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Music Therapists' Experiences of Providing Telehealth Music Therapy for People with Dementia: A Qualitative Exploration

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Abstract

Due to the impact of COVID-19, music therapy practice rapidly transitioned from the traditional in-person format to an online context. Despite the return of in-person services, telehealth music therapy has the potential to support people with dementia who do not have access to or are no longer able to attend in-person services. This qualitative exploration aims to contribute to the emerging literature on telehealth music therapy for people with dementia, providing practical recommendations for practice. Semi-structured interviews were conducted with four senior music therapists who provided telehealth music therapy for people with dementia during and after the COVID-19 pandemic. Telehealth music therapy appears to be a viable alternative to in-person music therapy, particularly for those people at the end stages of dementia, who have physical limitations, who have unreliable access to transport, or who are socially isolated. It is particularly appropriate for those who live in rural areas where access to community supports is limited. The delivery of music therapy via telehealth allows music therapists to continue to support people with dementia and their family from the comfort of their own homes when access to community-based services is no longer feasible. Barriers such as digital literacy, access to technology, and caregiver support must be acknowledged. Findings from this study indicate that a therapeutic relationship can be both established and maintained through music via telehealth music therapy.

Keywords: telehealth; music therapy; telehealth music therapy; dementia; accessibility

Introduction

The unique potential of music therapy for people with dementia includes many features, such as offering non-verbal possibilities, the engagement of all the senses, offering opportunities for artistic spontaneity and musical narrative, as well as the physical, intellectual, and emotional capacity of music (Odell-Miller, 2021). The focus of music therapy on process, feelings and relationship makes it an especially appropriate intervention to enhance well-being of people with dementia and to provide support for caregivers (Baird et al., 2020). For people with dementia, music therapy has been reported to improve quality of life (Cho, 2018; Clair, 2011), reduce behavioural and psychological symptoms of dementia (McDermott et al., 2013; van der Steen et al., 2018), reduce anxiety levels (Chang et al., 2015), reduce agitation (Wall & Duffy, 2010) and have moderate effects on depressive symptoms (Chang et al., 2015; Ueda et al., 2013; van der Steen et al., 2018). Furthermore, music therapy can meet the core psychological needs of people with dementia including attachment, comfort, identity, inclusion, and occupation (Kitwood, 1997), and facilitate person-centred dementia care (Kelly et al., 2024).

Traditionally, music therapy is delivered face-to-face in a variety of contexts including at home, in the community, residential care and hospitals with the development of a client/therapist relationship being central to the therapeutic process. The music-based intervention is conceived as therapeutic when the sonorous element of music is combined with the relationship component, with the goal of eliciting positive change. Telehealth music therapy, which describes remote synchronous music therapy delivery, became prominent in 2020 due to the impact of COVID-19, radically changing many music therapists' clinical and research practices (Clements-Cortés et al., 2021). Literature relating to the topic was limited, and telehealth music therapy was only an emerging area of practice (Baker & Krout, 2009; Fuller & McLeod, 2019; Lightstone et al., 2015; Vaudreuil et al., 2020). The rapid transition to online delivery has resulted in an increasing body of literature for various clinical populations (Ahessy, 2023; Brault & Vaillancourt, 2022; Clements-Cortés et al., 2021; Folsom et al., 2021; Molyneux et al., 2022), professional perspectives (Knott & Block, 2020), the experiences of music therapy practitioners (Baker & Tamplin, 2021; Clements-Cortés et al., 2023; Cole et al., 2021; Dassa et al., 2021; McLeod & Starr, 2021; Wilhelm & Wilhelm, 2022) and researchers (Schmid et al., 2021). As telehealth music therapy emerges as a developing area of clinical practice, significant opportunities have arisen to "expand access to music therapy in order to meet needs in our healthcare systems, educational settings, and communities" (Knott & Block, 2020, p. 152).

There is a small but emerging body of literature on the impact of telehealth music therapy, including its potential benefits and challenges, for people with dementia. Clements-Cortés et al. (2021) highlighted that engaging in telehealth music therapy can offer people with dementia and their family caregivers unique opportunities to interact with one another outside of the caregiver and care recipient relationship. Subsequently, online music programmes can promote social connection for this population while promoting inclusivity and accessibility (Lee et al., 2021). Molyneux et al. (2022) found that telehealth music therapy provided support and increased interconnectedness between clients with dementia and their companions. Contrastingly, other authors concluded that some people with dementia may not be a candidate for telehealth music therapy depending on their stage of dementia and disposition (Clements-Cortés et al., 2021; Dassa & Clements-Cortés, 2021); this has also been highlighted by researchers reporting on telemedicine delivery for this population (Elbaz et al., 2021). Molyneux et al. (2022) highlighted that communication must be more explicit and therapist actions and invitations must be obvious; the physical and gestural cues that we so inherently rely upon in the same physical environment are not available.

Notwithstanding, telehealth has the potential to alleviate the disparity of care for people with dementia residing in the community living in rural or isolated areas, or those with health or physical limitations (Dal Bello-Haas et al., 2014). With appropriate preparation, telehealth music therapy can offer a more diverse, person-centred service, resulting in wider reach, increased accessibility, and convenience for people with dementia (Kelly et al., 2024). Reasons such as geographical location, reduced mobility, increased cognitive decline and unreliable access to transport are some of the barriers that hinder access to in-person and/or community-based music therapy services (Kelly, 2023). Given the lacuna of research on telehealth music therapy for people with dementia and limited guidance for facilitation, this paper explores music therapists' experiences of providing telehealth music therapy for people with dementia with the aim of offering practical guidance to music therapists practicing in this area. Moreover, it aims to address the implications of online delivery on the therapeutic relationship between the music therapist and person with dementia; the practical, musical, and technological considerations when facilitating telehealth music therapy with this population; and the potential role of telehealth music therapy for community dwelling people with dementia who cannot access in-person services in the community.

This paper is situated in a larger PhD project which explored the potential benefits of telehealth music therapy for people with dementia and their family carers living in the community (Kelly, 2023). Findings from this paper were used to inform the design and delivery of a telehealth music therapy programme for people with dementia and their spouses (Kelly et al., 2024).

Method

Research Approach

Conducive to the exploratory nature of the research question and considering the constructivist or naturalistic nature of music therapy (Wheeler & Kenny, 2005), a qualitative approach was adopted for this study. As the authors were interested in understanding the experience of the music therapists, Interpretative Phenomenological Analysis (IPA) was deemed the most suitable qualitative model as it takes an idiographic perspective, is concerned with representing the essence of the lived experience of the participants (Creswell, 2007), and can also expand professional knowledge (Neubauer et al., 2019). IPA was used to analyse the data (Smith et al., 2009). This method of data analysis focuses on the selection of small, homogenous, and purposive samples with lived experience of the phenomenon of study, to ensure the selection of information-rich cases (Creswell, 2007; Patton, 2002). This methodological approach has been employed in multiple music therapy studies (McCaffrey, 2018; McCaffrey & Edwards, 2016; Thompson et al., 2017).

Participants

Purposeful sampling is used in IPA to select participants that can provide insight into a particular experience. Given that the central focus of IPA is the detailed account of lived experience, IPA studies benefit from "a concentrated focus on a small number of cases" (Smith et al., 2009, p. 51). Thus, the inclusion criteria for this study were as follows: (a) Fully qualified music therapist or equivalent with a minimum of five years' experience working with people with dementia, (b) the participant must read, speak and understand English, and (c) must have facilitated music therapy via telehealth for a minimum of 10 individual and/or group sessions.

Six potential participants were identified and emailed with an invitation to participate

in the study. They were identified via an online search and via professional contacts. Five participants initially responded, and four participants completed the online interview. Recruited participants were music therapists (three female/one male) each with over twenty years' experience working as a music therapist and have worked extensively in dementia care settings. Interviews were conducted between June – August 2022. Three participants worked in the United Kingdom and one in Canada.

Ethical Considerations

Ethical approval was sought and subsequently obtained by the Faculty of Arts, Humanities and Social Sciences at University of Limerick, Ireland. Written and informed consent was obtained from each participant prior to the online interview.

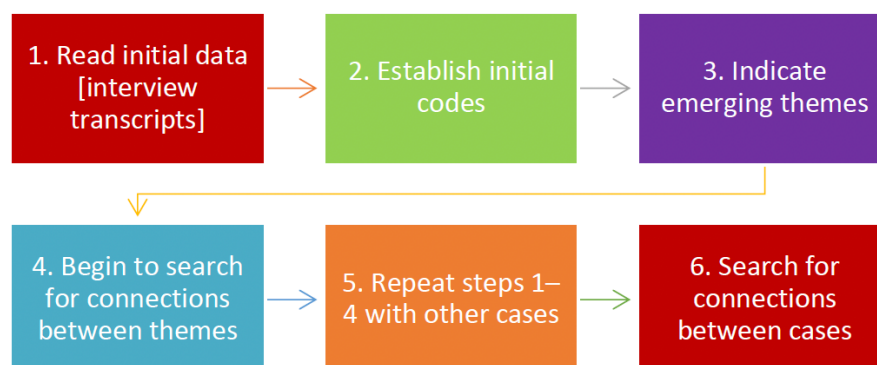
Data Collection

Data was collected using semi-structured interviews. Fifteen open-ended questions were devised based on gaps identified in the literature and are presented in the Appendix. The interviews were exploratory in nature and for the duration of one hour. The interview questions were formulated after an extensive literature search of telehealth music therapy practices in general, and more specifically for people with dementia and their caregivers. The open-ended questions focused on the practical, technological, and musical considerations when facilitating telehealth music therapy for this population. They also endeavoured to elicit information about the participants' experiences of facilitating the intervention. Due to widespread geographical dispersion of participants, interviews were facilitated on Zoom and audio recorded using the record function on the application. Transcriptions of the recordings were produced for analysis and subsequently, the audio files were permanently deleted. All data relating to the project were stored on an encrypted password-protected laptop.

Data Analysis

Generated by the verbatim transcription of the individual online interviews, data were analysed using Interpretative Phenomenological Analysis (IPA). In accordance with IPA's idiographic obligations, each interview was individually analysed in detail before being collectively interpreted and presented (Smith et al., 2009). The IPA researcher engages in a double hermeneutic, making sense of the participant trying to make sense what is happening to them. The inductive, flexible, and non-linear nature of IPA is guided by a six-step model (visually represented in Figure 1) including the reading of original data, establishment of initial codes, indication of themes, searching for connections between the themes, repetition of process with a new case and seeking connections across cases (Smith et al., 2009).

Figure 1. The IPA Process.



The superordinate themes, subordinate themes and initial codes generated from this process are outlined in Table 1. Actions were taken to minimise researcher bias, and to maximise reliability and validity of the analysis process. A selection of the coded data was reviewed by the research supervisors to assure agreement of the chosen themes. Additionally, the final interpretation of the data was returned to the participants to ensure the researcher has recorded and represented their responses accurately (Birt et al., 2016).

Table 1. Superordinate Themes, Subordinate Themes and Initial Codes

Superordinate Themes	Subordinate Themes	Initial Codes
“It’s different but possible”	Ability to create new relationships via telehealth	- Causal relationship between music and gestures - Connection - Musical recognition - Barrier
Facilitation and Structure	- Benefits of co-facilitation - Caregiver assistance during the session - Practicalities of facilitating telehealth music therapy - Curating the space	- Consistency - Flexibility - Modelling - Hand-over-hand - Exaggerated gestures
Broadening access and extending attendance	- Increased access - Hybrid model	- Mobility issues - Transportation limitations - Crisis situation
The benefits and challenges of telehealth	- Unexpected benefits - Challenges - Latency and seeking alternative ways to engage musically	- Transferable skills - Muting/unmuting - Access to appropriate devices - Access to internet - Abstract nature of telehealth - Latency issues

Epoché

In phenomenological research, researchers actively identify and consciously suspend or “bracket” their assumptions and preconceptions regarding a phenomenon (Hiller, 2016). Here, the primary author identifies their preconceptions regarding telehealth music therapy and dementia prior to analysing the data, allowing the interview data to be experienced newly (Hiller, 2016).

The first author has worked as a music therapist for four years, predominantly in older age residential care settings. The impetus for understanding the role of telehealth music therapy for people with dementia and their family caregivers was mainly driven by the impact of the COVID-19 pandemic. The music therapist was unable to continue working with clients in residential care during this time, and her attention was drawn to people with dementia and their families living in the community who were further isolated due to social distancing measures. As a practitioner, her aim was to consider creative solutions

to provide social engagement to those who were unable to access it in person and thus, this research project came to fruition. The first author acknowledges her positive assumptions towards telehealth music therapy given her positive experiences of delivering sessions and continual research in this subject area. These were carefully monitored throughout the interview and data analysis process.

Findings

Four superordinate themes were derived from data analysis and where appropriate titled using individual participant quotes representing group data. These were: (1) It's different but possible, (2) facilitation and structure, (3) broadening access and extending attendance, and (4) the benefits and challenges of telehealth music therapy. Subordinate theme titles have been included in theme two and four to aid the reader in navigating the findings. The four music therapists interviewed, hereby referred to as the participants in this section, had not practiced telehealth music therapy pre-COVID-19 restrictions in March 2020. Three of the participants facilitated telehealth music therapy groups for people with dementia (Participant A, C & D), two of which were specifically for people with dementia and their companions (Participant C & D). Participant B provided both individual and group telehealth music therapy for people with dementia.

Theme 1—"It's Different but It's Possible"

Each of the participants reflected on the impact that the virtual environment had on developing and maintaining their therapeutic relationship with the client(s), describing how it was possible but different than when in person. Participant D noted that "you get such a small glimpse of people on the screen," acknowledging that it is more challenging to assess their needs. Participant B compared the differences of in-person and telehealth practice:

I feel like I was able to make a connection. I think it's different in person. I can't say that it isn't, you know, I think in person we feel people's energy in a different way—I don't know how to describe it...But I do think it's possible and I think a lot of it comes down to the therapist's ability to form relationships with their clients... I can't say there isn't a barrier, I do think it's harder.

Participant A who was initially hesitant about conducting music therapy via telehealth, described a scenario in their first session, recalling the moment when they realised that one of the clients in the day room of the nursing home that the session was broadcasting into, engaged with the therapist on the television screen. The music therapist addressed the client as part of the song and watched the client raise their hand in response and look towards them on the television set. The music therapist then played a downward major scale on the piano and watched the client lowering his arm. Participant A went on to describe how they were unsure of whether there was a connection between them, given the latency issues associated with video-conferencing technology. The visual and audio were out of sync, but the music therapist was able to discern that there was a causal relationship between what they were doing and the client's musical gesture.

While Participant A had previously established a therapeutic relationship with most of the clients in person before moving to telehealth music therapy delivery, several new clients joined the music therapy groups without having met the music therapy facilitator or other group members in person. They reflected upon how musical recognition is still possible online:

What is it about musical recognition that, in a sense, can tolerate online? ... That someone

with cognitive problems can actually still make a relationship with someone who is simply a two-dimensional image on a television.

Participant A describes a case where a music therapeutic relationship was created and sustained with a resident with dementia in the nursing home through telehealth delivery. This client liked the music of the classical composer Johann Sebastian Bach and when the music therapist would play “Jesu, Joy of Man’s Desiring” during the telehealth music therapy session, the client would mime playing the piano in the air. The client in question could not verbally articulate that they knew the piece, but the music therapist could see their fingers making the chordal shapes in the air. Participant A reflects on this case and the development of their music therapeutic relationship online:

We have a very intimate, musical, personal connection and one that’s sustained over time... So, for me, that is a music therapeutic relationship—one that’s been established in and through music and through the particular kind of intimacy that music can allow people... and in that case, and a few others, that’s been both created and then developed only online... which has really, really, really surprised me.

Participant C stated that they had “more questions” than “easy answers” and pondered the questions: “Well what is a therapeutic relationship?” They spoke about the immediacy of the conclusion of the music therapy session in a telehealth environment versus an in-person setting. They compared it to an in-person music therapy session where participants would stand up and gather their belongings, have a conversation with other members of the group or the music therapist. Participant D reflected on how this happened to an extent online but that some participants would leave immediately once the session had concluded. On occasion, they would be left with questions or concerns about how the participants were managing or what they might have witnessed in the music therapy session.

Theme 2—Facilitation & Structure

The theme of facilitation and structure emerged in several capacities: (a) Two music therapists co-facilitating a telehealth music therapy group session together or remotely, (b) caregivers in the room with the clients assisting or mediating the music therapist during the session, and (c) the practicalities of facilitating telehealth music therapy.

The middle person

Participant B spoke about how sometimes the carer becomes the co-therapist; something Participant A referred to as the “middleman or middle woman.” Participant B described that the carer could prompt the person with dementia or facilitate hand-over-hand movements. Similarly, they could model how to play instruments as it is difficult for the music therapist to model the movement when performing on the piano or guitar. If the session is focused on the dyad (the carer and person with dementia), the focus is not on the person with dementia engaging with the music therapist but rather encouraging the dyad to engage directly with each other.

The importance of structure

Structure was highlighted as important for the purposes of continuity, consistency and to provide an anchor “that people could hold onto and recognise” (Participant C). Furthermore, structure was vital for the music therapists who were co-facilitating the session so that they knew “who was doing what, who was going to lead...who was in what role,” which was also instrumental in ensuring the participants were “held in the process” (Participant C).

Curating the virtual space

Participant C highlighted the importance of trying to mirror the in-person therapeutic space by curating the structure of the virtual environment. They described how in an in-person therapy session it would be just the therapist and the participants in the room. Therefore, they aimed to mirror this in the virtual environment. At the beginning of the session, the co-ordinator joined the participants and the therapists for “tea-time,” where all participants engaged in verbal discussion. When the music therapy session officially started, the co-ordinator would turn their camera and microphone off but remain in the background to troubleshoot any connection issues. This was also echoed by Participant D who emphasised the benefits of having distinguished roles:

It felt very, very helpful that we had somebody who looked after the practicalities of the Zoom calls and of inviting people and making sure everybody could be heard and all that and the running the group was more in the domain of the music therapist... Having one person doing all that—your attention is much too divided, I think.

Each of the participants spoke about how they had to adapt to and use more exaggerated gestures and direct communication. Participant A noted that they intuitively found themselves exaggerating their gestures and the verbalising the actions they observed the participants making.

Additionally, Participant B recommended facilitating an orientation session where the person with dementia and their caregiver became accustomed to the video conferencing platform and functions including turning on and off the microphone and camera. Participant C and their colleagues facilitated a similar orientation prior to the sessions by distributing “self-help sheets for how to use Zoom.”

Theme 3—Broadening Access and Extending Attendance

The participants had varying perspectives regarding the role of telehealth practice in music therapy for this population going forward in the future. Participant D noted that telehealth music therapy may “extend the life of people’s attendance” when they are no longer capable of attending in person due to increased cognitive decline, physical limitations, or transition to residential care.

Participant A echoed this, speaking of its value in supporting community dwelling people with dementia and their caregivers who may have physical or transport limitations, those who are at the later stages of their journey or may have been transferred to residential care.

Participants C & D both commented on how telehealth practice in music therapy provides greater access to those who may not be able to avail of in-person community supports. Their telehealth music therapy group enabled companions; in this case, spouses, to separately attend the online music therapy group and virtually see the other members of the group on the screen. Participant D provided a case example of a couple who attended the online music therapy group. The woman had moved into a care home during the COVID-19 pandemic, and her husband was not allowed to visit, but the care home set it up so that she could attend the online music therapy group from the residential home with assistance from a formal caregiver and her husband accessed the group from home. The online delivery of the music therapy group allowed the couple to see each other virtually once per week when it was not possible to do so in person. However, since the transition of the group back to in-person, this couple were no longer able to attend. The music therapist commented on how being online “actually broadened access to the groups” (Participant D).

Participant D also reflected on their experience with a couple who began attending the

music therapy group online but were not able to transition back to in-person sessions in the community due to the progressive nature of their dementia. The technology afforded opportunities to regulate participant interaction via the mute function, which helped to manage group dynamics and include participants who might otherwise be unable to attend in-person safely. In this instance, the person with dementia had become quite disinhibited in their language at times, which made it difficult to participate in a group setting. In this specific case, the mute function on Zoom enabled the couple to participate in a social environment with others and offered the music therapist a “clear clinical thinking about why we would need to keep or think about keeping an online option.” Participant D noted, “It was very striking that being in a group online was possible because of the mute button—that made it socially possible to be together with other people in a way that being in person didn’t.”

Participant C & D saw a future for telehealth music therapy but were against the idea of offering a hybrid model, due the difficulty of “attending to and dividing your attention between those in the room and those online” (Participant C). They recommended that there were two group offerings: one for those in the community; and one for those who live in a rural area, have reduced mobility, or have unreliable access to transport. Participant D voiced a similar opinion: “There’s something about the relational part of being hybrid, particularly with that client group that I think would be pretty tricky. Not for everybody, but for some. Would I want to run those groups? No, maybe not.”

Theme 4—The Benefits and Challenges of Telehealth Music Therapy

The benefits, challenges and limitations of the telehealth music therapy were identified by each of the participants. Initially, each of the participants did not utilise external microphones to enhance audio quality and relied on the built-in internal microphone in their laptop. Three participants used Zoom (Participants B, C, D) as a video conferencing platform, while Participant A used Skype to facilitate their sessions.

Unexpected benefits

Participant C commented that one of the unexpected benefits of the online delivery of the music therapy programme was the transferrable skills it offered the group members:

Some people were so motivated to join [the programme] online, that they had to be able to develop a digital literacy to do that. It opened up the possibility for people to stay connected with other family members. They were just more comfortable using the technology and that was something that we hadn’t anticipated... I think it’s a good outcome.

Participant B noted that telehealth delivery relieved the burden of travel placed on older caregivers who were “trying to navigate all the other health appointments” and perhaps offered greater accessibility and reduction of travel time.

Challenges

While acknowledging that access to technology offers greater accessibility to some, Participant B considered the systemic barriers that exist for those in lower socio-economic groups and under-resourced countries. They highlighted that not everyone has access to the internet or the financial resources to pay for a higher speed internet connection which is essential for telehealth music therapy delivery.

Participant B also reflected on the abstract nature of telehealth for people with dementia due to cognitive impairments, stating that this sometimes was a challenge:

Some of the clients with dementia, I think, confuse the platform [Zoom] like you’re a TV and

so like, I think for a few people it was a little bit of a hurdle. Like, I'm supposed to interact with her, and she can hear it? I think that was a bit confusing because it's a bit abstract. Normally you don't talk to the TV and the TV doesn't talk to you. So, I think for some that was a little confusing.

Participant A questioned the role of telehealth in future music therapy practice but recognised its value in a crisis situation. They suggested that now that COVID-19 restrictions have been lifted and social distancing measures are no longer in place, it is more challenging to get support staff engaged in the telehealth process:

So, my experience recently is that in a sense, it's got harder. So, as the crisis [COVID-19] had gone down, the problem of doing this has got harder for one simple reason. Everything we described earlier about what made—what helped it to help—so, staff willingness, staff availability, the energy to do something special when nothing else was possible... Lots of those things are more difficult now... But I think that's more circumstantial rather than to do with the technology.

Latency and Seeking Alternative Ways to Engage

Challenges with latency were also experienced by the music therapists and playing synchronously was not an option. Participant B used interventions such as songwriting, movement to music and music and mindfulness during the telehealth music therapy sessions. They spoke of how they used call and response activities as well as introducing recorded music and media into the telehealth music therapy sessions:

We tended to resort to things more like call and response so that there wasn't simultaneous playing of things. We also used media. You know, more recorded type things than I would ever use in person. So, looking at the video of maybe *The Sound of Music* and then talking about that, talking about the lyrics of this song, and doing reminiscence through that opportunity and sharing a video together.

Participant D pondered alternative ways to musically engage with the members of the group synchronously as they would in person:

How do we bring all the stuff we would usually do in person and what are the constraints? How do we need to shape it so that it stays as live as possible, and it stays as group based as possible, and so as many people as possible are heard and feel themselves to be heard as well. Yeah, I think ... the playing was surprising. I think that we did still manage to have a sense of playing together.

They provided examples of how they navigated latency issues by encouraging group members to do solos or call and response activities with the music therapist:

So, we would set something up so that we play altogether and then do solos... So, one person would unmute themselves and have a solo or we would do a call and response, between me and one person who unmuted themselves and have that kind of coming backwards and forwards and then go back into playing altogether and then do somebody else call and response. So, mixing it up because if everybody plays together... you're not going to hear everybody, but you can mix that with, with doing some solo work or one to one kind of playing.

Discussion

This study describes four music therapists' experiences of telehealth music therapy

provision with people with dementia during and post COVID-19 restrictions. Results illuminated the multifaceted experiences of practitioners, with both challenges and opportunities arising from the online delivery of music therapy to a selection of people with dementia and their caregivers (both formal and informal) and the capacity of members of these populations to engage with telehealth music therapy. Results indicate a duality of experience regarding the accessibility of telehealth music therapy for this population. For some, telehealth expanded service delivery to community dwelling people with dementia or those who are in residential care who do not have access to music therapy. Inversely, other members of the population were unable to access telehealth music therapy due to increased cognitive decline, lack of caregiver support, lack of access to technological devices, or limited internet connection. This “digital divide” has been reported by other dementia researchers exploring telemedicine provision (Arighi et al., 2021).

The participants were satisfied that they were able to develop and maintain a therapeutic relationship with their clients in an online context, although they noted that the experience differed from the traditional in-person music therapy environment. Schmid et al. (2022) highlighted that music therapeutic presence and the intimacy of a relationship through the medium of music is not necessarily dependent on physical and psychological proximity. Cephas et al. (2022) stated that the therapeutic and musical relationship built over a screen relies on “collaboration through empathy, openness, and joint exploration of the technological environment” (p. 216). Previous research suggests that developing therapeutic relationships may take more time than in-person therapy, with technological limitations such as poor resolution and latency detracting from the therapeutic experience (Krout et al., 2010).

While most music therapy services facilitated by the participants have returned to in-person delivery, some programmes have remained online or have a mixture of in-person or online attendance to enhance accessibility. Unfortunately, some people with dementia and their companions who joined the music therapy group online were unable to return to the in-person community programme due to the progressive symptoms of dementia. This provides a rationale for the provision of telehealth music therapy supplementary to in-person music therapy. This dual mode of delivery ensures that people with dementia can avail of psychosocial support services at the later stages of their journey with dementia from the comfort and security of their own home when social engagement or mobility can become difficult. Furthermore, it can attenuate the significant burden placed on family caregivers who do not live in close proximity or within reasonable travelling distance to health care providers and dementia support services (Ruggiano, 2018).

The most prominent benefit of telehealth for people with dementia is increased access not only for those who live in geographically remote areas, have physical limitations, or limited access to transport, but also those who are unable to attend community support services due to increased cognitive decline or a move to residential care.

While the benefits of telehealth music therapy for this population are numerous, the limitations must also be acknowledged. Some clients with dementia found it difficult to engage with the telehealth music therapy sessions due to impairments with reality orientation (Clements-Cortés et al., 2021). Some people with dementia mistook the music therapy facilitator on the computer screen for someone on a television programme. The abstract nature of engaging with an online platform may be confusing to interpret and comprehend. Additionally, it must be acknowledged that access to appropriate technology devices (smartphones/laptops) may be limited for people with dementia from a lower socioeconomic background as opposed to their more affluent counterparts (Gately et al., 2022).

The benefits of having at least two facilitators were addressed. When two music therapists were not available to co-facilitate the synchronous telehealth music therapy

session, the need for a co-facilitator with the client was highlighted to mediate the session (Participant A), particularly given the geographical distance and latency issues involved in synchronous telehealth delivery (Schmid et al., 2022). Subsequently, participants C & D recommended the appointment of a co-ordinator who was responsible for admitting clients to the online meeting, troubleshooting technological difficulties and liaising with clients who needed assistance. This also provided a therapeutic boundary when administration and therapist roles were separated.

Further research is needed to explore the potential psychosocial benefits of telehealth music therapy for this population both via quantitative assessments and qualitative feedback. The adaptation of a mixed-method design in future research on this subject may broaden the exploration and integration of these findings into clinical practice and illuminate what the participants themselves are experiencing. Furthermore, participants of this study specifically delivered synchronous telehealth music therapy sessions for people with dementia and/or their companions/family caregivers. Additional research on asynchronous music therapy resources included in telehealth music therapy delivery is warranted (see Knott & Block, 2020).

Limitations and Future Recommendations

This study has several limitations that must be considered when interpreting findings. While the sample size was appropriate given the selected methodology, further diversity among participants would enhance this study. Despite efforts to recruit music therapists from different parts of the world, the final sample consisted of individuals from Western, English-speaking countries. A potential limitation of this research could be the dual role of the first author in conducting interviews and analysing the data. There is a possibility that preconceived perspectives regarding telehealth music therapy may have influenced both the participants' and interviewer's responses, along with her impressions of the data. More research regarding the role of informal and formal caregivers in mediating the music therapy relationship is recommended. Sometimes engagement with caregivers is positive, in that what happens in music therapy can be continued during the week and resource the caregiver. However, reliance on caregivers can also reduce confidentiality for the client and influence the direction of therapy and further exploration is warranted.

Conclusion

The results presented in this research study suggest that telehealth music therapy is a valuable psychosocial support for some people with dementia and their caregivers and offers a feasible alternative for those who are unable to access in-person music therapy services in the community. Moreover, findings from this study indicate that a therapeutic relationship can be both established and maintained through music via telehealth music therapy. Barriers to community access appear to include increased cognitive decline, physical mobility issues, unreliable access to transportation, or geographical location. Digital literacy, access to technology, and caregivers support are important factors to be considered.

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Disclosure Statement

The authors report no conflict of interest.

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Appendix

List of Interview Questions

1. Did you provide telehealth music therapy to this population before March 2020 when social distancing was enforced?
2. Can you describe the type of telehealth music therapy sessions you provided to this population? Had you provided in-person sessions prior to this?
3. At what stage of the dementia trajectory were the clients that you worked with? Were there people at a certain stage that you think telehealth was more beneficial for?
4. Were clients able to engage in telehealth music therapy/with technology?
5. Can you describe some of the methods that you used in the telehealth sessions?
6. What are some of the practical considerations that had to be made when facilitating telehealth music therapy for this population?
7. What are some of the musical considerations that had to be made when facilitating telehealth music therapy for this population?
8. Did your clients have access to their own instruments? Do you think this impacted the scope of your practice?
9. Were there any technological limitations in terms of accessibility? How did you combat this?
10. Were clients able to access the session independently or was caregiver help necessary?
11. Did family caregivers participate in the sessions? In what capacity?
12. Do you think the therapeutic relationship was impacted?
13. Did you compile/provide any additional resources outside of the live telehealth session?
14. Have you continued to provide telehealth music therapy to this population since the easing of restrictions?
15. Do you think that telehealth music therapy services should remain available for this population?