Aligning Kitwood's Model of Person-Centered Dementia Care with Music Therapy Practice

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ABSTRACT: Person-centered dementia care has been extensively integrated into music therapy practice; its central aim being to meet the core psychological needs of people with dementia, uphold personhood, and contribute to enhanced quality of life. Furthermore, Kitwood's model has been widely referenced as the theoretical framework underpinning multiple studies with people with dementia. However, few studies explore it in more concrete terms, expand on how it is implemented in practice, or describe how "positive person work" can be facilitated in music therapy with this population. This paper aims to address these lacunae, by presenting a comprehensive overview of Kitwood's model; identifying how it has informed music therapy practice, and highlighting current applications of "person-centered music therapy" in relation to meeting the core psychological needs of people with dementia. Furthermore, the authors present practical considerations on facilitating "positive person work" in music therapy, drawing on their experiences of providing music therapy in dementia care.

Keywords: *person-centered music therapy, Kitwood, person-centered dementia care, positive person work, music*

Introduction

Over the past 35 years, there has been a major paradigm shift in dementia care from the traditional medical model, which focused on the deficits of the individual and prioritized organizational processes, schedules, and needs (Fazio et al., 2020). In contrast, person-centered dementia care, rooted in "client-centered therapy" (Rogers, 1961), was pioneered by Tom Kitwood in the 1980s (Kitwood, 1998). Kitwood's model provided a set of guiding principles that emphasized communication and meaningful relationships and put the person first, and the evidence base for technical or clinical interventions second (Dewing, 2008; Fazio et al., 2018). Its essence was expressed in the VIPS framework, which entails: *V*aluing people with dementia and those who care for them, treating them as unique *I*ndividuals; considering the *P*erspective of the person; and providing a *S*ocial environment supporting psychological needs and well-being (Brooker, 2007).

The tenets of Kitwood's work on personhood, malignant social psychology, psychological needs of people with dementia, and positive person work were seminal and remain the cornerstone of best practice, advocated internationally by healthcare organizations (National Institute for Health and Care Excellence [NICE], 2019; World Health Organization [WHO], 2017). To deliver high-quality person-centered care, there must be a clear understanding of the model by those working in dementia care (Colomer & de Vries, 2016, p. 1159).

Creative arts therapies and person-centered dementia care are "natural partners" that demonstrate a "concern for fullness of life, and prioritize connection, interaction and all forms of communication" (Kasayka, 2002, p. 9). Kitwood (1997) highlighted the importance of emotion and feeling in dementia care, and music is a natural vehicle that can hold and carry both (Ahessy, 2017). Historically, various music therapy (MT) approaches have drawn on humanistic holistic psychology (Noone, 2008), and practitioners continue to strongly identify with a "humanistic/person-centered" theoretical orientation (Ahessy, 2020) and integrate it into their practice. It focuses on individual experiences, creating meaning, "comfort, growth and continued well-being" (Hatfield & McClune, 2002, p. 84). When memory and cognitive function have diminished because of dementia, musical memory, perception, and music-related emotions are often preserved (Jacobsen et al., 2015; Särkämö, 2018). For this reason, MT is dynamic in eliciting and expressing emotions, feelings, and memories, while affording the capacity of narrative social agency, telling one's story, and participating in a more meaningful and mutually engaging social connection (Matthews, 2015). While music therapists have long integrated person-centered dementia

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care into their practice and research (Ahessy, 2017; Cho, 2018; Hatfield & McClune, 2002; Isaac et al., 2021; Kelly & Ahessy, 2021; Melhuish et al., 2019; Ridder & Aldridge, 2005; Simpson, 2000), very few studies expand on how this is achieved. Additionally, no authors, to our knowledge, have yet explored how "positive person work" (Kitwood, 1997) can be facilitated through MT. Therefore, the purpose of this paper is: (a) to outline the central tenets of Kitwood's model, (b) to present the current applications of "person-centered music therapy" (PCMT) in dementia care, and (c) to provide recommendations as to how positive person work can be implemented through MT.

Rationale and Method

This paper stemmed from the experiences of Authors 1 and 2 working as music therapists in dementia care, where Kitwood's (1997) model has underpinned our clinical work and research (Ahessy, 2017; Kelly & Ahessy, 2021). This work highlighted for us the need for a more robust exploration and reflection on how MT and person-centered dementia care align in practice. We developed the aims following an extensive literature review, engaging in reflective clinical discussions, as well as critical feedback from experienced music therapists working with this population. Additional reflection prompted by the anonymous reviewers of this paper has been pivotal and further informed its development.

The Tenets of Person-Centered Dementia Care

The Person's Perspective

Kitwood (1998) asserted that the social psychology of the care culture had a deep impact on the personal psychology of the person with dementia and for this reason proposed that the individual experiences of dementia must be understood from a biopsychosocial perspective. This lens highlighted the complex interactions that occur between the person's stage of neurological impairment, personality and coping style, life history, health, and the social environment in which they live (Kitwood, 1993). These factors inform and shape the experience and presentation of dementia (McDermott et al., 2014; Spector & Orrell, 2010). A key concept of Kitwood's model is the importance of engaging directly with the experience of people with dementia and understanding their viewpoint. Over the past decade, the perspective and lived experience of people with dementia and their caregivers are increasingly contributing to policy and debate (Gove et al., 2018). The input and reflective practice of caregivers is particularly important for care of people with advanced dementia (Clare et al., 2008).

Personhood

The key goal of person-centered dementia care is supporting personhood (Hennelly et al., 2018). Kitwood defined personhood as "a standing or a status that is bestowed on one human being, by another in the context of relationship and social being (Kitwood, 1997, p. 8). "Selfhood" and "self-identity" are intertwined and essential parts of personhood, which is primarily "concerned with how the person living with dementia perceives themselves" (Hennelly et al., 2018, para. 4) and with the things that really matter to them (Leibing, 2008). This includes the broader socio-cultural aspects and the person's intersecting identities which impacts their experience of the condition, for example, in working with LGBTQIA+ who have dementia (Peel & McDaid, 2015).

Kitwood defined good dementia care as sustaining the personhood of each person in the face of decreased abilities and increased cognitive impairment, and the understanding that people with dementia rely on those around them to replenish and uphold their personhood and sense of identity. Interpersonal relationships are key in building and maintaining personhood. Kitwood and Bredin (1992) highlight interventions that dissolve the dichotomy between "they and us" (the person with dementia and the caregiver), thus promoting intersubjectivity. Due to the cognitive decline that occurs with dementia, the caregiver can adopt the vital role of "holding" the person's story and supporting them in communicating it (Fazio et al., 2018). Attention to personhood includes acknowledging "the centrality of relationship, the uniqueness of persons [and] the fact of our embodiment" (Kitwood, 1997, p. 8). The person with dementia's active role in the care relationship is important (Baldwin et al., 2007; Dewing, 2008), as well as the personhood of the caregiver and their need to "experience relationships that promote a sense of security, belonging, continuity, purpose, achievement, and significance" (Clare et al., 2020, p. 1123).

Psychological Needs of People with Dementia

Kitwood (1997) identified the five core psychological needs of people with dementia as attachment, comfort, identity, inclusion, and occupation. This model regards behaviors such as agitation as a reflection of underlying unmet psychosocial needs and a communication of these. For this reason, creativity is highly valued within this person-centered care model, enabling the promotion and expression of personhood and opportunities for meaningful engagement and enriched relationships (Kitwood, 1997). A detailed description of each of these psychological needs are included in Table I.

Malignant Social Psychology and Positive Person Work

Kitwood (1997) was one of the first writers to emphasize the importance of the social environment in supporting personhood and meeting a person with dementia's psychological needs. "Malignant Social Psychology" was the term he used to describe 17 negative interactions (detractors) that undermined personhood. These include: intimidation, withholding, outpacing, infantilization, labeling, disparagement, accusation, treachery, invalidation, disempowerment, imposition, disruption, objectification, stigmatization, ignoring, banishment, and mockery. Kitwood hypothesized that negative detractors arose as a result of a lack of specialized education among healthcare professionals rather than for malicious reasons (Mitchell & Agnelli, 2015).

In contrast to malignant social psychology, Kitwood developed a new care culture he termed "positive person work," which aimed to fulfill the core psychological needs of people with dementia, giving greater attention to the person's existing strengths, individuality, and preferences (Kitwood, 1997). He described 12 positive interactions that support "personhood," and promote dignity, respect and enhance well-being. These are celebration, collaboration, creation, facilitation, giving, holding, negotiation, play, recognition, relaxation,

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Table I.

Simpson (2000), Hatfield and McClune (2002), and Ahessy (2017) presentation of Kitwood's (1997) "enriched model of psychological needs"

Simpson (2000, p. 182)	Hatfield and McClune (2002)	Ahessy (2017, p. 26)
***Attachment:* To have connection, to have trust, to have security, to have close bonds with people**		
The communicative potential of improvised music means that relationships may continue unimpeded by verbal losses.	Attunement through improvisation promotes attachment and inclusion and bolsters their unique role in the relationship. In a group context, inclusion and attachment are supported as "participants are reassured by others as they witness their experiences, "struggles and triumphs" (p. 91).	Engaging the client in musical dialoguing through improvisation, regardless of cognitive or communication deficits allows the person to express what they are experiencing and feel heard through interactive music-making. Central to this is recognizing the feelings and emotions a person has for present and past relationships and their current sense of reality.
***Comfort:* Tenderness, closeness, calming of anxiety, soothing of pain, bodily contentment, security, empathy, and support from another person**		
Music's consoling power can reach depths of the psyche that far surpass the level that can be reached by words.	Maximum comfort is achieved when the person with dementia informs the type of session (individual/closed/open group) that will best meet their needs. Intentional touch is an effective way to "provide support and comfort for the individual" (p. 104).	Demonstrating warmth and acceptance of the person when talking with them. Developing therapeutic alliance in a safe environment. Music-listening experiences and empathic music-making can provide consolation and support.
***Identity:* A sense of self, who we are, where we come from, a sense of continuity with the past, "a story to present to others" or that is held and maintained by others (Kitwood, 1997, pg. 83).**		
To experience oneself in a dynamic relationship with another reinforces a sense of self.	Autonomy, choice, and personal contribution to the music experience helps to reinforce identity, regardless of the ability to independently recall events and contributions brought forth by the therapist.	Identity and life story are promoted by song/musical preferences and music-based reminiscence. Singing, lyric analysis, and song writing can all validate personhood.
***Inclusion:* To belong to a group, to have social interaction**		
The music is created spontaneously and is incomplete without the individual's personal contribution.	A mutual exchange involving improvisation, inclusion, and encouragement by the therapist (and others) with the person can lead to attachment.	The therapist can enable the person to be involved both physically and psychologically. The client's spontaneous musical contribution supports shared interaction and increased awareness.
***Occupation:* Meaningful activity, use of abilities and skills, sense of agency, control to make things happen**		
Participative music-making concentrates the mind, encouraging the development of skill and imagination.	Active music-making can promote occupation.	Music therapy experiences that are participative can promote the mastering of new skills and provide meaningful experiences.

and timalation, and he highlighted "validation," "holding," and' facilitation' as having particularly psychotherapeutic value. These positive interactions offer caregivers the building blocks to implement high-quality care. Kitwood *et al*. later expanded "positive person work" in "Dementia Care Mapping" (Bradford Dementia Group, 2005), an observational tool to support the delivery of person-centered dementia care and provide a deeper understanding of the lived experience of people with dementia. In the tool, the 12 original positive interactions were extended to 17 and called "positive enhancers." These supported person-centered dementia care and stood in direct contrast to the 17 "negative detractors" associated with "Malignant Social Psychology" (Brooker, 2005). See Appendix 1 for how these align with the core psychological needs of people with dementia.

MT in Dementia Care

Music is used widely in dementia care to provide aesthetic pleasure, creative engagement, to improve quality of life and to enhance therapeutic programs (Ahessy et al., 2021; Brotons, 2000; Clair, 2011; McDermott et al., 2014; Tamplin et al., 2018; van der Steen et al., 2018; Vink, 2004) and is "considered the treatment choice by many clinicians and researchers" (Hanser, 2021, p. 160). Its focus on process, feelings, and relationships make it an especially appropriate range of applied interventions that meet the needs of people with dementia and provide support for caregivers (Cho, 2018: Baird et al., 2020). These include but are not limited to: individual MT (Ridder et al., 2013; Hsu et al., 2015); group MT (Chu et al., 2014; Clare et al., 2020; McDermott et al., 2013); therapeutic songwriting (Ahessy, 2017; Baker et al., 2018; Clark et

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al., 2020); therapeutic choir and group singing (Ahessy, 2015, 2016; Cho, 2018; McDermott et al., 2014; Tamplin & Clark, 2020; Tamplin et al., 2018), "reminiscence-focused MT" (Kelly & Ahessy, 2021), and technology-based music interventions (Dahms et al., 2021).

Community MT (Pavlicevic & Ansdell, 2004; Stige et al., 2010) has expanded beyond the micro level of individualized MT and considers the wider systems including: caregivers, families, staff, peers with dementia, care environments, and the community (Pavlicevic et al., 2015). This context-driven approach can support participation and connection and promote social capital and community well-being (Denis & Rickson, 2014).

Music therapists are increasingly involved in skill sharing, where they "work in parallel as well as in consultancy, advisory, and supervisory roles, with musicians not trained as therapists, and with carers" (Odell-Miller, 2021, p. 3). Recently, there has been a call for standardization, transparent qualifications, and the development of clinical guidelines that set out best practice for music therapists and other professionals who deliver music interventions (Hanser, 2021; Mercadal-Brotons et al., 2021).

PCMT in Dementia Care

Many years before the publication of Kitwood's model, music therapists in dementia care had been noting how music engagement contributed to significant improvements in quality of life such as social acceptance and sense of belonging gained by communicating with others (Aldridge, 1994). Since its inception, the principles of person-centered dementia care have been widely integrated in MT (Ridder & Wheeler, 2015) and have led to the development of PCMT, now synonymous with best practice (Ahessy, 2017; Hatfield & McClune, 2002; Ridder & Aldridge, 2005; Simpson, 2000).

A recent systematic review and meta-analysis revealed MT to be the second most frequent person-centered intervention, after reminiscence, for people with dementia (Lee et al., 2022). Music is a central part of being human and "communicative musicality" can support personhood, allowing us to understand more deeply the communication of people with dementia (Ridder & Wheeler, 2015; Trevarthen & Malloch, 2008). Furthermore, the "quality and sensitivity of the interpersonal process" in the care relationship can be easily mirrored in MT, where "relationship-building through musical interactions is the core of the therapeutic intervention" (McDermott et al., 2014, p. 707). Central to person-centered practice is knowledge of a person's music preferences, significant songs, life story, and interests as well as musical flexibility.

PCMT can support people throughout their condition and can enable them to "continue experiencing personal growth in spite of advancing cognitive impairments" (Hatfield & McClune, 2002, p. 84). For example, the music therapist might involve a person with mild dementia and their caregiver in a verbal reflection on a significant piece of music, engage a person with moderate dementia in therapeutic songwriting or respond musically to a person with advanced dementia's vocalizations. The improvisatory nature of live music affords the music therapist opportunities to mirror and musically reflect responses such as changes in breathing, eye movement, or vocalization, supporting meaningful connection. Simultaneously, the person with dementia can influence the live music and through improvised musical conversations experience an increased sense of agency (Clare et al., 2020). By musically matching an individual's level of awareness and cognitive function through music engagement, personhood is validated and expressed in the deepest and most meaningful way allowing the person with dementia to maintain their essential uniqueness (Robertson-Gillam, 2008).

Simpson (2000) heavily drew on Kitwood's work in a creative MT case study, which focused on the psychological and emotional needs of a man with advanced dementia. Music transcended cognitive and communicative deficits and supported non-verbal communication allowing the individual and therapist to "mean the same thing in the same moment" (Simpson, 2000, p. 171).

Hatfield and McClune's (2002) chapter highlighted the alignment between person-centered dementia care and MT practice and validated their integration through the introduction of the term PCMT. It illustrated how if music therapists assume the validity of Kitwood's core psychological needs (Kitwood, 1997) and uphold "personhood" through "recognition, respect and trust," they can successfully develop, implement, and interpret MT practices that support these concepts. A key principle of PCMT they highlight is that its effectiveness is proportional to the overall environmental support provided (Hatfield & McClune, 2002).

Ridder et al. draw attention to certain aspects of MT sessions that overlap with Kitwood's model and emphasize that "the heart of the matter (is) acknowledging the reality of a person's emotions and feelings and giving a response on the feeling level" (Ridder, 2005, p. 91; Ridder, 2011; Ridder & Aldridge, 2005; Ridder et al., 2009; Ridder & Wheeler, 2015). They illuminate how songs can stimulate memory and emotions in people with dementia as they "recognise and identify" themselves within them (Ridder & Aldridge, 2005, p. 100). Furthermore, MT holds ample possibilities for applying Kitwood's positive person work, particularly the psychotherapeutic interactions of "validation," "holding," and "facilitation" (Ridder & Wheeler, 2015).

In person-centered MT with a woman with Alzheimer's disease, Ahessy (2017) highlighted songwriting as "a potent technique" in upholding personhood, "for recovering one's narrative agency and allowing the authentic self to emerge" (p. 25). The client's musicality, personality, memories, life story, sense of humor, creativity, emotions, and feelings informed the MT and songwriting process, which validated and strengthened identity, afforded the client opportunities to express difficult-to-verbalize emotions and process what was happening in her life.

Two recent MT studies in dementia care embraced Kitwood's work (Cho, 2018; Swall et al., 2020). In a MT singing intervention with a focus on individual choice and needs (Cho, 2018), person-centered philosophy informed the goals of promoting a sense of self-worth, belonging, and accomplishment. In addition, the recognition of identity and maintenance and development of selfhood through interactions and communications were cited as fundamental components of person-centered care. In another study (Swall et al., 2020), caregiver singing fostered person-centered connection in the care dyad. It "allows bridges to be built and an unspoken understanding of the situation. They meet at a level that only singing makes possible" (Swall et al., 2020, p. 7).

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MT: Meeting the Psychological Needs of People With Dementia

Kitwood's "enriched model of psychological needs" has been explored by various MT authors. Simpson (2000) first illustrated how creative MT resonates with the model, while throughout their chapter, Hatfield and McClune (2002, p. 95) outline how the "completeness of the musical experience" meets the core psychological needs of people with dementia. Ahessy (2017) extended Simpson's (2000) interpretation of the model and offered ways in which music therapists can "provide support, meaning and beauty" through person-centered practice (Ahessy, 2017, p. 29). These three interpretations are presented in Table I.

Facilitating Positive Person Work Through MT

In the following section, we aim to define the interactions of "positive person work" and offer practical considerations on how to facilitate them in MT.

Celebration. Celebration is any moment in one's life, which is experienced as "intrinsically joyful" (Kitwood, 1997, p. 90). It is an interaction in which "the division between caregiver and cared-for comes nearest to vanishing completely," as selfhood is expanded and a similar positive mood is shared (Kitwood, 1997, p. 91). The music therapist, caregiver, or family member and the person with dementia as equal partners experience and celebrate together moments of joy that occur through creative expression, interaction, and achievement.

Examples in practice may include: (a) being in the moment with the person who is happy and celebrating, clapping, singing, and dancing, (b) recognizing, supporting, and taking delight in the person's skills and achievements, (c) celebrating the person's independence within a session, or (d) celebrating through musical expression, such as a favorite song, or joyful or energetic music-making.

Collaboration. Collaboration means "working together." The music therapist and person with dementia are an equal partnership and should work collaboratively in such a way that the person feels supported in a process in which their own initiative and abilities are involved" (Kitwood, 1997, p. 90).

Examples in practice include: (a) allowing space and time for the person with dementia to initiate musically through instrument, voice, or movement, (b) maximizing the person with dementia's abilities and strengths and allowing them to inform the type of music experience, or (c) working in collaboration through music, for example, rhythmic musical activities, singing, composing a song together, improvising on an instrument or with voice together, etc.

Giving. Acknowledgement and accepting expressions of kindness by the person with dementia such as "concern, affection or gratitude, an offer of help, or presentation of a gift" (Kitwood, 1997, p. 93). Ultimately, this acknowledges the active role of the person with dementia in creating a reciprocal interpersonal and musical relationship with another person and recognizing the rich musical–cultural–social resources that they contribute to sessions (Rolvsjord, 2010 in Pavlicevic et al., 2015).

Examples in practice include: (a) receiving and appreciating the interpersonal, cultural, and musical offerings (the person with dementia gives) that foster the therapeutic relationship, (b) receiving what the person with dementia offers verbally (memory, story, joke, and feedback), musically (significant song, piece of music, and improvisation), or creatively (artwork, poem, rhyme, or movement), (c) the person with dementia offers to help the therapist or a peer in the session, or (d) the person with dementia expresses warmth and appreciation toward the therapist.

Creation. Kitwood (1997) reinforces the need for therapeutic activities for people with dementia and emphasizes that wherever possible, they should be self-initiated and meaningful. Creation empowers people with dementia to harness their creativity and use it as a resource when engaging in preferred activities and experiences (Hobson, 2019). The therapist provides a variety of creative experiences, so that the person can explore, express, and initiate in music, other creative experiences, or recreational activities that they are drawn to (cooking, gardening, pets, etc.).

Examples in practice include: (a) the person with dementia may spontaneously begin to tap a rhythm, sing, vocalize, dance, or recite a poem within a session, (b) the person with dementia invites others in a MT group to join in with their expression, (c) the person with dementia initiates a significant song, or (d) the person with dementia incorporates preferred interests and activities into MT.

Facilitation. Facilitation involves enabling a person to do what otherwise they would not be able to do, by assessing the level of support they need and providing it. Facilitation initiates and amplifies an interaction that a person may then enhance with meaning and thus extends the strengths and capacities that the person maintains (Kitwood, 1997, p. 109). It is similar to collaboration, except that the music therapist primes the interaction and may scaffold certain music experiences.

Examples in practice include: (a) omitting the last words at the end of a phrase in a preferred song to facilitate spontaneous self-expression, (b) allowing ample time during and between music experiences for processing, meaning–making, and reflection, (c) modifying of instruments so that the person can express themselves freely despite physical limitations, or (d) using a person's life story and music preferences to facilitate reminiscence. Music may also be also used for mnemonic purposes to assist retention of newly acquired verbal information or as a support for "chaining" to relearn tasks or activities of daily living in various steps (Moussard et al., 2014).

Holding. Holding means providing a safe psychological space, "a container"; where hidden trauma, distress, pain, and conflict can be brought out and managed safely by the therapist. Winnicott (1990, p. 28) asserted "holding can be done well by someone who has no intellectual knowledge of what is going on in the individual; what is needed is a capacity to identify, to know what they are feeling like." When the holding is secure a person can know, in experience, that overwhelming emotions and feelings can pass. "Holding" can be generated by how the music therapist uses themself and the environment—attuning to the person and creating a safe, consistent, and boundaried environment.

Examples in practice include: (a) ensuring the person feels held through the safety of the therapeutic relationship, (b) using a musical ritual to begin or end a session can create safety and consistency, (c) attuning musically to the person and matching their expression can provide a "container" for feelings and emotions, (d) holding the client's feelings while

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still remaining grounded, or (e) providing soothing or familiar music to support holding and security.

Negotiation. The characteristic feature of negotiation is that people with dementia are consulted about their preferences, desires, and needs, rather than being subjected to others assumptions (Kitwood, 1997). As a starting point, the music therapist might assess if the person wants to engage in MT and if so, in what context. PCMT promotes autonomy and agency, consulting with the person, taking their lead, including their preferences, and supporting them to be involved in decision-making. Skilled negotiation acknowledges the anxieties and insecurities and level of cognitive impairment of people with dementia and "puts the power back into their hands" (Kitwood, 1997, p. 90).

Examples in practice include: (a) offering a choice of engaging in MT or not, (b) offering a choice of experience (individual, with caregiver or family member, group, therapeutic choir, music and movement, music and relaxation, etc.), (c) offering a choice of location (bedroom or public area) and time, (d) offering active and receptive experiences, instrument and song choices, and (e) engaging in appropriate pacing and supportive communication to facilitate meaningful decision-making and choice.

Play. Play is central to creativity and in its purest form is spontaneous and has no goal that lies outside the activity itself, but rather is an exercise of self-expression which is itself a valuable experience (Kitwood, 1997). Through mutual play, we share experiences about ourselves and creatively express the instinctive aspects of our personality (Malloch & Trevarthen, 2018). Play "is a means of mastering the gap between the inner and outer world" and in MT may include bodily, musical, and vocal expressions and actions (Hart, 2011, p. 95).

Examples in practice include: The use of any creative experiences within MT that promote playfulness including (a) instrumental and vocal improvisation, (b) movement to music, (c) dance, and (d) singing. These allow in-the-moment creative expression of self and act as a bridge between the internal and the external. PCMT supports the development of playfulness and self-expression through spontaneous and interactive music experiences. Musical play fosters meaningful non-verbal communication and connection.

Recognition. The person is identified as an individual and their unique thoughts, feelings, and preferences are acknowledged and validated (Kitwood, 1997). It is imperative that people with dementia are recognized in context of their intersecting identities (gender, age, nationality, culture, sexual orientation, race, ethnicity, religion, belief, socioeconomic status, education, ability, and cognitive impairment) and that music therapists consider the impact they have on the individual life experience. Recognition can be verbal or non-verbal and supported with gestures, facial expression, eye contact, appropriate touch, and music. "Recognition may be achieved in a simple greeting, or in careful listening over a longer period" to a person's life story (Kitwood, 1997, p. 90). The person's music preferences, interests, and life story inform MT and affirm their unique experience.

Examples in practice include: (a) incorporating the person's name or other biographical information into personalized songs, singing familiar or significant songs, or improvisational experiences, (b) reviewing their life through music (Grocke & Wigram, 2007), (c) reminiscence prompted by music, (d) songwriting based on a person's past or present experiences, providing an outlet for their feelings and emotions (Ahessy, 2017), or (e) creating a playlist of the person's significant songs.

Relaxation. Relaxation acknowledges the need for stillness and tranquility. Therapy can provide a quiet and peaceful experience that supports calmness and reflection, where sound is contrasted with silence. Due to their strong social needs, many people with dementia can only relax when others are near them. The music therapist or caregiver can become an anchored presence, holding the space, offering support and comfort, and meeting the person's need for attachment (Kitwood, 1997). Self-selected music in the genre and style that the person enjoys is most beneficial for relaxation. Inevitably, at the later stages of the condition, the music therapist may need to choose the music, taking regard of the age, level of energy, physical health state, and mood of the person (Grocke & Wigram, 2007).

Practical examples include: (a) listening to a preferred song or piece of music (recorded or live), (b) using personally chosen music with guided relaxation or meditation, (c) using personally chosen music with hand massage or sensory input, (d) matching the person's breath with music, or (e) sharing skills or providing music and relaxation resources to caregivers to incorporate into daily care.

Timalation. Timalation refers to all forms of interaction, where the prime modality is sensory; stimulating the sensory channels that are still intact (vision, touch, hearing, smell, taste, and movement). Timalation is suitable at any stage of dementia as it provides contact, reassurance, and pleasure. It can be facilitated during daily care by caregivers stimulating the intact senses, particularly with people at end-stage dementia. MT readily blends aural input with the other senses and is highly suitable as part of sensory work in combination with hand massage and in sensory rooms.

Examples in practice include: (a) using a variety of instruments that provide tactile vibroacoustic feedback. This may be useful when a person has hearing deficits, (b) movement to music—holding the person's hand while swaying to the rhythm of the music, (c) the use of sensory items (touch/taste/smells) within sessions (Kelly & Ahessy, 2021), or (d) training the caregiver in the use of music sensory techniques as part of daily care.

Validation. Validation involves seeing things from the reality of the person with dementia and acknowledging and responding to their emotions and feelings with empathy, sensitivity, and patience. Central to this is an awareness of how mental health needs and the care environment influence behavior (Brooker, 2007; Hobson, 2019). Validation aims to reduce stress and anxiety and minimize withdrawal for people with dementia by stimulating residual skills, fostering meaningful interaction, and validating the person's feelings (Feil, 1993). "When our experience is validated, we feel more alive, more connected and more real" (Kitwood, 1997, p. 91). MT offers opportunities for validation on multiple levels.

Examples in practice include: (a) accepting the individual's subjective experience without judgment, (b) expressing creatively through music with the person's experience and reality in the moment, or (c) acknowledging the person's emotions and feelings and reflecting them musically through vocal or instrumental improvisation or songwriting.

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Conclusion

Kitwood's (1997) conceptual approach to care offers a framework, bolstered by guiding principles that reinforce and support personhood and well-being for people with dementia and encourages caregivers, health professionals, and music therapists to "focus less on what is done and more on how it is done" (Fazio et al., 2018, S11). Person-centered care aligns closely with MT practice in dementia care and for the last quarter of a century, music therapists have recognized this congruence and adopted and integrated this approach into their work. The influence of community MT and its "broad perspective exploring relationships between the individual, community, and society in relation to music and health" have expanded PCMT outside the therapy room and beyond (Stige et al., 2010, p. 15–16).

This paper collates and outlines the work published to date on meeting the core psychological needs of people with dementia through PCMT (Ahessy, 2017; Hatfield & McClune, 2002; Simpson, 2000) and in many ways highlights the shared vision that person-centered care and MT possess. To add to this body of knowledge, we provide reflections and recommendations on facilitating "positive person work" based on our experience of working as music therapists and researchers in dementia care settings. We hope that they will encourage reflection and guide practitioners in recognizing and implementing "positive person work" in their practice. MTs flexibility and improvisational nature creates a focus on the whole person and their lived experience and perspective. It offers multiple opportunities for upholding personhood, meaningful engagement, and increased well-being for people with dementia.

Although person-centeredness is recognized as a core value of dementia care by both international and national authorities, there is sometimes a disparity between policy and practice (Colomer & deVries, 2016). It can be challenging for care providers, aged-related services, and hospitals to provide truly person-centered care; something that is often perceived as idealistic (Richter et al., 2022). Only by listening to the voice of people with dementia will it be possible to understand their lived experience and provide truly person-centered care (Brooker, 2004). The embedment of MT within dementia care settings offers ample opportunities for this. Through the facilitation of positive person work and the continued integration and development of person-centered care with clients, caregivers, family members, care providers, and stakeholders, music therapists can contribute to the "ripple effect" MT can have on micro, meso, and macro levels in dementia care, providing multiple opportunities for "flourishing, shared participation, and for expanded self-identities" (Pavlicevic et al., 2015, p. 659).

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Appendix 1

Positive enhancers	Negative detractors
Attachment	
Acknowledgement—Recognizing, accepting, and supporting the person as a unique and valued individual.	*Accusation*—Blaming a person for things they have done or have not been able to do.
Genuineness—Being open and honest with a person in a way that is sensitive to their needs and feelings.	*Treachery*—Using trickery or deception to distract or manipulate a person in order to make them do or not do something.
Validation—Recognizing and supporting the reality of the person. Sensitivity to feeling and emotion must take priority.	*Invalidation*—Failing to acknowledge the reality of a person in any situation.
Comfort	
Warmth—The demonstration of care, concern, or affection for another person.	*Intimidation*—Making a person frightened or fearful by using spoken word or physical power.
Holding—Providing safety, security, and comfort.	*Withholding*—Refusing to give asked for attention, or to meet an evident need for contact.
Relaxed Pace—Recognizing the importance of helping create a relaxed atmosphere and allowing ample time for the person to engage.	*Outpacing*—Providing information and presenting choices at a rate too fast for a person to understand.
Identity	
Respect—Treating a person as a valued member of society and recognizing their experience and age.	*Infantilizing*—Treating a person in a patronizing way as if they were a small child.
Acceptance—Embracing the person's reality and demonstrating positive regard.	*Labeling*—Using a label as the way to describe or relate to a person.
Celebration—Recognizing, supporting, and taking delight in the skills and achievements of a person.	*Disparagement*—Telling a person that they are incompetent, or incapable through words or actions.
Inclusion	
Recognizing—Meeting a person in his or her own uniqueness, bringing an open, unprejudiced attitude.	*Stigmatizing*—Treating persons as if they were a diseased object.
Including—Enabling and encouraging a person to feel and be involved, physically and psychologically.	*Ignoring*—Carrying on in conversation or action in the presence of a person as if they are not there.
Belonging—Providing a sense of acceptance in a particular setting regardless of abilities and disabilities.	*Banishment*—Sending a person away or excluding them physically or psychologically.
Fun—Finding a way to use positive humor and encouraging the person to do so.	*Mockery*—Making fun of a person, teasing, humiliating, or making jokes at their expense.
Occupation	
Empowerment—Assisting a person to discover or employ abilities and skills.	*Disempowerment*—Not allowing the person to use the abilities they have.
Facilitation—Assessing levels of support required and providing them.	*Imposition*—Forcing persons to do something, over riding their own desires or wishes. Denying them choice.
Enabling—Recognizing and encouraging a person's level of engagement within a frame of reference.	*Disruption*—Intruding in or interfering with something a person is doing or crudely breaking their frame of reference.
Collaboration—Treating a person as a full and equal partner in what is happening. Consulting and working with them.	*Objectification*—Treating persons as if they were an object.

Adapted from Bradford Dementia Group (2005).