A Time of Turmoil: Music Therapy Interventions for Adolescents in a Paediatric Oncology Ward

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Abstract
A diagnosis of cancer during adolescence can potentially complicate an already challenging phase of development. Music therapy techniques, including song parody and performance, music relaxation and imagery, and instrument learning, can provide age-appropriate and innovative ways to help meet the unique needs of adolescents undergoing hospital cancer treatment. Case studies are provided to illustrate their effectiveness with this population.

Introduction
Adolescence is a unique and challenging period of growth, change, and possible turmoil as a child progresses toward adulthood (Carr-Greg & Shale, 2002; Matlin, 1995). The adolescent’s ability to cope with such transitions can be compounded when diagnosed with and treated for a life threatening cancer or experiencing a relapse of a childhood cancer (Kennelly, 2001; Palmer et al., 2000; Roberts, Turney, & Knowles, 1998). The adolescent patients described in this article were receiving treatment in a children’s hospital where the paediatric cancer literature usually informs treatment procedures. Adolescents are often treated in child or adult hospital wards, depending on bed availability and the adolescent’s size and age, rather than psychosocial needs (Taylor & Müller, 1995). While there is literature about the use of music therapy to support and treat children experiencing cancer (Daveson, 2001a; Dileo, 1999; Hadley, 1996; Standley & Hanser, 1995), adolescents have received less attention (Kennelly, 1999; Ledger, 2001). Literature reviews of paediatric oncology, the adolescent life stage, and music therapy with young cancer patients, will provide the foundation for describing how varied music therapy techniques may help adolescents through cancer treatment in a children’s hospital.
Paediatric Oncology

Continuing advances in research and treatment of childhood cancers have occurred over the past decade. This has resulted in the prolongation of life for many children diagnosed with the illness into adolescence (Rait et al., 1992). Acute Lymphoblastic (or lymphocytic) Leukaemia (ALL) is the most common form of childhood cancer. Presently, 95% of all children with ALL achieve complete remission, with 70% remaining in remission for 5 years or longer (Rostad & Moore, 1997). Increased survival rates do not necessarily mitigate the challenges faced by the patients and their families (Rait et al., 1992). Bauld, Anderson, and Arnold (1998) stated that “with progress in medical treatments, the imminence of death is replaced by uncertain survival” (p. 120). The illness status of patients may change from life-threatening to chronic, with chronic illness often occurring as a result of aggressive treatment regimes such as chemotherapy, radiation, surgery, and bone marrow transplants (Rait et al., 1992).

Cancer treatment and associated side effects can cause more distress and pain than the disease itself. Several childhood cancer survivors rated the treatment side effects as the worst thing about having had the disease (Redd, 1994; Roberts et al., 1998; Zelter, 1993). Side effects range from acute nausea and vomiting, hair loss, and lethargy, to chronic complaints such as infertility, organ damage, cognitive and growth deficits, and secondary cancers (Bauld et al., 1998; Boldt, 1996; Rait et al., 1992).

Psychological effects include changes to independence and daily activities, increased risk of reduced self-esteem and heightened family stress (Kazak, 1993; Palmer et al., 2000; Ragg, 1994; Roberts et al., 1998; Susman et al., 1981). Due to their prolonged periods of isolation, patients receiving bone marrow transplants (BMT) are at particular risk of increased dependence, reduced levels of activity, flattened affect, loneliness, and depression (Sanger, Copeland, & Davidson, 1991).

A diagnosis of cancer at any age is stressful. For adolescents, however, diagnosis comes when they are already experiencing physiological and psychological changes and uncertainty.

Cancer in Adolescence

Adolescents experience unique changes in cognitive, emotional, social, and physical functioning. Young people are establishing their independence and identity and creating new roles and boundaries regarding responsibility and autonomy (Pendley, Dahlquist, & Dreyer, 1997; Robb, 1996). Peer acceptance, sexuality, and body image are issues of paramount importance (Kennelly, 1999; Palmer et al., 2000; Pendley et al., 1997; Roberts et al., 1998).
Cancer treatment increases the adolescents’ dependence on parents and can separate them from their peers (Kennelly, 1999; Roberts et al., 1998). Their ability to control their bodies and make decisions about their lives is compromised. Adolescents’ usual concerns with body image, emerging sexuality and peer relationships are complicated by the life-threatening nature of cancer and resultant treatments (Roberts et al., 1998). Hospitalisation therefore introduces restrictions and stressors that can impact on normal development (Robb, 1996). Compliance with treatment remains a challenge for many. Lansky, List, Ritter-Smith, & Hart (1993) view their refusal to comply with treatment as a medium to assert independence and demonstrate that they are in charge of their own lives.

Most adolescents who survive cancer show no serious long term emotional complications (Bauld et al., 1998; Madan-Swain et al., 1994; Redd, 1994; Roberts et al., 1998). They may, however, experience subtle but lasting psychosocial challenges in comparison to their healthy peers (La Greca, 1990; Roberts et al., 1998), including (a) body image disturbances (Madan-Swain et al., 1994; Pendley et al., 1997), (b) adjustment difficulties post-treatment (Madan-Swain et al., 1994), (c) a tendency to employ non-productive avoidance strategies such as denial (Bauld et al., 1998), (d) fewer problem-solving skills (Bauld et al., 1998; Bull & Drotar, 1991), (e) anxiety and shyness (Noll, Bukowski, Davies, Koontz, & Kulkami, 1993), and (f) reduced peer activity participation and consequent social isolation (Noll et al., 1993; Pendley et al., 1997; Redd, 1994).

Music Therapy in Cancer Care with Young People

Music Therapy for Cancer Treatment in a Paediatric Hospital

Music therapists in a hospital setting aim to facilitate patients’ and, where indicated, family members’ adjustment and effective coping (Edwards, 1999). Music therapy interventions have assisted paediatric oncology patients to cope with pain, anxiety, isolation, stimulus deprivation, increased dependency, and loss of control (Boldt, 1996; Brodsky, 1989; Daveyson, 2001a; Edwards, 1999; Hadley, 1996; Kennelly, 1999; Kennelly, 2001; Plaff, Smith, & Gowan, 1989; Robb, 1996; Standley & Haner, 1995; Turry & Turry, 1999). Daveyson (2001a) summarised methods used during hospital treatment as creative, receptive/listening, recreative, improvisatory, and compositional.
Music Therapy Techniques for Hospitalised Adolescents
Undergoing Cancer Treatment

Music is a precious and motivating vehicle for adolescent people. Fitzgerald, Joseph, Hayes, and O'Regan (1995) revealed that the most preferred leisure interest for both male and female adolescent participants was listening to music. Kampner (1995) also demonstrated that male adolescent participants' most treasured possession was music, and it was female participants' third most treasured possession (after jewellery and stuffed animals). These studies had similar outcomes despite being conducted in different countries and with subjects from different socio-economic backgrounds. McFerran-Skewes (2000) reported that she initially relied on the importance of music to adolescents as the incentive for them to join a bereavement group. She believed that the music would provide a non-verbal and safe medium through which they could share themselves and their stories.

Kampner (1995) suggested that treasured possessions "may contribute, at least indirectly, toward the development of self-identity during adolescence" (p. 313). Rather than being passive artefacts, possessions may function as an "additional or indirect means" (p. 314) through which the factors shaping identity operate and developmental needs are met. This would include music treasures and experiences. Given the potentially complex scenario faced by adolescents diagnosed with cancer, music may offer creative and age-appropriate opportunities to meet their developmental needs, as well as address social and emotional needs arising from having a life-threatening illness.

The author has found that three music therapy techniques are particularly pertinent to the unique developmental, social, emotional, and musical needs of adolescents being treated for cancer, including (a) song parody or lyric substitution and performance, (b) music relaxation and imagery, and (c) instrument learning. These techniques were also regarded as useful by music therapists working in the fields of both childhood and adolescent cancer (Aasgaard, 2000; Aasgaard, 2001; Davison, 2001a; Hadley, 1996; Kennelly, 1999; Kennelly, 2001; Ledger, 2001; Plaff et al., 1989). Relevant literature and case studies (permissions for inclusion received) are now provided to extend understanding about how these techniques can significantly help adolescents receiving treatment in paediatric oncology wards.

Song parody and performance

Music therapy techniques, including the use of songs, may provide opportunities for young people to communicate their experiences of hospitalisation. Hadley (1996) stated that "the use of songs is one of the
most common approaches in music therapy, whether it be singing, song recall, song communication, or song writing” (p. 22). Providing possibilities for the self-expression of feelings and thoughts to their experiences can potentially assist adolescents to process and adjust to the range of issues they are dealing with as part of normal development, as well as those issues arising from their cancer experience.

Song writing provides a flexible yet structured musical medium for the expression and communication of thoughts and feelings (Bailey, 1984; Dileo, 1999; Hadley, 1996; Kennelly, 1999; Kennelly, 2001; Robb, 1996; Turry & Turry, 1999). Song parody, the setting of new lyrics to familiar music, may especially appeal to adolescents. The familiar song can provide structure and a sense of security, while also offering the freedom and flexibility to express personal words and feelings. It may also help make the song writing process seem less overwhelming and thus ensure success (Robb, 1996), potentially leading to feelings of mastery and increased self-esteem and self-worth.

The idea of parodying songs is highly appealing to adolescents, perhaps because popular music is such a normal and valued part of their lives. Through writing their own lyrics to a favourite song, adolescents not only express themselves but also gain a unique sense of accomplishment. (Ledger, 2001, p. 23)

Song parody exercises can facilitate the expression of feelings related to hospitalisation and treatment (Edwards, 1998). Ledger (2001) described how a 12-year-old girl’s song parody assisted her adjustment to her cancer, treatment and hospitalisation, and provided opportunities for feelings of mastery and control. It seemed to allow her time to process her illness and reflect personally on her condition, as indicated by her self-reference in a song towards the end of a 10 week period. Kennelly (2001) reported that song-writing with a sixteen-year-old male provided opportunities for him to express his constantly changing feelings throughout treatment. The client’s music altered according to his treatment phase and he was able to repeatedly relate his musical experiences to his own feelings.

Song performance allows adolescents to bring to life their creations and to showcase their ownership of the material to their carers and peers. Song performance brings a new dimension to the song creation (Aasgaard, 2000) and the journey of the song from text to performance can provide pleasurable moments for many people within the hospital environment (Aasgaard, 2001).

Adolescents with cancer have performed song compositions in hospital concerts (Hadley, 1996), and for families, and staff (Ledger, 2001), which is likely to increase feelings of self-esteem. Song performance may increase feelings of empowerment and promote the development of self-
identity, particularly if one’s song creation and consequent performance becomes a treasured possession and embodies important meanings (Kamptner, 1995).

“Amanda”, a 17-year-old girl, was in hospital for an extended stay due to continued respiratory difficulties, malnutrition, and arthritic joints. Amanda had undergone a BMT one year earlier for treatment of an ALL relapse but had returned to hospital on several occasions for treatment of chronic side effects. During this hospitalisation Amanda was reported to be withdrawn and sad. She was referred to music therapy to provide alternate ways to express her feelings, and staff felt it might “cheer” her up. Music therapy sessions aimed to provide Amanda with opportunities to participate in normalising and positive experiences to help address self-esteem issues, and to provide opportunities for self-expression. Amanda had been an accomplished pianist and singer prior to her illness. Music, therefore, was one of the few activities that Amanda could still participate in despite her chronic conditions. In particular, she enjoyed singing, which allowed her to express her feelings and exercise her lungs.

Each session Amanda requested songs for the music therapist to sing and accompany on her guitar. Amanda often joined in and harmonised. Nurses visited regularly during sessions and told her how beautifully she was singing. Amanda appeared excited and flattered at the positive attention she was receiving.

In the tenth session, after two weeks, song writing was discussed. Amanda appeared sad and the music therapist began to improvise music and words to reflect her interpretation of Amanda’s feelings. The music therapist suggested they could write a song, or change the words of a favourite song, so that Amanda could decide how to express what she was feeling. Amanda chose a song parody exercise and altered the words to “What’s Up” (Perry, 1993, track 3). She retitled it “Sixteen Years”, adjusting it to “Seventeen Years” on her birthday. Ideas for the lyrics were discussed in the music therapy session and sung by the music therapist, however, Amanda wrote the final words of the song when alone one night. She included original lyrics that she identified with, and changed the words she felt were not relevant to her situation. With Amanda’s permission, her lyrics were forwarded to her psychiatrist, who had expressed an interest in reading them, speculating whether they might offer a new avenue for them to discuss her feelings.
Seventeen Years
To the tune, “What’s Up” (Perry, 1993)

Seventeen years and my life is still
Trying to get up that great big hill of health
For a drug-free place
And I realised quickly when I knew I should
That doctors and nurses aren’t really that good for me
In this world of needles

And so I cry sometimes
When I’m lying in bed
Just to get it all out
What’s in my head
And I’m feeling a little bit dizzy

And I wake in the morning
And the drip is beeping
My back is sore and my peg is seeping
And I scream at the top of my lungs
I hate pills

(Chorus) And I said hey yeah yeah yeah, hey yeah yeah yeah, I said hey, what’s going on (repeat)

And the pain oh my God the pain
It strains my brain in this institution
And I pray, oh my God do I pray
I pray every single day
For some more morphine

And so I think sometimes
When I’m lying in bed
How to get out of here
How to stop feeling dead
And I say why not go through the sharps bin

Instead I wake in the morning
And the physio comes
And he breaks my legs and he makes me cough
And I scream at the top of my lungs
Physio stinks

Chorus (repeat)

Seventeen years and my life is still
Trying to get up that great big hill of health, for a destination.
After Amanda considered performing the song for the staff, the music therapist encouraged her to present a concert and also include other patients and their families. Amanda performed known songs and the parody in her room and 30 to 40 people attended. Amanda’s mother and aunt provided food and drinks, adding to the party atmosphere. The concert was a great success. Amanda and the music therapist sang a range of popular songs together either in unison or in harmony and the music therapist accompanied each song on the guitar. Amanda played percussion to some of the songs. Other allied health staff members also participated in the concert. Amanda continued performing other song parodies at subsequent concerts.

Music therapy provided Amanda with psychosocial support during her long hospital treatments. Song parody enabled her to express thoughts and feelings she had previously felt uncomfortable discussing with medical staff. She was also able to experience mastery and have some control over aspects of her life again. Positive feedback from staff and peers boosted her feelings of self-esteem, evident through her increased social interaction, laughing, smiling, and more relaxed state during and after music therapy sessions. Staff reported that Amanda would hum all afternoon and be more approachable and more willing to comply with treatments after music therapy sessions. Amanda’s story validates Hirsch and Meckes’ (2000) view that “treating patients with respect and encouraging a positive focus can ultimately increase their desire to cooperate throughout treatment” (p. 74).

Music relaxation and imagery

Relaxation. Music listening can help cancer patients perceive less pain, discomfort (Bailey, 1986; Beck, 1991), and nausea (Boldt, 1996; Frank, 1985; Standley, 1992). Combined with relaxation techniques, music listening may also help to reduce their perceived anxiety (Davison, 2001a). Music and relaxation techniques have also been used to reduce anxiety (Edwards, 1999; Edwards, 1995), pain (Plaff, Smith, & Gowan, 1989), and increase relaxation (Robb, Nichols, Rutan, Bishop, & Parker, 1995) in hospitalised patients with other conditions.

When considering the type of music conducive to promoting relaxation, the advice is mixed. Research indicates that choice of music does not affect the degree of relaxation that listeners self-report (Thaut & Davis, 1993), although others argue that personal preference is vital (Stratton & Zalanowski, 1984). If the music is being chosen by the music therapist, research generally supports the use and preference of classical (Weber, Neussler, & Wilmanns, 1997; Wolfe, O’Connel, & Waldon, 2002) over New Age (Weber et al., 1997) music. Brown, Chen, and Dworkin (1989) suggested that physical and mental relaxation may be facilitated by music
comprising slow tempi and constant rhythmic patterns, and Han (1998) asserted that the addition of rich harmonies may also enable a sense of security, being nurtured, and safety.

Cognitive cues are also considered important in contributing to a relaxed state. A randomised controlled research study comparing a verbal progressive relaxation method with listening to Mozart piano sonata music, to promote relaxation in 67 normal male participants, revealed that the cognitive cues elicited higher self-reported relaxation levels. The music elicited lower heart rate levels and greater self-reports of feeling distracted (Scheufele, 2000). Relaxation and progressive muscle relaxation programs also increased self-reported relaxation and comfort levels in six patients undergoing BMT, aged 14 to 53 years (Boldt, 1996). Interestingly, observed results and questionnaire feedback revealed that pain levels decreased and comfort increased when a progressive muscle relaxation protocol was accompanied by slow instrumental background music.

Music therapists can both facilitate relaxation and coach clients in relaxation techniques (Gfeller, 1992). This can provide opportunities for empowerment and control (Ellis, 1991), as adolescents may manage some of their own pain, playing a greater role in their cancer treatment.

Imagery. Music and elicited or directed imagery may also be useful tools to assist an adolescent’s symptom management and relaxation. Music-elicited imagery involves listening to music in a relaxed state to elicit a client’s spontaneous imagery to address therapeutic goals, including relaxation (Maranto, 1993). In music and directed imagery, specific suggestions for imagery, relevant to therapeutic goals, are provided (Maranto, 1993). Music to accompany either kind of imagery processes can be decided by the client and/or therapist. Music length is limited and images are discussed afterwards. No interaction is usually carried out between the client and therapist when the music is playing (Maranto, 1993). Before the music is played though, the therapist gives a relaxation induction. For example, clients may be verbally directed to close their eyes, become aware of their breathing and relax muscles, either mentally or through direct muscle contraction-relaxation sequences.

"Jonathon", a 13 year old boy, was referred to music therapy for anxiety and pain management after an ALL relapse. He was being treated with chemotherapy, radiation, and surgery in preparation for a BMT. During initial music therapy sessions Jonathon identified that pain and anxiety related to treatment were his main concerns and that he wanted to control them better.

The program goals were to provide opportunities for Jonathon to experience success and mastery, to reduce feelings of anxiety associated with hospitalisation, and to provide strategies for pain
management. The music therapist explained to Jonathon techniques that could be used to help address pain management and assist in reducing anxiety. Jonathon chose music relaxation and imagery and asked if he could learn the induction so that he could practice the relaxation exercises with his tape on his own.

Each session began with an induction followed by the music relaxation activity. Colour inductions were used rather than physical muscle tension / relaxation techniques due to pain that Jonathon was experiencing. Jonathon chose a colour and the therapist guided the specific relaxation of muscle groups by instructing him to imagine the colour moving through his body. Jonathon then elected to experience either: (a) music-elicited imagery; or (b) music and directed imagery, verbally describing the image himself.

At the end of the induction the music therapist said, "I am going to play the music now. Allow the music to accompany you on your journey". Music from the "Music for Dreaming" (Ross, 1995) CD was played each session for approximately seven minutes. No interaction was encouraged during the music. At the end, Jonathon usually reported feeling sleepy and relaxed, and discussed what he called "the trip".

Jonathon travelled to many places in his mind, including the beach, mountains, and Antarctica. He reported imagery of animals and beautiful landscapes that were "calming and gentle". He used imagery and relaxation during his music therapy sessions and also at other times when the music therapist was not present, including one day when he experienced a high fever. It was reported that Jonathon asked his mother to put on his music so that he could "go on a trip". After the exercise his temperature had dropped noticeably. His mother asked, "Where did you go because, wherever it was, it worked in bringing down your temperature?" Jonathon replied, "I’ve been to Antarctica".

Jonathon had struggled with his illness since childhood but now, as an adolescent, he seemed to have a clear understanding of his future treatment protocol and appeared anxious about the unknown outcomes of a BMT. He was at an age when he wanted to participate in decision making about his body but had limited opportunities. This case study illustrated how a client can be taught to self-administer one’s own relaxation and imagery technique, and thereby have some control over the treatment and one’s body. Using music and imagery Jonathon was able to influence his perception of pain and discomfort when he needed to. This is important as "the need for control is linked with the need for survival, security, and a sense of dignity and self-confidence" (Hirsch & Meckes, 2000, p. 70).
Jonathon seemed particularly aided by the specific music used. The CD was chosen because it was produced with the specific goal of creating a relaxed and nurtured environment, and was classically orchestrated. It incorporated major keys and repetitive triple rhythms, designed to imitate the resting heartbeat. Instruments included the flute, harp, and strings (Ross, 1995). The use of music comparable with lullabies seemed appropriate as adolescence can be identified as a transitional time between childhood and adulthood. During illness people can revert to previous developmental stages (Rowland, 1990), hence the adolescent may feel more vulnerable and child-like when ill and may find lullaby music soothing.

Instrument learning

Mastery is an experience of empowerment and increased sense of control over one’s environment achieved through the successful completion of a set task. Daveson (2001b) summarised empowerment as a process or mechanism that results in people, organisations, and communities gaining control over their own lives or situations. Empowerment may result in a change in the perception of one’s opportunities for choice and control (Daveson, 2001b) and may also result in the acquisition of practical skills (Keiffer, 1984). In an oncology setting, the lack of control that patients have over their bodies, coupled with fear and isolation, may lead to their experience of learned self-helplessness (Hirsch & Meckes, 2000). O’Callaghan (1997) reported that choice is especially important for people when they are experiencing decreased control over their lives and bodies. Flower (1993) emphasised the importance of encouraging control and creativity when working with adolescents who feel helplessness, enabling them to experience the power of which they were previously robbed.

Learning an instrument provides a motivating and age-appropriate way to engage a teenager in music therapy. The guitar interests many teenage boys and the basics can be easily learnt in a relatively short period of time. Guitar playing might also be regarded as “cool” by teenage boys, while singing with the female music therapist might be regarded as “not so cool”. Romanowski (2003) suggested that the guitar may represent an object of power, which could positively affect the instrument’s appeal to hospitalised young men. Teenagers perceive music as an activity that they have under their control (Becker, cited in McFerran-Skewes, 2000), therefore, they may find participation in a music activity less threatening than a non-music activity.

Standley (1996) described how a guitar was introduced to engage a withdrawn 15-year-old boy with end stage cancer. He immediately became interested at the prospect of learning the guitar and participated in lessons over several months. His levels of motivation, cooperation, and communication were reported to increase. Daveson (2001b) suggested that
music lessons may also be a useful method for meeting the psychosocial needs of children in isolation for a BMT.

"Ryan", a 14-year-old boy with a long history of illness, was referred to music therapy because he appeared to be socially withdrawn. He was experiencing a relapse of ALL and treatment in preparation for a BMT. Ryan appeared reluctant to engage with the music therapist in initial sessions, minimising eye contact and responding to questions with yes/no answers. After a week of music therapy sessions pre-transplant, Ryan’s mother suggested that he could learn the guitar while in isolation to help alleviate the "boredom". Ryan thought this was a good idea, particularly when his dad added that he would be able to serenade girls when he got better.

"Lessons" began in music therapy with the program goals to: (a) provide opportunities for mastery, empowerment, self-expression, and control; (b) reduce isolation; and (c) increase feelings of self-esteem. Sessions began with identifying songs that Ryan would like to learn, followed by the learning and practising of chords and repertoire. Each session concluded with a performance by the music therapist of songs that Ryan requested. Despite becoming too ill to play for a while, Ryan continued to request music therapy several times a week and ask the therapist to play for him. As he recovered, he continued to play the guitar, with his repertoire including traditional folk songs to assist with new chord learning and pop songs of his own choice. Staff came to hear Ryan play and complimented his skill. After treatment finished for transplant, Ryan experienced chronic side effects that resulted in him having to stay in hospital for a lengthy period. A local charity donated the money for Ryan’s own guitar after his mother requested one, to help cheer him up and allow him to continue playing following discharge.

Learning an instrument provided opportunities for Ryan to experience mastery despite his illness and physical weakness. It also encouraged him to make decisions which allowed him to feel empowered at a time when his independence was compromised.

Conclusion

A diagnosis of cancer during adolescence inevitably leads to many stressful situations and potential barriers to effective coping. The music therapy techniques of song parody and performance, music relaxation and directed imagery, and instrument learning, provide opportunities for adolescents hospitalised with cancer to participate in tasks that address their
developmental needs and vulnerable medical status. Case studies in this article illustrate how music therapy can help adolescents to establish their independence and identity, practice new found control over themselves and their environment, feel empowered and experience mastery, express their thoughts and feelings, improve in self-esteem, and perceive less pain and anxiety.

Whilst all people can rejoice in the medical advances that prolong the lives of young people with cancer, approaches are still needed that help them deal with ongoing challenges and upheavals during and following treatment. Music therapy provides unique and innovative ways to address socio-emotional and physical needs experienced by adolescents in a paediatric oncology setting.

References


Author's Note

At the time of print Ms Abad is the Acting Course Director, MA in Music Therapy, Irish World Music Centre, University of Limerick. The clinical work in this article was conducted while the author was at the Royal Children’s Hospital, Brisbane.