></th>
<th>Kolmogorov-Smirnov\textsuperscript{a}</th>
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<tr>
<td></td>
<td>Statistic</td>
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<tr>
<td>Physical State Pre</td>
<td>.189</td>
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<tr>
<td>Physical State Post</td>
<td>.260</td>
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<td>Psychological State Pre</td>
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\textsuperscript{a} Lilliefors Significance Correction
Although I interviewed nine musicians, I was only able to observe eight, as Marco, the group coordinator as well as a musician, never showed up at his scheduled times as he was busy coordinating the other musicians and dealing with his teaching.

In both Figures (6.20 and 6.21) one of Pietro’s self-reported measures stands out from rest of the group. On that day, he arrived in hospital being physically tired as his two young children had a troubled night. During the morning he was not as focused as he expected to be. Consequently, some of his songs were not musically accurate, his voice cracked in few occasions, he forgot some of the lyrics, and during his ‘round’, he was unable to involve two children in the musical activity. At the end of the morning, he reported himself to be very low, both physically and psychologically.
It appears that soon after they had played, musicians felt significantly better, ‘almost on a high’ (see section 6.2.3 ‘Average length of an intervention’) as if playing in the hospital had the same kind of effect of an after-performance, when the adrenaline is still flowing in their systems (cf. Williamon, 2004). The emotional peak that they reached after the performance in the hospital, according to what the musicians reported in the interviews, went down soon after they arrived at home and started relaxing. Some musicians reported that they could not even make it to the hospital the next day because they felt too tired. Even if it was difficult to disentangle the concept of ‘being tired’, it appeared, from both observations and interviews that musicians had to deal with an emotional-psychological tiredness, which translated into physical symptoms. This seemed to reflect the nature of their musical performance in the hospital, which appeared to be made up of two components: (i) musical-emotional and (ii) physical.

(i) Musical-emotional
Musicians reported that they were constantly experiencing a set of emotions connected to a musical performance, with the difference that they were performing regularly from three to ten hours a week, every week, throughout the year, with little scheduled time to recover. In addition to the performance elements, there was an interpersonal and direct involvement with children, their carers and the hospital staff, and as a consequence, related stress and distress in being in direct contact with the suffering witnessed in the hospital. Paradoxically, it was also the intensity of these relationships that constituted the rewarding reason that kept the musicians going into hospital. If, on one hand, the work in the hospital was perceived as exhausting, on the other hand it was perceived as extremely rewarding; so rewarding that they seemed to be able to forget the negative aspects of it and to be able to find new energies to keep going into hospital.

A possible explanation for the musicians’ attitude can be traced in flow theory, (Csikszentmihalyi, 1990), which suggests that ‘optimal experience requires a balance between roughly equals levels of perceived challenge and skill in a situation that involves intense concentration’ (O’Neill and McPherson, 2002: 35). In this case, the challenges for the musicians are represented by: (i) performing at a high standard, whilst (ii) detecting the emotional situation of the room they are walking in; (iii) selecting the right piece of music to establish a contact with the child whom they are about to start a musical interaction with; (iv) perform variations on the piece, often improvising, both according to the mood of the child (e.g. making onomatopoeic sounds to surprise and amuse the child - see 6.1 (3) Common musical techniques characterizing the intervention) and the musical piece, in order to promote an informal learning experience. Overall, the musicians’ work appears to be a tight combination of musical and interpersonal skills and goals.

Musicians explicitly talked about the musical challenge of their work in the hospital in relation to the variety of children involved and the need to master a broad repertoire, which they
did not have the time to update (see 6.2 (4) Shortage of new repertoire). To compensate for a lack of new repertoire, they often used musical improvisation with percussion instruments which, nonetheless, they had to prepare, as most of the musicians, except two, were coming from a strictly classical background where not much space is traditionally left to improvisation (cf. Creech et al., 2008). The musicians appeared to be self conscious of their musical limitations (see 6.2 (4) The role of percussion instruments), and this aspect was highlighted by the fact that they were performing regularly, and therefore the ‘sameness’ of their repertoire was more noticeable.

According to the Yerkes-Dodson law (Yerkes & Dodson, 1908), a performance is better when arousal is at moderate levels — that is, when the performer is neither too relaxed nor too anxious. The relationship between arousal and performance outcomes is commonly referred to as the inverted U function. As Williamson comments (2004: 12) ‘low arousal can result in dull or lifeless performances, whereas very high arousal can lead to physical and psychological impairment of ability’. However, as Williamson suggests (ibid), the relationship between arousal and performance quality is often not so straightforward. Fazey and Hardy (1988) made a distinction between the impact of psychological and cognitive components on the quality of a performance. As reported by Williamson, they argued that:

‘When cognitive anxiety is low (i.e. when there is little fear of failure and its consequences), the Yerkes-Dodson law holds; however, when cognitive anxiety is high, performance quality is susceptible to a catastrophic drop, from which immediate recovery is difficult to achieve. The basic idea, based on data from performance in sports, is that excessive apprehension and rumination can lead to a vicious spiral of negative thoughts and hence, can cause performance to collapse.’
(Williamon, 2004:13)

According to the musicians’ self-reported measures, they reported feeling worse at the beginning of their ‘performance’ compared to the end. This might indicate that they were generally ‘tired’ due to the continuous amount of playing that they were doing, but also, that behind what they described as ‘being tired’ there were different feelings such as anxiety and fear, symptoms that are usually associated with performance anxiety (Papageorgi et al., 2007).

In the Florentine setting, musicians were performing on a regular base and appeared to have few occasions for scheduled breaks from the hospital, unless they independently decided not to turn up. Their work as performing musicians is characterized by playing in a context that requires additional musical skill (e.g. improvisation) and interpersonal skills that they seemed to have learnt by playing in the hospital. Musicians were also observed to monitor continuously the multiple interactions with different audience(s) (children, parents, staff) that evolved on a moment-to-moment bases. Also, different interactions appeared to require an adequate musical
repertoire and a range of different communications skills that musicians had to re-adjust to in real time.

What seems to emerge from these data is that the Florentine musicians, who played in the hospital, appeared to behave like performers. They exhibited high levels of arousal at the end of their sessions in the hospital, but these levels seemed to drop as soon as they arrived at home and they tended to stay low until the next day (Figures 6.20 and 6.21). Musicians seemed to have little time to recover in between ‘performances’. It appeared that there was no support among themselves as a group, nor a support system that had been organized by the association managing the project. The latter might have helped the musicians to overcome the specific stress associated with musical challenges and with working in a stressful environment, ultimately preserving them from the risk of a burnout.

(ii) Physical
Musicians often had to play bent on their knees (to be able to make eye-contact with the child), and they usually had to carry a large suitcase for the percussion instruments apart from their main instrument, in addition to their special waistcoat. Also, the musicians did not have time to recover after their intervention in the hospital, as some of them (three at least, according to the official timetable, without considering the extra-timetabled arrangements) had to play consecutively for three or more hours on consecutive days (see Appendix N). What they reported as ‘tiredness’ appeared to be a mixture of emotional and physical elements, not easily distinguishable, which resemble to a definition of ‘burnout’ as defined by Maslach and Jackson (1981). They conceive burnout as a syndrome characterized by emotional exhaustion (feeling of being emotionally overextended and exhausted by one’s work), depersonalization (an impersonal response towards recipients of services) and reduced personal accomplishment (feelings of competence and successful achievement in one’s work).

Overall, the self-rating, interview data and observations, suggests, that, in the observed hospital context, powerful positive and negative psycho-physical correlates are associated with the musical intervention. For the musicians, playing in the hospital appears to be an advanced form of performance. In order to succeed in their work, they have to be equipped with musical and interpersonal skills. Their ‘audience’ is generally constituted of distressed, often in pain, anxious children and their, consequently worried and stressed, parents. Children have different ages, different socio-cultural backgrounds, different experiences of hospitalization, and, often, different ethnicities. None of them has chosen to be in the hospital and, in a way, the musicians have to be able to ‘convince’ and motivate the children to join in the session, allowing themselves to be distracted, even if only for few minutes.

The tools at their disposal to involve the young patients appears to be (i) a suitable choice of music, (ii) the little percussion instruments that they distribute to the children to encourage their participation and foster a sense of control over the session; (iii) their enthusiasm and
energy levels to motivate and involve different participants (including carers), improvising on a number of both musical and emotional levels; (iv) a constant awareness of the changes, both emotional and spatial, that progressively unfold around-and-within the session, and consequently, an ongoing musical and emotional ‘tuning’ (adjustment) to the new situation. The musicians appear to be live agents of change in the hospital and this is simultaneously perceived by them as both enriching and exhausting. Their work is a solitary professional activity with little sense of working as part of a collective and in an emotional pressured environment.

6.4 Chapter summary

From the observations and interviews with the nine musicians working in the Musica in Ospedale project at the Meyer paediatric hospital in Florence, it has emerged that:

• The ‘musician in hospital’ appears to be an emerging professional identity (see also Chapter 8, section 8.2.5). The professionalism of the musicians was not exclusively musical. Important features of their role included the requirement for interaction and communication skills with different ‘audiences/participants’ simultaneously in variable performance settings, based on empathic ways of communicating with the children that were in the hospital, as well as knowledge of the hospital rules and regulations (e.g. such as observing hygienic norms). This knowledge and skills had been partly learned in a qualifying training course, prior to their employment in the hospital, and partly identified and elaborated by the musicians themselves during their long-term experience in the hospital.

• Although the nature of hospitalization implies a high degree of unpredictability in terms of which children the musicians would meet and the nature of their physical and psychological conditions, the musical intervention appeared to be carried out on the basis of a musical framework. This comprised a structure made up of a set of action-reaction steps that helped the musicians to have at least one aspect of their work that did not require improvising. In some respects, the framework that the musicians had elaborated could be compared to modules that they were combining within the free structure of their musical intervention.

• Improvisation techniques appeared to be a key element for a ‘musician in hospital’. The fact that the majority of musicians were classically trained and, therefore, likely to be unfamiliar with improvisation techniques, appeared to impact on the perceived stress that they reported about their work.

• Although they identified themselves as a ‘group of musicians’, the reality of their work in the hospital was noticed to be a solitary and, often, isolated one. The musicians did not share their emotionally charged experiences with any colleague or hospital staff. This
appeared to be partially due to the quality of their lives, which being very busy and made up of different jobs and family commitments, did not allow any extra-time to stay in the hospital after the intervention. It was also observed that they were not provided with any space to verbalize their experiences, neither by the association, nor by the hospital and, ultimately, nor by themselves as there was not any observed or reported attempt to organize a support network among themselves, although they recognized the need to have one.

- Music in hospitals, as an activity, appeared to require constant preparation and updating of the repertoire. Because of the lack of time available reported by the musicians, they did not focus on this aspect as much as they thought they should, leading them to admit an underlying, albeit mild, sense of frustration and perhaps professional guilt.

- Although musicians worked on a part-time basis, they tended to identify themselves with their work in the hospital, as this would play a major role in the construction of their working/musical identity.

- The musicians were passionate and committed about their work in the hospital. Even if they perceived the work as being very demanding, emotionally and physically, at the same time they described their work in highly positive terms. The reward of the work appeared to lie in a powerful awareness that they were able to 'make a difference', even if for a short time, in the lives of the children and carers in the hospital.

- Musicians appeared to suffer from a non recognized form of 'burnout', which forced a few to stay out of the hospital for long period of time. This was possibly due to the emotional exhaustion of working in stressful environment where their contribution was not fully acknowledged (even financially), neither by the hospital, nor by the association.
Chapter 7. Musical intervention from a client perspective

7.1 Children, their parents and other carers

After the initial focus on the musicians, the second group to be observed systematically were the 'children'. It soon became clear that every child in the hospital was, without exception, accompanied by a carer, who, since the early stages of the fieldwork, appeared to play a key role within the dynamics of the musical intervention. In 70% of the cases these were mothers (see Chapter 5, Table 5.3).

The selection of children and their carers for observation was almost entirely random, deriving from the nature of hospitalization, except for children with long-term illnesses that spent long periods in hospitals¹. In these latter cases, there was a degree of predictability in their recurring hospitalizations and the musicians were noticed to be willing to make an exception to their timetable to be able to spend some extra time with these children and their parents, with whom they had become familiar. However, this group represented an exception, and most children were met on a one-off basis. Even if there was a degree of unpredictability in the selection of participants, there were at least three criteria that appeared to determine the likelihood of an interaction between the child and the musician: (i) the children's willingness to take part in the music session, which was chiefly connected to the presence of pain and their more general physical conditions (e.g. anxiety and being intimidated by the new environment); (ii) the level of distress exhibited by their accompanying carers; and (iii) the selection of the child, based on the musician's perception of who was likely to be more responsive to music on entry to the ward. In the case of the interviews, participants were selected by a nurse who was familiar with their conditions on the agreed day of the interview.

¹ Depending on their pathology, long-term hospitalized children would stay in hospital from an average of few weeks to over a month. In the case of dialysis or metabolic-related illnesses, children would generally come to the hospital on weekly basis.
7.1.1 Observations

The following observations-based commentary draws on the 22 hours of observation\(^2\) and additional 11 hours of video material\(^3\), focused on children \((n=162)\) and carers \((n=146)\) conducted from Week 2 to Week 4 (see Chapter 5, section 5.4 for a detailed structure of the fieldwork). Interviews with participant children and carers are analysed in the next section of the thesis. It was noticed that the musical relationship between the musician and child included, almost without exception, a relationship with the carer that was accompanying the child. Three recurring situations were observed:

1. The child was interacting directly with the musician;
2. The parent was acting as a facilitator, encouraging the child to start a musical interaction with the musician;
3. The musician was acting as a facilitator, fostering a musical interaction between the child and the parent(s).

(1) Children interacting directly with the musician

Two common reactions towards music were observed across the hospitalized children. They either were attracted by the music, immediately switched on by it and ready to join in the activity, or otherwise they were intimidated by the music and, therefore, more cautious in getting closer to the musician, often shielding themselves behind the parents. The degree of these reactions varied according to the age of the children observed. Generally, these responses were noticed with children up to 6 years old, which represented 55% of the observed population (see Table 5.3).

The direct interaction with the musician was noticed to be more likely to take place in common rooms, as the child was allowed to move freely in the room and to get closer to the musician or play with other children, whilst the parent was either dealing with hospitalization paperwork, talking on the phone, or discussing the child’s condition with a member of staff. Also, the presence of other children was noted as acting as a facilitator for the more intimidated or younger patients, as shown in the figure below (Figure 7.1). In this particular case, the child was directly interacting with the musician, usually through the exploration of a new instrument.

\(^2\) This is 33 observations x average length of 40 minutes = 22 hours (see Chapter 5, Table 5.1).

\(^3\) Due to the ‘incremental’ nature of the fieldwork which was based on the idea of coding actions that would start from the group that originated the action (the musicians) moving to the next groups, the 11 hours of videos that were previously analysed with a focus on the musician, were now reanalyzed with a focus on the children and their carers and their action/reaction response to the musicians’ interventions.
eliciting the curiosity of other children in the room who moved closer to observe the instrument. The children were subsequently involved in the session through the handing out of new instruments that they were likely to exchange among themselves after having tried them out, either improvising or whilst accompanying a song.

Figure 7.1 A musician interacts with a child demonstrating how to use a kalimba, while progressively other children gather around her

In the ward, the chances to establishing a one-to-one interaction with the musician diminished because of the constant presence of parent(s). They were noticed to be constantly monitoring the responses of their child, almost in real time, making sure that the child was not uncomfortable or too tired to continue with the music, especially if they were perceived to be frail or still recovering from a surgical intervention, like in the picture below (Figure 7.2). With very few exceptions (Figure 7.3), the observed children, regardless of their physical conditions, were noticed to welcome the music in their room. The ‘acceptance process’ was non-verbal, as the musician was usually (gently) entering the room whilst playing, without asking for permission. The parents acted as ‘interpreters’ of their child’s body language, politely declining the music if their child was perceived not to be interested in the music or not well. Depending on their conditions and their mobility, the children were either listening to some of the songs, or become more involved, taking up a percussion instrument.
When children were not willing to have the musician in their room, the musician usually tried to play for a short while, testing if the rejection was a genuine one or the product of an initial discomfort. If parents appeared to understand the distraction-potentialities of music, and were keen to facilitate the relationship between their child and the musician, then the musician had higher chances of establishing a relationship with the child. But sometimes this was not enough, as in the case portrayed in Figure 7.3, where the child had just arrived in the hospital and was very anxious and scared. In this case, his mother tried to motivate him to join the session, but without results. After having used all his tricks, the musician left the room, respectful of the child’s decision not to engage with the music. This behaviour was subsequently reported by the musician to be typical of children that were hospitalized for the first time and that needed to familiarize themselves with the environment. In this particular case, the child was booked into hospital for a surgical intervention and he was aware of it.
(2) The parent(s) acting as facilitator

Mothers were generally observed to act as facilitators in the musical interaction (e.g. Figure 7.4). If the child was in pain or distressed and, therefore, unwilling to focus on any external activity often the mother would start the interaction with the musician, usually by taking the instrument that the musician was offering her, exploring it briefly and then passing it to the child who was noticed to start their own exploration. Only at this point would the musician start to engage directly with the child. The mother would either (i) focus on the hospital paperwork that she needed to fill in; (ii) keep interacting with the musician, who meanwhile was likely to have replaced the instrument passed to her child with a new one (Figure 7.5); (iii) interact directly with the child, whilst the musician was focussing on a new child to be included in the music session. The musical interaction was observed to be more likely to occur if the mother (or the carer) was verbally encouraging the child to start either singing or taking the percussion instrument that the musician was handing out as an example for the child. The mother’s attitude was noticed to stretch across all the children’s age range.

No perceived differences were observed in the relationship between child and the parents according to the degree of illness of the child. Irrespective of the seriousness of the illness, the parents were generally observed to be worried and to have a protective attitude towards their child. Parents of children that were in the emergency ward, even if the illness was not so severe (often a domestic accident), were noticed to be more anxious and distressed compared to long term hospitalized children and parents who had the time to get used to both the new environment and the time in the hospital, and also to the presence of music in such an environment.
Regarding the presence of a specific parent, mothers were usually noticed to accompany the child in the hospital, whilst fathers were hardly ever observed to be alone with their child. If a father was in the hospital, he was almost always with the mother of the child and this was observed in two distinctive circumstances: when the child was very young (from few months to 2 years old) or when the child had to undergo a surgical/painful procedure. In all other cases, the child was mostly accompanied by the mother, even if it was a long term hospitalization.\footnote{In long-term wards the presence of one parent at the time was the general rule. Usually a family needs to be organized to face the long-term illness of a child. A common observed and reported arrangement was that the father usually worked and took care of the siblings at home, whilst the mother was in hospital with the ill child.}
In several circumstances, the child that had to undergo a medium to long-term hospitalization was likely to meet the same musician during their stay in the hospital. When this happened, the child was noticed to increase their familiarity with the musician and the musical activity and consequently, to become more engaged in the activity. The figure below (Figure 7.6) shows an example of a child that met the musician for the first time, after having just arrived in the hospital (pictures 1 and 2) and that met the musician again after four days, when he also had his intervention (pictures 3 and 4).

“The child was initially disoriented and afraid about being in a new environment and was crying most of the morning when Marta was playing in the neurosurgery ward. Only at the end of her session the mother brought the child close to the guitar and Marta sung a child’s song for him, with lots of animal sounds. The mother was singing along and was smiling whenever she heard Marta making a funny sound, whispering comments about the sound to the child. The child, that was initially crying, stopped and was both looking at the mother and at the musician. He eventually smiled at the end of the song.’ (C. Preti: Case study notes, June 2007).

When a new musician turned up in the ward few days later after he had his operation, the child was sitting in the corridor, waiting for the musician to interact with him (Figure 7.6/3). He looked familiar with the environment and with the musical activity and appeared to be interested in exploring further what he had only observed, suspiciously, on the first day. The father was called in to help out with the interaction and he was given a little rattle to wrap around a finger. The child had an egg shaker, but was very attracted by the guitar. In general, children appeared
to be more interested in the instruments that other people were playing and were often asking for a swap.

Figure 7.6 Example of a child that meets the musicians on different days

(3) The musician acting as a facilitator

Meeting the same child in repeatedly the same, and in different, locations, was perceived to represent an occasion, not only for the child, but also for the parents, to become familiar with the spaces created by the music. Parents were noticed to be more cooperative when they were exposed to music more than once during their stay in the hospital. Their behaviour was noticed to become progressively more cooperative with the musicians, in terms of facilitating their interaction with the child through their active participation in the session, either by playing a percussion instrument or through singing, as they seemed to recognize at least the ‘distractive’ effect that music had on their child and more, in general, on their time in the hospital.
In the context of a room within a ward (made up of two beds), the musicians would often hand out the instruments to one family and then would concentrate on the interaction with the other family. In so doing, the different members of the family were noticed to focus on the musical activity, apparently refocusing on something different from the illness, even if just for a short time (Figure 7.7).

Figure 7.7 A family playing percussion instruments

After few sessions of music, the parents appeared to be aware of a new tool that they had at their disposal to distract the child and they were noticed to welcome the musician and encourage them to interact with their child during subsequent visits. The use of percussion instruments as a means of interacting with the child was often left to the parents, whilst the musician was creating new interactions in the surrounding space (Figure 7.8). Parents appeared to engage with the child through the little instruments, even though, in most observed cases, their musical stimuli were not that interesting for the child, who kept on looking at the musician as the main attraction.
7.1.2 Interviews

Children and their carers presented some difficulties for interviewing within the hospital. In part, this was because if they were in waiting rooms, they were likely to leave soon after their visit or procedure, and if they were in a ward, they were either too distressed to be able to be interviewed, or there was something happening in the ward - such as doctors doing their rounds, or an emergency within the ward, or lunch being served, or play therapists having their session, or simply the child being asleep. Another difficulty was represented by the age of the children observed, with 55% of them being between few months to six-years old (see Chapter 5, Table 5.3). Interviews proved to be a difficult task with this group and, in some of the cases, parents ended up having an informal conversation on behalf of their children. Of the fourteen children interviewed, only six were interviewed directly and eight via their parents (see Chapter 5, Table 5.6). The number of parents interviewed was twenty-two.
The interviews took the shape of informal conversations on the musical preferences of both parents and children, hospitalization, and on their perception of music in the hospital. The conversations were fully transcribed and analysed according to a thematic and content analysis (Strauss & Corbin, 1990). Eleven codes were initially derived from the transcripts (see Appendix K for the interview transcript and a list of derived codes), which were then grouped into the following thematic areas:

(1) Children responding to ‘music in hospital’;
(2) Children who do not respond to ‘music in hospital’;
(3) The role of familiar music in promoting a musical interaction with a child.

(1) Children responding to ‘music in hospital’

Fifteen of the twenty-two parents interviewed reported that their child had an immediate response to the music and that they were almost drawn out of the room by the sounds, like a sort of Pied Piper of Hamelin:

“This morning, when she heard the violin, she started fretting because she wanted to go in the corridor, but we couldn’t! So I was holding her and we went by the door, but we couldn’t go out.” [mother of a three-years old child in the infectious diseases ward]

Four parents appeared to have noticed the impact of music on their children from their experiences of ‘music in hospital’. They also reported to have learnt a musical repertoire from the musicians and to have used the same song when they were with the child, especially in critical situations:

‘He always relaxes when he hears the music. When he is in the procedure room he is hardly ever scared, as the nurses switch the radio on and with the music he dances, sings and doesn’t worry at all. We even manage to do ‘cat’ [computerized axialtomography] and nuclear magnetic resonances without sedation, which is very unusual because children, and especially young ones, are afraid of all the noises coming from the machines. But he just gets in there and the only thing he wants is that I sit next to him and sing. When I get stressed I tend to forget the songs. I usually sing ‘Ci son due coccodrilli’ [a song that musicians continuously sing in hospital]. I sing very close to his head and hold his hands, in other words I end up having a ‘cat’ myself, which is not exactly the best outcome!’ [mother of a two and half -years old boy relapsed with cancer]
Children were described by their parents as often being fixated on certain songs that they especially liked and that they kept playing over and over. The parents also reported that their child, in the case of having a favourite song, kept asking the musician to play that song, continuously:

‘He is in charge of the music. Whenever he watches TV, the only bit he is interested in is the music [the child has a music player that he keeps pressing forward looking for a particular song. When he finds the song he smiles and starts moving. The mother sings] […]. This is a song that he has learnt from Pietro [one of the musicians]. He is absolutely crazy about this song! Even when we are in the car, this is the only song he wants to listen to, even if the travel lasts for four hours! On top of this, he wants us to sing-along, otherwise he gets annoyed.’ [mother of a two and half -years old boy relapsed with cancer]

‘He likes the guitar a lot. My husband plays the guitar with him in his lap. In the house there’s always music. He [the child] started with ‘Io vagabondo’ [a rather well-known song from the sixties] and he only wanted that song.’ [mother of a two and half-years old boy in the neurosurgery ward]

Moreover, it appeared that children that reacted positively to music were often coming from families that were listening to music themselves on regular basis and were transmitting their values to their child.

(2) Children who do not respond to music in hospital

Not all children responded to music in the same positive way. One of the main variables in engaging with music in the hospital was the age of the child which was perhaps connected to a repertoire that appeared to be tailored to younger children rather than pre-adolescents. But also the response appeared to be connected with the coping strategies that older children had elaborated.

‘When she is not well, she doesn’t listen to music.’ [father of a 18-years old girl with Down’s syndrome, relapsed with leukaemia]

‘I like music in the corridor, but not in my room, because the sound [of the violin] is too acute and I find it annoying, but in the corridor is not too bad.’ [11-years old boy with his mother]
‘She doesn’t like to listen to music when she is stressed’ [father of a 13-years old girl]

The influence of the parent in encouraging a child’s positive response to music was noticed to be connected to the enthusiasm that the parents themselves showed towards the music. Also, talking about their child’s musical preference, parents were noticed to simply list their own:

‘I listen to quite a lot of Italian pop music, things like Pausini, Baglioni [melodic singers]. She likes this music and she knows all their songs. When I was eight months pregnant with her, I went to a Baglioni’s concert and – this might seem unbelievable – but when she was a baby and she was crying, I played a Baglioni’s CD and she stopped as if she would have recognized the music!’ [mother of a three-years old child in the infectious diseases ward]

A contrasting account was reported from a mother that had noticed that the selection of music did not match her son’s tastes:

‘The songs that the musicians sing here are songs of my generation. These kids are living in a totally different world… and then you have kids that like sports and are less attracted by the instruments.’ [mother of a 11-years old boy]

When asked which kind of music they, and their children, were listening to at home, most parents (sixteen out of twenty-two) were not able to specify the genre. They would generally mention ‘music on the radio’, ‘music from a CD’, ‘modern music’, without being able to name any of the singers. Children, on the contrary, were more specific about their music, especially older ones:

‘I like Shakira and music from Festivalbar [a national competition of pop music, broadcasted on TV]. My brother has downloaded some of his music and it’s all in the Ipod.’ [11-years old boy, with his mother]

‘He listens to the music from Disney Channel and loves all the songs from Zecchino d’Oro [a TV programme about children’s songs].’ [mother of a 18-years old special needs boy in the neurosurgery ward]

‘She learnt these songs from me [mother]. I try to sing with the help of DVD and similar kinds of supports.’ [mother of a six and a half-years old girl in the general paediatric]
Although parents were often vague about the music that they were listening at home, when they recognized some of the songs that the musicians were playing in the hospital, they were able to be more specific and commented positively on the effect that music had on their child:

‘Once she was having a blood test and she was focused on the procedure, but she recognized the violin and then she recognized ‘Alla fiera dell’Est’ because her dad often sings that to her.’ [mother of a four-years old child in the infectious diseases ward]

‘Alla fiera dell’Est’ is really pleasant, especially if you are in an isolation ward. Music becomes the only contact you can have with the outside. When we heard the music we left everything and we went close to the door.’ [mother of a three-years old child in the infectious diseases ward]

But music did not always work in distracting the child, as in the case of a one-year old boy that every two weeks had to come to the hospital for a blood test. The mother reported that the child started crying in the car, as soon as he recognized the parking area because he was fully aware of what would happen to him once in the hospital. Although, after the procedure, when the child was still crying, his father was noticed to play one of the percussion instruments that the musicians had left him, and the child got distracted and calmed down.

The musicians were observed to enter the environment with the underlying aim to change it, seeking to stimulate the reactivity of the children that through the music, switched from being passive to be more engaged. For the children, music in the hospital appeared to represent an occasion to interact with different people around them, playing together with their parents or other children, often for the first time, which also constituted an enriching human and learning experience for them. Children were observed to become instantly or more gradually engaged, chiefly through looking at their parents being involved, as a reassuring example, or through engagement with other children that were already playing along. It was relatively rare for a child not to become involved in the musical context created by the musician.
7.2 Hospital staff: Nurses and doctors

Across the four weeks, nurses were noticed to be an important medium between the musician and the hospital, in so far as the musician would always communicate with the nurses, especially when they were playing in the wards. The musicians were regularly asking for an updating on the conditions of the children in the ward and the nurse would usually suggest which children were more likely to welcome music on that day. This exchange was perceived by the musicians as helpful and it represented one of the rare occasions of contact with a member of staff. Also, depending on the degree of tension in the ward and on the workload of the day, nurses were observed to participate in the music sessions, even if only by reinforcing the presence of the musician, introducing them to the new child.

Nurses were noticed to relate to the musicians more often than doctors, except in two isolated observed cases, when the doctors came to find the musicians asking them to play with children that were being difficult to relate with. This would mainly occur if there was a pre-existent relationship between the doctor and that specific musician, or if there had been previous (positive) experiences of collaboration in another delicate situation. When this happened, the musicians were noticed to talk more positively about their work in the hospital as they felt rewarded and recognized by the doctors in their professionalism, as well as feeling part of the hospital team, if only for few minutes. However, doctors were usually observed to be rather indifferent to the presence of the musicians in the hospital, or at best they were looking at the musicians with a sort of estrangement, a sort of positive surprise for the service that their hospital was offering.

The rhythm of the hospital was noticed to slow down in the afternoons, with less staff working (while mornings in the hospital were generally busier, with doctors having their rounds, patients examination taking place, children being moved across different wards, procedures scheduled). Staff were observed to be more relaxed in the afternoon as well and more willing to participate in the music, if the occasion arose. In some sporadic cases, nurses were observed to join the group of parents and children singing. When the situation in the ward was tense, musicians were observed to play very softly or to stay away from the emergency area, leaving the staff the space to work without creating obstacles.
7.2.1 Interviews

The nurses and the doctors interviewed were selected to represent an approximate proportional sample of staff from the wards and waiting rooms where musicians were playing. The waiting room in front of the first aid emergency service and the oncology ward, for example, had more hours of music than other spaces and therefore it was assumed that staff in these wards would have had a more clear view on the impact of music in the hospital being more directly involved. The overall number of staff interviewed was nineteen, constituted by eleven nurses and nine doctors from three typologies of hospital stay: Waiting rooms (light examination); Waiting rooms (procedures); Wards (see Chapter 5, Table 5.7). Three main thematic areas emerged from the interviews with the hospital staff (see Appendix L for the interview transcript and a list of derived codes):

(1) The perceived effectiveness of the musical intervention for the hospitalized children;
(2) The impact that music had on their work;
(3) The perceived professionalism of the musicians playing in the hospital.

(1) The perceived effectiveness of the musical intervention for the hospitalized children

Both nurses and doctors openly recognized the positive effects of music on hospitalized children. They were recurrently talking about particular groups of children as being most responsive to music, such as special needs children (autistic and Down syndrome in particular). Moreover, they could all recall specific cases of children for which the musical intervention had made a significant difference, especially in relation to being able to carry out a procedure, when all the odds appeared to be against that:

‘Once we had a special needs adolescent with cognitive deficits, very agitated and quite a big boy. His mother told us that in other hospitals they had never been able to take a sample of blood from him, but with the music we managed do that, and it was very easy too. His mother cried and, honestly, we were all rather moved by what happened. With some children it works, with other it doesn’t, like with all

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5 Both wards were covered by the musicians for six hours a week, every day from Monday to Saturday. The waiting room, which was behind the main entrance, was considered to be one of the busiest spaces in the hospital. Also, for most children that space represented their first experience in hospital and, therefore, the hospital administration was very keen to ‘welcome’ the children with music to make their experience less stressful as possible (see section 7.1.1). The oncology ward is a long-term stay ward where children need numerous occasions for distraction.
things. But I have to say that this boy came back subsequently, and as he had a positive memory of his previous hospitalization, he was very calm, and we didn't even have the music.' [Nurse from the Metabolic Service]

'With children that have panic attacks or autistic children, they [the musicians] seem to have a better response.' [Head nurse from the Emergency Service]

'It happens that music is often requested by some of the nurses when there are children with Down's syndrome or that have behavioural problems. In such cases music helps a lot and it becomes easier to approach them.' [Doctor (1) from the Emergency Service]

Each member of staff that was interviewed agreed that music in the hospital was a beneficial activity for the children in so far as it helped them to become familiarized with a new environment, such as through the recognition of songs that they already knew from home (as in the case of the most popular children's songs, but also songs from Disney's cartoons that they were likely to have watched at home), or that they had learnt in the nursery or at school. The familiarity of the repertoire emerged through the words of the staff as a characterizing trait of the musical intervention:

'The aim of music in the hospital is to distract the child from the unfamiliarity of the hospital environment and to give them a sense of familiarity through the songs that they know so that they might feel like as if they are in the nursery or at home.' [Head nurse from the Emergency Service]

'Kids are enchanted by music.' [Doctor (1) from the Oncology Department]

'I think that music is a language that children understand better and that arrives directly to them, and to which they are attracted, especially with certain tunes that are the classic melodies that the mothers sing to their children.' [Doctor (1) from the Emergency Service]

'Music helps the child to familiarize with the hospital environment, by turning it into something more playful and familiar.' [Doctor (2) from the Oncology Department]

The staff, and especially doctors, commented on the selection of the musicians' repertoire which they appeared to have noticed, picking on some insightful details:
‘They mainly play children’s songs, some Disney’s songs or folk songs from the sixties and seventies. And then there is a very interesting attempt to involve the children through the use of percussion instruments, something that works especially well with younger children.’ [Doctor (1) from the Oncology Department]

‘The musicians have a repertoire for adolescents and sing what they are requested or ‘the songs of the moment’. With younger children, needs are different and the songs they sings are suitable to make them sing in a group.’ [Nurse (1) from the Emergency Service]

One of the identified weaknesses of the music programme was reported to be the limited selection of repertoire, especially for older children. Staff reported a perceived ‘sameness’ about the musical repertoire. Even if they recognized that young children welcomed the same songs played over and over again, in some cases they perceived this as a stressful element adding to their already emotionally demanding work:

‘For adolescents you need to update the repertoire, but for the younger ones the songs that they like are always the same.’ [Doctor (2) from the Oncology Department]

‘Sometimes the repertoire is perceived as stressful because the songs tend to be the same. Some members of staff have complained. Children are happy to listen to the same songs over and over again, especially if they are little ones.’ [Doctor (3) from the Oncology Department]

‘In these fours years the repertoire has not changed. Maybe there are children particularly connected with a song and they don’t want to hear anything but that, so I don’t think this is a problem for the children.’ [Doctor (4) from the Oncology Department]

Nonetheless, staff appeared to welcome the music into the hospital, both conceptually and as result of their direct experience:

‘The effectiveness of music in the hospital context depends on the surprise element created by these people that play in a context where the children would not expect them to.’ [Psychologist from the Pain Control Service]
"The important role of music is that it distracts the child from his thoughts. There isn't an absolute rule, it depends on their experience.' [Nurse from the Infectious Disease Service]

'I think that music is more powerful that other activities and that it gets to the child more directly.' [Doctor (1) from the Emergency Service]

Staff were also aware of the movements of the musicians within the hospital and commented on music as being more appropriate in certain spaces:

'Musicians come in the morning and sometimes in the afternoon. They mainly play in front of the first aid emergency service as that is the place where is most needed, because it's really helpful for the children that are waiting.' [Head nurse from the Emergency Service]

'Certainly the music in front of the emergency service is very pleasant and I have noticed from the looks of the people that are there, that is effective. In the wards it's more difficult; we need to evaluate the situation moment by moment.' [Doctor (2) from the Emergency Service]

(2) The impact that music had on their work

Although music was described as positive and staff recognized the beneficial effects on the children, when they were asked about their perception of music in the hospital, their responses were considerably less positive and music was often explicitly described as a stressful element for the staff, especially doctors, at least in five distinct cases:

"The repertoire that they sing is always the same and this is a problem for us. When the musician accompanies the child during a procedure, we are also part of the musical intervention as we are forced to listen to the music and respond to encourage the child. Sometimes we sing along, but some others [times] it's annoying.' [Doctor (4) from the Oncology Department]

"When it comes to the impact that music has on the staff, it all depends on the relationship that they have with music. Some of us are used to concentrating with music and others perceive it as disturbing, also because they listen to the same songs [he laughs]" [Doctor (1) from the Oncology Department]
‘Music is usually pleasant, but sometimes it is also something that can disturb you if you are having a bad day.’ [Doctor (2) from the Oncology Department]

‘The little instruments are very good for the children…. for us, well, I am not sure…. if you have to concentrate and you hear all that noise around, it can disturb your work […] all in all, we need to have a certain concentration and having the children playing all those instruments, especially if out of time [laughs]…. but certainly the effect that the music has on the children overcomes the perplexities of the staff.’ [Doctor (1) from the Oncology Department]

A major problem appeared to be the ‘sameness’ of the style adopted by the musicians. Although staff were occasionally ‘annoymed’ by the music, the fact that they experienced its positive effects on the children - which consequently impacted positively on their work – appeared to facilitate their acceptance of music:

‘Music facilitates the procedures, because the children are distracted and we deal with calmer children.’[Nurse from the Metabolic Service]

‘We sometimes use music during the procedures; let’s say that we use it to distract the children. I personally find it rather boring.’ [Nurse (1) from the Emergency Service]

‘I like music. With a colleague of mine, we were looking for a CD to play music for the children when the musicians are not here.’ [Nurse from the General Paediatric Service]

‘When the child is in the waiting room, involved in the musical activity, being distracted, when [they] finally get to us we find a more relaxed child and parents, and as a direct consequence, we are more relaxed as well.’ [Doctor (2) from the Emergency Service]

Even though nurses and doctors recognized the positive impact of music on the children - and the indirect benefits that music was having on their work as they were dealing with less anxious children - most of them were not able (or willing) to make a systematic use the service. Despite the fact that the music programme had been running since 2003, the staff did not seem to have integrated the service into their daily practice:
‘Generally, we don’t call the musicians, but if there is a special situation then we call them.’ [Nurse (1) from the Emergency Service]

‘The music programme works even though it is not systematized. It is very much left to the individual sensitivity of individual nurses and doctors.’ [Psychologist from the Pain Control Service]

‘We are always running here and we don’t really call them. If they are around when we need them, then we call them.’ [Head nurse from the Emergency Service]

Whilst the use of music during procedures was not systematic, staff reported to have often used music to distract the child, as one of their tricks of the trade:

‘We don’t usually request the presence of the musician unless the child or the parents requests it, but we have always used recorded music during our procedures [in the oncology ward]. But then there are children that like it and children that don’t like it.’ [Doctor (4) from the Oncology Department]

‘Sometimes we use the music from a mobile phone. There’s one of our colleagues that has some ringtones on a laptop and, especially when we do sutures. The child watches the screen and listens to the music. Then their mother usually sings.’ [Nurse (2) from the Emergency Service]

But for at least five members of staff (all doctors) music was, nonetheless, reported as a negative element, adding to the stress of their work, especially when they were already dealing with stressful cases themselves and were not considering music as being part of their procedures:

‘When we have an emergency, music is disturbing. Generally the musicians play outside the ward.’ [Nurse (3) from the Emergency Service]

‘I have to admit that music disturbs my concentration.’ [Doctor (2) from the Oncology Department]

‘When there is stress and need to focus, I don’t even hear the music, because you are focused on the emergency and, therefore, music is more in the background. In a quiet day it becomes easier to appreciate music.’ [Doctor (2) from the Emergency Service]
If music was generally accepted when it was directed at the children, it was not as positively received by the staff when the musicians were playing in common spaces or were playing for the staff. Of the nineteen staff interviewed ten reported that they were not so keen in having music played just for them or in the background:

‘I believe that music needs to be played for the children. The songs are more acceptable than just classical or only instrumental music. Sometimes, even parents have complained about classical music.’ [Doctor (3) from the Oncology Department]

‘There is a difference between the guys [referring to the musicians] that come in that involve all the children, handing out little instruments, or those who enter in every room, and those who play in the corridor without interacting with anybody in particular.’ [Doctor (2) from the Oncology Department]

Even if there were some exceptions:

‘The girls that come here are very good, and their music... it was very pleasant.’ [Nurse (1) from the Infectious Disease Service]

‘Two weeks ago, they played a piece on the violin that nearly made me cry... one of those classical music pieces, now I don’t remember the tune, but they are really very good.’ [Nurse from General Paediatric Department]

‘Last week there was a girl playing the violin and she played a famous piece, just for us and I was thrilled and really pleased that they played for us.’ [Nurse from the Acute General Paediatric Department]

(3) The perceived professionalism of the musicians playing in the hospital

When asked to speculate on the musician’s main employment, nurses and doctors were surprised about the question and gave a very diverse range of answers, which highlight mixed views about the professionalism of the musicians. Some of them thought that the musicians were in the hospital on voluntary basis; others thought they were musicians who had failed to become professional performers; others believed that they were music teachers:
‘I don’t know. Maybe they are voluntary.’ [Nurse from the Metabolic Service]

‘From their professional level, I think that they are musicians. When they are outside the hospital maybe they teach children or are engaged in some music-related activities. I play the guitar, so I can tell which their average level is.’ Doctor (1) from the Emergency Service

‘I don’t know... maybe a job where they don’t have a lot of contact with people and therefore they come here to compensate, or the other way round.’ [Nurse (2) from the Infectious Disease Service]

‘I think that some of them might be music teachers, others are amateur musicians so that their main occupation might be a total different one. But I am sure that they are involved in some voluntary activities, for sure.’ [Nurse (3) from the Emergency Service]

‘I think that they [the musicians] are involved in this kind of activity first of all because they are motivated and second because I think that earn some money, but I don’t think that that is the main reason. They could also be musicians that, inverted comas, have not found any music related job and therefore this one can be a way to cultivate their passion.’ [Doctor (1) from the Oncology Department]

The issue of not perceiving the musicians as being professional performers was noticed by the staff in a non-judgmental way. They made clear that the priority of a ‘musician in hospital’ was to engage musically with the children. Therefore, a high level of musicianship was not necessarily required for such work, instead other characteristics were more valued:

‘In the end, I don’t think it is that important that they are professional musicians. The most important thing is that they are able to engage and interact with the children. A professional musician might be a fantastic performer, but might as well be hopeless in engaging with children. I think that the crucial skill they need to have is to be able to establish a relationship with the children so that they can distract them. They could even use pots and lids: that is not the issue.’ [Head nurse from the Emergency Service]

‘I think that they are professional musicians and that they are able to play. But for us their musical professionalism is not the top priority. For us it is more important
that they turn up on time or that we can call them whenever we need them.’

[Doctor (3) from the Emergency Service]

From the comments of nurses and doctors, it emerged that their own personal connection with an instrument or a song was what often triggered their interest in the music and what made them stop and notice a certain musician:

‘My favourite one is definitely Pietro. I like “The lion sleeps tonight” and “I bambini fanno oh”. He is really good when it comes to involving all the children, giving them the percussion instruments and making them sing along. The other two girls [referring to the musicians] that come up here - the one with the violin and the one with the guitar - are not as good in involving the children. But generally, I don’t pay too much attention... maybe if they play a song that I know I am more likely to stop, especially if they sing a song that I knew from my childhood. The other girls have a peculiar repertoire, less familiar. When I was a child we used to listen to songs like ‘Alla fiera dell’Est’, ‘Per fare un albero’, ‘Nella vecchia fattoria’ [the Italian version of ‘MacDonald had a farm’], but I have never heard them singing these songs.’ [Doctor (3) from the Oncology Department]

‘There’s a girl [referring to a musician] with a very beautiful voice.’ [Nurse (3) from the Infectious Disease Service]

‘I remember a guy [referring to the musician] that plays the guitar. He is really good and funny and he plays really well. Then there are other musicians, but I prefer the guitar. I am closer to this instrument because I play it.’ [Nurse (2) from the Emergency Service]

The perceived professionalism of the musicians and their success in involving children in their activity was also considered an important element that staff noticed and valued:

‘There’s a worker [referred to a musician] that I know better because I often see him in the corridor outside the ward. He has a beard and uses very strange little instruments, mostly hand-made objects; I particularly remember one made with walnuts.’ [Nurse (1) from the Emergency Service]

‘There is a guy [referred to a musician], that I especially like, that is often in front of the emergency service where there are often a lot of children waiting, in pain and rather distressed. He looks very committed to his work, trying to involve all
the children. It looks like if music is therapeutic.’ [Nurse (3) from the Emergency Service]

7.3 Administrators

7.3.1 Interviews

In the fourth week of fieldwork, three in-depth interviews were conducted respectively with the Chief Executive of the Fondazione Meyer (the hospital charity) - responsible for the fundraising of the programme - and with two directors of Athenaeum Musicale Fiorentino, the association that managed the work of the musicians in the hospital. The aim of these interviews was to gather an ‘official’ perspective from the administration of the hospital, and from the association implementing what the hospital was funding on the basis of a pre-existing understanding of the characteristics and aims of the programme.

The Fondazione Meyer had an annual contract with the Athenaeum Musicale Fiorentino which they had been renewing each year since 2003, on the basis of available funding. No evaluation had ever been commissioned by the Fondazione Meyer on any of their funded projects (such as their clown programme and the pets in hospitals programme). Therefore, funding was allocated independently and irrespectively of any alleged ‘effectiveness’ of the music in the hospital, but rather on more anecdotal evidence. Musicians were employed by the association on the basis of a contract that was renewed each year.

The Chief Executive of the Fondazione Meyer reported that the overall cost of the project had been around €90,000 a year since its inception. This sum was broken down in monthly instalments that the Fondazione Meyer paid to the association on the basis of the hours that the musicians played. The contract also included the ongoing training for old and new musicians; a commitment on behalf of the association to participate in conferences and public debate; and the dissemination of the music in the hospital experience in conferences and public debates.

The Athenaeum Musicale Fiorentino is, by definition, a cooperative, i.e. an association made up by several members who are the shareholders of the profits. In this case, it constituted only two members, of which only one was a ‘musician in hospital’. Therefore, the option of having a cooperative made up from all the musicians which would have eliminated necessity for mediation by the association, and consequently acquiring a stronger contractual position in dealing with the hospital, was not explored by the musicians and somehow it appeared as a sort
of disengagement from their work in the hospital. As a result, issues were resolved at the discretion of the association.

Three main themes emerged from these interviews (see Appendix M for the interview transcript and a list of derived codes):

(1) The hospital’s official vision of the function and role of music in the hospital;
(2) The profile of an ideal ‘musician in hospital’;
(3) The conceptualization of the Musica in Ospedale project according to the association.

(1) The hospital’s official vision of the function and role of music in hospitals

The Chief Executive of the hospital charity made clear that, in his opinion, music in the hospital did not have a direct therapeutic function, but was rather focused on improving the hospital atmosphere and the welcoming of the new patients and their families:

‘We say that music is part of a welfare path to recovery. We don’t use music to treat directly the child, but we can intervene with music in order that the staff find a more relaxed child with a more positive perception of the hospital as an environment […] this is a sort of intervention that impacts on the environment.’

‘Music is integrated into a welfare path, in the sense that these interventions don’t treat the illness per se, but contribute to support the children and their families.’

Whilst pointing out the objective of a musical intervention in the hospital, he gently commented on the issues of the repertoire, which appeared to have been a source of indirect complaints by some of the staff:

‘Music is a sort of therapy that improves the quality of the reception in the hospital. Generally, music alleviates tensions in both children and parents and, therefore, as a consequence, the work of medical staff is facilitated if they have to deal with calmer children. Music is not directed to the staff. In fact, it might also be that they end up being annoyed by the music, which is a bit the same and would need updating.’

The association’s view on the aims of the project appeared to be in line with those of the hospital:
In a paediatric hospital, the first objective of music is to improve the welcoming of the children and their carers into the hospital and their perception of the environment. The second is to improve the working environment by creating a more relaxed atmosphere which will impact on the staff that will maybe start looking at the child in a more humane way, less mechanic, as a person to treat in a holistic way, which is not only something that a doctor can do.

(2) The profile of an ideal ‘musician in hospital’

Whilst the view of the Chief Executive on the characteristic of a ‘musician in hospital’ was a reasonable one (e.g. respect the timetable, observe hygienic norms) without detailed specifications, the association’s members had a very precise view on the qualities that a ‘musician in hospital’ should possess:

‘To be a professional musician doesn’t necessarily mean to be a good player, that one is a good performer. But in the hospital context, a professional musician is someone that can communicate emotions and that is able to interact with the audience. A good ‘musician in hospital’ needs to be able to manipulate the music.’

‘The ability that a musician needs to have in order to be a good ‘musician in hospital’ is to monitor the continuous feedback that comes from the child, the carers and the staff and to react to that with appropriate musical choices.’

The abilities of an ideal ‘musician in hospital’ became progressively more elaborated, until the figure that emerged was a highly specialized and multifaceted one:

‘The musicians should be ideally equipped with a large bag where there should be their voice, their instrument, the percussion instruments, their repertoire, their ability to communicate musically, their ability to improvise, to compose, to rearrange songs in different styles, their ability to work on the sonic environment, their ability to play the same piece of music for half an hour whilst making it sound like fifty different pieces.’

‘The musicians are not jukeboxes. Obviously, the wider is their repertoire, the higher will be their chance to establish a successful relationship with more children and staff. But what should prevail in a ‘musician in hospital’ would be to be able to do something different from what other musicians could do without any specific training [...]. If the musician plays one song and with that song he manages to
involve all the children in the room, that is the ability to modify and revise a song. The ability to perform variations on songs is an important skill to make up for the shortage of repertoire, otherwise the musicians should have an endless repertoire. Instead, with the same song, the musicians need to be able to work with children, adolescents and adults; otherwise they are jukeboxes, but that is something that everyone [who is employed] can do.

The ability of the musicians to improvise and perform variations on a given song appeared to be considered paramount by the members of the association, especially to enable the musician to interact with non-Italian children:

‘In the last four years there has been an evolution that has developed through the improvisation on the percussion instruments, because through that there are no more barriers to communication. Obviously, we still need the songs, but through the improvisation it is much easier to break the cultural barriers.’

The association organized an in-house training day on the theme of ‘variation’ where all the musicians were asked to participate, bring some of their own pieces and give each other feedback on their musical choices. They were planning to organize these sorts of events at least twice a year. The musicians did not receive any financial compensation for participating in the training day.

(3) The conceptualization of the ‘music in hospital’ project according to the association

Both members of the association showed a degree of understanding about the emotional and more practical difficulties connected to the work in the hospital. They recognized that the work in the hospital was potentially very demanding if carried out properly:

‘The preparation before the intervention requires at least an hour to focus on the intervention, and to have different plans according to different possibilities that could unfold in the hospital. I think that there should be an ideal before starting the intervention, an evolution while doing it, and a reflection on what have happened afterwards. If something special happens, the musicians usually report it, but also if there are problems in the sonic environment.’
‘A musician cannot play for more than ten hours a week. Emotionally, it is not sustainable. If one works in other places and has a family, it’s impossible to work more than that.’

‘To each hour of work in the hospital, there is an hour of preparation and an hour of reflection. So a musician that plays for ten hours, in actual fact has worked for thirty. Maybe this is an exaggeration, but if one would really like to be a professional ‘musician in hospital’, this is what they should do. We are only at the beginning of the creation of a new professional figure and I admit that from a financial perspective it is not a very satisfying job.’

Moreover, the association appeared to be aware of the musicians’ stress connected to the job, and although they were conscious of the need to employ a counsellor in the project, they did not have the financial resources to afford this. Instead, to support the musicians, they implemented a system of ‘instructive’ observations every two months when they were commenting on the musician’s performance.

### 7.4 Chapter summary and overall conclusions

(1) The children and their carers

The live music intervention appeared to have the following effects on the children and their carers that were in the hospital:

- The sounds of the instrument and the voice of the musicians were the first point of contact with the music and the initial sonic elements to which the children reacted. However, the familiarity of the repertoire and the use of percussion instruments appeared to be necessary tools to keep the children in the musical interaction.

- Although the majority of the children were attracted by the live music, they were often, initially, intimidated by the musicians. Consequently, the parents and the carers were usually acting as facilitators to help the child engage with the musician.

- For most of the children, music in the hospital represented the first occasion to experience such a close encounter with live music, different musical instruments and the chance to play unusual percussion instruments within a group. Therefore, beside the distraction and relaxing impact that music was perceived to exert on the children, music in the hospital
appeared also to be a learning experience (both in terms of music and of self awareness) for most of the hospitalized children.

- Music in the hospital also appeared to be a learning experience for some of the parents and carers, especially those with long-term hospitalized children. Parents were observed to learn the musical repertoire from the musicians, which they then sang to their child during stressful procedures, having experienced their positive reactions to certain songs.

- The musical intervention, on some occasions, helped the different members of the family to refocus on a common non-stressful objective, such as the music making, rather than the illness and related anxieties. Even if this was only a short break, it appeared to give the parents a chance to refocus on a more normal interaction with their child, facilitated by the musician.

(2) The hospital staff

The following considerations emerged in relation to the observed attitudes of nurses and doctors towards music in the hospital:

- Overall, they appreciated the provision of musical activities in the hospital, especially when they observed the positive reaction of the children involved.

- Staff were not as positive about music when musicians were playing exclusively for the nurses and doctors. This appeared to be connected with a choice of non suitable repertoire (mostly classical music).

- For some of the staff, the ‘sameness’ of the musical repertoire was perceived as being a little stressful and sometimes it was even reported to disturb their concentration whilst they were working.

- Although they were aware of the music in the hospital programme, they did not necessarily make a systematic use of the service, in so far as they could have requested the presence of a musician to support the children during selected procedures through the pain control service, but they reported a tendency to ‘use’ music only if the musicians happened to be there when they needed them.

- From the way that hospital staff reported their views on musicians, it appear that they did not recognize the musicians as part of their team, but something external that was coming into the hospital.

- Hospital staff recognized the ‘professionalism’ of the musicians in relation to their musical and communication skills as well as their musical activity in the hospital. Staff were also able to recognize that communication skills were as important as musical skills for the success of an intervention in the hospital.
Overall, the staff had a positive view of the musicians playing in hospitals, recognizing them as having a professional status of 'musician in hospital', understanding the diverse range of communication skills that they required to be successful in their musical activities in the hospital.

(3) The administrators

From the interviews with the Chief Executive of the Fondazione Meyer and the two directors of Athenaeum Musicale Fiorentino, it emerged that:

- Although the hospital charity did not seem to be actively monitoring the musical activities in the hospital, nevertheless it appeared that their idea of the aims and objectives of the music project corresponded with the reality of it.

- Informal feedback from the staff led the Chief Executive to point out the 'sameness' of repertoire, or stylistic approach, as one of the few drawbacks of the project.

- The directors of the association appeared to have a more ambitious view about the aims and objectives of a musical intervention, and about the overall professionalism of the musicians. On the other hand, they were also aware of the limitations connected to the part-time nature of the job and its emotional implications.
Part 4. Discussion and conclusions
Chapter 8. Discussion and conclusions

8.1 Introduction

As stated in the Introduction (Chapter 1), the aims of the thesis are to understand better the nature and the perceived value of music provision in a hospital setting. The focus of this chapter is to review the findings from the various strands of the fieldwork in relation to earlier research and related literatures.

The results from the web-based survey (as well as the fieldwork conducted both in UK and in Italy) suggest that music in hospitals is a structured activity that is increasing in a number of clinical settings across the US and Europe, with some recent evidence of a shift from voluntary engagement, by both charities and musicians, to one that is becoming more formalized.

As an activity, music in hospitals tends to comprise four sets of interventions: bedside music; regular concerts in common spaces; special musical events and artist-in-residence programmes. The nature of the activity, as stated in the aims of charities and associations involved in the provision of music in hospitals, is described as therapeutic, educational and sometimes cultural. The therapeutic aspects of the intervention are generally attributed to the 'power of music', often described in promotional literature in mystical terms, and to the ability of musicians to communicate effectively through the music. Educational and cultural aspects on the other hand are attributed to the experience of music in a relatively unusual setting, i.e. a hospital. From the fieldwork and the literature reviewed, it appears that music in hospitals has features of an integrated process whose success depends on the interaction of different people at a given moment in time: the musician, the patient/child and their carers, and, less frequently, the hospital staff. The discussion that follows focuses on each participant group.
8.2 Music provision in a hospital setting: The musicians’ perspective

8.2.1 Musicians’ personal backgrounds

Whilst a group of seventeen musicians is too small to draw any sort of generalization about ‘all’ musicians working in hospital settings, they were gathered from two distinct national populations and had a correspondence with the musical activities that were offered under the ‘music in hospital’ umbrella as reported in the web-based survey data that covered a variety of countries (18 from US, 5 from UK and 4 from mainland Europe – see Appendix A). In the absence of any other research on this group of musicians, therefore, the current research represents an initial and significant attempt to begin to trace the profile of an emerging identity of professional performers.

Musicians who took part in the research had different experiences when playing in hospitals. The eight UK musicians working for the charity Music in Hospitals were usually playing on a one-off basis, in the form of a concert performance, with a repertoire that had been broadly discussed and agreed in advance with a member of the hospital staff and designed to meet the audience’s musical preferences. In contrast, the nine Italian musicians had been playing in the Meyer paediatric hospital on a long-term regular basis, across the whole hospital, including meeting children for the first time in different parts of the hospital, often trying to match the children’s musical tastes on the basis of a first impression by drawing on their professional craft knowledge. All the musicians in this group were playing in the hospital on a part-time basis.

Despite these differences, there are some demographical and biographical similarities between the two groups (see Table 8.1). Unlike music therapists, a profession that is approximately 90% female (Clark & Kran, 1996: 127), these two groups of musicians in hospitals appear to be more gender balanced, with 7 male and 10 female musicians. Their average age is between 30 and 50 years old (20-30y=2; 30-40y=7; 40-50y=6; 50-60y=2), with the majority of musicians having some kind of musical qualification (n=12) and teaching experience (n=14). They all tended to describe themselves as ‘professional musician’ (n=14). Although they played a variety of instruments, each also engaged in singing in the hospital whilst playing their main instrument, with the exception of one UK-based pianist. The majority of musicians were observed to play a string instrument (Table 8.2), with seven of the seventeen musicians playing guitar. One of the likely explanations for this proportion is that the selected string instruments
allowed the musicians to accompany themselves while singing, which for some of the non-professional singers was considered an important support.

Table 8.1 Demographical and biographical profiles of the UK (1 to 8) and Italian musicians (9 to 17) participating in the research

<table>
<thead>
<tr>
<th>Musicians</th>
<th>Gender</th>
<th>Age group</th>
<th>Musical Qualifications</th>
<th>Instruments played</th>
<th>Professional musician</th>
<th>Teaching experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hugh</td>
<td>M</td>
<td>50-60</td>
<td>Self taught</td>
<td>Guitar and voice</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Ann</td>
<td>F</td>
<td>40-50</td>
<td>EALCM A-level music</td>
<td>Singer</td>
<td>Yes</td>
<td>Some</td>
</tr>
<tr>
<td>Tom</td>
<td>M</td>
<td>50-60</td>
<td>Self taught</td>
<td>Guitar and voice</td>
<td>Don't know</td>
<td>Yes</td>
</tr>
<tr>
<td>John</td>
<td>M</td>
<td>30-40</td>
<td>Graduate at RAM</td>
<td>Piano</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>May</td>
<td>F</td>
<td>20-30</td>
<td>BMUS (hons)</td>
<td>Singer</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Louis</td>
<td>M</td>
<td>30-40</td>
<td>GRSM (p)</td>
<td>Guitar and base guitar</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Helen</td>
<td>F</td>
<td>30-40</td>
<td>GRSM,LAEM</td>
<td>Harp and voice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lana</td>
<td>F</td>
<td>20-30</td>
<td>Self taught</td>
<td>Guitar and voice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Marta</td>
<td>F</td>
<td>30-40</td>
<td>Self-taught</td>
<td>Guitar and voice</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Bruna</td>
<td>F</td>
<td>30-40</td>
<td>Conservatorio Diploma</td>
<td>Guitar, Oboe and voice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cinzia</td>
<td>F</td>
<td>30-40</td>
<td>Conservatorio Diploma</td>
<td>Violin and voice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pietro</td>
<td>M</td>
<td>40-50</td>
<td>Self-taught</td>
<td>Guitar and voice</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Maria</td>
<td>F</td>
<td>30-40</td>
<td>Conservatorio Diploma</td>
<td>Violin and voice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Paola</td>
<td>F</td>
<td>40-50</td>
<td>Conservatorio Diploma</td>
<td>Viola and voice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Luca</td>
<td>M</td>
<td>40-50</td>
<td>Conservatorio Diploma</td>
<td>Saxophone and voice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Luisa</td>
<td>F</td>
<td>40-50</td>
<td>Conservatorio Diploma</td>
<td>Flute and voice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Marco</td>
<td>M</td>
<td>40-50</td>
<td>Conservatorio Diploma</td>
<td>Sax and voice</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
Musicians appeared also to be both experienced performers and experienced teachers. Due to their relative ages, they were likely to have a family and to have some prior knowledge (or direct experience) of hospitalization themselves. Similar to many other types of professional musicians (Creech et al., 2008) and music therapists (Stewart, 2000), they did not have a single full-time position, but rather a portfolio of different jobs.

### 8.2.2 Musicians' motivations and satisfactions: Observed strengths and weaknesses

Although there were some observed differences in the way UK and Italian musicians played in hospitals, both groups reported that they had similar motivations to undertake their commitment in the hospital (see section 2.3.3.5 and 6.2.1). These were chiefly (i) moral; (ii) pragmatic: the need to get some performing work and (iii) self-worth: a sense of reward associated with their performance. These motivations were in line with those found by Clark and Kranz (1996: 143) in a sample of 297 music therapy students in US who reported that among the most frequent motivations to become a music therapist were: (i) a desire to help others, (ii) an interest in music as a career, and (iii) a desire to combine music with a helping career. Oppenheim (1984) and Ben-Shem and Avi-Itzhak (1991) also identified ‘altruism’ as one of the main reasons to undertake such a career.

Musicians tended to identify themselves with their work in hospitals, as this appeared to play a major role in the construction of their working and musical identity. Although musicians were careful to avoid terms such as ‘therapy’ when talking about the impact of music on their audience-patients, their comments suggested that they nonetheless recognized the therapeutic potential of their musical interventions and the positive impact that these were perceived to

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1 Some musicians played more than one instrument, hence the total is greater than 17.
The musicians appeared to be passionate about and committed to their work in hospitals. Even if they perceived their role as being rather demanding, both emotionally and physically, at the same time they described it in highly positive terms. The rewards of their work appeared to lay in a powerful awareness that they were able to ‘make a difference’, even if for a short time, in the lives of the children and carers in the hospital. Such perceptions are substantiated by the music therapy literature which supports the notion that listening to music, and live music in particular, can indeed make a difference in the patient, in terms of enhancing relaxation (Hanser, 1985; Curtis, 1986; Malone, 1996; Davison, 2001; Aldridge, 2002; Longhi & Pickett, 2008), providing distraction (Evans, 2001; Robb, 2003; Standley et al., 2005) and helping the patient to verbalize the hospital experience in order to cope better with it (Froehlich, 1984; Brodsky, 1989). Furthermore, seen through the lens of Lazarus’s transactional stress theory (1991), music, through the familiarity of the repertoire and its distracting and soothing qualities, may function as ‘social support’ and impact on the coping mechanism of the hospitalized child. Music, therefore, may influence positively the child’s perceptions of the hospital environment, and consequently of any threat associated with it. The Child Life Program, widely employed in paediatric hospital across the US (see Chapter 3), seems to fit the Lazarus model in so far as it attempts to support the newly hospitalized child specifically through a form of social support. In that case, the social support takes the shape of developmentally appropriate play, aimed at increasing children’s understanding of their hospitalization experience, which, if successful, might lead to better coping outcomes (Johnson et al., 1997) with positive repercussions on the hospital staff who will deal with a calmer patient. Music in hospitals as an activity observed in the UK and Italian context, has, only marginally, acquired a role of ‘social support’. Variation in this type of impact likely relates to the one-off type of musical intervention, as in the case of Music in Hospitals, or to a partial integration of the musicians with the hospital staff, as in the example of the Meyer paediatric hospital in Florence. However, in this latter case, the regularity of the interventions and the passionate perseverance of the musicians may have compensated for some organizational drawbacks and so the ‘social support’ role may be larger.

Notwithstanding the success of the musical interaction between performer and patient, there is also evidence of a non-recognized form of burnout which forced a few of the musicians in Italy to stay out of the hospital for several periods of time (sessions, days, weeks). This was likely due to the emotional exhaustion of working in a stressful environment where the

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2 Social support is defined by Cobb (1976: 300) as information belonging to one of more of the following three classes: 1) Information leading the subject to believe that he is cared for and loved; 2) Information leading the subject to believe that he is esteemed and valued; 3) Information leading the subject to believe that he belongs to a network of communication and mutual obligation.

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contribution of the musician was not fully acknowledged (professionally and financially), neither by the hospital, nor by their association. In addition, the association managing the musicians did not appear to have the necessary knowledge (e.g. of music therapy practices and related supervisions) to deal with any such stress of the musicians. The association perhaps underestimated the issue of the musicians' stress, with the result that they tended to attribute the cancelling of musicians' shifts to their busy lives and family commitments, rather than to more enduring causes, such as stress and exhaustion.

Moreover, musicians' cancellations of scheduled sessions, together with the longer-term breaks that they were taking from time to time, appeared to lead the hospital staff to perceive the music programme as rather inconsistent. Indeed, although there was a timetable for the scheduled music interventions in every ward involved in the programme, hospital staff did not seem to be aware of the regularity of such a schedule. Musicians reported that they did not feel sufficiently integrated with hospital staff and the fact that they were allowed to have a 'flexible' approach to their work in the hospital might be one of the reasons. The hospital staff worked on a strict timetable based on hospital rounds, and any flexibility in the musicians' sessions appeared to be perceived as disruptive in some cases, rather than helping them to deal with the patients. Although the literature on music therapists reports that they invest considerable importance in their identity as 'outsiders' (Waller, 1987; Hinshelwood, 1994), identifying themselves as 'creative, subversive, change-seeking and critical of status quo' (Waller, op. cit.: 212), in this case, the Florentine musicians did not appear to view such dissonance with their hospital colleagues as a positive factor and the sense of job satisfaction and professional identity were damaged as a result.

These organizational weaknesses need to be recognized by all the stakeholders (musicians, associations managing music in hospitals programmes and hospital administrators) as a collective, and systematically addressed. For example, the implementation of a more frequent rotation across the wards, the absence of which was reported by some of the musicians as a source of difficulty (see section 6.2.3 'Rotation'), would have been a simple improvement to realize for the association, with immediate benefits for the musicians as well as for the hospital staff that often complained about the 'sameness' of the repertoire (and see section 8.3).

As Stewart discovered (2000: 19; see also Sutton, 2002) in a related context, the music therapist's sense of fulfilment largely depended on a variety of support networks, such as individual supervisions, good communication with parents and hospital staff, individual opportunities to share work with colleagues and further training opportunities. In contrast, the reality of the musicians working in the Meyer paediatric hospital was noted to be a solitary and, often, isolated existence. The association did not have a system of supervisions in place and the musicians appeared to have few opportunities to share their emotionally charged experiences with any colleague or hospital staff. This absence appeared to be partially due to the quality of their working lives which, being very busy and balanced between different jobs and family
commitments, did not allow them any extra-time to stay in the hospital after their musical intervention. Non-session time was not considered part of their work and, therefore, not remunerated. Also, neither the musicians nor the association managing them seemed to be aware of the potential importance of supervisions in preserving musicians' personal and professional lives. It appeared that musicians were not provided with any space to verbalize their experiences, neither by the association nor by the hospital and, ultimately, nor by themselves, as there was no observed or reported attempt to organize a support network among themselves, although they recognized the need to have one.

The intrinsic reward and satisfaction of the Florentine musicians appeared to be largely dependent on their musical interaction with children and their carers and, sometimes, the hospital staff. Although they never mentioned dissatisfaction openly, a number of issues were considered to be problematic and a source of discontent and personal frustration. The main one was probably the awareness of the amount of time needed to prepare a musical intervention, in terms of renewing the repertoire and building new percussion instruments. Musicians reported that the weekly preparation needed at home was at least the same amount of time that they spent (weekly) in the hospital, but with the difference that this time was not factored in by the association. The result was that, although musicians had to spend time preparing their interventions, this time was not considered by them to be enough, hence causing a mild sense of frustration for not being able to perform at their best. Moreover, the association did not offer any chance of professional development to its musicians, with the result that five out of the nine musicians had been playing for five years in the same hospital without receiving any new training.

Literature about job satisfaction among music therapists suggests that their average length of employment is five years or less (Braswell et al., 1979; Lathom, 1982; Oppenheim, 1987). The relatively short average length of experience suggests that many of them do not find the satisfaction (professional, financial) that they had hoped for in music therapy practice. Oppenheim (1987: 105) believed that the majority of therapists do not work in the field long enough to experience burnout. In the case of the Florentine musicians, they appeared to be highly rewarded emotionally by the contact with the children, but they were perhaps not sufficiently aware of their professional identity as 'musicians in hospital' and of the potential impact of their work on their personal and professional lives. Similarly, inadequate salary, lack of professional recognition, lack of advancement opportunity and lack of professional development, were among the recurrent concerns that 836 female music therapist reported in a survey conducted by Curtis (1990) and these issues also seemed to characterize the experience of the Florentine musicians.

Compared with the Italian musicians, their UK counterparts appeared to be more protected from the risk of burnout, perhaps due to the irregularity of their performances in a wider variety of hospitals, the concert-type nature of their interventions, and to the established
and successful management of the organization. With over thirty years of experience in organizing concerts in hospitals, the Music in Hospitals office was reported by participants to be smoothly handling all the phases of the performance, from getting the hospitals to participate, to helping them finding the funding, to selecting the most suitable musician (or group of musicians), to organizing the meeting with a contact person in the hospital that was usually advertising the concert and who was also creating a degree of positive expectation in the hospital patients and among the hospital staff who welcomed the musician subsequently.

8.2.3 Music in hospitals as an activity and the role of being a ‘musician in hospital’

From the web-based survey and the fieldwork conducted in UK and Italy, it emerges that music in hospital activities are usually coordinated by a managing association, often a charity, that liaises within the designated healthcare settings, selects the musicians, organizes some form of training prior to the beginning of their activity and, in some cases, evaluates the musical performance and its impact on the audience/patient.

These associations, like Music in Hospitals and the Athenaeum Musicale Fiorentino, may often be struggling to find funding to subsidize and promote their musical activities as they have to convince the staff of the selected healthcare settings about the value of offering live music to their patients. Often, the evidence that these associations draw on to promote their work is anecdotal and based on a ‘free taster’ session and a few positive comments of carers and hospital staff previously involved in their activities. Of all the associations reviewed, only Musique et Santé mentioned ‘research’ amongst their aims. This same association was the only one that, in collaboration with the University of Strasbourg, was able to provide a structured year-long training for musicians playing in healthcare settings as part of a university course. The need to support the anecdotal evidence of the positive effects of music with relevant research is a central issue within the Arts and Healthcare movement (Brenner et al., 2003). Evidence-based measures are seen as being more effective in attracting funding and to raise the awareness of arts in healthcare (Staricoff, 2005). Although there is increasing pressure to provide such evidence, in Florence the Musica in Ospedale project has been running since 2003 without having been evaluated. Occasionally, there has been some small scale research conducted by undergraduate students from the Psychology department of the University of Florence

(www.meyer.it/notizia_2.php?IDNotizia=5213&IDCategoria=368 retrieved on 24 November 2008) as part of their studies, but overall, neither the hospital, nor the hospital charity that has been funding the project, has ever put pressure on the association and their musicians to
provide some formal research evidence of the impact of their interventions. Although this degree of 'freedom' had enabled the musicians and the association to explore creatively and without any pressure the emerging contours of a new professional activity, neither musicians nor association appeared to be under any pressure to reflect on their long-term practice, nor to address specific aspects of their work in hospitals that seemed to be problematic (see section above).

The nature of musical activities in hospitals appeared to be characterized by a high degree of unpredictability with regard to which patients the musicians would meet and what knowledge was available concerning the patients' physical and psychological conditions. Perhaps in order to cope with such uncertainties, the associations involved mentioned that musicians working in a healthcare setting should be 'flexible' and ready to adapt their repertoire according to the variable needs of the audience/patients. Nevertheless, an emerging profile of a 'musician in hospital', as outlined by most associations, was that of a musician possessing a high level of musicianship, being able to offer a varied and suitable choice of music, having good presentation skills and an ability to establish a rapport with the audience. Although there was no age limit to apply, in one case (Live Music Now!) priority was explicitly given to younger musicians (the maximum age for application being 27 years for instrumentalist and 30 for singers) as working in a healthcare setting was considered to be an additional opportunity for musicians to perform.

One of the main observed differences between UK musicians and Italian musicians was that the UK musicians were improvising on a selection of generally well-known repertoire, whilst the Italian musicians, in addition to their song repertoire, were also improvising simple rhythmic patterns on little percussion instruments. Such an approach was recommended in the one-year training course that the musicians had to undergo prior to their enrolment in the project, where four-day seminars were focused on the use of improvisation (http://www.athenacummusicale.it/Cooperativa/Musica%20in%20Ospedale/struttura_del_corso.htm retrieved on 24 November 2008). Considering that seven out of the nine musicians were classically trained and, therefore, likely to be less than familiar with improvisation techniques than musicians with a jazz, folk or popular music background (Creech et al., 2008), it is not surprising to notice that the Florentine musicians did not appear to have mastered this technique after such a relatively short training, with the result that they were observed to be playing rather basic rhythmic patterns. This was not perceived to be an obstacle in their musical relationship with the child, as the sound appeared to be the first stimulus to which children responded and to which they directed their attention. On the other hand, however, musicians reported themselves as being aware of their limited musical abilities, especially when comparing their perceived improvisational skills on the percussion instruments with those on their main instrument.
Percussion instruments appeared to be used by the musicians as 'ice-breakers', as children were noticed to react to the sound and the shape of the instruments that was used to focus their attention and only afterwards were they drawn into the rhythmic improvisation that was used by the musicians to sustain the musical interaction. The Italian musicians unanimously considered the handing out of the percussion instruments as an effective way to establish a deeper connection with the child and of establishing a non-verbal channel of communication.

In some cases, improvisation on little percussion instruments appeared also to provide a means of self-expression for the children involved in the music session and as an aid to develop creativity and playfulness with a degree of structure and freedom of choice. The use of improvisation within the Meyer paediatric hospital appeared to be close to the non-referential type of clinical improvisation used in music therapy (Bruscia, 1998; Wigram, 2004), although neither musicians nor the association were willing to recognize such similarities and denied any explicit therapeutic aim behind their musical intervention. However, according to a survey of paediatric music therapist (Robertson, 1992) both musicians in hospitals and paediatric music therapists appeared to use similar techniques because the survey highlighted the importance of live music-making, including the singing of familiar songs and the use of instrumental improvisation among the techniques that music therapist used more frequently.

Because of the constant preoccupation with the use of the word 'therapy' to describe any aspect of the work in hospitals, the musicians' conceptualization of their musical activity did not fully emerge from the interviews. When they were asked directly about the aims of their music intervention in the hospital, they replied that it was aimed to 'distract' the children from a threatening environment and to provide the child with a positive experience that would have relaxed them. But when commenting on their intervention, motivating their musical choices within the observed session, they often used terms like 'change of emotional state' and 'release of emotions' which appeared to go beyond the notion of 'distraction' and revealed a different underlying conceptualization of their work.

Although the musicians working in the Meyer paediatric hospital were not aware of related theoretical underpinning that could be applied to their work, such as stress-coping theories (Lazarus, 1966, 1991, 1993) or Family-centered care (Schaffer, 2004), they appeared to have developed a set of beliefs about children's reactions to hospitalization that intuitively had incorporated some of the above mentioned theories. For example, the musicians often referred to the need to establish a musical relationship with the child before the beginning of a medical procedure (see Chapter 6, section 6.2.5 'Children's previous hospitalization experiences') because they had observed that, through the familiarity of the music (e.g. the music might remind the child of a school activity or a familiar environment), the child was more likely to perceive the hospital environment as less threatening, increasing the likelihood of the child relaxing. This might also have potentially positive implications for doctors because they would then be dealing with a less stressed child. As the literature points out, the main source of stress
for the child in a hospital is not the illness itself, but rather the hospitalization and the perception of the illness experience (Youngblut & Shiao, 1993; Melnyk, 2000; Rennick et al., 2002). Therefore, even if the musicians did not seem to be aware of children's different conceptualization of illness in relation to their developmental stage (Bibace & Walsh, 1981), they appeared to be aware of the fact that children were likely to be equally intimidated by the unfamiliar environment and the anxiety of their carers, as well as by the severity of their illness. In this respect, the musicians' technique of sometimes eliciting crying in the carers so that they would leave the room (Chapter 6, section 6.2.2 'Perceived aims of their work') has to be contextualized within the perception that the musicians had formed about the role of the parents in determining the child's reaction to music, and more broadly, to hospitalization.

The attitude of parents towards the musical intervention was considered to be crucial by the musicians in children's reactions to music, as children were perceived to be emotionally dependent by their parents and to respond to their (parental) anxiety. Moreover, the musicians reported that, when parents were particularly distressed, their protective attitude prevented the musicians from getting close to their child. When they managed to break the 'wall' that the parent had put up, musicians noticed that the music was likely to have a calming effect on both the parent and the child. Although the expectations of the musicians was primarily based on their craft knowledge, the literature on the dynamics of hospitalization reports similar findings, in so far as it supports the notion that one of the main factors determining the child's reaction to illness is the way the family responds to their illness (Turk & Kerns, 1985; Roberts & Wallander, 1992; Darbyshire, 1994). Similarly, research indicates a significant correlation between children's coping style and mother's ability to parent effectively during hospitalization (Jacobsen et al., 1990). In this context, the Florentine musicians' intuitive behaviour of fostering the (short-term) self removal of a distraught parent appeared to be justifiable as it sought to provide an anxiety-free space for the children where they could enjoy the music without the mediation of their anxious carers.

The view that musicians were observed to develop in relation to children's coping strategies appeared to be in line with Lazarus' transactional stress theory (1991) which maintains that an individual's coping mechanisms are mediated by the individual's appraisal of a certain situation, together with the perceived social support available. Translated to this Italian context, social support is represented by the selected musical intervention, based on the selection of age/cultural-appropriate repertoire and the encouragement of a positive reaction from the adults present. As mentioned above, if the musical experience is perceived as a positive experience by the child, it should lead to a more constructive appraisal of the hospitalization experience, with important implications for further hospitalizations (Thompson, 1985; Rennick, 1996; Vernon & Thomson, 1993) and for the kind of patient that the hospital staff will deal with. In this case, although music in hospitals was not directly therapeutic in its intent, it might have a therapeutic function in shaping the child's perception of hospitalization and of the hospital as an
environment. Moreover, music in hospitals, as an activity, appears to be a culturally and educationally enriching experience for the children, as they are exposed to the live sound of instruments that the majority of them may have never had the chance to experience; children also had the opportunity to learn new songs and to play a variety of percussion instruments, sometimes with other children or their carers, experiencing group music making, possibly for the first time.

8.2.4 The repertoire

In the 70% of cases observed in this research, the carers present during the musical activities were mothers (see Chapter 5, section 5.5). This represents a significant potential link with what the literature suggests about the transmission of the mother’s preferred music to the developing foetus, and the preference that keeps being transmitted to the children when they are in the outside maternal world as they remember the music from their foetal experience (Hepper, 1991; De Casper & Spence, 1986).

Depending on the age of the child, the overlapping area of musical influence of the family on the child will progressively reduce (and will shift) in favour of the influence of the child's social network (Miell et al., 2005). According to Welch (2000: 3), musical behaviour is defined as the interface between three generative elements 'namely (i) the overall nature and individual developmental history of our human anatomy/physiology, (ii) socio-cultural context, and (iii) music (however defined).’ In this context, the choice of a more formal repertoire, such as a piece of folk music that conveys a strong ethnic link, was not observed to be a consistently engaging enough repertoire to connect musically with the child and their carers. Although the songs were part of the regional cultural heritage (a selection that had been strongly encouraged in their training course), the choice of such a culturally specific repertoire sounded rather distant from the more modern musical tastes that children were likely to have been exposed to by their parents.

For the hospital staff, the repertoire was perceived as the main limitation of the programme and in some cases, as a stressful element. Both the stylistic choice connected to the child-focused repertoire and the repetition of the same songs were reported to be among the main perceived difficulties. Paradoxically, the repetition of songs, together with the musical structure of the intervention, were the aspects of the music session that created a safe and predictable environment for the child where they could feel in control and, therefore, possibly reassured by such predictability. Robb (2000) stresses that the structure of a musical session serves to diminish the effects of chaotic environment by encouraging children ‘to be active
agents in their environment' (Robb, op.cit: 21). Moreover, she observes that such feelings of security enable the children to reengage with their environment during times of distress. According to Robb (2000; 2003), music therapy references three aspects of music intervention that create safe, predictable environments where children can master their fears and experience success. These are: the structure of the music and its predictability, the ordering of the session activities, and the client-therapist relationship. From this perspective, musical activity repetitions appeared to be a positive aspect of the observed sessions, notwithstanding the more varied response from some of the hospital staff.

The musicians themselves realized that an appropriate selection of songs was crucial to the likelihood of a musical intervention being successful (see Chapter 6, section 6.2.5 ‘Familiar music and musicians’ personal musical tastes: Influence on the selection of the repertoire’). However, they reported the constant updating of their repertoire as problematic, partly due to a lack of time and partly due to the fact that they did not appear to receive any such support from the managing association.

Observations and interview data suggested that what worked particularly well in the hospital was music that explored simple sonic features, such as rhythm and timbre, through the use of simple tuned and un-tuned percussion instruments. Improvisation techniques were employed by the musicians to communicate with children across different ages and cultures, suggesting that parents and their children (especially younger ones) responded to basic musical techniques (e.g. imitation, opposition, and integration; see Chapter 6, section 6.1.3 ‘Common musical techniques characterizing the intervention’) that they were likely to be familiar with as typical of the early stages of communication between babies and their carers (and mothers in particular — e.g. Papousek, 1996). In this case, the parental-care hypothesis (Deliege & Sloboda, 1996; Trehub, 2001; Trehub & Hannon, 2006) which supports the biological origins of musical abilities, might find some resonance in the observations of the musicians in the Meyer paediatric hospital, as improvisation seemed to offer the musicians a sort of culturally neutral means to interact with a multicultural (and wider) audience.

Aspects of mother/infant interactions such as singing to the child to soothe or calm them, or singing to the child in order to stimulate them when passive and inattentive, were observed to be reproduced either by the musicians or by other carers, or members of staff, in an (involuntary) attempt to recreate a safe, soothing and familiar environment for the hospitalized child. Furthermore, research indicates that participants in the music sessions would have been endowed with a musical heritage that was transmitted to them by their own mother in the early stages of their lives (cf. Deliege & Sloboda, 1996) and, therefore, each would have experienced aspects of musical communication in their infancy, so that the dynamics of basic musical communication used in the Meyer paediatric hospital appeared likely to have a common cultural basis for everyone involved.
The observed role of 'ice-breakers' that little percussion instruments assumed seemed to take on the function of strengthening the communication between the musician and the child. Handing out the percussion instruments involved a set of multimodal sensory stimulations identified by Papousek (1996) as typical of the interaction between mother and infant, and therefore, familiar to the child. These involved (i) tactile stimulation, when the musicians were handing out the instruments, encouraging the child to explore their shape and their physical characteristics, by demonstrating how to play them; (ii) kinaesthetic stimulation, as the child was encouraged to join a set rhythm and, depending on their age, were encouraged to move to the rhythm of the song; and, (iii) visual stimulation, as the musicians were constantly using their body language to promote confidence in the child to keep playing the little instruments or to engage in focused listening.

The importance of music per se is central to the evolutionary debate on the functions of music at a neurological, social and cultural level. Such functions (reviewed in Chapter 4) represent a framework for understanding and contextualizing the significance and the impact that music had, and still has, on human lives, including where it might have originated and in which forms. This literature also helps to clarify the role of music in relation to a number of its powerful effects. The musicians in Florence were observed to use music with the child in order to calm, soothe, promote bonding between the child and their carers and to modify their arousal levels. It also appeared that, in this context, music (and improvisation in particular) was a powerful tool to communicate with children across different cultures, as music drew on a system of multimodal interactions that the child was already familiar with, in so far as it was based on the dynamics of early communication, as mentioned above (cf. Papousek [H], 1986).

Within the debate on the evolutionary origins of music and its adaptive causes, one of the explanations for the survival value of music and its transmission is theorised to lie in the ability of music to promote cohesion and cooperation at the level of a social group (Cross, 2001, 2002, 2005; Freeman, 2000). In Florence, the group interaction was observed to be a prominent aspect in the musical intervention, mainly because of the hospital design which was organized through a range of common spaces (waiting rooms, wards and single rooms that, despite the name, hosted at least two children and their carers).

The musical interaction of different age groups, different musical and cultural backgrounds, different ethnicities, cultures and social classes represented an extraordinary audience to engage with in terms of the likely diversity in musical tastes. The musicians playing in the Meyer paediatric hospital appeared to have found a successful key to engage with such a multifaceted audience, chiefly by exploring rhythmic features of music, combined with simple tunes, together with primarily a selection of a familiar repertoire of children's songs. All musicians had a minority of foreign songs in the repertoire that were targeted at interacting with non-Italian children, a choice that demonstrated an understanding of the cultural-specific use of music and of the importance to be equipped with a broad repertoire in order to establish a
musical channel with children coming from different cultures. Although the association managing the musicians promoted a regional-folk repertoire in the attempt to embrace a cultural idea of ‘music in hospital’ (see Chapter 6, section 6.1.2 ‘Repertoire’), musicians were observed to interact musically with the children on the basis of their individual perceptions of the children’s needs at that moment in time, rather than on the basis of a cultural choice. The selected repertoire was mainly aimed to distract, calm or relax the child.

As mentioned earlier, in several cases, the musicians reported the use of emotionally charged lyrics to elicit crying in the carers as one of the strategies that they sometimes needed to employ (Chapter 6, section 6.2.2 ‘Perceived aims of their work’). This feature has been discussed above (section 8.2.2) in relation to the family dynamic aspects and the intuitive choices operated by the musicians on the bases of their personal sensitivity and craft knowledge. Musically, the question whether words are more powerful than music to elicit emotion is still central to research. Stratton and Zalanowski (1994) found that lyrics appear to have greater power to direct mood change than music alone and could permeate a particular melody with affective qualities. However, Ali and Peynircioglu (2006), in a more recent study, reported that melodies of songs were more dominant than the lyrics in eliciting emotions. Observations carried out in the hospital in Florence, although not specifically focused on testing the mood of participants in relation to specific musical choices, suggested that carers were often distressed, especially those with severely ill children. Therefore, eliciting crying appeared to be a relatively easy task for the musicians if they were intentionally oriented to do so. Moreover, the music that the musicians were playing to elicit crying contained emotionally charged lyrics and a melody that was also rather ‘sad’ (cf. slow tempo, moderate loudness, legato articulation, moderate timing deviations - Bresin & Fiberg, 2000).

Personally, observing four situations where musicians employed what they described as a ‘technique’, I found that the musicians were somehow imposing their perceptions on the carers, deciding that this was the right time to elicit crying and to ‘force’ them to release their emotion, something that the carers were not necessarily willing to engage with. The musician seemed to realize that they had a rather powerful tool, the music, with which they were able to manipulate the mood of their ‘audience’. Possibly, a more careful planning of their intervention, discussed with the managing association, between the musicians themselves, and refreshed in the light of regular training, could be a willing support for the musicians that too often were observed to act solely on the basis of their individual experience.
8.2.5 An emerging professional identity?

Various anthropological accounts on the use of music in healing rituals unanimously report that the use of sounds, chants and the presence of a mediator between the music - as healing ritual - and the sick person, are part of the historical background of different cultures (Kleinman, 1980; Blacking, 1995; Laderman & Roseman, 1996). Music seems to produce changes in the body and mind, and societies value the musical gifts of healers that often acquire a higher status within the community (Merriam, 1964; Laderman, 1996; Stoller, 1996). Musicians playing in hospitals have somehow inherited the shamanic role of mediating between the music and the patients, an aspect that becomes evident in palliative care programmes where music therapists feature increasingly. At the end of life stage, traditional medicine - which mainly addresses the physical dimension of the patient - reportedly struggles to address a more spiritual dimension and music may offer an effective means to facilitate the expressions of fears and anxieties connected to death (Martin, 1991; Aldridge, 1999).

Although most associations involved in the provision of music in hospitals claimed the effectiveness of their musical interventions, none of them seemed to undertake a specific evaluation of their work based on an in-depth assessment of the intervention itself and of the elements that might have contributed to its perceived and reported success. Even if the musical activity in most of the cases was monitored through evaluation forms filled in by patients and hospital staff after each intervention and by observations carried out by fellow musicians and members of the team, this technique appeared to be more an internal procedure to ensure some sense of customer focused quality of the service rather than a research activity per se.

Nevertheless, despite the lack of internal research, it would seem that organizations are empirically able to identify the elements that are crucial to the success of a musical intervention and consequently to select a range of musicians that respond to those unwritten criteria. These features, which appeared to be common to all associations, give a sense of the profile of an ideal ‘musician in hospital’ that each of them outlined in their programmes, namely (i) extensive communication skills, together with (ii) a high level of musicianship, seemed to be the main ingredients in defining a successful performer. Both these skills were prominent in the selection procedures followed by the UK charity *Music in Hospitals* when it auditioned and interviewed the people that it wished to employ. Indeed, both the charity and its musicians agreed that being able either to play or sing well, although necessary, was not a sufficient condition for being a successful performer in a hospital – what was needed also was the ability to communicate effectively with an audience in a non-musical way. Additionally, (iii) the choice of music and breadth of repertoire followed as a third element, whilst the musical instrument played seemed to have a less significant impact on the selection criteria.
The need for an in-depth preparation of such musicians is not only a philosophical point, but also embraces financial and organizational issues. Both studies 1 and 2 in Chapter 2 suggested that there are two emerging typologies of associations: 1) associations focused on providing musical interventions (Live Music Now!, Music in Hospitals, Musicians on Call); and 2) associations focused on training (Musique et Santé, University of Strasbourg, Athenaeum Musicale Fiorentino). Charities that were struggling for funding appeared unlikely to be able to provide a structured and prolonged training and, therefore, perceived that they needed a 'naturally skilled' musician to be ready to perform and meet the diversified demand of playing in a variety of settings. Universities and associations (such as Musique et Santé), on the other hand, based their funding on training courses, with a main focus on the organization and quality of the course itself. They then marketed the musical activities through the reported excellence of their trained musicians, who gained added value after the specialized training, acquiring a new professional status that could be publicized within a high quality professional preparation package.

The personal and professional characteristics of musicians undertaking this activity, as well as the nature of their engagement in such activities, became relevant aspects that contributed to a more general understanding of the dynamics of a musical intervention itself. The emerging portrait seemed to be consistent across different associations, regardless of the focus on the training or if there was a more voluntary approach. The emerging portrait of a 'musician in hospital' is that of a highly motivated musician, wanting to perform in a variety of settings, often for strongly moral reasons, occasionally because of religious ones. Whilst musicians frequently denied that their work had direct therapeutic effects, they seemed to be very conscious of the fact that their work could be positively consequential for patient's well-being, if only in the short-term. In Florence, musicians were observed to use a set of skills that were not only musical in order to establish an interaction with different 'audiences/participants', in a variety of settings. They also possessed a knowledge of the hospital rules and regulations (e.g. such as observing hygienic norms) which had been partly learned in a qualifying training course prior to their employment in the hospital, and partly identified and elaborated by the musicians themselves during their long-term experience in the hospital. The musicians, despite a high degree of unpredictability involved in hospitalization, appeared to carry out their musical intervention on the basis of a consolidated framework that they had elaborated during their years of practice in hospitals.

Musicians appeared to be conscious of the fact that any positive outcome was unlikely in the absence of them possessing specific skills of social interaction, entailing empathy, appreciation, openness, flexibility of response and a sense of humour. Whilst they were not qualified 'therapists', their work provided indirect therapeutic effects as the observed number of musical interventions confirmed.

The status of the profession of 'musician in hospital' is in its early stages and at the moment there are only isolated attempts to create a curriculum and a formal professional preparation.
The University of Strasbourg, together with Musique et Santé and the Athenaeum Musicale Fiorentino has offered the first example of an institutionalised curriculum for musicians playing in the hospital, supported by a partnership with the local government and the hospital. The debate on the training of musicians in hospitals seems to have ripened quickly. One sign of this has been an increasing number of conferences revolving around the theme (e.g Music, Health and Happiness, RNCM, Manchester, 2008; Music and Health: Current Developments in Research and Practice, University Centre Folkestone 2008; Inspiring Transformations: The Arts and Health, University of Northampton 2007; Music and Medicine, St Cecilia’s Hall, University of Edinburgh, 2006) and the interest demonstrated by associations, such as the American Music Therapy Association, in stepping into the area by creating a new branch of music therapy, ‘medical music therapy’, which looks like an attempt to catch up on some lost ground (Standley et al., 2005).

The ‘musician in hospital’ appears to be a professional pathway within this emergent field. The professionalism of the musicians observed was noticed to be not exclusively musical but to draw on other disciplines. Important features included their interaction and communication skills, based on empathic ways of communicating with the children who were in the hospital and a knowledge of the hospital rules and regulations. These skills and understanding were partly learned in a period of professional preparation, prior to their employment in the hospital, and partly identified and elaborated by the musicians themselves through their developing craft knowledge acquired during their long-term experience of performing in the hospital.

Hoyle (1990: 13) states that the criteria for a profession includes: (i) a high degree of skill, based on a body of systematic knowledge; (ii) a lengthy period of training; (iii) a high degree of autonomy for the practitioner and the occupation as a whole and (iv) a commitment—often expressed in a code of ethics to the primacy of client interests. Evidence from the Florentine hospital suggests that (i) these musicians exhibited a high degree of musical and interpersonal skills that drew on a body of systematic knowledge; (ii) they had to undergo a year-long period of initial training prior to their formal employment; (iii) they exhibited autonomy in their music practice and (iv) they expressed a commitment—as part of the hospital culture—to the primacy of their clients interests. Although it is possible to identify strengths and weaknesses in the current Florentine arrangements, the basis for further professional structuring is in place, at least according to these criteria. Although the UK context had less formal preparation (the nature of the expected musician behaviour is not as intensive, nor as varied), there was similar evidence to that found in Italy.

The debate on what constitutes professionalism and professional identity in healthcare settings is the subject of interdisciplinary analysis ranging from sociology (Evets, 2006; Khulman & Burau, 2008), political sciences (Freidson, 2001; Moran, 2002), to medical education research (Stark et al., 2006) and social psychology (Lindesmith et al., 1999). Definitions vary
according to the focus on different medical disciplines. However, in recent years, healthcare teams have been playing an increasingly important role, particularly in the US healthcare system, as a 'response to advances in medical technology and service, growing professional specialization, and the pervasiveness of managed care' (Apker et al., 2005: 94). Healthcare teams, consisting of professionals representing a variety of medical disciplines have emerged as a primary method of maximizing patient care effectiveness and efficiency (ibid). The use of team-based structures has transformed the responsibilities of healthcare workers and forced them to redefine their professional role (Bailey & Armer, 1998), although in various literatures, the professionalism is still defined according to each discipline (e.g. nurses, physicians, physiotherapists). In Florence, musicians were not integrated formally in the hospital team and as consequence they did not always feel valued by the hospital staff. Sometimes this caused a mild sense of frustration that neither the managing association nor the hospital charity was able to recognize and address. Nevertheless, the ongoing commitment by the hospital management to sustaining musical activities over a number of years suggests, at least implicitly, that they viewed the musicians as part of a team-based approach.

Ohlen and Segesten (1998) maintain that professional identity is viewed by nurses as an integral part of their personal identity, something that is also common to the musicians playing in hospitals. Furthermore, Ohlen and Segesten maintain that, in the context of nursing practice, the development of professional identity is a process that involves the personal motivating force which consists of will, insight and ability (after Lindstrom, 1983). Professional development, therefore, is considered to be an important tool for nurses to increase their self-esteem and to develop 'a deep valuing and commitment to themselves' (Bunkers, 1992: 155). Ohlen and Segesten also point out that the professionalism of a nurse will be developed through interaction with other nurses and through internalization of knowledge, skills norms, values and culture of the nursing profession (1998: 722). The concept of nurse professional identity appears to relate closely to concepts as occupational identity, self-esteem and self-image. Stenbock-Hult (1985: 9) defines professional identity as

'to feel oneself as a person who can practice a profession with knowledge and responsibility, and who is aware of one's resources but also of one's limits. It also means development of certain knowledge and qualities, and further, identification with the norms and ethics of their own profession'.

Musicians playing in hospitals, both in UK and in Florence, worked on a part-time basis. Nonetheless, they tended to identify themselves with their work in hospitals, as this played a major role in the construction of their work and musical identities. Although they were strongly motivated to undertake their activities in hospitals, their self-esteem in relation to their professional identity, especially in the case of the Italian musicians, was not observed to be very
high because the majority of the musicians reported that they were uncomfortable with the 'sameness' of their repertoire and, in general, of the 'sameness' of their musical approach with the audience in the hospital. As previously noted, the musicians in the Meyer paediatric hospital would have benefited from professional development courses and regular, structured evaluations, especially because their work in the hospital had been long-term, with five out of the nine musicians working in the hospital since 2003, a period when the musicians had to rely exclusively on their own personal and musical resources. Moreover, it was noticed that in both cases (UK and Italy) the communication between musicians was limited, if not absent, although musicians recognized the benefit of sharing their musical and emotional experiences with their colleagues. Within these limitations, musicians in hospitals appear to make a new, emerging, professional group that needs to become aware of its own identity. They also need to promote and affirm their professionalism in a context where music is sometimes considered a luxurious accessory.

8.3 The children’s and carers’ perspectives

The hospital staff and parents appeared to act as team members in seeking to support the positive effects of musical interventions. Whether by word or deed, in general, the adults were very supportive of the musical provision because for them the effects of music were directly observable.

As far as the child/adolescent patient is concerned, music is likely to be a central feature of their personal and social identity (Lamont, 2002), being interwoven in their daily leisure and school activities and omnipresent through the media (Heargreaves & North, 1997; Miell et al., 2005; North & Heargreaves, 2008). The adapted model of Bronfenbrenner's social ecology theory (Figure 3.3, Chapter 3, section 3.2.2) represents the contextual influences that are likely to have shaped the social identity of the child, specifically when illnesses occur.

The process of enculturation suggests that children were arriving into the hospital already biased towards accepting musical activities, particularly in a live context, where the performer is directly in front of them, encouraging participation. For the younger patients, this accepting experience was observed to be both sonic and tactile, especially when they experienced the musical improvisation on the 'little instruments'. As children grow older, their musical preferences became more differentiated. Therefore, the challenge for the musicians was to be able to provide a wider selection of music in their repertoire, including updated examples from the popular music culture. Nevertheless, all the available evidence (literature and fieldwork) suggests that music was overall a positive and powerful tool for alleviating some of
the more negative aspects of hospitalization for these children and also for nurturing a sense of individual, group and institutional well-being. These findings are in line with Robb's tested contextual model of music therapy (Robb: 2000) when she found out that therapeutic music interventions possessed more environmental support elements than other activities (e.g. reading) and events experienced by children in the hospital environment.

Children were observed to react to the sounds of the instrument and to the voice of the musicians. The familiarity of the repertoire and the use of percussion instruments appeared to be necessary tools to keep the children engaged in the musical interaction. Additionally, the reasons why children responded to music, and familiar music in particular, seems to be in need of a culturally located answer. Music has been described as a ‘flexible’ medium for communicating and, at the same time, a powerful means to effect and change emotional state (Cross, 2000; Gabrielsson, 2001). Following a pre-birth form of musical enculturation, newborns enter the world already programmed to recognize sounds, express musical preferences and distinguish perceptually between basic musical features. Sounds seem to be what children react to in the first place as a consequence of their biological design (Papousek, 1996). In this respect, music has been demonstrated to be an important element in establishing the first bond with the mother and subsequently with other members of a social group in order to preserve group identity or modify collective behaviour through different rituals (Freeman, 2000).

Most of the ‘working’ features of a musical intervention in a hospital seem to originate from ancient functions of music that are embedded in our genetic design (Zatorre & Peretz, 2001; Peretz & Zatorre, 2003), and nurtured by our contemporary environments, and hence especially effective in eliciting a set of responses (Nettle, 2000; Mithen, 2005). Even though evolutionary evidence about the ‘innateness’ of music remains controversial (Patel, 2008), research highlights the central role that music occupies in the dynamic of human evolution (Dissanayake, 2000) and in human lives in general (Trehub, 2001; 2003).

Although the majority of the children were attracted to live music, they were often, initially, intimidated by the musicians if this was their first meeting. Consequently, the parents and the carers were usually observed to be acting as facilitators to help the child engage with the musician. This behaviour finds a correspondence in view of the family as a system of interdependent interactions (Schaffer, 2004) (and see Chapter 3, section 3.3). Especially when illness occurs, there is a privileged relationship that develops between the mother and the child (as Figure 3.4 in Chapter 3 shows). Moreover, children are usually distressed about being in a threatening environment, where procedures are often perceived as worse than the disease itself and where their fantasy can be worse than reality (Menke, 1981; Hockenberry & Bologna-Vaughan, 1985). The mediation of the parent, therefore, was observed to be an important step towards establishing a musical channel between the musician and the child. On some occasions, the intervention was observed to help the different members of the family to refocus on a
common non-stressful objective, such as the music making, rather than the illness and related anxieties. Even if this was only a short break, it appeared to give the parents a chance to engage in a more normal interaction with their child, facilitated by the musician.

For most of the children, music in hospitals represented the first occasion to experience a close encounter with live music, different musical instruments and the chance to play unusual percussion instruments within a group. Therefore, beside the distraction and relaxing impact that music was perceived to exert on the children, music in hospitals appeared also to be a learning experience (both in terms of music and of self) for most of the hospitalized children. As Ockelford (2000: 212) observes, music sessions can be a ‘unique and secure framework’ providing children with an opportunity to listen and respond to sounds. Music listening and playing engage cognitive skills such as concentration and memory, as well as co-ordination. Children learn both in and through music. Accordingly, in this context, although music can be considered as an informal and relatively unstructured form of education, it can be powerful and long lasting.

Music in hospitals appeared also to be a learning experience for some of the parents and carers, especially those with long-term hospitalized children. Parents were observed to learn the musical repertoire from the musicians, which they then sang to their child during stressful procedures, having experienced their positive reactions to certain songs. Improvisation on percussion instruments appeared also to be an occasion for informal learning (cf. Green, 2001; 2008) for both children and parents.

8.4 The hospital staff

Overall, notwithstanding any concerns about musician attendance, the hospital staff appeared to appreciate the provision of musical activities in the hospital, especially when they observed the positive reaction of the children involved. Nevertheless, there were also issues that emerged during both observations and interviews that were perceived to be less positive. For some of the staff, the ‘sameness’ of the musical repertoire was perceived as being stressful. Sometimes it was reported to disturb their concentration whilst they were working, and to cause indirect stress. This had been mainly reported by staff working in the oncology and emergency wards, where music was noticed to be scheduled more often than in other spaces. In such wards, the underlying contextual tension was generally high due to treatment-related decision-making and to the need in some instance for end-of-life care (Hinds et al., 2003). Therefore, a sensitive and cautious approach in planning the musical intervention appeared to be particularly needed in
these spaces. However, musicians were noticed to adopt the same style and same repertoire in these spaces as in the rest of the hospital.

Although the effects of music on hospitalized patients have been widely investigated (see Chapter 4, section 4.3), the effects of music on hospital staff are under-researched at present. A recent study based on a survey of 171 nurses and doctors in an Israeli hospital (Ullmann et al., 2008) suggests that music had positive effects on the hospital staff, with 63% of the participants reporting that they listened to music on a regular basis in the operating room. While 61% of the staff believed that music should be played on a regular basis, only 20% of the respondents viewed music as a distracting factor, especially when played during emergency procedures. In this context, music was reported also to influence positively communication among staff as reflected by 63% of the respondents. The study found a significant correlation between the professional status of the staff and a willingness to listen to music during surgery, with nurses having the highest preference for music. Ullmann and colleagues also discovered a positive correlation between the staff's willingness to listen to music during free time and in the operating room, with 93% of the participants reporting listening to music on a regular basis outside the hospital. As for the most popular musical genre, classical music was reported by 45% of the hospital staff as their preferred music, followed by folk music (29.8%), rock (12.3%), jazz (10.5%) and blues (9.4%). In this particular case, Ullman and colleagues pointed out that, although music in the operating theatre might not provide pleasure to the entire staff, it may be beneficial in reducing stress and sometimes to improve the surgeon's efficiency.

Other studies investigated the effect of specific music on the performance of different professions among hospital staff. Hawksworth (1997) found that self-selected music, compared to silence, did not affect the performance of anaesthetists. Allen & Blascovich (1994) evaluated cardiovascular reactivity, autonomic responses, task speed and accuracy for surgeon’s performance during challenging task under three conditions: with no music; self-selected music and investigator’s selected music. They found that the speed and accuracy of the task performance were greater with self-selected music. Both experiments were performed in a laboratory and, as such, their correlation with medical practice may be argued.

Although the musical intervention in Florence was not directly targeted at the hospital staff, they had been exposed regularly to live music during the five years of the project, for an average of 45 hours a week (see Appendix N for an example of timetable of musical intervention in the hospital). In this case, what they reported as the ‘sameness’ of repertoire, for some of them (five out of nineteen) had become an issue, as they perceived music as being stressful and in some cases as disturbing their concentration.

From the interview with the chief executive of the hospital charity it emerged that he was aware of the problem and had raised it with the chief executive of the association managing the musicians. Nevertheless the association appeared to have addressed this issue only marginally by encouraging the musician to broaden their repertoire, but without providing
resources (neither in-house development, nor paid time off to study). Moreover, neither the hospital charity nor the association considered the possibility of surveying the staff to evaluate the musical interventions and to obtain some new ideas to refresh the structure of the project and renew the repertoire with suggestions coming from a group that was indirectly (and yet directly) involved in the music interventions.

Staff did not generally engage formally with the music and did not perceived the intervention to be directed to them, although amongst the various aims of the project there was an idea of musical interaction between the staff and the musicians that would have eventually led to the integration of music in the staff’s procedures so that they would have used some of the songs to interact with the children, or just listened to the music while taking a short break from their busy routine. Although this was an original and integral interesting aspect of the project, it did not appear to be a priority in the musicians’ agenda, nor in the agenda of the managing association that did not seem to have any particular suggestions to offer to the musicians in relation to this aspect of their work. Moreover, the musicians were observed to be mildly uneasy when performing exclusively for the staff, perhaps because of a lack of suitable repertoire for an adult audience and a difficulty in shifting from interacting musically with children and their carers to the hospital staff.

This aspect found a correspondence in the interviews with nurses and doctors who reported that they preferred music when it was directed to the child rather than to them. Nevertheless, there were some exceptions, as four out of the nineteen staff reported enjoying the music and relaxing when musicians were playing for them, mentioning the quality of the voice of two musicians in particular.

Although the hospital staff was generally aware of the ‘music in hospital’ programme, they did not necessarily make a systematic use of the service, in so far as they could have requested the presence of a musician to support a child during selected procedures through the pain control service, but they reported a tendency to ‘use’ music only if the musicians happened to be there when they needed them. A similar attitude was reported by Mathur and colleagues (2008) when surveying the awareness, the knowledge and use of music therapy by members of the American Academy of Pediatrics in Michigan. The majority of respondents (n=247, 68.3%) reported awareness that music could be part of the paediatric health care team; however, only one fourth of the respondents (23.4%) reported currently offering music therapy in their practice or institution. A large number (60.5%) did not offer such services, and the remainder (16.1%) were not sure. The main problem seemed to be the doctors’ lack of formal education in music therapy and that they had only acquired such knowledge ‘informally’ (e.g. medical education courses, magazines, internet sources). However, in this study, most paediatric practitioners were willing to learn more about music therapy and would have liked to see it included formally into medical school curricula. The majority of paediatric practitioners also wanted to include music therapy as a part of their patient care management. Based on the
survey, the authors concluded that more dissemination was needed about music therapy, as well as the inclusion of music therapy in the formal curricula of medical schools. This appeared to be an important issue, common to the situation of the music project in the Meyer paediatric hospital. A dissemination of aims, structure, potential benefits and possible cooperation with hospital staff should have been put in place by the hospital charity prior to the beginning of the project and refreshed periodically. This might have been helpful in integrating the musicians with the other staff and to introduce their work as an aid for the hospital staff and, therefore, also to foster cooperation.

Hospital staff recognized the 'professionalism' of the musicians in relation to their musical and communication skills as well as their musical activity in the hospital. Staff were also able to recognize that communication skills were as important as musical skills for the success of an intervention in the hospital. In one case, three nurses and four doctors reported that they benefited indirectly from the musical interventions because they were dealing with calmer children. This was noticed especially in the emergency ward, where waiting times were considered to increase the stress in both children and their carers.

Notwithstanding some of the organizational drawbacks mentioned above, overall the staff appeared to have a positive view of the musicians playing in the hospital, recognizing them as having a professional status of 'musician in hospital', understanding the diverse range of communication skills that they required to be successful in their musical activities in the hospital and appreciating what they described as a positive value of the musical intervention, in relation to its effects on the children.

8.5 Conclusions and recommendations

This thesis has investigated the provision of live music in hospitals, a newly emerging field that is under-researched and under-theorised. Within this context, the thesis provides a unique insight into the nature of being a professional musician in a hospital context. In particular, the musician's voice has often been notable by its absence in all the related literature. The research also suggests that 'music in hospital', as an activity, might be represented as the interconnection between three systems, interacting with and within a hospital setting, embracing the child as a patient, the family as the carers, the musicians, and the hospital staff.

One way of representing these interconnections is shown in Figure 8.1, which brings together (i) an adapted version of Lazarus's transactional stress theory to include the social support offered to the hospitalized child and the family through a musical intervention, (ii) systems theory as applied to the family-unit and (iii) Bronfenbrenner's social ecology theory
adapted to contextualize the event of the child's hospitalization within the family, the closer community and the wider society.

According to the literature and the data from the Meyer hospital, the family dynamics is likely to determine the child's reactions to hospitalization and consequently the child's elaboration of more or less successful coping strategies which will ultimately affect the child's well-being. This is represented in the first two boxes of the Lazarus model ('Life events' and 'Resources' see the bottom right of Figure 8.1) with a link to system theory (the green circle) to highlight the importance of the family dynamics in the child's appraisal of illness and hospitalization. In Florence, observations and interviews with both hospital staff, parents/carers and musicians, suggest that the child's reactions to the music were mediated by the encouragement received by their parents and that the effectiveness and the sustained musical interaction was also mediated by the parents (see Chapter 7, sections 7.1 and 7.2).

According to social ecology theory, the family as a unit belongs to a socio-cultural context that is bound to shape their emotional reaction to illness. Such context will also shape their response to music and, in particular, to a certain repertoire of music that will be more or less effective according to the degree of familiarity and sense of identity for both the family and the child. Therefore, the first line of effectiveness of a musical intervention relies on the selection of the repertoire, as the expression of the socio-cultural identity of the child and their family, as represented by the social ecology circle (mesosystems) in Figure 8.1. If the selection of music is successful, the family is more likely to encourage the child to join in and sustain the musical interaction. Otherwise the family will tend to follow the child's initial response to the sonic stimulus of the musicians and consequently will be unable to sustain and promote the child's involvement adequately. One explanation, as according to the social ecology component of the proposed interconnection, is that the music played is something they don't know how to engage with because it is unfamiliar. This was evident in the case of musicians playing classical music and in the case of non-Italian families that were only able to be involved in the musical intervention when the musician was improvising (non culturally connotated) rhythmical patterns on the percussions instruments or when the musician was playing song in the language of the families.

The connection between the social ecology and the Lazarus theory suggests that in order to be effective, the music needs to belong to the socio-cultural context of the family and the child because this will facilitate their involvement in the session and will increase the effectiveness of the intervention because the music will be effective in helping the child to relax and to release anxiety, especially in waiting rooms, and before and after painful procedures. In these situations it was observed that music was used chiefly as a distraction and that the familiar repertoire was chosen not only to encourage the child to join in the session, but also to foster a sense of familiarity in the child (and ultimately to manipulate their perception of the hospital environment) because the repertoire might have echoed events experienced in less threatening
locations such as school, home or playground (and see Chapter 6, section 6.1 for examples, specifically DVD examples as illustrated in the chapter).

The musical intervention is considered to be part of the social support offered to the hospitalized child that might help the child cope with hospitalization in a positive way. Music appears to be a privileged channel of communication between carers and infants, consistent across different cultures (see Chapter 4). Sound seems to be what children react to in the first place as a consequence of their biological design and, therefore, it is an especially powerful medium to connect with the hospitalized child (Deliege & Sloboda, 1996).

In this context, hospital staff also belong to a socio-cultural context where the selection of music is important in order to appeal to their socio-cultural identity. Staff were observed to have two kinds of reactions: 1) their personal reaction to music (imbedded in the social ecology theory shown in Figure 8.1) and 2) their mediated reaction to music in the light of the perceived effectiveness that music has on the child/patient. Hospital staff belong to the support system as grouped in the mesosystem that includes the closest circle of individuals surrounding the child and the family. Their reaction to music and their endorsement of the musical activity are important predictors for the acceptance of the musical activity in hospital.

In light of the data emerging from this research, music appears to be a potentially powerful tool to help the child and their family to refocus their attention on something external to the illness and to reconnect with another world outside the hospital that is likely to have positive associations. Music, through the familiarity of the repertoire, draws on the connections that the child has with the mesosystem, a system of interrelationships between the child and different settings (e.g. school, neighbours, friends). Such connections are ultimately shaped by the external context that surrounds the child: the exosystem (e.g. the kind of society that they live in, including social class, culture and religion, its values and the kinds of medical care it values and provides).

The provision of music in hospitals is likely to help the child and their families to refocus their attention on something external to the illness and, through a familiarity with the repertoire, might turn the perception of the hospital environment into a more familiar and less threatening space. Consequently, the musical intervention is likely to constitute for the child and their family a psychosocial space where they interact without the mediation of anxiety and stress elicited by the child’s illness (Robb, 2000; 2001).

Provision of music in hospitals in the case of the Meyer paediatric hospital are sustained financially and politically by a hospital policy that supports music intervention as part of a wider process of hospitalization that seeks to promote a sense of well-being within the hospital. At the centre of this process there is the hospitalized child and consequently their carers. The ‘music in hospital’ project appears not only to be limited to the child, but to be extended to the staff and the hospital as a whole. The concept of improvement of the atmosphere (the working clinical environment) of the hospital through the music was reported by each participant group.
Figure 8.1 Integration of three theories illustrating the multifaceted nature of music in hospitals.

RESOURCES
- Personal
- Social
- Material

EXOSYSTEMS
- Technology
- Religion
- Music

MESOSYSTEMS
- Peers
- Schools
- Religion
- Music

MICROSYSTEMS
- Hospitals
- Staff
- Parents
- Siblings
- Neighbourhood
- Illness
- Parents’ social networks

CHILD
- Medication
- Family

FAMILY
- Mother
- Father
- Child

Casual antecedents

Life Events
- Impact
- Duration
- Predictability
- Controllability

Resources
- Personal
- Social
- Material

Mediating processes

Appraisal(s)
- Challenge
- Threat
- Harm or loss

Coping

Social Support

Health Consequences

Musical Intervention
Within this context, the figure of the 'musician in hospital' appears to be a relatively new professional pathway within an emergent field. The professionalism of the musicians observed was noticed to be not exclusively musical, but to draw on communication skills, based on empathic ways of communicating with the children, allied to a knowledge of the hospital rules and regulations.

An 'effective' musical intervention in hospitals appears to be characterized by specific features, according to the needs of each participant group: Musicians, children and their carers, and hospital staff.

1) Musicians

In order to be able to deliver an 'effective' musical intervention in hospital, musicians need to:

- Become aware of their professional identity as musicians in hospitals and to feel integrated in the hospital community. Such integration should be promoted by a managing association in partnership with the hospital charity that explains the function of the musical interventions, their potential benefits for the hospital as whole and for each and every participant. In order to establish themselves as members of the hospital team, the musicians need to be effective in time management, such as being reliable in terms of punctuality and turning up regularly, as other members of the hospital staff are expected to do. Professional identity also implies continuing professional development, of seeking ways and opportunities to extend and deepen their professional capabilities to undertake the work, such as being part of a team-based approach to patient health care.

- Perform in different spaces of the hospital through frequent rotations so as to prevent them from performing in the same ward for long, consecutive periods. A frequent rotation would help the musicians to avoid updating the repertoire too often, an issue that the Italian musicians perceived as problematic because they kept meeting the same staff, and in the case of long-term hospitalized children, the same child, without being able to offer a wider selection of songs.

- Master a wide musical repertoire and further develop musical skills, specifically in relation to improvisation techniques because these techniques are an effective way to interact musically with a multicultural audience.

- Address the risk of burn out arising from the contexts where they perform (the hospital) and from their long-term and continuous solo performance employment. To help the musicians to cope with the stress arising from performing in the hospital, the managing association should provide musicians with a professional support system, regular external evaluation and regular professional development courses. Musicians
should also organize a support group among themselves where they can share their experiences, musical repertoire and new tricks of the trade.

2) Children and their carers

For these groups of participants an 'effective' musical intervention is characterized by:

- A positive role of the carers/parents in which they act as facilitators between the child and the musician to establish a positive musical relationship in the hospital.

- An engaging choice of repertoire, including the selection of musical activities to establish an initial connection with the child and then expand it in new directions so that the musical intervention becomes a learning experience for both the child and their carer(s) and an opportunity for critical self-development in the musicians.

- A repetitive, but interesting, structure within the music session to create a secure framework in which the child can interact. Musical improvisations on simple percussion instruments appears to be a successful strategy to keep the child engaged with the musical interaction. This can often lead to group music making with parents, and sometimes members of the hospital staff, and resulting in enhanced group cohesion and social inclusion.

3) Hospital staff

An effective intervention for the hospital staff is likely to be characterized by:

- A perception that what is being provided by the musicians has value. Musicians should be perceived as a professional group within a team-based approach to care, particularly in relation to their commitment to their work in hospitals, and to their flexible and differentiated ways of playing in diverse contexts.

- A formal introduction to the music in hospitals programme and to the direct and indirect benefits that a music programme could have on their work.

- A musical repertoire that takes into account the musical taste of the hospital staff and that would include the staff being seen as members of the audiences to interact with.

This thesis has presented case studies of specific hospitals and a limited sample of musicians playing in hospitals. Further research should explore the extent to which the distinctive features of this project are to be found in other hospitals. Moreover, future research could include experimental studies of real time musical activity of physical and psychological responses in participants involved in a live music intervention in hospitals.

It is highly commendable that the Meyer paediatric hospital has a programme of systematic employment of musicians and that the musicians are expected to undergo a period of sustained training prior their employment. However, in the case of the Italian 'music in hospital'
project, once employed there was an evident lack of support that the musicians experienced in the hospital where there was no senior manager that was responsible for overseeing or improving the programme.

The literature suggests that the arts, including music, are powerful media in the promotion of psycho-physical health and well-being. One of the challenges of the music in hospitals programme is to ensure that music is as effective as it can be, for all participants, including the musicians, because their well-being should also be factored in by their managing association and management. Arguably, if musicians are better prepared and adequately supported, the musical provision in this context and with this population would be even more effective.
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Appendices

Appendix A. Selection of organizations providing music in hospital programmes

A) Hospitals hosting music programmes

Europe (n=7)
Addenbrooke’s Hospital, Cambridge
Birmingham Children’s Hospital
Great Ormond Street Children’s Hospital, London
Guy’s and St Thomas’, London
Royal Hospital for Sick Children, Glasgow
Ospedale Pediatrico Meyer, Florence, Italy
Hôpital, de Saint Nazaire, France

US (n=19)
Beth Israel Hospital, NY
C.S. Children Hospital, Michigan
Cedars-Sinai, NY
Children Memorial Hospital, Chicago
Children’s Hospital Boston
Children’s Hospital, Los Angeles
C.S. Mott Children’s Hospital, Michigan
El Camino Hospital, Mountain View, CA
Flagstaff Medical Center, Arizona
Golisano Children’s Hospital, NY
Maria Fareri Children’s Hospital, NY
Northwest Hospital, North Seattle
Our Lady of Lourdes Medical Center, NJ
Pembroke Hospital, MA
Rady Children’s Hospital, San Diego
Stanford Hospital & Clinics, CA
University of New Mexico Hospital
Thomas Jefferson University Hospital, Pennsylvania
University of Rochester Medical Centre, NY

Australia (n=1)
The Children Hospital at Westmead, Sydney

B) Associations providing music in hospitals services

Europe (n=7)
Musique & Santé - http://www.musique-sante.com/
Centre de Formation de Musiciens Intervenants, Université Marc Bloch, Sélestat - http://musims.fr/
Athenaeum Musicale - http://www.athenaeummusicale.it/
Musica nos Hospitais - http://www.musicanoshospitais.com/
US (n=4)
Music for All Seasons - http://www.musicforallseasons.org/
Musicians On Call - http://www.musiciansoncall.org
Snow City Arts - http://www.snowcityarts.com/index.html
Mihnuet (Music in Hospitals and Nursing Homes Using Entertainment as Therapy) - http://www.hcs.harvard.edu/~mihnuet/
Appendix B. Example of an observation schedule

<table>
<thead>
<tr>
<th>Time start</th>
<th>Time finish</th>
<th>Interaction in space</th>
<th>Map of the space and environment</th>
<th>Direction of interaction</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
<td>n</td>
<td>n</td>
<td>n</td>
<td>n</td>
</tr>
</tbody>
</table>

Note: After each interaction, indicate the number of parents and staff present.
Appendix C. Example of a ‘working’ observation schedule

<table>
<thead>
<tr>
<th>Time (AM)</th>
<th>11:32</th>
<th>11:36</th>
<th>11:37</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Event:**
- 11:32: Begin observation. (Panels 1 and 2,长沙市。

**Notes:**
- 11:34: Shift focus to new subject. (Panel 6, 北京).

**Diagram:**

**Charts:**
- 11:38: Data analysis summary. (Panel 8, 深圳).

---

*Note: Diagrams and charts are placeholders and do not reflect actual content.*
Appendix D. Example of a preliminary model of observation schedule

<table>
<thead>
<tr>
<th>Observation no.</th>
<th>Ward</th>
<th>Space</th>
<th>Type of staying: L M S other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time: Begin</td>
<td></td>
<td>End</td>
<td></td>
</tr>
</tbody>
</table>

CHILD
- Age
- Sex: M F
- Ethnicity
- Length of hospitalization at the time of the musical intervention
- Physical/Psychological condition at the moment of the music
- Medical treatment

MUSICIAN
- Instrument
- PARENTS

<table>
<thead>
<tr>
<th>CHILD</th>
<th>MUSICIAN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MUSIC / STRUCTURE OF THE SESSION

<table>
<thead>
<tr>
<th>PARENTS</th>
<th>STAFF</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix E. Authorization from the hospital

THIS IMAGE HAS BEEN REDACTED DUE TO THIRD PARTY RIGHTS OR OTHER LEGAL ISSUES
Appendix G. ‘The European Association for Children in Hospitals (EACH) Charter’

The EACH (European Association for Children in Hospitals) Charter adopted in 1988 in Leiden/NL, is a list of the rights for all children before, during or after a stay in hospital.

Article 1
Children shall be admitted to hospital only if the care they require cannot be equally well provided at home or on a day basis.

Article 2
Children in hospital shall have the right to have their parents or parent substitute with them at all times.

Article 3
Accommodation should be offered to all parents and they should be helped and encouraged to stay.

Article 4
Children and parents shall have the right to be informed in a manner appropriate to age and understanding.

Article 5
Children and parents have the right to informed participation in all decisions involving their health care.

Article 6
Children shall be cared for together with children who have the same developmental needs and shall not be admitted to adult wards.

Article 7
Children shall have full opportunity for play, recreation and education suited to their age and condition and shall be in an environment designed, furnished, staffed and equipped to meet their needs.

Article 8
Children shall be cared for by staff whose training and skills enable them to respond to the physical, emotional and developmental needs of children and families.

Article 9
Continuity of care should be ensured by the team caring for children.

Article 10
Children shall be treated with tact and understanding and their privacy shall be respected at all times.
Appendix H. Aid memorie of themes discussed with the musicians pre and post their musical intervention

PRE intervention:

Come ti senti oggi?

Ti va di va diandare in reparto?

Perché?

(planning)
Hai un piano per oggi?

E’ specifico per ogni reparto che visiti?

(choice of music)
In base a cosa scegli la musica? (chi c’è nel reparto, o nella stanza, eta, etnia, altro)

POST intervention:

Come ti senti?

Come è andato l’intervento?

Perché?

Perché queste scelte musicali?

Ci sono delle situazioni di riferimento? delle tipologia di intervento che senti di seguire?

Cosa ha determinato l’andamento dell’intervento?

Cosa rifaresti?

Cosa non rifaresti?

ADDITIONAL QUESTIONS

Repertorio

Quanti canti hai in repertorio?

Quanti ne avevi all’inizio (quando hai cominciato a suonare in ospedale)?

Quanto tempo, in media, dedichi alla settimana per preparare questo intervento? (specificare tempo per imparare nuove musiche e tempo per preparare strumentini)

Che tipi di canti scegli di imparare e perché?
I canti sono divisi per eta? Con quale criterio si attribusce l’eta adatta a un canto (esperienza personale con figli o bambini nelle scuole, esperienza in ospedale, altro)?
C’è la consapevolezza di quali canti producono quali reazioni?
(La modalità e l’intenzione con cui si canta e suona non possono essere le sole variabili che influiscono)

I canti che vengono suonati sono generalmente canti della tradizione popolare toscana. Perché una scelta stilistica così precisa?

Ci sono degli strumentini che producono più o meno interesse? Quali?

C’è una relazione tra come ti senti nella giornata e il repertorio che scegli in quella stessa giornata quando vai a suonare?

C’è una relazione tra la musica che ascolti e che ti piace e il repertorio che selezioni per suonare in ospedale?

(opţ)
Sentì che c’è un progresso nel tuo modo di suonare?

Come si è evoluto?

Cosa l’ha determinato?

Su quali aspetti del tuo lavoro e personali influenza l’esperienza di aver suonato così a lungo in ospedale?

In ospedale

Musica per staff o per aiutare lo staff durante le procedure?

Diversi reparti – diabetologia – stessi bambini – repertorio cambia? Difficoltà nel suonare in ambienti dove ci sono le stesse persone?

Siete al corrente della valutazione fatta dall’ospedale?

Trovi l’ambiente stressante? (rumore, pianto, gente che cammina, stress dei genitori e staff, atmosfera pesante)

I musicisti

Differenze tra musicisti del primo e secondo corso?

Aggiornamento e incontri tra musicisti – bisogno individuale? – necessità della cooperativa?

Come è la struttura della cooperativa? I musicisti sono soci?
Appendix I. Aid memorie of themes discussed with children and their carers

BAMBINO

Che musica ti piace?
Conosci molte canzoni?
Ti vengono in mente alcuni titoli?
Potresti cantarne una?
Ti piace cantare?
Dove le hai imparate?
Canti a casa?
Come ti senti quando canti?
Cosa ti ha colpito di più della musica in ospedale?
Ti ricordi qualcosa in particolare della musica in ospedale? (una canzone, uno suono, uno strumento, una voce)
(per bambini che tornano spesso o che sono ricoverati per tempi più lunghi)

GENITORE

Ti piace la musica?
Che musica ti piace?
Ascolti musica?
Che genere?
I tuoi gusti musicali sono cambiati negli anni?
Come?
Sono cambiati da quando hai avuto tuo figlio?
Che musica ascolti insieme a tuo figlio/a? , Cantate insieme?
Al tuo bambino piace la musica?
Che musica ascolta tuo figlio/a?
Cosa ti ha colpito di più della musica in ospedale?
Cosa credi che abbia colpito tuo figlio/a?
Appendix J. Musicians’ interview transcript and list of derived codes

Codes:

After intervention
Aims of the intervention
Background
Before intervention
Collaboration with staff
Coming in - coming out
Contract
Coping strategies
Diaries
Disinfecting instruments
Educational aspects - unintended
Emotional implications in the job
Emotional levels after having played
Emotional levels before playing
Establishing a relation with the child
Experience
Familiar music
Familiarity with staff
Fatigue
Favourite ward/waiting room
Hospital time
Impact of personal life in the job
Improvisation - Lyric substitution
Improvisation
Ingredients for a successful intervention
Length of intervention
Meeting the same child again
Meetings
Motivations
Music as a liberating experience for Parents
Music as therapy
Music more effective than other interventions
Music with non Italian children
Musical instruments
Musical preferences - personal
Musicians' busy lives
Musicians' musical choice - reasons
Musicians' musical choice - reasons in relation to hospital's spaces
Musicians' routine in hospital
Musicians' sense of professionalism
Non-verbal communication - first impact
Observation- how it should be conducted
Parents’ role
Perception of children's age
Perception of parents' reaction to music
Perception of their intervention
Percussion instruments - self made
Playing as a time to rest and look around
Playing in a duo
Posture problem
Preparing the musical intervention
Repertoire
Retribution
Self esteem
Structure of the intervention
Styles - differences between musicians
Time perception when playing
Timetable changes
Vignette
Voice - direct way to communicate
Waiting room vs wards
What is required from a ‘musician in hospital’

Code: AFTER intervention [9-0]

P 2: MUSICIANS.doc - 2:70 [CP - come è andata? C - bene, ..] (393:396) (Super)
Codes: [AFTER intervention]

CP - come è andata?
C - bene, sono stata in tutte le stanze, alcuni bambini si sono addormentati, era l'ora del sonno, dopo pranzo. Così ho suonato senza usare gli strumentini, perché
Fuì sono anche andata a suonare fuori dalle due stanze di isolamento. C'era una famiglia albanese e ho cantato una canzone e la madre che era dentro cantava insieme a me. Le sanno tutti questa canzone. A me l'ha insegnata una mamma violoncellista albanese, amica della Cinzia.
Adesso mi sento bene, appena finisco va bene, sono le pause che mi buttano giù.

P 2: MUSICIANS.doc - 2:83 [CP - cosa avresti voluto fare ..] (444:447) (Super)
Codes: [AFTER intervention]

CP - cosa avresti voluto fare che non hai fatto?
P - mi sarebbe piaciuto riuscire a coinvolgere più persone contemporaneamente, ma però era difficile.

P 1: TRANSCRIPT audio files 22 MAY .doc - 1:8 [CP - non avete uno psicologo n..] (32:35) (Super)
Codes: [AFTER intervention]

DATA SOURCE UNACCESSIBLE: C:\Documents and Settings\Costanza\Desktop\TRANSCRIPT audio files 22 MAY .doc

P 2: MUSICIANS.doc - 2:109 [Siccome l'intervento è andato ..] (563:564) (Super)
Codes: [AFTER intervention]

Siccome l'intervento è andato bene, adesso mi sento meglio. Sia fisicamente che psicologicamente.
Se uno fa 4 ore, verso la fine non si vede l'ora di finire. Magari si preferisce andare in reparti dove non devi dare strumentini, puoi cantare ninnananne.

P 2: MUSICIANS.doc - 2:152 [Ora mi sento stanco,] (697:698) (Super)
Codes: [AFTER intervention]

Ora mi sento stanco,

E' andata abbastanza bene. Ho provato a vedere se c'era la possibilità di organizzare un gruppo di insieme, ma c'era troppa gente e così ho deciso di concentrarmi su singoli bambini e di porvare a seguirli nella stanza dei prelievi.
Con la bambina X è andata bene, perché ho stabilito la relazione con lei nella sala d'aspetto e così lei ha continuato a concentarsi sulla musica e il prelievo è quasi diventato un interruzione di quello che stavamo facendo, mentre nel secondo caso, sono entrata nella stanza del prelievo e il bambino era già stressato, imparato e completamente concentrato sul prelievo e sulla paura associata e così è stato più difficile distrarlo.

CP: come è andato?
P: bene
C: ci siamo trovate bene a suonare insieme, in sintonia. Non succede sempre così bene insieme
P 2: MUSICIANS.doc - 2:134 [A- stamani mi sento benissimo ..] (616:616) (Super)
Codes: [AFTER intervention]
A- stamani mi sento benissimo! [molto gratificato sia dall'essere stato chiamato dal dottore che dall' aver fatto un bell'intervento e aver risposto alle aspettative del personale e della famiglia]
P 2: MUSICIANS.doc - 2:68 [P- psicologicamente mi sento b..] (375:381) (Super)
Codes: [AFTER intervention]
P- psicologicamente mi sento bene, ma fisicamente sono molto stanca.
CP - la Luisa l'avevo vista molto carica....
C - anche io , sto bene, ma appena mi si abbassa la tensione ritorno alla mia stanchezza fisica.
P- dipende dalle persone, anche Marco, esce sempre carico.

Code: Aims of the intervention {11-0}
P 2: MUSICIANS.doc - 2:88 [CP - qual'è la finalita di que..] (470:472) (Super)
Codes: [Aims of the intervention]
CP - qual'è la finalità di questo intervento in una sala d'aspetto.
P di suonare insieme
P 2: MUSICIANS.doc - 2:142 [Il musicista deve creare armon..] (648:648) (Super)
Codes: [Aims of the intervention] [Music AS THERAPY]
Il musicista deve creare armonia, quiete e non di aggiungere stress a un lavoro e a una situazione potenzialmente già sovraccariche di stress. E' vero che non è musicoterapia quella che facciamo, ma se si raggiunge una finalità terapeutica ben venga.
P 2: MUSICIANS.doc - 2:133 [Funzione della musica in osped..] (610:614) (Super)
Codes: [Aims of the intervention]
Funzione della musica in ospedale: accoglienza (sale d'attesa) accompagnamento alle cure supporto alle terapie (aspetto più importante)
P 2: MUSICIANS.doc - 2:136 [Quando la musica diventa suppo..] (627:627) (Super)
Codes: [Aims of the intervention] [Music AS THERAPY]
Quando la musica diventa supporto alle terapie allora la musica ha esplicitamente una finalità terapeutica che è quella di sciogliere l'ansia, la depressione, l'angoscia.
P 2: MUSICIANS.doc - 2:190 [Quando sei entrata sapevi cosa..] (845:845) (Super)
Codes: [Aims of the intervention]
Quando sei entrata sapevi cosa fare? Ho visto il messaggio della Silva nel libro e così mi sono immaginata che canzoni gli aveva cantato lei e di solito
P 2: MUSICIANS.doc - 2:219 [N- quando suono bisogna avere ..] (993:994) (Super)
Codes: [Aims of the intervention]
N- quando suono bisogna avere uno scopo che è o preparare l'ambiente, o rilassare l'infermiere che è dietro nella stanza oppure rilassare genitori tesi, però se devo fare solo musica allora non faccio il corso, io evito di fare il concerto perché non voglio avere il pubblico, voglio arrivare al loro livello, se suoni sempre non arriva questo.
P 2: MUSICIANS.doc - 2:252 [CP - se un bambino piange? S -..] (1181:1185) (Super)
Codes: [Aims of the intervention]
CP - se un bambino piange?
S - mi attira ancora di più perché voglio calmarlo, distrarlo, oppure calmare i suoi genitori, portarlo via dal suo dolore o trasformarlo. Anche un sorriso, uno sguardo,
...certe volte si crea una situazione

Luisa - In genere ce la faccio a fare cantare tutti. I genitori lo fanno per i bambini, farebbero qualsiasi cosa per i bambini in queste situazioni. Io in un intervento cerco di farli rilassare, di farli suonare, di farli cantare una cosa che conoscono infatti hanno cantato FRA MARTINO, vado sul sicuro perché lo so che la conoscono, eppoi cerco di farli imparare una cosa nuova. Quando ho questa tipologia di gruppo, un un reparto, uso questa struttura, questo approccio. A noi non ci interessa la malattia, ci interessano le persone, e quando si crea un gruppo che collabora tutto insieme cerco di fare un po di tutto, di fare attività strumentale, improvvisazione ritmica (gesti -suono), di modo di fare un intervento vario.

Per me è importante che imparino una piccola canzone perché è come un regalo che gli faccio, diventa loro, la hanno imparata e possono decidere se cantarla o no quando sono andata via.

Siccome si lavora su altri livelli, si comunica attraverso le proprie energie. Se te sei depresso è vero che può fare da terapia per il musicista. Perché la musica mette in moto nuove energie che fanno da terapia, sia per chi suona che per chi ascolta.

Te stai suonando per migliorare la qualità della vita delle persone, allora indirettamente la positività di questo scopo ha un ritorno benefico anche su te stesso e quindi se sei depresso, questa azione diventa terapeutica, se sei nervoso, scarichi, se sei ansioso ti rilassi.

Calmare, addormentare, far scoprire, sorprendere, divertire, distrarre.

Per ogni situazione c’è uno scopo preciso.

Ale - questa è una disciplina nuova che deve venire fuori.

Tutti i musicisti hanno una formazione musicale al livello di conservatorio, solo 2 non hanno studiato musica formalmente.

A - C’era simone, che non aveva studiato musica e che uscì primo del corso, io credo che dipenda da un altro tipo di doti caratteriali, di creatività.

Ale - lavoro come guardia medica e faccio sostituzioni ai medici di base e alla ASL. Sono orientato sulla medicina generale.

CP- ci sono mattine che ti va piu o meno di venire a suonare?

S- si ... dipende dalla stanchezza, da come sto, fisicamente, ma anche tanto psicologicamente. Se uno non è tanto disposto a essere un vetro, di far passare quello che succede, allora sei un muro su cui tutto rimbalza. Il mio lavoro rispecchia anche la mia vita,

CP- vi va di andare in reparto stamani?

P- stamani abbastanza, a volte non tanto

C- io sono stanca oggi, dopo tutte le ore che ho fatto ieri

Io stamattina ho mangiato due uova, e prendo il caffellatte con I biscotti. Se non mangio per bene quando vengo a suonare qui casco per terra perché è lo stress da un punto di vista fisico e mentale. Si carburà meglio. Poi contano anche le ore di sonno.
Fisicamente 3, oggi un po' a terra, ho il mal di gola e non riesco a cantare.

S- adesso bene, ma stamani sono arrivata stanca e ho avuto dei problemi con gli strumentini, alcuni mi si sono rotti e c'era molta confusione... bambini che piangevano.

In questo reparto devono aspettare prima di farsi la radiografia e a volte non devono bere o mangiare per diverse ore e così si agitano, specialmente se sono più piccoli.

quest è il massimo dell'interazione possibile. Il dottore ti chiama per fare supporto alle terapie. Se conosci e ti conoscono ti chiamano e sei integrato. Il dottore ha suonato e ha partecipato all'intervento.

Il Tucci per esempio quando puoi si butta, canta, altri dottori magari un po' meno. Sono in minoranza i dottori che vengono coinvolti e si lasciano coinvolgere. Dipende molto dalla situazione che c'è.

quest è il massimo dell'interazione possibile. Il dottore ti chiama per fare supporto alle terapie. Se conosci e ti conoscono ti chiamano e sei integrato. Il dottore ha suonato e ha partecipato all'intervento.

Un dottore gli richiede di passare dal pronto soccorso perché c'è una situazione delicata. Un bambino di 9 anni con i due genitori in una stanza che piange e non vuole accettare di essere ricoverato per una notte, per una piccola operazione chirurgica. Il dottore chiede al musicista di suonare per far calmare il bambino.

Inizia a cantare sulla porta della stanza, alla fiera dell'est, calmo, lento, piano. Chiama il babbo e gli da una bacchetta e inizia ad accompagnare il canto, un canto pop e cantano insieme. Si avvicinano al bambino che ha smesso di piangere e guarda con sospetto il musicista. Da il bastone della pioggia al bambino dopo avere dimostrato come si usa. Il bambino si concentra sullo strumento e inizia a suonare con il babbo e il musicista. Madre piange. Cantano altre due canzoni e il musicista esce. Il bambino ricomincia a piangere.

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P 1: TRANSCRIPT audio files 22 MAY .doc - 1:6 [Quello che voglio dire è che a...]. (28:28) (Super)
Codes: [Coming in - coming out]

DATA SOURCE UNACCESSIBLE!: C:\Documents and Settings\Costanza\Desktop\TRANSCRIPT audio files 22 MAY .doc
P 1: TRANSCRIPT audio files 22 MAY .doc - 1:7 [AP - poi invece c'è gente come...]. (30:30) (Super)
Codes: [Coming in - coming out]

DATA SOURCE UNACCESSIBLE!: C:\Documents and Settings\Costanza\Desktop\TRANSCRIPT audio files 22 MAY .doc
P 2: MUSICIANS.doc - 2:268 [CP- se sei più stanca cosa succede se arriv...]. (1294:1297) (Super)
Codes: [Coming in - coming out]

P 2: MUSICIANS.doc - 2:41 [C- Sono 5 anni che vengo qui a suonare. Molto tempo. Conosco turn e...]. (217:217) (Super)
Codes: [Contract]

P 2: MUSICIANS.doc - 2:157 [C -si certo, un po si, certe cose vengono automatiche. Io ho sempre suonato...]. (372:373) (Super)
Codes: [Contract]

P 2: MUSICIANS.doc - 2:319 [A - abbiamo fatto un improvvis...]. (1714:1721) (Super)
Codes: [Contract] [Timetable changes]

P 2: MUSICIANS.doc - 2:344 [A - il contratto è un co co co...]. (1935:1936) (Super)
Codes: [Contract]

P 2: MUSICIANS.doc - 2:110 [Se uno fa 4 ore, verso la fine...]. (564:564) (Super)
Codes: [Coping strategies]

P 2: MUSICIANS.doc - 2:220 [CP - per te suonare è un momento...]. (1005:1007) (Super)
Codes: [Coping strategies]

Code: Contract (3-0)

Code: Coping strategies (3-0)

A - no, fa parte del rimbors...
Sono stanca, cantare ininterrottamente per me è faticissimo. Se suono mi rilasso, mi viene molto più naturale, sono nel mio... introduco spesso le canzoni con lo strumento, senza cantare, perché mentre suono mi ripasso lo parole. Prima suonavo di più il violino, magari nei corridoi. Però mi sembra che la musica classica è vista un po' strana... mi sembra quasi che qui la receppano come con una cosa triste e allora ho smesso. [Q Paola]. Secondo me in base a quello che trovi devi adattarti. Alla TIN suono musica classica.

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Code: Diaries (2-0)

P 1: TRANSCRIPT audio files 22 MAY .doc - 1:1 [MUSICIANS' DIARIES Pietro ..] (9:16) (Super)
Codes: [Diaries]

DATA SOURCE UNACCESSIBLE: C:\Documents and Settings\Costanza\Desktop\TRANSCRIPT audio files 22 MAY .doc

Codes: [Diaries]

MUSICIANS' DIARIES
Pietro li seleziona e li consegna alla Fondazione meyer. L'Atehneum conserva tutti gli originali. In teoria sarebbero settimanali ma in pratica i musicisti li consegnano in scadenze meno regolari.
Ogni anno l'Atehneum produce una relazione di fine anno con una selezione dei diari.

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Code: Disinfecting instruments (2-0)

P 2: MUSICIANS.doc - 2:162 [CP - come ti riposi tra un inter..] (729:731) (Super)
Codes: [Disinfecting instruments]

CP - come ti riposi tra un intervento e un altro?
C - vengo qui nella stanza, disinfecto gli strumenti, gia passano 10 minuti, poi tomo in reparto e ricomincio.

P 2: MUSICIANS.doc - 2:52 [DISINFETTARE STRUMENTI - lo fa..] (290:290) (Super)
Codes: [Disinfecting instruments]

DISINFETTARE STRUMENTI - lo facciamo sempre, a volte anche tra stanza e stanza quando siamo agli infettivi.

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Code: Educational aspects - unintended (5-0)

P 2: MUSICIANS.doc - 2:208 [io come tendenza uso pin gli o..] (944:944) (Super)
Codes: [Educational aspects - unintended] [Percussion instruments - self made]

io come tendenza uso più gli oggetti sonori perché, il canto per me è difficile in italiano. La musica si fa ma non spesso, perché loro ascoltano ma non partecipano, invece con gli oggetti, diventano protagonisti e possono scaricare la tensione. Eppoi imparrano a usare degli strumenti che poi possono anche usare a casa [selezione di oggetti sonori che fa con materiali di casa]

P 2: MUSICIANS.doc - 2:236 [Fa vedere come si usa lo strum..] (1090:1090) (Super)
Codes: [Educational aspects - unintended]

Fa vedere come si usa lo strumento, come si smonna l'archetto - didattico.

P 2: MUSICIANS.doc - 2:99 [Per un 12 enne magari lo strum..] (522:522) (Super)
Codes: [Educational aspects - unintended]

Per un 12 enne magari lo strumento è più adatto. Magari lo conoscono ma non l'hanno mai visto così da vicino.

P 2: MUSICIANS.doc - 2:62 [P- il punto è che vai lì con l..] (339:339) (Super)
Codes: [Educational aspects - unintended]

P- il punto è che vai lì con il violino, la chitarra e anche se non suoni proprio lo stile di musica che ascoltano, è comunque un esperienza per loro. Vedono da vicino uno strumento che magari non conoscono e sentono il suono così da vicino.

P 2: MUSICIANS.doc - 2:155 [Per me è importante che impari..] (154:154) (Super)
Codes: [Educational aspects - unintended]

Per me è importante che imparino una piccola canzone perché è come un regalo che gli faccio, diventa loro, la hanno imparata e possono decidere se cantarla o no quando sono andata via.

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Code: Emotional implications in the job (21-0)
Qui ci sono situazioni brutte. Una volta un bambino era in fin di vita e io sono uscita, non ce l'ho fatta a rimanere. Magari c'è chi ci rimane.

Comunque questo è un lavoro di grandissimo impegno psicofisico, come lavoro. E' teso, è faticoso. Specialmente da un punto di vista psicologico, perché devi entrare in relazione con il bambino, con i genitori, con il personale, quello che c'è intorno, cogliere le emozioni, gli stati d'animo e poi riprocessarli velocissimo, elaborare tutte queste informazioni e selezionare al musico adatta.

Luca ha detto che può farlo fino a 50 anni max e poi basta! [tide]

Io stamattina ho mangiato due uova, e prendo il caffellatte con i biscotti. Se non mangio per bene quando vengo a suonare qui casco per terra perché a lo stress da un punto di vista fisico e mentale. Si carburà meglio. Poi contano anche le ore di sonno.

Marta non posso fare a meno di immedesimarmi nella prospettiva di una madre e. Specialmente quando suono in ceri reparti (ten e rianimazione) mi sento davvero triste quando vedo le madri e mi sento male.

Un bambino alle ustioni mi ha mandato una lettera ringraziandomi per essergli stato accanto in un periodo così difficile. Questo bambino piangeva sempre, ma nella lettera ha scritto che anche se piangeva, ascoltava la musica e questo lo aveva aiutato.

C' tantissime volte che arrivo male, perché ho litigato con qualcuno, mi sono alzata male, e dico `maremmana, stamattina proprio non ci vorrei andare' e a volte succede che arrivo nel parcheggio e dico 'oggi non ce la posso fare' e torno a casa. Quello che voglio dire è che al dì la do come arrivi, che a volte arrivi proprio male emotivamente, stanco, quasi variabile, pero poi dopo esci tutto in un altro modo. A volte invece arrivi molto bene, poi vedo delle situazioni molto brutte e quindi esci molto male e ci sta pure molto male dopo.
Per me è un regalo molto speciale che faccio al bambino. La felicità che vedo nei loro occhi mi ripaga di tutto il tempo che mi ci è voluto per imparare la canzone.

Cosi io ho iniziato dalla parte più facile e ho visto un infermiere che piangeva e che mi ha detto di non andare verso di loro, e ho anche visto il padre che sosteneva la madre. E mi sono ritirata immediatamente. Io non me l'aspettavo. E in quel momento stava suonando musica allegra. Ed ero distrutta. Per fortuna ho incontrato Luca che ha molta esperienza e abbiamo parlato a lungo e mi sono sentita meglio.

Cosi io ho iniziato dalla parte più facile e ho visto un infermiere che piangeva e che mi ha detto di non andare verso di loro, e ho anche visto il padre che sosteneva la madre. E mi sono ritirata immediatamente. Io non me l'aspettavo. E in quel momento stava suonando musica allegra. Ed ero distrutta. Per fortuna ho incontrato Luca che ha molta esperienza e abbiamo parlato a lungo e mi sono sentita meglio.

Quasi sempre succede che sono distrutta fisicamente ma psicologicamente molto su. Mi succede spesso così.

Una volta sono uscita che mi sentivo depressa perché un infermiera della TIT era stata sgarbata. Senza a tardar, in genere con i bambini va tutto bene e partecipano, indipendentemente dal fatto che sono malati.

AP - poi invece c'è gente che cerca male e non vorrebbe venire qui perché quando esce di qui è rilassato. Per lui è tale la soddisfazione di suonare e di vedere rispondere il bambino che veramente lo appaga.

Cinzia - Dopo un anno o due che suonavo io gli dissi che dovevo stare a casa almeno un mese perché non ce la facevo più. Tutte le volte che arrivavo qui mi veniva l'angoscia. Sentivo i bambini piangere e mi veniva un senso di rigetto, non ce la facevo ad entrare. Marta - C'è stato un periodo che anche io non sentivo altro che piangere, non mi sembrava che ci fosse altro suono che quello appena entravo e mi è costata molta fatica. A me colpisce più lo stato d'animo dei genitori, perché un bambino malato non sa neanche cosa ha ma il genitore si e quindi lo leggi di più nei suoi occhi e quindi essendo genitore è quello che mi colpisce di più.

A - La stanchezza a un po anche come ti senti dentro, credo che conti tanto anche l'aspetto psicosomatico. ...insomma quando è morto il mio babbo io sono stato male. Insonnia tutto è gratificante, ma se poi non ce la fai ....

Cinzia - Dopo un anno o due che suonavo io gli dissi che dovevo stare a casa almeno un mese perché non ce la facevo più. Tutte le volte che arrivavo qui mi veniva l'angoscia. Sentivo i bambini piangere e mi veniva un senso di rigetto, non ce la facevo ad entrare. Marta - C'è stato un periodo che anche io non sentivo altro che piangere, non mi sembrava che ci fosse altro suono che quello appena entravo e mi è costata molta fatica. A me colpisce più lo stato d'animo dei genitori, perché un bambino malato non sa neanche cosa ha ma il genitore si e quindi lo leggi di più nei suoi occhi e quindi essendo genitore è quello che mi colpisce di più.

CP - voi non avete delle tecniche per proteggervi?

C- si, ma a volte sei stanco e ti viene tutto addosso.

Faceavo due volte alla settimana, ma ho cercato di squeeze three days into 2. It's a bit trying. When it's hot is hard.

CP - non avete uno psicologo nel vostro gruppo che può aiutare i musicisti in una sorta di debriefing after stressful interventions?
Nella mia esperienza si tenevano riunioni mensili a cui era obbligatorio partecipare. Le riunioni seguivano i principi dell'attitudinali healing, pur essendo totalmente laiche, c'era un livello di spiritualità che faceva riflettere sulla pratica musicale a un livello più profondo che riguardava anche le proprie motivazioni nell'intreprendere un lavoro simile. In quel caso la musica era limitata al reparto di oncoematologia, nel quale regolarmente ci si trovava davanti a cure palliative o al tema della morte.

AP - no, ma questo è un progetto che andrebbe portato avanti, in realtà non si è mai fatto anche soppervalutando la capacità dei musicisti di assorbire queste esperienze.

C - sicuramente meglio di prima, carica energetica eppoi a me cantare piace. Per me è stata proprio una scoperta, specialmente durante il corso e adesso mi fa proprio piacere, fisicamente, mi sento più leggera quando canto.

C: - come ti senti ad andare a oncoematologia?
C - in genere io ci vado sempre lunedì quando mangiano che non è il massimo come orario, quindi, boh...

C: - che cosa ci vuole per acc.
C - [ride] eh, ci vogliono tante cose! Ci vuole lo sguardo, ci vuole l'intenzione, la decisione di volerlo acciappare, spesso se sei indeciso te, anche lui rimane indeciso. Magari capita che non voglia partecipare o di disturbalo. Invece se ti buttì, magari agganciando prima i genitori, il bambino timido si lascia andare e si fida se vede che partecipano.

[recurring theme - AGGANCIARE BAMBINO PRIMA DELLA PROCEDURA]

56.00 tape 20046 - experience told by the musician to be added to the two I have observed and the comments from P and A.

C: - come ti senti ad andare a oncoematologia?
C - [Con la bambina X è andata bene] perche ho stabilito la relazione con le nella sala d'aspetto e così lei è rimasta concentrata sulla musica e il prelivo è stato piuttosto tranquillo. Con la bambina X è andata bene, perché ho stabilito la relazione con lei nella sala d'aspetto e così lei ha continuato a concentrarsi sulla musica e il prelivo è stato piuttosto tranquillo. Con la bambina X è andata bene, perché ho stabilito la relazione con lei nella sala d'aspetto e così lei ha continuato a concentrarsi sulla musica e il prelivo è stato piuttosto tranquillo.

C: - come ti senti dopo aver suonato?
C - sicuramente meglio di prima, carica energetica eppoi a me cantare piace. Per me è stata proprio una scoperta, specialmente durante il corso e adesso mi fa proprio piacere, fisicamente, mi sento più leggera quando canto.

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[recurring theme - AGGANCIARE BAMBINO PRIMA DELLA PROCEDURA]

56.00 tape 20046 - experience told by the musician to be added to the two I have observed and the comments from P and A.

C: - come ti senti dopo aver suonato?
C - sicuramente meglio di prima, carica energetica eppoi a me cantare piace. Per me è stata proprio una scoperta, specialmente durante il corso e adesso mi fa proprio piacere, fisicamente, mi sento più leggera quando canto.

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Prima preferivo suonare con bambini più piccoli perché è più facile entrare nella dinamica del gioco [Bruna insegna musica nelle scuole elementari] che nei problemi di un adolescente. Ora ultimamente, mi piace anche lavorare con i ragazzi perché se trovi il canale per entrare in contatto con loro è più divertente perché hanno più capacità.

Con noi generalmente sono i bambini che agiscono su di noi, sono responsabili di quello che stanno facendo. Io potevo anche andare via e loro avrebbero continuato a suonare da soli. Con la musica sono più partecipi che non con il clown. La musica è un tramite che mette in relazione anche i bambini con i genitori.

Marco ha una magia. Appena entra lui, coinvolge tutti quanti, anche se ci sono 20 persone tutti suonano, specialmente Marco è proprio magico. Marco usa soprattutto oggetti sonori, specialmente se ci sono tante persone lui coinvolge tutti e tutti suonano insieme. ... Anche con gli anziani lui riesce a coinvolgere tutti, non capisco come fa... magari lui è magico per davvero. Io vorrei capire da dove viene questa magia?

Bruna è molto ricca di oggetti sonori e li inventa ed è molto interessante. Luisa è molto brava perché lavora da tanto tempo con i bambini e quindi ha un repertorio infinito.

L'esperienza è tanto. Adesso sono 4 milioni di esperienze, tutte le settimane. Si copre un bel range di situazioni vissute.

Per me questo è fondamentale. C'è la formazione di base poi ognuno fa le proprie scelte. Qualcuno ritiene che noi non siamo juboke, non possiamo soddisfare sempre le richieste. Però io ho sperimentato che andare incontro alle esigenze e gusti delle persone aumenta la riuscita degli interventi e la loro qualità e risultato. Suonando la musica che loro conoscono. Magari un giorno vai a chiedere per caso al bambino che canzoni ascolta e poi magari la prossima volta la risuoni.

L'esperienza è tanto. Adesso sono 4 anni di esperienza, tutte le settimane. Si copre un bel range di situazioni vissute.
C- si, specialmente in alcune fasce di età, specialmente per quelli fino ai 6 anni.

Lo so che queste canzoni sono un po' sputtanate, sono sulle pubblicità, ma i bambini le sanno e così la cantano, le sanno tutte.

Grande interazione con lo staff, nurses and doctors. Tutti lo conoscono e gli richiedono canzoni.

[she ask the nurse about the situation and where to play - not all musicians does this, musicians from 2 course all ask and are very much by the book]

La situazione none particolarmente tesa. Tutti lo conoscono e gli richiedono canzoni.

[she take a week off from the hospital]

N- una persona voleva fare 7 ore al giorno... Luca e io volevamo andare a vedere la sua settima ora.

Il caldo mi ha dato noia stamani ai prelievi. C'era troppa gente, una vera bolgia! È stata proprio dura li.

Io faccio 7 ore settimanali. Sono disponibili a fare di più. Fare 4 ore insieme a un po' pesante. Vediamo anche se mi sento domani.
Poi lo sai cosa è stato, sono stata ferma una settimana per l'influenza e riprendere il ritmo su certe canzoni è difficile, perché sono alte e non ci arrivo con la voce. Prima di fare una figuraccia evito di cantarla. Magari le canzoni più acute non le ho fatte. Oggi era la prima volta che tornavo dopo due settimane, perdi un po il ritmo.

P 2: MUSICIANS.doc - 2:89 [P- suonare in due è più facile...] (474:475) (Super)
Codes: [Fatigue]

P- suonare in due è più facile ma si copre meno reparti.
Poi a quest'ora non ho più voce. Anche se non canto molto, mi va via lo stesso.

P 2: MUSICIANS.doc - 2:324 [...nel caso di Lorenzo, io avr...] (1752:1752) (Super)
Codes: [Fatigue]

...nel caso di Lorenzo, io avrei dato il mailaino al suo babbo, e se ci fossero stati solo loro, Lorenzo si sarebbe aperto. Non sono rimasta perché faceva troppo caldo e c'era troppa confusione.

P 2: MUSICIANS.doc - 2:311 [CP - ti senti bene? Mi sembra...] (1648:1650) (Super)
Codes: [Fatigue]

CP - ti senti bene? Mi sembra che stai per svenire
S - sì... mi sento bene... forse un po debole [fa caldo, è mattina]

P 2: MUSICIANS.doc - 2:267 [N-ieri quando sono tornata a...] (1288:1293) (Super)
Codes: [Fatigue]

N-ieri quando sono tornata a casa dopo l'ospedale ho dormito un ora e mezzo,... ieri ero tesa, emozionata, quando sono entrata nel reparto, ma quando tomo a casa me ne rendo conto che non ce la faccio

CP - è più faticoso suonare qui o in teatro?
N - sì, sicuramente più stancante qua. In teatro ho il mio leggio e non devo fare altro che suonare. Qui devo essere molto su per tirare su gli altri. Se mi sento già invece non funziona.

P 2: MUSICIANS.doc - 2:333 [P - per me la mattina è terrib...] (1839:1840) (Super)
Codes: [Fatigue]

P - per me la mattina è terribile... preferirei andare a spazzare la strada, così non penso a niente.
La settimana prossima non ci sono perché andiamo tutti a inaugurare uno spazio dello spettro al nuovo Meyer. Pietro ci ha detto di dare l'aria sulla quarta corda...

Codes: [Emotional implications in the job] [Fatigue]

A - La stanchezza è un po anche come ti senti dentro, credo che conti tanto anche l'aspetto psicosomatico. ...insomma quando è morto il mio babbo io sono stato male. Insomma tutto è gratificante, ma se poi non ce la fai...

Codes: [Fatigue]

P- mi sento stanca. Una mattina così mi distrugge fisicamente. Psicologicamente mi sento bene.

P 2: MUSICIANS.doc - 2:209 [Ovviamente faccio un po meno, ..] (948:948) (Super)
Codes: [Fatigue] [Musicians' busy lives]

Ovviamente faccio un po meno, perché sono stanca. Oggi ho lavorato a geriatricia per 2 ore e adesso stiamo facendo Wagner al teatro e sono molto stanca. La scorsa settimana non sono andata venire.

P 2: MUSICIANS.doc - 2:278 [Oggi mi sento distrutto, non h...] (1374:1379) (Super)
Codes: [Fatigue]

Oggi mi sento distrutto, non ho dormito per niente. I bambini sono stati svegli tutta la notte. Caterina (3 anni) voleva dormire con noi. Sono distrutto.

L'importante è che mangi bene. Se mangio male mi viene la fame [stanco visibilmente]

P 2: MUSICIANS.doc - 2:326 [N - si, mi sono svegliata. Sta...] (1765:1770) (Super)
Codes: [Fatigue]

N - si, mi sono svegliata. Stamattina sono venuta solo per dovere perché ero molto stanca.
CP - puoi chiedere un altro orario?

N - io vorrei chiedere una riduzione. Anche Marco non ce la fa a coprire tutto il suo orario [il problema per la Cooperativa è che hanno troppi richieste e non abbastanza musicisti - connection with BURN OUT issue]

P 2: MUSICIANS.doc - 2:258 [Molto stanca. She has been plas.] (1237:1239) (Super)
Codes: [Fatigue] [Musicians' busy lives]

Molto stanca. She has been playing until midnight, with the orchestra as they are rehearsing Wagner. Now she has been in the ward since 8.

N - I like this time, even if it’s early, because I am sure I can make it. My job is odd, it changes time every week, but with this time I am sure I can make it.

P 2: MUSICIANS.doc - 2:176 [Quando mi fermo crollo ! martedì..] (799:799) (Super)
Codes: [Fatigue] [Musicians’ busy lives]

Quando mi fermo crollo ! martedì, mercoledì e venerdì, vedo poco la mia bambina. Mi dispiace, ma come si fa, si deve anche lavorare.

P 2: MUSICIANS.doc - 2:282 [Ale - si , ci sono bambini più..] (1400:1402) (Super)
Codes: [Fatigue]

Ale - si, ci sono bambini più o meno relazionati. A volte sono più stanca e le cose diventano più faticose, più strascicate. Perdo la concentrazione, magari sto con la voce, sbaglio gli accordi...
Se dovessi fare altre due ore non ce la farei !
E’ un lavoro molto impegnativo, sia fisicamente che psicologicamente, molto pesante, più psicologicamente che fisicamente.

Code: Favourite ward/waiting room {4-0}

Codes: [Favourite ward/waiting room]

CP - ci sono dei reparti che preferisci?

P 2: MUSICIANS.doc - 2:44 [P- non è nemmeno un reparto ch..] (227:227) (Super)
Codes: [Favourite ward/waiting room]

P- non è nemmeno un reparto che mi sta particolarmente simpatico (Pediatria C)

P 2: MUSICIANS.doc - 2:226 [N- dove c’è gente. TIN non mi ..] (1046:1047) (Super)
Codes: [Favourite ward/waiting room]

N- dove c’è gente. TIN non mi piace. Perché i bambini dormono, sono nell’in incubatrice e non posso avere nessuna interazione o risposta. Eppoi hai visto, è un sacco di rumore. Eppoi ho visto molte di correggi e volevo smetter con questa attività.
Quando entro, come sempre, anche quella volta ho chiesto all’infermiere e lui mi ha detto si, si, perché era stressato e mi ha detto da sinistra c’è una situazione grave e a destra meno. Così io ho iniziato dalla parte più facile e ho visto un infermiere che piangeva e che mi ha detto di non andare verso di loro, e ho anche visto il padre che sosteneva la madre. E mi sono ritirati immediatamente. Io non me l’aspettavo. E in quel momento stava suonando musica allegra. Ed ero distrutta. Per fortuna ho incontrato Luca che ha molta esperienza e abbiamo parlato a lungo e mi sono sentita meglio.

P 2: MUSICIANS.doc - 2:90 [CP- ci sono dei reparti che pr..] (476:479) (Super)
Codes: [Favourite ward/waiting room]

CP- ci sono dei reparti che preferisci?

P 2: MUSICIANS.doc - 2:20 [Adesso devo andare a suonare a..] (107:107) (Super)
Codes: [Hospital time]

Adesso devo andare a suonare a oncologia perché senno dopo arriva il pranzo.

Code: Impact of personal life in the job {1-0}

294
CP - il fatto di avere 3 figli influisce sul tuo modo di interagire?

C - sì, per capire i gusti dei loro coetanei.

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**Code:** IMPROVISATION - Lyric substitution (2-0)

Te stai suonando per migliorare la qualità della vita delle persone, allora indirettamente la positività di questo scopo ha un ritorno benefico anche su te stesso e quindi se sei depresso, questa azione diventa terapeutica, se sei nervoso, scarschi, se sei ansioso ti rilassi.

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**Code:** IMPROVISATIONs (1-0)

Gli strumentini vengono usati come accompagnamento ritmico e non come c'è stato insegnato anche perché il tempo che può impiegare in una relazione attraverso gli strumentini è limitato molto dall'età del bambino. Se sono troppo piccoli non è il caso perché dopo poco si stufano. Con quelli più grandi, bisogna fare dei ritmi interessanti perché altrimenti è penoso.

TEORIA

Integrazione - il bambino fa 1 e io faccio 2
Opposizione - un bambino batte X e io batto Y oppure batter piano e io forte
Ignorare - il bambino fa una cosa e io ignoro il suo stimolo e io ne introduco un altro, non deve guidare lui.
Questo è molto vicino alla musicoterapia. Però se gli strumenti li usi così è noioso e lo puoi solo fare con bambini un po più grandi. In genere ci dicono di non avere fretta nelle relazione musicale, prendere il tempo che biologicamente serve.

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**Code:** Ingredients for a successful intervention (10-0)

CP - che cosa determina l'andamento di un intervento, il suo successo?

SUCCESS of the INTERVENTION - reasons
C - uno sicuramente è come sei te in quel momento. Io musicista devo essere capace in poco tempo di rendermi conto della situazione che c'è.
Per esempio, nella prima stanza di pediatria, mi sono accorta che avrebbero partecipato tutti allora è chiaro che distribuisco gli strumenti a far situazione si cerca da sola. Se invece provo a dare uno strumento e quello non fa niente, magari lo dà a un altro bambino e questo è timido, allora devi essere te capace di aggregarti comunque, o cantando o inventando delle cose. Siamo noi principalmente che determiniamo l'andamento dell'intervento. Poi c'è anche il bambino che sta male e non se la sente di partecipare o del genitore che è particolarmente preoccupato e va via appena arrivi te.

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**Code:** Cosa determina l'efficacia dell'intervento - presenza del genitore è fondamentale.

SUCCESS dell'intervento: distrazione dal dolore e dall'ansia

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**Code:** Successo dell'intervento: distrazione dal dolore e dall'ansia
MUSICA E PROCEDURE - aggancio pre intervento (same quote as P)
Per esempio, la bambina del prevlievo, si è calmata. Si è calmata perché è stata distratta dal dolore e dalla procedura, arriva un altro stimolo visivo e sonoro, effetti fisiologici della musica che modula ansia e depressione. Se te agganci la bambina, da 5 a 10 minuti prima, fuori eppoi entra dentro allora ha tempo di scaricare le angoscie prima di entrare e quando entra si è scordata della preoccupazione invece di essere entrata in una spirale dalla quale è difficile farla ritornare giù. E' un po come quando c'è un'operazione, la sedazione va fatta prima, non si può fare mentre ti stanno tagliando. [ride].

P 2: MUSICIANS.doc - 2:111 [Ci vuole una grande osservazione.] (569:569) (Super)
Ci vuole una grande osservazione e un grande ascolto. Osservazione di tutto quello che fanno, non verbale, tutto quello che viene fatto non è casuale. Bisogna osservare il body language e facial expressions e interpretarlo. Ascoltare quello che possono dire. Cercare con l'empatia e con l'intuizione di interpretare il loro bisogno al momento.

P 2: MUSICIANS.doc - 2:147 [CP - E' importante un appoggio fisico, di posizione, di distanza, visivo, di comunicazione non verbale, e la musica che posizione occupa?]
A- la musica come pertinenza del repertorio, pertinenza di intensità (volumi), pertinenza degli strumenti sonori (adeguati all'eta) pertinenza dell'utilizzo degli oggetti sonori, dell'ergonomia degli oggetti sonori, adeguati all'eta del bambino. Pertinenza della modalità di intervento

P 2: MUSICIANS.doc - 2:50 [CP- ci sono altre cose che hanno contribuito al funzionamento?]
P- la partecipazione dei genitori, che in questo reparto è un po più difficile. I bambini erano tranquilli, ascoltavano, erano interessati. Quello ti arriva subito.

P 2: MUSICIANS.doc - 2:112 [La prima impressione è quella .] (575:576) (Super)
La prima impressione è quella che conta. Già dagli sguardi si intuisce chi è interessato e chi no.
Io sono uno che deve stare attento alla voce, perché ho un po di raucedine cronica e tendo a cantare un po piano. Un fatto cehe mi puo condizionare è quello di cantare troppo piano, quando dovrei invece cantare più forte. Così la gente non sente e la perdo. Insomma calibrare l'intensità dei suoni.

Successo intervento:
collaborazione
sinergia
facilitazione

P 2: MUSICIANS.doc - 2:113 [Quello che puo condizionare l'.] (577:581) (Super)
Quello che può condizionare l'andamento dell'intervento:
1. l'intensità dei suoni,
2. la pertinenza del repertorio,
3. la pertinenza e la qualità degli strumenti.
4. come mi sento io.

Code: Lenght of intervention [35-0]

P 2: MUSICIANS.doc - 2:179 [INTERVENTO PEDIATRIA A (neuroc.)] (814:814) (Super)
INTERVENTO PEDIATRIA A (neurochirurgia - severe pathologies ward) [13] durata 20 min
DEA - [16] length 20 min.

INTERVENTION ONCOEMATOLOGY - Durata - 20 min.

INTERVENTION neurosurgery ward [28] length 30 min (Pietro)

INTERVENTO WATING ROOM CENTRAL DH [21] durata 30 min

INTERVENTO PEDIATRIA A [14] durata 35 min

INTERVENTION oncoematology DH ward [29] length 15 min (Pietro) [VIDEO]

INTERVENTO ONCOEMATOLOGIA - [7] durata (30 min)

INTERVENTO Pediatria A ward [32] durata 40 min

INTERVENTION - TIN Durata - 40 min.

INTERVENTION central DH ward [25] length 30 min (Pietro)

INTERVENTO Pediatria A ward [32] durata 30 min [Maria]

INTERVENTION Pediatria D infettivi - [39] Marta length 40 min. [VIDEO]
INTERVENTION Oncoematology - Cinzia length 50 min

INTERVENTION - NEUROSURGERY durata 15 min

INTERVENTION surgery waiting room [30] length 30 min (Pietro) [VIDEO]

INTERVENTO ONCOEMATOLOGIA - durata (30 min)

INTERVENTO ALLERGOLOGIA (sala d’aspetto) - durata 20 min

INTERVENTO Pediatria A ward [33] durata 15 min [Bruna]

INTERVENTO PRELIEVI [5] durata - 45 min

INTERVENTO DEA [12] durata 40 min

INTERVENTION Allergology waiting room - Cinzia length 20 min [VIDEO]

INTERVENTION METABOLISM related DH ward [23] length 35 min

INTERVENTION Pediatria B infetti - Cinzia e Marta length 40 min. [VIDEO]

PRELIEVI [5] durata - 45 min

INTERVENTO DEA [12] durata 40 min

INTERVENTION DEA Pietro [40] - [video] e il Portiere

INTERVENTO Pediatria A ward [33] durata 15 min [Bruna]

INTERVENTO PRELIEVI [5] durata - 45 min

INTERVENTO DEA [12] durata 40 min

INTERVENTION Allergology waiting room - Cinzia length 20 min [VIDEO]
INTERVENTION Chirurgia 2 lattanti [11] DURATA 1 ore

Codes: [Length of intervention]

INTERVENTION TIN [10] DURATA 15 min

P 2: MUSICIANS.doc - 2:320 [INTERVENTION Dismetabologia - ..] (1726:1726) (Super)
Codes: [Length of intervention]

INTERVENTO DEA [20] durata 40 min

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Code: Meeting the same child again [6-8]

P 2: MUSICIANS.doc - 2:275 [N- ho commesso due errori ! ho..] (1362:1362) (Super)
Codes: [Meeting the same child again] [Perception of their intervention]

N- ho commesso due errori ! ho usato troppi oggetti . Poi quel bambino quando mi ha visto ha spento il game boy e per me questa è una vera gioia vincere sul game boy....ma ci conosciammo, avevamo già suonato insieme 5 o 6 volte. Dopo mi sono accorta che dopo 2 o 3 minuti lui si è stufato e allora ho usato più strumenti, per non perderlo.

P 2: MUSICIANS.doc - 2:29 [S - not sure because in genera..] (158:159) (Super)
Codes: [Meeting the same child again]

S - not sure because in general in this ward children stay an average of 7 days. Sometimes I do meet them more than once. For example, there’s a child that I have met last week and that will have his operation tomorrow, so I’ll definitely meet him again on Monday. He really likes music and his mum asked me if we can come back. I am going to write this is in the book so that if someone has some spare time in the next few days, they can visit him.

P 2: MUSICIANS.doc - 2:262 [Ad allergologia c'è un bambino..] (1249:1253) (Super)
Codes: [Meeting the same child again] [Repertoire]

Ad allergologia c’è un bambino di 6 anni che sa come funziona l’intervento e spiega agli altri

Posso continuare sempre con la stessa cosa, ma sono stanca a volte [esprime un disagio]

P 2: MUSICIANS.doc - 2:259 [- a volte sono stanca ... maga] (1243:1243) (Super)
Codes: [Meeting the same child again]

- a volte sono stanca ... magari quando ho suonato tutto il giorno prima i... peggiora cose c'è ore la semina sono troppi. Specialmente qui, i bambini sono sempre gli stessi, ritornano e ritornano... e io non ce la faccio a cambiare repertorio tutte le volte.

P 2: MUSICIANS.doc - 2:260 [Per fare un intervento, bisogn..] (1244:1244) (Super)
Codes: [Meeting the same child again] [Preparing the musical intervention]

Per fare un intervento, bisogna studiare almeno 3 ore. Io mi sento un po a disagio a suonare sempre le stesse musiche....c'è chi lo fa ma io vorrei sapere come si fa a vedere sempre la stessa gente e suonare le stesse cose.

P 2: MUSICIANS.doc - 2:332 [P - si, con quella bambina e l.] (1825:1831) (Super)
Codes: [Meeting the same child again]

P - si, con quella bambina e il suo babbo abbiamo suonato molte volte insieme
CP - c'è un cambiamento, un evoluzione, nel modo di interagire musicalmente con una bambina se è da tanto tempo che la conosci?
P - per esempio questa era una situazione ottimale per fare cose con gli strumenti. In mezz'ora ho fatto solo una canzone.
CP - erano i gusti musicali dei bambini che vedi regolarmente?
P - no
CP - quante volte l'hai vista lei?
P - 4 o 5 volte... magari la vedo due volte di fila eppoi non la vedo più

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Code: Meetings [6-0]

P 2: MUSICIANS.doc - 2:334 [C - quando andare a fare cose ..] (1842:1849) (Super)
Codes: [Meetings]
C: - quando andate a fare cose extra vi danno dei rimborsi?
P: - a volte si, a volte no
C: - perché i musicisti non vogliono entrare nella cooperativa?
P: - ce lo chiesero quando successe quel caos, e allora non me la sentivo... poi non ci ho più pensato.
C: - è una gestione paritaria
P: - si, è molto rilassata, se io chiamo Marco e gli chiedo di stare a casa una settimana non c'è problema.
C: - ti fa piacere suonare per questo evento al nuovo Meyer?
P: - sì, anche perché non si suona mai musica classica insieme.

C: - vorrei sapere una cosa organizzativa e una più generale sulla musica
A- si dice sempre di incontrarsi ma non ce la facciamo ad incontrarci sistematicamente. Per me questo è un problema. Io l'ho detto molte volte che vorrei fare degli incontri, ma sembra difficile. Lo spirito di corpo c'è quando ci si vede. Tra noi siamo uniti.
Io credo che almeno un po' di volte al mese ci si dovrebbe incontrare per suonare, almeno in coppia. Ci sono delle difficoltà nel combinare gli orari di tutti, però io stamattina c'era Cinzia e così si potrebbe suonare insieme. E' più divertente e meno faticoso. [vorrebbe che l'associazione organizzasse gli orari per suonare insieme]
P 2: MUSICIANS.doc - 2:343 [C - ho saputo di questo corso ..] (1925:1929) (Super)
Codex: [Meetings]

DATA SOURCE UNACCESSIBLE!: C:\Documents and Settings\Costanza\Desktop\TRANSCRIPT audio files 22 MAY .doc
Codex: [Meetings] [Repertoire]
Pietro Perondi, ha proposto di fare un workshop tra noi e di proporre una canzone fatta in 10 modalità diverse. Ma tutti dicevano 'bravo, Bravo' e non c'era veramente una critica.
Io non mi sento in grado di essere critica.
P 2: MUSICIANS.doc - 2:177 [C - ho saputo di questo corso ..] (804:804) (Super)
Codex: [Meetings]

Le occasioni per vedersi tutti insieme non sono molto. Sarebbe bello avere dei momenti di scambio e lavorare insieme.
Codex: [Motivations]

Ero al pronto soccorso con mio figlio ed è arrivato Marco (un musicista) e ha cominciato a suonare e così l'atmosfera è proprio cambiata... questo è proprio utile, con la musica cambia tutto perché si rilassa. Quindi sono andata a chiedere se potevano fare la volontaria invece Marco mi ha detto con grande orgoglio 'noi siamo musicisti in ospedale di professione, bisogna fare il corso per un anno'. Ci ho pensato perché io lavoro nell'orchestra del maggio, ma vengono ad applaudire non per me, ma per il direttore. Manca il contatto diretto, ma qui ho un contatto diretto e controllare la direzione della musica.
a sono contenta, è un lavoro che mi piace... mi piace quello che lascio alle persone quando esco.

CP - e cosa lasci?

MOTIVATION and function of music
C - un po di spensieratezza, a un momento in cui pensano a quello che hanno, specialmente i bambini. Oggi non c'erano cose gravi, però a volte capita quello che sta male e riuscire a far partecipare una stanza, come è successo per due volte oggi, è una cosa un po' magica perché alla fine - è vero - è un quarto d'ora, però loro quel quarto d'ora li è stato un momento di pausa.

Code: Music as a liberating experience for Parents [7-0]

P 2: MUSICIANS.doc - 2:293 [Ale- allora qui c'è da fare un'...] (1526:1527) (Super)

Code: Music as a liberating experience for Parents

Ale- allora qui c'è da fare una considerazione. Hai visto quella ragazza grande che stava in piedi? Ha 19 anni e si chiama Celeste. Io ho fatto una canzone di Alex Britti, alla fine il mamma ha pianguto. Quello è un bene, è la tensione che si scarica, infatti mi hanno ringraziato. Insomma non è sempre negativo il piangere.


Code: Music as a liberating experience for Parents

CP - è il fatto che piangano, come lo senti?

C - io sono tranquilla.

CP - la finalità della musica è di far piangere?

C - di sciogliere comunque delle tensioni?

CP - attraverso il piangere?

C - anche

CP - è attraverso il riso?

C - anche. Pero... personalmente, se sento un a musica anche se non la collego a cose particolari, mi arriva a un canale che mi metto a piangere, mi commuovo, il fatto di sentirmi in sintonia con le cose, mi fa piangere, ma non vuol dire che sia particolarmente triste. Per dire anche alla TIN è successo. C'era una mamma a cui dovevano operare al bambino, e la madre piangeva, così l'infermiera che è passata le ha detto 'ti fa bene piangere, farla uscire queste lacrime'. Io lo vedo anche per me, teneri tanto queste lacrime alla fine appesantisce.

CP - e l'atmosfera si appesantisce?

C - no, poi ritorna, è un attimo, ti lasci andare fuori dalla maschera e poi ritorni.

CP - e per il bambino vedere la madre piangere?

C - è una cosa normale, come dire 'ti voglio bene' come è normale manifestare la preoccupazione invece di dire 'eh eh eh ' e tutti i versetti per cercare di estranerarsi sempre al cento per cento. Chiaro che se si li c'è della tensione ed è umano metterla in comune.

P 2: MUSICIANS.doc - 2:303 [C - per quello che ti posso dì..] (1602:1602) (Super)

Code: Music as a liberating experience for Parents

C - per quello che ti posso dire io, durante il corso ci hanno sempre detto che il piangere era un momento liberatorio. A me non mi è mai tornata questa cosa del piangere, ne la regola fissa di non parlare. E' chiaro che è meglio non parlare, perché la madre ha cominciato a raccontare la sua vita e io mi sono allontanata gentilmente.

P 2: MUSICIANS.doc - 2:232 [CP - Pietro mi ha detto che..] (1077:1077) (Super)

Code: Music as a liberating experience for Parents [Musicians' musical choice - reasons]
CP: Pietro mi ha detto che 'il corchio della Vita' fa piangere almeno il 90% delle mamme, e il lui usa questa canzone deliberatamente quando c'è una situazione di tensione e la madre sta bloccando il bambino, e così la madre generalmente inizia a piangere ed esce dalla stanza e così il bambino è sbloccato e così lui può interagire musicalmente con il bambino.

P 2: MUSICIANS.doc - 2:306 [Perché il musicista va in ospedale?] (1615:1618) (Super)
Codes: [Music as a liberating experience for Parents]

Perché il musicista va in ospedale? Per suscitare emozioni, che possono essere positive e negative, e così si liberano, perché il pianto è liberatorio.

Lei pensava che il signore avesse bisogno di piangere, e così ha fatto una canzone che ha ottenuto quel risultato.

spirito missionario di far tirare fuori le emozioni e decidere in che modo ma che dice che la genitrice voglia farlo - molto invasivo

P 2: MUSICIANS.doc - 2:32 (S- C'è un bambino piccolo, appena operato con la testa aperta. Ho iniziato a suonare, stando sulla porta e la nonna ha iniziato a piangere da morire, come sfogandosi. Una delle motivazioni della musica è anche quella di dare un'occasione per buttare fuori per sfogarsi. Ho aspettato un po' che si calmasse, pur continuando a suonare e poi sono entrata e sono andata dal bambino, lei l'ha lasciata fare perché non era convivibile, in quel momento aveva bisogno di un momento per se e di qualcuno che la distraesse il bambino. Io gli ho ripetuto quel momento per star male in pace. Io sono stata lì a suonare con il bambino, poi l'attito era passato e lei si è avvicinata e ha detto al bambino 'hai sentito che bella musica!'. Sai, il pianto fa bene, specie in certe situazioni, e lei mi ha sembrata più rilassata. Questo intervento mi è piaciuto molto più di questo.

Code: Music AS THERAPY (3-0)

P 2: MUSICIANS.doc - 2:242 [Il musicista deve creare armonia..] (648:648) (Super)
Codes: [Aims of the intervention] [Music AS THERAPY]

Il musicista deve creare armonia, quiete e non di aggiungere stress a un lavoro e a una situazione potenzialmente già sovraccaricate di stress. E' vero che non è musicoterapia quella che facciamo, ma se si raggiunge una finalità terapeutica ben venga.

P 2: MUSICIANS.doc - 2:136 [Quando la musica diventa supporto alle terapie allora la musica ha esplicitamente una finalità terapeutica che a quella di sciogliere l'ansia, la depressione, l'angoscia.

Code: MUSIC more effective than other interventions (4-0)

P 2: MUSICIANS.doc - 2:200 [CP- secondo te questo succede..] (897:900) (Super)
Codes: [Music with NON Italian children] [NON VERBAL communication - first impact]

C- per quello che ho visto io, il cane è un animale e suscita l'interesse e l'emozione più nel bambino che nell'adulto. Il clown coinvolge di più, ma è il clown in prima persona che agisce, te puoi partecipare al gioco del clown ma non sei in prima persona che fai qualcosa. Con noi generalmente sono i bambini che agiscono su di noi, sono responsabili di quello che stanno facendo. Io posso anche andare e loro avrebbero continuato a suonare da soli. Con la musica sono più partecipi che non con il clown. La musica è un tramite che mette in relazione anche i bambini con i genitori.

Code: Music with NON Italian children (4-0)

P 2: MUSICIANS.doc - 2:195 [C - loro ti dicono di fare come vuoi te.] (876:877) (Super)
Codes: [Music with NON Italian children] [NON VERBAL communication - first impact]

C- loro ti dicono di fare come vuoi te. Per esempio, prima, io mi stavo avvicinando al bambino e il babbo ha messo una sedia che era come nel mezzo, io non ho capito se voleva farmi sedere o se invece mi diceva di non avvicinarmi a suo figlio. Io non lo so. Lui non parlava italiano, e non ho capito cosa stava succedendo. La sedia cosa voleva dire?

Sotto entrata lì perché il babbo mi guardava e poi ballava sul letto, è chiaro che una canzone gliela fai, ma l'atteggiamento del babbo era strano. Se non parlano la tua lingua è difficile.
C'ho suonato anche nella stanza con i giochi. C'erano due bambini arabi, e li è più difficile suonare, non so molti canti arabi. Uso piuttosto le improvvisazioni con strumenti e vocalizzazioni.

C'era una famiglia albanese e ho cantato una canzone e la madre che era dentro cantava insieme a me. La sanno tutti questa canzone. A me l'ha insegnata una mammà violoncellista albanese, amica della Cinzia.

11 babbo ha cominciato a cantare una canzone nella loro lingua mentre suonavamo le calimbe.

CP - che differenza c'è tra suonare l'oboe e la chitarra.

S- la chitarra mi sostiene, e mi appoggia perché non ho una gran voce. Quando suono l'oboe ho in mente di fare qualcosa di bello professionalmente, perché lo posso fare perché è il mio strumento.

La chitarra ha dei vantaggi e degli svantaggi. Ti accompagna, ma ameno che non sei un chitarrista classico, certe musiche non le suoni. La chitarra è uno strumento più comune, il violino attira più attenzione, e curiosità che magari per la chitarra non c'è.

Ale- poi contano anche i gusti personali e l'estrema soggettività di quello che facciamo

Ale - poi contano anche i gusti personali e l'estrema soggettività di quello che facciamo

CP - che musica ascolti?

Ale - poca. A me piace il sound americano di bob Dylan, Cat stevens, Simon and garfunkel. Ogni tanto suono Gli 883, Zucchero, Ligabue, Bennato. Poi le mie ninnanannann le faccio anch'io!

CP - la musica che suoni insomma quando suoni Bennato [pesso] , ti piace quello che suoni, insomma è la tua musica, ti senti a tuo agio ...

P 2: MUSICIANS.doc - 2:2313 [S - si, mi piacciono quelle et.] (1675:1675) (Super) Codes: [Musical preferences - personal]

S - si, mi piacciono quelle etichette primi di tutto sono bellissime, come rime, come colori, come suoni, eppoi secondo me le parole che non capisci sono più magiche e varano bene anche per i ragazzi più grandi

CP - che musica ascolti ?
P. Mi piace di tutto, musica anni 30, jazz di allora, Elisa, Bocelli per i suoi testi, le canzoni tradizionali irlandesi, inglesi, la musica etnica in generale.

C. Più che altro classics, la radio, jazz, musica anni 30, jazz di allora, Elisa, Bocelli per i suoi testi, le canzoni tradizionali irlandesi, inglesi, la musica etnica in genere.

P 2: MUSICIANS.doc - 2:277 [CP - fai improvvisazioni con 1.1 (1369:1371) (Super)] (1369:1371) (Super)
Codes: [Musical preferences - personal] [Repertoire]

CP - fai improvvisazioni con la viola?


Codes: [Musical preferences - personal]

Ascolto qualsiasi tipo di musica, forse più jazz ma anche molta musica per bambini perché questo lavoro richiede costante aggiornamento.

Codes: [Musical preferences - personal]

CP - cosi questa è la tua tecnica per coinvolgere anche bambini più grandi? Musica etnica con parole di altre lingue

S. La uso spesso per la fascia più grande, perché a me non piace cantare la musica pop, leggera.

CP - perché?

S. Non trovo molto gusto nel suonare, non mi sembra che abbiano un grande valore musicale

I think she is missing the point here

CP - che musica ascolti?

S. Io ascolto musica classics, musica un po' straniera, jazz... Keith jarret, eppoi i led Zeppelin. La musica italiana in generale non mi piace tanto

P 2: MUSICIANS.doc - 2:301 [CP - suoni mai classica?] (1587:1593) (Super)
Codes: [Musical preferences - personal]

CP - suoni mai classica?

C. Si

CP - ti piace la musica classics?

C. Si, ma per esempio qui non è tanto apprezzata. In TN certi infermieri quando suono musica classics mi dicono che gli stressa

Code: Musicians' busy lives (12-0)

P 1: TRANSCRIPT audio files 22 MAY.doc - 1:10 [Imusicisti sono molto occupati.] (40:40) (Super)
Codes: [Musicians' busy lives]

DATA SOURCE UNACCESSIBLE!: C:\Documents and Settings\Costanza\Desktop\TRANSCRIPT audio files 22 MAY.doc

P 2: MUSICIANS.doc - 2:31 [S- questo lavoro è meraviglioso!] (165:165) (Super)
Codes: [Musicians' busy lives]

S. Questo lavoro è meraviglioso! Io faccio da un anno e mezzo. Ho interrotto un po' perché ho lavorato anche alle scuole mediche, supereroi, nidi, mi chiamo come esperta esterna. Faccio di tutto e di più.

P 2: MUSICIANS.doc - 2:17 [neche se all'atto pratico abbi] (58:58) (Super)
Codes: [Musicians' busy lives]

neche se all'atto pratico abbiamo tutti delle viste molto occupate. Specialmente chi lavora nel settore, queste settimane sono davvero una full immersion. Polo in estate magari è un po' più di disponibilità, per chi non ha figli, per chi ne ha invece diminuisce la disponibilità.

P 2: MUSICIANS.doc - 2:258 [Molto stanca. She has been pla..] (1237:1239) (Super)
Codes: [Fatigue] [Musicians' busy lives]

Molto stanca. She has been playing until midnight, with the orchestra as they are rehearsing Wagner. Now she has been in the ward since 8.
N - I like this time, even if it's early, because I am sure I can make it. My job is odd, it changes time every week, but with this time I am sure I can make it.

P 2: MUSICIANS.doc - 2:176 [Quando mi fermo crollo ! martedì, mercoledì e venerdì, vedo poco mia bambina. Mi dispiace, ma come si fa, si deve anche lavorare.]

Codes: [Fatigue] [Musicians' busy lives]

Imusicisti sono molto occupati, tra la vita familiare e quella lavorativa, in cui music in ospedale è solo una parte del loro lavoro anche perché economicamente è abbastanza interessante, che che ne diano alcuni.

P 2: MUSICIANS.doc - 2:209 [Ovviamente faccio un po meno, ..]

Codes: [Fatigue] [Musicians' busy lives]

Ovviamente faccio un po meno, perché sono stanca. Oggi ho lavorato a geriatria per 2 ore e adesso stiamo facendo Wagner al teatro e sono molto stanca. La scorsa settimana non sono potuta venire.

P 1: TRANSCRIPT audio files 22 MAY .doc - 1:17 [Le occasion per vedersi mail (54:54) (Super)]

DATA SOURCE UNACCESSIBLE!: C: \Documents and Settings\Costanza\Desktop\TRANSCRIPT audio files 22 MAY .doc

P 2: MUSICIANS.doc - 2:39 [C - Puoi venire con me a Scarperia ! (dopo una mattina passata all'ospedale, lei va a Scarperia e suonare per gli anziani).]

C - Puoi venire con me a Scarperia ! (dopo una mattina passata all'ospedale, lei va a Scarperia e suonare per gli anziani).

P 2: MUSICIANS.doc - 2:56 [C- mi sveglio alle 6.30 (ha 3 bambini)]

P- anche io perche entro presto (due giorni al Meyer e all'ospedale di Prato)

P 2: MUSICIANS.doc - 2:175 [C day today: 2 hours of music .1 (797:797) (Super)]

C day today: 2 hours of music in hospital in Pistoia (20 Km from Florence it takes an hour to travel), then 3 hours of music in this hospital, then rehearsal with the orchestra until midnight.

P 2: MUSICIANS.doc - 2:173 [Maria teaches in Montepulciano.] (791:791) (Super)

Maria teaches in Montepulciano 2 days a week. She stays there overnight. She also teaches in 2 other music school. She plays professionally in several orchestras. She plays in two different pediatic hospitals, and her life has changed since she has started playing.

Code: Musicians' musical choice - reasons {28-0}
L'aggressività viene scaricata da ritmi veloci e anche un'intensità molto forte. Questo fa parte di una esperienza personale che non di una formazione. Quello che ci a star insegnato nel corso, e che se un bambino è troppo rilassato si fa qualcosa di stimolante, mentre se èagitato si fa qualcosa di calmante. Però a volte con i bambini che piangono c'è una grande agitazione intorno. Non è proprio scontato che a livello di medici e infermieri. Magari, se un bambino piange arriva un infermiere mi prende questo strumento (un sonaglio fortissimo che lui suona per dimostrare) e intanto a suonarlo...ma questo è una bomba atomica suonata così, ma se inizi a suonarlo in modo diverto allora può funzionare.

P 2: MUSICIANS.doc - 2:137 [A- un musicista deve essere le...] (625:625) (Super)
Coden: [Musicians' musical choice - reasons] [Perception of their intervention]

A- un musicista deve essere leggero come il vento, deve essere sempre molto discreto, non invadere gli spazi, senso fa l'effetto contrario. Quando c'era il bambino che piangeva, sono uscito, ma la mamma cantava e io sono rimasto per valorizzare il coinvolgimento della mamma e il bimbo si è anche calmato vedendo la madre che cantava.

P 2: MUSICIANS.doc - 2:239 [CP - Quando sei entrata hai suonato un... (1111:1113) (Super)
Coden: [Musicians' musical choice - reasons]

CP - Quando sei entrata hai suonato un Boogi boogi, perché ?
N- così, perché ci hanno detto che bisogna avere musica allegra, poi osservando Cinzia e Marta, (violiniste) bisogna avere musica ritmica.

P 2: MUSICIANS.doc - 2:149 [Il mio cavallo di battaglia è...] (678:681) (Super)
Coden: [Musicians' musical choice - reasons]

Il mio cavallo di battaglia è una sorts di biglietto da visita, di firma. Canto il 'leone si è addormentato' e così sono che arrivò io. Mi piace molto, tutti la sanno, è ritmica, aiuta le persone ad entrare in contatto ad essere stimolate e meno intimidite.
Poi se mi accorgo che la situazione non è quella giusta per questa canzone, ovviamente non la faccio.

P 2: MUSICIANS.doc - 2:281 [CP- Ho notato che suonavi una... (441:443) (Super)
Coden: [Musicians' musical choice - reasons]

CP- Ho notato che suonavi una musica tendenzialmente soft, minore, tutta su una modalità simile.
P- quando sono piccoli così, per me è meglio no esagerare mai nel forte

P 2: MUSICIANS.doc - 2:94 [ why do you play classical... (502:504) (Super)
Coden: [Musicians' musical choice - reasons]

CP - why do you play classical music when you start and when you finish and intervention?
P- perché secondo me rilassa (è la musica che lei ascolta e che le piace). Nel contesto mi sembra che questa musica nell'aria rilassi. Non mi a mai successo che un adolescente si sia irrigidito. Si fa un pezzo corto e ho sempre riscontrato un certo interesse. I pezzi sono molto brevi.

P 2: MUSICIANS.doc - 2:53 [P- qualsiasi canzone la puoi fare a ninnananna o veloce. In questo reparto tendiamo a fare canti più calmi. Se il bambino è più agitato facciamo un canto più calmo. A me spontaneamente non mi viene di fare una canzone allegra se il bambino è agitato e piange. Poi , se si calma c'è la relazione e poi anche iniziare a fare un canzone diverso.

C- a volte se un bambino è agitato o arrabbiato, mi a capitato di usare uno strumento a percussion, con un suono forte o un suono di spressa, li sospendi dall'arrabbiaura, e si distraggono. Basta cambiare al modalità, puoi anche prendere una ninnananna ma farla in modo spiritoso.

P 2: MUSICIANS.doc - 2:273 [A noi non ci interessa la mala...] (153:154) (Super)
Coden: [Musicians' musical choice - reasons]

A noi non ci interessa la malattia, ci interessano le persone, e quando si crea un gruppo che collabora tutto insieme cerco di fare un po di tutto, di fare attività strumentale, improvvisazione ritmica (gessi-suono), di modo di fare un intervento vario.

Per me è importante che imparino una piccola canzone perché è come un regalo che gli faccio, diventa loro, la hanno imparata e possono decidere se cantarla o no quando sono andata via.

P 2: MUSICIANS.doc - 2:218 [N - per me è importante suonar...] (988:990) (Super)
Coden: [Musicians' musical choice - reasons]

N - per me è importante suonare all'inizio perché capiscono che sono professionista. Io vado ad allegorizia che ci sono tante persone che aspettano. Io non entro subito, rimango fuori dalla porta, suono 3 o 4 brani classici che loro ascoltano e così intanto chi è interessato e curioso viene a vedere cosa succede e così quando entro so già con chi relazionarmi musicalmente [VIDEO].
Con i bambini canto, poi oggetti, indovinello.

P 2: MUSICIANS.doc - 2:232 [CP Pietro mi ha detto che...] (1077:1077) (Super)
Codex: [Music as a liberating experience for Parents] [Musicians' musical choice - reasons]

CP Pietro mi ha detto che il cerchio della Vita' fa piangere almeno il 90% delle mamme, e che lui usa questa canzone deliberatamente quando c'è una situazione di tensione e la madre sta bloccando il bambino, e così la madre generalmente inizia a piangere ed esce dalla stanza e così il bambino è sbloccato e così lui può interagire musicalmente con il bambino

P 2: MUSICIANS.doc - 2:21 [Con le due bambine ho deciso d...] (110:110) (Super)
Codex: [Musicians' musical choice - reasons]

Con le due bambine ho deciso di fare la canzone della donna perché da molte possibilità di variazioni e ci sono tanti suoni diversi, inclusi quelli degli animali e così si può facilmente improvvisare sulla sillabazione.

P 2: MUSICIANS.doc - 2:216 [In queste stanze (il DH di onc..) (559:559) (Super)
Codex: [Musicians' musical choice - reasons]

In queste stanze (il DH di oncematologia), dove c'è tanta gente e tanta confusione, è difficile creare delle relazioni individuali, io preferisco creare una situazione collettiva in modo che la confusione viene canalizzata nella musica.

P 2: MUSICIANS.doc - 2:265 [N no, però io sento l'ambient] (1271:1273) (Super)
Codex: [Musicians' musical choice - reasons]

N no, però io sento l'ambiente, se io sento che ci vuole una cosa allegro io suono brani allegri. Per esempio su in reparto ho fatto brani allegri, ma nel corridoio dovevo suonare piano (le stanze delle visite sono aperte) e così la scelta era più limitata. Però non dipende da me.

P 2: MUSICIANS.doc - 2:248 [CP queste le canti in ogni r.] (1161:1163) (Super)
Codex: [Musicians' musical choice - reasons]

CP queste le canti in ogni reparto?

S si ma comunque anche se non ascolterei mai Wisky ragnetto, certe volte mentre lo suono diventa interessante anche per me... nella sua trasformazione.

P 2: MUSICIANS.doc - 2:315 [P si, questa è la formula ch.] (519:520) (Super)
Codex: [Musicians' musical choice - reasons]

P si, questa è la formula che più facilmente si adatta. Usare lo strumento è un modo per introdursi e per cominciare l'intervento e dare tempo al bambino di familiarizzare con la musica. Quando comincia a cantare il bambino si tranquillizza e capisce.

La curiosità è attratta dallo strumento e la voce serve per stabilire una relazione e perché il bambino si fidii. La voce è più calda, c'è più relazione attraverso la voce. Bambini, piccoli.

P 2: MUSICIANS.doc - 2:287 [CP perche hai suonato le ultì...] (1444:1458) (Super)
Codex: [Musicians' musical choice - reasons]

CP perche hai suonato le ultime due canzoni [ref video - C'è un senso di te ' la mamma]

C perche è perfetta per le bambine romantiche della facia adolescenziale e pre adolescenziale... io mi ci riconosco molto! [ride]

CP ma la madre della bambina è andata in crisi...

C sì, è un testo per ragazzi, ma capisco che per una madre ci sia altro... come cantante Elisa è semplice, è molto soft, di rilassamento.

CP - e la canzone della mamma? [video image of this]

C quella l'ho fatta per le mamme, perché sono sempre li tese a che cercano di reggere una parte... un ruolo difficilissimo da mantenere, sempre con una grande ansia, per cui anche sentirsi dire, come è successo, dalla bambina e dal babbo 'ti voglio bene'... insomma dilo!

CP - e l'ha detto?

C sì! la bambina li è avvicinata e le ha detto 'mamma ti voglio bene' e anche il marito. Insomma è scontatissimo, certo che si vogliono bene, e certo che sono tesi, però anche poterlo dire scioglie tante tensioni, rafforza tanto, secondo me, questo è unico punto di vista personale.
si, ma i confini sono molto labili perché qualsiasi canzone si adatta all'intenzione con cui la vuoi cantare [GABRIELSSON studies agree with this] e così una canzone può diventare qualsiasi cosa... una ninna nanna un rap e un rap una ninna nanna. Anche fra martini, nella sua banalità è diventato un pezzo che andava bene per tutti.

N- io uso lo strumento specialmente per gli infermieri. Lo so che Toro ascoltano e così lo uso per bro.

C- Si oggi avrei voluto fare altre canzoni che non mi venivano in mente in quel momento. Mi sono venute in mente un paio di canzoni, ma poi ho deciso di non farle all'ultimo minuto perché avevo paura che fossero un po troppe da bambini. Per esempio, in quella stanza c'era un ragazzino, più grande della bambina e le cose ritmiche le faceva ma avevo paura che ha cantare cose un po troppo semplici, avrebbe detto... be questa che fa... e allora non gli ho fatto, ho fatto un passo indietro e sono rimasta sulle cose che stavo facendo. A volte non mi vengono in mente perché ho così tante cose a cui pensare, con gli strumenti e... così me lo scorro.

N- per acchiappare al gente io uso il canto e lo strumento. Ma a me piace fare solo intervento con oggetti. A me non mi va disuonare at viola, perché non è una novità per me. Per suonare l' viola, basta chiamare un mio collega. Per usare gli oggetti devo studiare invece con la viola no.

Bruna - Sings and uses percussions more than using the guitar. Hardly ever uses the oboe.

CP - quando quel bambino ha iniziato a piangere te hai usato subito fl suono, perché ?

N - perche e più forte il suono

CP- hai fatto un suono schock ! (bum)

MARTA e il PIANTO [the whole issue of music selection here - when it's comfortable for them and they have to justify the limited and similar repertoire then they claim that they can adapt any song by singing it in a different way, or what they call 'modalities' or manners - when they deliberately wants to elicit some sort of reaction though they use very specific songs, and don't adapt any modalities of more neutral songs example GATTA vs ENDRIGO]

CP - io ancora non capisco perché hai cantato quella canzone al singore di onco.... Per me quella era una canzone tristissima. CP - tu ha detto, appena hai cominciato a suonare 'così lei mi fa piangere'

C- sì, ma se suonavi una canzone più neutra, tipo 'c'era una volta una gatta' ...

C - c'è spirito e spirito secondo me

CP- si ma quello era volutamente intenso

C- e voleva esserlo perché secondo me uno che sta ad aspettare fuori da oncologia è molto intenso

C- e te non vuoi smorzare quella tensione? C- magari partire dall'intenso insieme a lui eppoi magari anche smorzarlo, ma non andandoli contro
CP - pero se scegli una canzone più neutra...
P - insomma è abbastanza allegra
C - insomma, rispetto a uno che ha un pensiero...
P - ma cantare una canzone allegra è come dirgli in cuento senso 'o, stai su'
C - secondo me quando uno sta li, ti devi mettere una maschera, perché senso, uno piangerebbe dalla mattina alla sera, secondo me.

P 2: MUSICIANS.doc - 2:26 [Luisa - In genere ce la faccio...]

Luisa - In genere ce la faccio a fare cantare tutti. I genitori lo fanno per i bambini, farebbero qualsiasi cosa per i bambini in queste situazioni. Io in un intervento cerco di farli rilassare, di farli suonare, di farli cantare una cosa che conoscono, eppoi cerco di farli imparare una cosa nuova. Quando ho questa tipologia di gruppo, un un reparto, uso questa struttura, questo approccio.

Code: Musicians' musical choice - reasons in relation to hospital's spaces (2-0)


S - dipende dai reparti. In certi reparti mi trovo più a mio agio. Qui ho capito certe dinamiche, anche lavorative dello staff. Se non sai come funziona un reparto è difficile. Per esempio, qui ho capito che bisogna avere delle sonorità basse perché ci sono tutte le sale da visita.
Per mettermi a mio agio ho delle canzoni che ho studiato molto e poi che mi piacciono particolarmente, così mi diverto anche io e mi rilassano anche a me.

P 2: MUSICIANS.doc - 2:54 [P - se vai in un reparto come...

P - se vai in un reparto come quello dove siamo state ora (pediatria B - lattanti) o neurochirurgia, il modo di suonare e il repertorio sono simili, ma se vai in rianimazione o TIN, è ovvio che sono diverse. Perché non ci sono i bambini che reagiscono, in una situazione di terapia intensiva la relazione è limitata, è un altro tipo di relazione. Più che il tipo di reparto la differenza di scelte comportamenti musicali dipende dal tipo di ambiente.
Ci sono 3 ambienti diversi: le sale d'attesa, i reparti e le terapie intensive (tianimazione e tinn).
In una sala d'attesa le modalità cambiano, se per esempio la sala d'attesa è piena e piccola e stretta, allora diventa difficile dare gli strumenti. Se uno ce la fa riesce a coinvolgere più persone, altrimenti mi concentro su relazioni con singoli bambini.

Code: Musicians' routine in hospital (1-0)

P 2: MUSICIANS.doc - 2:342 [Tutti i musicisti hanno una fo...

Tutti i musicisti hanno una formazione musicale al livello di conservatorio, solo 2 non hanno studiato musica formalmente.
A - C'era Simona, che non aveva studiato musica e che uscì primo del corso, io credo che dipenda da un altro tipo di doti caratteriali, di creatività.

P 2: MUSICIANS.doc - 2:355 [Marta va a parlare con la ca.

[Marta va a parlare con la caposala chiedendole il permesso di fare un fuori orario e chiedendo se e possibile e a quale ora a meglio per loro]

Code: Musicians' sense of professionalism (7-0)


L'esperienza è tanto. Adesso sono 4 anni di esperienza, tutte le settimane. Si copre un bel range di situazioni vissute.


Philippe mi ha detto di suonare un po perché io sono unica in questo gruppo [come musicista professionale]

P 2: MUSICIANS.doc - 2:342 [Tutti i musicisti hanno una fo...]

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A - C'era Simona, che non aveva studiato musica e che uscì primo del corso, io credo che dipenda da un altro tipo di doti caratteriali, di creatività.

P 2: MUSICIANS.doc - 2:355 [S- un infermiere mi ha chiesto...]

N- all'inizio io volevo farlo come volontario, ma dopo un anno ho capito che non potevo farcela. Io faccio anche volontariato e ho notato la differenza. Dove non sono pagata sono meno rispettata, dove sono volontaria mi rispetto meno. Eppoi se sono pagata c'è un interesse da parte dello staff di discutere con me le modalità dell'intervento e la mia professionalità è riconosciuta. Qui mi ripetono tanto, il personale.

S- C'è un bambino piccolo, appena operato con la testa aperta. Ho iniziato a suonare, stando sulla porta e la nonna ha iniziato a piangere da morire, come sfogandosi. Una delle motivazioni della musica è anche quella di dare un'occasione per buttare fuori per sfogarsi. Ho aspettato un po che si calmasse, pur continuando a suonare eppoi sono entrata e sono andata dal bambino, lei l'ho lasciata fare perché non era coinvolgibile, in quel momento aveva bisogno di un momento per se e di qualcuno che distraesse il bambino. Io gli ho ritagliato quel momento per star male in pace. Io sono stata lì a suonare con il bambino, poi l'attimo era passato e lei si è avvicinata e ha detto al bambino 'hai sentito che bella musica'. Sai, il pianto fa bene, specie in certe situazioni, e lei mi ha sembrata più rilassata. Questo intervento mi ha piaciuto molto più di questo.

Una volta mi hanno scambiato per un ambulante abusivo cinese e una mamma mi ha detto 'non voglio nulls!' e allora quel giorno mi sentivo pesante... mi è successo solo una volta in un anno e mezzo, ma quella volta mi sono sentita proprio male.

C- loro ti dicono di fare come vuoi te. Per esempio, prima, io mi stavo avvicinando al bambino e il babbo ha messo una sedia che era come nel mezzo, io non ho capito se voleva farmi sedere o se invece mi diceva di non avvicinarmi a suo figlio. Io non lo so. Lui non parlava italiano, e non ho capito cosa stava succedendo. La sedia cosa voleva dire? Sono entrata là perché il bambino mi guardava e poi ballava sul letto, e chiaro che una canzone gli la fai, ma l'atteggiamento del babbo era strano. Se non parlano la tua lingua è difficile.

Ale - questo stile di canzoni celtico, che si suonava con Marco, mi piace. Tendenzialmente io sono più allegro e scherzoso. Io ti dico, bisogna leggere una persona. Ti dico, bisogna leggere una persona.

CP - Come hai fatto a capire che la distanza era troppo ravvicinata?
N - Perché lui non guardava - Quando sento piangere, io vado subito, perché mi dà un'idea di calma e guardo se ci sono problemi. La distanza era troppo ravvicinata.

Mi fanno male anche le gambe, devo sempre stare piegata. [recurring problem Marta]

E' mentalmente faticoso. Devi decodificare comportamenti non verbali, che accadono in pochi secondi.

CP - Come hai fatto a capire che la distanza era troppo ravvicinata?
N - Perché lui non guardava - Quando sento piangere, io vado subito, perché mi dà un'idea di calma e guardo se ci sono problemi. La distanza era troppo ravvicinata.

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E' una cosa visiva, è meglio avere gli occhi alla stessa altezza del bambino.

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Mi fanno male anche le gambe, devo sempre stare piegata. [recurring problem Marta]

E' una cosa visiva, è meglio avere gli occhi alla stessa altezza del bambino.
N - ci hanno insegnato di non parlare, vietato parlare. Se incomincio a parlare poi parlano anche loro e la situazione diventa di conversazione e non di musica... comincio a sfuggire sulla malattia, invece con la musica possono dimenticarsi dei loro problemi per un po e magari anche sentirsi consolati dalla musica, senza usare parole.

E' difficile controllare la situazione quando cominciano a parlare perch'èmage mi chiedono: da dove vieni? E io devo dire io sono Giapponese, e così inizia la conversazione.

CP - come scegli la musica? In base alle situazioni?

A - é un segreto... ! ci vuole una grandissima osservazione e un grande ascolto, quindi una grande empatia e una grande intuizione. Quando arrivi ti devi mettere nei panni dell'altro, leggere attraverso i suoi gesti quello che fa e leggere il messaggio. In quel momento dove si trova, cosa sta facendo, che oggetti ha intorno, cosa ha disegnato sulla maglietta, per come niente è casuale. Per esempio, mi é successo che a volte le bambine hanno una maglietta con il disegno di un gatto e allora io so '44 gatti', ed é azzeccatissima e così si stabilisce un appiglio attraverso cui comunicare.

90% delle volte funziona, il musicista deve leggere la realtà del bambino, codificarla e riprodurla. Io cerco di fare così, ma non é facile. Qualche volta é più immediato, altre volte più complicato perch'è non ci sono messaggi o segnali mi stanno sfuggendo e allora cerco di coglierli ma anche di non invadere il suo spazio

P 2: MUSICIANS.doc - 2:111 [Ci vuole una grande osservazione.] (569:569) (Super)

Ci vuole una grande osservazione e un grande ascolto. Osservazione di tutto quello che fanno, non verbale, tutto quello che viene fatto non é casuale. Bisogna osservare il body language e facial expressions e interpretarlo. Ascoltare quello che possono dire. Cercare con l'empatia e con l'intuizione di interpretare il loro bisogno al momento.

P 2: MUSICIANS.doc - 2:4 [Il musicista entra nella stanza.] (26:26) (Super)

II musicista entra nella stanza e la prima cosa che vede é una situazione, come una fotografia, in pochissimo tempo deve capire cosa sta succedendo, che é qualcosa che si capisce da uno sguardo della situazione (che piange, chi ride, chi dorme, chi sta giocando) ma che richiede anche una sensibilitá speciale dettata dall'esperienza

P 2: MUSICIANS.doc - 2:323 [N - il problema che é che è n.] (1749:1750) (Super)

N - il problema che é che non sono molto fisionomica, non riconosco le persone e per me é un problema. Sono negata per riconoscere le persone. Cosi faccio finta di riconoscere la gente, e quando mi salutano con una certa simpatia allora mi rendo conto che gli riconosco.

Cosi ci sono anche problemi per ricordarmi a chi ho cantato cosa.

P 2: MUSICIANS.doc - 2:215 [N - Per fortuna il mio lavoro ..] (976:976) (Super)

N - Per fortuna il mio lavoro é la musica, perch'è non devo parlare

P 2: MUSICIANS.doc - 2:144 [A - é un approccio visivo, c.] (658:662) (Super)

A - é un approccio visivo, é un approccio di posizione e distanza dal bambino che non sia troppo vicino, non superi lo spazio del bambino. E' meglio fermarsi un po' lontano eppoi avvicinarsi. Controllare anche la tua posizione, che deve essere al livello del bambino. Con i bambini, specialmente piccoli, bisogna non stare troppo addosso. Anche lo sguardo può intimorire il bambino. A volte se sei lontano e finiti un bambino mentre canti quello si può mettere a piangere, allora meglio guardare la mamma [ride].. insomma un parente.

Se uno fa le cose come si deve, ci sono così tante variabilitá!

A strasburgo fanno un corso universitario

Code: Observation how it should be conducted - Secco.. {3-0}

P 2: MUSICIANS.doc - 2:2 [OBSERVATION SCHEDULE AP - Secco.] (22:23) (Super)

OBSERVATION SCHEDULE

AP - Secondo il Perondi il primo approccio all'osservazione deve essere spaziale. Si osserva la situazione: definire la situazione: bambino grande, bambino piccolo, in collo, a letto, seduto, seduto, con che tipo di mediciné.. etc, tutta una serie di specifiche che rendono unito l'intervento e non paragonabile ad altri. Questa é una descrizione oggettiva, fisica di come l'osservatore percepisce la situazione.

P 2: MUSICIANS.doc - 2:3 [C - L'osservazione di come l'of.] (24:26) (Super)

Codes: Observation how it should be conducted - Secco..
C - l’osservazione di come l’osservatore percepisce la situazione: il bambino piange, il bambino è sereno, la mamma piange, la mamma è serena, l’infermiera è agitata, l’infermiera è serena. Il musicista entra nella stanza e la prima cosa che vede è una situazione, come una fotografia, in pochissimo tempo deve capire cosa sta succedendo, che è qualcosa che si capisce da uno sguardo della situazione (che piange, chi ride, chi dorme, chi sta giocando) ma che richiede anche una sensibilità speciale dettata dall’esperienza.

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Il Peroni e Marco fanno le osservazioni, Philippe fa lezione solo per il secondo corso. Si, è utile avere degli osservatori esterni.

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Peroni e Marco fanno le.

\[\text{Observation how it should be conducted - Seco.}\]

1. Il Peroni e Marco fanno le osservazioni, Philippe fa lezione solo per il secondo corso. Si, è utile avere degli osservatori esterni.

2. Con noi generalmente sono i bambini che agiscono su di noi, sono responsabili di quello che stanno facendo. Io potevo anche andare via e loro avrebbero continuato a suonare da soli. Con la musica sono più partecipi che non con il clown. La musica è un tramite che mette in relazione anche i bambini con i genitori.

3. Secondo is mia esperienza il successo nel coinvolgere il bambino, dipende molto dal coinvolgimento del genitore. I bambini rispondono all'agitazione del genitore. Con noi generalmente sono i bambini che agiscono su di noi, sono responsabili di quello che stanno facendo. Io potevo anche andare via e loro avrebbero continuato a suonare da soli. Con la musica sono più partecipi che non con il clown. La musica è un tramite che mette in relazione anche i bambini con i genitori.

4. A parent asks for a special song. Encourage participation by (I) verbal comments [Q.] or by responding to the musical stimulus started by the musician. ACTIVE AND REACTIVE behaviour. Some parents remember special songs sung by different musicians and they requests them to different musicians [Q]

5. Often happen that parents congratulate with musicians in very positive terms. Other times [Paola] there are negative comments. Sometimes they ask questions about the instruments.

6. Perdoni e Marco fanno le.

\[\text{Observation how it should be conducted - Seco.}\]

7. in the corridor we met a parent that asked whether she could go to play in intensive care as there was a child that was very keen to listen a Branduardi’s song (Italian songwriter).

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11. A parent asks for a special song. Encourage participation by (I) verbal comments [Q.] or by responding to the musical stimulus started by the musician. ACTIVE AND REACTIVE behaviour. Some parents remember special songs sung by different musicians and they requests them to different musicians [Q]

12. Often happen that parents congratulate with musicians in very positive terms. Other times [Paola] there are negative comments. Sometimes they ask questions about the instruments.
Poi dopo l'intervento, se il bambino è tranquillo, ti vedono come una cosa liberatoria, cioè 'bene, vieni, distrailo, fammi riposare un attimo' da parte dei genitori. Quando invece il bambino sta male, invece mettono un muro, e allora spesso vado oltre e così mi sentono da lontano, tanto la musica la sentono lo stesso.

**Code:** Perception of their intervention [10-8]

P 2: MUSICIANS.doc - 2:170 [C- oggi mi a sembrato tutto ok.] (782:782) (Super)

Codex: [Perception of their intervention]

C- oggi mi a sembrato tutto ok. Tutti hanno cantato e suonato. Il reparto è più semplice perché c'è più tempo ed è più calmo, qui (sala d'attesa) è tutto più di cosa. [SAME VIEW]

P 2: MUSICIANS.doc - 2:137 [A- un musicista deve essere le.] (625:625) (Super)

Codes: [Musicians' musical choice - reasons] [Perception of their intervention]

A- un musicista deve essere leggero come il vento, deve essere sempre molto discreto, non invadere gli spazi, senon fa l'effetto contrario. Quando c'era il bambino che piangeva, sono uscito, ma la mamma cantava e io sono rimasto per valorizzare l'coinvolgimento della mamma e il bimbo si è anche calmato vedendo la madre che cantava.

P 2: MUSICIANS.doc - 2:276 [C/P - come ti sei sentita con q.] (1364:1366) (Super)

Codes: [Perception of their intervention]

C/P - come ti sei sentita con quella signora [una signora si è avvicinata e le ha detto che quello che suonava era inappropriata per i bambini]?

N - va bene se qualcuno mi critica perché così imparo e cambio quello che sto suonando. Se mi dicono così, io devo trovare qualcosa di diverso. Se tutti mi dicono complimenti, non migliorò.

P 2: MUSICIANS.doc - 2:275 [N- ho commesso due errori! ho..] (1362:1362) (Super)

Codes: [Meeting the same child again] [Perception of their intervention]

N- ho commesso due errori! ho usato troppi oggetti. Poi quel bambino quando mi ha visto ha spento il game boy e per me questa è una vera gioia vincere sul game boy...ma ci conosciamo, avevamo già suonato insieme 5 o 6 volte. Dopo mi sono accorta che dopo 2 o 3 minuti lui si è stufato e allora ho usato più strumenti, per non perderlo.

P 2: MUSICIANS.doc - 2:184 [E' andata bene, tutti partecipa..] (834:835) (Super)

Codes: [Perception of their intervention]

E' andata bene, tutti partecipavano e in un certo senso guidavano loro, e' meno faticoso.

I genitori sono interessati a far partecipare il bambino e quindi partecipavano loro per primi. Tutti quelli che erano nella stanza avevano uno strumento e partecipavano.

P 2: MUSICIANS.doc - 2:325 [N - ho sentito che erano cone..] (1755:1756) (Super)

Codes: [Perception of their intervention]

N - ho sentito che erano concentrati sulla musica, un momento di silenzio. Quando alla fine dell'intervento io ho finito, e stavo rimettendo a posto ho sentito un silenzio magico

P 2: MUSICIANS.doc - 2:57 [C/P - il bambino era contento ..] (318:322) (Super)

Codes: [Perception of their intervention]

C/P - il bambino era contento

CP - da cosa si vedeva?

C/P- dal fatto partecipava, che suonava.

P 2: MUSICIANS.doc - 2:214 [N- per esempio dagli sguardi i..] (970:970) (Super)

Codes: [Perception of their intervention]

N- per esempio dagli sguardi interessati, poi quella bambina ha risposto con gli oggetti e ha voluto comunicare, con gli oggetti, abbiamo fatto una specie di concerto.

P 2: MUSICIANS.doc - 2:143 [MUSICA E PROCEDURE - aggancio ..] (649:653) (Super)

Codes: [Ingredients for a successful intervention] [Perception of their intervention]

MUSICA E PROCEDURE - aggancio pre intervento (same quote as P)

Per esempio, la bambina del previelenlo, si è calmata. Si è calmata perché è stata distratta dal dolore e dalla procedura, arriva un altro stimolo: visivo e sonoro

effetti fisiologico della musica che modula ansia e depressione. Se te agganci la bambina, da 5 a 10 minuti prima, fuori eppoi entra dentro allora ha tempo di scaricare le angosce prima di entrare e quando entra si è scordata della preoccupazione invece di essere entrata in una spirale dalla quale è difficile farsi rinomare giù. E' un po come quando c'è un'operazione, la sedazione va fatta prima, non si può fare mentre si stanno tagliando. [ride].

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S - quel bambino l'avei stroncato! perché voleva fare tutto lui!!! e mi ha preso tutti gli strumenti. alla fine la musica lo attirava e le ripetizioni senza senso con la voce, riprendevano il legame musicale che si è creato nel percorso.

S - Non avendo strumenti, ho capito che io potevo usare le mani e tutte le cose che si potevano suonare, non convenzionali. E' bello quando ci è questo misto di età e che possono tutti interagire suonando insieme. Può una cosa bella che qui vengono dei bambini che magari ho visto prima nel DH. E così per me è più facile se reincontro bambini già visti prima.

Marco ha una magia. Appena entra lui, coinvolge tutti quanti, anche se ci sono 20 persone tutti suonano, specialmente Marco è proprio magico. Marco usa soprattutto oggetti sonori, specialmente se ci sono tante persone lui coinvolge tutti e tutti suonano insieme. ... Anche con gli anziani lui riesce a coinvolgere tutti, non capisco come fa... magari lui è magico per davvero. Io vorrei capire da dove viene questa magia?

Bruna è molto ricca di oggetti sonori e li inventa ed è molto interessante. Luisa è molto brava perché lavora da tanto tempo con i bambini e quindi ha un repertorio infinito.

A - ci sono delle vibrazioni che sbloccano più di altre. Se un bambino suona la comunicazione è andata più in profondità, perché si fida prendendo il tuo oggetto.

C - questi strumenti vanno sempre rifatti. A volte li devo regalare, in situazioni proprio speciali. La maggior parte degli strumenti gli ho comprati.

S - le maracas! Perché sono abbastanza per tutte le età e perché si suona bene insieme.

TEORIA
Integrazione - il bambino fa 1 e io faccio 2
Opposizione - un bambino batte X e io batto Y oppure batter piano e io forte
Ignorare - il bambino fa una cosa e io ignoro il suo stimolo e io ne introduco un altro, non deve guidare lui.
Questo è molto vicino alla musicoterapia. Però se gli strumenti li usi così è noioso e lo puo solo fare con bambini un po più grandi.

DATA SOURCE UNACCESSIBLE!: C:\Documents and Settings\Costanza\Desktop\TRANSCRIPT audio files 22 MAY .doc
io come tendenza uso più gli oggetti sonori perché, il canto per me è difficile in italiano. La musica si fa ma non spesso, perché loro ascoltano ma non partecipano, invece con gli oggetti, diventano protagonisti e possono scaricare la tensione. Eppoi imparano a usare degli strumenti che poi possono anche usare a casa [selezione di oggetti sonori che fa con materiali di casa]

Suonare il violino è un momento per riposarmi. Per i bambini piccoli non lo faccio tanto. I bambini sono più attratti dalla voce, dal canto e dagli strumenti. La voce arriva di più, specialmente ai più piccoli. Con gli adulti e specialmente staff, invece è più lo strumento che apprezzano, specialmente musica classica.

E' anche un momento per guardarci intorno, capire chi c'è, chi è, cosa fa e cosa fare di conseguenza.

Suonare il violino è un modo per me per vedere che situazione c'è. Se è una sala dove non si chi c'è e quanta gente c'è.

C - abbiamo fatto un elenco di date per suonare insieme, una volta o due al mese. Per fare insieme bisogna avere un repertorio comune e noi ormai ci conosciamo da tanto. Noi ci siamo trovate per provare, adesso sempre meno. C'è stato un periodo che abbiamo suonato insieme. E abbiamo composto delle canzoni per il cd insieme.

CP - qual'è il criterio di scelta?
C- adesso vado al Dea e così mi porto dietro una selezione di strumenti, li la fascia di età a ampia. Ho strumenti per tutte le fascie di età. Non c'è mai una situazione fissa. Posso sapere la fascia di età ma non so cosa suonare.

CP - hai un piano per oggi?
C- si, le canzoni me le preparo, ho la mia scaletta e il mio repertorio. Ci sono una decina. Poi capirà che ne canti 4 o magari 12. Questo è tutto il mio repertorio.
CP - studi molto?
N - si, altrimenti diventa noiosa come attività se si ripete sempre la stessa musica.

P- No è impossibile pianificare. Ho un repertorio, delle idee e esperienze per combinarle insieme. A volte decido di cantare delle canzoni. Associo gli strumenti a certe canzoni e così quando li do ai bambini poi li canto. Prima di iniziare oggi, volevo cantare certe canzoni.
Durante un intervento non voglio cambiare canzoni molto spesso, cerco di lavorare sulla canzone, su arrangiamenti, tempi, melodie, parole, per dare il tempo al bambino di familiarizzare con la canzone.

Qui è più impegnativo anche fisicamente.
Io cerco di sentire che musiche ascoltano e adattarmi. Non è facile imparare bene una canzone, a memoria e bene. Per imparare bene una canzone ci vuole del tempo. Io cerco di ritagliarmi un po' di spazi per suonare.

Ho una lista di canzoni, ma non ho proprio un piano per la giornata.

C - dipende da come percepisco la situazione li per li. Di solito con i bambini piccoli faccio filastrocche, canzoncine, a tutto soggettivo.

Per fare un intervento, bisogna studiare almeno 3 ore. Io mi sento un po' a disagio a suonare sempre la stessa gente e suonare le stesse cose... c'è chi lo fa ma io vorrei sapere come si fa a vedere sempre la stessa gente e suonare le stesse cose.

Code: Repertoire (38-0)

C - dipende da come percepisco la situazione li per li. Di solito con i bambini piccoli faccio filastrocche, canzontine, è tutto soggettivo.

I repertorio, imparo, e poi la...

Altra volta c'era un bambino che sapeva cosa sarebbe successo e ha detto: 'adesso la tua tina fuori il maiale!' [ride]

P 2: MUSICIANS.doc - 2:60 P- il punto è che vai li con i] (338:341) (Super)
Codes: [Repertoire]
P: il punto è che vai li con il violino, la chitarra e anche se non suoni proprio lo stile di musica che ascoltano, è comunque un'esperienza per loro. Vedono da vicino uno strumento che magari non conoscono e sentono il suono così da vicino.

C: poi a volte nelle sale d'aspetto ci sono bambini grandi accanto a bambini più piccoli. Per esempio, una volta che mi sono trovata in questa situazione, ho cantato WISHKY il ragnetto per un versione rap, perché così anche il più grande potesse essere coinvolto.

P: MUSICIANS.doc - 2:277 [CP - fa improvvisazioni con i.] (1369:1371) (Super)

C: Il repertorio 'animalesco' fino alla terza elementare gli piacciono tanto (fino a 8 anni). Con bambini più grandi il repertorio cambia. Io ho una canzone di Elsa per le più grandi.

P: io non faccio Pop. Posso avere una canzone ma non più di quella. Non è il mio repertorio (suona violino classico, professionalmente).

C: - ho un repertorio per lo staff ma lo faccio di rado.... sono canzoni, colonne sonore, musica che mi piace e che mi rilassa.

P: MUSICIANS.doc - 2:59 [C: il repertorio 'animalesco'-] (332:337) (Super)

C: il repertorio 'animalesco' fino alla terza elementare gli piacciono tantissimo (fino a 8 anni). Con bambini più grandi il repertorio cambia. Io ho una canzone di Elsa per le più grandi.

P: non faccio Pop. Posso avere una canzone ma non più di quella. Non è il mio repertorio (suona violino classico, professionalmente).

C: il repertorio che suono è della tradizione popolare e per bambini. Non tutti i musicisti hanno lo stesso repertorio, alcuni suonano cose più pop (Pietro) e altri più classiche (Paola).

P: REPertoire difficile per lei perché non conosce canzoni in italiano e non conosce il repertorio culturale musicale in relazione ai bambini (ha un figlio maschio di 12 anni).

P: MUSICIANS.doc - 2:305 [C - oggi alla TIN ho fatto una.] (1606:1606) (Super)
C - oggi alla TIN ho fatto una musica tranquilla, ma non ninnananne, insomma non tutto quel tipo di musica, anche per le infermiere! L'infermiera mi ha ringraziato per aver suonato brani allegri.

P 2: MUSICIANS.doc - 2:281 [La musica popolare dopo un po ...] (1391:1395) (Super)
Codes: [Repertoire]


CP - si ma sono un po' datate?

Ale - io preferisco suonare cose un po' più ritmate, non troppo melodiche ... dipende dalle situazioni. Se un bambino sta dormendo parti da canti più soft.

P 2: MUSICIANS.doc - 2:312 [CP- Perché hai suonato Wisky R....] (1656:1666) (Super)
Codes: [Repertoire]

CP- Perché hai suonato Wisky Ragnetto?

S- Perché è una canzone che facilmente conoscono.

CP - anche un bambino di 10 anni?

S- no, solo per più piccoli.

CP - ma li c'era anche un bambino di 10 anni...

S- si, ma in fondo con lui avevamo già fatto un bel momento di improvvisazione con le percussioni e lui essendo anche portato, si è divertito.

N- osservando gli altri io ho notato che mi annoio. Per esempio a me e successo che member of staff in the geriatric ward, told me he had enough of 'Romagna mia'[ride]. Romagna mia è un grande successo e così io continuo a cantare quella, perché so che agli anziani piace.

S - entra nel reparto e chiede uno spuntino. L'infermiera dice 'of course' and explain whi is in the ward (only a child). She plays:

the music that has learnt for the nursing home

Edit puff song (pur ma vie), which I personally find inappropriate songs as soon as hear them.

La vie en rose

Ninnananna braham

.... classic music

Love me tender

P 2: MUSICIANS.doc - 2:242 [CP- la musica come l'avete sc....] (1126:1126) (Super)
Codes: [Repertoire]

CP - la musica come l'avete scelta?

C- abbiamo il 'repertorio marino' in cui ci sono dei canti e anche gli strumentini usati vengono di conseguenza.
Musicians from the second course have a similar repertoire. All musicians met to revise their repertoire and exchange songs. The theme of the workshop was on improvisation.

Bruna and Marta use a kind of very basic 'rap style improvisation.'

C'era una famiglia albanese e ho cantato una canzone e la madre che era dentro cantava insieme a me. La sanno tutti questa canzone. A me l'ha insegnata una mamma violincellista albanese, amica della Cinzia.

C - con la musica classica io sono frenata dalla situazione. Il musicista ormai a quello che suona e che canta. La musica classica fa piangere, prende il genitore e invece allontana il bambino. Fosse dovessi cercare musica più allegra. Ti può anche succedere che mentre stai cantando una canzone ti più succedere anche che senti dire 'basta, non se ne può più di questa canzone' ... e in quella situazione magari magari finisco, se cambio canzone.

Certo musica viene da loro... ogni volta che suono Cenerentola a tin successo, invece quando suonavo Bach non coinvolgevo nessuno, raramente magari un dottore molto colto esce dalla stanza e dice 'Ah finalmente Bach!' pero altri non apprezzano. Ave maria is anche un grande successo

Poi l'ultima canzone che ho suonato love song form the 30' è stata richiesta da un anziano, poi l'ho provata qui è l'infermiere mi ha detto che questa canzone era bellissima | l'ho non dicono mai niente ma se dicono qualcosa vuol dire che davvero gli piace.

Io cerco di variare il repertorio, specie se ci sono degli adolescenti. Prevalentemente ci sono bambini dai pochi mesi ai 10 anni. Poi ci sono anche degli adolescenti.

Io cerco di variare il repertorio, specie se ci sono degli adolescenti. Prevalentemente ci sono bambini dai pochi mesi ai 10 anni. Poi ci sono anche degli adolescenti.

Pietro Perondi, ha proposto di fare tin workshop tra not e di proporre una canzone fatta in 10 modality diverse. Ma tutti dicevano ‘bravo, bravo’ e non dava veramente una critica.

Non mi sento in grado di essere critics.

Faccio l'aria sully 4 cords di bach, in momenti molto particolare, per le sedazioni, in rianimazion

Capita che a volte is trovo qui, capita the a volte lei e qui a fare tin recupero e allora sento le canzoni che canta, insomma, piu o meno si sa. Eppoi so le canzoni che piacciono ai bambini. Per esempio adesso c'è la canzone di Winsky il ragnetto che va molto di moda, la cantano all'isola e nelle scuole in greco, poi c'è 'per fare un tavolo' poi ci sono due coccodrilli, sono quelle più battute in questo periodo. C'è stato un periodo che davano alla televisione 'lapa maya' e così tutti cantavano richiedevano quella. Sono sempre a contatto con i bambini e così sento cosa cantano. Le canzoni che richiedono sono in base a quello che danno alla televisione. Oggi una bambina a pistoia mi ha insegnato la canzone della zanzara [musicians learn their repertoir from people in hospital - they gather songs from mothers e.g. * MARTA and children ] adesso non mi ricordo le parole, ma magari domani vado sull'intemet e is cerco e così Is imparo. Insomma, ti guidano loro. Difficilmente io decidio di imparare una canzone che scelgo, le imparo perché me le richiedono.
Se mi chiedono una canzone che non so ma che ho sentito suonare da qualcun'altro di noi, allora me la faccio dare e la imparo.

Una volta al mese in teoria ci dovevamo incontrare sempre per scambiarci materiali, ma poi non si è mai fatto perché gli impegni di tutti sono tanti. Però capita che telefono a chi ha fatto il corso con me, è più facile con la Paola o con la Luisa.

Ad allergologia c'è un bambino di 6 anni che sa come funziona l'intervento e spiega agli altri.

Posso continuare sempre con la stessa cosa, ma sono stanca a volere [esprime un disagio].

La canzone più adatta è quella di cenerentola, i sogni son desideri, adatta a tutti i reparti e Ave Maria, queste due sono brani fortissimi, siiii.

Cerco di dedicare un'ora alla settimana ad aggiustare gli strumentini e ad imparare nuove canzoni. A volte capita che un bambino ti chieda se conosci una canzone e se non la so, cerco di impararla per la prossima volta che vado in ospedale.

Prima suonavo di piano il violin, magari nei corridoi. Però mi sembra che la musica classica mi sembra quasi che qui si recepiscano come con una cosa triste e allora ho smesso. [Q Paola]. Secondo me in base a quello che trovi devi adattarti. Alla TIN suono musica classica.

REPERTORIO e IDENTITÀ musicale [cfr Cross’ quote]

N- so che se non studio abbastanza io non posso fare questo lavoro. Cerco di imparare una canzone nuova alla settimana, ma è molto. In questo periodo sto lavorando molto in teatro e allora cerco di portare delle nuove musiche, solo strumentali, perché per me è più facile. Ma devo imparare anche il canto. Se canto mi avvicino di più a loro... per esempio, la canzone dei porcellini.

Per me una canzone in italiano è difficile ... per imparare una canzone come 'i sogni son desideri' io ci ho messo 4 mesi.

CP - il tuo bambino ascoltava musica italiana da piccolo?

N - no, giapponese.

CP - il tuo marito non cantava al tuo bambino?

N - no, cantavo io.

[mentre Paola canta per dimostrarmi come fa la canzone, una mamma si unisce e inizia a cantare e commenta sul fatto che si ricordava la canzone da quando la figlia era piccola]

It needs constant updating and you have to learn and memorize a new song, at least every week, otherwise it becomes boring to keep repeating the same 10 songs all the time. It takes time to build up a repertoire and it's something you do as your activity out of your paid hours. [common view about repertoire]

Le mie canzoni sono quelle là. Non inizio con una fissa.

320
C- dalle mamme che erano qui. Me le hanno cantate e io le ho trascritte nel pentagramma. Erano canzoni arabe.

Code: Retribution [3-0]

P 2: MUSICIANS.doc - 2:10 [I musicisti vengono pagati 20... ] (45:45) (Super)

I musicisti vengono pagati 20 Euro lordi, che netti diventano 19 euro. I musicisti si lamentano perché sostengono che una gran parte del loro lavoro consiste nella preparazione a casa, che non viene contata.

P 2: MUSICIANS.doc - 2:11 [C - C'è una preparazione in te... ] (47:47) (Super)

C - C'è una preparazione in termini di preparare il repertorio, costruire gli oggetti sonori, comprare, aggiustare, eppoi l'aspetto della riflessione post intervento. C'è un impatto emotivo che lascia molto stanchi e che dura anche dopo che sei tornato a casa e a volte non ti lascia per giorni e continui a pensare a quello che è successo in ospedale. Se si paragona il coinvolgimento emotivo con la paga, non c'è nessun rapporto e la retribuzione è molto bassa.

P 2: MUSICIANS.doc - 2:13 [AP - so per... ] (49:49) (Super)

AP - so perché come controbilanciamento, questo è un lavoro flessibile (da parte dei musicisti, dell'associazione e dell'ospedale) che decidi tu quando fare (?? CP). Inizialmente si chiede al musicista quando puoi fare i suoi interventi e da li si modella tutto.

Code: Self esteem [1-0]

BRUNA - Oboe - 29 years old

Non ho fiducia in me, in generale nelle mie capacità. Infatti oggi mi hanno detto (official observations are taking places, 2 people observing musicians - observation had not been happening for a long time but two members of the cooperative were showing the hospital setting and their intervention to a musician they were trying to get involved in the next training course for musicians in hospital) hai fatto una cosa spettacolare, bellissima eppoi l'hai troncata. Loro mi hanno fatto notare... erano di tutte le età, di tutte le nazionalità, si sono aggiunti dalle altre stanze, sono venuti a suonare insieme, cosa che non capita tutti giorni. Ma io a un certo punto ho smesso, perché io non mi sento piuttosto... basta.

Code: Structure of the intervention [11-0]

P 2: MUSICIANS.doc - 2:280 [He plays 17 songs in 30 mins] (1384:1385) (Super)

He plays 17 songs in 30 mins

P 2: MUSICIANS.doc - 2:194 [CP- vi hanno dato delle indica... ] (869:871) (Super)

CP- vi hanno dato delle indicazioni specifiche sulla struttura dell'intervento da seguire?

no, giudichi te.

P 2: MUSICIANS.doc - 2:87 [Ci sono state varie fasi: coin... ] (467:468) (Super)

Ci sono state varie fasi: coinvolgimento tutti insieme. Più personale, con la bambina da sola. Le interazioni durano qualche minuto ciascuna. Dipende dai momenti, nella sala d'aspetto, tutto cambia da un momento all' altro.

P 2: MUSICIANS.doc - 2:193 [Se decid... ] (867:867) (Super)

Se decid...
introduco spesso le canzoni con lo strumento, senza cantare, perché mentre suono mi ripasso lo parole.

In the corridor at the entrance - plays for 7 minutes.
Habanera - Carmen
Medley: classical - O sole mio
Watussi
Pink panther theme - playful way, slow fast
Bolero theme

She starts singing the theme handing out little instruments

Plays a mambo, while

[very musical in her body language]

Parents reinforce what the child is doing while playing: 'brava'!

Music therapy techniques employed in the music improvisation

Finishes with the same song played at the beginning. [31.03 - 31.43 on tape 20046 background noise while she plays]

She personalizes the intervention by using the child's name while she improvise on the lyric substitution

1. Entratata - suona un pezzo classico mentre entra come per farsi annunziare, di maniera
2. Inizia canto accompagnata dal violino, spesso pizzicata.
3. Solo voce continua il canto,
4. tira fuori uno strumento che inizia a suonare.
5. Poi passa lo strumento al bambino,
6. ne tira fuori uno simile che inizia a suonare lei, e così può rispondere alla musica che decide di fare il bambino.
7. Inizia a cantare una canzone accompagnandosi con le percussioni
8. Torna al violino - fine interazione
Il violino suona una melodia che si trasforma nel tema del canto che segue.

Stessa routine

Musicians from the second course have a similar repertoire. All musicians met to revise their repertoire and exchange songs. The theme of the workshop was on improvisation.
Bruna and Marta use a kind of very basic 'rap style improvisation.

P 2: MUSICIANS.doc - 2:243 [Mi sembravano tutti molto pia . .] (1127:1130) (Super)

Codes: [Styles - differences between musicians]

Mi sembravano tutti molto pia nel gestire l'interazione con il bambino. Secondo me c'è anche una differenza tra uomini e donne, le donne sono più didattiche.
Pietro suona molto e vuole coinvolgere tutti, far cantare tutti. Ha un repertorio diverso, pia da grandi. Luca l'ho visto poco, ma ha un repertorio più simile a Marta e Cinzia.
Marta fa anche cose un po diverse, giochi con le mani, indovinelli.
Tutti mi siete sembrati molto sicuri nel suonare, usate gli strumenti, cantare, riprendere gli strumenti.

P 2: MUSICIANS.doc - 2:103 [Entra cantando - stile canti, ..] (538:539) (Super)

Codes: [Styles - differences between musicians]

Entra cantando - stile canti, pia pop, allegri, sonorità più forti, - canta molte piu canzoni, repertorio vasto. Canta sempre.

Children and parents are excited, cheered up and requests song. The percussions instruments are used to accompany the songs.

Musica coinvolgente per il ritmo e le sonorità e perché è familiare in un senso più di identità che non 'conosce'

P 2: MUSICIANS.doc - 2:181 [Ciao! Io sono Maria, e te ch..] (819:820) (Super)

Codes: [Styles - differences between musicians]

Ciao! Io sono Maria, e tu chi sei? - to get the name of the child that she then use during the intervention to establish a more personal connection. She also use the name of the child in the lyric substitution

Slightly different approach. Words and conversation are integrated in the intervention (less, but similar to A. but very different from P and C that are religiously careful in NOT using any spoken language.

P 2: MUSICIANS.doc - 2:93 [Compare with Marta which sing..] (499:500) (Super)

Codes: [Styles - differences between musicians]

Compare with Marta which sings a lot more and use voice. Voice is her instrument.

Cinzia, cannot sustain the singing for too long (training?) and compensate with the solo playing and musical improvisations through percussion instruments (she appear to use mainly campane). She has families of similar instruments that she hands out to create an atmosphere [as in the video in onco]. She can sustain rhythmic improvisation /dialogues for quite a long time (3-5 minutes).

P 2: MUSICIANS.doc - 2:168 [[there is a difference between..] (761:761) (Super)

Codes: [Styles - differences between musicians]

[there is a difference between more experienced musicians (those form the first course have been playing for 4 years, regularly every week - and those from the second course who just started this year. These musicians are less confident, more hesitant musically and emotionally in handling situations in hospital]

P 2: MUSICIANS.doc - 2:104 [Coinvogente - sing a long acca..] (544:554) (Super)

Codes: [Styles - differences between musicians]

Coinvogente - sing a long acca piu spesso. People do join in partly because they know the songs as they are chosen from a less folk/traditional repertoire, but are taken form either Disney repertoire from the little ones or a pop repertoire for the elder ones.

Lyrics substitution very funny words adapted at what is happening

Distribuisce strumentini perché accompagnino il canto che spesso è rimato

The father was very amused himself and very keen.

Ale has a suitcase to carry all the instruments.

P 2: MUSICIANS.doc - 2:263 [CP - l'impresione e che la mu..] (12661266) (Super)

Codes: [Styles - differences between musicians]


P 2: MUSICIANS.doc - 2:273 [N - si, secondo me i musicisti..] (1337:1338) (Super)

Codes: [Styles - differences between musicians]

N - si, secondo me i musicisti del primo corso hanno avuto il lavoro molto facilmente. Invece per voi non c'era nessuna garanzia.
Per tutto l'anno eravamo preoccupati per lavorare. A nessuno a stato dato lavoro. Poi piano piano la situazione è cambiata. Alcuni sono andati via, perché non volevano fare il tirocinio gratuitamente per tutti i mesi che venivano richiesti (da maggio a settembre). Da maggio fino a febbraio c'è stato molto musica nell'ospedale.

P 2: MUSICIANS.doc - 2:240 [N- anche io ho osservato due v..] (1117:1117) (Super)

Codes: [Styles - differences between musicians]
N- anche io ho osservato due volte ma ho avuto la stessa impressione. Mi è servito osservare Cinzia, ma mi è sembrato tutto monotono. Io vorrei fare qualcosa di diverso, più movimentato.

**Code: Time perception when playing (3-0)**

P 2: MUSICIANS.doc - 2:19 [C - ho suonato per mezz’ora e ..] (105:106) (Super)

C - ho suonato per mezz’ora e mi è passato molto velocemente

**Code: Time perception when playing (3-0)**

P 2: MUSICIANS.doc - 2:15 [Sono entrata suonando forte, c..] (54:54) (Super)

Sono entrata suonando forte, come fa Marco e dopo due secondi erano tutti con gli strumenti a cantare! Bello bello. Ci sono stata 40 minuti e non me ne sono nemmeno accorta.

**Code: Timetable changes (15-6)**

P 2: MUSICIANS.doc - 2:73 [Oggi ho pensato di fare piu ore..] (398:400) (Super)

Oggi ho pensato di fare più ore perché la settimana prossima poi non ci sono. Ogni tanto ci sono dei controlli sul registro delle presenze. Nei reparti si ricordano gli orari e quando no si va bisogna avvertire.

**Code: Timetable changes (15-6)**

P 2: MUSICIANS.doc - 2:37 [Paola è malata e non fa le sue..] (8:8) (Super)

Paola è malata e non fa le sue 3 ore nel pomeriggio

**Code: Timetable changes (15-6)**

P 2: MUSICIANS.doc - 2:117 [Anche io ho preso dei giorni..] (590:590) (Super)

Anche io ho preso dei giorni per staccare. [A. E un dottore che sta iniziando la carriera medica e preferisce lavorare in ospedale come musicista che non come dottore, più divertente e meno responsabilità]

**Code: Timetable changes (15-6)**

P 2: MUSICIANS.doc - 2:43 [Inoltre questo è un giorno di..] (224:225) (Super)

Inoltre questo è un giorno di recupero per entrambi

**Code: Timetable changes (15-6)**

P 2: MUSICIANS.doc - 2:228 [CP - hai chiesto di non andare..] (1050:1057) (Super)

CP - hai chiesto di non andare più in TIN.

N- no, non si puo fare.

CP - come sono gli orari?

N- il totale delle ore, che è stabilito, e gli orari anche. Ogni reparto ha degli orari precisi. E dipende anche da me. Lunedì vado in geriatria e il pomeriggio al Meyer.

**Code: Timetable changes (15-6)**

P 2: MUSICIANS.doc - 2:266 [CP - te sei l’unica musicista..] (1280:1287) (Super)

CP - te sei l’unica musicista che viene all’orario stabilito. Nella prima settimana non c’è stato un giorno che sia andato come nell’orario.

N- io 4 mesi fa volevo osservare altri musicisti, ma invece non venivano.

N- una persona voleva fare 7 ora al giorno... Luca e io volevo andare a vedere la sua settima ora.

CP - la settima scorsa ho osservato Pietro che aveva provato a fare 4 ore insieme, ma poi ha deciso di spezzarle e fare 2 e 2 perché non ce la faceva.

**Code: Timetable changes (15-6)**

P 2: MUSICIANS.doc - 2:42 [Marco non c’è oggi pomerigg.] (221:223) (Super)

Marco non c’è oggi pomeriggio deve fare delle prove per uno spettacolo
Così noi suoniamo nei suoi reparti oggi.

**P 2: MUSICIANS.doc - 2:36 [S- Lunedì non ci sarà perché ho gli scrutini a scuola.]** (194:194) (Super)

Codes: [Timetable changes]

**S- Lunedì non ci sarà perché ho gli scrutini a scuola.**

**P 2: MUSICIANS.doc - 2:321 [La prossima settimana vado in ...]** (1728:1729) (Super)

Codes: [Timetable changes]

La prossima settimana vado in Giappone a riprendere mio figlio. Sto dicci giorni. Solo che non posso stare tanto tempo per via di questo lavoro! lavoro più qui che a teatro!

Specialmente a geriatria, io non posso mancare troppo [she seems to be attached to that ward more that to the children's wards]

**P 2: MUSICIANS.doc - 2:40 [L'orario rimane fisso per 7-8 ...]** (215:215) (Super)

Codes: [Timetable changes]

L'orario rimane fisso per 7-8 mesi. In estate cambia un po.


Codes: [Timetable changes]

Non sono sempre in tempo. I tempi dell'ospedale non sono così precisi. A volte ti chiudono di andare fuori e di aspettare e possono essere anche attese lunghe. Se arrivo più tardi rimango di più.

**A - abbiamo fatto un improvvisazione con le radiografie, poi avevamo dei tubi e i richiami degli uccelli e abbiamo coinvolto il pubblico. Fatto do abbiamo iniziato a cantare un canto degli intillimani. La gente è rimasta entusiasta. Alessandro ha spiegato brevemente quello che facciamo e noi abbiamo cominciato a sorpresa. La stessa cosa l'abbiamo fatta a Grado, dove c'è stata molta partecipazione.**

**CP - vi pagano per fare questo?**

**A - no, fa parte del rimborso spese.**

[i musicisti in genere non vengono pagati per attività extra ospedale, ne per le prove che fanno in relazione a questi eventi - molto malcontento - non si sentono valorizzati]

**P 2: MUSICIANS.doc - 2:75 [P- faticoso, oggi è una giornata...]** (417:417) (Super)

Codes: [Timetable changes]

P- faticoso, oggi è una giornata piena. Sono 3 sale d'aspetto ed è molto faticoso. In questa c'erano tantissimi bambini. Oggi ho fatto un cambio, invece di andare al DEA vado in un reparto, ho cambiato con la Luisa e per me è meglio perché è meno faticoso.

**P 2: MUSICIANS.doc - 2:105 [Facevo due volte alla settimana...]** (556:556) (Super)

Codes: [Emotional implications in the job] [Timetable changes]

Facevo due volte alla settimana, ma ho cercato di squeeze three days into 2. It's a bit trying. When it's hot is hard.

**P 2: MUSICIANS.doc - 2:341 [A - io sono sempre venuto, an...]** (1918:1918) (Super)

Codes: [Timetable changes]

A - io sono sempre venuto, anche quando stava male, magari prendevo un po più di break

Code: Vignette (4-0)

**P 2: MUSICIANS.doc - 2:32 [S- C'è un bambino piccolo, app...]** (167:167) (Super)

Codes: [Music as a liberating experience for Parents] [Vignette]

S- C'è un bambino piccolo, appena operato con la testa aperta. Ho iniziato a suonare, stando sulla porta e la nonna ha iniziato a piangere da morte, come sfogandosi. Una delle motivazioni della musica è anche quella di dare un'occasione per battere fuori per sfogarsi. Io ho aspettato un po che si calmasse, pur continuando a suonare e poi sono entrata e sono andata dal bambino, lei l'ha lasciata fare perché non era convivibile, in quel momento avevo bisogno di un momento per se e di qualcuno che distruggesse il bambino. Io gli ho risposto quel momento per stare male in pace. Io sono stata là a suonare con il bambino, poi l'attimo era passato e lei si è avvicinata e ha detto al bambino 'hai sentito che bella musica? Sì, il piano fa bene, specie in certe situazioni, e lei mi è sembrata più rilassata. Questo intervento mi è piaciuto molto più di questo.

**P 1: TRANSCRIPT audio files 22 MAY .doc - 1:15 [S - una stanza con tre bambine...]** (50:50) (Super)

Codes: [Vignette]

DATA SOURCE UNACCESSIBLE! C:\Documents and Settings\Costanza\Desktop\TRANSCRIPT audio files 22 MAY .doc
Un dottore gli richiede di passare dal pronto soccorso perché c'è una situazione delicata. Un bambino di 9 anni con i due genitori in una stanza che piange e non vuole accettare di essere ricoverato per una notte, per una piccola operazione chirurgica. Il dottore chiude al musicista di suonare per far calmare il bambino. Inizia a cantare sulla porta della stanza, alla fiera dell'est, calmo, lento, piano. Chiama il babbo e gli da una bacchetta e inizia ad accompagnare il canto, un canto pop e cantano insieme. Si avvicinano al bambino che ha smesso di piangere e guarda con sospetto il musicista. Da lì bastone della pioggia al bambino dopo avere dimostrato come si usa. Il bambino si concentra sullo strumento e inizia a suonare con il babbo e il musicista. Madre piange. Cantano altre due canzoni e il musicista esce. Il bambino ricomincia a piangere.

S - una stanza con tre bambine, gli stavano mettendo la cannula per fare il prelievo e c'erano tutti i rispettivi genitori. Sono entrata suonando forte, come fa Marco e dopo due secondi erano tutti con gli strumenti a cantare! Bello bello. Ci sono state 40 minuti e non me ne sono nemmeno accorta. Poi ho accompagnato un paio di bambini a fare dei prelievi.

La voce è più importante del suono

La voce è più relazione attraverso la voce. Bambini, piccoli.

Il violino non l'appoggio quasi mai - tutto l'intervento a fatto con il violino in mano. Ho altri due ore - se sono tutte cosi sono tanti. La stanchezza dipende da quanta gente c'è e dalla confusione.

Il musicista entra nella stanza con tre bambine...
Appendix K. Children and carers’ interview transcript and list of derived codes

Child reaction to music
Memories of a particular musician - reasons
Music and stress
Musical taste - child
Parent’s musical taste
Parents’ musical influence on child’s musical preference
Perception of intervention
percussions
Repertoire
Stress connected to hospital procedures
Stress connected to hospitalization

Codes-quotations list
Code-Filter: All [12]

Code: Child reaction to music (5-0)
P 1: CHILD AND PARENTS.doc - 1:16 [M - si! stamani appena sentito. ] (355:361) (Super)
Codes: [Child reaction to music]

M - si! stamani appena sentito il violino ha cominciato a smaniare che voleva andare nel corridoio, ma non si poteva! poi l'ho portata sulla porta, ma non si puo uscire.
CP - appena ha sentito il violino?
M - si! appena ha sentito il suono

P 1: CHILD AND PARENTS.doc - 1:31 [In america, c'era il best fire..] (567:567) (Super)
Codes: [Child reaction to music]

In america, c'era il best firend. Mio figlio non me ha voluto sapere. C'era anche la musica ma non ha voluto sentirla mai. Lui ascolta musica rock (Godzilla e altre robe del genere), la musica che gli veniva proposta era per bambini più piccoli. Quando sta male non ascolta musica. In US aveva tutta una play station accanto al letto che non ha mai usato.

P 1: CHILD AND PARENTS.doc - 1:17 [B - nel corridoio si, in camera no. ] (332:332) (Super)
Codes: [Child reaction to music]

B - nel corridoio si, in camera no, perche il suono acuto mi dà fastidio, li lo sento di meno.
CP - quando Pietro ha suonato prima della sedazione ha funzionato?
M - si, lui si tranquillizza sempre quando sente la musica, tant'è che in medicheria lui non ha mai avuto paura perché gli mettono la radio e con la radio accesa lui balla, canta e lui non si spaventa, addirittura, riescono a fare all'addormentato e le risonanze magnetiche senza sedazione, che invece è normale con i bambini piccoli perché i bambini hanno paura con i rumori che fa la macchina, ma lui ci entra dentro, basta che io stia lì e gli canti, ma se uno si innervosice mi dimentico. Li canto vicino alla testa, e li tengo le mani, insomma me la faccio anche io la tac che non è proprio il massimo.

P 1: CHILD AND PARENTS.doc - 1:26 [CP - e cosa canti? M - quello ..] (433:436) (Super)
Codes: [Child reaction to music]

CP - e cosa canti?
M - quello che mi viene in mente, in quei momenti è difficile...in genere sono due coccodrilli.

Code: Memories of a particular musician - reasons (1-0)

P 1: CHILD AND PARENTS.doc - 1:22 [M - si, gli piace Luca e pl.]. (401:402) (Super)
Codes: [Memories of a particular musician - reasons]

M - si, gli piace Luca e gli piace tantissimo Pietro [suona la chitarra]. Pietro è molto coinvolgente, molto coinvolgente, lo ha anche accompagnato in sala operatoria una volta per una lombare.

Stavano facendo delle prove sull'effetto della musica sulla sedazione e lui era lì che suonava... la sedazione comincia dopo, il bambino si agita. Di solito mettono una canzone i dottori.

Code: Music and stress (1-0)

P 1: CHILD AND PARENTS.doc - 1:9 [CP ...la musica non l'aiuta a ..] (199:203) (Super)
Codes: [Music and stress]

CP ...la musica non l'aiuta a rilassarsi?
M and F - No, gli fa il contrario, la stressa
F - quando sta bene gli piace ascoltarela.
CP - voi ascoltate musica?
F - eh lei ascolta tanta musica!

Code: Musical taste -child (3-0)

P 1: CHILD AND PARENTS.doc - 1:13 [CP - che musica ascolti? Cosa ..] (310:318) (Super)
Codes: [Musical taste -child]

CP - che musica ascolti? Cosa hai nell'tuo mp3?
B - shakira...[e altri nomi strani che non capisco]
CP - che musica è?
M - molta glie l'ha scaricata il suo fratello più grande
B- è musica che si sente al Festivalbar

P 1: CHILD AND PARENTS.doc - 1:12 [Lui e molto iperattivo, divers..] (36:36) (Super)
Codes: [Musical taste -child]

Lui è molto inquieto, diverso dagli altri bambini. Ma ama molto le canzoni dello zecchino d'oro e le musiche del Disney channel.

P 1: CHILD AND PARENTS.doc - 1:23 [M - in verità è più lui che ge..] (410:415) (Super)
Codes: [Musical taste -child]

M - in verità è più lui che gestisce la musica... anche quando guarda la televisione, la cosa che gli interessa sono i pezzi della musica.
[Il piccolo ha un registratore che fa andare avanti, ha una idea precisa del pezzo che vuole ascoltare e continua ad andare avanti - finché trova una canzone che di solito canta Pietro - la madre inizia a cantare]

CP - ma questa canzone la canta anche Pietro!
M - si, infatti la prima volta l'ha sentita da lui ... questa è la canzone che preferisce e non la cambia. Anche quando siamo in macchina, vuole solo sentire questa canzone, anche se il viaggio dura 4 ore!! oppo vuole che noi cantiamo, sonno si arrabbia [la canzone finisce]...proverebbe a rimmerla ma qui non gli riesce tornare indietro, quindi va avanti ma di queste ne ascolta solo un pezzo.

Code: Parent's musical taste (3-0)

P 1: CHILD AND PARENTS.doc - 1:6 [M a me piace musica classica..] (170:171) (Super)
Codes: [Parent's musical taste]

M - a me piace musica classica poi ascolto tutto. Poi ascoltiamo le canzoni che piacciono a Francesco, sono canzoni da bambini. ...ho preso queste così un po a caso.
F - la Marta è brava !!

Codes: [Parent's musical taste]

M - musica leggera, tipo Pausini, Tiziano Ferro, Baglioni... a lei gli piacciono, li conosce tutti e li canta, o secco zecchino d'oro... è venuta anche con me, quando era in pancia, a un concerto di Baglioni, e lo sai quando era piccola, appena nata le ho messo una cassette, come se avesse veramente riconosciuto la musica, perché la portai a un concerto che ero di 8 mesi. Era in carrozzina, misi questa cassette e lei si fermò come se conoscesse.
M: no, la classica mi annoia un po... un po di tutti i generi. Siccome abbiamo una cassetta con le musiche della televisione. Ma siccome a lui piace di più la televisione, quando la metto lui mi dice 'mamma spegni che voglio vedere la televisione' ma quando siamo in macchina gli piace.

P 1: CHILD AND PARENTS.doc - 1:19 [M - si, una volta al prelievo...] (375:375) (Super)

M - si, una volta al prelievo del sangue, probabilmente era presso dall'analisi...ma ha riconosciuto il violin e poi ha riconosciuto 'ala fiera dell'Est' perché gliela canta anche il suo babbo.

P 1: CHILD AND PARENTS.doc - 1:2 [A casa ascoltate musica? Si, ..] (186:189) (Super)

A casa ascoltate musica?

Si,

Musica in genere [spesso non riescono a specificare che tipo di musica - interessante]

Dopo che abbiamo sentito la musica qui adesso stiamo facendo tutta la raccolta di canzoni sugli animali e cantiamo insieme.

P 1: CHILD AND PARENTS.doc - 1:29 [CP - e le canzoni che sai dove..] (535:538) (Super)

CP - e le canzoni che sai dove le hai imparate?

M - ...della mamma, che cerca di cantare, con dvd e vari supporti! ...alla Marta piace molto cantare

Ha un problemino agli orecchi, perché è tutta tappata.


A me piace il rap. I Poeti lirici.....Noi viviamo di musica, anche la musica che fa mio m

Code: Perception of intervention {3-0}
Marta ha una voce bellissima, ci fa piangere tutte. I suoi modi sono molti gentili e rispettosi, e le canzoni che canta sono dolcissime.

Code: perceptions [3-0]

CP - ti hanno dato degli strumenti?
B - si, era un bastoncino con attaccate delle cose sopra
Cp - lo conosci?
B - no,
CP - ti ha incuriosito?
B - un po.

CP - questo strumentino che ti ha dato Luca ti sembrava interessante?
B - sembrava una scopetta! (radiografie attorcigliate e tagliate ad un estremita)

M - gli strumenti gli piacciono moltissimo, indipendentemente dal fatto che conosca una canzone.
Code: Repertoire [3-0]

B - si, la tartaruga, whisky il ragnetto,
CP - se torna la musicista vorresti risentirla?
B - nel corridoio si, in camera non, perché il suono acuto mi da un po fastidio, li lo sento di meno.
CP - se lei cantasse una canzone di Shakira di piacerebbe?
B - [ride] no, ci vogliono i tamburi!
CP - tra una canzone che non conosci di Neck e una che conosci che canta la musicista, quale preferisci?
B - va bene quella di Neck

P 1: CHILD AND PARENTS.doc - 1:10 [CP - che canzoni anno cantato?...] (263:269) (Super)
Codes: [Repertoire]
CP - che canzoni anno cantato?
B - alla fiera dell’est
CP - la conoscevi?
B - si, la cantavo a scuola

Code: Stress connected to hospital procedures [2-0]

F - Ancora non ha fatto colazione...
B - Vorrei che passasse almeno...
Codes: [Stress connected to hospital procedures]

M - Vorrei che passasse almeno da casa prima di partire, che vedesse la sua sorella per tre giorni, la mamma vuole stare con lui e la sorella, poi a Pavia lo aspetta un mese in ospedale, 45 giorni di camera sterile, lo chiamano l'acquario. La sua sorella era al mare e l'ho fatta ritornare di corsa [madre, molto esperta con i globuli e con i trattamenti - molto stressata, preoccupata, ansiosa, affaticata, alienata da una vita normale che si sta dimenticando]

Code: Stress connected to hospitalization (1-0)

P 1: CHILD AND PARENTS.doc - 1:3 [M- la musica non gli fa niente..] (53:53) (Super)

Codes: [Stress connected to hospitalization]

M- la musica non gli fa niente perché lui ha la sua idea ed è difficile che lo smonti. Stamani non voleva entrare nel cancello dell'ospedale, quello esterno, sicché sa già dove va, sa già che gli farà

Code: VIGNETTE - music as a facilitator for relation between parent and child (1-0)

P 1: CHILD AND PARENTS.doc - 1:4 [Il bambino continua a piangere.] (62:104) (Super)

Codes: [VIGNETTE - music as a facilitator for relation between parent and child]

[il bambino continua a piangere ed è molto nervoso, continua a dire no, no no, no, il babbo prende lo strumento che ha lasciato la Paola, una mucca, e inizia a muoverlo, il bambino è distratto e comincia a giocare con un altro strumentino che ha un suono di un uccellino]

Andrea - uhhhhhh, uhhhh

Babbo - via che si è fatto tutto ...oh che proteste!

Mamma - vieni che si va a fare colazione

A- no, no , nooo

B- dai vieni in collo che si fa un po di colazione

A- no, no , nooo

B- guarda i gamberini che ballano? [pointing a child book nearby]

[io prendo uno degli strumenti lasciati dal Paola, un cilindro colorato con delle figure di mucche, se lo giri dalla parte opposte fa il suono di una mucca - lo faccio suonare e rido]

B- senti? ...hai sentito ? o che verso fa?

[il bambino guarda stupito e ancora intimorito - io gli offro lo strumento - lui lo prende]

B - ora prova te?

[il bambino gira il cilindro e produce il suono - io rido]

B - visto, la tata ride

[io prendo un sonaglietto che produce il suono di un uccellino e lo produco - il babbo guarda]

B- o cosa succede qui, diglielo, cosa succede?

[il bambino prende il sonaglietto perché è più piccolo e riesce a muoverlo meglio - il babbo prende lo strumentino che fa il suono della mucca - lo suona]

B- ha sentito ! oh che verso fa?

A ... dice qualcosa che il babbo interpreta come 'pallina'

B - si, ma ora si va a casina, perché se no si sta qui tutta la mattina , hai ciao alla tata, fagli ciao, mandagli un bacino, così, (fa il segno),…ciao tata, hai ciao, dagli grazie

Escono ..

[example of how sounds and musical interaction - or acting as a facilitator to foster a musical interaction between the child and his father, like in this case - can be a useful device to bring back the child to a normal situation and get out form the distress of the previous situation that has been building up since he got in the car]
Appendix L. Staff’s interview transcript and list of derived codes

Age range of hospitalized children
Bigger issues in hospital than music
Evaluation of the project
Groups with which music is more effective
Memories of specific musicians - reasons
Music as facilitating staff’s job
Music as relaxing for staff
Music as stressful for staff
Music for staff
Music is on request for special occasion
Musical taste - personal
Musician’s intervention
Perceived professionalism of musicians
Perception of the aims of music
Perception of parents’ role
Positive impression
Repertoire
Repertoire - classical music
Repertoire - stress
Therapeutic use of music
Timetable - issues
Why is music therapeutic?

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Codes-quotations list
Code-Filter: All [22]

Code: AGE RANGE OF HOSPITALIZED CHILDREN (1-0)

P 1: STAFF.doc - 1:105 [CP - qual'è l'età media dei bambini ricoverati qui?] (581:583) (Super)
Codes: [AGE RANGE OF HOSPITALIZED CHILDREN]

CP - qual'è l'età media dei bambini ricoverati qui?
D- la grande maggioranza dei bambini sono sotti i 5 anni, poi magari c'è una fascia di bambini da 5 a 10 ma sono interventi programmati. Sopra i 10 è una percentuale minore, e sono cronici oppure traumi e lesioni più gravi. La grande maggioranza dei bambini che arrivano sono sotto i 5 anni.
Io penso che la scelta del repertorio è legata a chi suona.

Code: Bigger issues in hospital than music (2-0)

P 1: STAFF.doc - 1:16 [CP- come mai l'ospedale non fa valutazioni?] (120:123) (Super)
Codes: [Bigger issues in hospital than music]

CP- come mai l'ospedale non fa una valutazione?
Perché non c'è un interesse. Non c'è controllo su questo servizio, ne sulla qualità... non c'è controllo anche sui servizi istituzionali... come la cardiology per esempio,
La musica è un problema minore. Le valutazioni non sono fatte su niente, inclusi i servizi medici.

P 1: STAFF.doc - 1:17 [Una madre in oncologia] (125:125) (Super)
Codes: [Bigger issues in hospital than music]

[Una madre in oncologia si è lamentata che la musica è un servizio aggiuntivo che non è necessario se prima non ci sono dottori, bagni, una struttura. Quello che vuole lei è un servizio professionale medico]
CP - ho parlato con le psicologhe della terapie del dolore che hanno fatto una valutazione informale commissionata da Busoni (primario di anestesia e promotore del progetto musica in ospedale) nel 2003, dopo un anno dall’inizio, ed era emerso che il personale dell’ospedale riteneva il repertorio molto ripetitivo e che a lungo andare provocava stress perché era sempre il solito repertorio. Per cui se da una parte la musica era un elemento positivo per i bambini, dall’altra se uno sente la stessa canzone per 4 anni...

CP - non c’è mai stato fatta una valutazione ...

TP - questa è stata anche un po una mancanza di questo progetto, perché è stato previsto un intervento, ma non è stato anche ipotizzato ne dei tempi di attuazione ne di valutazione e di ricaduta, sia sull’organizzazione, sia sui bambini, sia sugli operatori

M- al di là di questo, è difficile fare una valutazione della musica. Si parla della qualità della vita in ospedale. Quando entri nel merito di questo, si parla di ricerche qualitativa, che ancora non ha sviluppato una metodologia adeguata.

Noi abbiamo anche adulti, ragazzi grandi. Una volta abbiamo avuto un ragazzo psichiatrico, molto agitato e la mamma ci disse che non erano mai stati capaci di fare un prelievo, ma con la musica se lo fece fare. La mamma piangeva, perché effettivamente fu una cosa che fece effetto a tutti. Rimase calmo e fece il prelievo. Per qualcuno a una tecnica buona, per altri meno, come in tutte le core.

Poi c’è da dire che questo ragazzo è ritornato e siccome si vede che aveva un ricordo positivo è stato calmassetto. Non essendoci nemmeno is musics.

N- si, soprattutto sui ragazzini che hanno delle crisi di panico, di carattere psicologico, o bambini autistici che sentono la musica, hanno delle risposte più sensibili.

Succede che la musica viene spesso richiesta con bambini down o che hanno dei problemi a livello comportamentale. Le infermiere hanno visto che con tanti bambini che non riescono ad avvicinarsi, specialmente se sono down o con problemi comportamentali e magari anche adolescenti così che è difficile tenerli, la musica aiuta molto e perciò la richiedono.

D1 - io non l’ho sentita suonare, anche classics.... non l’ho sentita cantare. L'altra ha una voce melodiosissima... fa un repertorio un po meloso a volte, ma la voce è molto bella.

D1 - io non l’ho sentita suonare, anche classica... non l’ho sentita cantare. L’altra ha una voce melodiosissima... fa un repertorio un po meloso a volte, ma la voce è molto bella.

D1 - a me piace più di tutti Pietro e mi piace Il leone si e addormentato, e i bambini fanno oh. Se devo fare una preferenza dico lui. Perché è bravo a coinvolgere i bambini, a dargli gli strumenti. Anche la ragazza con il violino, coinvolgono, ma le altre due ragazze non coinvolgono così. Ma in generale non ascolto... magari anche perché fanno canzoni che non conosco, mi fermo più volentieri se c’è una canzone che ho sentito da bambina, le due ragazze hanno un repertorio più particolare, meno conosciuto. Quando eravamo bambini si sentivano canzoni come ‘alla fiera dell’ese, per fare un albero’, nella vecchia fattoria. Questi ragazzi non gli ho mai sentire cantare queste canzoni.

CP - ti ricordi alcuni musicisti, qualcosa che ti ha colpito?
N - c’è un operatore che conosco di più, con la barba che utilizza tutti gli strumentini particolari, tipo le noci attaccate insieme, strumenti che fanno loro. E’ capitato più di frequente di vedere lui qui. Oppure anche la ragazza con la chitarra e gli occhiali, non mi ricordo più...

CP - Cosa ti colpisce di lei?

N - la voce che è molto bella.

P 1: STAFF.doc - 1:69 [CP - c’è un musicista che le p. ] (417:418) (Super)

CP - c’è un musicista che le piace particolarmente, di cui si ricorda?

D - in questi anni ne ho visti tanti uno ragazzo con cui suonai in una camera sterile, e me lo ricordo perché era bravo, era divertente, suonava bene, suonava la chitarra. C’è anche un musicista medico che ha fatto la tesi su questo argomento e che continua a venire non come medico ma come volontario. Ci sono anche altri strumentisti con cui ho un rapporto un po’ più distante rispetto alla chitarra, che è uno strumento che io suono un po’.

P 1: STAFF.doc - 1:124 [D - lei suona e canta, Alessia.. ] (691:692) (Super)

D - lei suona e canta, Pietro è quello che gioca di più è più divertente

P 1: STAFF.doc - 1:130 [N- C’è differenza tra ragazzi..] (740:740) (Super)

N - C’è differenza tra ragazzi che vengono e fanno usare degli strumenti, e quelli che invece suonano nel corridoio, oppure altri che entrano nelle stanze e si fermano a suonare con tutti i bambini. C’è un ragazzo particolarmente carino che fa partecipare tutti i bambini, l’ho visto anche davanti al dea, dove ci sono tutti bambini in attesa e anche sofferenti, e lui è li che partecipa a questo lavoro di coinvolgimento dei bambini. La musica mi sembra terapeutica

P 1: STAFF.doc - 1:125 [D - la Cinzia suona di pin e..] (688:688) (Super)

D - la Cinzia suona di pin e gioca molto di meno.


N - Molto rilassante. C’è musica e musica. Quella che ha fatto questo ragazzo con i tamburelli, molto ritmica, mi è piaciuta molto. Invece quella musica che fa la ragazza con la viola è un po’ troppo, è un po’ troppo melodica e classica. O piace o alla fine forse innervosisce, una nenia...

Non li so spiegare.

Code: Music as FACILITATING staff’s job {12-0}

P 1: STAFF.doc - 1:127 [CP - com’è lavorare con la mus..] (720:723) (Super)

CP - com’è lavorare con la musica?

N - bello! I bambini sono contenti e anche noi.

P 1: STAFF.doc - 1:81 [CP - facilitano il vostro lavo..] (464:466) (Super)

D - non li utilizziamo per le procedure, diciamo che li utilizziamo per distrarre i bambini. A me personalmente mi fa dormire.

P 1: STAFF.doc - 1:57 [CP. quindi la musica favorisce..] (352:355) (Super)

CP - quindi la musica favorisce il loro lavoro?

N - decisamente. Credo che vada fatta per i bambini però nel senso che le canzoni che fa la Marta sono molto più accettabili di quelle fa la Noemi. Lei fa musica anche bella ma fa troppa musica classica. A volte ci sono stati anche dei genitori che ce l’hanno detto.

P 1: STAFF.doc - 1:100 [P - i benefici di questo inter..] (558:559) (Super)

P - i benefici di questo intervento?

D - bambini e genitori e di riflesso anche noi, perché troviamo un bambino più rilassato.

P 1: STAFF.doc - 1:112 [CP - voi non la richiedete la ..] (611:613) (Super)

334
CP - voi non la richiedete la musica?

D - noi abbiamo sempre messo delle cassette, dello Zecchino d’oro, o mi ricordo di un bambino che voleva sempre ‘Il cocodrillo come fa’. Poi dipende dai bambini, ci sono quelli a cui piace e a cui non piace.

P 1: STAFF.doc - 1:75 [CP - possiamo dire che la musica facilita il vostro lavoro?] (438:439) (Super)

CP - possiamo dire che la musica facilita il vostro lavoro?
N - diciamo che fa stare meglio i bambini e che loro si distraggono, perciò facilita delle procedure.

P 1: STAFF.doc - 1:93 [CP - per il personale c’è un vantaggio?] (528:529) (Super)

CP - per il personale c’è un vantaggio?
D - avere poi a che fare con bambini più rilassati e tranquilli.

P 1: STAFF.doc - 1:88 [CP - preferite musica in un situazione di tranquillità che non di emergenza?] (494:495) (Super)

CP - preferite musica in una situazione di tranquillità che non di emergenza?
N - di tranquillità

P 1: STAFF.doc - 1:78 [CP - facilita il vostro lavoro?] (450:451) (Super)

CP - facilita il vostro lavoro
D - per l’attesa tanto.

P 1: STAFF.doc - 1:79 [CP - e per le procedure, la usate?] (452:455) (Super)

CP - e per le procedure, la usate?
D - a volte usiamo la musica dei cellulari, c’è un nostro collega che ha delle suonerie su un computer. Piu che altro quando facciamo delle suturazioni, allora il bambino guarda lo schermo e sente la musica.

P 1: STAFF.doc - 1:116 [CP - questo aiuta il vostro lavoro?] (630:633) (Super)

CP - questo aiuta il vostro lavoro?
D - [ride] dipende... ogni tanto manderemo volontieri a quel paese la musica! Poi dipende da chi viene a suonare. Pietro viene spesso ....

P 1: STAFF.doc - 1:97 [CP - questo servizio potrebbe migliorare, cambiare?] (546:548) (Super)

CP - questo servizio potrebbe migliorare, cambiare?
D - forse potrebbe essere più presente. ma forse ho anche io l’idea che il pronto soccorso lavora 24 ore per cui forse vorrei averne di più

Code: Music as relaxing for staff {4-0}

P 1: STAFF.doc - 1:128 [N - due settimane fa hanno suonato una musica con il violin che mi ha fatto quasi piangere, sai quelle musiche classiche...ora non mi ricordo il pezzo, ma brave!] (727:727) (Super)

N - due settimane fa hanno suonato una musica con il violin che mi ha fatto quasi piangere, sai quelle musiche classiche...ora non mi ricordo il pezzo, ma brave!

P 1: STAFF.doc - 1:95 [CP - si ricorda di uno stile musicale della musica che suonano?] (531:533) (Super)

CP - si ricorda di uno stile musicale della musica che suonano?
D - c’è quello con il violin, musica rilassante, coinvolgono il bambino. Non saprei dire che canzone era, ma forse perché io sono particolarmente ignorante di musica.

P 1: STAFF.doc - 1:30 [CP - e questo aiuta il vostro lavoro?] (184:186) (Super)

CP - e questo aiuta il vostro lavoro?
N - si, com'è rilassamento nostro sicuramente... forse è una cosa personale perche a me piace molto la musica,


Codes: [Music as relaxing for staff]

CP - la musica vi rilassa?

N - si, poi a me piace tanto. Con una mia collega si stava cercando un cd per mettere della musica per bambini quando non ci sono i musicisti

Code: Music as stressful for staff [12-0]

P 1: STAFF.doc - 1:80 [N - stressante no, ma magari n... ] (456:457) (Super)

Codes: [Music as stressful for staff]

N - stressante no, ma magari non so che suonano. A me la musica non piace.

P 1: STAFF.doc - 1:118 [D - qualche volta si, ma in ge... ] (645:645) (Super)

Codes: [Music as stressful for staff]

D - qualche volta si, ma in generale non è una cosa che da fastidio, puo essere che in particolari momenti, con voci particolarmente melliflue che dici basta l'è anche quella l'è finisce lì

P 1: STAFF.doc - 1:31 [ci sono alcuni colleghi che 'a... ] (186:186) (Super)

Codes: [Music as stressful for staff]

ci sono alcuni colleghi che 'ah questa musica!' si lamentano... proprio per il suono continuo, per la musica, sono persone a cui non piace la musica, perch in secondo me è solo positivo e rilassante. Però sono pochi quelli che si lamentano, il giudizio generale è positivo.

P 1: STAFF.doc - 1:109 [CP - ho parlato con alcune inf... ] (596:597) (Super)

Codes: [Music as stressful for staff]

CP - ho parlato con alcune infermiere del des, e mi hanno detto che alcune infermiere hanno la sensazione di saturazione sonora.

D - la musica soft è un valore aggiunto

P 1: STAFF.doc - 1:77 [D - Quando abbiamo delle emerg... ] (448:449) (Super)

Codes: [Music as stressful for staff]

D - Quando abbiamo delle emergenze, la musica da noia. Generalmente stanno fuori dal reparto.

P 1: STAFF.doc - 1:119 [D2 - invece a me la musica mi... ] (648:649) (Super)

Codes: [Music as stressful for staff]

D2 - invece a me la musica mi disconcentra, lo ammetto. Sentire la musica intorno, mi disconcentra.

P 1: STAFF.doc - 1:99 [CP - musica e stress D - per n... ] (554:556) (Super)

Codes: [Music as stressful for staff]

CP - musica e stress

D - per noi questo non è tanto percepito perché da noi suonano prevalentemente nella sala d'attesa.

È probabile che ci sia questa percezione, noi li abbiamo nel reparto e nella sala d'attesa, così li vedì passando e hai la sensazione di vederli più volte

P 1: STAFF.doc - 1:98 [CP - lei reagisce diversamente... ] (549:552) (Super)

Codes: [Music as stressful for staff]

CP - lei reagisce diversamente se ascolta la musica sotto stress o quando è più rilassato?

D - quando c'è stress e necessità di concentrarsi la musica non si sente nemmeno, perché la concentrazione è sull'emergenza, e così la musica diventa una musica più di sottofondo.

In una giornata tranquilla si apprezza di più.

P 1: STAFF.doc - 1:120 [D - io si, anche io ascolto ma... ] (658:658) (Super)

Codes: [Music as stressful for staff] [Repertoire - classical music]

D - io si, anche io ascolto musica classica, ma second me ai bambini piace più l'interazione, il gioco, non tanto la musica di per se.

Magari da più fastidio sentire una che gira nel corridoio cantando quando in giro non c'è nemmeno mezzo bambino, perché allora li può scatenare che dici ma che vuole! Il bambino ha bisogno di essere coinvolto.

P 1: STAFF.doc - 1:64 [Per quanto riguarda l'impatto ...] (402:402) (Super)

Codes: [Music as stressful for staff]
Per quanto riguarda l'impatto sugli operatori, questo è molto legato con il rapporto che hanno con la musica. Qualcuno ha abituato a concentrarsi con la musica, altri invece la percepisce come un disturbo, anche perché si sentono sempre le stesse canzoni! [ride] Ma più in generale dipende dal rapporto che uno ha con la musica, per alcuni ascoltare qualsiasi tipo di musica, disconcentra.

P 1: STAFF.doc - 1:74 [Per i bambini è buona questa c..] (434:435) (Super) Codes: [Music as stressful for staff]

Per i bambini è buona questa cosa ma noi non ci facciamo caso perché siamo molto indaffarate. Io personalmente non sono una grande appassionata di musica, perció non so dire che musica suonano. A volte non si sente nemmeno se i bambini piangono si accavalla.

P 1: STAFF.doc - 1:67 [CP - gli strumentini come li v..] (409:411) (Super) Codes: [Music as stressful for staff]

CP - gli strumentini come li vede?
D - ab i bambini si divertono un mondo... l'operatore, siano sempre li, se deve essere concentrato e sente confusione può dare fastidio, aumenta il fastidio di sottofondo. Io ricordo sempre che quando entrai per la prima volta nel reparto dei lattanti rimasi sconvolto dal pianto continuo dei bambini e mi chiesi 'come ti fa a lavorare in questo ambiente con questa confusione' poi dopo 10 giorni non te ne accorgi più.

Tuttosommato uno ha bisogno di avere una certa concentrazione e avere i bambini che suonano le percussioni, specialmente fuori tempo [ride] se uno ha anche un po di occhio, insomma faielo andare a tempo!... ma sicuramente l'effetto che la musica ha sul bambino è positivo e supera le piccole perturbazioni dell'operatore.

Code: music for staff (5-0)

P 1: STAFF.doc - 1:132 [Comunque quelle due ragazze ch..] (746:749) (Super) Codes: [music for staff]

Comunque quelle due ragazze che vengono insieme, sono davvero brave, e quella musica... mi ha fatto davvero molto piacere.

Poi a volte succede che fanno partecipare anche noi, quando il reparto è più tranquillo...
con questo ragazzo che ti dicevo si facevano anche dei balletti, se la situazione è più tranquilla, insomma ci piace anche a noi... ci coinvolgono, partecipare con i bambini.

P 1: STAFF.doc - 1:85 [CP - suonano musica per inferm..] (486:487) (Super) Codes: [music for staff]

CP - suonano musica per infermieri?
N - no, mai, solo canzoni per bambini

P 1: STAFF.doc - 1:110 [CP - il primo target sono i ba..] (601:603) (Super) Codes: [music for staff]

CP - il primo target sono i bambini?
D - si, non siamo ancora al livello tale da pensare che i musicisti servano agli operatori, perché quello è un passaggio ulteriore, per loro è una distrazione. Il musicista è tollerato, ma a chi non piace, è tollerato per il rilassamento del bambino. E' un problema culturale.

P 1: STAFF.doc - 1:129 [N - due settimane fa hanno suo..] (726:727) (Super) Codes: [music for staff]

N - due settimane fa hanno suonato una musica con il violino che mi ha fatto quasi piangere, sai quelle musiche classiche...ora non mi ricordo il pezzo, ma brave!

P 1: STAFF.doc - 1:40 [CP - avete avuto musicisti che..] (217:219) (Super) Codes: [music for staff]

CP - avete avuto musicisti che suonano appositamente per voi?
N - si, musica classica, e anche la ragazza con gli occhiali fa un repertorio più pop. L'altra volta mi ricordo che c'era una ragazza che suonava l'Ave Maria di Schubert.

Code: Music is ON REQUEST for special occasion (13-0)

P 1: STAFF.doc - 1:126 [CP - vi sentire di collaborare..] (697:707) (Super) Codes: [Music is ON REQUEST for special occasion]

CP - vi sentire di collaborare con questi musicisti?
D2 - no, io no mi sento di collaborare per nulla.

CP - la terapia del dolore mi diceva che riceve delle chiamate da voi
D - ho visto anche la musica in sala sedazione.

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CP: chi la chiamava la musica?

D: a volte succedeva che si sapeva che a un bambino piaceva la musica e allora si chiamava. Se c'è il bambino che gli piace allora si rilassa, se c'è il bambino che piange, a volte la musica non basta. Quello dipende dal bambino. Se il bambino è agitato reagisce piangendo, anche se magari lo accompagnavano prima, poi quando arrivava alla stanza iniziava a piangere.

P 1: STAFF.doc - 1:133 [Magari si richiede piu per i b. ] (755:755) (Super)
Codes: [Music is ON REQUEST for special occasion]

Magari si richiede più per i bambini che stanno più a lungo, ma è a discrezione della caposala.

CP: la musica viene usata specificamente per certi interventi, su richiesta....

TP: se l'infermiere ha degli elementi per decidere che il bambino beneficiere della musica in un determinato momento durante la procedura allora ben veng! L'importante è che non la si dia a tutti perché è di moda usare la Musica. Bisogna chiedere al bambino e ai loro genitori se un certo repertorio in un certo momento può aiutare il bambino a ridurre l'ansia.

P 1: STAFF.doc - 1:28 [CP - usate la musica 'su richi..] (180:182) (Super)
Codes: [Music is ON REQUEST for special occasion]

CP: usate la musica 'su richiesta' per situazioni speciali?

N: tendenzialmente non li chiamiamo però se c'è una situazione particolare allora li chiamiamo.

P 1: STAFF.doc - 1:76 [CP - voi li chiamate i musici..] (441:444) (Super)
Codes: [Music is ON REQUEST for special occasion]

CP: voi li chiamate i musicisti?

N: no, generalmente no.
CP: perché io ho visto il DR. Masi chiamare un musicista
N: si, lui è un appassionato di musica! no, non lo sapevo che c'era questo servizio.

P 1: STAFF.doc - 1:1 [Tutte le caposala sanno che c'..] (40:40) (Super)
Codes: [Music is ON REQUEST for special occasion]

Tutte le caposala sanno che c'è la musica in ospedale. I musicisti fanno la loro attività rispettando gli orari, poi in alcuni casi le caposala fanno la richiesta per avere un musicista in un certo giorno, passando attraverso di noi.

P 1: STAFF.doc - 1:18 [Il servizio di musica funziona..] (129:129) (Super)
Codes: [Music is ON REQUEST for special occasion]

Il servizio di musica funziona ma è lasciato alla sensibilità dell'operatore che chieda il musicista per una procedura, non c'è una sistematizzazione nell'uso della musica durante le procedure dolorose.

P 1: STAFF.doc - 1:94 [Se c'è qualcosa del gruppo che..] (530:530) (Super)
Codes: [Music is ON REQUEST for special occasion]

Se c'è qualcuno del gruppo che è il lo chiamiamo ma è casuale perché noi facciamo prelievi 24 ore al giorno. E' molto lasciato alla sensibilità del singolo medico/ infermiere, alla confusione che abbiamo in pronto soccorso. Non è sistematico.

P 1: STAFF.doc - 1:48 [N ......si, l'unica cosa è che..] (263:267) (Super)
Codes: [Music is ON REQUEST for special occasion]

N: ......si, l'unica cosa è che magari al pronto soccorso siamo abbastanza di fretta a fare le cose e così magari la sfruttiamo poco. Magari se c'è da fare qualche procedura in reparto.

CP: li chiamate?

N: no, passano loro. Come quando c'era quel bambino agitissimo che non voleva fare un intervento, era gia la seconda volta, e gli era presa una crisi, invece con quegli strumenti si è rilassato. Però sono interventi di urgenza qui e quindi forse è sfruttato un po poco.

P 1: STAFF.doc - 1:3 [CP - allora a base a che cosa..] (49:56) (Super)
Codes: [Music is ON REQUEST for special occasion]

CP: allora in base a che cosa l'infermiera richiede la musica?

In base alla richiesta del bambino, o del genitore che conosce i suoi gusti.

CP: chiedono anche un musicista in particolare?
No, questo no. Succede che la musica viene spesso richiesta con bambini down o che hanno dei problemi a livello comportamentale. Le infermiere hanno visto che con tanti bambini che non riescono ad avvicinarsi, specialmente se sono down o con problemi comportamentali e magari anche adolescenti così che è difficile tenerli, la musica aiuta molto e perciò Is richiedono.

Magni invece a capitato che altri ragazzi, che magari hanno il cane a casa, e così le infermiere hanno pensato che quello poteva essere più adatto.

P 1: STAFF.doc - 1:60 [CP - i musicisti fanno parte d..] (380:383) (Super)
Codes: [Music is ON REQUEST for special occasion]

CP - i musicisti fanno parte di un team integrato nell’ospedale?

N - si, è un discorso che purtroppo non possiamo fare per problemi di tempo materiale. Qui non si può proprio fare per tanti motivi. Fanno prelievi a digiuno, poi magari dobbiamo fare un prelievo un ora esatta dopo che hanno mangiato.

P 1: STAFF.doc - 1:111 [D - è proprio ultimamente che ..] (608:609) (Super)
Codes: [Music is ON REQUEST for special occasion]

D - è proprio ultimamente che si è iniziato a chiamare la musica quando si fanno le lombari, quando io sono arrivata nel 2003 si faceva meno. Appena sono arrivata c’era la terapia del dolore. Prima c’era solo la sedazione, ultimamente Pietro entra con la chitarra.

Code: musical taste - personal [9-0]

P 1: STAFF.doc - 1:47 [CP - che musica ascolti? N- eg..] (257:259) (Super)
Codes: [musical taste - personal]

CP - che musica ascolti?
N - egizia, un po araba, o italiana, musica ritmica

P 1: STAFF.doc - 1:106 [CP - che musica ascolta? D- io ..] (586:588) (Super)
Codes: [musical taste - personal]

CP - che musica ascolta?
D - io ascolto musica dei cantautori italiani, degli anni 70, poi ascolto anche musica classica.

P 1: STAFF.doc - 1:44 [N - sinceramente non ho cd di ..] (231:232) (Super)
Codes: [musical taste - personal]

N - sinceramente non ho cd di musica classica, qualche volta ho ascolto musica linec perché la mia mamma è un appassionata di musica linec, Vivaldi e Puccini, ma solo in sottofondo, io no. Alcune volte in montagna, con i nostri amici sento Vivaldi, come sottofondo non mi dispiace per leggere o rilassarmi.

Codes: [musical taste - personal]

CP - che musica ascolti?
D - classicamente prevalentemente

P 1: STAFF.doc - 1:62 [CP - che musica ascolta leip N..] (393:395) (Super)
Codes: [musical taste - personal]

CP - che musica ascolta lei?
N - io preferisco musica moderna! La musica mi piace tanto, mi piace andare a ballare, anche latino americano, mi piace tantissimo.

P 1: STAFF.doc - 1:70 [CP - lei che musica ascolta? D-] (419:421) (Super)
Codes: [musical taste - personal]

CP - lei che musica ascolta?
D - sia musica classica che ovviamente musica dei miei tempi, dai 60 agli 80.

P 1: STAFF.doc - 1:82 [CP - che musica ascolti? D -Ce..] (467:475) (Super)
Codes: [musical taste - personal]

CP - che musica ascolti?
D - Celine Dion, i Queen... ma questa è musica per bambini. Personalmente mi fa dromire, nel senso tranquillizzante. Non ascolto tanta musica ma quando l’ascolto sento roba che mi viene su.
N- La Pausini,

CP - così se i musicisti suonassero i Queen le farebbe più piacere?
D - si!

[arriva un bambino in reparto devono correre via]

P 1: STAFF.doc - 1:96 [Cp - che musica ascolta? D - r.] (534:542) (Super)
Codes: [musical taste - personal]

Cp - che musica ascolta?
D - rock anni 70, anche straniero.

CP - se qualcuno suonasse rock anni 70 ...
D - a me piacerebbe! Non so ai bambini... odioso, a mio figlio che ha 7 anni piacciono i Beatles

CP - che musica vorrebbe ascoltare qua, se la musica fosse diretta al vostro rilassamento?
D - forse musica classica .... forte jazz.

P 1: STAFF.doc - 1:43 [N - non ho un genere in partic.] (227:227) (Super)
Codes: [musical taste - personal]

N - non ho un genere in particolare, mi piace De Gregori, Renato Zero, Ligabue, Cammeriere, Paolo Conte, pop italiano, Barbra Streisand, quando mi devo rilassare

Code: Musician's intervention {3-0}

CP - ha una percezione di quante ore di musica avete qui?
D - intorno a 12 ore settimanali...

CP - 12? (sono 6 - un ora alla settimana)

P 1: STAFF.doc - 1:35 [N- non particolarmente, lei fa ..] (202:202) (Super)
Codes: [Musician's intervention]

N- non particolarmente, lei fa anche repertori ... non mi ricordo, mentre Luca fa la vecchia fattoria, spesso che dopo poco tutti iniziano a fare dei versi, queste sono quelle che maggiormente mi ricordo, però l'altra ragazza fa il suono genetico, non l'ho vista fare il coinvolgimento di bambini.

P 1: STAFF.doc - 1:104 [CP- come definirebbe la musica..] (575:576) (Super)
Codes: [Musician's intervention] [Repertoire]

CP- come definirebbe la musica che viene suonata qua?
D- musiche semplici per bambini, si rifanno ai cartoni animati Disney, oppure le vecchie ballate degli anni 60' e 70. Tutte musiche molto soft. Eppoi c'è il tentativo di coinvolgere i bambini attraverso strumenti a precussione che soprattutto per i bambini molto piccoli sono molto interessanti.

Code: Perceived professionalism of musicians {11-0}

P 1: STAFF.doc - 1:61 [CP - che lavoro fanno i musici..] (389:391) (Super)
Codes: [Perceived professionalism of musicians]

CP - che lavoro fanno i musicisti fuori dall'ospedale?

N - non lo so, sicuramente gente che ama la musica, però non saprei, si puo fare anche per passione, anche tipo volontario, senza necessariamente lavorare nel campo

P 1: STAFF.doc - 1:122 [CP - secondo voi cosa fanno i ..] (674:676) (Super)
Codes: [Perceived professionalism of musicians]

CP - secondo voi cosa fanno i musicisti?
D- possono fare un lavoro inerente alla musica, insegnati, legati alla musica. Poi è vero che uno puo suonare uno strumento, ma poi fare tutto un altro lavoro.

P 1: STAFF.doc - 1:107 [CP - che lavoro fanno i musici..] (590:591) (Super)
Codes: [Perceived professionalism of musicians]

CP - che lavoro fanno i musicisti quando non sono qui?
D- penso che per la qualità del livello professionale, penso che facciano musica anche fuori da qui, magari insegnano ai bambini o sono impegnati in qualche attività sempre relativa alla musica. Molti sono professionisti, sono in grado di capire se uno è
professionista, insomma, capisco chi suona più o meno al mio livello con la chitarra e allora so distinguere quante sono le differenze. Poi sugli altri strumenti meno. Ma mi sembra che ci sia la professionalità.

P 1: STAFF.doc - 1:25 [CP - cosa pensi che facciano i musicisti oltre a suonare qui?]

CP - cosa pensi che facciano i musicisti oltre a suonare qui?

TP - secondo me sono musicisti professionisti, ma magari insegnano musica nelle scuole.

P 1: STAFF.doc - 1:86 [CP - cosa vi immaginate che facciano i musicisti fuori dall'ospedale.]

N - sono preparati, avranno fatto un corso, alcuni vanno alla conservatorio.

P 1: STAFF.doc - 1:53 [CP - secondo te che lavorano i musicisti quando escono da qui?]

N - non lo so dire... o fanno lavoro dove hanno poco contatto con le persone e quindi vengono qui per dare un aiuto, o senso l'altro estremo.

P 1: STAFF.doc - 1:13 [CP - da un punto di vista del...]

CP - da un punto di vista del dottore, sentire un musicista professionista o no c'è una differenza? E questa si riflette sulle decisioni di 'usarli' per i vani interventi?

Sì, io credo che siano professionisti, e credo che possano suonare. Però gli operatori non lo vivono come una necessità la professionalità musicale, forse per loro è più importante la puntualità o la possibilità di averli quando c'è bisogno.

P 1: STAFF.doc - 1:54 [CP - cosa fanno i musicisti quando non vengono qui?]

Portiere - lavoreranno in qualche scuola privata presumo, o faranno delle lezioni private.

Ale - lavoro come guardia medica e faccio sostituzioni ai medici di base e alla ASL. Sono orientato sulla medicina generale.

P 1: STAFF.doc - 1:45 [CP - secondo te questi musicisti cosa fanno di lavoro quando escono dall'ospedale?]

N - me lo sono chiesta anch'io! secondo me sono insegnanti di musica, altri lo fanno di livello amatoriale, e così potrebbero fare anche un altro tipo di lavoro, ma comunque fanno del volontariato sul sociale, per fornire!

CP - non pensi che siano anche musicisti professionisti?

N - sì, si anche. Luca secondo me... non lo so. La Marta anche. Ma poi non mi ricordo gli altri.

P 1: STAFF.doc - 1:11 [CP - ti sembra che siano musicisti.]

CP - ti sembra che siano musicisti professionisti?

N - direi che sono musicisti che suonano in un'orchestra. Magari hanno bambini e lavorano poco e questo è l'unico lavoro che hanno. Forse insegnano musica... Alla fine non credo che sia importante che siano musicisti professionisti, la cosa più importante è che riescano a coinvolgere il bambino. Il musicista professionista magari è bravo ma non riesce a coinvolgere il bambino, invece la cosa più importante è stabilire una relazione e usare la musica per interagire e distrarre il bambino. Potrebbero anche usare delle pentole, ma non è fondamentale.

P 1: STAFF.doc - 1:68 [CP - che lavorano i musicisti fuori dall'ospedale?]

D - secondo me credo che alcuni fanno questo tipo di attività prima di tutto perché si sentono motivati, poi credo che ci sia anche un ritorno economico, non credo che lo facciano per quello, per cui possono fare qualiasi tipo di attività. Se invece sono musicisti che non hanno trovato una volta o sempre nessun altro tipo di attività allora questo può essere un modo per coltivare la loro passione senza magari aver intrecciato la carriera che volevano... anche perché come erano stabilita eternamente.
P 1: STAFF.doc - 1:37 [CP - qual’è l’intenzione della musica in ospedale come programma?]
N - secondo me è di distrarre il bambino dal dolore e dalla infamiliarità dell’ambiente, dando un momento di sollievo per la permanenza di un bambino che magari pensa di essere all’asilo o a casa, attraverso la familiarità delle canzoni. Spesso vengono cantate queste canzoni per i bambini.

P 1: STAFF.doc - 1:89 [CP - perché vengono a suonare?] (497:498) (Super)
N - per far stare bene i bambini. Loro rimangono incantati.

P 1: STAFF.doc - 1:73 [CP - perché l’ospedale ha deciso di investire in un progetto di musica?] (429:430) (Super)
D - per migliorare la percezione del luogo da parte dell’utenza

P 1: STAFF.doc - 1:101 [CP - la musica in ospedale che senso ha?] (566:567) (Super)
D - A me piace molto, primo perché mi piace la musica, poi perché la trovo affascinante, rilassante e credo che sia una delle espressioni che bambini colgono di più, è un linguaggio che i bambini colgono subito, specialmente con certi tipi di musica, per esempio il canzoni, la chitarra, certi tipo di melodie, che sono le canzoni classiche trasmesse dalle madri, i bambini sono molto attratti da questo.

P 1: STAFF.doc - 1:92 [CP - perché l’ospedale ha deciso di adottare il programma di musica?] (525:526) (Super)
D - secondo me perché aiuta i bambini ad accettare di più un ospedale, lo rende qualcosa di più ludico in cui si può distrarre e interagire con la musica

P 1: STAFF.doc - 1:90 [CP - perché l’ospedale ha deciso di estendere la musica a tutti i reparti?] (506:507) (Super)
N - per far passare meglio il tempo... eppoi un aiuto anche da, i bambini si tranquillizzano.

P 1: STAFF.doc - 1:50 [CP - Secondo te su chi è focalizzato l’intervento musicale?] (268:271) (Super)
N - sui bambini ma anche su i genitori, su tutti e due.

P 1: STAFF.doc - 1:115 [D - ai bambini piace, non a tutti, ma alla maggioranza si. Però come gli piace quando vengono i clown, i cani, credo che sia un’attività più di svago, credo che tutto quello che li porta fuori dall’ospedale come percezione, lo accettino volentieri]

P 1: STAFF.doc - 1:100 [P - i benefici di questo intervento?] (558:559) (Super)
D - bambini e genitori e di riflesso anche noi, perché troviamo un bambino più rilassato.

P 1: STAFF.doc - 1:39 [CP - e il genitore che ruolo ha in questo?] (213:215) (Super)
N - secondo me reagisce in maniera positiva. Alcune volte vengono coinvolti anche i genitori e spesso cantano e suonano nelle sale d’attesa. Quando passo e vedo sono sempre sorridenti.
secondo me un sottofondo musicale è positivo per tutti, indipendentemente dal genere di musica.

E la settimana scorsa una ragazza con il violino è venuta e ha suonato un pezzo famoso, adesso non mi ricordo, ma bello! Mi venivano i brividi e mi ha fatto tanto piacere, insomma, qualche volta suonano anche per noi. Sono carine quelle due ragazze che vengono. Poi quella con le lentiggini, brava, veniva sempre qui e ci cantava.

N - si, spesso vengono la mattina e anche qualche volta il pomeriggio e soprattutto stazionano davanti al pronto soccorso per che c'è l'attesa dei bambini e li aiuta davvero tanto.

C'è da dire che quando ci sono adolescenti, i musicisti cantano musiche più adatte a loro tipo degli 883, neck, quelli che sono di moda, perciò se li richiedono e li sanno... quando sono più piccoli le esigenze sono minori, perciò le canzoni sono più adatte per farli cantare in gruppo.

CP - che musica ti sembra che suonino?
M - no, come lavorano lo decido loro, anche se il repertorio è un po' noioso.

Codes: [Musician's intervention] [Repertoire]
CP - come definirebbe la musica che viene suonata qua?
D - musiche semplici per bambini, si rifanno ai cartoni animati Disney, oppure le vecchie ballate degli anni 60' e 70. Tutto musiche molto soft. Eppoi c'è il tentativo di coinvolgere i bambini attraverso strumenti a precussione che soprattutto per i bambini molto piccoli sono molto interessanti.
N- si, sono musiche per bambini, fanno musiche dei cartoni, tre porcellini, musiche di Walt Disney.

N- secondo me è di distrarre il bambino dal dolore e dalla infamiliarità dell’ambiente, dando un momento di sollievo per la permanenza di un bambino che magari pensa di essere all’asilo o a casa, attraverso la familiarità delle canzoni. Spesso vengono cantate queste canzoni per i bambini.

D- inizialmente suonano strumenti diversi, per cui l’approccio è diverso ed è diverso anche il tipo di cose che possono fare, però direi che l’aspetto che gli accomuna di più è l’approccio con i bambini piccoli fino agli 8 anni perché è chiaro che con un ragazzo più grande è più difficile riuscire ad interessarlo con uno strumento come il violino o l’arpa, li ci vuole il repertorio adeguato e secondo me funziona più la chitarra.

P- ha notato uno stile diverso tra i musicisti?

D- magari con i bambini più grandi è un po’ inutile suonare le canzoni da bambini. E’ capitato che con ragazzi più grandi gli hanno chiesto che music ascoltavano e hanno suonato canzoni moderne e così si sono distratti. Se cantano Giorgia o Neck, va bene lo stesso.

D- io si, anche io ascolto musica classica, ma secondo me ai bambini piace più l’interazione, il gioco, non c’è nessun problema con la musica di per se. Magari da più fastidio sentire una che gira e canta quando in giro non c’è nemmeno mezzo bambino, perché allora può sembrare che dica ma che vuole! Il bambino ha bisogno di essere coinvolto.

P- come ti senti quando senti la musica classica?

N- benissimo! A me rilassa, secondo me è positiva, ma il genere di musica è un discorso molto soggettivo.

P- e qui la suonano musica classica?

D- raramente, magari durante la sedazione suonano cose più blande, tipo la chitarra in arpeggio, però con i bambini non puoi fare musica classica, meglio le canzoni dello Zecchino d’Oro

P- credo che vada fatta per il bambino per un senso che le canzoni che fa l’Isabella sono molto più accettabili di quelle fa la Noemi. Lei fa musica anche bella ma fa troppo musica classica. A volte ci sono stati anche dei genitori che ce l’hanno detto.

P- quindi il repertorio non è importante?

No, il repertorio è una cosa diversa, perché il personale sente sempre lo stesso repertorio e modificarlo è uno dei problemi. Il personale è coinvolto perché quando suonano la musica per il bambino sono contorni ad ascoltarla. Io ho assistito ad una
procedura in oncoematologia in cui anche il dottore canticchiava e il clima era decisamente più disteso, se la musica è piacevole ma è
piacevole per tutti, anche se la subiscono.

Per cui spesso quando facciamo la sedazione not spesso richiediamo la musica e se un dottore deve sentire ler 7400 volte la stessa
canzone dello Zecchino d'oro in effetti può essere stressante!

P 1: STAFF.doc - 1:12 [CP - sulla musica in generale..] (188:190) (Super)
Codes: [Reperoire - STRESS]

CP - sulla musica in generale o sulla qualità di questa musica in particolare?

N - il sottofondo musicale. Spesso loro fanno le musiche per i bambini... si lamentano tanto per lamentarsi, raramente, il giudizio è
più positivo.

CP - ho parlato con le psicologhe della terapie del dolore che hanno fatto una valutazione informale commissionata da Busoni
(primario di anestesia e promotore del progetto musica in ospedale) nel 2003, dopo un anno dall'inizio, ed era emerso che il
personale dell'ospedale riteneva il repertorio molto ripetitivo e che a lungo andare provocava stress perché era sempre il solito
repertorio. Per cui se da una parte la musica era un elemento positivo per i bambini, dall'altra se uno sente la stessa canzone per 4
anni....

Invece quella musica che fa la ragazza con la viola è un po troppo .... è un po troppo melodica e classica. O piace o alla fine forse
interessisce, una nenia...
Non ti so spiegare.

CP - E quindi la musica può essere anche un elemento di stress se non è quella giusta?

N - si, secondo me si. Se viene diretta ai bambini la tolleri di più, pera può essere un momento di stress.

CP - la musica funziona? D - per quanto riguarda i bambini sicuramente credo che l'apprezzino, sia perche serve a passare periodi che sono vuoti, tra una
visita e una prestazione, tra la visita e quando si risvegliano.

Come quando c'era quel bambino agitatissimo che non voleva fare un intervento, era già la seconda volta, e gli era presa una crisi,
insie che con quegli strumenti si è rilassato. Però sono interventi di urgenza qui e quindi forse è sfruttato un po poco.

Per esempio, se fai un prelievo con l'anestetico, magari la parte a desensivizzata, ma se lo fai a un bambino lui ha più paura dell'ago
e così sarà ansioso ugualmente. Allora soffiare le bolle di sapone o concentrarsi sulla musica sarà una distrazione utile per lui.

N - si, gli distrae. Per i piccini intorno ai due anni, gli fa distrazione, gli piace.

N- si, e ho anche avuto esperienza con un bambino a cui dovevamo trovare una vena e c'era un ragazzo che
sinceramente l'ha tranquillizzato.

P 1: STAFF.doc - 1:49 [Come quando c'era quel bambino..] (267:267) (Super)
Codes: [Therapeutic use of music]

Come quando c'era quel bambino agitatissimo che non voleva fare un intervento, era già la seconda volta, e gli era presa una crisi,
insie che con quegli strumenti si è rilassato. Però sono interventi di urgenza qui e quindi forse è sfruttato un po poco.

Bisogna chiedere al bambino e..] (154:154) (Super)
Codes: [Therapeutic use of music]

Si cerca sempre di abbinare i bambini con la musica. Se c'è solo ansia e paura allora si usano soltanto le tecniche non farmacologiche, ma se c'è
anche il dolore allora si usa anche il farmaco insieme alla musica, perché 2 è meglio di uno!
Bisogna chiedere al bambino e ai loro genitori se un certo repertorio in un certo momento può aiutare il bambino a ridurre l'ansia.

...è capitato tempo fa che c'era una bambina che aveva un attacco di pianto isterico e non si riusciva a calmare, però io sentii la musica nel corridoio e la mandai la e sentii che smise di piangere. Quindi secondo me la musica è sempre positiva.

In quel momento serve per alleviare il dolore, l'ansia e la paura, soprattutto. Si chiama tecnica non farmacologica per il trattamento del dolore. C'è una lista delle tecniche di supporto.

N- aiuta quando il bambino è agitato, quando deve pensare di fare qualche indagine, o un prelievo, allora inizia ad agitarsi un pochino, ma se sente la musica o vede i clown non ci pensa.

Comunque il bambino sente la musica in reparto anche se non viene suonata appositamente per lui ed è distratto dalla pratica in se per se, anche sentendo la musica in sottofondo.

CP - c'è una struttura nell'intervento?
D - credo che siano più focalizzati sui reparti cronici, tipo onco. Loro passano tutte le mattine e fanno la loro cantatina, e mi dispiace quando vanno via... io credo che senza musica questa musica non sarebbe lo stesso.

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Dall'gioco, dal fascino del vedere queste persone che suonano in una situazione che è sorprendente perché non è quello che si aspetterebbero.
Appendix M. Administrators’ interview transcript and list of derived codes

Aims of the intervention
Approval of the project from the hospital
Criticisms to musicians’ approach
Defining the “musician in hospital” profession
Differences between musicians
Evaluation
How do you start a musical interaction?
Meetings
Meetings - issues
Nature of the job
Observation
Other projects
Payment from the hospital
Playing for the staff
Playing in stressful wards
Repertoire
Stress connected to the job
Timetable
Timetable - issues
Unsatisfaction of musicians
Use of words

Code: aims of the intervention {8-0}

P 1: ADMINISTRATORS.doc - 1:25 [Perche noi organizziamo questi..] (211:211) (Super)
Codes: [aims of the intervention]
Perche noi organizziamo questi interventi non in un schema di intenzimentimento e distrazione, ma nella logica di un percorso assistenziale. Questi interventi non curano di per se ma contribuiscono ad assistere meglio i bambini e i genitori. E quindi per noi è importante avere una base ‘scientific’ che dimostre la validità di questi interventi, anche perché l’inserimento di professionisti all’interno dell’ospedale è facilitato se alle spalle ci sono delle ricerche che confermano la validità dell’intervento.

P 1: ADMINISTRATORS.doc - 1:29 [L’altro aspetto importante e c..] (221:222) (Super)
Codes: [aims of the intervention]
L’altro aspetto importante è che cerchiamo di fare dei progetti che coinvolgano contemporaneamente musicisti, clown e animazione, non affrontiamo solo setorialmente la musica, ma in maniera trasversale. Per esempio è già il secondo spettacolo che abbiamo organizzato tra le attività che ci sono in ospedale. Questa consapevolezza della necessità di integrare le attività si è rafforzata nel tempo.

P 1: ADMINISTRATORS.doc - 1:32 [CP - e perché richiedono la mus..] (235:237) (Super)
Codes: [aims of the intervention]
CP - e perché richiedono la musica? cosa credono che faccia? un terapia ?
B- la musica è come una terapia che migliora la qualità dell’accoglienza quindi in una sala d’attesa c’è meno tensione, i bambini e i genitori si rilassano e quindi l’intervento del sanitario è facilitato. Non è tanto per il personale medico, perché magari puo darsi che loro a forza di sentire sempre la stessa musica si annoiano anche [ride] . E’ mirata al bambino e ai genitori.

P 1: ADMINISTRATORS.doc - 1:34 [CP - ha una venta di terapia in..] (239:240) (Super)
Codes: [aims of the intervention]
CP - ha una venta di terapia in questa circostanza?
B- no, qui c’è sempre un dibattito sui termini. Noi non diciamo che la musica è uno strumento per guarire in maniera specifica. Noi diciamo che la musica è un percorso assistenziale, con un suo ruolo e una sua importanza. Non uso la musica per curare direttamente un bambino, ma posso intervenire per far sì che sia curato meglio, per esempio non ricorrendo a certi sedativi, o magari perché essendo lui più sereno e recettivo migliora la sua percezione dell’ospedalizzazione. Il nostro è un tipo di intervento che interviene sull’ambiente. Siccome parliamo in un ospedale di interventi di questo tipo, che hanno un intervento terapeutico può suscitare nei medici qualche forma di idiosincrasia, allora preferiamo dire che la musica ha una sua importanza, per cui alcuni clinici richiedono l'intervento del musicista, sono i primi loro ad essere convinti che la musica serve.

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La ricerca non può essere impostata sugli effetti terapeutici, sugli effetti relativi al benessere, perché il progetto musicale abbraccia vari aspetti. Se io migliorò l'ambiente lavorativo, e che gli infermieri sono più tranquilli e allegri quando fanno un'attività di cura e di preludio, quando fanno una medicazione, sono sicuro che questo si rifletterà positivamente anche sul bambino.

Non è un effetto diretto sul bambino ma è un effetto sull'ambiente.

Io direi che normalmente è centrato sul bambino, perché c'è anche un'esagerazione. I problemi a trovare l'attenzione con il musicista. Poi a ben guardare si ha sempre il gruppo familiare e il genitore ad essere coinvolto, quindi non è solo il bambino. Con tutte le limitazioni, e gli ostacoli, la necessità di coinvolgere le infermiere, il medico... metti un musicista che entra in ospedale in un reparto, suonano l'oboe o il violino, facendo un pezzo classico o quello che è, esce il dottore - molte volte è successo, ho assistito io - e dice 'ah, questo è tal de ral' questo è una cosa che hai fatto per tutti ma che magari colpisce di più il medico o l'infermiere. Te proponi qualcosa di classico al dottore e lui si sente valorizzato perché sente che te gli proponi qualcosa di più culturale.

Nell'ospedale pediatrico il primo obiettivo della musica è migliorare l'accoglienza e l'ambiente per il bambino e i suoi genitori, secondo, migliorare l'ambiente lavorativo perché il creare un clima disteso, di facilitare la comunicazione, implica come conseguenza inevitabile, che il operatore sanitario veda il bambino in maniera diversa, più umana e meno meccanica, come una persona da curare nella sua totalità, che curare nella totalità non è la medicina sola. Se te lavori sugli operatori allora si riesce ad avere davvero un cambiamento dell'ambiente.

La musica in ospedale è un'opportunità, di vedere uno strumento da vicino, di sentirlo suonare, di sentirsi in concerti.

Il processo decisionale, non riguarda solo noi, ma anche l'ospedale per che decide di investire in questo ambito è stata valutata positivamente dalla fondazione. E' una cosa abbastanza informale. Quando noi presentiamo un progetto viene di massima accettato, compatibilmente allo stato di salute della fondazione.

Il processo decisionale, non c'è una discrezionalità sui progetti che presentate? Come mai relazionate alcuni invece di altri? B - noi abbiamo un consiglio di amministrazione e quando c'è stata l'opportunità di investire in questo ambito è stata valutata positivamente dalla fondazione. E' una cosa abbastanza informale. Quando noi presentiamo un progetto viene di massima accettato, compatibilmente allo stato di salute della fondazione.

Perché finché possiamo, vogliamo cercare di mantenerla. Noi abbiamo deciso di continuarmi sempre.

Lei ha una copia della convenzione che ha con l'Ateneo?

No

Non c'è una copia della delibera fatta nella riunione con l'ospedale in cui decisero di finanziare la musica? B - noi non facciamo delibere, noi facciamo due consigli di amministrazione l'anno e sono macro decisioni quelle che vengono prese. Questo è solo un punto nell'agenda. Poi sono io che ho l'autonomia di decidere.

Quindi è più utile informarvi?

Assolutamente sì, la struttura della fondazione è nata per essere una struttura agile, veloci decisioni, è fatta apposta per uscire dall'ospedale che è pieno di delibere, etc.
La fondazione è una struttura privata quindi come tale non deve onerare a tutti quelli obbligh formal che ha una struttura pubblica.

CP - chi vi sovvenziona?
B - facciamo il foundaraising.

CP - osservando i musicisti, io l'impressione che ho avuto è che loro fanno un lavoro sul bambino.
P - l'impressione che hai avuto è giusta perché nattroppo il loro lavoro sul bambino è troppo, troppo esclusivo.

P 1: ADMINISTRATORS.doc - 1:38 [CP - osservando i musicisti, l.] (271:273) (Super)
CP - osservando i musicisti, io l'impressione che ho avuto e che loro fanno un lavoro sul bambino.
P - l'impressione che hai avuto è giusta perché nattroppo il loro lavoro sul bambino è troppo, troppo esclusivo.

P 1: ADMINISTRATORS.doc - 1:44 [CP - in questo caso quanto è l.] (286:288) (Super)
P - in questo caso quanto è importante la scelta di un repertorio adeguato per allacciare questo rapporto con lo staff?

P 1: ADMINISTRATORS.doc - 1:49 [P - non sempre, assisti a degli..] (304:304) (Super)
P - non sempre, assisti a degli interventi in cui in mezz'ora senti cantare 7, 8 pezzi diversi che vuol dire non aver afferrato la potenzialità della musica. Io gli ho fatto un corso proprio su questo. Il corso era su come si trasforma il materiale sonoro in qualcosa di diverso.

Quello a cui noi vorremmo arrivare nel prossimo corso è quello di creare un musicista che abbia da un lato la capacità di operare all'interno di un progetto anche relazionandosi con gli altri attori di questo progetto. La difficoltà mia e di Marco e quella di dovere, non di voler, controllare il lavoro perché il musicista spesso si limita solo all'aspetto esecutivo, lo scalino più basso del lavoro - tra virgolette - e tende a dimenticarsi che le cose che gli sono state insegnate nel corso sono altre.

P - Questo è un extra?

C - come definiresti il lavoro dei musicisti?
G - Secondo me dovrebbe essere presa come una attività che da un certo tipo di reddito, però l'intervento dovrebbe essere preparato prima, poi c'è il diario di bordo da completare....

G - come definiresti il lavoro dei musicisti?
G - secondo me si. Questo è un extra?
G - secondo me si. Questo è un lavoro, sei un professionista, però, in fondo a fondo lo devi amare, ma non solo questo, tutti i lavori. Se davvero ci investi, allora ti senti coinvolto e ci investi molto.

P 1: ADMINISTRATORS.doc - 1:14 [C - che cosa è cambiato dagli inizi del progetto 4 anni fa?]

G - musicalmente, c’è stata una evoluzione che si è sviluppata attraverso l’improvvisazione sonora, perché così non hai più barriere. E’ chiaro che c’è bisogno di cantare, ma attraverso l’improvvisazione si arriva più facilmente a rompere le barriere culturali.

P 1: ADMINISTRATORS.doc - 1:15 [C - come ci siamo avvicinati a questa conclusione?]

G - attraverso l’esperienza, attraverso i corsi, i video..., siamo andati recentemente a fare un corso sul uso delle percussioni, io e Marta e ci hanno aperto gli occhi.

P 1: ADMINISTRATORS.doc - 1:45 [CP - lo capisci se uno è un professionista se canta canzoni per bambini o deve per forza suonare un pezzo classico?]

P- Professionista non vuol dire un buon esecutore. Io posso essere un musicista bravissimo, a cantare e suonare, con un vasto repertorio, ma questo non è un musicista in ospedale. Musicista è un termine che va ridimensionato. Il musicista è ritenuto uno che deve avere un grande repertorio, ma questo non è un musicista in ospedale. Musicista è uno che va ridimensionato. Il musicista è uno che deve avere una grande capacità di lavorare sull’ambiente sonoro, la sua capacità di lavorare con il pubblico. Un musicista deve essere uno che sa manipolare la musica.

Le capacità che un musicista deve avere per essere musicista in ospedale sono la capacità di entrare in un ambiente rendendosi conto di quell’ambiente. Proporre e reagire continuamente al feedback che viene dal bambino e lo staff. C’è differenza tra chi è capace di mantenere una grande attenzione e chi si focalizza solo su aspetti ristretti.

P 1: ADMINISTRATORS.doc - 1:46 [Facciamo una distinzione tra quello che è e quello che dovrebbe essere. L’obiettivo della formazione è quello di formare una persona che ha queste caratteristiche, perché le caratteristiche a cui penso te sono difficilmente riscontrabili in un unico persona. E’ chiaro che a me piacerebbe avere un musicista favoloso, versatile, che conosce un grande repertorio, che abbia una grande sensibilità, ma uno così non lo trovi, perché sarà già diventato famoso per qualche altro motivo (grave commento), quindi devi accontentarti, ma avere della base su cui partire. Il musicista deve essere professionista. Se te sei un medico professionista, io voglio avere accanto a me nell’ospedale solo persone professioniste.

P 1: ADMINISTRATORS.doc - 1:48 [Il suonare e il cantare sono molto] (301:301) [Super]

Facciamo una distinzione tra quello che è e quello che dovrebbe essere. L’obiettivo della formazione è quello di formare una persona che ha queste caratteristiche, perché le caratteristiche a cui penso te sono difficilmente riscontrabili in un unico persona. E’ chiaro che a me piacerebbe avere un musicista favoloso, versatile, che conosce un grande repertorio, che abbia una grande sensibilità, ma uno così non lo trovi, perché sarà già diventato famoso per qualche altro motivo (grave commento), quindi devi accontentarti, ma avere della base su cui partire. Il musicista deve essere professionista. Se te sei un medico professionista, io voglio avere accanto a me nell’ospedale solo persone professioniste.

P 1: ADMINISTRATORS.doc - 1:51 [Il musicista non è un jetbox, c.] (305:306) [Super]

Il musicista non è un jetbox, certo maggiore è il tuo repertorio e maggiore avrai possibilità di agganciare più persone. Ma quello che deve prevedere nel musicista di ospedale, è fare qualcosa di diverso da quello che altri musicisti possono fare senza una formazione specifica.

Se io vado in ospedale e in mezz’ora suono, come ho sentito fare, 20 canzoni, le fai bene, ma hai fatto una gran faccia e forse non sei arrivato a niente perché è un materiale che non hai sfruttato in maniera giusta. Ma se te utilizzi una sola canzone e con quella riesci a far partecipare tutti, quella è la capacità di ricaricare il materiale sonoro. E’ l’importanza della variazione, altrimenti uno dovrebbe avere un repertorio stenninato. Invece il musicista deve essere capace con la stessa canzone di far lavorare sia i bambini che gli adolescenti che gli adulti, altrimenti si tratta di fare il jetbox, perché quello lo sauro fare tutti.

P 1: ADMINISTRATORS.doc - 1:57 [Per esempio, nell’ultimo corso...] (318:320) [Super]

Per esempio, nell’ultimo corso si fece una parte dedicata a 4 progetti che si dovevano abituare a pensare al tuo lavoro in maniera diversa. I progetti sono questi: a) l’ambiente sonoro, in cui il musicista nota i rumori che ci sono nel reparto, le macchine, le porte che sbattono, la televisione che viene sempre tenuta accesa. I progetti sono questi: b) interazione con il personale. Il musicista non può stabilire un intesa con il personale solo quando lo incontra in reparto, ma deve stabilire con il personale un rapporto di collaborazione a prescindere. Questo vuol dire che il personale ti conosce, sai di se e
ti chiama per accompagnare durante le procedure. Questo si fa presentandosi al personale dicendo i giorni e gli orari in cui vai a suonare in reparto e rispettando quegli orari.

P 1: ADMINISTRATORS.doc - 1:61 [CP - chi sono i musicisti da u._] (337:340) (Super)

Codes: [defining the "musician in hospital" profession]

CP - chi sono i musicisti da un punto di vista professionale?
P - da una parte c'è la figura professionale del musicista. Dall'altra parte i musicisti tempesti possono anche essere freelance. E' una situazione complessa, il musicista spesso tende ad identificare il suo lavoro solo con l'intervento in ospedale, ma non è solo quello. Noi abbiamo dei fogli che diamo al personale in cui vogliono fare delle richieste speciali per bambini per cui credono che la musica funzioni. In quel modo, il lavoro del musicista viene integrato nell'ospedale come parte integrante del progetto di cura.

Altri due progetti fondamentali sono a) quelli che chiamiamo le tracce sonore. Un musicista in ospedale non può essere notato solo quando fa il suo intervento, ma bisogna percepire la sua presenza anche quando non c'è. Le tracce sonore sono per esempio le canzoni che un musicista ha fatto e che lascia in reparto a disposizione di chi vuole usarle. Oppure è il musicista che decide di registrare le canzoni che ha suonato e di darle ai bambini e ai genitori perché così possono continuare ad ascoltarle anche quando sono a casa.

P 1: ADMINISTRATORS.doc - 1:64 [L'ospedale inaugura uno spazio._] (356:358) (Super)

Codes: [defining the "musician in hospital" profession]

L'ospedale inaugura uno spazio interreligioso e ha chiesto ai musicisti della cooperativa di organizzare la musica per la giornata. Sono coinvolti 10 musicisti.

Il musicista deve essere un mediatore culturale, di cui il suo intervento è una parte. Può organizzare una serie di concerti in ospedale, etc...

P 1: ADMINISTRATORS.doc - 1:65 [Questo è un extra? P - no._] (342:345) (Super)

Codes: [defining the "musician in hospital" profession]

CP - Questo è un extra?
P - no, questo faceva parte della formazione. Io ho fatto una serie di lezioni su come si registra, come si usa il computer, proprio perché ciascuno potesse fare da solo... certo di qualità... bastano dieci lire per fare una cosa di un certo tipo, a volte solo un microfono e fai un prodotto...

Per esempio al Barburini adesso ho proposto di fare un cd, con le canzoni dei musicisti, fatto dai musicisti e che sia il regalo al bambino che esce dall'ospedale perché mantenga questo ricordo della musica. Noi lo stiamo già facendo con mezzi artigianali perché ci viene spesso richiesto, così perché non istituzionalizzare?

Questo è importante, perché rientra in un discorso di musicista in ospedale a tutto tondo. Perché la presenza deve essere avvertita. Questo presuppone di sentirsi parte di un progetto.

Code: differences between musicians (1-4)

P 1: ADMINISTRATORS.doc - 1:16 [C - c'è una differenza tra mus._] (135:137) (Super)

Codes: [differences between musicians]

C - c'è una differenza tra musicisti del primo e secondo corso?

G - abbiamo avuto problemi a farli diventare autonomi, ci sono stati tanti problemi nel corso.

Code: Evaluation ? (2-0)

P 1: ADMINISTRATORS.doc - 1:24 [CP - avrete fatto una valutazione._] (209:213) (Super)

Codes: [Evaluation ?]

CP - avrete fatto una valutazione per stabilire questa soddisfazione?

B - si, abbiamo costituito un comitato scientifico, anche se ora langue... formato dal personale sanitario e dal personale della fondazione e aveva l'obiettivo di effettuare delle ricerche su tutti questi interventi che attengono a quello che noi definiamo la qualità dell'accoglienza, dal clown, alla musica, al teatro etc. Perché noi organizziamo questi interventi non in un contesto di intrattenimento e distrazione, ma nella logica di un percorso assistenziale. Questi interventi non curano di per sé ma contribuiscono ad assistere meglio i bambini e i genitori. E quindi per noi è importante avere una base 'scientifica' che dimostri la validità di questi interventi, anche perché l'inserimento di professionisti all'interno dell'ospedale è facilitato se alle spalle ci sono delle ricerche che confermano la validità dell'intervento.

Noi abbiamo anche fatto delle ricerche interni eppoi le tesi fatte, che scoprono le tesi fatte. Poi come ti dicevo, avevamo anche un comitato per la valutazione di queste attività ma è molto tempo che non è attivo. Lo scopo era quello di essere noi, l'azienda, il soggetto che si attivava per acquisire questi dati per la valutazione.

P 1: ADMINISTRATORS.doc - 1:27 [CP - avrete fatto un riassemen._] (215:216) (Super)

Codes: [Evaluation ?]

CP - avrete fatto un riassunto del servizio dopo i 5 anni di attività? o il servizio è rimasto invariato?

B - il servizio varia in termini di reparti che coinvolge, in alcuni reparti è aumentato, in altri diminuito, poi anche i musicisti hanno un turn over, e da qui anche il bisogno di formare nuovi musicisti, poi anche l'attività dell'Arenseum musicale si sta ampliando, per cui ci sono anche altri ospedali pediatrici coinvolti, caso di riposo, questo è un discorso di formazione continua.
C - come lo agganci un bambino?

G - ognuno ha le sue strategie, o con lo strumento, o con gli oggetti sonori, questo dipende dal musicista.

C - gli interventi hanno una durata da rispettare?

G - no, dipende da come si sente il musicista, non si può dare delle indicazioni precise. Un interazione può durare dai 5 ai 20 minuti, ma è impossibile stabilire precisamente... sei in una camera, si sta creando una situazione e allora rimani

Il suonare e il cantare sono modi per cominciare una relazione, ma il musicista dovrebbe avere una grande borsa di attrezzature, all'interno di questa borsa ci dovrebbe essere la sua voce, lo strumento, gli oggetti sonori, le percussioni, il suo repertorio, la sua capacità di comunicare, di rispondere, di prendere il materiale musicale e stravolgerlo e cambiarlo, la sua capacità di lavorare sull'ambiente sonoro, la sua capacità di usare lo stesso pezzo per mezz'ora facendolo sembrare 50 pezzi diversi, tutti una serie di cose che il musicista si dimentica.

G - credo che sia una cosa positiva. Come gruppo ci vediamo. Ci siamo incontrati ad aprile, per fare una giornata di studio sulla variazione, per non trovarsi alla famosa routine. I musicisti hanno preparato un pezzo e presentato 10 variazioni. Ognuno ha commentato sulle esecuzione degli altri.

C - ogni quanto gli organizzate questi corsi?

G - ne abbiamo fatto una ad Aprile e ne faremo uno in Settembre.

CP - perché solo Marco e Marta sono entrati nella cooperativa?

P - all'inizio dovevano entrare nella cooperativa solo lui e Marta, perché da un punto di vista di professionalità era le persone più preparato, più capaci di andare avanti, di ristrutturare in discussione. La Marta ha delle capacità musicali al di là dell'esecuzione e una voglia di cercare e di spingersi verso nuove strade musicali. Anche un discorso egoistico di fidanzamento. Marta però non ha disponibilità fisica, per esigenze familiari. E non ha nemmeno la disponibilità di usare il tempo come investimento per il futuro. Se uno lavora in ospedale deve mettere in conto che il tempo in cui lavora è gratis... fosse la metà del tempo... ma è molto di più perché per il lavoro che si fa io e Marco occupa tanto tempo
G - io sono fortunato perché arrivo in treno e così mi preparo e poi torno a casa in treno e mi rilasso.

Code: Observation [2-0]

P 1: ADMINISTRATORS.doc - 1:1 [G - faccio supervisione con i musicisti ogni 2 mesi, dipende da chi ha più bisogno. Le osservazioni sono formativi. Si osserva il musicista, si ascolta la sua visione degli eventi e poi si dicono i nostri commenti.]

P 1: ADMINISTRATORS.doc - 1:56 [Quello a cui noi vorremmo arrivare nel prossimo corso è quello di creare un musicista che abbia da un lato la capacità di operare all'interno di un progetto anche relazionandosi con gli altri attori di questo progetto ... La difficoltà mia e di Marco e quella di dover, non di voler, ma di dover, controllare il lavoro perché il musicista spesso si limita solo all'aspetto esecutivo, lo scalino più basso del lavoro - tra virgole, e tende a dimenticarsi che le cose che gli sono state insegnate nel corso sono altre]

Code: other projects [2-0]

P 1: ADMINISTRATORS.doc - 1:23 [ALTRI PROGETTI Pediatric: Meyer - Cooperativa]

P 1: ADMINISTRATORS.doc - 1:47 [I musicisti ti servono? P - se non ho musicisti non vado più avanti, non possiamo coprire le ore. Normalmente proponiamo un progetto e poi ci fanno contratti per lavorare. In questo momento abbiamo smesso di presentare progetti perché non abbiamo operatori musicali. Quando organizziamo un corso usi il tirocinio come un momento dimostrativo per la struttura che così può capire di cosa si tratta e per agguantarla.]

Code: Payment from the hospital [2-0]

P 1: ADMINISTRATORS.doc - 1:4 [COME AVVEIEN PAGAMENTO Meyer - Cooperativa]

Il meyer ci paga mensilmente, in base alle ore che abbiamo fatto (c'è il registro delle presenze). I musicisti vengono pagati mensilmente. Il contratto viene rinnovato annualmente.

P 1: ADMINISTRATORS.doc - 1:69 [85.000 euro che divide per 48 settimane che viene circa 46 ore settimanali, Code: playing for the staff [2-0]

P 1: ADMINISTRATORS.doc - 1:5 [G - in teoria uno entra in reparto, chiede come va e poi uno vede cosa sta succedendo. Sta a noi decidere di suonare per lo staff. Siamo interessati a tutto quello che gira intorno al bambino. In certe situazioni, specialmente ai pedi, ti chiamano spesso.]

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Cp - lo staff usa la musica per facilitare il loro lavoro. P - va ridimensionato il termine 'terapia'. Può essere una componente che influenza la cura, inserita in un progetto di cura, la musica può avere un aspetto fortemente terapeutico, ma pensare che la musica indipendentemente sia uno strumento di guaitigione, questo lo non lo credo. La musica ha degli effetti strabilianti... arriva direttamente all'inconscio. Se si pensa che la musica è un veicolo emotivo, io riscio a trasmettere molto, senza quantificare cose trasmetto, senza barriere e senza filtri.

L'operatore sanitario che partecipa all'intervento è interessato anche lui all'effetto della musica. Non è solo la facilitazione perché agisce sulla musica

Code: Playing in stressful wards

C - in un reparto tipo quello dei prelievi, piuttosto stressante, non trovi che sarebbe giusto fare una rotazione

G - si cerca sempre di soddisfare le esigenze dei musicisti e parla con i musicisti prima di decidere e se loro non se la sentono allora si rivede la decisione.

Al meyer è più difficile perché è una situazione caotica [rispetto ad altri ospedali pediatrici in cui vanno - Maria ripete spesso questo], ma a Pistoia, Pescia, nella realtà più piccola, noi accompagniamo i bambini dentro perché ce lo chiedono le infermiere. Se aggiungi il bambino prima dell'intervento è tutta un'altra cosa.

Il meyer è una città, un mondo, negli altri ospedali non succede niente rispetto alla frenesia che c'è li.

Code: repertoire

C - sulle scelte musicali ce' stato un cambiamento?

G - si, cerchiamo un repertorio più moderno, jazz che poi trasformiamo.

Poi c'è un lavoro sul repertorio, intervenire per rinnovarlo, aggiornarlo, adeguarlo.

B - questo del repertorio è un po' un problema, perché le esigenze sono le più diverse, da chi vuole la canzona del cartone animato giapponese, a chi vuole musica classica, quindi non è facile trovare una strada che riesca a collegare il rigore, l'innovazione.

CP- lei va in ospedale? B - si.

CP - si ricorda delle canzoni che ha sentito?

B- sono tutte filastrocche, abbiamo anche un CD. Tutte le informazioni che ci pervengono dai reparti sono positivi. Per esempio, abbiamo dei settori dell'ospedale in cui non c'è la musica e che è stata richiesta. Quando è l'operatore che chiede la presenza vuol dire che è un servizio che funziona.

Non è tanto per il personale medico, perché magari può darsi che loro a forza di sentire sempre la stessa musica si annoiano anche [ride]. E' mirata al bambino e ai genitori.

Con tutte le limitazioni, e gli ostacoli, la necessità di coinvolgere leinfermiere, il medico,... metti un musicista che entra in ospedale in un reparto, suonano l'oboè o il violino, facendo un pezzo classico o quello che è, esce il dottore - molte volte è successo, ho assistito io - e dice 'ah, questo è tali de tali' questo è una cosa che hai fatto per tutti ma che magari colpisce di più il medico o l'infermiere. Te proponi qualcosa di classico al dottore e lui si sente valorizzato perché sente che te gli proponi qualcosa di più culturale.
La musica ha degli effetti strabilianti... arriva direttamente all'inconscio. Se si pensa che la musica è un veicolo emotivo, io riesco a trasmettere molto, senza quantificare cose trasmetto, senza barriere e senza filtri. L'operatore sanitario che partecipa all'intervento è interessato anche a far intendersi anche lui all'effetto della musica. Non è solo la facilitazione perché agisce sulla musica.

Ho visto vedere lavorare un ragazzo adolescente con Fra Martin, che di solito a un pezzo con cui non si avvicinerebbe nemmeno, ma se prima glielo fai blues e poi rap, e cominci a cantare con le percussioni, e trasformi un linguaggio musicale da infantile ad adolescenziale, vuol dire che hai fatto un lavoro da musicista.

Se io vado in ospedale e in mezz'ora suono, come ho sentito fare, 20 canzoni, le fai bene, ma hai fatto una gran fatica e forse non sei arrivato a niente perché è un materiale che non hai sfruttato in maniera giusta. Ma se te utilizzassi una sola canzone e con quella riesci a fare partecipare tutti, quella è la capacità di rielaborare il materiale sonoro. E l'importanza della variazione, altrimenti uno dovrebbe avere un repertorio sterminato. Invece il musicista deve essere capace con la stessa canzone di far lavorare sia i bambini che gli adolescenti che gli adulti, altrimenti si tratta di fare il juebox, perche quello lo sanno fare tutti.

Poi invece lo staff non lo incontri solo in certi momenti. Lo staff è più vicino a come si tratta un adolescente che non un professore universitario, non gli fai un brano classico il più delle volte, ma non è neanche vero, perché qualcuno chiede anche il Bolero - pero si avvicina più ai gusti di un adolescente che a quelli di un adulto, quindi devi avere una certa conoscenza del repertorio, che secondo me non vuol solo dire fare la hit del momento.

Barbutini, parla sempre del punto debole del progetto: il repertorio. Stress connected to the job {3-0}

G - non facciamo fare più di 10 ore settimanali. Emotivamente non credo che sia sostenibile. Se lavori in altre strutture e fai altri lavori e hai una famiglia, allora non puoi farcela.
C: ogni quanto lo fate l'orario?

G: a settembre e a gennaio e durante l'estate.

C: cambia molto?

G: non è detto. Dipende se un musicista non può più venire nei giorni stabiliti e vuole cambiare [they don't seem to have noticed any problem with the same musician in the same ward for a long time]. L'orario è abbastanza costretto perché ci sono i clown, gli animali, i volontari, e così bisogna stare attenti a non sovrapporsi

Code: Timetable - issues (6-0)

P 1: ADMINISTRATORS.doc - 1:3 [C- come avvengono i recuperi? ..] (45:46) (Super)

Codes: [Timetable - issues]

C- come avvengono i recuperi?
- il musicista lo chiede a me quando può andare e io cerco uno spazio dove non si sovrapponga ad altre attività... il problema dei recuperi è proprio questo degli incastri

P 1: ADMINISTRATORS.doc - 1:8 [G - le segna, il problema è se..] (82:82) (Super)

Codes: [Timetable - issues]

G - le segna, il problema è sempre di fare ore in meno... poi si cerca che l'orario venga rispettato. Ma è difficile.

P 1: ADMINISTRATORS.doc - 1:54 [CP - chi sono questi musicisti..] (312:313) (Super)

Codes: [Timetable - issues]

CP - chi sono questi musicisti? Hanno un contratto molto flessibile...
P - loro sono collaboratori, i musicisti tendono a renderlo più flessibile di quello che non è.

P 1: ADMINISTRATORS.doc - 1:58 [CP - ho notato che gli orari s..] (322:323) (Super)

Codes: [Timetable - issues]

CP - ho notato che gli orari sono difficili da mantenere
P - la flessibilità che hai notato non è concordata con noi. I musicisti se la pigliano perché sanno che nessuno può dirgli 'da domani non lavori' perché questa non è una flessibilità a cui si può sottomettere.

P 1: ADMINISTRATORS.doc - 1:59 [CP - Perche mi sembra che anch..] (325:327) (Super)

Codes: [Timetable - issues]

CP - Perché mi sembra che anche se i musicisti non fanno parte della cooperativa mi sembra che ci sia un rapporto paritetico con voi
P - qui si ritorna al tema del contratto che si chiama 'di collaborazione' e che prevede un rapporto paritetico, e così è. L'orario e la sua elaborazione è fatta insieme ai musicisti ed è giusto che loro rispettino gli orari stabiliti, perché quelli orari sono in reparto e medici e infermieri si aspettano che vangano rispettati. Allora la flessibilità se la prendono loro. Siecime la fanno regolarmente, è arrivata a dire, 'domani e giovedì prossimo non posso venire in ospedale perché ho da lavorare', allora non le e stato detto niente, ma insomma....

P 1: ADMINISTRATORS.doc - 1:60 [CP - la flessibilità è favorir..] (333:335) (Super)

Codes: [Timetable - issues]

CP - la flessibilità è favorita da voi.
P - il problema è che esiste già un problema di salute in relazione all'orario. Se il musicista è malato non può andare in ospedale.

Code: unsatisfaction of musicians (2-0)

P 1: ADMINISTRATORS.doc - 1:22 [C- economicamente è soddisfacce..] (168:177) (Super)

Codes: [unsatisfaction of musicians]

C- economicamente è soddisfacente ?
G- rispetto al tempo che ci metti, alle ore che fai, c'è tanta energia in questo
C - i musicisti sono soddisfatti della paga?
G - no. Dicono che è poco.
C - voi pagate i musicisti in relazione al contratto con l'ospedale?
G- si, sono le spese amministrative

P 1: ADMINISTRATORS.doc - 1:63 [CP - perché? P - da una parte ..] (349:352) (Super)

Codes: [unsatisfaction of musicians]

CP - perché?
P - da una parte perché ad ogni ora di lavoro, più o meno corrisponde un'ora di preparazione e un'ora di riflessione, quindi te fai 10 ore e in realtà ne fai 30, forse è un po' esagerato, ma a pensarci bene volessi acquisire una vera professionalità ... siamo soltanto ad un inizio di figura professionale, quindi da un punto di vista economico ha delle soddisfazioni relative.
CP - Quindi te sei d'accordo con i musicisti.
P - si, anche se non d'accordo in assoluto rispetto a quello che il musicista produce, in certi casi.

C - cosa pensi sul uso della parola?
G - io sono contrario. Noi si deve suonare. Se cominci a parlare, dal mio punto di vista, vuol dire che non sai più tanto cosa fare.... quando vedo un musicista che parla io gli chiedo 'perché. Se un musicista entra e chiede, 'posso suonare', invece deve entrare e suonare.
Io sono un musicista e attraverso la musica io ti posso dare delle sensazioni, con la parola, no
Poi si capisce se è un momento di imbarazzo se non sai cosa fare con lo strumento. Poi magari se invece è un momento pedagogico in cui si spiegano gli strumenti va bene.
## ORARIO DEI MUSICISTI AL MEYER

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