Resonance between theory and practice: development of a theory-supported documentation tool for music therapy as procedural support within a biopsychosocial frame

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Abstract

Music therapists are challenged to communicate the therapeutic relevance of their work in a manner that enables other health professionals to appreciate and comprehend the subtleties and unique contributions of their practices. When music therapists provide support during painful or anxiety-provoking procedures, their nuanced and patient-centred interactions with children may not be fully understood or appreciated by the interdisciplinary team, which may undermine the team's understanding of the therapeutic aim. Music therapists need to convey the theoretical and practical aspects of their work to the interdisciplinary team in a way that is comprehensible yet is consistent with their unique identity and contributions. The purpose of this article is to build from the working model of music therapy as procedural support (Ghetti, 2012) by proposing a documentation tool that provides a practical translation of the various on-going therapeutic processes taking place during procedural support. The music therapy as procedural support documentation tool presented in this article serves a dual purpose: 1) to provide a practical tool that furthers music therapists' reflections on the therapeutic processes occurring in music therapy as procedural support, and 2) to translate that reflection into terms and concepts that can be effectively communicated to interdisciplinary staff to improve continuity of care. We demonstrate the clinical relevance of the documentation tool through use of an illustrative case example. Developing theory-supported documentation tools can contribute to the evolution of professional practice, by helping music therapists and interdisciplinary staff to become more aware of important therapeutic processes. If such a documentation tool strikes a balance between the professional languages, cultures and values of music

therapists and the interdisciplinary staff, it may facilitate more meaningful communication amongst professionals, which in turn may contribute to better biopsychosocial care of paediatric patients and their families.

Keywords: *procedural support, biopsychosocial, documentation, interdisciplinary collaboration*

Introduction

When music therapists write about their work, they contribute to the generation of discourse. This discourse is necessarily situated within the contexts and frames in which music therapists practice, contemplate, and in essence *perform* themselves. Such discourse reflects a system of thinking that is both constituted and executed within and by a system of verbal communication (Ansdell, 2003). How we describe and discuss music therapy (whether the focus is theory, practice or research) then contributes to our understandings of it. Music therapists practicing in medical contexts are posed with the challenge of navigating how to describe their various roles and the nature of their work to their interdisciplinary colleagues.

In the fast-paced environment of a medical hospital, the electronic health record becomes a key avenue for enabling communication between disciplines and promoting collaborative care (Reitz, Common, Fifield & Stiasny, 2012). Patients may transfer between several medical units during a single hospital stay, and staff with busy schedules are challenged to find efficient ways to communicate with each other in a way that assures quality patient care. The electronic health record enables various professionals to track what each person is doing with a patient, allowing them to support each other's efforts and contribute to a shared treatment approach (Reitz et al., 2012). Documenting in the patient's health record enables professionals to provide continuity of care across time and despite variations in care providers (Waldon, 2016).

Through music therapy, a child[1] may connect with resources that can be drawn upon in subsequent challenging situations that present themselves in the medical environment. The music therapist can document about patient preferences, coping strategies, and resources, in such a way that other disciplines can beneficially incorporate such elements into their care of the child and family. For example, a music therapist may document particular support

1 Here and elsewhere in the text, "child" may refer to an infant, child or adolescent

factors (e.g. child choosing volume, nature and pacing of music used before, during and after the procedure; child's preferences for attending to aspects of the procedure or for alternatively engaging attention elsewhere; child's choice of specific images/sounds/video to play on a tablet or song playlist that is specifically tailored to the procedure) that have been beneficial to the child and that other interdisciplinary team members might be able to implement during a medical procedure. When procedures occur repeatedly over time, some children may develop more fixed support rituals, elements of which can be facilitated in an adapted manner by others in the team, given sufficient preparation from the music therapist. Some of these factors will require the presence and expertise of a music therapist in order to facilitate, while other factors may be effectively incorporated into the standard care practices of other members of the interdisciplinary team when they interact with that child. If the latter, it is important that the team clearly understands the intention behind the supportive use of music and knows how to use the agreed upon strategies to accommodate the child's preferences and needs. Effective interdisciplinary communication enables staff to use or build upon key strategies that are identified through music therapy, in order to improve the quality of family-centred care. Such practices do not negate the unique role and expertise of the music therapist within the team, but instead enhance the quality of care given by the interdisciplinary team when the music therapist is not able to be present.

How music therapists describe music therapy within patient documentation impacts not only the patient's care, but also how interdisciplinary colleagues understand music therapy. Words become the representation of music therapy clinical work within a medical record (Loewy, 2000). Clear and readily comprehensible written communication can facilitate mutual understanding between music therapists and their interdisciplinary colleagues, and promote further collaboration (Edwards & Kennelly, 2016; Leinebø & Aasgaard, 2017). Documenting in the medical record enables other professionals to gain awareness of the therapeutic aims and approaches used in music therapy (Ghetti, 2013), which contributes to their understanding of music therapy practice (Loewy, 2000). When music therapists provide support during painful or anxiety-provoking procedures, their nuanced and patient-centred interactions with children may not be fully understood or appreciated by the interdisciplinary team, which may undermine the team's understanding of the therapeutic role of the music therapist and the music. Music therapists need to convey the theoretical and practical aspects of their work to the interdisciplinary team in a way that is comprehensible yet is consistent with their unique identity and contributions. Flexible documentation tools may facilitate this aim, by helping structure music therapists' reflection and documentation practices in a way that enables interdisciplinary exchange.

The discourse on music therapy in medical settings is expanding in breadth and depth within Norwegian contexts (e.g., Aasgaard, 2002, 2004; Due & Ghetti, 2018; Leinebø & Aasgaard, 2017; Mangersnes, 2012; Noer 2017; Ærø, 2016; Ærø & Aasgaard, 2011; Ærø & Leinebø, 2017). The literature is characterized by music therapists who critically examine their roles within the medical context and interdisciplinary team, and bring salutogenic, humanistic and ecological perspectives to the fore in their work. The current article aims to contribute to this discourse by introducing a theory-supported documentation tool to help frame how music therapists might describe their work when supporting children through painful or anxiety-provoking medical procedures. It is acknowledged that the way this tool is created and used will influence how music therapists will perceive, contemplate and write about their work, which may then influence how other interdisciplinary team members understand such work. Such constructive influence presents both opportunities and limitations.

Contextual considerations

Within the practice of music therapy in paediatric medical contexts, the use of music therapy as procedural support for painful or anxiety-provoking procedures provides a rich ground for examining practice and developing and testing theory. Music therapy as procedural support requires the competence of a qualified music therapist and may be defined as, "the use of music and aspects of the therapeutic relationship to promote healthy coping and decrease distress in individuals undergoing medical procedures" (Ghetti, 2012, p. 6). The process involves a complex interplay of factors related to the child, the context, the music therapist, the music, the procedure, family members and other healthcare workers. It is particularly challenging to support children during prolonged, repeated, and painful procedures, as children may develop traumatic responses to the procedures themselves (Ghetti & Whitehead, 2015; Loewy, 2019; Saxe, Vanderbilt & Zuckerman, 2003).

As music therapists, we have journeyed with children as they encounter, struggle with and persevere through potentially painful and anxiety-producing medical procedures. Tone comes to this work with a background as a trained nurse. She has extensive practical experience being a music therapist within an interdisciplinary team that uses a biopsychosocial perspective to explain and understand the relevance of their work. Tone's background as a nurse also impacts her familiarity with and appreciation for standardized documentation, which she feels can give care a joint direction, limit misunderstandings between interdisciplinary staff, and enable music therapists to share strategies identified through music therapy that can transfer to other areas of a patient's care.

Claire has additional qualification in the area of Child Life, a profession that focuses on providing developmentally-appropriate support to children in medical contexts, and has experience supporting children through intensely painful medical procedures. Her theoretical orientation to music therapy practice in medical settings is primarily humanistic and relationship-based, with an appreciation for biopsychosocial and ecological perspectives related to health and to care. After articulating a preliminary theoretical model of how music therapy might serve as procedural support for invasive medical procedures (Ghetti, 2012), Claire is currently interested in further developing the model through critical reflection, including consideration of how ecological perspectives might inform its further development.

We feel that our orientation to music therapy within paediatric medical settings is well represented by Ærø's (2016, p. 55) "Trident for music therapy in pediatrics" (Figure 1). This trident illustrates that music therapists can address physiological, psychological, and environmental aspects of health, and these practices are informed by theory within areas of biology, neurology, psychodynamic psychotherapy, cognitive psychotherapy, resource-oriented approaches and social psychology. Thus, the trident represents clinical practice in paediatric medical settings, and is adapted to a Nordic practice with emphasis on ecological and milieu-oriented approaches. The trident, and the biopsychosocial and ecological perspectives inherent within it, are consistent with our practice of music therapy, and inform our understandings. Our orientation and understandings also impact our valuing of, and approach to, documentation in the area of music therapy as procedural support.

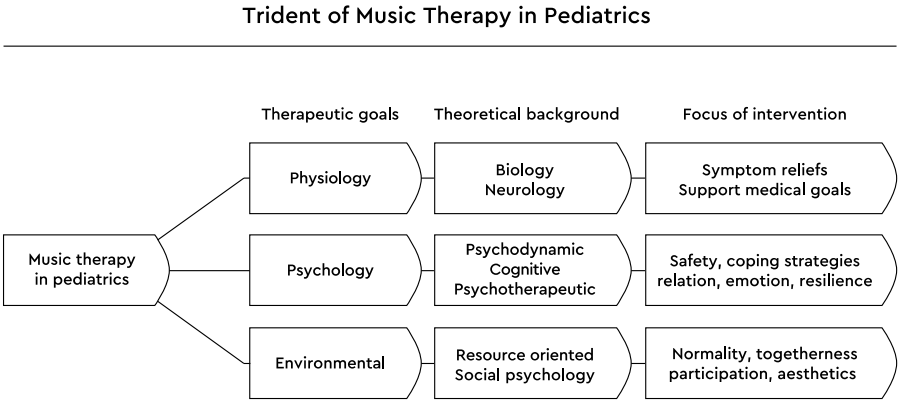

Figure 1. Trident of music therapy in pediatrics (Ærø, 2016, p. 55)

Our shared interest in further exploring theoretical aspects of music therapy as procedural support and a desire to translate the working model into a practice-relevant documentation tool, form our motivation for this article. We hope that generating a practical documentation tool can serve a two-fold purpose: 1) to further music therapists' understandings of the therapeutic processes involved in music therapy as procedural support, and 2) to provide a practical avenue to communicate the processes and outcomes of music therapy as procedural support to interdisciplinary staff in order to improve quality and continuity of care.

In Norway, patients have the right to view and receive a copy of their entire medical record, and to receive a simple explanation of information that is unclear to them (Pasient- og brukerrettighetsloven, 1999, §5–1). In certain parts of Norway, patients over 16 years of age, and parents of child patients under 12 years of age can access medical records digitally (Helsedirektoratet, 2018). The medical record includes information related to diagnosis, course of illness, and treatment; and other information that may be of importance to treatment. Thus, the medical record serves an important communicative function, not only for members of the interdisciplinary team, but also for patients who wish to review specific aspects of their care.

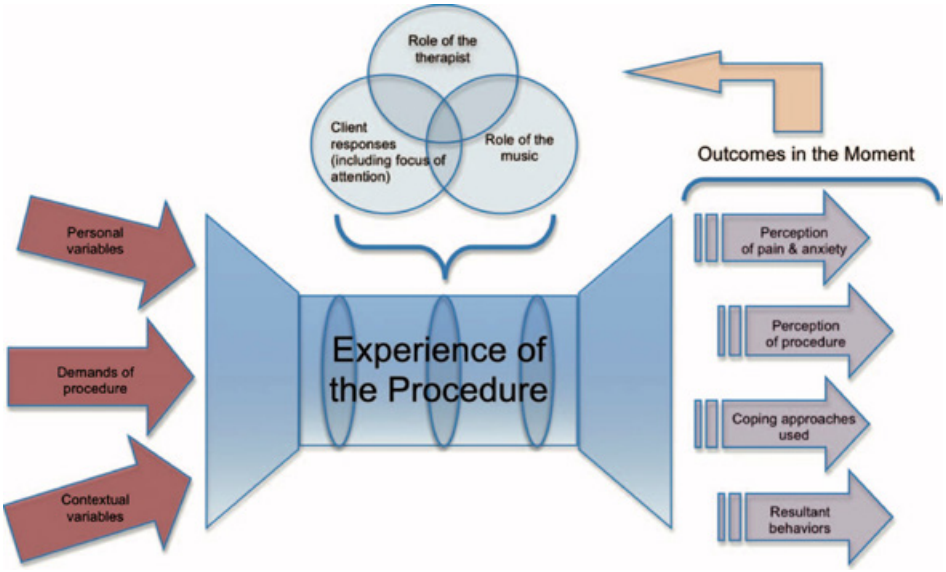

Figure 2. Working model of music therapy as procedural support (Ghetti, 2012, p. 28)

A theoretical model of music therapy as procedural support

Music therapists describe a variety of approaches for using music therapy as procedural support (e.g., Fratianne et al., 2001; Loewy, 2019; Loewy, MacGregor, Richards & Rodriquez, 1997; Mondanaro, 2013), but their rationales for these various approaches differ, and in some cases conflict (see Ghetti, 2012, for further elaboration). For example, there are various conceptualizations related to how music therapy promotes pain and anxiety management during procedures. Some music therapists argue that music therapy enables procedural support by helping a child actively engage their attention in musical and interpersonal interactions with the therapist (and others present) as a means of reducing awareness of painful or anxiety-provoking occurrences during the procedure (e.g., Prensner et al., 2001; Fratianne et al., 2001). Other music therapists posit that the therapeutic means underlying music therapy for pain and anxiety management relate to its ability to integrate the experience, enabling a child "to come into the body by focusing on the breath, heart rate, emotional intention, and resonance, i.e., the feeling of the pain itself" (Loewy et al., 1997, p. 48). The resulting release that comes from integrating the pain experience is understood to diminish pain perception, while also building trust among therapist, child, family and staff (Loewy, 2019, Lowey et al., 1997). Some of these authors do not distinguish between *alternate engagement* and *distraction* and argue that distraction can be perceived by children as manipulative (e.g., Loewy, 2019). In this brief example, one set of music therapists is arguing for the therapeutic importance of *alternately engaging* attention in a sensorily absorbing experience *away* from the pain sensations, while the other set is arguing for the therapeutic importance of acknowledging and integrating current sensations related to the pain (as well as experiences of all those present in the room), and focusing inward before enabling externalizing release (Loewy et al., 1997; Turry, 1997). Despite articulating different rationales for the use of music therapy as procedural support, the aforementioned authors generally agree that music therapy assessment plays a critical role in enabling effective procedural support (Edwards, 1999; Fratianne et al., 2001; Loewy, 2019; Loewy et al., 1997).

Claire found it curious that despite contrasting theoretical rationales regarding procedural support, music therapists report flexibly using a variety of approaches, in order to meet the needs of the patient in the moment. Could there be an overarching theoretical frame that helped explain why music therapists would naturally choose to alternate approaches and/or adjust them in the moment? In order to inductively construct a theoretical frame from the existing music therapy literature, Claire engaged in a process of qualitative document analysis. The process of qualitative document analysis included systematic analysis of 19 journal articles and book chapters, and subsequent synthesis of the data in order to identify key concepts, define those concepts and begin to elucidate the relationships between

concepts in order to develop a preliminary conceptual model (Ghetti, 2012). The model, therefore, is grounded in music therapy clinicians' and researchers' descriptions of how and why they make certain decisions when using music therapy as procedural support.

Theoretical synthesis of the 19 music therapy texts included in the qualitative document analysis led to the identification of concepts that play a key role in the use of music therapy as procedural support: 1) assessment is an ongoing and continuous process that often begins before a procedure and ends after it, 2) this continuous process of assessment influences how a therapist adjusts clinical approaches before, during and after the procedure, which results in an individualized approach to care, 3) preparation prior to procedures is advisable, 4) various individual factors (e.g., developmental level, personality traits, medical and coping history, trauma history, pain history and sensitivity, level of anticipatory distress, level and nature of family support, cultural background, relationships with staff, medications) impact how the patient perceives and/or responds to a procedure, and 5) music therapy can play an important role in assessing and altering the environment in which the patient experiences the procedure, including how caregivers and medical staff interact with the child, how the child perceives the medical staff, or how sensory aspects of the environment can be modified to meet the child's needs or preferences (Ghetti, 2012). In addition, patients' level of engagement in musical processes, and the focus of their attention are dependent upon the role of the music, role of the music therapist, and role of the patient within the process of procedural support. When a music therapist assesses a patient's needs continuously across time and adjusts the role of the music, role of the patient and/or role of the therapist, it is considered to be an example of the concept of *reflexivity*. Claire identified these concepts through the process of qualitative document analysis and proposed relationships among them within a "Working model of music therapy as procedural support" (see Figure 2), which may be summarized as follows:

> Multifaceted moderators including personal variables, demands of the procedure, and contextual variables enter into the individual's experience of a procedure. Factors relating to the therapist, role of the music and patient responses combine to serve as a lens that filters the individual's experience of the procedure. This filtering process results in the individual's perceptions of the procedure, perceptions of pain/anxiety, coping approaches, and resultant behaviours. The music therapist uses these outcomes in the moment within a reflexive process of re-assessing and re-focusing the intervention 'lens' in an on-going manner to positively alter outcomes. (Ghetti, 2012, p. 28)

The conceptual model is primarily situated from the therapist's perspective, as was the literature that was analysed to generate it. Family members who might be present to support the patient are part of the "contextual variables" that directly impact how a patient experiences a procedure. Staff may be included when a music therapist draws them into the musical experience, enabling them to be humanized and to gain the child's trust, which may be considered a way in which music therapy "modifies the context" in which the child and staff experience the procedure. In a recent extended discussion of how music therapy enables *integration* during procedural support, Loewy (2019) articulates how music therapy integrates the team with the child through music, a process that plays a critical role in engendering trust, and in turn, promoting resiliency. In Loewy's perspective, inclusion of family members must be considered carefully, as parents/caregivers may on some occasions be so overwhelmed by the situation that their capacity to effectively support the child is severely limited (2019).

The working model of music therapy is meant to be a transactional model, in that it depicts complex and non-linear interactions among therapist, patient, caregivers, music, procedure and context; and outcomes in the moment in turn impact the further evolution of the procedural support given. The patient's perception of the procedure is similarly impacted by these interrelationships, and not solely by one element alone. The model has informed the theoretical description of single studies evaluating music therapy as procedural support (e.g., Sanfi, 2012), and various music therapists have informally reported that it aligns with their practice, but to our knowledge, it has not yet been translated into a pragmatic tool that could be used in clinical practice. Our aim is to create a documentation tool grounded in the theoretical constructs inherent in the working model that: 1) furthers music therapists' understandings of the therapeutic processes occurring in music therapy as procedural support, and 2) helps communicate the processes and outcomes of music therapy as procedural support to the interdisciplinary staff so that they can better support patients' coping efforts.

Documentation tool for music therapy as procedural support

This documentation tool addresses key elements in the therapeutic process of music therapy as procedural support and places particular emphasis on clarifying how, why and when the music therapist adjusts her/his therapeutic "treatment lens" (Figure 3). From this information, the music therapist is able to summarize translatable patient outcomes, and synthesize this information into implications for interdisciplinary staff.

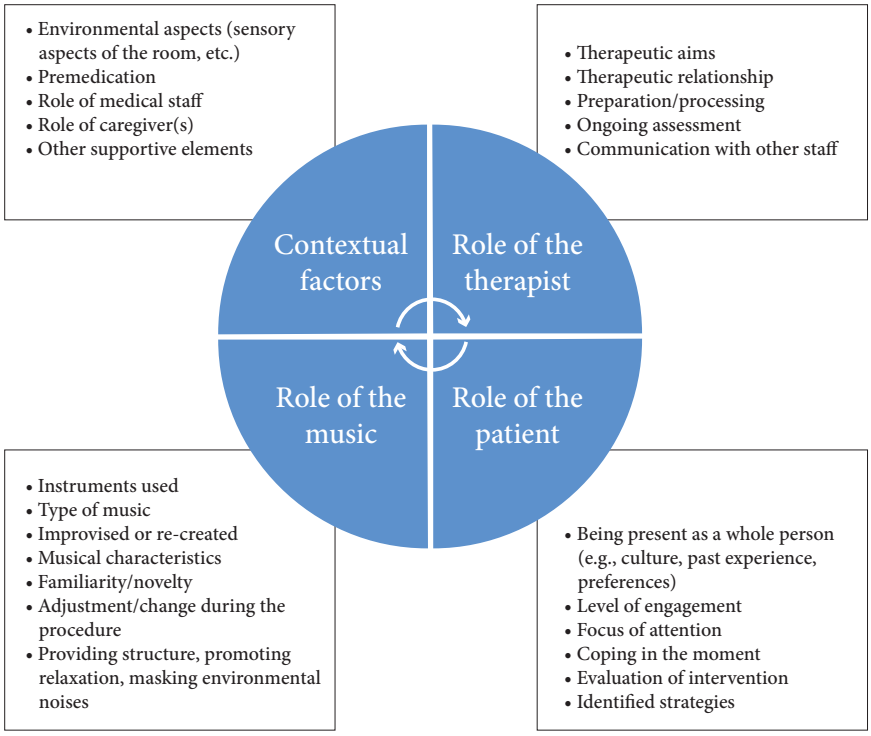

Figure 3. Adjustment of the therapeutic "treatment lens" during procedural support

The documentation tool consists of two parts: 1) a pre-procedural assessment portion, and 2) a per-session template to document the procedure itself. The pre-procedural assessment will be completed when the patient is first referred to music therapy, and the procedural component will be completed following each procedure that had significant impact on patient outcomes. In instances where a patient will be seen more than once, or will be seen in other contexts in addition to procedural support, a comprehensive music therapy assessment is indicated in addition to this pre-procedural variant (for examples of a comprehensive music psychotherapy assessment see: Loewy 1999, 2000; for other comprehensive music therapy assessments see: Douglass, 2006; Ghetti & Walker, 2008; Lindenfelser, 2013; Shaller Gerweck & Tan, 2010; for an example of a prioritization matrix see Ghetti, 2013). The procedural documentation tool can be used for single procedures, or for procedures that occur multiple times across a patient's hospitalization. The templates are formatted in a way that make them easy to incorporate into a hospital's electronic documentation system and can be adapted to incorporate culturally-specific terminology. The tool is being trialled in clinical use by three experienced music therapists in a paediatric hospital setting for children who must

undergo the same procedure multiple times. Still in an early stage of implementation, the tool enables the music therapists to more clearly articulate session outcomes, which enables better cooperation with other staff. The degree to which other staff are accessing the tool in the documentation system has yet to be determined.

Procedural support might sometimes be conceived of as occurring "in the heat of the moment" with the focus of getting the job done. Completing the tool while considering what occurred before, during and after each procedure helps the therapist take a more conscious approach to documentation and may promote the use of more consistent and translatable language. The tool is structured around the various actors within the procedural support experience, namely, the patient, music therapist, family members, and other staff; and the music, procedure and context. It is recommended that music therapists complete a pre-procedural assessment of the patient and their resources and needs (Ghetti, 2013; Loewy, 2019). Table 1 provides a template for a pre-procedural assessment.

Pre-procedural assessment tool	**Key points**
Procedural demands	Define the procedural frame. When does the procedure start for the patient? What must the patient do and experience during the course of the procedure? What are the requirements from the medical staff, and what can the patient choose, if anything?
Brief patient background	Diagnosis, age, developmental level, communication skills, cultural frames, previous medical history and hospital experience, previous music experiences and preferences, previous experiences with music therapy
Family history	Assess family-related elements that could affect ability to support child during procedure. Parental stress level? Siblings? Other resources?
Coping assessment Identified stressors Identified resources Previous coping strategies Coping preferences for procedural support	Trauma assessment, as appropriate. Are there known factors that might stress the child? (e.g. fear of new things, fear of medical staff, fear of people talking over the child's head?). What type of coping strategies does the child use? How does the child use other people for support? What do we know of the child's attachment style? What has previously comforted the child? Who does the child trust?

Table 1. Pre-procedural assessment tool

Pre-procedural assessment facilitates better coordination between staff members for subsequent support of the patient and helps the music therapist build a treatment alliance with the patient and family prior to the procedure. The preparation and assessment process provide a mutual ground for involving team members and patient alike and defining clear roles and expectations for the procedure. The music therapist becomes familiar with how the procedure has been described to the patient, what choices the patient can make regarding the procedure, and the team becomes aware of the patient's preferences and coping strategies.

During a preparation and pre-procedural assessment session, the music therapist can begin to build rapport with the patient and family and collaborate to identify and try out various music-facilitated coping strategies. In collaboration with the therapist, the patient can plan how she or he would like to use music during the procedure, and in so doing, exercise choice and control in a way that promotes a sense of agency and facilitates healthy coping. For example, the child can determine how she will use a specific instrument, sound or phrase to indicate that she needs a short break during the procedure, and this information can be conveyed to the staff through the pre-procedural assessment documentation. The music therapist can serve as anchor point during the procedure, a person that the child can rely on to meet their needs. The music therapist will also note particular fears, stressors, and psychosocial factors that would otherwise cause the patient or staff distress if not addressed and suggests means for successfully eliminating or reducing such challenges. Since this assessment process provides a frame for subsequent procedural support, it is important that the music therapist practices therapeutic reflexivity.

After completing an assessment prior to the first session, the music therapist will use the session-based documentation tool (Table 2) after each occurrence of the procedure itself. For repeating procedures, the music therapist is encouraged to use the tool each time, to help further tailor and develop the intervention and update interdisciplinary staff of any changes in patient preferences or responses. Once a child copes consistently well with procedural support, and support can be carried out sufficiently by other members of the interdisciplinary staff, the music therapist may no longer be required for that patient and other patients may instead receive priority. The documentation tool for music therapy as procedural support helps structure reflection upon the various factors that inter-relate during a session of procedural support and includes implications for other interdisciplinary staff that can continue to support the child even in the absence of the music therapist.

Documentation tool for each session	
Contextual factors	Where did the procedure take place and what were important aspects of the environment? Which contextual factors were critical, and which were preferred, but not critical? Who was present and what effect did that have? Pre-procedural medication given (and effect)? MT already present (e.g., environmental MT to change the atmosphere of the room?). Equipment for the procedure prepared in advance?
Role of the therapist	Pre-assessment completed? First time? Therapeutic aims (intentions) for the procedure? Took role as interdisciplinary team leader? Verbal and musical roles, for example: *arousal regulation* (e.g., Ghetti & Whitehead, 2015), *tension-release* (e.g., Loewy, Azoulay, Harris & Rondina, 2009; Mondanaro, 2013) including *tonal intervallic synthesis* (Loewy, 2011), *musical alternate engagement* (e.g., Prensner et al., 2001), validation of emotions and sensations (e.g., Turry, 1997), or clarifying aspects of the procedure (e.g., Edwards, 1999)? Support for parents, and inclusion in music therapy, as appropriate? Support for staff performing the procedure? How did the therapist adjust approaches over the course of the procedure? Post procedure: to what degree were *reconstitution and reorganization* necessary (Turry, 1997), and how were they promoted?
Role of the music	Type of music therapy approaches used (if not already included in "role of the therapist")? Type of music (e.g., genre, improvised vs. re-created, familiar vs novel) and instruments used? Musical characteristics? Nature of child's engagement in the music and how this changed over the procedure.
Patient role	Level of engagement? Focus of attention? Role within the music? Body language? Eye contact? Signs of distress? Interaction with other staff? Interaction with supportive person? Choices made and preferences during procedure?
Patient and family outcomes	Which coping strategies were used? How did the patient and family perceive the procedure and MT approaches (What worked and why? What did not work and why?)? What fears or fantasies were expressed? Patient preferences for future.
Interdisciplinary implications	What are the practical translatable outcomes? What does the patient need from other staff? What does the staff need from the music therapist to build a trusting environment? Which techniques can be used by other staff when MT is not present? Important contextual factors? Is a supplement to MT required (e.g., need for medication)? How did the staff respond to the presence of MT?

Table 2. Documentation tool for music therapy as procedural support

It should be noted that there are occasions when a child does not wish to engage in music therapy as procedural support. In such cases, an attempt should be made to understand the child's (or family's) resistance, and the choice not to have music therapy should be respected. The music therapist can work to connect the child and family to other sources of support and can remain available in case the child or family desires to engage at a later point. Similarly, a music therapist may encounter staff members who resist the presence of music therapy during procedures, for various reasons. When such resistance occurs, the music therapist can work to build rapport and alliances with these staff members and seek to understand why they feel their needs or the needs of the patient are not being met. A concerted effort to try to understand and meet the needs of staff can often help open possibilities for future collaboration.

In order to demonstrate how the music therapy as procedural support documentation tool can be used in practice, we will provide a case example, followed by corresponding pre-procedural assessment and session documentation that follows the templates given above. The following case is a typical example from clinical practice that has been modified slightly for the purpose of this article. Sensitive information has been anonymized and written consent was obtained from both parent and child.

An illustrative case example of music therapy as procedural support: *Lisa*

Lisa is a 12-year-old girl and is the youngest child of three siblings. Her family lives in a small town. Her mother is a teacher and her father is a carpenter. Lisa loves to read, listen to music and play soccer when she is not at school or playing with her friends. Lisa had no prior history of hospitalization or illness, until she was admitted to the hospital due to disturbances in sense of balance and reports of nausea during the past month. She had been feeling unwell for some time and found it difficult to be as active as she used to. Sometimes she would vomit after engaging in simple activities and her need to rest was markedly increased. She had to stay at home from school and did not feel like spending as much time with her friends as she normally would. After admission to the local hospital, an MRI scan confirmed a brain tumour that required resection. The family was then referred to the general hospital for further treatment and care. Comprehensive treatment of the malignant tumour included: chemotherapy in various forms and methods of administration, possible radiation and additional surgery, all depending upon how the tumour responded to treatment. After the initial surgery, Lisa found it hard to adjust to the demands of the hospital and of treatment. She underwent numerous procedures, required continuous monitoring of her neural activity, which impeded her independence, and experienced a high volume of staff involved in her care. She missed her friends, her home and her dog. She often felt overwhelmed with fear, and had difficulty regulating her own feelings

and articulating what she was specifically afraid of. It was during a moment of particularly acute distress that Lisa's nurse first paged the music therapist and asked for assistance.

When the music therapist entered the room, Lisa was sobbing and had a look of panic in her eyes. Her father was trying to comfort her by stroking her hair. The music therapist began by acknowledging Lisa's fear and offered Lisa a chance to use music to help her relax. Lisa nodded in assent, and the music therapist began playing her guitar quietly and leading Lisa in a brief relaxation exercise that focused on slowing down her breathing and alternatively contracting and relaxing various parts of her body. Once Lisa's breathing became slower and deeper, her body tension eased, and she was ready to engage verbally with the music therapist, they talked a bit about what she was afraid of, what she likes to do, and how she felt about the music. Lisa talked about her interests and her friends at home, with her father supplementing from time to time, and expressed how much she loves stories. The music therapist offered that they could explore a musical story together (via an adapted form of Guided Imagery and Music composed by music therapist and researcher Ilan Sanfi). Lisa closed her eyes and listened closely to the story, and soon fell fast asleep.

The music therapist came back to process the experience once Lisa had awoken. Lisa said that the music made her feel relaxed, and that the story helped her stay focused. She experienced vivid images facilitated by the music story and said, "it was almost like being in the forest." This first meeting served as both an actual supportive session and as an initial assessment, and it enabled building of rapport as well as identification of strategies for further support.

At the time of this first session, it was not yet known to what extent the resection of the tumour would affect Lisa. Considering Lisa's preferences and needs as expressed in the initial music therapy session along with dialogue with the interdisciplinary team, it was decided that Lisa might benefit from help to: 1) improve her ability to self-regulate during stressful experiences, and 2) promote resilience through regaining a sense of control and the ability to identify and use concrete coping strategies.

Due to Lisa's fascination with stories and her preferences for using music, the music therapist decided to continue using an adapted form of Guided Imagery and Music. Aims were to promote relaxation and to help Lisa focus on breathing, picturing a safe place in order to relax. Verbal processing after sessions opened up for self-expression. Lisa was able to use the music to regulate her stress levels, report vivid imagery and respond to input from the music therapist in her initial two sessions.

As part of chemotherapy treatment, Lisa needed to have medicine injected through a thin needle into a reservoir that is surgically inserted under the skin to provide access to the spinal canal, known as an Ommaya reservoir. The procedure itself is not very painful but may be perceived as uncomfortable and potentially anxiety provoking. The medical staff must position themselves very close to the patient's head while the patient remains completely still while the medicine is injected. Patients may be intimidated by these procedural demands, due to the perception of medical staff invading such a personal space, and due to fears and anticipation about what might happen next.

The interdisciplinary team, Lisa and her parents decided it might be a good idea to use music therapy as procedural support. Lisa's father admitted that he himself was not very comfortable in procedural situations due to his own heightened level of stress, and thus it was decided that in this procedure, Lisa's mum would accompany her. For the pre-procedural assessment, the music therapist talked with Lisa about what the procedure would be like from a sensory standpoint (the sights, sounds and sensations). The nurses and doctors had already informed Lisa about practicalities of the procedure. The music therapist used the structure of the pre-procedural assessment to get an idea of which elements of the procedure were frightening for Lisa, and to create a plan for how to best support her through it. Based on the previous two music therapy sessions, Lisa identified that she would like to use the relaxation techniques they practiced to create an image of her favourite beach where she could "just be safe and relaxed." She was not sure if she wanted anyone to be there with her in the imagery but wanted to leave it open to "just see what happens." Lisa talked about her fear of being held down and how she feels overwhelmed when there are many people standing over her. Lisa also expressed that it is important to her that she receives information that is accurate and consistent and that the procedure is as predictable as possible. In other situations within the hospital, Lisa benefits from a clear delineation of when she is finished with an important job. Through dialoguing with the music therapist, Lisa identified that she would like to be in her own room for the procedure with as few staff present as possible. It is standard practice for procedures to take place in the treatment room, however, Lisa clearly indicated that she had been so scared in the treatment room previously that she wanted the procedure to take place in her own room. She felt safer in her own bed and knowing that there was an established plan for her procedure. The music therapist discussed these preferences with the interdisciplinary team who would perform the procedure. To honour Lisa's choices and need for control, the team decided to try accommodating her wishes, and affirmed that they were pleased to have the music therapist provide procedural support.

The procedure:

Lisa and the music therapist chat together a bit before the procedure. Lisa chooses the ocean drum that was previously introduced by the music therapist, to create an image of a safe and calming beach where she can simply "be" while the procedure takes place.

The music therapist is present before the procedure starts and agrees with Lisa to start the relaxation induction while the nurse and the doctor are preparing for the procedure. Lisa says that she is "really nervous," but follows the therapist's instructions. The music therapist intensifies the cues for relaxation by reminding Lisa to focus on her breathing, or by prompting Lisa for details in the imagery when needed, such as when Lisa opens her eyes, starts to cry or expresses fear in other ways. The music therapist creates a slow, back-and-forth rhythmic "swoosh" with the ocean drum as a foundation for introducing the imagery. The music therapist cues Lisa to consider how she experiences the weather, the sun that warms her body from her fingertips to her toes, head etc., in order to promote progressive relaxation. Lisa engages in describing what she sees at her beach. At this point, the doctor is ready to pump the reservoir and Lisa starts to cry, asking for her mum to hold her hand. The music therapist gently cues Lisa to keep taking deep breaths and asks how the ocean is right now, to which Lisa replies, "The ocean is chaotic, and the waves are big!" Lisa also envisions two seagulls flying over her. The music therapist plays louder to reflect Lisa's input. Lisa's eyes are now open, and she continues to engage in the imagery while maintaining intense eye contact with the music therapist. The doctor is ready to place the needle into the catheter, where it must remain undisturbed for approximately 2–3 minutes to extract spinal fluid for analysis and to subsequently inject the chemotherapy. Lisa tells the music therapist that she is scared and wonders if it hurts. The music therapist reassures her and tells her that she might feel it (specific and accurate information), but that she is doing such a great job of helping things go smoothly and sitting still. Once Lisa's current emotions have been fully validated, the therapist guides her back into the imagery. Lisa reports that the waves have quieted down a bit, which is also reflected in the music therapist's play. Lisa describes how the water feels on her feet, and tells the music therapist that her favourite pet, the family dog, is also at the beach together with her. The doctor comments on Lisa's imagery and says that it sounds like a lovely beach. The procedure is finished, and the doctor pushes the reservoir eight times to finish, then tells Lisa that the procedure is over and that it went very well. Lisa is surprised that the procedure is over, and says that even though it was scary, she feels proud that she could do it. As the music therapist is about to start playing one of Lisa's favourite songs for closure, the doctor starts talking to Lisa's mum and says that he will "just have a look at the reservoir." Lisa starts to cry as the doctor moves in closer and the music therapist reminds the doctor that the team has previously made a deal with Lisa that once she is told the procedure is finished, she can relax and be done with procedural aspects.

The doctor laughs and moves away, gesturing that he will come back to talk to Lisa and her mum later that day. The music therapist stays after the other medical staff have left to finish the concluding songs, promote a sense of reconstitution and reorganization (Turry, 1997), and to assess feedback from both Lisa and mum's perspective. Together they agree on some basic rules that will help the next time Lisa has the procedure, and the music therapist also highlights that it was Lisa that did the real work here, and that she did it so well despite the fact that she was initially so afraid of the needle. The music therapist reminds Lisa of what she said after the procedure, mainly that she did not really feel the injection when she was relaxed and focused on something else. Lisa had found a way to cope with her fear. After concluding with Lisa and her mum, the music therapist briefly chats with the team to assess how they perceived the procedure and to discuss ways in which they could more actively engage in the music during future procedures, and then completes her documentation in the medical record.

Example of corresponding documentation

Given the rich case example above, we can now illustrate how the documentation templates might be used to describe music therapy as procedural support with Lisa. The following is an example of documentation that might be included in Lisa's electronic medical record.

Pre-procedural assessment: *Lisa*

Procedural demands: *Ommaya procedure involving intrathecal injection into scalp, Lisa needs to sit completely still during procedure. Must tolerate pressure pre and post pump (x 8) onto the reservoir. Skin numbing by EMLA 1 hour prior to procedure. Expected pain experience: minimal, however, psychological component of fear is highly possible due to nature of the procedure.*

Brief patient background: *12-year-old female, youngest of three children; loves reading, music and soccer. Age coherent, recently admitted to hospital with no prior history of hospitalization.*

Communication/appearance: *Withdrawn, high anxiety level, fear of needles and hospital staff dressed in "white."*

Previous hospital experience: *First time in hospital, met with the MT x 2 during current hospitalization (receptive interventions with focus on deactivation of stress, emotional support and identifying coping strategies).*

Caregiver / family history: *Supportive family with both parents actively involved in care. Father experiences elevated anxiety during procedures. Mother able to effectively support Lisa during procedures.*

Coping assessment: *No previous history of traumatic experiences that might impact current coping. When fearful, is able to refocus on preferred safe place when given cues and musical support by music therapist. Safe place is the beach, engages in vivid imagination and is able to articulate imagery. Loves family dog, many good friends at home, close relationship with both parents (although mum preferred for procedures due to father's level of anxiety).*

Stressors: *Becomes acutely distressed when actively held down during procedures, and when there are multiple staff people in the same room.*

Resources: *Able to express needs verbally and nonverbally; able to become highly absorbed in music and imagery experiences; consistent emotional support from parents, with calming and nurturing support from mother during procedures.*

Preferred coping strategies for procedural support: *Lisa desires adequate time for preparation & explanation prior to procedure and is an information-seeker. Benefits from calm environment with as few staff as possible. Prefers own room/ lying in own hospital bed. Lisa desires support for self-regulation and alternatively engaging attention during procedures.*

In Lisa's case, completion of the pre-procedural assessment helped the music therapist identify Lisa's preferred coping strategies and resources, which in turn helped her form a plan for subsequent procedural support. It also enabled Lisa to bring in safe and familiar elements of her choice into a new and scary situation. The assessment helped the music therapist identify contextual elements of the procedure that Lisa could control according to her preferences; including location, number of people present, and the particular parent present. Furthermore, Lisa's preference for receiving clear information regarding the logistical and sensory aspects of the procedure in advance of the procedure itself, assured that she was adequately prepared for the sensations she would experience. The process of pre-procedural assessment also enabled Lisa and the music therapist to identify that a

modified version of Guided Imagery and Music incorporating imagery related to Lisa's safe space of the beach and including her beloved dog would likely serve as effective supports to alternatively engage her attention and promote self-regulation during the course of the procedure. Communicating Lisa's preferences to the medical team created a joint focus that enabled a predictable procedure to take place.

After Lisa completed the procedure, the music therapist documented outcomes related to the procedural support within Lisa's medical record. The following is an example of this template completed for Lisa's experience of the Ommaya reservoir procedure.

> Session documentation tool: *Lisa*
>
> Contextual factors: *As per her choice, Lisa is in her own room, lying down on her bed. EMLA cream has been administered by Lisa's mother, no use of other pre-medication. Established ground rules: only one doctor, one nurse, MT and caregiver present at the procedure; once the doctor declares the procedure is "finished," no further examination or handling should occur. All procedural materials will be ready before the procedure begins.*
>
> Role of the therapist: *As Lisa and music therapist have agreed upon during pre-procedural assessment, MT introduces a brief music-assisted relaxation exercise, prior to engaging Lisa in an adapted form of jointly-created guided imagery and music as support to the procedure. Lisa signals doctor when she is ready for the procedure to commence then closes her eyes and engages deeply in imaging. MT intensifies verbal support and musical accompaniment on the ocean drum in accordance to changes in Lisa's imagery, and particularly when Lisa shows signs of fear. MT sings phrases like: "you are safe," "we are looking after you," "you are being very brave." MT cues Lisa to identify sensations in her body and to refocus on positive resources, when appropriate. Afterward, the MT verbally processes the procedure with Lisa and caregiver to evaluate their experiences and plan for future support.*
>
> Role of the music: *Use of ocean drum to reinforce Lisa's preferred imagery of being on a favourite beach with pet. Continuous rhythm that cues deep inhalations and exhalations, conveys intention of creating a holding space, and is predictable and framing.*
>
> Patient role: *Lisa engaged throughout procedure in instructing therapist to create desired ocean wave intensity using ocean drum. She contributed to adjusting imagery as her needs changed during the procedure.*

Patient and family outcomes: *Lisa states she benefits from refocusing strategies. When scared, music therapy helps guide her back to a calm and relaxed state. Maintaining eye contact helps her stay focused on the imagery and support. Lisa expresses feeling very proud and happy after completion of the procedure. She says it helps to "think of other things and picture herself relaxing on a beach." Lisa's mum supported Lisa's engagement in guided imagery and music and stated that she feels comfortable enough to try to use safe space imagery with Lisa during procedures when the music therapist cannot be present.*

Interdisciplinary implications: *Lisa feels safer when the procedure takes place in her own room, with as few staff present as possible. Lisa benefits from preparation related to the sensory and logistical aspects of the procedure, information given during the procedure, predictability, and reassurance that connect her with her coping resources. Concrete strategies for support include: preparing equipment prior to procedure, maintaining continuity of staff, and providing reminders to take deep breaths. When staff state that Lisa is finished with the procedure, this should be respected as final in order to promote trust and predictability. Lisa requests music therapist to be present at procedures when possible and perceives her mother as a support during procedures.*

Use of a pre-procedural assessment and communication of Lisa's preferences and coping strategies identified during that assessment to interdisciplinary staff helped assure that Lisa experienced elements of choice, control and mastery during the procedure itself. Although Lisa exhibited some anxiety during the procedure, she maintained resilience and felt safe enough to release her anxiety through tears, which enabled her to express what she needed during the procedure. She was subsequently able to refocus on her preferred safe space and coping resources and remained an active participant in both the procedure and the guided imagery and music experience.

Discussion

Reflecting upon use of the documentation tool for music therapy as procedural support

The biopsychosocial model, originally developed by George Engel (1977), offers a holistic and systems-based approach to understanding how multiple factors from the societal to the molecular interact to result in health and/or illness. A biopsychosocial consideration

of music therapy practice in medical settings acknowledges how biological, psychological, and social aspects are interrelated when addressing children's needs through music therapy (Dileo, 1997; Ullsten, Eriksson, Klassbo & Volgsten, 2018). These areas influence the patient's lived experience of a medical procedure and require a high level of knowledge, reflexivity and flexibility from the music therapist. A music therapist may need to use different therapeutic approaches and musical interventions within a single procedure, in order to adequately meet a child's needs (Ghetti, 2012). How the music therapist, child, family and staff work together to best meet the child's needs and assure a successful procedure evolves throughout the course of a single procedure and develops over time for repeated procedures.

Ommaya reservoir procedures provide a useful context for a discussion of the importance of procedural support documentation, since patients who require these procedures will experience them repeatedly. The usual treatment protocol involves approximately 4–7 punctures (1–2 per day over 3–4 days) every second week for up to a year. Standardized documentation of the therapeutic process and outcomes of music therapy as procedural support can help positively alter patient experiences during subsequent procedures. Paediatric patients and their families have already experienced severe stress, sometimes possibly even traumatic in nature, prior to commencing with Ommaya procedures. Thus, they enter into the experience of this medical procedure carrying the baggage of previous experiences and are potentially taxed in their coping resources. The procedure itself requires several professionals, the number of which can be particularly high at teaching hospitals and specialized hospitals like Rikshospitalet where medical staff come for training. For the family, this entails encountering a large number of different professionals, who do not always know the patient or the family's full story. By systematically identifying and documenting key elements of a child and family's coping strategies and preferences, the music therapist can contribute to better care of the patient during such procedures, despite the large number of professionals involved.

Elements that promote healthy coping including a sense of predictability, feelings of safety, and opportunities for choice and control, are important to assess and document, as well as factors that contribute to the development of the therapeutic relationship. Since a child's coping strategies and abilities may vary over the course of hospitalization, it is important that the music therapist documents such changes over time (Ghetti & Whitehead-Pleaux, 2015). Use of the documentation tool for music therapy as procedural support helps to systematically assess and track variation in coping strategies and preferences over time, which can improve the quality of support and ensure continuity of care across providers. Such documentation helps improve continuity of care when one music therapist is passing off care to another. Consistent documentation over time can provide valuable information

for professionals who are involved less frequently in care of the patient, such as psychologists, who need reliable sources of information to obtain a broader understanding of the patient and family.

In Lisa's example, the documentation tool enabled the music therapist to reflect more consciously over the different aspects that took place in the procedure. When writing directly about the role of the music within music therapy, it became clear that the ocean drum served to reinforce and enhance Lisa's preferred imagery. The music therapist also chose to document on the therapeutic role of the music in order to educate the team about music therapy and avoid misconceptions. Nursing and medical staff sometimes have the impression that all that is required to support the patient is to just play a certain instrument. Documenting the therapist's specific role highlights the therapeutic intention and how the therapist uses a reflexive process of continual assessment and adjustment of the therapeutic "treatment lens" to meet the child's changing needs. This documentation also reveals competencies that the therapist possesses, and reports in a practical and concrete manner the processes that are taking place with Lisa. By clarifying the therapeutic intention, the music therapist can elucidate why it is important that Lisa be left alone to focus solely on the music therapist when she is engaged in an imagery experience. When other members of the interdisciplinary team understand the therapeutic intention, they may be able to avoid making well-intentioned, but ill-advised comments that end up breaking the patient's concentration.

Implications for interdisciplinary collaboration and communication

When all team members have a conscious awareness of what is actually taking place during music therapy, the results benefit the patient as everyone is working from a shared understanding. The music therapist must communicate in concise and professional language, in a way that can be easily understood by medical staff. The documentation tool may be used to help the therapist develop such a practical language. By articulating various factors inherent in the tool, the music therapist can clarify which elements of procedural support require the specific skills of a music therapist, and which elements can be effectively implemented by other staff. The latter is documented within the "interdisciplinary implications" section of the tool and should be stated in language readily understood by all members of the interdisciplinary staff. In Lisa's case, the practical suggestions mentioned in this section were easy for other staff to implement (e.g., have equipment ready beforehand, procedure to take place in her own room). By respecting and consistently following Lisa's "ground rules," the staff gain Lisa's trust.

One may argue that identifying and following a patient's coping preferences in relation to a procedure falls within the professional domain of nurses or doctors, which is often the case. In North America, it is common for Child Life Specialists, as well as music therapists, to take a leading role in providing developmentally-appropriate preparation and procedural support. Some music therapists choose to pursue additional education and certification in Child Life, in order to learn more about how development impacts perceptions of illness and injury and how development, in turn, is impacted by illness and injury (Ghetti, 2011). Music therapists have a relatively long history of providing procedural support, supported by their own theoretical and research base, and are well-qualified to assess and address the biopsychosocial needs of children undergoing anxiety-provoking or painful procedures, and those of the families and staff who surround them (Ghetti, 2012). Music therapists are specifically trained in how to work nonverbally and verbally to help others process a broad range of emotional experiences. Music therapy assessment processes help determine how past or current traumas might impact current plans of care, and how current resources can be built upon. The various professions represented within the interdisciplinary team will vary by hospital, but all teams should strive to help each other while keeping the patient's best interests in mind. Music therapists often have the privileged position of being able to focus exclusively on helping patients, families and staff cope, and as such, serve as an important anchor within the interdisciplinary team for supporting children and their parents during medical procedures.

Incorporating documentation tools into standard practice may facilitate a practical and conscious approach to care. The act of completing such tools can enhance clinical reflection, and the content within the notes themselves can help bring awareness to the professional role of the music therapist within the interdisciplinary team. This documentation practice and the accompanying reflection inherent within it may heighten the holistic quality of care involved in procedural support since key elements of the tools are derived from salient concepts in the literature (e.g., Edwards, 2005; Loewy, 2000, 2019; Loewy et al., 1997; Turry, 1997; Whitehead-Pleaux, Baryza & Sheridan, 2006). Furthermore, documenting the processes and outcomes of procedural support is in alignment with expectations of professional practice (Waldon, 2016).

The aforementioned case of procedural support for Lisa provided an example of interdisciplinary collaboration and procedural support that worked well. When patients are given the opportunity to articulate their preferences related to procedural support, and these preferences are clearly communicated to the team, better quality and continuity of care are possible. When team members are familiar with working with each other, have good interdisciplinary communication practices, and have a shared understanding of the

therapeutic aim, they are more likely to provide patient-specific support in a coherent manner. In contrast, it is sometimes difficult to identify factors that are likely to support the patient's coping, and the team struggles to find ways to console a child and complete the procedure without unduly stressing the child. When procedural support does not lead to a child successfully tolerating a procedure, and when the procedure must be discontinued, one wonders what can be meaningfully documented.

Within this chaotic and challenging context, there often lay key elements upon which the music therapist can reflect in an effort to understand what went "wrong". The music therapist might have perspectives that vary from the perspectives of other team members, and documentation of such can help to further the team's thoughtful response to the challenging situation. Completing the documentation tool offers the music therapist a chance for structured reflection, with the various sections and questions serving as conceptual prompts that can promote deeper and more holistic reflection. The music therapist is prompted to think of aspects related to where, when, what, why, and how elements happened, and how the therapist adjusted (or failed to adjust) the therapeutic "treatment lens" (Figure 3). The therapist can clearly articulate the therapeutic intention during a documentation note, along with comments about what did or did not ultimately support the child, so that both the music therapist and team learn from the experience. Therapeutic aims should include provision of support to parents and framing the patient's fear. The latter may occur separately from the parents, as some children may not feel safe enough to fully express their fears while their parents are present. Music therapy can serve as an anchor and companion throughout the course of the procedure, most particularly when it proves difficult to reduce the patient's perceptions of fear or pain. It is important that the team understands the therapeutic aim and the corresponding approaches that were used, in order to counter the overly simplistic conclusion that "music therapy didn't work for this child." Thus, the documentation tool provides an opportunity for the music therapist to document the full therapeutic process. When procedures occur repeatedly over time for a particular patient, it is especially important for the team to become familiar with what the tool provides, so that they can find information relevant for future procedures. It must be acknowledged, however, that no amount or quality of procedural support may sufficiently ease distress and pain for some patients. In such cases, it is important that the staff evaluate their approaches, but also acknowledge that such situations will arise, despite their best coordinated efforts.

Limitations and future directions

As therapists who frequently move between verbal and nonverbal experiences, we are often challenged to set words to the complex phenomenon that is music therapy. It is

acknowledged that the exploration of the qualities of the music and the role of the music within procedural support is limited within the proposed documentation tool. The aim of the documentation tool is to provide a pragmatic means of enabling discipline-specific reflection while also promoting interdisciplinary understanding and communication. Though some music therapists have gone further to explore the particulars of the *music* within music therapy as procedural support (e.g., Loewy, 2019; Loewy et al. 1997; Turry, 1997; Ullsten, Eriksson, Klassbo & Volgsten, 2016), there is a need for further theoretical and empirical exploration of this essential element. There is also a need to understand how social and cultural values tied to Nordic contexts impact the manifestation of health care, and how these manifestations might impact the development of theory and practice related to music therapy as procedural support. For example, in countries where health care is considered a human right for children and adults alike, and not a privilege, user perspectives and preferences are given serious weight. In order to understand the significance of music therapy as procedural support, we must seek the perspectives of the child or adolescent themselves, as well as their families. Thus, asking children, adolescents and parents about their experiences during music therapy will provide essential understandings of the role of music therapy in this context.

We maintain that clinical documentation is an important part of music therapy practice within medical settings, and we encourage music therapists to test out and adapt the tool described herein. Written documentation can serve as a crucial bridge between professionals in a way that improves patient care (Edwards & Kennelly, 2016), however, "even the best-written information still cannot completely replace verbal communication and exchange of thoughts between professionals" (Leinebø & Aasgaard, 2017, p. 298). Thus, we also recognize that in-person verbal communication plays a significant role in facilitating interdisciplinary collaboration, and we are aware of the value of oral communication. Music therapists will be well served by updating the team verbally when patient preferences have recently changed, or when a new approach to support is warranted. Updates typically occur during daily rounds, but could also arise during less formal interludes, such as when a patient's status changes or when procedures occur emergently. Furthermore, a music therapist may choose to make brief comments during the course of a procedure to help illustrate what is happening in the therapeutic process, so that all team members and family present can better understand the therapeutic aims and approaches.

The documentation tool for music therapy as procedural support was pilot tested at Rikshospitalet during its development, which helps assure that it is relevant and functional in practice. With continued use, and expansion to a variety of cultural settings, the tool will no doubt evolve and require adaptation. Our hope is that the templates included herein

will serve as a useful starting point for music therapists working in medical settings and will promote both reflection and interdisciplinary communication. Further evolution of the tool from a conceptual and practical standpoint is welcomed.

Conclusion

The professional practice of music therapy in paediatrics is expanding within Norwegian hospitals, a consequence of a growing recognition of the benefits of music therapy for the individual patient, the family unit and the hospital environment. As Norwegian hospitals increasingly adopt a biopsychosocial approach to care, music therapy can provide an essential model for how patients and their families can be met, understood and helped in a holistic manner. When music therapists specifically and clearly describe the processes underlying procedural support, including patient and family contributions and preferences, other health professionals can use such knowledge to help the child cope more effectively in other contexts. For example, music therapists can explain ways in which staff can adjust environmental factors or verbally prepare children according to the therapeutic outcomes from music therapy to better support the child and family. Some of these strategies may be appropriate to implement when the music therapist is not able to be present.

Given the ineffable nature of music itself, it is no surprise that it is difficult to describe what music therapy is, or to clearly articulate its processes and value. It is not surprising that other health professionals sometimes struggle to grasp the full and complex scope of what music therapy as procedural support represents. The proposed theory-supported documentation tool represents a modest and pragmatic step in translating theoretical processes into practical terms in a way that promotes understanding for the music therapist and interdisciplinary team, alike. Developing theory-supported documentation tools can contribute to the evolution of professional practice, by helping music therapists and interdisciplinary staff to become more aware of important therapeutic processes. By striking a balance between the professional languages, cultures and values of music therapists and the interdisciplinary staff, the tool may facilitate more meaningful communication between these professionals, which in turn may contribute to better biopsychosocial care of paediatric patients and their families. If the tool is found to be culturally relevant, it can be used by a wider body of music therapists, to navigate their clinical work and better communicate outcomes to co-workers, employers and patients.

In conceiving of music therapy as a discourse, Ansdell (2003) asks us to consider what our theoretical depictions of practice allow us to do. When situated within an interdisciplinary context that espouses a biopsychosocial perspective to understanding health, describing music therapy in a procedural support context using the guiding frames of the proposed tool enables us to enrich our own understandings of our practices as well as more fully share some of the wonders and challenges we encounter along the way with our valued interdisciplinary colleagues.

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