



## Song parody for adolescents with cancer

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### Abstract

*Cancer treatment can be extremely stressful during adolescence, which is regarded as a period of searching for personal identity, striving for personal control and perceived invulnerability to illness and death. This article examines some of the challenges facing adolescents undergoing cancer treatment in hospital and provides an overview of necessary interventions for these patients. Music therapy literature supports the use of compositional methods to address the unique psychosocial needs of adolescents with cancer. A case study is presented, which demonstrates that song parody can assist an adolescent in adjusting to cancer and treatment.*

In recent years several authors have used knowledge of developmental tasks to inform music therapy work in the paediatric setting (e.g. Barrickman, 1989; Kennelly, 1999; Robb, 1996, 1999). These authors have emphasised that an understanding of developmental considerations is necessary in order to facilitate a patient's adjustment to hospitalisation.

Developmental concerns seem to be lacking in health care provision for adolescents. Adolescents are often admitted to children's wards or adult wards, depending on physical size, age and bed availability, rather than psychosocial needs (Taylor and Müller, 1995). Research suggests that neither of these environments are ideally suited to adolescents (Burr, 1993) and there is a need for therapeutic interventions appropriate to adolescents' developmental levels.

Music therapy, specifically the use of song parody, is one intervention that can address the unique needs of adolescents. This article focuses on the needs of adolescents with cancer and presents a case study of a song parody program designed to address such needs.

### Cancer Treatment

The term cancer refers to those diseases that involve the uncontrolled growth and spread of abnormal cells. In order to combat these abnormal cells, a person with cancer may require surgery (e.g. amputation), chemotherapy, radiation therapy, or a combination of these treatments. Treatment protocols require recurrent and/or prolonged hospitalisations, and are therefore highly disruptive to daily life (Queensland Cancer Fund, 1994).

In addition, these treatments can have a number of unpleasant side effects. These include: hair loss, headaches, nausea and vomiting, mouth ulcers, weight loss or gain, mood changes, skin rashes, sun sensitivity, lowered blood counts and risk of infection, growth abnormalities and impaired reproductive capability. Roberts, Turney and Knowles (1998) reported that these treatment side effects often seem worse than the disease itself.

### Cancer Treatment and Adolescence

Cancer treatment can be particularly stressful during adolescence, when a young person is already experiencing major physical, cognitive, social and emotional changes. Chronological definitions of adolescence vary widely. Many equate adolescence with the teenage years, other definitions state that adolescence begins as early as 10 years of age. Some experts on adolescence argue that there are two subperiods, a transition period beginning at age 11 or 12 (early adolescence) and a consolidation period beginning at age 16 or 17 (late adolescence) (Bee, 1998). Due to marked individual differences, it is more useful to define adolescence in terms of



developmental characteristics. According to developmental theorists such as Erikson, Freud and Piaget, adolescence is a period of searching for personal identity, striving for personal control and perceived invulnerability to illness and death (Bee, 1998; Rowland, 1990; Taylor and Müller, 1995). These characteristics are complicated by cancer and its treatments.

Adolescence is a time when personal identity is largely defined by one's relationships with peers. Self-esteem is closely linked with peer acceptance, and adolescents strive to "fit in" with the crowd, rather than be seen as different. Adolescents typically become concerned with their physical appearances and attractiveness to potential partners. Self-image is also defined by one's participation in school life. An adolescent's self-worth is often dependent on academic or sporting ability, and plans for a career may begin (Ragg, 1994; Roberts et al., 1998; Rowland, 1990; Taylor and Müller, 1995).

Adolescents with cancer are separated from their peers. They spend much of their time in hospitals, thinking and talking about cancer and treatments, rather than teenage concerns. As explained in the previous section, cancer treatment can cause adolescents to look different to their peers. Recurrent hospitalisations may result in frequent absences from school, which in turn may lead to decreased academic performance. Weakness may also mean decreased ability to participate in favourite hobbies and interests, and may render future plans unrealistic. Ragg (1994) reported that many adolescents with cancer lose self-confidence and withdraw from friends when experiencing such changes.

Adolescence is also a time of striving for personal control and independence from parents (Ragg, 1994; Roberts et al., 1998; Rowland, 1990; Taylor and Müller, 1995). However, an adolescent with cancer has little control over the cancer, treatment or restrictive routine of the hospital ward. In addition, parents who had begun to allow freedom, may revert to being protective when their children are ill. Ragg stated that many parents become overprotective – making decisions about an adolescent's care behind his/her back, trying to control minor aspects of the adolescent's life, or not allowing an adolescent necessary privacy. Rowland reported that adolescents with cancer commonly respond to diminished freedom and parental overprotectiveness by regressing to an earlier developmental level (being dependent again), or by being angry and non-compliant with treatment.

Finally, adolescents typically view themselves as invulnerable to illness and death. Whilst they are usually capable of understanding the finality and universality of death, ego-centric thinking leads to a view that it "can't happen to me" (Rowland, 1990). As a result, adolescents with cancer commonly become shocked or deny they are ill upon diagnosis (Ragg, 1994; Rowland, 1990).

### **Appropriate Interventions**

To meet the unique needs of adolescents with cancer, several authors have recommended interventions which encourage interaction with peers and continuation of normal activities, minimise feelings of diminished control and provide adolescents with opportunities to talk about their anxieties (Ragg, 1994; Roberts et al., 1998; Rowland, 1990; Taylor and Müller, 1995).

Roberts et al. (1998) stated that peer groups are ideally suited to meeting many of the psychosocial needs of the adolescent with cancer. However, in the paediatric setting there are often very few adolescents in hospital at the one time, making establishment and maintenance of age-appropriate support groups difficult. Instead, health professionals can assist an adolescent to feel more normal by encouraging continuation of normal activities. Rowland (1990) recommended that adolescents be encouraged to continue school work while in hospital and be provided with opportunities to explore new areas of expertise or mastery. There is considerable evidence to indicate that music is a normal part of an adolescent's experience. Adolescents in industrialized countries listen to music daily and buy the majority of popular music recordings (Arnett, 1995). Larson (1995) reported that popular music listening peaks during adolescence.



Taylor and Müller (1995) suggested that health professionals can meet adolescents' needs for independence, by providing open and detailed communication. Adolescents should be involved in decision making and care planning whenever feasible. Health professionals may restore feelings of control, by offering adolescents as many options as possible and allowing them to choose for themselves. Arnett (1995) proposed that the diversity of music available allows adolescents a high degree of choice and freedom. Adolescents can choose music which best suits their individual preferences and personalities, and use it to control their moods, explore possible identities and create meaning in their lives.

Roberts et al. (1998) suggested that in order to cope with their fears and frustrations, adolescents with cancer need to express views about their physical appearances, treatments and procedures, family over-protectiveness and the possibility of death. In the absence of peers, adolescents may feel more comfortable talking about these sensitive topics with a trusted member of the treatment team, rather than with family members. Larson (1995) stated that "it is in music listening that we see the clearest manifestation of the private self" (p. 45). He emphasized that through listening to music, adolescents explore their fantasies and concerns for the future. This suggests that music may be an ideal medium for developing a trusting relationship and enabling expression of feelings.

### **Therapeutic Song Writing**

The literature states that music therapy is an effective means for providing opportunities for self-expression, choice and feelings of mastery. Music therapists have demonstrated that therapeutic song writing is one intervention that provides these opportunities.

Hadley (1996) and Kennelly (1999) have reported that song writing can assist patients who hide their emotions or find it difficult to express their feelings in words. These authors have explained that song writing can be an effective non-threatening medium for stimulating or enhancing unguarded expression. Both Hadley and Kennelly have presented examples of songs through which adolescents with leukaemia have expressed desires to remain positive through cancer treatment. Hadley stated that activities such as song parody, which involve changing the words to an existing song, can "delight, surprise and stimulate, . . . and this . . . increases the sense of mastery of the environment" (p. 20). In the current author's experience, the idea of parodying songs is highly appealing to adolescents, perhaps because popular music is such a normal and valued part of their lives. Through writing their own lyrics to a favourite song, adolescents not only express themselves but also gain a unique sense of accomplishment.

Edwards (1998) also recommended song writing procedures, including song parody, to facilitate expression of feelings about hospitalisation and treatment. Although describing work with paediatric burns patients, Edwards emphasised that patients can be offered choice over their level of participation in song writing. Edwards suggested that a patient should choose whether or not to write a song, make final decisions on the lyrics, and decide on the future of the song. Recording the song on paper or cassette was recommended, to provide the patient with tangible evidence of his/her achievements. The value of music therapy in providing opportunities for mastery and control within a mostly restrictive environment is well established by Edwards.

Robb (1996) reported that therapeutic song writing can enable hospitalised adolescents to express their unique concerns. Three song parodies were presented, in which adolescents expressed their frustrations. Robb reported that the structure of an existing song can make the song writing process seem less overwhelming, and ensure success for the patient. This is important for an adolescent with cancer, who is likely to be experiencing diminished self-confidence.



## Case study: Chelsea

Chelsea was 12 years old when she was admitted to a large paediatric hospital with enlarged lymph nodes. She was subsequently diagnosed with B-cell lymphoma, a cancer involving cells of the lymphatic system. Her doctor considered this disease to be life-threatening but thought it likely that Chelsea would make a full recovery with appropriate treatment. Chelsea was to receive aggressive chemotherapy (cytotoxic drugs) in cycles over the coming months.

At the time of her cancer treatment, Chelsea was an only child, and her parents were reported as “amicably separated”. Chelsea lived with her mother, although her father remained involved in her care. Chelsea’s parents were born in Eastern Europe and Chelsea and her mother often communicated in Hungarian.

Chelsea was in her final year of her local Catholic primary school. She was popular amongst her peers, and had achieved excellent school results. She enjoyed school, and her favourite hobby was riding and looking after horses.

Nursing staff reported that Chelsea was very intelligent, positive, friendly and highly co-operative with treatment. Chelsea’s cousin had survived leukaemia 5 years earlier, and this may have contributed to Chelsea’s denial of the seriousness of her illness. The oncology psychosocial team were concerned that by “being brave”, Chelsea was in fact avoiding issues concerning her illness, treatment and hospitalisation.

Chelsea’s mother was openly stressed and scared. She was observed as being tearful and seemed to expect the worst, saying “I wish I’d had another child”. Oncology staff reported that Chelsea’s mother had different views of what Chelsea wanted and needed, to those held by Chelsea. This often caused conflict, as evidenced later in the music therapy program.

The psychosocial team had also noticed evidence of declines in Chelsea’s confidence since admission. For example, the ward school teacher reported that although Chelsea had initially expressed a keen interest in continuing school work, she didn’t attempt any work given to her.

The other staff members referred Chelsea to the music therapist to increase her self-expression and control opportunities. It was also perceived that Chelsea might benefit from being involved in a “normal activity”.

### Music Therapy Assessment

Through assessment, the music therapist was aiming to ascertain Chelsea’s musical preferences and experience, consolidate knowledge of Chelsea’s needs and determine appropriate goals and techniques for Chelsea’s music therapy program.

The music therapist initially met with Chelsea and her mother to arrange a time for the assessment session. During this time, the music therapist explained the role of music therapy and Chelsea agreed that she’d like to “give it a try”. Chelsea stated that her favourite singer was Britney Spears (no. 1 on the Australian popular charts at the time) and her mother added that Chelsea had previously learnt piano.

During her music therapy assessment session (thirty minutes), Chelsea appeared more comfortable expressing herself musically than verbally. The music therapist brought in a metallophone and introduced Chelsea to improvisation. This instrument was selected out of the other instruments available because it was portable and least likely to be perceived as childish. Chelsea seemed confident when engaging in improvisation on the metallophone, stating “it’s just like the piano without the black notes”. She and the therapist shared the instrument at first. Chelsea initiated musical material and laughed as the music therapist imitated her rhythms. Chelsea seemed struck by the timbre of the metallophone, naming the improvisation “Ding Dong”. In a second improvisation, Chelsea played on her own. This improvisation sounded more disjointed and exploratory, jumping from pitches at one extreme to the other and lacking a clear sense of beat. Chelsea named this improvisation “Jerky Jerk”.

Chelsea appeared reluctant to express herself verbally. She responded to questions about how



she was feeling with one-word answers (“good”, “yes” or “no”). The music therapist explained that music therapy is a time when patients can talk about how they are feeling. To this, Chelsea replied “my family doesn’t like to talk about things”. (Chelsea’s mother was not present during this first session.)

Chelsea seemed to recognise that feelings could be expressed through songs. After the song *Iris* (Rzeznik, 1998), Chelsea stated, “I like the lyrics, but they don’t relate to me”. Similarly, Chelsea identified that she liked the positive attitude of the song *I will Survive* (Fekaris and Perren, 1978). These were songs that Chelsea had selected out of those in the therapist’s songbook.

Before the end of this assessment session, Chelsea asked what other sorts of activities she could do in music therapy. The therapist explained that she could sing songs, write her own songs, learn an instrument, or simply listen and talk about music. Chelsea then said that she wanted to write her own songs, and learn the guitar for something new.

Chelsea’s mother seemed to be trying to retain control over her daughter’s life. Before the second music therapy session, Chelsea’s mother told the therapist that Chelsea was too sick for music. The music therapist felt that she was restricting her daughter’s ability to choose and that music therapy could be of benefit to Chelsea if she was feeling ill. For these reasons, the therapist requested that Chelsea’s mother ask Chelsea if she wanted a session (including the mother in the decision process). Chelsea said that she did wish to see the music therapist. Her mother then took the therapist aside and stated, “Today you are like radio, you do not ask questions, you do not make her sing”. The music therapist found it necessary to explain to Chelsea’s mother that music therapy aims to provide choices, and that Chelsea would not be doing anything against her will. Chelsea’s mother then began to use music therapy sessions as a time out for herself, suggesting that she understood the importance of allowing Chelsea to be independent.

### Goals and Objectives

After the music therapy assessment, appropriate goals and objectives were devised for Chelsea’s music therapy program. The goals were to encourage Chelsea to express herself and to provide her with opportunities to experience mastery and control. Objectives related to song parody were that Chelsea would verbalize feelings about her illness, treatment and hospitalisation, verbalize feelings of success during music therapy and make decisions as to her level of participation, songs to be sung and the lyrics of her own songs. It should be emphasised that whilst verbal responses were anticipated as concrete outcomes, it was intended that these responses would be achieved through musical means, i.e. parodying the song.

### Method

Chelsea received a further twelve 1:1 music therapy sessions, over a period of ten weeks. Sessions were between a half-hour and an hour long, and took place in Chelsea’s room on the oncology ward. It was Chelsea who decided on the content of music therapy sessions. Chelsea chose to participate through song parody, lyric discussion, or learning the guitar, depending on her health on the day.

During her second music therapy session, after the song *I will Survive* (Fekaris & Perren, 1978), the therapist asked Chelsea whether she was still interested in writing her own songs. Chelsea suggested that *I will Survive* was a song about a “love kind of surviving”, and maybe it could be changed to be about “a sickness kind of surviving”. Over the next 3 sessions, Chelsea and the therapist worked on the song line by line. The therapist would sing a line, then use verbal probing and clarifying techniques to ascertain whether it needed to be changed, or suited how Chelsea was feeling. After Chelsea and the therapist had discussed an issue, Chelsea decided on the exact wording of the lyrics, the therapist sang them back and if satisfied, Chelsea recorded the words on paper.



## Outcomes

The lyrics of Chelsea's song were as follows:

At first I was afraid, I was petrified,  
I kept thinking I could never live without a normal life,  
I spent so many nights just thinking what went wrong,  
I grew strong, I learned how to get along.

And so you're here from outer space,  
I just walked in to find you here with those lumps across your face,  
I should have changed my stupid lock, I should have hidden my special key,  
If I'd have known for just one second you'd be here to bother me.

Oh now go, walk out the door,  
Just turn around now, you're not welcome any more.  
Weren't you the one who tried to break me with disease?  
Did you think I'd crumble? Did you think I'd lay down and die?  
Oh not I!

Chorus:

I will survive.  
As long as I know how to fight, I know I'll be alive.  
I've got all my life to live, I've got all my strength to give,  
I will survive, I will survive.

It takes all the strength I have just not to fall apart,  
I'm trying hard to keep the bad things out of mind,  
I spent so many nights just wondering how long this'll go on.  
I used to wonder, but now I hold my head up high and just fight!  
(Repeat chorus)

Through changing some of the words, and retaining others, Chelsea expressed feelings about her illness and treatment. Chelsea admitted that she felt afraid when first told that she might have cancer, and was worried as to how she would cope without a normal life. She also expressed that she wanted to know what had caused the cancer, and how she could have prevented it.

Similarly to the adolescents described by Hadley (1996) and Kennelly (1999), Chelsea expressed a desire to remain positive. She personified the cancer, as an alien with lumps across its face, and expressed a wish to continue "fighting it". In writing the final verse, she said it was difficult to keep a positive attitude when she felt awful all the time. Chelsea said that the morphine made her sleepy, and that her mouth hurt. She said that the only way she could cope was to keep busy – "to keep the bad things out of my mind". Chelsea's use of war imagery to cope (considering cancer treatment as battling an enemy) is common among adolescents with cancer (Ragg, 1994).

Initially, Chelsea seemed to be projecting her feelings onto someone else. She suggested, "maybe the song could be about someone who has had cancer, and it is coming back". However, as work on the song progressed, Chelsea came to speak about herself. For instance, she said, "I'm wondering how long this'll go on".

On the whole, the song parody process was very useful for identifying what Chelsea was experiencing. Furthermore, the song served as an effective reference, when exploring feelings further in later sessions.

The song parody procedure also provided opportunities for feelings of mastery and control.



When she completed her song, Chelsea appeared very proud and excited. She stated that she wanted her mother and a favourite nurse to hear the finished product. During these performances, Chelsea sang loudly along with the music therapist and spontaneously performed gestures along with the lyrics. This was the first time Chelsea had ever sung during music therapy. "You know why I like this song? . . . because I wrote it!", she squealed.

Music therapy was a time when Chelsea made decisions for herself. It was Chelsea who chose to write the song parody, selected the song she would change and how to change it, and what she would do with the final product.

### Conclusions

Song parody was an effective method for assisting this young adolescent to adjust to cancer, treatment and hospitalisation. Changing the words to a favourite song appeared to be a novel, non-threatening medium for expression of worries and frustrations normally avoided. A line by line procedure ensured success for this adolescent, who showed signs of decreased confidence in the absence of her peers and normal activities. Throughout the process, music therapy offered choices in an otherwise restrictive environment. Through addressing needs specific to developmental levels, music therapy can assist adolescents in their fight to survive cancer.

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