Qualitative Inquiries in Music Therapy
2019: Volume 15 (Monograph 2), pp. 34-67.
Barcelona Publishers

RESOURCE-ORIENTED MUSIC THERAPY IN PEDIATRIC ONCOLOGY: A PHILOSOPHICAL INQUIRY

Annabelle Brault, MA, MTA, MT-BC
Concordia University

ABSTRACT

The purpose of this philosophical inquiry was to make a case for the clinical relevance of a Resource-Oriented approach in pediatric oncology music therapy, and then propose a conceptualization of this approach using Rolvsjord's (2010) four characteristic statements of the resource-oriented approach as guiding principles. The characteristics are: (a) *the nurturing of strengths, resources, and potential*, (b) *collaboration rather than intervention*, (c) *the view of the individual within their context*, and (d) *the view of music as a health resource*. Background information instrumental in the development of this philosophical inquiry was explored and presented. This included a description of the pediatric oncology context, the needs of children with cancer and their families, and salient tenets of the approach. The pediatric oncology music therapy literature was systematically reviewed using the four defining statements of the Resource-Oriented approach to argue its relevance in the pediatric oncology context. The characteristics were first explicated, then used as a lens to explore the four categories of needs (physical, emotional, social, and developmental) of children with cancer and their family. From this critical analysis, parallels between the literature and the resource-oriented approach were identified, while new insights emerged. This philosophical inquiry provides a conceptual framework that may serve as a starting point for those wanting to explore a Resource-Oriented approach and discourse within problem-oriented and/or biomedical contexts.

INTRODUCTION

Music therapy has been used in pediatric health care since the 1980s (Barrera, Rykov, & Doyle, 2002), and is increasingly understood to be a viable treatment option by health care providers and administrators (Standley, Gooding, & Swedberg Yinger, 2014). In this area, music therapy services are used to address the physical, emotional, social, and developmental needs of children undergoing treatment for a life-threatening disease such as cancer throughout the course of the disease; needs of their families may also be addressed (Dun, 2007; Hilliard, 2006). Standley and Hanser (1995) provide a comprehensive list of typical music therapy goals addressed in pediatric oncology. These include:

> anxiety and pain reduction, tension release and relaxation; provision of opportunities to exercise control of an aversive environment; expression of feelings, facilitation of hope, nurturance, normalization and improvement in parent/child relationships; promotion of self-esteem; and celebration of the healthy/positive aspects of the child's life. (p. 6)

While these goals align with a Resource-Oriented philosophy (described further below), how they are currently conceptualized within pediatric oncology contexts is not clear, thus requiring music therapists to conceptualize them in their own ways or within various facility-driven philosophies that may align more with a medical model or problem-oriented framework.

Relevance to Music Therapy

In my past experiences as a music therapy graduate intern in pediatric oncology, I used music as a tool for empowerment, to provide a sense of mastery and to nurture the strengths of the patients. When hospitalized, children may be put in situations in which they have very little control; they may be restricted in their daily activities and may be required to undergo uncomfortable or even painful treatment without fully understanding why. While the importance of health care specialists addressing medical concerns is undeniable, music therapy sessions may constitute a rare opportunity for these children to express their individuality and have a collaborative, rather than prescriptive, relationship with a healthcare practitioner. In my own experience working within a pediatric oncology setting, offering such therapeutic space was beneficial. For instance, I worked with a young boy who was able, through music therapy experiences, to express his feeling of powerlessness with regards to a prolonged hospitalization. Providing a success-oriented and safe environment also allowed him to experience a sense of mastery, which in turn, may have enhanced his sense of self-agency. The boy was also supported and encouraged to explore ways of using music to express his emotions and to connect with others in and outside the music therapy sessions.

Upon searching the literature, I came to realize that no post-modernist music therapy approach yet existed within pediatric oncology that could help me conceptualize my clinical work. Upon learning about the Resource-Oriented Music Therapy approach, as conceptualized by Rolvsjord (2010) for use in mental health contexts, I saw the potential for re-conceptualizing this approach within pediatric oncology settings. Rolvsjord's Resource-Oriented Music Therapy approach "draws on literature related to theories from empowerment philosophy, the common factors approach, positive psychology, and current musicology" (p. 73). It is characterized by the following four statements:

1. Resource-Oriented Music Therapy involves the nurturing of strengths, resources, and potential.

2. Resource-Oriented Music Therapy involves collaboration rather than intervention.
3. Resource-Oriented Music Therapy views the individual within their context.
4. Resource-Oriented Music Therapy music is seen as a health resource. (p. 74)

Traditionally, music therapy approaches have often been developed initially for specific client populations and later expanded upon to suit other populations and contexts. For example, the Nordoff-Robbins Music Therapy approach was first developed for working with children living with a developmental disability, and was later adapted to a variety of populations and settings (Kim, 2004). The Bonny Method of Guided Imagery and Music is another that, since its origins, has been enriched over the years with the addition of new music programs and modifications of session length to suit client's needs, as well as adaptation for use in group therapy and short-term therapy (Meadows, 2010). Da Costa (2014) developed a Resource-Oriented Music Therapy support group intervention for adults living with fibromyalgia in her master's thesis. Wagner (2014) adapted the Resource-Oriented Music Therapy approach for use in a wellness context through the development of a music listening protocol in her doctoral dissertation. These examples suggest the adaptability of this approach to potentially suit different client populations. A review of the literature indicates that the Resource-Oriented Music Therapy approach has not yet been formally conceptualized within the pediatric oncology music therapy context.

This topic is relevant to music therapy because of the importance of representing both positivist and post-modernist thinking in approaches to music therapy in pediatric oncology. Ruud (2005) explains that within some, but not all medical music therapy approaches, there can be a prevailing scientific attitude grounded in the positivistic philosophy of science. Yet, the great reflexivity brought forward by postmodernist thinking, which emphasizes a myriad of subjective realities, differently informed by language, values, and cultural realities, could contribute to new theoretical insights needed to establish indigenous theories (Ruud, 2005). Aigen (2014) also explains that "[c]linical practice, which is not guided by theory, has no rationale for the procedures undertaken, and research unguided by theory has no means for ensuring its relevance to clinical applications" (p. 217).

While models developed based on or borrowed from the field of psychology are explicated (Edwards & Kennelly, 2011; Robb, 1999 & 2003), there seems to be sparse literature conceptualizing the work with this population within a post-modern music therapy approach. It is also important to provide those wanting to work within a Resource-Oriented Music Therapy approach in pediatric oncology with the vocabulary necessary to articulate their rationale.

RELATED LITERATURE

In this section, I provide background information that was instrumental in the development of this philosophical inquiry. I describe the pediatric oncology context, giving an overview of childhood cancer in Canada, information on the types of cancer groups, and information on the types of medical treatment. I explore the needs of children with cancer and their families addressed in music therapy. I locate the Resource-Oriented Music Therapy approach within the chronology of music therapy theory development, and review salient tenets of the approach.

Pediatric Oncology Context

Living with Childhood Cancer in Canada

In Canada, cancer constitutes the second leading cause of childhood death in children after accidents (Ellison & Janz, 2015). During the 2006-2010 period, there were 161 new childhood cancer diagnostics (under age 15) per million children, per year. There was an increase in the rate of newly diagnosed cases of childhood cancer by an average of 0.4% per year from 1992 to 2010. In that same period, there was an average 2.0% decrease per year in the rate of childhood deaths caused by cancer (Ellison & Janz, 2015). Most childhood cancers are diagnosed before age 5 and the rate of cancer diagnosis is 10% higher in boys than girls (Ellison & Janz, 2015).

Childhood Cancers: Group Types and Medical Treatment

Leukemias, cancers of the central nervous system (CNS), lymphomas, neuroblastomas, and soft tissue sarcomas are the five most common childhood cancer groups; together, they represent almost three-quarters of all new childhood cancers cases (Ellison & Janz, 2015). Leukemias (cancers of the blood cells that do not behave normally and grow uncontrollably) account for 32% of all childhood cancer in Canada. The many different types of childhood leukemias are classified depending on the type of blood they develop from, and growth speed. Acute Lymphoblastic leukemia is the most common (Ellison & Janz, 2015; Dun, 2013). Cancers of the central nervous system (accounting for 19% of all childhood cancer) usually "begin when normal cells in the brain or the spinal cord change and grow uncontrollably, forming a mass (tumor)" (Ellison & Janz, 2015, p. 4). Representing 11% of all childhood cancer, the third most commonly diagnosed is the lymphomas' group. Lymphomas "begin when cells in the lymphatic system (a system of the body responsible for fighting infection or other diseases) change and grow uncontrollably" (Ellison & Janz, 2015, p. 4). Lymphomas can originate almost anywhere because lymph tissue is found in many parts of the body, including lymph nodes, skin, stomach, intestines and other organs (Ellison & Janz, 2015). Neuroblastomas (8%) constitute the fourth most common group. A neuroblastoma is a solid cancerous tumor that begins in the nerve cells. It most often begins in the adrenal glands, but can also develop in other areas of the abdomen and in the chest, the neck, and near the spine. The fifth most common childhood cancer group includes soft tissue sarcomas, representing 6% of the cancer cases. These cancers develop in the supportive and connective tissues of the body, such as those found in the muscles, nerves, and tendons.

Cancer treatment usually requires the development and implementation of a treatment protocol tailored to the child's specific presentation of an oncological or hematological condition. The treatment protocol may include one or more forms of treatment such as chemotherapy, radiotherapy, and/or surgery (Dun, 2013). Treatments are most often administered in specialized childhood cancer treatment facilities. Canadian pediatric oncology specialized centers are often university-affiliated, which facilitates the development and implementation of new technology and most effective treatment available. In his chapter on assisting children with hematological conditions to create and perform original song, Aasgaard (2005) explains that not only is medical treatment a first priority in cancer care, but it is these carefully planned and implemented treatment protocol that save the lives of the majority of children diagnosed with hematological oncological conditions. While a more detailed description is beyond the scope of this paper, a complete overview of childhood cancer types, and treatment can be found in Dun's (2013) chapter, *Children with Cancer*.

Needs of Children with Cancer and Their Families Addressed in Music Therapy

Diversity exists in the lived experiences of children with cancer and their families. In fact, Dun (2013) explain that "each stage is different and dependent on a number of variables, including age, developmental level, specific diagnosis and responses to treatment, and cultural and/or psychosocial issues that pre-existed prior to diagnosis" (p. 294). Similarly, Standley and Hanser (1995) note that "all effects of music are influenced by age, sex, and cultural background of the patient combined with the degree of pain, intensity of psychological trauma, the type of medical treatment, the outcome desired, and the perceived stress experienced by the individual" (p. 4). While the needs of children with cancer and their families vary greatly, it is possible to identify four areas of needs most often addressed in music therapy: physical, emotional, social, and developmental needs (Dun, 2007; Hilliard, 2006).

Physical Needs

The physical needs of children with cancer are varied and complex, which is why interdisciplinary teams work together collaboratively to develop a treatment protocol and help manage symptoms. Music therapy has been used effectively before operations, during procedures, during bone marrow transplants, and in other types of hospital admissions (Standley & Hanser, 1995). Ghetti and Whitehead-Pleaux (2014) also identified arousal reduction and facilitation of body awareness as possible physical music therapy goals when working with hospitalized children at risk for traumatization. Bufalini (2012) studied the effectiveness of interactive music in reducing anxiety that may be related to painful procedures, such as lumbar injections, bone marrow aspiration, and arterial catheter. He found that music therapy may have physiologically-based benefits such as decreased anticipatory anxiety, increase induction compliance, decreased perceived pain and increased relaxation response (Bufalini, 2012).

Emotional Needs

At the initial stage of the illness, children and adolescents may experience anxiety as they adjust to the diagnosis and the hospital environment. Parents may need support in coping with their own anxieties and/or those of their child (Dun, 2013). Aasgaard (2005) also explains that "several health aspects related to the young cancer patient's social relationships, self-concepts, hopes and joys are threatened, thereby restricting the young patient's possibilities for action" (p. 156). The longer the hospitalization period, the greater the psychosocial impact may be for both child and family. Families not living in major city centers often must temporarily move their whole family to care for their sick child. Such disturbance in daily routine may impact family dynamics negatively and increase stress (e.g. financial stress due to time away from work). Providing the child and her/his caregivers with a supportive environment is a priority as it may help lessen the negative impact of hospitalization. Research in trauma-informed music therapy with hospitalized children also support the importance of stress, coping and resilience as an integral part of addressing emotional needs in this setting (Ghetti & Whitehead-Pleaux, 2015).

Social Needs

Children with cancer may be immunocompromised for extended periods of time. Thus, access in and out of the hospital room may be restricted, and strict infection control protocols may be in place. This often places the child in a situation of isolation: the child's access to social activities/events may be compromised. In these circumstances, immediate caregivers constitute a vital source of support, which is why O'Callaghan and Aasgaard (2012) assert the importance of

helping caregivers. They mention that children with cancer "need responsive and sensitive [caregivers] to develop a sense of security and ongoing emotional health" (p. 50). Standley, Gooding, and Swedberg Yinger (2014) reported that caregivers' involvement during music therapy led to a reduction of children's stress behaviors. Similarly, O'Callaghan, Baron, Barry, and Dun (2010) explained that "children's musical interactions encompass family and wider educational, social, and electronic networks, which extend music's capacity to support the children's resilience in their cancer journey, alongside "normal development" (p. 783). The child may use music as a resource to overcome social isolation.

Developmental Needs

Shared musical moments may promote a more normative environment conducive to achieving developmental milestones. This may be particularly relevant as children who are hospitalized for extended periods of time are at risk of developmental delay and regression (Dun, 2013). Supporting the importance of developmental considerations in pediatric oncology is Robb's (2003) *Contextual Support Model of Music Therapy*. This model is in part rooted in psychology theories such as Piaget's stage of cognitive development and Erikson's psychosocial development process. The Contextual Support Model of Music Therapy "seeks to explain how music functions… create supportive environment and, in turn, promote active coping behaviours in children" (Robb, 2003, p. 27). The model takes into consideration the contextual stressor of the child (such as being hospitalized for treatments), and her/his personal attributes. Contextual support interventions (aimed at providing structure, autonomy, and involvement) are designed and implemented, leading to a coping response. It is hoped that the development of self-regulation skills will lead to long-term outcomes, and a continued development of self. In chapter 4, the four areas of needs described above are further explored and analyzed through the lens of four characteristic statements of the Resource-Oriented approach.

Contextualizing the Resource-Oriented Approach

Locating the Approach Within Music Therapy Theory Development

In this section, I locate the Resource-Oriented Music Therapy approach within the larger music therapy theory development context. Aigen (2015) identified three waves of theory development in the field of music therapy. The first wave is characterized by the prevalence of theories imported from psychology such as psychoanalysis and behaviorism. Within this wave, few new constructs or novel mechanisms indigenous to music therapy were suggested, and no specific training methods were developed in relation to the theory. The second wave provides foundations for new music therapy practices. This is done through the creation of treatment models developed in practice, and the origination of theories to support them. Specific training methods were developed in which treatment models including procedures, techniques, goals and theories were addressed. Examples of theories from the second wave include Nordoff-Robbins' Creative Music Therapy, The Bonny Method of Guided Imagery and Music, and Mary Priestley's Analytical Music Therapy (Aigen, 2015). The third wave is marked by the beginning of indigenous theories that explain rather than dictate practice (Aigen, 2015) such as Carolyn Kenny's *Field of Play* (2006). These contemporary frameworks are integrative and are relevant to multiple models and forms of practice. Most of the third wave orientation emphasizes the primacy of music, and the importance of context. Examples of orientations from this stage include Culture-Centered Music Therapy (Stige, 2002), Aesthetic Music Therapy (Lee, 2003), Music-Centered Music Therapy (Aigen, 2005), and Resource-Oriented Music Therapy

(Rolvsjord, 2010). As the main tenants of the Resource-Oriented approach are addressed below, its belonging in the third wave classification is explored.

Tenets of the approach

In her book and numerous articles describing the approach, Rolvsjord thoroughly explores the epistemology and etymology of the Resource-Oriented perspective. In this section, the following salient tenets are briefly reviewed: critique of the medical model; description of empowerment philosophy; positive psychology; and the power of discourse.

Critique of the Medical Model

In introducing the frames and descriptors of the resource-oriented approach, Rolvsjord (2010) offers a critique of the medical model (also referred to as the *illness ideology*). The illness ideology defines a person by her/his defects (e.g. illness) rather than defining her/him as a person living with an illness. In this view, the illness defines the person, and no attention is given to her/his strong and healthy "parts" despite the presence of the illness.

Rolvsjord (2010) argues that the medical model is widespread within the music therapy profession. Amongst other examples, she identifies the prevalence of an illness ideology-based discourse, which includes the use of terms such as intervention, treatment, patients, illness, and symptoms when talking about the music therapy work. She also cites evidence-based music therapy approaches such as Neurologic Music Therapy (Thaut & Hoemberg, 2014), which provides its clinicians with a manual containing specifically-tested procedures and interventions on how to work with people who have neurologic conditions. The therapist is then in an "expert" position, deciding on the appropriate intervention to implement in order to restore this person's health.

Aigen (2015) provides a critical analysis of evidence-based practice and its root in the illness ideology. His article also documents the presence of the medical model in music therapy. For instance, he explains how music therapy is being defined as an evidence-based practice by important music therapy organizations such as the American Music Therapy Association, and how adopting this approach to music therapy research imposes a narrow view of effectiveness in the field (Aigen, 2015). In evidence-based practice, the quality of evidence is contingent on a hierarchy that favors quantitative methodologies: in fact, out of the 7 levels of this hierarchy, only two of the lower levels value the findings obtained from qualitative inquiries (Aigen, 2015). Aigen (2015) further argues that this narrow view of effectiveness (rooted in an objectivist epistemology) does not allow for the consideration of central tenets of the music therapy work (which are rooted in an interpretivist epistemology). He explains that "many aspects of the medical framework conflict with approaches in music therapy where relationship is a central factor, where artistic and creative processes are central and where flexibility and spontaneity are necessary" (Aigen, 2015, p. 15).

Similarly, Rolvsjord (2010) believes that an approach in which the therapist is in the role of the expert reinforces a type of power relation that is not conducive to equality and mutuality, while simultaneously reinforcing other forms of systemic oppression often present in healthcare. Aigen (2015) even claims that "the importation of a framework from medicine is inappropriate and threatens central forms of music therapy practice" (p. 17). Accordingly, the Resource-Oriented approach, like other contemporary music therapy approaches, is rooted in an alternative model. The contextual model recognizes multiple ways of knowing, and takes into consideration the multiple forces at play when considering an individual's paths towards

optimum health. What follows next is an exploration of the empowerment philosophy as it relates to the Resource-Oriented approach.

Empowerment Philosophy

Rolvsjord (2010) explains that "therapy as empowerment has to do with collaborating with the client in the development of her or his ability to act and to participate in community" (p. 44). It involves a person's ability to take part in decision-making processes, as well as a sense of self-determination and self-righting (Rolvsjord, 2006a; 2010). Rolvsjord (2006a) describes empowerment as a multi-level construct that unfolds in culture and is context specific. It has implications at the individual, organisational, and community levels, and can also be seen as a perspective, a process, and an outcome indicator (Rolvsjord, 2006a). Empowerment is an interdependent and interactive process, and is therefore congruent with a contextual model, which "views the whole therapeutic context as providing potentials for change and development related to the client's health" (Rolvsjord, 2006b, p. 8).

Rolvsjord (2006a) explains that "empowerment philosophy embodies a critique of the traditional expert-patient relationship because it takes aspects of self-determination directly into the core of therapy, the therapeutic relationship" ("Mutually Empowering Relationships," para. 2). The therapist's role is to provide a safe work space where he/she provides tools and methods to help clients mobilize their ability for self–healing (Rolvsjord, 2006b). Mutuality and interdependency are also identified as relational qualities that promote empowerment (Rolvsjord, 2006a). A mutually-empowering relationship involves a co-constructed interaction founded on mutual trust, authenticity, attunement, and a willingness to change (Rolvsjord, 2006a).

In her article on therapy as empowerment, Rolvsjord (2006a) offers important observations that hint at the politics of empowerment in the music therapy context. She explains that empowerment philosophy challenges our conceptualizations of health, therapy, music, and power relations. It also questions the individualization of health and therapeutic practices, and calls for an acknowledgement of the political dimensions of clinical practice and research. Most importantly, it calls for the acknowledgement of people's rights to music (Rolvsjord, 2006a). Empowerment is also concerned with what is available for the client, such as support, close relationships, meaningful activities in which to participate, etc. These contextual variables are seen as having an impact on one's abilities and participation potential. Rolvsjord (2010) explains that "empowerment includes access to valued resources, and therefore empowerment is so much concerned with politics" (p. 44). One strong case made in this book describing the resource-oriented music therapy approach is the importance of considering the political dimension of music therapy. Part of this political dimension involves access to resources which are regulated by government bodies through policies. Another political dimension pertains to the discourse of music therapy, which is addressed later in this section.

Positive Psychology

As mentioned earlier, a Resource-Oriented music therapist provides a space for clients to use in order to activate or mobilize their own resources for change. Rolvsjord (2006b) explains that "in a contextual model, the specific "ingredients" are not seen as the main source of change in the therapeutic process" (p. 8). This is also true from a common factors approach, whereby the specific techniques or methods used are considered less important than extra-therapeutic factors, and factors that are common to all psychotherapeutic models (Rolvsjord, 2010). These new areas of focus identified through meta-analysis include strength-based concepts such as hope,

resilience, empathy, and motivation, which are all central to the field of positive psychology (Rolvsjord, 2010).

Tedeschi and Kilmer (2005) also identify a growing focus on strength-based approaches in the field of psychology. In fact, some practitioners are moving away from a more traditional and pathology-focused approach to move towards a strength-focused approach. There are many advantages associated with this shift of paradigm. For example, it provides clinicians with a more holistic view of their clients (Tedeschi & Kilmer, 2005). Accordingly, they explain the importance of assessing both the clients' strengths and difficulties. They suggest that "clients are more likely to experience the intervention as affirming and empowering, even motivating" (p. 231) if the therapist recognizes their wholeness, not merely their diagnostic profile. The resilience framework also offers a strength-focused way of working towards positive change. Recognizing the protective influences at the individual, family, and community levels is an important process towards healthy adjustment and the fostering of resilient adaptation. Using strengths, resilience, and growth as a guide in clinical practice may offer clinicians with a more holistic picture of their clients, which in turn may help their clients to feel more confident about their ability to deal with life's challenges.

When adopting a strength-based approach, clients are described as "bearers of unique talents, skills, resources, life experiences, and unmet needs" (Tedeschi & Kilmer, 2005, p. 230). Focusing on adaptive aspects of clients' functioning can be a motivating factor in therapy and promote a sense of self-efficacy (Tedeschi & Kilmer, 2005). Similarly, Rak's (2002) article about the "heroes in the nursery" (p. 247) highlights the importance of identifying the strengths/protective factors the clients develop as a proactive response to stress, trauma, and loss.

Rolvsjord (2010) identified experiencing positive emotions and the building of strength as important contributions of the positive psychology movement to the Resource-Oriented approach. Research has shown that experiencing positive emotions is linked with well-being in daily life, and longevity. Rolvsjord (2010) also found that “positive emotions contribute to efficient emotion regulation, to enhance the ability to bounce back from negative emotional experiences and to flexibly adapt to stressful experiences” (pp. 54-55). Enjoyment in therapy may not only promote experiences of achievement, mastery, and self-actualization, it may also enhance the therapeutic learning processes (Rolvsjord, 2010).

Rolvsjord (2010) ends the part of her book dedicated to positive psychology with the idea that techniques do not define positive psychology therapists: it is rather their deeply rooted believe in humankind’s self-actualizing potential. It is embracing the therapeutic role of providing a safe space where a client’s self-healing tendencies can emerge and where their resources can be nourished. This encapsulates the mindset of strength-focused music therapy, and serves as a segue to the next and last section of this chapter on the power of discourse.

Power of Discourse

In an article entitled “The Stories We Tell”, Ansdell (2003) explains that “as a discourse, music therapy is not something discovered ‘outside’ language and subsequently described ‘inside’ language, but something actively constructed *in-and-through* language” (p. 154). The discourse of music therapy is powerful because it defines the practice, the research, the public opinion, and the policies, etc. That is why Ansdell (2003) emphasizes the importance of looking critically at “the stories we tell” about music therapy to establish whether or not the discourse about the profession accurately depicts the way clients and therapists experience music therapy.

Rolvsjord (2006a) explains that "music therapy is part of the co-construction of our culture and hence our reality. Furthermore, the ways in which we conceptualize music therapy processes influence not only our clinical practice, but also the broader political discourse on organizational as well as community levels" ("The Discourse," para. 1). In line with this premise, Rolvsjord (2010) aims to define the Resource-Oriented approach in a way that "acknowledges and demonstrates the craft, the resources, and the competences used by the clients in the process of music therapy" (p. 5), which is a part of the discourse of music therapy she argues is often missing. With this paper, I aim to provide music therapists wanting to work within a Resource-Oriented approach with a discourse that aligns with its tenets and that is context-specific (pediatric oncology), but that also advocates for the fundamental values/worldview upon which the approach is built.

STATEMENT OF PURPOSE

Given the lack of a post-modern music therapy approach to pediatric oncology in the literature, the purpose of this research was to argue a case for the clinical relevance of a Resource-Oriented approach in pediatric oncology music therapy, and then propose a conceptualization of this approach using Rolvsjord's four characteristic statements of the Resource-Oriented approach as guiding principles.

Assumptions

In this research, I assumed that music therapy can address the multifaceted and complex needs of patients in pediatric oncology. I assumed that it is important to conceptualize music therapy clinical practice within a clearly delineated, indigenous approach. I assumed that clients and their families would greatly benefit from the resource-oriented music therapy approach in pediatric oncology contexts. I also presumed that music therapists would have the ability to conceptualize this approach within interprofessional medical contexts, regardless of the facility philosophy (implied or explicit).

Key Terms

For the purpose of this inquiry, *Resource-Oriented Music Therapy* was defined using Rolvsjord's (2010) conceptualization of this approach. Despite Rolvsjord's belief that the act of defining and describing implies an expert position (which is contradictory to the participatory perspective inherent to the approach), she offers four characteristic statements to give a general sense of reference and direction for understanding the approach:

> 1. Resource-Oriented Music Therapy involves the nurturing of strengths, resources, and potential.
> 2. Resource-Oriented Music Therapy involves collaboration rather than intervention.
> 3. Resource-Oriented Music Therapy views the individual within their context.
> 4. Resource-Oriented Music Therapy music is seen as a health resource. (p. 74)

I use the terms *Pediatric oncology* to refer to all phases of treatment and remission of children ages 0 to 18 who have been diagnosed with any form of childhood cancer being seen either on an in- or out-patient basis (Dun, 2013).

Research Questions

The research question was "Why is a Resource-Oriented Music Therapy approach indicated in pediatric oncology contexts and how might it be conceptualized?" The subsidiary research questions were: (a) "Why and how can pediatric oncology music therapy be conceptualized using Rolvsjord's first characteristic statement *Resource-Oriented Music Therapy involves the nurturing of strengths, resources, and potential*?"; (b) "Why and how can pediatric oncology music therapy be conceptualized using Rolvsjord's second characteristic statement *Resource-Oriented Music Therapy involves collaboration rather than intervention*?"; (c) "Why and how can pediatric oncology music therapy be conceptualized using Rolvsjord's third characteristic statement *Resource-Oriented Music Therapy views the individual within their context*?"; and (d) "Why and how can pediatric oncology music therapy be conceptualized using Rolvsjord's fourth characteristic statement of *Resource-Oriented Music Therapy, music is seen as a health resource*?"

METHOD

I used a philosophical inquiry to explicate why a Resource-Oriented Music Therapy approach might be indicated in pediatric oncology contexts. This section describes the design, but also how materials, data collection, and data analysis procedures were used to conceptualize the approach.

Design

I used a philosophical inquiry research design to answer the research questions. In adherence with an Anglo-American approach to philosophy, a philosophical inquiry "…involves the use of philosophical procedures to analyze and contextualize theory, research, and practice within the history of ideas" (Aigen, 2005, Introduction section, para. 6). This design is well-suited to facilitate communication between individuals from different theoretical traditions, to stimulate the development of sophisticated theory, and to remediate practical problems (Aigen, 2005; Daveson & Kewes, 2002). Similarly, I explored an axiological issue (an issue related to questions of value). Questions such as "What approach to music therapy is more appropriate for what type of client?" and "What is the purpose and ultimate significance of music therapy for the lives of individuals?" were at the core of this inquiry (Aigen, 2005).

In the chapter "Philosophical Inquiries" of the third edition of the book *Music Therapy Research*, Stige and Strand (2016) contrast the Anglo-American philosophy approach with continental philosophy, explaining that "[c]ontinental philosophy typically spends less time on conceptual clarification and more time on interpreting and reflecting upon the significance of various empirical and analytical matters of fact, our use of language, and so forth" (Stige & Strand, 2016, "Philosophy and Controversy," para. 2). The latter approach views philosophy as a creative endeavor that closely intertwines with socio-political context (Stige & Strand, 2016). In this current research, I used both approaches to philosophy, as I clarified concepts, and critically analyzed the literature within a specific context (Stige & Strand, 2016). As such, I adopted an interpretivist stance as I sought "to fully explicate, describe, and understand a phenomenon in its wholeness and within […] context" (Baker & Young, 2016, "Defining Knowledge Within the Interpretivist Tradition," para. 2).

Materials

To develop claims (arguments) relevant to answer the research questions, I compiled salient ideas from the selected literature using an Excel spreadsheet. I also kept a journal to write down my responses and ideas as I reviewed the literature.

Data Collection

To plan the philosophical inquiry, I identified the following sources as potentially helpful in answering the research question. I investigated journal articles, monographs, and scholarly books/chapters using the following search engines: Google Scholar, PsychInfo, Medline, ProQuest, and the Concordia University library database, Clues. Music therapy journals such as *Music Therapy Perspectives*, *Music Therapy Journal, Canadian Journal of Music Therapy, British Journal of Music Therapy, Voices*, *Music Therapy Today*, and the *Nordic Journal of Music Therapy* were used as well as other related field journals such as *Journal of Pediatric Oncology Nursing*, *European Journal of Integrative Medicine,* and *Social Work in Health Care.* Books on music therapy in pediatric care were also used. Search terms included the following words in multiple combinations: Resource-Oriented Music Therapy, Randi Rolvsjord, pediatric oncology, pediatric music therapy, hospitalized children, music therapy, empowerment, strength-based counselling, positive psychology, community music therapy, medical model, music therapy approaches, and problem-oriented approaches. I selected music therapy pediatric oncology articles based on whether they clearly stated the needs of children with cancer, how these needs were addressed in music therapy, and/or what framework/model/philosophy guided the music therapy process. For articles pertaining to the resource-oriented approach (not specific to pediatric oncology), I selected works that discussed the types of needs and contexts that would be similar to those experienced by children with cancer and their families. From the selected literature, I organized the gathered data using an Excel spreadsheet containing the following categories: author, year, type of document source, notes, quotes, key ideas. I then identified the relevance of the key ideas (yes/no) with regard to the four categories of needs of children with cancer, as well as the four characteristics of the Resource-Oriented approach. While this method was used to facilitate the development of a clear and well-supported argument, the classification of the literature was not aimed at filtering out articles. Rather, it was aimed at including as many, if not all selected articles found on the topic in a relevant way.

Data Analysis

According to the selected design, I used argumentation "as [a] primary mode of inquiry" (Aigen, 2005, Introduction section, para. 7). To analyze the data gathered, I used three characteristic procedures: clarifying terms, exposing/evaluating underlying assumptions, and relating ideas and showing their connection to other conceptual and theoretical systems (Aigen, 2005). Through these characteristic procedures, I analyzed "contextually relevant variables […] in order to generate theoretical constructs and build theory that can potentially be further refined by subsequent studies" (Baker & Young, 2016, "Defining Knowledge Within the Interpretivist Tradition," para. 2). This process involved the identification of practices reported in the literature that could be classified as resource-oriented, as well as new insight that a resource-oriented intertextuality could contribute to the specialized field of pediatric oncology music therapy.

I also kept track of my own ideas over time by writing research journal entries.

Delimitations

In keeping with the research design chosen and in order to focus the scope of the inquiry, I imposed several delimitations. First, no research participants were part of this inquiry. I did not include considerations related to pediatric oncology patients in palliative care due to this population's unique needs. The data collection process was delimited to English sources only, within the years of 1995 to 2017. Finally, the Resource-Oriented approach formulated was not tested in practice within the context of this study.

RESULTS

In this section, I systematically review the pediatric oncology music therapy literatures using the four defining statements of the Resource-Oriented approach to argue its relevance in the pediatric oncology context. The characteristics are first explicated, then used as a lens to explore the four categories of needs (physical, emotional, social, and developmental) of children with cancer and their families. Part I explores pediatric oncology music therapy through the lens of characteristic one: *nurturing of strengths, resources and potential*; Part II explores pediatric oncology music therapy through the lens of characteristic two: *collaboration rather than interventions*; Part III explores pediatric oncology music therapy through the lens of characteristic three: *viewing individuals within their context*; and Part IV explores pediatric oncology music therapy through the lens of characteristic four: *music as a health resource*.

Part I. Nurturing of Strengths, Resources, and Potential

Overview of the Characteristic

"Resources are seen as an essential part of the focus of therapy at every stage of the therapy: in other words, they should be a significant part of the assessments, of the therapeutic collaborations, and of the evaluation of the therapy" (Rolvsjord, 2010, pp. 74-75). This statement about Resource-Oriented Music Therapy celebrates the positive emotions and outcomes that are linked to exploring and expanding upon a person's strengths and resources. This *nurturing of strengths, resources, and potential* is an integral part of a holistic approach to music therapy, and it is seen here as its focus. While using musical skills and competencies as a resource seems like a natural choice in the context of music therapy, Rolvsjord (2010) also encourages music therapists to view music therapy as an arena in which non-musical strengths and resources can be developed and acknowledged. In one study, Rolvsjord (2015) explored clients' experiences of agency in a music therapy setting. The participants in this study identified the following aspects of agency as part of their therapeutic process: taking initiative, exerting control in sessions, committing to the relationship, and engaging across contexts (Rolvsjord, 2015). This article therefore points to music therapy as being conducive to the development of non-music-based resources.

Physical Needs

In analysing the physical needs-related pediatric oncology music therapy literature, the following topics were identified as particularly relevant from a *nurturing of strengths, resources and potential* lens: nurturing creative resources to address physical changes and side effects, and developing self-regulation potential through active music-making to facilitate procedure-related coping.

Music therapy can be used to address physical changes and side effects that can cause distress for both the child with cancer and her/his caregivers. Physical changes related to cancer treatments include, but are not limited to: weight loss; weight gain; scars from surgery; decreased physical skills, including athletic abilities, balance, and agility; hair loss; and lymphedema manifested by swelling of the arms and legs (Aasgaard, 2005; Daveson, 2001; Bradt, Dileo, Magill & Teague, 2016). Examples of children improvising or writing poems and songs about hair loss can be found in the music therapy literature (Aasgaard, 2005; Daveson, 2001). In an article about her work in pediatric oncology, Daveson (2001) describes a vignette in which a child (who had recently loss her hair) used a tambour (a type of drum) as a hat instead of striking it with a mallet. The music therapist's response was to improvise a song talking about a girl who was very ill and lost all her hair so she could get better. In this same vignette, the young girl later imitates a horse with a beautiful mane during musical play. Daveson (2001) suggests that the child used the musical play to remember the pleasure she felt of having long hair, as well as to express feelings of loss and fear. She argues that the child used the musical play to cope in a developmentally appropriate way (Daveson, 2001). From a *nurturing of strengths, resources, and potential* lens, the child's creativity resource is nurtured through the musical play, and used as a powerful resource to cope with cancer-related physical changes.

Side effects of cancer treatment include, but are not limited to, loss of appetite, nausea, vomiting, diarrhea, constipation, and fatigue (Aasgaard, 2005; Daveson, 2001; Bradt, Dileo, Magill & Teague, 2016). In her review of the literature, Daveson (2001) found that listening to music and/or engaging in music and imagery can reduce nausea and emesis, which are known side effects of cytotoxic drugs. Indeed, music listening is a creative process through which "our minds actively reassemble physical vibrations into an artistic entity" (Aigen, 2015, p. 16). Another side effect of chemotherapy treatment is fatigue. Thus, children with cancer often experience physical weakness that can affect their ability to play, or even perform activities of daily living. Music therapy can provide a space where the children can explore and play in their imagination, in a world where their body does not restrain them (Froehlich, 1996; Hirsch & Meckes, 2000). This exemplifies how fostering children's creative potential and strength can in turn help them respond or even transcend their physical needs.

Throughout cancer treatment (particularly during the intensive treatment phase), children may undergo numerous invasive procedures. In a chapter on *Music Therapy for Hospitalized Children*, Ghetti and Whitehead-Pleaux (2014) explain that "children who undergo painful or anxiety-producing medical procedures can experience anticipatory anxiety if such procedures are repeated, and such anxiety can exacerbate feelings of fear and helplessness" (p. 325). They identify arousal reduction, self-regulation, and facilitation of body awareness as important music therapy goals when working with hospitalized children at risk for traumatization. Particularly, they identify self-regulation as an important process by which the child can modulate aspects of her/his emotions to reach a comfortable state of arousal (Ghetti & Whitehead-Pleaux, 2014). They explain that one way to develop self-regulation abilities is to engage in active music-making as it "enables the traumatized child to build tolerance for experiencing in-the-moment sensory input" (Ghetti & Whitehead-Pleaux, 2014, p. 333). From a *nurturing strengths, resources, and potential* lens, developing self-regulation potential through active music making may facilitate procedure-related coping.

Emotional Needs

Children in oncology have particular emotional needs (Dun, 2013). These needs are often a priority for children, their caregivers, and music therapists working in pediatric oncology (Tucquet & Leung, 2014). Rolvsjord (2010) explains that using strengths and developing resources can be connected to the prevention of emotional distress and one's ability to cope with stressors and illness (Rolvsjord, 2010). Particularly relevant to a discussion on emotional needs is the related concept of enablement. Enablement involves helping people use their strengths (i.e. helping people reach their goals, establish cooperative relationship, assert their individuality, and respond to their circumstances), which is related to experiencing positive emotions, including happiness (Rolvsjord, 2010). This concept was not found in the music therapy pediatric oncology literature, which led me to question the language being used when addressing emotional needs with this population. In the following section, differences in the language used (and the approach this reflects) when addressing the emotional needs of children with cancer are discussed.

In their case study, "Music Therapy for Children in Hospital Care: A Stress and Coping Framework for Practice", Edwards and Kennelly (2011) identify four important concepts at the core of their work with hospitalized children: "theories of stress, coping and adjustment; transactional models of stress; developmental theories; and family-centered care" ("Stress Management," para. 3). Research in trauma-informed music therapy with hospitalized children also supports the importance of stress, coping and resilience as an integral part of addressing emotional needs in this setting (Ghetti & Whitehead-Pleaux, 2015). Resilience is a strength-based concept that focuses on an "individual's ability to tolerate stress and comprises such aspects as hardiness and power of resistance" (Rolvsjord, 2010, "Nurturing of Strengths, Resources, and Potentials," para. 4). While Ghetti and Whitehead-Pleaux (2015) mention resilience as a component of their trauma-informed approach, a resource-oriented approach would make resilience the main focus of therapy. It is argued here that these articles consider emotional needs of children through a coping and stress lens (which implies a more problem-focused approach).

Other examples from the pediatric oncology literature use more Resource-Oriented language (O'Callaghan & Aasgaard, 2012; O'Callaghan, Baron, Barry, and Dun, 2010). In an article about the use of creative arts therapies including music therapy in pediatric oncology, O'Callaghan and Aasgaard (2012) explain that music therapists in this setting aim to promote the children's strengths, ability to cope, and their resilience through music-based interventions. They note that "music therapy may promote endurance and resilience as [children] try to cope" (O'Callaghan & Aasgaard, 2012, p. 50). While still addressing issues of coping and stress, the language used in these examples and the approach it reflects are much more empowering, celebrating the individual's strengths and resources when faced with adversity. It provides a strength-based perspective that is in line with the resource-oriented approach's first characteristic of *nurturing strengths, resources, and potential*.

Social Needs

Rolvsjord (2005) defines resources as "a sensitizing concept that includes social, cultural, and economical aspects, such as social network and possibilities for participation in cultural activities" (Rolvsjord et al., 2005, p. 18). Examples from the pediatric oncology literature support social resources, including those stimulated by musical interactions, as an important part of the total health of children with cancer. When considering the social needs of children with cancer through a *nurturing of strength, resource, and potential lens*, one main theme emerged

from the music therapy literature: the role of music in maintaining and expanding social networks beyond the limitations of illness (O'Callaghan, Baron, Barry, & Dun, 2010).

When children are hospitalized for cancer care, their participation in social activities is hindered, which can negatively impact their holistic (body, mind and spirit) sense of health and well-being (Rolvsjord, 2010). In their study on music's relevance for children with cancer, O'Callaghan, Baron, Barry, and Dun (2010) found that "children's musical interactions encompass family and wider educational, social, and electronic networks, which extend music's capacity to support the children's resilience in their cancer journey, alongside 'normal development'" (p. 783). They later examined music therapists' perspectives on music's relevance for children with cancer (O'Callaghan, Dun, Baron, and Barry, 2013). Through interviews and focus groups, the research team was able to identify three prominent views: preferred music and opportunity for music therapy involvement should be accessible for children in oncology hospital settings; music and music therapy can provide children with a sense of normalcy and health, while supporting them in the face of adversity; and the creativity, enjoyability and playfulness of music therapy is invaluable for children facing disease-related limitations (O'Callaghan et al., 2013). Music therapist participants in the above study identified music as a resource available for children to fulfill their creative, play, and social connection needs, despite a life-threatening illness such as cancer. From a *nurturing of strength, resources, and potential* perspective, using music's potential to maintain and expand social networks may contribute to the holistic health of the children.

Developmental Needs

Analysing the developmental needs of children with cancer through a *nurturing of strengths, resources, and potential* lens revealed that music is used as a resource to facilitate learning and to explore developmentally-related tasks.

As mentioned previously, being hospitalized and undergoing medical procedures may significantly impact a child's development (Wolfe & Waldon, 2009). One setting that may be particularly suited to address potential developmental needs is the pediatric playroom. In a chapter on *Music therapy in the Pediatric Playroom*, Wolfe and Waldon (2009) explain that music therapy can serve as a normative developmental experience by providing hospitalized children with the opportunity to interact with similarly aged peers, to practice socially appropriate behavior, to engage in cooperative processes, and to have fun. Music therapy in the pediatric playroom may foster engagement in activities that would otherwise be absent in the hospital environment. This offers further opportunity to exercise choice and control, as well as to develop and restore friendship with peers and family (Wolfe & Waldon, 2009). Opportunities for choice and control include choosing which instruments to play, deciding what happens in a musical story, and exerting control over the rhythms, dynamics, and melodic contours of musical creations.

During the bone marrow transplant phase, music therapy may constitute a rare learning opportunity as the context of the single isolation room limits connection with the outside world (Daveson, 2001). Creating a space where the child can explore abilities not otherwise stimulated in this context may lead to nurturing the child's strength and to an opportunity to tap into unexplored potential. This again may promote normative development and/or prevent developmental regression often observed in children in situations of isolation for extended periods of time (Daveson, 2001). In this context, music therapy may be particularly helpful in augmenting or facilitating hospital schooling (Wolfe & Waldon, 2009). For example, music can

be used as a motivator to complete schoolwork, and it can be used to reinforce academic concepts. The aesthetic nature of music may help to create a warm and safe environment propitious to learning (Wolfe & Waldon, 2009). Thus, music may be used as a resource to facilitate learning. This may reduce academic delay due to hospitalization, which may facilitate the personal and community reintegration following the hospitalization (Ghetti & Whitehead-Pleaux, 2014).

Another important developmental task that may be compromised by hospitalization is autonomy (Ghetti & Whitehead-Pleaux, 2014). "Younger children who have recently achieved this milestone can become quite frustrated when their independence is threatened" (Ghetti & Whitehead-Pleaux, 2014, p. 333). They emphasize the importance of empowering the child or adolescent in the music therapy context by creating situations where they can experience mastery and success. For example, engaging in movement-based music activities can help children regain a sense of control over their body (Robb, 1999). This can help buffer feelings of helplessness and frustration that may result from loss of autonomy and independence. Thus, music therapy can be used to stimulate development by providing an environment that is conducive to learning and that provides opportunities to exercise choice and control, to develop and restore friendship with peers and family, to experience mastery and success, and to tap into unexplored potential.

Summary of Findings

Children possess creative potential and strengths (music is one) that they can use to respond to some of their own physical, emotional, social, and developmental needs. Creating a space where the child can explore abilities not otherwise stimulated in the hospital environment may lead to not only nurturing the child's strength and development, but also to an opportunity to tap into unexplored potential. Analysing the literature through a *nurturing of strengths, resources, and potential* lens revealed differences in the way music therapists talk about the needs of children with cancer. While practitioners adhering to a coping and stress model used more problem-focused language, others used more empowering language, providing a strength-based perspective that is in line with the Resource-Oriented approach's first characteristic of *nurturing strengths, resources, and potential*. It is argued here that this empowering view of the children's experience in music therapy contributes a constructive perspective to the work of music therapists in pediatric oncology.

Part II. Collaboration Rather than Intervention

Overview of the Characteristic

Rolvsjord (2010) argues that to truly enact the first statement of the Resource-Oriented approach, client and therapist must share responsibility throughout the process of music therapy. The client will be engaged actively in deciding many aspects of the therapy process, including defining the therapy goals, ways of working, and evaluation of therapy outcomes. In an article published in 2006, Rolvsjord examined the concept of therapy as empowerment, and its implication in terms of collaborative therapeutic relationship. Rolvsjord (2010) also situates this statement in related psychotherapy literature, which revealed that change, growth, and developmental processes in therapy seem to be related to a collaborative relationship between client and therapist.

Rolvsjord (2010) outlines three interconnected aspects of collaboration in therapy: equality, mutuality, and participation. Equality in music therapy involves the collaborative understanding of the therapist and the client's shared responsibility as well as role differences in the therapeutic process. Mutuality "involves a person-to-person responsive relationship in which

both client and therapist are directly and personally involved" (Rolvsjord, 2010, p. 79). Participation in music therapy involves the shared musicking process of both therapist and client. Musical interplay in music therapy may provide experiences of mutuality where people can grow through the musical connection (Rolvsjord, 2006a). This next section will address the needs of children with cancer through the collaboration rather than intervention lens.

Physical Needs

While it is not possible for one to empower another person (as the act of helping them towards self-help would defy the purpose), it is possible to develop empowering interactions (Rolvsjord, 2006a). These interactions recognize the interdependency between clients and therapists. The therapist may act as a role model by having a clear voice as a person in order to give the client space to do the same (Rolvsjord, 2006a). While such collaborative decision-making may not be possible when it comes to making medical decisions, it is possible and encouraged in the context of music therapy. This can be particularly useful when working with parents or caregivers. This section examines how children, caregivers and music therapists collaborate to mitigate the impact of cancer-related physical limitations on daily living and procedure-related distress.

Children who are sick are often perceived as being "fragile", especially if they are surrounded by a considerable amount of medical equipment (intravenous line and pole, breathing assisting devices, heart-rate monitors, etc.). As a result, people (including the child's caregivers) may be anxious and/or unsure about what is permissible in terms of physical contact, play, or activities. Robb (1999) explains that "with guidance, even the most anxious parents can be empowered to interact positively and supportively with their hospitalized child" (p. 17). Barriers to these positive interactions between parent and child may include: uncertainty about what is permissible in terms of play or activity; feeling overwhelmed by the medical equipment; feeling unclear about role in the hospital environment, etc. Music therapists can work in collaboration with the parents by modelling safe, positive, and playful interaction with the child, while clearly defining parental expectations within the music therapy setting (Robb, 1999; Flower, 2014). This type of role modeling can contribute to "building a positive, empowering initial hospital experience [that may] help to mitigate future stress responses to medical care" (Ghetti & Whitehead-Pleaux, 2014, p. 340) for both the child and her/his caregivers.

Ghetti and Whitehead-Pleaux (2014) also suggest that parents or caregivers can be coached on how to provide grounding and emotional support to the child during distressing procedures. This genuine collaboration between therapist and parent or caregiver allows the benefits of music therapy to radiate outside the music therapy context. Examples of music-based procedural support that caregivers may provide include: singing or playing familiar songs, music-assisted relaxation, and musical play (using instruments). This is in line with Rolvsjord's claim that "clients in music therapy are not passive recipients of, or respondents to, the therapist's skillful interventions, but are actively engaged in making therapy useful for themselves both in therapy sessions and in their everyday life contexts" (Rolvsjord, 2015, p. 313).

Emotional Needs

As mentioned before, members of interdisciplinary teams work together to provide holistic care to children undergoing cancer treatment. The families are regularly informed and consulted with in regards to treatment implications, options, and implementation. The parents or caregivers of children with cancer may at times feel overwhelmed and helpless, especially when faced with

their child's suffering or with difficult treatment-related decisions to make, such as having to decide whether a sibling should donate part of her/his bone marrow. In this section, the concepts of participation and mutuality are used to explore the collaboration between children with cancer, their caregivers, and music therapists when addressing emotional needs.

One way in which music therapists can support parents in supporting their child emotionally is through the process of shared musicking (concept of participation). One example of such musicking was mentioned earlier: parents can be coached on how to ground and provide emotional support to their child during procedures. Parents can also be involved in the creative process of songwriting. In a case report, Aasgaard (2005) presents the songwriting process of Hannah, an 8-year-old girl diagnosed with aplastic anemia. Hannah composed a song with her family called 'Hair poem' (addressing the physical change of hair loss) and a song with text written by her mother about the bone marrow she received from her sister. In this case, songwriting was used to document illness-related events that the family experienced together. Aasgaard (2005) reports that the family's songs were put together in a slide show with pictures of the isolation room, and were presented to Hannah's classmates. This family used shared-musicking as a way to contextualize their experience throughout hospitalization, "paving the way for both personal and community reintegration" (Ghetti & Whitehead-Pleaux, 2014, p. 339).

Mutuality is also useful in conceptualizing emotional needs of children with cancer from the *collaboration rather than intervention* lens. Mutuality is defined as "a way of being in the relationship: empathically attuned, emotionally responsive, authentically present, and open to change, and can also be constructed between people with very different abilities" (Rolvsjord, 2006a, "Mutually Empowering Relationships," para. 5). The concept of mutuality is embedded in a more comprehensive concept: attendance. In earlier texts, Kenny (2006) deconstructs the meaning of therapy using, amongst other terms, the concept of attendance:

> "Attendance implies a mutuality, an alert, resourceful, caring, vigilant patience and guidance. It represents an attitude, a way of being. Attention concerns itself with intention" (Kenny, 2006, p. 12).

Evidence of such mutuality between client and therapist can be found in the pediatric oncology literature (Daveson, 2001; Dun, 2007). Of particular relevance to this topic is Dun's (2007) exploration of *bricolage* as a framework for understanding music therapy in pediatric oncology. She defines bricolage in the context of her work as a way of "being in the moment… while holding the past…anticipating the future" (Dun, 2007, "The Bigger Picture," para. 10). She describes her journey with Olivia, a former patient, through exploring the perspective or history of the client (Olivia), the therapist (Beth Dun), and the bigger picture (the emerging context). She explains that throughout the years, they had met in many contexts, but what was constant was the history they shared as a dyad across these different contexts. She concludes by acknowledging that she is a different person as a result of the journey she shared with Olivia and many other patients, holding them (as defined above) and creating possibilities with them. Dun's bricolage framework makes a compelling argument for the relevance of mutuality and a collaborative therapeutic relationship in pediatric oncology music therapy.

Social Needs

In this section on social needs from a *collaboration rather than intervention* lens, the following topics are explored: community music therapy in pediatric oncology and equality as an integral part of collaborative relationships.

It seems intuitive for me to address the topic of Community Music Therapy when considering social needs of pediatric oncology patients through a *collaboration rather than intervention* lens. While not overwhelmingly present in the literature, some Community Music Therapy-oriented interventions are reported in pediatric oncology settings (Aasgaard, 2004; Clements-Cortes & Pearson, 2014; O'Callaghan & Aasgaard, 2012). Such examples include music-related activities for children groups; diverse performance opportunities for the patients (Aasgaard, 2005), staff and community members within the hospital environment (Aasgaard, 2014; O'Callaghan & Aasgaard, 2012); and the implication of orchestra members in health musicking teams (Clements-Cortes & Pearson, 2014). Clements-Cortes and Pearson (2014) explain that "through enhancing health-promoting activities and creating equal relationships between community members, music can encourage and enable a more holistic environment of care" (p. 97). When children with cancer and their families have the chance to participate in these music-related activities within the hospital, it provides possibilities for new forms of collaborations between the patients, relatives, medical doctors, nurses, etc. (O'Callaghan & Aasgaard, 2012).

Another important aspect of collaboration that was not specifically addressed in the pediatric oncology literature is equality. Rolvsjord (2010) explains that "music therapy as a process of collaboration underlines both equality and the difference between the two agents involved, as there is shared responsibility for different roles" (Rolvsjord, 2010, p. 78). Rolvsjord (2010) explains that equality in the relationships requires active and conscious striving towards equal rights, and a willingness to engage in the negotiations resulted from collaborative decision-making. Similarly, Rolvsjord (2006a) emphasizes the importance of modelling an egalitarian relationship within the therapeutic context so as to not reproduce the power inequalities present in society. In a qualitative multiple case study looking at "what clients do to make music therapy work" (p. 296), Rolvsjord (2015) found four main categories of actions clients take in music therapy: taking initiative, exerting control in sessions, committing to, and engaging across contexts. In the third category, subthemes are closely related to the concept of collaboration explored here; subthemes such as caring for the therapist, establishing equal structures, and nurturing commonalities speak directly to the client's effort to foster equality and mutuality in the therapeutic relationship. To the best of my knowledge, these subthemes were also absent from the pediatric oncology music therapy literature.

Developmental Needs

In this collaborative relationship, music therapy may also provide the child with opportunities to work on developmental needs that involve collaboration, such as turn-taking, sharing, cooperation, etc. In a situation where the child is unable to interact with same-age peers, giving an opportunity for the child to exercise a collaborative role may contribute to achieving socially-related developmental milestones (Dun, 2013). In fact, these shared musical moments may mimic relationship expectations normative to the child's developmental stage. It is worth noting that there is an increasing amount of research studies that examine the use of music technologies with this population (Burns, Robb, & Haase, 2009; Barry, O'Callaghan, Wheeler & Grocke, 2010). While no report on the use of technology to address developmental needs was found in the pediatric oncology music therapy literature, it is possible that electronic devices (such as mobile phones, tablets, and laptop) and their related applications and Internet access may provide collaborative opportunities for addressing the developmental needs of children in the pediatric

oncology context. Further research exploring the therapeutic benefits of online collaboration within a music therapy context is needed.

Summary of Findings

In this collaborative view of the therapeutic relationship, children with cancer and their caregivers are actively engaged in making music therapy useful for themselves in both music therapy and everyday life contexts (Rolvsjord, 2015). Participation in shared-musicking experiences expands possibilities for new forms of collaborations and provides a more holistic environment of care. Mutuality in the therapeutic relationship opens the door to collaborative decision-making, and active participation between children, caregivers, and music therapists. While not discussed in the pediatric oncology music therapy literature, the concept of equality allows for the acknowledgement of what clients do to make music therapy work. Finally, collaboration is key ingredient in promoting the attainment of cooperation-related developmental milestones, and the transfer of skills (e.g. coping skills, self-knowledge, etc.) from the context of music therapy to everyday life.

Part III. Viewing Individuals within their Context

Overview of the Characteristic

This characteristic of the Resource-Oriented approach is particularly influenced by feminist and empowerment theories (Rolvsjord, 2010). It necessitates that music therapists view the clients within their context, which includes the interpersonal, structural, societal, and cultural aspects of their lives. When therapists acknowledge the clients within the complexity of their contexts, the client is empowered as a holistic being. Similarly, the impact of music in the client's life cannot be limited to its place in music therapy. Rolvsjord (2010) explains that “from a musical perspective, an interest in the client’s use of music outside therapy also contextualizes the therapy, providing possibilities for making use of the musical experiences gained inside music therapy in everyday life" (p. 82).

Physical Needs

The notion of flexibility emerged from the music therapy literature as an important consideration when addressing the physical needs of children with cancer. From a *viewing the individual within their context* lens, parallels between the phase of cancer treatment, the child’s physical needs, and the contexts of session can be made.

In describing the different phases of cancer treatment, Daveson (2001) includes the context of session: during the time of diagnosis, sessions may occur in the ward playroom, music therapy room, or at the bedside, and during the bone marrow transplant phase, sessions occur in single isolation rooms. When describing these settings, Daveson (2001) explains that the different contexts are associated with different children’s needs, priorities and goals. For instance, the therapeutic priorities for a child who has undergone a bone marrow transplant and is in a single isolation room may differ from the priorities for a child who has been admitted for a first round of chemo-therapy and is in a ward playroom. In pediatric oncology music therapy, the child’s physical state is always the first variable to consider (i.e. if the child is feeling nauseous, the music therapy goals and expectations will vary accordingly). Because there is considerable variability in the patient’s state, music therapists are well advised to remain flexible, and “let the patient’s current situation determine what is possible" (Dun, 2007, “My Story,” para. 3). Kenny (1985 & 2006), who pioneered systemic and ecological views of music therapy, also supports a

malleable approach to therapy; she explains that "music therapy is different to different people at different times in different places" (Kenny, 2006, p. 11). In describing her journey with Olivia, a young patient with cancer, Dun (2007) emphasizes that the key for music therapists working in these settings is to blend the historical elements of the relationship with the emerging elements arising in the different contexts. An example of this would be to use a song that has acquired meaning in the context of music therapy (historical element) and use the emergent elements from the "here and now" (e.g. feeling weak and nauseous) to meet the child's immediate needs (e.g. reassurance and distraction brought by hearing a familiar song). Nurturing this historical thread between contexts may help the child with cancer preserve a connection to a healthy self-image.

Emotional Needs

In this section, the different concepts of context in music therapy are further explored and exemplified using existing music therapy models addressing the emotional needs of children with cancer.

Rolvsjord and Stige (2013) contributed an article on the concepts of context in music therapy. They identify three types of context awareness: music therapy in context, music therapy as context, and music therapy as interacting contexts. These types of context awareness are described as follows:

> (1) Music therapy in context: awareness of the surroundings of music therapy.
>
> (2) Music therapy as context: awareness of the ecology of reciprocal influences within a music therapy situation.
>
> (3) Music therapy as interacting contexts: awareness of the ecology of reciprocal influences between various systems that music therapy is part of and relates to (p. 51).

These three types of context awareness are further condensed using two metaphors: Context as a given frame "which surrounds" or as dynamic links "which connect" (Rolvsjord & Stige, 2013, p. 57).

One example of context as frame in the pediatric oncology music therapy literature is the Contextual Support Model of Music Therapy (Robb, 2003). In this model, the term context refers to environment. Robb (2003) explains that music therapists can use the functions of music to enact the three forms of contextual support: structure, autonomy support, and involvement. She argues that these contextual supports contribute to the development of active coping behaviors in hospitalized children and adolescents. In other words, the music therapists skillfully use the functions of music to create a frame, which hopefully fosters positive coping behaviors. This specific model is rooted in the medical model, which was described earlier.

Context as a dynamic link, however, requires a contextual model, which views "the whole therapeutic context as providing potentials for change and development related to the client's health" (Rolvsjord, 2006b, p. 8). The whole therapeutic context extends beyond the music therapy sessions; it includes relational, structural, and community levels (Rolvsjord & Stige, 2015). Dun's (2007) framework of bricolage, presented previously, is in line with this idea of context as dynamic links; It is an example of how pediatric oncology music therapy can be used to address relational concerns across important adaptive developmental tasks in mid-childhood and adolescence that may be compromised by the context of hospitalization include individuality and identity development (O'Callaghan et al., 2013; Robb 2003). Autonomy and sense of privacy (which are related concepts) are often challenged in the hospital context, and a child or adolescent may need to rely on his parents for daily care and support (Ghetti & Whitehead-Pleaux, 2015). Re-establishing healthy ways of connecting and relating may be

necessary as intense dynamics may develop as a result of the stress of the illness and hospitalization. Fortunately, music allows for both connective relationships and separation, which may be useful in re-establishing healthy power dynamics (O'Callaghan et al., 2013). One method used to reestablish power dynamics within the parent-child dyad is music improvisation. This may contribute to the child's and the family's quality of life across context; it may facilitate interactions within the hospital setting, and it can also pave the way towards reestablishing satisfactory power dynamics at home during the reintegration phase.

Social Needs

One theme emerging from the Resource-Oriented literature that is particularly relevant when considering the social needs of children with cancer from a *viewing individuals within their context* lens is engagement across contexts. In discussing "what clients do to make music therapy work" (Rolvsjord, 2015, p. 296), Rolvsjord explains that this theme emerged as the analysis of the multiple case studies revealed several ways in which clients interlinked their engagement in music therapy with engagements across contexts. Examples of these links included clients bringing artefacts (such as songs, CDs, or text) from music therapy to other areas of life and vice versa; purchasing an instrument to enhance therapy through practicing at home, or as a health resource outside of the therapy context; and using music at home (Rolvsjord, 2015). As illustrated by a case reported earlier in this chapter, "music therapists can facilitate reintegration to community by assisting children in composing songs about the hospitalization that can be shared" (Ghetti & Whitehead-Pleaux, 2014, p. 339). This sharing of songs across context can be instrumental in the reintegration of a child within her/his wider context following hospitalization. Accordingly, Rolvsjord (2015) suggests that "music as social and cultural engagement [is] specifically helpful for people in their efforts to make connections between different life contexts and to pursue goals and change across contexts" (p. 313). Community music-based projects such as concerts where children with cancer perform songs they wrote in music therapy (Aasgaard, 2005) also exemplify how music can give a voice to the unheard in the broader social and cultural context (Rolvsjord & Stige, 2013). From this contextual lens, children with cancer and their caregivers may use music therapy to make connections between different life contexts and facilitate reintegration following hospitalization.

Developmental Needs

When viewing children with cancer within their context, it is important to discuss the impact of hospitalization from a developmental viewpoint. One particularly important developmental context for children is school, but when a child is diagnosed with a life-threatening illness such as cancer, schooling may not seem a priority. Yet, "for many children with cancer, school represents health and normalcy, and can be a safe place for learning, fun, and social interaction while providing an escape from the all-consuming world of cancer and treatments" (American Childhood Cancer Organization, 2017). Efforts are made to reintegrate the child in his classroom as soon as possible, but because of its effect on immune function, cancer treatment often results in extended periods of time away from school. When treatment is particularly lengthy, a child may end up repeating a grade. Fortunately, educational accommodations such as hospital tutors and online learning are available (American Childhood Cancer Organization, 2017). In the pediatric oncology context, music may be an important educational resource. For example, music may support learning through "expanding multisensory awareness, providing the neural foundations for advanced recall (e.g. singing the alphabet), making concept acquisition

more fun, and assisting social skill development" (O'Callaghan et al., 2013, p. 138). Refer to Part II of this chapter for a discussion on the relevance of music as an educational resource.

Understanding a child's psychosocial and cognitive development is important as it may significantly influence the way he/she reacts to the illness (Daveson. 2001; Ghetti & Whitehead-Pleaux, 2014). Ghetti and Whitehead-Pleaux (2014) explain that "developmental level is a crucial factor impacting how children understand, experience, and cope with hospitalization" (p. 326). Therefore, it might also be useful for hospital educators to understand how musical skills develop relative to other non-musical skills (Gooding & Standley, 2011). An assessment of the child's musical skills may offer insight into her/his global developmental trajectory, and possibly uncover latent potential. For example, a child generally showing a low level of engagement with her/his surroundings in the hospital context (e.g. limited use of speech), may be actively engaged during music therapy sessions (e.g. vocalizing, engaging in creative and interactive musical play).

Summary of Findings

When music therapists view children with cancer within their context, they acknowledge all aspects of their lives: They recognize the complexity of the person beyond the illness. Children and music therapists co-create a shared history which they enrich each time they meet through the new elements emerging from the different contexts. This flexible approach allows for a sensitive provision of care that is centered around the children's needs in the "here and now". Through this lens of the Resource-Oriented approach, engagement across context is a primary goal. Thus, clients are encouraged to use what they acquire in music therapy and apply it across the multiple contexts (interpersonal, structural, social, developmental, and cultural) of their lives.

Part IV. Music as a Health Resource

Overview of the characteristic

This last characteristic statement is based on the assumption that music is a resource for improving people's quality of life (Rolvsjord, 2010). Rolvsjord (2010) explains that

> Music as a health resource must be understood both on an individual level and on social and structural levels. In other words, music as a health resource comprises the individual's musical competences as well as being something that can be accessed through some kind of engagement with music. (p. 83)

She addresses the importance of considering the social, economic, political, cultural, and individual factors, which may limit or promote one's access to music. As a result, she considers providing people with opportunities to access music an important goal for music therapy. This starts by giving back the "power of music" to clients, enabling them to use their musicality and musicking to promote their health and quality of life (Rolvsjord, 2006b).

Physical Needs

Rolvsjord (2006) emphasizes the importance of giving back to clients the power of music: "We might have attributed too much power not only to music "itself" but also to the intervening music therapist, and that we might therefore have failed to see that it is the client her/himself that uses music as a health resource" (Rolvsjord, 2006, p. 8). From this perspective, the music therapist serves merely as a resource and supportive guide for the patient who heals herself/himself through music (Kenny, 2006). Therefore, music-based self-care constitutes a central component of *music as a health resource* in pediatric oncology, and is discussed here in relation to physical needs.

Hirsch & Meckes (2000) report that patients with cancer can learn to use music as a distraction from their pain and as a way to change their emotional experiences. Dun (2013) also suggests teaching older children relaxation techniques to offer them an opportunity to manage their pain and anxiety independently in the absence of the music therapist. Music therapy can be particularly useful before, during and/or after procedures as it can provide opportunities for choice and control, which may facilitate self-expression, reduction of anxiety, pain management, and use of developmentally appropriate coping skills (Daveson, 2001). Other examples of the use of music as a physical health resource have been discussed already in this chapter: These include children and caregivers' use of music to mitigate physical changes (Aasgaard, 2005; Daveson, 2001), subdue side effects (Daveson, 2001; Hirsch & Meckes, 2000), and assist during procedures (Burfalini, 2009; Ghetti & Whitehead-Pleaux, 2014). Refer to Part I of this chapter for more information on these topics. A discussion on the use of music-based self-care to address emotional needs is provided in the next section.

Emotional Needs

In this section, the use of music-based self-care to address emotional needs in pediatric oncology is explored. Subsequently, children's use of music and music therapy as a resource to maintain a healthy self-image is discussed.

Research shows that people use music to benefit their daily life in various ways: for the purposes of emotional regulation, identity construction, building of social relations, etc. (Rolvsjord, 2010). Wagner (2014), who developed a Resource-Oriented Music Therapy technique using music listening with well adults, explains that music, when used in everyday life, may offer protective health benefits. Accordingly, reports of music-based self-care can be found in the pediatric oncology literature (Hirsch & Meckes, 2000; O'Callaghan et al., 2010; O'Callaghan, Barry, & Thomson, 2012). One way in which children use music for self-care is through imaginative play and story creation to improvised music; children use these opportunities to rehearse and prepare for scary situations such as hospital procedures (O'Callaghan et al., 2010). This type of rehearsing, or preparation is also present in the trauma-related research of Ghetti and Whitehead-Pleaux (2015). From their perspective, the child prepares for these scary situations through emotional regulation, which can constitute a goal in music therapy.

Supporting the idea that music is a useful health resource in the process of identity adjustment and development, O'Callaghan et al. (2013) explain that "given that cancer can dramatically alter the child's sense of being, music can arguably be a safe haven and companion for grappling with internalizing a healthy self-image alongside patient identity" (p. 138). As such, the idea that music can be used as a health resource to preserve and nurture the "healthy-self" is recurrent in the pediatric oncology literature (Aasgaard, 2005; O'Callaghan & Aasgaard, 2012; O'Callaghan, Barry, & Thomson, 2011). Procter (2001) explains that enabling people to discover their musicking potential increases their possibilities for actions. He further explains that it is precisely because music is like nothing else that it can play an important role in health promotion services. Aasgaard (2005) notes that musicking allows the child to expand upon their role repertoire, to get out of the "patient" role to explore the role of a creative, social, and interactive being. Similarly, O'Callaghan, Dun, Baron, and Barry (2013) found that music and music therapy can provide children with a sense of normalcy and health, while supporting them in the face of adversity. Ghetti and Whitehead-Pleaux (2015) also point to the usefulness of the creative arts to solidify "a child's integrated identity as he prepares to go home" (p. 339). Thus,

children with cancer may use musicking as a resource for identity adjustment through treatment and recovery.

Social Needs

Music can be used for personal and social empowerment, as a way to grow, change, and develop, and as a way to participate in culture and society (Rolvsjord, 2006a). When considering music as empowerment (an important aspect of the *music as a health resource* characteristic), concepts of musical affordance and musical appropriation must be addressed. Rolvsjord (2006b; 2010) defines musical affordance as "the resources provided by music and its materials in situations of use" (p. 7). She defines appropriation as "how the affordances are used – the "takings" and "using" of music" (Rolvsjord, 2006b, p. 7; DeNora, 2003). Similarly, Stige (2007) describes *health musicking* "as a process where various agents negotiate and collaborate (or split) in relation to the agendas, artefacts, and activities of any given arena" (Introduction section, para. 4-5). From this point of view, music is not an autonomous object because to be meaningful, it must be appropriated by the client and used in a way that meets her/his own needs in context. The only way music therapy can help is if the client uses it as a health resource (Rolvsjord, 2006b). This section addresses how children with cancer use *music as a health resource* to address their own social needs.

As mentioned earlier, children with cancer may use musicking as a way to develop their identity. They may also use music to connect with others. Research on children's and adolescents' use of music in pediatric oncology reveals that musical preferences and identification to musical subcultures may play an important role in identity formation, group belonging and peer relationships (O'Callaghan, Barry, & Thomson, 2012; O'Callaghan et al., 2013). In fact, belonging to a certain musical subcultural may become an important part of one's identity (e.g. heavy mental, punk). Older children may become more conscious of peers' musical tastes, which may in turn affect their own musical preferences and musical expressions. They may idolize certain celebrities and, through this admiration, bond with other peers of the same age group. O'Callaghan, Barry, and Thompson (2011) found that adolescents with cancer use music as a "normalized form of expression, support, and companionship" (p. 696). With most adolescents having Internet access on their cellphones, tablets, and/or laptops, access to recorded music has changed dramatically. With video-sharing website such as YouTube, the world's music is at their fingertips. They can learn about the latest music trends, and follow their favorite idols on diverse social media. These virtual music platforms are used by adolescents to express themselves to other peers, and to explore social interactions (O'Callaghan et al., 2013). Thus, children with cancer use music and technology to tend to their social connection needs despite their illness.

Developmental Needs

Evidence presented above suggests that music can be used as a health resource to address physical, emotional, and social needs of children with cancer. Some of these needs may be related to developmental milestone, such as using musicking as a way to explore the developmental task of autonomy (Ghetti & Whitehead-Pleaux, 2014). As discussed previously, music may be used to buffer the effect of hospitalization on reaching developmental milestones. Music can also help counteract the late effects of cancer treatment on development (O'Callaghan et al., 2013). These include: Problems with memory and attention, poor hand-eye coordination, slowed development over time, behavioural problems, and difficulty with psychosocial

adjustment associated with the cancer experience (American Cancer Society, 2016; National Cancer Institute, 2016). Music can promote the maintenance and development of physical and cognitive abilities children may have acquired through learning an instrument, creating songs, or improvising in music therapy. In addition, "correlations between neural music function and development and improved intellectual ability also suggest that music lessons could buffer late effect cognitive deficits [due to cancer treatment]" (O'Callaghan et al., 2013, p. 128). This evidence supports the idea that music may not only be a useful health resource for promoting the development of children during their treatment, but also after their remission.

Summary of Findings

Whether it is for managing physical discomfort, to develop one's identity, as a means to belong to a group of peers, or to counteract late effects of cancer treatment on cognitive abilities, children and adolescents with cancer have considerable competence in using music for health benefits. While concepts of musical affordance and appropriation have been briefly presented, the role of music therapist is the one of an enabler; it is to help people discover their own musicking potential and aspirations. The following statement embodies the versatility of music as a resource, and clients' empowerment resulting from its utilization:

> Music is a resource pool. It contains many things – images, patterns, mood suggestions, textures, feelings, processes. If selected, created, and used with respect and wisdom, the clients will hear what they need to hear in the music, and use the ritual as a supportive context. (Kenny, 2006, p. 13).

DISCUSSION

Revisiting the Research Question

With this study, I aimed to provide music therapists wanting to work within a Resource-Oriented approach in pediatric oncology music therapy with the vocabulary necessary to do so, while arguing the feasibility of working with the approach in a problem-oriented context. The primary research question was: Why is a Resource-Oriented Music Therapy approach indicated in pediatric oncology contexts and how might it be conceptualized?" While none of the pediatric oncology music therapy literature was identified as "Resource-Oriented" *per se*, an in-depth look at its core assumptions revealed the presence of resource-oriented practices within the field. From this critical analysis, parallels between the literature and the Resource-Oriented approach were identified, while new insights also emerged.

Parallels between Existing Music Therapy Practice in Pediatric Oncology and the Resource-Oriented Approach

In analyzing the pediatric oncology music therapy literature from the *nurturing of strengths, resources, and potential* lens, I identified the following parallel between existing practice and the Resource-Oriented approach: children possess creative music and non-music based resources, potential and strengths (music as one) that can be used in and outside of music therapy to address physical, emotional, social, and developmental needs. For example, the literature suggests the benefits of nurturing creative resources as a way of: addressing physical changes and side effects; developing self-regulation potential through active music-making; expanding social networks beyond the illness limitations; and to facilitate learning.

When looking at the pediatric oncology literature from a *collaboration rather than intervention* lens, the concept of mutuality within the collaborative relationship emerged. It was particularly present in Dun's (2007) framework of bricolage where children and music therapists co-create a shared history which they enrich each time they meet. Several examples from the literature also emphasized the importance of adaptability and flexibility when working with children in pediatric oncology. Daveson's (2001) exploration of the different contexts of pediatric oncology suggests the importance of a sensitive provision of care that is centered around the children's needs in the "here and now".

Viewing individuals within their context involves the recognition of the person's complexity beyond their illness. In pediatric oncology, music therapists offer children opportunities to get out of the "patient" role to explore the role of a creative, social, and interactive being. Similarly, several examples in the pediatric oncology literature also support the use of music therapy as a context where the child can prepare for reintegration after hospitalization (Ghetti & Whitehead-Pleaux, 2015). This is in line with the *viewing individuals within their contexts* characteristic of the Resource-Oriented approach: It suggests an interest in the generalization of what is learned inside music therapy to the other contexts of that person's life.

Music therapists in pediatric oncology see children as having considerable competence in using music for health benefits. This is in line with the *music as a health resource* characteristic of the Resource-Oriented approach. For example, children may use music as a resource for identity development and preservation of a healthy self-image (Aasgaard, 2005). They may also use music to explore developmentally-related tasks. Music therapy provides a unique opportunity where children can explore abilities not otherwise stimulated in the hospital environment, and where children with cancer can tap into their unexplored potential.

New Insights Brought Forth by the Resource-Oriented Approach: Potential Implications for Practice

One potential implication for practice identified through analysis of the pediatric oncology music therapy literature from a *nurturing of strengths, potential, and resources* lens is the importance of viewing strengths, resources, and potential as an essential part of assessment, therapeutic collaboration and evaluation of therapy. While some examples of Resource-Oriented language (such as the use of the strength-based concept of resilience) were found in the literature, the focus on problem-oriented concepts suggested a predominantly problem-oriented approach. Similarly, the lack of literature addressing the assessment and evaluation of the strength of children with cancer supports the claim that strength-based considerations are peripheral to these therapeutic processes. It is argued here that an essential part of a holistic approach to music therapy involves the celebration and nurturing of an individual's strengths, resources, and potential.

As mentioned before, information about music therapy assessment and evaluation was scarce in the pediatric oncology literature. This minimized the opportunity to analyze whether these therapeutic phases were implemented in a Resource-Oriented way. From the perspective of the *collaboration rather than intervention* characteristic, clients are actively engaged in defining therapy goals, ways of working, and evaluation of therapy outcomes. Similarly, the concepts of equality & shared responsibility, which are central to the notion of collaboration, were lacking in the pediatric oncology literature. One supplemental insight emerging from viewing pediatric

oncology through this lens is that collaboration within the therapeutic relationship is a key ingredient in promoting the transfer of skills from the context of music therapy to everyday life.

Considering the pediatric oncology literature through the *viewing individuals within their context* lens also emphasized the role music therapy can play in helping children make connections between different life contexts. This lens of the Resource-Oriented approach contributed the concepts of *context as a given frame "which surrounds"* and *context as dynamic links "which connect*" (Rolvsjord & Stige, 2013). The use of this terminology provided the grounds for an in-depth discussion about the conceptualization of contexts in existing pediatric oncology music therapy models and frameworks.

Music as a health resource was also a characteristic of the Resource-Oriented approach that was well represented in the pediatric oncology music therapy literature that was reviewed. However, further reflection on the concepts of musical affordance, musical appropriation, and access to music could strengthen this view. In addition, the music therapy literature often emphasized the role of the therapist in helping the clients reach their goals. Yet this approach suggests a shift of focus towards "what clients do to make music therapy work" (Rolvsjord, 2015, p. 296). One significant contribution of this approach to the field of pediatric oncology could be the perspective according to which clients are seen as active agents of change in music therapy. The Resource-Oriented approach contributes a perspective of pediatric oncology in which the music therapist acts as a guide/facilitator to help people discover their own musicking potential and aspirations: The act of facilitating requires an in-depth understanding of music therapy processes and functions of music (e.g. using music in a way that connects people), which music therapists are specifically trained for.

It is worth noting that when analyzing the pediatric oncology literature, parallels and new insights were identified for all four characteristics of the Resource-Oriented approach. This suggests the relevance of each characteristic within the pediatric oncology context, but also, existing commonalities between the practice and this approach. To adopt a Resource-Oriented approach, music therapists working in pediatric oncology can use the parallels between the approach and the existing body of pediatric oncology music therapy literature, and weave in the emerging elements brought forward by this new perspective. I hoped that this research contributes to illuminating new areas of practice.

Limitations

As the Resource-Oriented approach that emerged from this study was not being tested, suggested benefits of this approach are theoretical in nature. The generalizability of findings is limited, because the literature analyzed addressed a narrow population with specific needs. The conceptualization of pediatric oncology music therapy practice was limited to its representation in articles published in the English language. The research method did not allow for consultation with music therapists to inquire about their work in pediatric oncology, and/or their opinion on the relevance of the Resource-Oriented approach. There was also a lack of literature looking at the perspective of children with cancer: this rendered me dependent upon other music therapists' perspectives of the needs of children with cancer. I was unable to collect the children's perspectives on the relevance of this approach to them due to the research design I selected. I used my own experience as a music therapy intern in this field to inform my decision as to which approach would best suit the perceived needs of children with cancer.

Future Research Implications

The Resource-Oriented approach formulated was not tested in practice within the context of this study; therefore, further research is warranted. While this research looked at children in oncology, future research could include children hospitalized for conditions other than cancer, or even children in other setting such as schools or daycare centers. The relevance of the approach for hospitalized adults (such as adults with cancer) could also be examined. Further research could address the children and caregivers' perspectives on the relevance of the Resource-Oriented Music Therapy approach to address their needs. Similarly, others could look at music therapists' and other healthcare providers' perspectives on the relevance of the Resource-Oriented approach within the context of interdisciplinary practices. The role of the music therapist in this model could be further explored across contexts and populations. The relevance of other post-modernist approaches to music therapy in pediatric oncology could be examined, and/or compared to the Resource-Oriented approach.

Conclusion

Through this philosophical inquiry, I explored the context of pediatric oncology and the Resource-Oriented approach. The literature in each area of research was reviewed and integrated, to co-construct new meaning; analyzing the literature through the lenses of the Resource-Oriented approach provided an empowering view of children's experience in music therapy and it contributed a constructive perspective for the work of music therapists in pediatric oncology. This research provides further evidence of the relevance of the Resource-Oriented approach outside of the context of mental health in which it was developed. I hoped that this theoretical application of the Resource-Oriented approach to music therapy in pediatric oncology encourages therapists working in this area to critically reflect upon their own music therapy approach. This philosophical inquiry provided a conceptual framework that may serve as a starting point for those wanting to explore a Resource-Oriented approach and discourse within a problem-oriented context.

References

Aasgaard, T. (2004). 'A Pied Piper among white coats and infusion pumps: Community music therapy in a paediatric hospital setting'. In M. Pavlicevic and G. Ansdell (Eds.), *Community music therapy* (pp. 147−167). London, England: Jessica Kingsley.

Aasgaard, T. (2005). Assisting children with Malignant blood diseases to create and perform their own songs. In F. Bake and T. Wigram (Eds.), *Songwriting: Methods, techniques and clinical applications for music therapy clinicians, educators and student* (pp. 154-179). London, England: Jessica Kingsley.

Aigen, K. S. (2014). *The study of music therapy: Current issues and concepts.* New York, NY: Routledge.

Aigen, K. (2015). A critique of evidence-based practice in music therapy. *Music Therapy Perspectives, 33*(1), 12-24. doi:10.1093/mtp/miv013

Aigen, K. (2005). *Music-centered music therapy.* Gilsum, NH: Barcelona.

Aigen, K. (2005). Philosophical inquiry, in B. L. Wheeler (Ed.), *Music therapy research* (2nd ed., pp. 526-539). Gilsum, NH: Barcelona.

American Childhood Cancer Organization (2017) *Diagnosis.* Retrieved from: http://www.acco.org/diagnosis/

American Cancer Society. (2016, June 9). *Children diagnosed with cancer: Late effects of cancer treatment.* Retrieved from https://www.cancer.org/treatment/children-and-cancer/when-your-child-has-cancer/late-effects-of-cancer-treatment.html

Ansdell, G. (2003). The stories we tell. *Nordic Journal of Music Therapy*, *12*(2), 192-159. doi: 10.1080/08098130309478085

Baker, F. A. & Young, L. (2016). The relationship between research and practice, in B. L. Wheeler & K. M. Murphy (Eds.), *Music therapy research* (3rd ed.). Dallas, TX: Barcelona.

Barrera, M. E., Rykov, M. H., & Doyle, S. L. (2002). The effects of interactive music therapy on hospitalized children with cancer: a pilot study. *Psycho-Oncology, 11*(5), 379–388. doi:10.1002/pon.589

Barry, P., O'Callaghan, C., Wheeler, G., & Grocke, D. (2010). Music therapy CD creation for initial pediatric radiation therapy: A mixed methods analysis. *Journal of Music Therapy*, *47*(3), 233-263. doi:10.1093/jmt/47.3.233

Bradt, J., Dileo, C., Magill, L., & Teague, A. (2016). Music interventions for improving psychological and physical outcomes in cancer patients. *Cochrane Database of Systematic Reviews.* doi:10.1002/14651858.cd006911.pub3

Bufalini, A. (2012). The effect of live music on oncological paediatric patients during painful procedures. *European Journal of Integrative Medicine, 4,* 111. doi:10.1016/j.eujim.2012.07.731

Burns, D. S., Robb, S. L., & Haase, J. E. (2009). Exploring the feasibility of a therapeutic music video intervention in adolescents and young adults during stem-cell transplantation. *Cancer Nursing, 32*(5), E8–E16. doi:10.1097/ncc.0b013e3181a4802c

Clements-Cortes, A., & Pearson, S. (2014). Discovering community music therapy in practice: Case reports from two Ontario hospitals. *International Journal of Community Music, 7*(1), 93–111. doi:10.1386/ijcm.7.1.93_1

Da Costa, D. (2014). *A resource-oriented music therapy support group intervention for adults living with fibromyalgia.* Masters thesis, Concordia University.

Daveson, B., & Skewes, K. (2002). A philosophical inquiry into the role of rhythm in music therapy. *The Arts in Psychotherapy, 29*(5), 265–270. doi:10.1016/s0197-4556(02)00196-x

Daveson, B. A. (2001). Music therapy and childhood cancer: Goals, methods, patient choice and control during diagnosis, intensive treatment, transplant and palliative care. *Music Therapy Perspectives, 19*(2), 114-120. doi: 10.1093/mtp/19.2.114

DeNora, (2003). *After Adorno: Rethinking music sociology.* Cambridge: Cambridge University Press.

Dun, B. (2013). Children with cancer. In J. Bradt (Ed.), *Guidelines for music therapy practice in pediatric care* (pp. 290-323). Gilsum, NH: Barcelona.

Dun, B. (2007). Journeying with Olivia: Bricolage as a framework for understanding music therapy in paediatric oncology. *Voices: A World Forum for Music Therapy, 7*(1). doi:10.15845/voices.v7i1.464

Edwards, J. & Kennelly, J. (2011) Music therapy for children in hospital care: A stress and coping framework for practice. In K. E. Bruscia (Ed.), *Developments in music therapy practice: Case study perspectives* (Chapter 8) Gilsum, NH: Barcelona.

Ellison & Janz (2015). Health at a glance: Childhood cancer incidence and mortality in Canada*., Statistic Canada, Catalogue no.82-624-X.* Retrieved from: http://www.statcan.gc.ca/pub/82-624-x/2015001/article/14213-eng.htm

Flower, C. (2014). Music therapy trios with child, parent, and therapist: A preliminary qualitative single case study. *Psychology of Music, 42*(6), 839-845. doi: 10.1177/0305735614547065

Froehlich, M. A. (ed.). (1996). *Music therapy with hospitalized children: A creative arts child life approach*. Cherry Hill, NJ: Jeffrey Books.

Ghetti, C. M. & Whitehead-Pleaux, A. M. (2015). Sounds of strength: Music therapy for hospitalized children at risk of traumatization. In C. A. Malchiodi (Ed.), *Creative interventions for traumatized children* (pp. 324-341). New York, NY: The Guilford Press.

Gooding, L. & Stanley, J. M. (2011). Musical development and learning characteristics of students: A compilation of key points from the research literature organized by age. *National Association for Music Education, 30*(1), 32-45. doi: 10.1177/8755123311418481

Hilliard, R. E. (2006). Music therapy in pediatric oncology: A review of the literature. *Journal of the Society for Integrative Oncology, 4*(2), 75. doi:10.2310/7200.2006.001

Hirsch, S., & Meckes, D. (2000). Treatment of the whole person. *Journal of Psychosocial Oncology, 18*(2), 65–77. doi:10.1300/j077v18n02_04

Kenny, C. (2006). *Music & life in the field of play: An anthology.* Gilsum, NH: Barcelona.

Kenny, C. B. (1985). Music: A whole systems approach. *Music Therapy, 5*(1), 3-11. doi:10.1093/mt/5.1.3

Kim, Y. (2004). The early beginnings of Nordoff-Robbins music therapy. *Journal of Music Therapy*, *41*(4), 321-339. doi:10.1093/jmt/41.4.321

Lee, C. A. (2003). *The architecture of aesthetic music therapy*. Gilsum, NH: Barcelona.

Meadows, A. (2010). The evolution of GIM programming. *Voices: A World Forum for Music Therapy, 10*(3). doi:10.15845/voices.v10i3.497

National Cancer Institute. (2016, August 11). *Late effects of treatment for childhood cancer*. Retrieved from https://www.cancer.gov/types/childhood-cancers/late-effects-pdq

O'Callaghan, C., & Aasgaard, T. (2012). Art therapies including music therapies. *Pediatric Oncology*, 45–57. doi:10.1007/978-3-642-04201-0_5

O'Callaghan, C., Baron, A., Barry, P., & Dun, B. (2010). Music's relevance for pediatric cancer patients: A constructivist and mosaic research approach. *Supportive Care in Cancer, 19*(6), 779–788. doi:10.1007/s00520-010-0879-9

O'Callaghan, C., Barry, P., & Thompson, K. (2011). Music's relevance for adolescents and young adults with cancer: A constructivist research approach. *Supportive Care in Cancer, 20*(4), 687–697. doi:10.1007/s00520-011-1104-1

O'Callaghan, C. Dun, B. Baron, A. & Barry, P. (2013). Music's relevance for children with cancer: Music therapists' qualitative clinical data-mining research. *Social Work in Health Care, 52* (2-3), 125-143. doi: 0.1080/00981389.2012.737904

Procter, S. (2001). Empowering and enabling. *Voices: A World Forum for Music Therapy, 1*(2). doi:10.15845/voices.v1i2.58

Rak, C. F. (2002). Heroes in the nursery: three case studies in resilience. *Journal of Clinical Psychology*, *58*(3), 247-260. doi:10.1002/jclp.10023

Robb, S. L. (2003). Designing music therapy interventions for hospitalized children and adolescents using a contextual support model of music therapy. *Music Therapy Perspectives, 21*(1), 27–40. doi:10.1093/mtp/21.1.27

Robb, S. L. (1999). Piaget, Erikson, and coping styles: Implications for music therapy and the hospitalized preschool child. *Music Therapy Perspectives, 17*(1), 14–19. doi:10.1093/mtp/17.1.14

Rolvsjord, R. (2015) What clients do to make music therapy work: A qualitative multiple case study in adult mental health care. *Nordic Journal of Music Therapy, 24*(4), 296-321. doi: 10.1080/08098131.2014.964753

Rolvsjord, R. (2010). *Resource-oriented music therapy in mental health care.* Gilsum, NH: Barcelona.

Rolvsjord, R. (2006). Therapy as empowerment: Clinical and political implications of empowerment philosophy in mental health practices of music therapy. *Voices: A World Forum for Music Therapy, 6*(3). Retrieved from: https://voices.no/index.php/voices/article/view/283/208

Rolvsjord, R. (2006). Whose power of music?: A discussion on music and power-relations in music therapy. *British Journal of Music Therapy, 20*(1), 5–12. doi:10.1177/135945750602000103

Rolvsjord, R., & Stige, B. (2013). Concepts of context in music therapy. *Nordic Journal of Music Therapy, 24*(1), 44–66. doi:10.1080/08098131.2013.861502

Ruud, E. (2005). Philosophy and theory of science. in B. L. Wheeler (Ed.), *Music therapy research - Second edition* (e-book). Gilsum, NH: Barcelona.

Standley, J. M., Gooding, L. F., & Swedberg Yinger, O. (2014). Pediatric medical music therapy. In L.F. Gooding (Ed.), *Medical music therapy: Building a comprehensive program* (pp. 117-133). Silver Spring, MD: American Music Therapy Association.

Standley, J. M., & Hanser, S. B. (1995). Music therapy research and applications in pediatric oncology treatment. *Journal of Pediatric Oncology Nursing, 12*(1), 3–8. doi:10.1177/104345429501200103

Stige, B. & Strand, R. (2016). Philosophical inquiries, in B. L. Wheeler & K. M. Murphy (Eds.), *Music therapy research* (3rd ed.). Dallas, TX: Barcelona.

Stige, B. (2007). The Grieg effect – On the contextualized effects of music in music therapy. *Voices: A World Forum for Music Therapy, 7*(3). doi:10.15845/voices.v7i3.548

Stige, B. (2002). *Culture-centered music therapy.* Gilsum, NH: Barcelona.

Tedeschi, R. G., & Kilmer, R. P. (2005). Assessing strengths, resilience, and growth to guide clinical interventions. *Professional Psychology: Research and Practice*, *36*, 230-237. doi:10.1037/0735-7028.36.3.230

Thaut, M.H., & Hoemberg, V. (2014). *Handbook neurologic of music therapy.* New York, NY: Oxford University Press.

Tucquet, B., & Leung, M. (2014). Music therapy services in pediatric oncology: A national clinical practice review. *Journal of Pediatric Oncology Nursing, 31*(6), 327–338. doi:10.1177/1043454214533424

Wagner, H. J. (2014). *Intentional music listening protocol: Development of a resource-oriented music therapy technique to promote well-being*. Retrieved from ProQuest Digital Dissertations. (UMI 3623299)

Wolfe, D. E. & Waldon, E. G. (2009). *Music therapy and pediatric medicine.* Springfield, MD: American Music Therapy Association.