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Words and Music

As Speech Therapists we frequently have cause to complain about people not understanding what we do - or saying they understand and demonstrating they don't! I recently found myself in the reverse role when I came into contact with the Music Therapist in the Geriatric Department where I work. She approached me with the suggestion that we run a group together and my initial reaction was one of panic: I don't play any musical instruments and I don't sing (certainly not to an audience).

Reassurance was quickly forthcoming; such skills were unnecessary and even the Music Therapist wasn't keen on singing. The patients she was suggesting were all long stay patients with severe communication problems following a CVA but they all enjoyed listening to music and some had showed evidence of joining in with occasional words in songs. They had all been discharged from Speech therapy.

We discussed possible activities and still feeling the need to suggest something firmly linked to my idea of Music Therapy I mentioned melodic intonation therapy (Sparks and Holland JSHD 1976), something I had previously avoided as intonation work does not come naturally to me.

We decided instead to start the group, each leading our own activities and see how it developed as we gained first hand knowledge of each others work.

From these rather shaky and unstructured beginnings a regular group has evolved, the activities of each Therapist have blended together and it can sometimes be difficult to draw a dividing line between 'music' and "speech'.

Currently the group has three members, all hemiplegic and in wheelchairs. MR has a severe dysarthria but good comprehension. EH is dysphasic, with severe impairment of verbal comprehension and expressive language essentially limited to some vowel sounds. AP has moderate impairment of verbal comprehension and expressive language limited to some automatic speech and the recurrent utterance 'Yes love'.

Initially EA and AP were unable to do a simple verbal comprehension task such as pointing to a named object and so we modified the task to one where sounds were associated with pictures, *eg* sound of telephone, sound of zimmer frame. Their performance on this task showed an improvement and subsequently we have modified the task further so that the patients are shown several pictures and have to point to the appropriate one(s) as the Music Therapist plays a song on a recorder, *eg* rabbit for Run Rabbit Run, stocking, shoe and sock for Mother Kelly's Doorstep. They are given no clues other than the music and their success at this task has surprised me.

At this stage I decided to introduce Amer-Ind as a means of communication and immediately encountered a further problem. Not only did EH and AP have right sided hemiplegias but all three patients had extremely limited movements in their non-affected sides, presumably due to lack of use. To overcome this problem we started two activities which involved arm and wrist movements. First the patients were encouraged to play percussion instruments such as tambourines and maracas to accompany a tune played by the Music Therapist: this gradually improved wrist and arm movements. From this we moved on to songs which traditionally have arm movements associated with them, *eg* Little Jack Horner and Hush a Bye Baby. Specific Amer-Ind signals were then introduced in a more traditionally structured approach so that the patients worked through a hierarchy of signal recognition, imitation and then production. As their repertoire has expanded we have continued to use musical instruments to facilitate motor movements wherever necessary - for example, all three patients initially found it impossible to move their fingers for the walking signal: an autoharp was introduced with the with the Music Therapist strumming the strings and the patients fingering the bars which alter the sound. To produce chords the patients have to move their fingers in a movement very similar to that of the walking signal and the goal of producing a pleasant sound certainly helped improve manual dexterity.

As well as giving traditional stimuli to elicit signalling (such as objects and pictures) we also use musical stimuli so that in response to a tune played by the Music Therapist the patients produce the appropriate signals, for example, 'Strolling' should elicit the signal walking and 'Show me the way to go home' should elicit the signals little and drink (although we also accept big!)

The group is now well established and enjoyed by both patients and Therapists. The patients have undoubtedly benefited and currently have a repertoire of approximately 12 Amer-Ind signals.

I have also benefited from working with another professional and although I realise that few Speech Therapists will have the opportunity to work with Music Therapists I would urge everyone to take any similar opportunities they can: undoubtedly pooling our ideas and resources has produced more than we could have had we continued to work in isolation.

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