

# Music Therapy as a Way to Enhance Lucidity in Persons with Dementia in Advanced Stages

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## *Abstract*

Instead of describing dementia as a permanent state of non-lucidity, where the person is not reasonable and reachable, dementia is described as a condition where periods of confusion and dimness might alternate with clear and lucid mental states. In these states, the person with dementia is present and attentive and is able to interact with others. Theories of person-centred care give a basis of ideas that focus on personhood and see psychosocial needs as important in order to establish a caring environment. The use of songs in individual music therapy is applied to illustrate an approach that enhances episodes of lucidity by using cuing- and arousal-regulating techniques and building up a safe and secure relation to the person with dementia. This leads to important states where the therapist has a possibility to meet psychosocial needs, hereby improving quality of life in persons suffering from dementia in advanced stages. The text is illustrated with case material and is partly based on a PhD thesis (Ridder 2003). The thesis was supervised by David Aldridge and carried out in collaboration with Aalborg University and gerontopsychiatric unit II, nursing home Caritas.

## *Zusammenfassung*

Anstatt Demenz als einen andauernden Zustand geistiger Unklarheit zu beschreiben, in dem der Mensch unvernünftig und unerreichbar ist, ist Demenz als eine Verfassung zu sehen, in der Phasen der Verwirrtheit und Abwesenheit in Wechselbeziehung mit klaren und wachen geistigen Zuständen auftreten. In diesen Phasen ist der von Demenz betroffene Mensch präsent, aufmerksam und fähig, mit anderen in Kontakt zu sein. Theorien der person-zentrierten Pflege bieten eine Basis, die sich auf das Personsein bezieht und die psychosozialen Bedürfnisse als notwendig wahrnimmt für die Etablierung eines pflegenden Milieus. Die Verwendung von Liedern in der Einzelmusiktherapie wird als eine geeignete Methode dargestellt, um die Phasen der geistigen Klarheit mit Hilfe von Stichwort gebender und Erregung regulierender Technik zu steigern und eine vertrauensvolle und Sicherheit gebende Beziehung zu dem Menschen mit Demenz aufzubauen. Dies führt zu dem wichtigen Umstand, in dem der Therapeut die Möglichkeit hat, den psychosozialen Bedürfnissen zu begegnen und sie zu befriedigen und damit die Lebensqualität der Menschen mit fortgeschrittener Demenz zu verbessern. Der Text beinhaltet eine Falldarstellung und basiert zum Teil auf einer Doktorarbeit (Ridder 2003). Sie wurde von David Aldridge begleitet und durchgeführt in Zusammenarbeit mit der Aalborg Universität und der Gerontopsychiatrie Station II eines dänischen Altenheims namens Caritas.

## Introduction

Mrs C is 80 years old. She is a small chubby woman dressed in colourful, fancy chintz dresses. Mostly you will find her sitting in an armchair with her eyes closed. Or you will see her when she potters about in a slightly stooping, but vigorous and stable gait. Mrs C suffers from severe dementia and lives in a special care unit. She seems to be living in her own world, although peer residents and staff surround her. In a gentle voice a flow of words comes out of her mouth – endless monologues, where she expects no answer, e. g. „Surely it was nicer. It was nicer, it was the nicest, surely it was, it was. He is out buying a new kitchen ... Well, give her a call, then she said that she had heard it ... Let life take it's course, he is sweet, he was, he was so sweet, yes he was, yes, yes, yes ...“ (Mrs C, sess. 15).

In contrast to these monologues, there are sudden glimpses in which Mrs C seems to be ‚beamed down‘ to a common reality. All of a sudden I have the impression that she ‚is here‘. She seems to recognize that there are other people around her; she makes comments that are connected to our common reality, or acts in a way in which she relates to other people.

These periods of lucidity are connected with the key points of our music therapy sessions. It is here Mrs C looks directly at me, comments on my presence, joins in the songs that I sing to her, and expresses herself – not in a monologue – but in a dialogue. It is in these periods that it is possible for me or staff to give Mrs C a sense of being with other people, to break her isolation, to make her feel understood and appreciated, and in this sense to make it possible to meet her basic psychosocial needs.

## Culture of Care

In this article I will put focus on episodes of lucidity in order to describe why music therapy with so-called „demented“ persons has relevance. In German an episode of lucidity is called ‚ein klarer Augenblick‘. Being lucid is the contrast of being demented, which in Latin means *out of (de) mind (mens)*. Viewing a person as demented is devaluing this person and focussing on deficits and missing functions. Putting focus on *lucidity* in persons that might be described as *confused* and out of their minds seems contradictory, and demands a view on persons suffering from dementia as persons that still „are there“ in spite of severe cognitive problems or dysfunctions. This might be related to our views on *coma* that in Greek means *deep sleep*, and where we in the health care system have been treating coma patients as if they „are not there“, until works from e. g. Dagmar Gustorff show us that actually unconscious coma patients have momentary ‚conscious‘ experiences.

„We draw the conclusion that consciousness and wakeness are no equal states. Moreover, being unconscious does not exclude making experiences.“ (Gustorff 2002, p. 4)

Dementia is entirely different from coma, but both patient groups might be viewed as „out of their minds“. This view is reflected in a culture of care where these groups are stigmatised as patients, and where concepts of identity and of psychosocial needs do not influence the work of care. In this article, I lean on the same epistemological ideas as psychologist and dementia researcher, Tom Kitwood. The concept of personhood is central to his work and is reflected in the title of his book from 1997: „Dementia reconsidered. The person comes first“. He argues for a ‚neurology of personhood‘, referring to e. g. brain scientist Antonio Damasio’s book „Descartes’ Error“ and seeing psychology and neurology as inseparable. Tom Kitwood defines a *new* culture of dementia care that develops into a many-sided model of ‚personal being‘. The *old* culture of dementia care is due to a *malignant social psychology*, where the malignancy is part of our cultural inheritance and contains a long list of elements (e. g. disempowerment, infantilization, intimidation, objectification) that leads to depersonalisation of the dementia sufferer, even though the work of the caregivers is done with kindness and good intent.

Oliver Sachs, who is clinical professor of neurology at the Albert Einstein College of Medicine and consulting neurologist for Beth Abraham Hospital in New York, has given a broad group of readers the possibility to gain an understanding of the subjective world of patients with severe neurological problems, through his insightful case descriptions. Before going on with an elaboration on episodes of lucidity, I want to give a short description of the dementia syndrome and how it might lead to confusion. This makes it necessary to put focus on the *deficits* that are caused by dementia. In order to understand the needs and symptoms of persons with dementia, we need to understand the lacks and losses.

„Neurology’s favourite word is „deficit“, denoting an impairment or incapacity of neurological function: loss of speech, loss of language, loss of memory, loss of vision, loss of dexterity, loss of identity and a myriad other lacks and losses of specific functions (or faculties)“. (Sachs 1985, p. 1)

Neurology’s favourite word is, according to Sachs, deficit. In what Kitwood calls a malignant social psychology, focus is entirely on deficits and not on resources and competencies. In a person-centred culture of dementia care it is important to understand the losses and deficits, in order to be able to highlight resources and competencies.

### **Dementia leading to confusion**

Mrs C has lost the ability to take care of herself. She is no longer able to plan her day, to get dressed, to prepare a meal, and to find her way. All these losses are due to severe changes in brain tissue that lead to cell death. For people suffering from dementia, there are many causes of loss of grey brain cells (neurons), and an absolutely certain diagnosis is not possible to make until autopsy. In the case of Mrs C, several small progressive strokes in small blood vessels in the brain have led to cell death. Her diagnosis says *vascular dementia*, stemming from the Latin word

vasculus, which means small blood vessels. When cells are not given nourishment and oxygen via the blood they die, and they die as well if a blood vessel ruptures and blood seeps into brain tissue. We also see cell loss when neuritic plaques or neurofibrillary tangles clump between cells, as described in e. g. Alzheimer's Disease, the most frequently diagnosed dementia type, and we see that neurons lose ability to communicate when neurotransmitter activity is reduced. It is important to notice that dementia is not a disease entity in itself: „The dementia syndrome is a cluster of behavioural symptoms that may or may not point to a disease, but dementia is not a disease entity in and of itself.“ (Zilmer & Spiers 2001)

The most common subgroups of dementia after Alzheimer's disease are Lewy-body dementia, multi-infarct (vascular) dementia, AIDS dementia, alcoholic dementia, herpes encephalitis, boxer's syndrome, heavy metal poisoning, and diseases named after Pick, Creutzfeldt-Jakob, Huntington, Parkinson, Wilson, and Binswanger.

Very different symptomologies are represented, but in WHO's diagnostic criteria ICD-10 or in DSM-IV some general main features are described. One of these is *loss of cognitive or intellectual function*. Progressively losing cognitive or intellectual function means first of all losing your job and your ability to make proper decisions and take responsibility. Our memory system is very complex (see Ridder 2004) and losing memory is not only losing the ability to remember where you put your glasses, or what Denmark's capital is called, or the first time you danced with your partner. Apart from losing old memories (retrograde amnesia), a person with dementia might also lose the ability to encode and learn new information (anterograde amnesia). It is clear that when a person loses memories – learned material and the ability to plan and relate to new things – the whole existence of this person is threatened. When a person is confronted with dementia and loses cognitive functioning, he or she is confronted with existentialistic questions such as: „Who am I?“ and „What is most important to me?“ – unless the person shows symptoms of anosognosia, meaning that he or she is unaware of his/her own illness. Anosognosia is mostly related to lesions in association cortex (Gade 1997) and therefore is expected to be a symptom with persons in highly advanced stages of dementia with global cognitive deficits.

It is clear that symptoms of dementia are expressed very differently when we see that the dementia syndrome covers all different kinds of degenerative and progressive types of brain damage. But these different diseases are similar in that they lead to what we could call confusion. This confusion is related to disturbances of a variety of abilities, either the ability to find the right nouns when talking, to recognise a cup as a cup, to follow a certain sequence of movements and acts when dressing, or abilities to remember – confusion that might be described with the following terms: aphasia, agnosia, apraxia, and amnesia.

## Confusion leading to isolation

Instead of seeing a person with dementia as globally ‚demented‘, we see a *person* who suffers confusion of different cognitive functions. This confusion is due to primary neurodegeneration that confronts the person with changes in details of daily living. When the person with dementia loses the ability to communicate, take responsibility, understand intentions of other people, remember, plan, etc., he or she might get more and more isolated when it becomes problematic to be part of social interactions in normal daily living. Confusion leads to isolation, which means that the primary neurological symptoms lead to secondary psychosocial symptoms.

In the book, ‚Performing Health‘, David Aldridge (in press) defines dementia as a ‚dialogic degenerative disease‘ and in this way he stresses a very severe consequence of dementia: that on top of the neurologic degenerative disease the person’s ability to enter dialogue with others is affected. The consequences of dementia have such terrifying perspectives because a dementia disease not only leads to confusion of cognitive abilities; it also makes it very difficult for a person to interact and engage with others and to be part of a community.

Mrs C has been a very active member of her church for a long time. Now she is unable to focus attention for longer periods, or to be part of what is actually happening around her. Her presence in church service is very challenging to others, as she potters about, talks to herself or organizes songbooks, flowers or other things that need to be put in order. No longer able to be part of communities, she is isolated from former ways of being with other people – unless groups are created where her ways of acting are acceptable (see Wood et al. 2004).

In dementia literature „behavioural disturbances“ are very often described as one of the main symptoms of dementia. The term reflects an attitude towards behaviours (such as pottering about, calling somebody over and over again, organizing things, etc.) as meaningless, purposeless and inappropriate. The term BPSD is suggested to replace the more negative view on problem behaviour that is included in the term behavioural disturbance“. BPSD is an abbreviation for Behavioural and Psychological Symptoms of Dementia and includes symptoms of psychosis, delusions, paranoia, hallucinations, aggression, hyperactivity, and depression. Psychological symptoms of dementia are underestimated or even ignored in traditional dementia care and treated with restraints and use of strong sedative medication. Kitwood argues that the lack of attention to psychological symptoms are due to a view on persons with dementia as persons that lack insight or – as described above – a view on these patients as demented or not-present.

„The view that people with dementia lack insight, or even that they have ceased to be subjective beings, rationalized a lack of attention to their distress, and justified substituting to mere behaviour modification for true engagement. Stage theories implied that the pathway of global deterioration was inevitable, and so legitimated the reduction of care to the meeting of obvious physical need.“ (Kitwood 1997, p. 141)

When psychological symptoms are ignored in a traditional culture of dementia care, it is not relevant to work with strategies that focus on meeting psychosocial needs. A person without insight is a body with no spirit, in line with contemporary views on Descartes and what we see as his distinction between matter and mind. This paradigm is to be replaced with a humanistic view, in order to integrate ideas about person-centred care. From a humanistic viewpoint, it is not enough to treat a person in the health care system without considering both physiological needs and psychosocial needs.

Relevant to humanistic theories are Abraham Maslow (1908–1970), who described a hierarchy of needs: physiological needs, safety, affiliation, esteem and self-actualisation, and Carl Rogers' (1902–1987) client-centred therapy. Erik Erikson (1902–1994) contributed with a focus on social relationship and described psychosocial development, stressing the interaction between the person and the psychical and social environment. Parts of these theories are further developed and changed, e. g. with a more integrative view on Erikson's 8 developmental stages of man.

When a person with dementia is confused about ‚reality‘, and is isolated from a giving interaction with other people, the following feelings are difficult to handle: fear of abandonment, fear of being controlled, sense of persecution, fear of humiliation, sense of being excluded, frustration at deficits, sadness at loss of familiar life, anxiety about being a burden, frustration at loss of abilities, feeling worthless, etc. This domain of ‚negative‘ experiences is described by Kitwood (1997, p. 78) and is connected with *global states* of terror, misery, rage, and chaos, or ‚*burnt-out*‘ *states* of despair, depression, vegetation, exhaustion, and apathy.

Kitwood sees it as a possibility for a person with dementia „to move out of fear, grief and anger, into the domain of positive experience“ (Kitwood 1997, p. 84). In order to do this the primary task is to maintain personhood. This makes it possible to meet psychosocial needs. Kitwood defines a cluster of five main psychological needs (*Attachment, Comfort, Identity, Occupation, Inclusion*) that come together in one central need for *Love*.

Not only does Kitwood mean that it is possible to avoid the global and non-reversible states of chaos or vegetation, he also provokes traditional dementia care by suggesting that person-centred care even might lead to a ‚rementing‘ process. In this rementing process, the psychosocial environment affects neuronal growth so that periodically we witness the brain compensates or even repairs neural losses.

„We have hints from several studies of ‚rementing‘ that good care promotes better nerve function; it is possible that it also creates the conditions that allow some degree of neuroregeneration.“ (Kitwood 1997, p. 101)

Kitwood and other researchers (Bender & Cheston 1997; Cheston 1998) represent an optimistic view on dementia, where a focus on deficits widens to include resources and personhood, and makes it possible to speak of *quality of life* and *promoting health*, even if the person suffers from a dementia disease. This makes it also relevant to look at episodes of lucidity in persons that now and then seem confused.

## Episodes of lucidity

Mrs C and I are having our 15<sup>th</sup> music therapy session. I find her at the unit, and we walk together to the music therapy room. She appears in a good mood, chuckles and verbalizes. As we have done all the first 14 times, we take seats on the sofa, and I am about to start our hello-song. But instead Mrs C starts singing. She sings her own self-made song/improvisation in a gentle voice with a smile on her face. After one minute she stops, and she does not sing any more in the session, except for a few stanzas of her favourite song in the last part of the session.

Even though Mrs C speaks a lot to herself, she rarely sings. In our first music therapy sessions she does not sing whatsoever and now in this session *she* is the one that initiates singing. I suggest this is a lucid interval. Mrs C is very clear in her expression and we are meeting in a meaningful act. We share an experience even if we do not talk and even if I do not sing with her, but listen to her, look at her, and move to the beat of her song.

In a doctoral dissertation from Umeå University in Sweden, Ketil Normann (2001) investigates episodes of lucidity in people with severe dementia. His research shows that episodes of lucidity appear when there is a close relation between the person with dementia and his/her communication partner, and when the relation is characterized by a situation without demands, but by acceptance and support.

As part of his research, Normann interviewed 16 licensed practical nurses and 4 registered nurses at 3 nursing homes in northern Norway. They had all worked with persons suffering from dementia for 4–24 years, with an average experience at 9½ years. The interviewees were asked to narrate episodes „where a patient with severe dementia appeared unexpectedly clear“ (Normann 1998, p. 1296). Results from transcriptions and content analysis showed 92 examples of episodes of lucidity. In a majority of these episodes the person with dementia would *talk* (n=83), and only 9 examples were episodes where the person *acted* in a relevant way, but without talking (Normann 2001, p. 32). This might reflect that episodes of lucidity lead to increased ability to verbal functioning *or* it reflects that staff are mostly inclined to observe and register episodes of lucidity when a person talks.

I believe that both options are possible: that the focused psychological state – that is characteristic for episodes of lucidity – leads to increased verbalising, but equally that we mostly register episodes where a person speaks comprehensively, as these episodes are clearer and more unambiguous to us. To me, Mrs C appeared unexpectedly clear when she started our session by singing, but it is obvious that characterizing this as an episode of lucidity is subjective and needs to be related to the context in order to be described more objectively.

In Normann's definition of episodes of lucidity, he refers to „situations when people who normally lack conversational skills suddenly surprise their conversation partner and speak and/or act lucidly in a way that is not normal for them“ (Normann 2001, p. 7). He includes speaking as well as acting, although most of the interview examples describe episodes in which the person with dementia speaks. I

believe that the reason for this is that verbal narratives are more valid for us to pass on to colleagues than observations of other persons' actions and interactions. Acts are more complex to refer to, as they are much more interwoven with the context. Saying a clear, relevant, and even wise sentence is one clear sign of lucidity. Performing a relevant act (finding the way out to the nice spot with flowers in the garden, hiding your purse at an ingenious place where you know *you* (and not some others) will find it tomorrow, pack clothes for the weekend into a suitcase, etc.) might as well be signs of episodes of lucidity for persons with dementia. But if we do not see this act as relevant and understandable, we do not consider it an episode of lucidity.

In my understanding of episodes of lucidity, I want to stress that lucidity might be expressed verbally, as well as in acts with objects or in interaction with other persons. A person with dementia who has severe cognitive deficits might periodically show confusion, but might also show episodes of lucidity. In these situations, the person seems to be in the present moment, seems to have an understanding of his or her presence in a certain context, interacts in a relevant manner, and seems to experience meaning. In the Swedish medical doctor, Karin Sundin's words, the person has a „sense of understanding and being understood“ (Sundin 2001).

In Normann's interviews, staff describe that in these situations they are able to ‚reach‘ or to be in contact with the person with dementia. Some find this important and fruitful to daily care situations, and Normann finds it striking that the carers' descriptions disclosed a positive attitude towards the patients with severe dementia and a relationship with the patients that was positive (Normann 1998, p. 1296). Other carers find the episodes of lucidity unpleasant because the unexpected lucid state of mind in the person they care for make them feel uncertain and afraid. I guess it is difficult to handle, when apparently ‚non-responsive‘ or ‚demented‘ patients actually have clear moments, where they in different ways express an understanding of a common reality.

In order to investigate how common episodes of lucidity are viewed, Normann asked staff to fill out questionnaires in Västerbotten County, Sweden. With 4297 residents living in nursing homes, 3804 questionnaires were returned. Ninety-two of these residents were rated to suffer from severe dementia and more than half of these residents (52) were described to show episodes of lucidity.

### **Breaking the isolation**

Normann's investigation shows that episodes of lucidity occur with people suffering from severe dementia. His research explores the phenomenon of lucidity, but it does not give objective measures of the phenomenon. For further research, it would be relevant to correlate episodes of lucidity with physiological change, such as change in different parameters of arousal level. But first of all, we need to ask why these episodes of lucidity are important? An answer to this might be that in periods of lucidity, it is possible to enter dialogue and to break the isolation that is



a secondary symptom of the dementia disease. When persons with dementia have a lucid interval, emotions that are present here-and-now might be shared with others and validated, or memories from long ago that still have a meaning might surface. This might not only have a positive effect on quality of life, but on BPSD as well, as basic psychosocial needs are met. Another important question to ask is if episodes of lucidity happen occasionally?

### Are episodes of lucidity occasional?

Normann defines episodes of lucidity as dependent on the interaction with the communication partner. Episodes of lucidity are connected with a *supportive attitude*, where the conversational partner avoids making demands on the patient, and are therefore not occasional episodes that happen out of the blue. A person, who has cognitive deficits, is dependent on others in order to enhance states of mind, where he or she is lucid and interacting. It is necessary with a caring environment, that the person with dementia is neither overwhelmed by demands and stimuli, or sub challenged by too few experiences.

It is possible to measure electrical activity of neurons by attaching electrodes to different places on the head. This EEG technique will show various cyclic changes in our rhythms of consciousness. A narrow focus, hyper arousal and anxiety is typically associated with high *Beta* activity (18–35 Hz) or *Gamma* activity (35+ Hz), whereas low *Beta* (12–15 Hz) and *Alpha* (8–12 Hz) activity of brain waves is associated with relaxed, passive, but wakeful states (Zillmer & Spiers 2001). Humans respond to rhythms that relate to day and night, but we also respond to shorter rhythms that follow 90-minute cycles of heightened and lowered brain arousal (ibid. p. 408). These biological rhythms of consciousness, that I here will relate to episodes of lucidity, make it clear that episodes of lucidity are not only dependent on a caring environment but also on biological premises. This means that Mrs C might need a small nap before she is ready for engaging with others, or that she needs to be awakened with e. g. movements or fresh air.

Strong medication and extreme states (that Kitwood calls *burnt-out states* or *states of e. g. misery* and *chaos*), that are a result of a *malignant social psychology*, assumably makes it difficult for episodes of lucidity to occur if the person is kept in a low arousal state.

If episodes of lucidity are seen as important in order to meet psychosocial needs, it means that methods of regulations – where focus is on states of mind where the person is most alert – must be considered in a caring environment. In this sense it seems relevant to further investigate ways to enhance episodes of lucidity.

## Ways to enhance episodes of lucidity

Generally it is suggested by researchers like Tom Kitwood and Ketil Normann that episodes of lucidity – or momentary rementing episodes – will occur when we carry out person-centred care, where there is focus on creating a relation with the person with dementia.

According to Kitwood, personhood is enhanced when we strengthen a positive feeling, when abilities are nurtured, or when helping to heal some psychic wound. In order to enhance personhood, Kitwood's work elaborates on different types of positive interaction.

When episodes of lucidity are seen as essential to interaction with other persons, it is important to understand these episodes in a broad sense that not only deals with a logical recognition of what is going on, but on an extended view on recognition in many respects.

In the following, I shall suggest different strategies that I see as important in order to enhance episodes of lucidity. Attention is a basic element to enhance lucidity. It is therefore important to initially work with *cuing techniques* in which the person with dementia is helped to draw his or her attention from other things to a common reality. This is not to be confused with *reality orientation* that in the 1980s was a very common strategy in dementia care. It was seen as important that persons with dementia were orientated to *our* reality. What is relevant in person-centred interaction is that a recognizable ‚frame‘ is built up around the interaction. Once the person with dementia, via clear cues (e. g. the first songs), is able to recognize this ‚frame‘, that defines the interaction, the frame does not have to be negotiated every time the person with dementia is invited to engage in an interaction.

The next relevant step is to regulate arousal level. This is elaborated on in Ridder (2003). A balanced arousal level is important in the way we perform and interact with others. If a person is trapped in one extreme – a hyper aroused state – a high-frequency asynchronous activity is seen in the brain, the sympathetic nervous system is on high speed and so called stress hormones (e. g. noradrenaline) is released in the blood. In this state, the person is able to focus intensively on one thing, e. g. an important test. As a metaphor, we might imagine a person with binoculars who is able to focus on details that he spots far away, but who is unable to view the scene or landscape as a unified whole, and has to adjust the binoculars before taking in information about very close things.

The other extreme that might trap the person is a hypoaroused (hypoaroused) state, with slow heartbeat and activation of the parasympathetic nervous system. The neurologist, Joseph LeDoux (1998), states that „without arousal, we fail to notice what is going on – we don't attend to the details“ (LeDoux 1998, p. 289). Metaphorically we might see a person who instead of binoculars looks at the landscape from a tower. He might have a broad view, but at the same time is dissociated from things, and even if he observes something going on, he is not able to react or intervene. Both extremes distance the person from the present moment, a

moment that e. g. is described by Daniel Stern (2004). In order to enhance episodes of lucidity it seems relevant to include *regulating techniques*, so that the person with dementia avoids getting trapped in either a state of hyper- or hypoarousal.

The third important point is to build up a relation with the person with dementia. This is described in person-centred care:

Person-centred care facilitated lucidity as the care providers then used a confirming and listening approach, were interested in the person with severe dementia and let her / him initiate and direct the conversation. Other forms of support were to avoid making demands on people with severe dementia and interrupting and correcting during conversations. Being aware of and having an interest in the person with the disease, creating a close relationship and sharing joint activities are also ingredients of a person-centred care according to this study. (Normann 2001, p. 7)

There are many ways of carrying out person-centred care and implementing activities that include cuing- and arousal regulating techniques. The use of e. g. ,remembrance therapy‘, ,Marte Meo methods‘, ,validation- and holding-interactions‘, and integration of ,life history‘ in dementia care are useful assets to person-centred care. From my clinical work at a gerontopsychiatric unit, I have seen that the use of *music therapy* is unique. With music, it is possible to

- *frame the setting*. Music is a useful way of cuing and in this way compensating for missing memory functioning (Ridder 2004; Ridder *in press*).
- *regulate*. Music consists of dynamic elements reflected in e. g. form, pulse, tempo, modality, and timbre that might be used to either stimulate or sedate the person with dementia (Wigram et al. 2002; Ridder 2003).
- *create a relation*. By singing or playing music together, participant and therapist are sharing musical experiences with an opportunity to express coherence and meaning (Ruud 1998; Pedersen 2000; Ridder 2005).

### **Music therapy as a method to enhance episodes of lucidity**

In the following, I shall illustrate how I have worked with cuing- and arousal regulating techniques in music therapy with Mrs C. In this example, the music therapy consists of singing well known songs, but using the songs with different foci. The advantage of singing in individual music therapy is that participants only have one source (the music therapist) on which to focus; the auditory, visual and tactile stimuli all originate there. With some persons with dementia in advanced stages, instruments can be confusing and distract attention away from the relationship. When I, as the music therapist, sing to a person with dementia, I am inviting him/her to a mutual activity. I could do this in other ways, e. g. by listening to music together, song creation, dancing, choir singing, or by using vibroacoustic or vibrotactile stimulation (see Ridder *in press*). In this material, I put focus on the use of singing in individual music therapy.

As described in the beginning, Mrs C potters about during the day, talking to herself. She seems very isolated and it is difficult to ‚reach‘ her. It has been a severe problem that Mrs C would hit staff during personal care in the morning, and in order to avoid these episodes she is prescribed anti-psychotic medication (Risperdal, ½ mg.). She is treated as well with antidepressive medication (Cipramil, ½ mg.), because of her negative emotional valance and withdrawal from social activities. On a cognitive test (MMSE), Mrs C scores 0 (out of 30), indicating severe cognitive problems. Mrs C is 80 years old and has been a resident at the unit for 3 years, after having been moved from the local residential home, where daily care became too problematic. She was born in a big family with 7 children, and she and her husband, who visits her regularly, had 2 children.

Mrs C participates in 18 individual music therapy sessions. During all sessions, she remains seated in the sofa besides me and does not get up a single time to potter about or to leave. In our first session, she sits with her eyes closed most of the time. During the second session, she verbalizes constantly, talking in a steady flow with words that do not seem related to what is going on. During the first 6 sessions, she now and then looks directly at me and smiles or verbalizes, but in a way that does not reflect a clear ‚contact‘ or lucid interval. She seems to like the setting, but sometimes, when we start, her flow of words has a negative character even though her voice is neutral (e. g. in session 2, 10:50 am: „because that’s a whore, that’s a damned whore, yes yes, that’s what it is, that’s what it is, yes, yes, yes, yes, ... because I don’t want to be here any more, because I don’t like you anymore, because ...“) changing gradually to be more positive (session 2, 11:05 am: „look that sweet one over there“).

In these sessions, I keep singing, even if Mrs C sits with her eyes closed. My first step is to set a frame for our music therapy sessions and to build up our relation. She does not recognize me and does not know what is going on. I therefore see the songs, the context and my presence as cues that gradually will give her information about what is going to happen. I sing the same „hello“ song every time. I sing her name, shake hands with her, and sing what we are going to do. Because of her severe cognitive deficits, stability, repetition and a high frequency of sessions are important. We therefore have daily sessions which last about 20–25 minutes and which have a very clear structure. The songs function as cues that inform about what is going on and when the session starts and ends.

A change occurs in session 7. Now we have a stable structure, or frame, and I introduce the „sofa-dancing“. In all sessions but one, Mrs C shows a very low heart rate level that might indicate a low arousal level. If I can regulate her arousal level without over stimulating her, it would hopefully bring her to a state with the highest optimum for episodes of lucidity. The sofa-dancing combines vigorous rhythmic movements with vivid folk songs that she likes very much. In session 7, Mrs C closes her eyes after the two first songs, and opens her eyes only a few times during my next 7 songs. After a pause that lasts almost 3 minutes, in which I do not sing, Mrs C opens her eyes. I sing a folk song to her, and with the refrain I take her hands and ‚dance‘ with her. Mrs C laughs and states: „You are sweet, yes,

yes. Yes, this we can!“ (11:08 am). We continue the ‚dancing‘ in the next song. Mrs C laughs and joins me in the song for a short while! In the next song she closes her eyes, but I have a song ready for her, and when she opens her eyes I sing „Oh Susanne“. Again she joins me in the song – and then she takes over and sings to me. Afterwards she comments: „Yes, we have seen it ... yes we have. Yes, yes, yes it is.“ (11:12 am).

To me, Mrs C’s way of being present and actively taking part in the session reflects an episode of lucidity. It seems that it has been possible to build up a secure setting and a safe relationship, by using the songs as cues. By making use of the dynamic features of a well known folk song, Mrs C’s arousal level is regulated to a level where she shows environmental attention and interacts in a relevant manner. After this session, Mrs C has sung all together 19 times. One time is in session 15 where, as described above, she starts the session by singing to me. One time is after the end of session 10, where she remains in the sofa, presumably sleeping. A quarter of an hour later I pass the room and see her sitting, singing to herself – still with her eyes closed. The rest of the events, in which Mrs C is singing, happen in the *last* part of the session, but never when I sing the very last song, indicating closure. Even if I do the sofa-dancing in the beginning of a session, Mrs C does not join in. This indicates that Mrs C needs the way the session is structured; she needs to adapt gradually to what is going on, she needs her small naps, and later the rhythmic stimulation combined with the songs, in order to experience episodes of lucidity.

It is not possible to generalize from one single case, but hopefully this example illustrates one way of applying music therapy with persons in advanced stages of dementia, creating a frame and a relation that enhance episodes of lucidity. When this is possible, the next important step is focusing on psychosocial needs. Mrs C very clearly enjoys the episodes where she is actively engaged in the music therapy and in these moments her isolation is broken. It is difficult to say if this is having an influence on her daily life. Kitwood would clearly have answered yes, as reflected in the citation below. None the less Mrs C stopped taking both antidepressive and antipsychotic medication 6 weeks after ending the 4-week period with music therapy. Antipsychotic medication was resumed after a period in which Mrs C again became aggressive during morning care. Antidepressive medication was stopped with good results.

As care improves the long-term patterns of dementia may prove to be very different from those described in the older literature, and epitomized in the standard stage theories. We may reasonably expect to find far less vegetation – possible none at all. There should be a much higher level of sustained well-being, and in a proportion of cases the kind of long-term therapeutic changes that I have described. Dementia will then be a different set of clinical conditions from those we have inherited, and which are described in the standard textbooks of today. (Kitwood 1997, p. 101)

## Conclusion

Episodes of lucidity are here used to describe events where a person in advanced stages of dementia expresses him-/herself in a way that is present, attentive and relevant. The events are not sporadic or occasional appearances, and in a person-centred culture of care it is possible to make a basis for these episodes to occur. In a music therapeutic setting, songs are employed in order to elicit periods of lucidity, using cueing- and arousal regulating techniques, and in this way breaking the isolation that is a devastating follower of the dementia disease. When a person that often seems to be in a confused state of mind is periodically lucid, it is possible to break the isolation, to make the person feel understood and appreciated and in this way having basic psychosocial needs met.

## Perspectives

When I teach music therapy students or nursing staff, and I want to illustrate music therapy work with persons suffering from dementia, I find it very useful to show video clips where ‚something‘ happens. Very often there seems to be a relation between episodes when-something-happens and episodes of lucidity. When I show these video clips, I assume this gives a picture of music therapy where *lots* of things happen *all* the time. Why show video examples where apparently ‚nothing‘ happens – where the participant is in a state of non-lucidity? Such video examples will show me singing, and the person with dementia sleeping or wandering about or occupied with replacing songbooks or other objects. But actually these episodes, where the person with dementia is non-present / non-lucid, occupy a great deal of the time, especially in the beginning of the whole therapeutic process, as well as in the beginning of each music therapy session. This makes it important for students or staff to experience that it does not mean that their therapy, care, or activities are not optimal because ‚nothing‘ happens. It takes time to build up a relation and to build up structure and cues. Episodes of lucidity are the peak experiences in a therapy session or in daily care, and stand out like tips of icebergs where we only see a very small part of the whole. It is important not to force the episodes of lucidity to happen, but carefully to build up and lay the ground so they happen in a natural flow.

With ‚normal‘ music therapy clients that do not have attention disorders and cognitive deficits, it seems irrelevant to focus on episodes of lucidity. But we all experience both phasic and context-dependent fluctuations in consciousness, and strategies that focus attention and concentration seem to be relevant when we work with emotional expression, creativity, and imagination. This leads us to Helen Bonny’s descriptions of *altered consciousness* in Guided Imagery and Music (see Bonny 1999; Bonde 2002; Ruud 2003), Csikszentmihalyi’s theory of *flow* describing deep concentration in a complex activity (Csikszentmihalyi 2003), and Carl Rogers concepts of *congruence* in connection with empathy and unconditional positive regard (Rogers 1961). These theories give very interesting perspec-

tives on the here delimited episodes of lucidity, and make it relevant in a pragmatic way to pick out and integrate techniques and methods into the music therapy field from a wide spectrum of theories.

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