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Staff perceptions of how music therapy can support palliative care patients in a New Zealand / Aotearoa hospice, with a particular focus on spiritual care.

A thesis submitted in partial fulfillment of the requirements for the degree of
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Abstract

Staff perceptions of how music therapy can support palliative care patients in a New Zealand / Aotearoa hospice, with a particular focus on spiritual care.

The purpose of this study was to explore the perceptions of staff from a hospice, in New Zealand / Aotearoa, regarding the use of music therapy in the care of dying patients. The study has a particular focus on spiritual aspects of palliative care in music therapy, as spirituality is an inherent aspect of the work done by caregivers in palliative care. Hospice staff were asked to reflect on what they knew and understood of music therapy before, and after, a music therapy student arrived at the hospice, and their narratives were explored to uncover the links between patients, music and spirituality. The aim of this was to identify what might be needed to increase knowledge, to improve referral processes, and to increase opportunities for collaborative team work. A cross-section of staff, i.e. two nurses, one doctor, an occupational therapist, and a counsellor, who were part of the palliative care team, were recruited to participate in two semi-structured interviews to discuss their perceptions of the potential for music therapy to support the spiritual needs of hospice patients. A qualitative approach was employed and narrative analysis was used to interpret the interviews. Narrative research emphasises the language of human understanding and in this research it involved gathering participants' 'stories' of their evolving perceptions over time. Findings suggest the language used to describe spiritual care in music therapy was different for each participant although common meanings were drawn from the participants' stories. Commonalities included: music therapy in the hospice was valued by the participants; some participants would like more knowledge to make an informed referral. In addition, staff understanding appeared to have increased over time partly due to educational seminars, sharing at team meetings, actual exposure to music therapy, informal conversations with staff, and participants' growing knowledge of music therapy through their own personal process of learning.

Keywords: spirituality, staff perceptions, hospice, music therapy, palliative

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Table of contents

Abstract.....	i
Acknowledgements.....	ii
Table of contents.....	iii
List of appendices.....	v
Ethical statement.....	v
Background.....	1
Why work with the dying? – a personal journey.....	2
Literature review.....	4
Introduction.....	4
Spirituality in music therapy.....	6
Music therapy as an escape from the limits of language – ‘An Art Beyond Words’ (Bunt, 1994).....	8
Staff perceptions.....	9
Education.....	10
Methodology.....	12
Research question.....	12
Method/design.....	13
Participants.....	13
Inclusion criteria.....	14
Method.....	14
Data.....	14
Data analysis.....	15
Dana.....	17
Barry.....	20
Jill.....	24
Jane.....	28
Cherie.....	32
Tessa.....	35
Answer/s to the research questions.....	38
General perceptions.....	38
Multi-disciplinary collaboration – a synergistic approach.....	39
Music to bring a sense of stability, calm and comfort and to uplift patients.....	39
Emotions evoked by ‘sad’ or ‘happy’ music – contrasting attitudes.....	39
Impact on staff of music therapy in the hospice environment.....	40
Perceptions of spirituality and music as a pathway to spiritual care.....	41
Education and resources are ongoing.....	41
Informed referrals – a need to understand the applications and benefits of music therapy in hospice care.....	42

Discussion.....	44
Introduction.....	44
The language of spirituality and music therapy – an art beyond words?.....	46
General attitudes towards music therapy.....	50
Music therapy in the background of the hospice environment.....	51
Experience with music therapy in hospice prior to the research music therapist arriving.....	54
Multi-disciplinary and inter-disciplinary collaboration – a synergistic approach.....	55
Music to bring a sense of stability or to uplift patients.....	57
Impact on staff of music therapy in the hospice environment.....	59
Cultural concepts in the hospice environment.....	59
Emotions evoked by ‘sad’ or ‘happy’ music – contrasting attitudes.....	61
A brief case study in emotional responses to music.....	63
Perceptions of spirituality and music as a pathway to spiritual care.....	64
Referrals – a need to understand the applications and benefits of music therapy in hospice care.....	65
Education and resources are ongoing.....	68
Strengths and limitations of this study.....	71
Conclusion.....	73
References.....	75
Magill, L. (2009). The Meaning of the Music: The Role of Music in Palliative Care Music Therapy as Perceived by Bereaved Caregivers of Advanced Cancer Patients. <i>American Journal of Hospice and Palliative Medicine</i> , 26: 33–39.....	83
Appendices.....	91

List of appendices

Appendix.1. Recruitment notice

Appendix.2. Consent form

Appendix.3. Information sheet for staff member

Appendix.4. Interview guidelines for staff participants

Appendix.5. Verbatim transcript example

Ethical statement

Participants gave informed consent to be involved and all names were changed to protect their identity. Palliative care is a sensitive area, so care was taken to keep all information confidential. Permission was granted for the study to be conducted at the hospice. The study was given ethical approval by the Central Regional Ethics Committee on 16th July 2010 (CEN/10/EXP/035).

Background

The professional practice of music therapy is relatively new in New Zealand / Aotearoa and the community of music therapists is small. Hospice staff has therefore had little or no exposure to music therapy and might have little understanding about how it can support the spiritual care of terminally ill patients. Yet multi-disciplinary team work is important in hospice care, and involves each team member having at least a basic understanding of the others' discipline.

I have been a music therapy student at a hospice for nine months, and when I began this work it seemed to me that staff members were generally unsure about what music therapy was, or what benefits it might have for patients in end-of-life care. I tried to be an advocate for music therapy, giving mini-talks and seminars to staff to help them to understand the potential for music therapy in palliative care. I was also aware of the interchange of ideas between staff members and their knowledge and experience of music therapy before I arrived.

Knowledge and understanding is presumed to improve over time as specialists share ideas and work together. However, specific training is also sometimes deemed to be necessary. This study aimed to uncover what a cross-section of hospice staff in one hospice knew and understood of music therapy to discover a starting point for further education and to bring music therapy into focus for hospice staff to learn from.

The study covers a wide scope: spirituality, palliative care, music therapy and education all come to play in the analysis. The theoretical grounding of this study is therefore informed by my experience in music therapy clinical work in the hospice, and also informed by my evolving knowledge of patients, my general teaching experience, and my spiritual practice. Underpinning this research is the understanding that spiritual care is an important consideration in healthcare (World Health Organisation, 2002). Hospice care in New Zealand / Aotearoa has a mandate of total care including the physical, social, emotional and spiritual domains (Ministry of Health, 2001), and The New Zealand

Palliative Care Strategy also includes the Māori model of spiritual well-being – tinana, whānau , hinengaro and wairua (Ministry of Health, 2001).

Kenny (1989, p. 8) says, ‘hidden beneath the surface of every music therapy practice of every music therapy practitioner is a unique theoretical foundation...the psyche or soul of the work is contained in the individuality of each and every music therapist.’

Why work with the dying? – a personal journey

‘The study of dying is like gazing into a reflecting pool’ (Kellehear, 2007, p. 1).

I have asked myself the question ‘why work with the dying?’ many times and have still found no easy answer. Hartley (2001, p. 135) also asks the question ‘Where is the inspiration and motivation found to continue working as music therapists with the dying?’ I confess the naivety of never having worked with dying people before this study took place. I acknowledge the staff at the hospice where my own learning took place as a music therapy student, and the value of collaborative work for my own development.

My background might partly explain my choice in this field. I have always strived to make meaningful connections in my life and to make a positive difference in the world. This led to my becoming an educator, a musician and a practitioner of Buddhist Dharma and yoga. Thus, the three points of the study emerge: education, music and spirituality. I have been influenced by two friends in my decision to work with dying people and their families. One of them was a palliative care nurse who practiced with a deep sense of the spiritual in her work, and the other was an ex Buddhist monk. With both of these friends I held many conversations on living, dying and death. I had not really given death a thought before this and it is not the usual topic of conversation for a social night out, but one which I became interested in through the lens of a Buddhist eye. We would discuss the concepts of ‘attachment’ in life, compassion for others, Buddhist perspectives of dying and other ‘enlightening’ spiritual topics.

My own spiritual journey has continued through most of my life culminating in the last five years with a regular practice in yoga and meditation. Buddhist philosophy believes that human beings are attached to life and that, although on an intellectual level we all know we are going to die, our awareness of death is superficial (Gyatso, 2003).

Contemplation of death, real or perceived, shows us where we are holding on so that we might learn to let go and live our lives more fully. We may be attached to wealth, possessions, people or life itself. The only certainty in life is that we will one day die – we may not know how or when, but we do know that it will happen. I believe that by confronting my own mortality then perhaps I would learn to refocus on what is most important in life and learn to be in a place of giving to others. My belief is that to have a spiritual dimension is part of being human, and that music therapy in palliative care encompasses the spiritual, to enable music therapists to fully understand and respond to the patients' needs (Marom, 2004; Hartley, 1999; Aldridge, 1995).

Literature review

‘The challenge for hospice is to keep the awareness of spirituality at the forefront of care, understanding that inherent in the work of dying (for the majority) is facing one’s pared down being. A being that has only soul, spirit, essence left, and must be reconciled with the past, present, future, community and, for some, the transcendent or God’ (Egan, 2009, p. 293).

Introduction

Literature was sourced from books, searches of hard copy music therapy journals, and electronic databases from The Massey University Library and the Hospice Library. Search platforms Web of Science, Web of Knowledge, Google Scholar and EBSCOhost were used. The initial literature search focused on the keywords music therapy, spirituality and palliative care. Subsequent searches included the keywords ‘education’ and ‘staff perceptions’.

Palliative care was originally developed by Dame Cicely Saunders at St. Christopher’s Hospice in the United Kingdom in the 1960s (Saunders, 2003). The Hospice philosophy of palliative care aims to provide patients with the means to live fully even as they are dying (O’Callaghan, 1996). The core idea behind this philosophy is that the needs and wishes of the patient are central to the work of palliative care (Randall & Downie, 2006). The practice of palliative care is a sensitive one which requires the therapist to address the needs of not only the person dying, but of their family and friends around them. Facing death can create a spiritual crisis – questions may arise such as ‘What has my life been about? Where am I going now?’ In palliative care there is an emphasis on listening and communication skills (Randall & Downie, 2006).

Music therapists can be a part of the collaborative hospice palliative care team, using music to support patients in the process of dying. Bunt (1994) provides a definition of music therapy: ‘Music therapy is the use of sounds and music within an evolving

relationship between client and therapist to support and encourage physical, mental, social, spiritual and emotional wellbeing’ (p. 8). Music therapy is used in palliative care to promote relaxation, support emotional expression, and to provide spiritual care using techniques such as song writing, musical improvisation and listening/responding to live or recorded music (Magill, 2005; Hepburn & Krout, 2004; O’Callaghan, 1996; Aldridge, 1995; Munro & Mount, 1978). A comprehensive bibliography for music therapy in palliative care was compiled by Rykov and Salmon (1998) which covered publications from 1963 to 1997. The literature cited in the current research includes some of the more recent publications of music therapy in palliative care.

Spirituality means different things to different people. For some, spirituality can be a very religious and devotional set of beliefs, for others, it is a sense of well-being (Marom, 2004; Aldridge, 2003; Wlodarczyk, 2003). In some societies death is grounded in spirituality and has many rituals with a set of beliefs and songs within the culture (Morgan & Laungani, 2005). In a New Zealand / Aotearoa context, it is important to consider *Te taha wairua*, or Māori spiritual health, which Māori believe to be the most essential aspect of health and death (Durie, 1985). The New Zealand Palliative Care Strategy uses Durie’s *Te taha wairua* holistic model of Māori health. ‘Palliative care embraces the physical, social, emotional and spiritual elements of wellbeing – tinana, whānau, hinengaro and wairua – and enhances a person’s quality of life while they are dying’ (Ministry of Health, 2001). The World Health Organisation (2009, p. 1) defines palliative care as ‘improving the quality of life of patients by addressing physical, psychosocial and spiritual needs of the dying person and their family’.

Egan’s (2009) seminal study investigated how spiritual care is provided in New Zealand / Aotearoa hospices. The study aimed to understand the spiritual needs of cancer patients to help inform and improve practice. Egan identified that there were gaps in contemporary hospice spiritual care and needs. Egan discovered that spirituality means different things to different people and a working New Zealand / Aotearoa definition of spirituality which arose from the study included: beliefs and values; meaning and purpose; connectedness; identity and awareness; and religion for some people (Egan,

2009). He states that spiritual care must therefore be patient led and asserts that spiritual care is 'doing, saying or allowing anything that assists a person's, a family's, a group's or an institution's spiritual well-being' (Egan, 2009, p. 275). He explains that this care may include creating space or assisting a person to find meaning, purpose and hope. He gives a list of spiritual care tools which includes music therapy, song, art and poetry. Egan says, 'These things must be acknowledged as critical points of entry and expression of the mystery that is personal spirituality for some people' (Egan, 2009, p. 30).

In the context of music therapy, Aldridge (1995) gives a useful list of 'Meanings of Spirituality' that contain key words such as: meaning, purpose, relationships, transcendence, hope and faith. In attempting to refine spirituality for the purposes of this study, I will quote the words of Kearney and Mount: 'spiritual issues, as we conceive them, have relevance beyond personal world view, for they lie at the very center of the existential crisis that *is* terminal illness' (Kearney & Mount, 2000, p. 357). Central to this research is the author's belief that an approach to palliative care includes spiritual care, to enable music therapists to fully understand and respond to the patient's needs (Aldridge, 1995; Hartley, 1999; Magill, 2007; Marom, 2004). Hartley (1999, p. 82) says 'Spirituality is a big part of this work, but there is no reason why it should not be part of all the work that we do.'

Spirituality in music therapy

'I have never found anything more powerful than sound, voice, and music in allowing people to move to what I call 'their own inner harmony' – their own core, their own soul' (Gaynor, 2003, p. 85).

Music therapy uses a holistic approach which recognises the whole person. Spirituality has been said to be at the centre of a holistic approach to music therapy in palliative care (Magill, 2002). It has been recognised that music therapists find it difficult to express the spiritual dimensions of musical experiences in their sessions with patients (Magill, 2007; Hartley, 2002; Starr, 1999). Increasingly, music therapists such as Aldridge (1995, 1996,

1999), Amir (2002) and Magill (2002, 2005, 2007) have opened the debate about the connections between music therapy and spirituality, especially in relation to palliative care patients. Sekeles (2007) stresses how important it is for therapists working with death-grief issues to be aware of their own attitudes towards death, dying, spiritual aspects of death, euthanasia and life-after-death to help guide their work.

Both Aldridge (1995) and Magill (2002, 2007) believe that it is through the creativity of music that a patient can learn more about one's inner self and achieve a new consciousness or way of being. Aldridge (1999, p. 12) says 'music therapy allows and encourages personal expression in others through music, enables another to communicate, not [in] words alone.' Pavlicevic (1999) says that the creative, transcendental nature of music is not unlike meditation and prayer which are 'being in this space now'. Both of these goals – learning about the inner self and being in the moment – are spiritual goals included in the literature. If the spiritual needs of a patient are being addressed in music therapy, there may follow an improvement in general well-being and inner fulfillment (Magill, 2005). Magill (2007) believes that music therapy enhances spirituality in those facing terminal illnesses, through transcendence, awakening faith and inspiring awareness of connectedness.

There is a common thread in the literature that music can help to (re)awaken this inner spiritual life within a dying person, and can begin a process of self-discovery, acceptance and growth (Aldridge, 2003; Magill, 2005, 2007; Mayne, 2002).

A study by Wlodarczyk (2007) was carried out to assess the effect of music therapy on the spiritual well-being of palliative patients. Self report was used with a 'Spiritual Well-Being Questionnaire' which included statements such as: 'Today I don't know who I am, where I came from, or where I am going' and 'Today I feel very fulfilled and satisfied with my life.' The results showed that there was a significant increase in sense of well-being by patients on the days they had music therapy. Wlodarczyk also reviewed a number of surveys on the attitudes of healthcare workers towards their patients' spirituality.

Marom (2004) surveyed music therapists for their stories on spiritual moments in different music therapy settings. She did this in an attempt to discover her own spiritual beliefs in the practice of music therapy. In addition, most of the studies in this area had previously focused primarily on the client's experience. She found that the variety of spiritual moments described created a challenge in developing a clear definition of spirituality within the context of music therapy (Marom, 2004).

Music therapy as an escape from the limits of language – ‘An Art Beyond Words’ (Bunt, 1994)

Music can be a natural way to express human emotions when words are not adequate, and Salmon (1993) believes that music can thus become a symbolic or spiritual language. Many music therapists have commented on the difficulties describing in words what they do to support clients (Magill, 2007; Hepburn, 2006; Bunt, 1994). In addition, Byrne (2002) and Taylor (2003) highlight the limitations in language to describe what spiritual care is. A number of writers have discussed the hidden aspects of spiritual care in the practice of palliative care (McSherry, 2005; Byrne, 2002; Taylor, 2003). They say that the spiritual dimension may be hidden beyond language and have hidden meanings. McSherry (2005, p. 100) says ‘Spirituality has a fundamental and central [often hidden] role to play within the context of palliative care in that we cannot have one without the other.’ McSherry (2005) uses Amenta's all-encompassing and comprehensive definition of spirituality.

The spiritual realm can be broadly defined as the life force springing from the unknown that pervades each person's entire being. It encompasses the volitional, emotional, ethical, social, intellectual and physical dimensions. It is the centre or core that integrates the whole person...It is the self...that which communicates with the transcendent. It is the part of each individual that aspires to ultimate awareness, meaning, value, purpose, beauty, dignity, relatedness and integrity. The spiritual is the source of faith, hope and courage. (p. 106)

Staff perceptions

The focus of this research is on staff perceptions of how music therapy can help address the needs of a dying person, with particular reference to spiritual care. The research is based on narrative analysis of six interviews from members of staff at a hospice in New Zealand / Aotearoa. This research was informed by some key studies on staff perspectives of music therapy in palliative care. These studies all included spiritual concepts using language such as: aliveness, expanded consciousness, inner harmony, core and soul.

Notably, O'Kelly and Koffman (2007) explored the role of music therapy in multi-disciplinary teams of palliative care professionals in the UK. This was to help guide the future development of palliative care focused music therapy worldwide which used multi-disciplinary approaches. The findings of this study were: music therapy was valued by most interviewees; there was some lack of understanding of the role of the music therapist; interviewees found witnessing music therapy is effective in developing understanding; more understanding and integration of music therapy could arise with collaborative work and educational workshops (O'Kelly & Koffman, 2007).

O'Callaghan (2001) researched patients', visitors' and staff members' experiences of music therapy in a cancer hospital. Findings substantiated how music therapy can support cancer patients throughout their illness. O'Callaghan and Magill (2009) examined the staff responses to music therapy programs they had witnessed in cancer centers. This study found that staff may benefit from witnessing music therapy programs through helpful emotions, teamwork, self-awareness and the observed positive effects on patients and their families. Magill (2009) also explored the role of music in palliative care music therapy through the perceptions of bereaved caregivers of cancer patients. The findings supported the benefits of music to support caregivers before the death of their loved ones. Other literature described the perceptions of music therapy from the perspective of hospice administrators (Hilliard, 2004), an oncologist (Gaynor, 2004) and community

liaison (Gifford, 2009). Hilliard (2004) surveyed hospice administrators throughout the United States to ascertain the level of knowledge of music therapy, current employment levels and obstacles to utilizing music therapy in hospices. The results showed that knowledge was high (95 per cent familiar with music therapy) and the benefits of music therapy were understood by many due to efforts by music therapists to educate palliative care staff. However, insufficient finances were stated as the main obstacle in employing music therapists (Hilliard, 2004).

American oncologist Mitchell Gaynor (2004) discussed his views on integrative care of cancer patients using ‘alternative modalities’ such as music. He described the positive effect of sound, voice and music on stress hormone levels and concluded that music allows people to reach ‘“their own inner harmony” – their own core, their own soul’ (Gaynor, 2004, p. 85). Elizabeth Gifford (2009), an American Community Liaison worker, highlighted the need to bring music therapy into partnership with palliative care teams. She recommended that music therapy should be available to all hospice patients and that hospice funding plans should include music therapy in the list of interventions. O’Callaghan and McDermott (2004) conducted an Australian study of staff (and patients and visitors) who had witnessed music therapy in a cancer hospital. This study concluded that patients, visitors and staff members affirmed their ‘aliveness resonating with an expanded consciousness’ through experiencing moments in music therapy (O’Callaghan & McDermott, 2004).

Education

‘...education is like the outline in a child’s coloring book. You must fill in the colors yourself.’ Louis L’Amour (unknown source)

It is beyond the scope of this paper to draw from the vast amount of literature on adult education. However, it has been stated that sharing knowledge of the roles of music therapy is a crucial undertaking for music therapists if its value is to be recognised (O’Kelly & Koffman, 2007; Daykin, Bunt & Stuart, 2006; Hepburn, 2006; Hogan & Cockayne, 2003; Wlodarczyk, 2003; Brooks & O’Rourke, 2002; Magill, 2002). O’Kelly

and Koffman (2007) say that for music therapy to develop in palliative care worldwide, music therapists need to be proactive in raising awareness of the unique nature of their work in a palliative care setting. Their study highlights the effectiveness of ‘accessible, public and performance related activities, in both creating a therapeutic environment, and in increasing the acceptance of music therapy by staff and service users.’ (O’Kelly and Koffman, 2007, p. 239) Strategies used to initiate or expand music therapy in Australia (Hogan & Cockayne, 2003) included educational presentations and submitting outcomes of music therapy student placements.

Marom (2004) studied spiritual moments in the work of her fellow music therapists. In exploring these moments, she aimed to learn from other music therapists what ‘spirituality’ meant for them. She said, ‘I needed to hear from other music therapists what spirituality could feel like within a therapeutic setting and how it could fit appropriately and ethically into music therapy.’ (Marom, 2004, p. 37) Key to the current study is the idea posed by Eduard Lindeman (in Smith, 2004) that the learner’s experience is paramount in the learning process and that teachers are simultaneously searchers of wisdom. Ako, in Māori, means both to learn and to teach. Learning is a process whereby people derive their own meanings over time and through their personal experiences. Likewise, during the process of an interview, participants may reach their own understanding simply by talking about a topic.

Methodology

‘One of the main purposes of doing research in music therapy is to find language that is congruent with the experience. I have a need to find out what forms and contents of language can authentically describe the music therapy experience, including its inherent, hidden qualities’ (Amir, 1996, p. 218).

Research Question

How do staff members perceive the use of music therapy, particularly with regard to the spiritual needs of patients, in palliative care in a New Zealand / Aotearoa hospice?

I chose a qualitative research approach for this study due to the following factors:

- The nature of the research question was subjective.
- The nature of spirituality and music therapy make them difficult to define with language.
- The participants’ responses may be personal expressions of human experience.
- I positioned myself in the study as a music therapy student who believes that music therapy in palliative care encompasses spiritual care.

The research is informed by my experience in music therapy clinical work, my teaching experience, and my spiritual practice. It is important for researchers to locate themselves within the research as their assumptions and experience might influence the research process (McSherry, 2005). Richards (2005) states that a theory is a human construct. The ideas and theories that emerged from working with the data in this study were therefore constructed from my position within the research.

As spirituality is not easily defined, qualitative investigation may more accurately reflect the data (Egan, 2009). The approach I chose for analysis was a narrative approach. Narrative research emphasises the story-based nature of human understanding and in this research it involved gathering staff participants ‘stories’ about their encounters with, and

reflections on, music therapy. With narrative analysis the participants' story is the object of investigation and the focus is on the details and language of the story (Rice & Ezzy, 1999; Riessman, 1993). Riessman (1993) asserts that in narrative analysis, personal narratives are subjective and are rooted in time, place and personal experience or perspective.

This study also draws on a constructivist approach. Crotty (1998) says constructivism builds on the idea that 'meaning is not discovered, but constructed...different people may construct meaning in different ways, even in relation to the same phenomenon' (Crotty, 1998, p. 9). The ways we understand a situation or phenomena are constructed and shaped by the language we use to describe it (Egan, 2009). The language the participants used became a central focus for the study as it emerged that each participant perhaps used different language to define spirituality, and did not always appear to have the language to describe music therapy processes. The strengths and limitations of language are discussed more fully on pages 46 of the Discussion and page 71.

O'Callaghan (2009, p. 41) has asserted that 'constructivism and palliative care are compatible in that both focus on understanding individualized and multiple interpretations of experience.' She says that although constructivist research cannot capture an 'absolute truth' about music therapy's effectiveness in palliative care, findings may be conceptualised in a clinical context.

Method/Design

Participants

The study involved two individual interviews with each participant. To recruit staff I posted notices on the hospice notice board to invite all nurses, doctors and specialist staff who met the criteria outlined below to participate (see Appendix 1). I stated that I would ideally like to interview people from a cross-section of professions to contextualise and perhaps bring different perspectives to the research findings. Participants recruited were: two nurses, one doctor, one occupational therapist, one art therapist and one counsellor.

They came from four different cultural backgrounds and five different health professions. These participants were each given a consent form explaining confidentiality (see Appendix 2), and an information sheet explaining the research question and purpose (see Appendix 3).

Inclusion Criteria

Participants were required to:

- Work on the same interdisciplinary team as a music therapist working in palliative care at the hospice.
- Have a minimum of one year's experience in palliative care.
- Give informed consent to be involved in the study.
- The first 4–6 people who responded would be included.

Method

Semi-structured interviews were undertaken with participants to uncover their perceptions of the potential for music therapy to support the spiritual needs of hospice patients. These interviews involved me gathering the participants 'stories' about working alongside a music therapist in palliative care. My approach was to ask open-ended questions, to listen with few interruptions, and to relate my questions and comments to the responses by repeating participants' words or seeking clarification.

The first interview aimed to uncover early staff perceptions of music therapy before and in the first few months that I started at the hospice. This interview focused on the question 'what do the participants already know?' The second interview, approximately four months later, aimed to uncover further understanding of music therapy after I had been working at the hospice for nine months, and to clarify anything said in the first interview.

Data

Audio recordings

Data was gathered from audio recordings of two semi-structured interviews. Interviews took place in the hospice at pre-arranged times. The interviews allowed the participants to

describe experiences in a way he/she wanted to while allowing me to probe particular identified parts of the discussion.

The interviews consisted of two parts:

1. The extended narrative of the interviewee (~25 minutes long);
2. Re-engagement with the topics discussed in the first narrative to seek clarification. I also invited participants to express any new perceptions that had emerged in the time since the first interview (~10 minutes long).

The researcher's reflective journal

I kept a reflective journal to generate and integrate new understandings to extend practice and to record observations (Barry & O'Callaghan, 2008). The reflective journal notes enabled me to reflect on my position in the practice of music therapy with palliative patients, to connect theory with practice and to interpret experiences. Reflection provided analytical thinking and self-analysis of my personal experiences in music therapy (DeVault, 1997). In this study, my reflective journal was used as a data source to reinforce and / or contradict commonalities in the interview data. It was also used to reflect on practice and emerging ideas throughout the research process.

Data analysis

Narrative analysis and reflective journal data

Narrative analysis involves reducing the data and re-interpreting it. By identifying narrative segments, interpretive categories emerge. Narrative analysis is a systematic method of story reduction to find the core narrative that then allows for comparison (Riessman, 1993, p. 13). Analysis is focused on the structure of the narrative as a whole and on unexpected narrative turns. Riessman (1993, p. 1195) explains: '[narrative analysis] does not fragment the text into discrete content categories for coding purposes. [It] identifies longer stretches of talk.' 'Hybrid stories' were created in this study by editing and reshaping what was told.

My analysis procedure was based on narrative analysis in health research which utilises a technique called emplotment. This is described as the process by which individual events

or clinical encounters are pulled together into a larger narrative structure to give them meaning and context (Ezzy and Rice, 1999). My rationality for having two interviews is based on Riessman (1993) who states that the past is a selective reconstruction and a story may change from one time to another. She says ‘human stories are not static, meanings of experiences shift as consciousness changes.’ (Riessman, 1993, p. 67)

Procedure for interview analysis

- Interview data was transcribed verbatim.
- Transcripts were returned to participants for amendments, additions, and approval.
- Amendments/editing were carried out if needed.
- Listened to recordings all the way through and underlined phrases/words/paragraphs in transcript that stood out.
- Listened to each interview twice more.
- Wrote memos describing common and inconsistent meaning units emerging.
- Identified passages for participants’ meanings, feelings and actions.
- Identified relationships between specific events and general processes.
- Constantly compared individuals, different ideas, and identifying passages or moments in narratives related to the research question.
- Developed condensed narrative stories from identified key passages in an attempt to understand the language of each participant and to give the reader a sense of participant’s overall perceptions.
- Member checks – analyst’s interpretations and reconstructions were verified for credibility with those whom data was collected from.

Based on: Mattingly (1994); Riessman (1993).

Findings

The interviews – participants’ stories and interpretations

The participants’ actual words or stories followed by the author’s interpretations.

Dana

Dana is an experienced counsellor at the hospice.

Dana’s story

I was aware that music therapy was a therapeutic modality, but I had little understanding of how music therapy is used. I have always been aware that it’s a good thing to have in an environment or create a mood. Now I have more of an understanding – that music and instruments would be involved and that there’s a difference between using music to create an environment and using music therapeutically. When I worked in the hospital where there’s a lot of noise we used music to create some space in the environment. Music could be soothing to people when a lot of things aren’t in their control. It made sense that music would be a good way to interact with people and that it talks to people in a different way. But I wasn’t sure how you would tune in to and read how the music’s affecting people. I have more awareness of the variety of instruments you’re using like the African nail piano, and placing a vibratory instrument on a person.

We’ve discussed how counselling sits beside music therapy, and how we could work with the same person but in different ways – different vehicles to the same end. With music therapy, like with counselling, there is quite often a verbal part and an exploration of goals so there was the need to work out our roles so we could collaborate. And ask the question how would that work for the patient, to have different therapeutic processes? One of the things we discussed was to not dilute by having too many therapists. It became really clear that music therapy is different. With the shared client we have, music has been very important in her funeral planning and music is something that buoys her up. I think it’s really powerful. I probably know enough to make a referral, but I think there’s always room to learn more.

Where I refer is people who articulate around music and the place of music in their lives or there's something that's resonating about things musically. If I've been doing talking therapy and the patient's energy becomes lower, they may lose their sense of control and need soothing. I think music is another way they can express themselves and be met because music can transcend the verbal. It can be passive or interactive for them depending on where their energy is. I don't know if that's the right way of thinking about it. Particularly in palliative care I see the beauty of music therapy. People enter a more internal phase in themselves and music might reach that place and support them. I think there's a window of opportunity for counselling because it requires that people cognitively need to still be able to conceptualise and express themselves. At times I meet people and I've almost missed that window. I can still work with them in the lucid moments but counselling wouldn't be as useful after their consciousness starts to change dramatically. I can still be empathically attuned by being present if I've already had a relationship with someone. The hospice philosophy is around holistic care so that's spiritual, physical, psychological, emotional and social care. Spiritual care to me is something we all dip in and out of. I can see how music is often a spiritual experience for people. For me personally I find music is one of the ways I can have a sense of spirituality. Music has a spiritual element because it touches you in a different way and opens up other kinds of energy. I also think being present in the moment with people is spiritual. I think music takes this to another level. Music might touch that spiritual side to people who wouldn't articulate around spirituality. Music can lift, energise, soothe and universally people respond because it's non-threatening. The nurses quite instinctively have been doing musical things at times. But a music therapist has in-depth understanding about how music can be used to support and work with people.

Dana's story – 2nd interview

I think the interface between my role and the music therapists is one we could really explore. Transitions that people go through in palliative care makes music therapy a useful process when they get beyond talking therapies. We have complementary therapies which come from similar therapeutic theories. I find this an interesting aspect, but quite

challenging too. I've been reflecting on the client that we shared who has died. I reflected on 'how did that go?' and mused that music was such a communication for her.

Dana interpretation

Dana's early perception of music therapy was that there was a difference between using music to create a calming and soothing environment and using music in a broader therapeutic sense. She also understood that music could be a powerful medium for some people and a positive way to interact. At this point she did wonder how a therapist would 'tune in' to how the music affected people. Her understanding of the techniques and therapeutic value of music appeared to have grown since experiencing music therapy at the hospice. She suggested that music therapy complimented other therapies and especially when patients were 'beyond talking therapies'. Dana expanded her ideas on the changing needs of palliative patients as they progress through their illness – 'at that point that their consciousness starts to change dramatically... music [is] probably more useful to them potentially.' Dana clearly recognised the value of collaborative work. However, in a narrative turn at the end of the second interview, she mentioned that there were also challenges in working with a shared patient. She does not elaborate upon what she finds challenging. It may be that she is saying that ongoing exploration and dialogue between the therapies was important when collaborating. Dana believed that being present and attuned with a patient in the moment is a spiritual act and she felt that in the late stages of their illness, music might connect with the patient in a deeper way. She would most often refer people for music therapy when 'there's something that's resonating about things musically', or if a patient had low energy and they might express themselves through music and 'transcend the verbal.' Dana understood that music could be either passive or interactive depending on the patient's energy levels. She described one patient who had experienced music therapy to uplift and transcend – 'music is something that buoys her up'. Dana personally believed that listening to music is often a spiritual experience and that music was a vehicle to access spiritual parts of people. She thought people could 'have a sense of spirituality' and that music 'opens up other kinds of energy'.

Barry

Barry is a specialist palliative care doctor at the hospice.

Barry's story

I had already encountered music therapy. I was here when another music therapist was here doing her work. My impression was a lot of the work in music therapy has been with children with mental disabilities and developmental goals. Her work was a broadening of music therapy into palliative care. I started to think about using music as a way of exploring hope and meaning and so I put together a collection of African-American blues songs. The songs bring the dry, academic literature to life when I've been teaching. They are my own musical life review and reflective practice tool, and a teaching tool to illustrate grief and bereavement. I am most excited using music to introduce concepts of spirituality because spirituality can be sort of scary or embarrassing for people, especially professionals, especially doctors. They think 'it's not my job'. The topic of blues are always how hard life is. But as a musical form it's quite safe – using music to introduce difficult topics of spirituality. I think it's important that anyone in our job in palliative care has to be able to stay with issues of spirituality when they arise – to be able to reflect back with the patient and be comfortable and to have their own thoughts about spirituality. I understood your technique to be both *making* music with somebody but also looking at what their music was like in their life before – a musical life review. When you were talking about 'L', the songs she chose were always sad songs – songs for her funeral. You said 'let's look at the happy songs'. That resonated with the book of that guy who's got leukemia – Phil Kerslake. He would use songs that he knew would help his emotional state when he got really sad and depressed. The interaction you had with 'T' – to be able to elicit an emotional response in a child whose condition is extremely low cognitively. I think that's important that it's discussed that he is responding in this way to this music therapy – all of us [staff] don't have the skills to see that interactive-ness. But to know that it's there is quite important. We try real hard in the hospice to remember the

humanity of absolutely everybody no matter what level they're at. It's nice just to get a good reminder of that from time to time.

I missed your music therapy seminar, so it would be good to offer these a couple of times to get 'capture'. Doing music with staff participants would be interesting. Being visible within the hospice is also important. Getting the guitar and ukulele is a great step. When I think of the music that happens here at the hospice, it's the piano, the CD player, and families bring in guitars. The other thing that happens is the Māori / Pacific Island singing around the bedside. I have never heard anybody – patient, family or staff – complain about that singing. Everybody loves it. Can we make it clear to patients and families that that's ok? Is there some music therapy connection with that form of music? I'm sure it's therapeutic, I *know* it's therapeutic. We all feel it. Is there a way to, in a research sense, capture that beneficial effect that everybody feels and says about that beautiful choral singing or guitars?

Barry's story – 2nd interview

I'm really intrigued that we talked a lot about 'L', and then she died yesterday [spoken softly]. You've done quite a lot with 'L', and then you saw her right through to the end. And I'm interested in commenting again on 'T', your connection with him, the clear and obvious response you were getting from him from the music and then your final session with him. He went from being responsive to non-responsive when he got sick and then he bounced back again. So you've seen real movement and direction and change in 'L', and change in 'T'. Then I thought the work with 'C' was fantastic, the speed with which the music therapy interaction with that family could happen. There was no 'I have to think about this'. That's how palliative care has to work. Because the time frame for our patients can be so short. You've been doing more work in the hospice and patients have been quite open and accepting. I think that people are intrigued by the idea of music therapy. I'm not sure that's changed over the time you've been here. Maybe *staff* now know more about you and feel more comfortable making a suggestion to the patient or family. I've been thinking about the whole notion of health promotion in palliative care. Music in general is a good way to be showing the positive effects that arise out of hospice

work. There is lots of evidence that for families and patients who have good palliative care, there is less depression and symptom withdrawal issues. So much dialogue about end of life is the euthanasia debate. There's a whole other range of emotional, spiritual and psychological things we have to deal with other than requests for euthanasia. How do we shift the public discussion about 'death and dying' away from the euthanasia debate? I think using song and music, the sort of transformational healing that happens in the context of hospice and palliative care can shift the dialogue from pain and suffering to positive transformation and transcendence.

Barry interpretation

Barry's early understanding of music therapy was in the area of child development. After encountering a music therapist in palliative care he understood that music could be used as a musical life review of a patient's life, to explore themes of hope and meaning, and for dealing with grief and bereavement. Barry described his own learning and journey of using African-American blues music in his teaching work in palliative care for introducing spirituality to professionals. This seems to parallel and be affirmed by the presence of music therapy at the hospice. He commented spirituality can be 'scary' or embarrassing for people, especially doctors, who think 'it's not my job'. Barry recognised that musical forms such as the blues could help people to express issues safely. Music enabled an exploration with doctors about what their 'job' is in palliative care and highlights the difficulties that some doctors may experience in this field. He believed that anyone working in palliative care needed to address their own spirituality to be able to work with patient's on spiritual issues. Barry's perception seemed to have broadened since the arrival of the music therapy student at the hospice. He gained an understanding of using patient-chosen music to uplift patients. He also mentioned the way that music could give hope and 'elicit an emotional response' from a child who was extremely low functioning. Barry was fascinated by the way that Māori and Pacific Island families used music in a 'therapeutic' way by singing around their loved one's bedside. He wondered how this spontaneous live group music might connect to music therapy. Barry has witnessed, and consequently discovered, the important cultural roles of music in addressing spiritual needs of Pacific Island and Māori patients in the hospice. He also

recognised that there is a need for deeper exploration of multi-cultural music in New Zealand / Aotearoa hospices. In the second interview, Barry understood that music therapy could build fast connections with families if a patient was entering the dying phase. He appreciated the immediacy of music therapy in palliative care when time frames of working with patients can be short. He felt that using song and music could bring about 'transformational healing' in palliative care, shifting the dialogue from pain and suffering to positive transformation and transcendence. Barry's ideas expressed in the interview seemed to take root and grow as he discussed them – his own personal experiences and shared experiences of music, seemed to shape his perceptions and his growing awareness of music therapy.

Jill

Jill is an experienced palliative care nurse who has worked in England and New Zealand / Aotearoa.

Jill's story

I had heard that certain places used music therapy, and at best I thought it would be classical, new age or instrumental music, angelic choirs, a bit of Enya and Hayley Westenra, playing tapes in the background and asking patients how it made them feel. And at worst it would be an organ playing 'Abide With Me'. The only time I've known music even playing in the background was at a New Zealand hospice – one of the volunteers playing the piano. That was kind of therapy but it wasn't formalised and it was the only experience I had with music therapy. I've worked in three hospices in England and two in New Zealand. It was the first time I'd been introduced to music therapy when I came here. People use the word 'therapy' quite loosely in health care. I didn't expect music therapy to be so well thought out and strategic. I thought it would be in the background – I didn't think it would make as much of an impact as it actually does. I thought the best places [laugh] will have music therapy because they'll recognise the value of it – I wondered if music therapy would be considered a necessity. When you introduced yourself at the nurses' staff meeting, you sung in Gaelic while beating an Irish drum and I felt that broke down any barriers. I was also struck by the professionalism of music therapy. The rationale wasn't obvious to me so I appreciated when you described what you'd done with patients, how they'd responded and your reasoning behind it. I realised music therapy wasn't something that you 'do to' people or is in the background. You use it as a tool to engage with people. You were using your musical ear to listen to the patients and you were acutely aware and responsive to them. You observed for non-verbal cues in the child who couldn't speak but who responded with body language. Nurses talk about emotional labour and trying to support patients. I could see that what you were doing was labour in a very deliberate and therapeutic way. I could be wrong, but this was how I perceived from you. I was surprised by your repertoire, your knowledge of musical instruments from various

cultures and countries. One example was the 'Round the World' activity in the Day Unit. You got them to think about wonderful memories of happier times and maybe not so happy times, but they were all relevant. I've worked in Day Units before and it's hard to break the ice and make people feel like they're enjoying it and getting a positive response.

But it wasn't always about being happy. It was about allowing tears. You think music therapy is going to be about chivvying [cheering] somebody up, but it was also about allowing the tears to flow. I could be wrong, but I got the impression that it was about finding expression for people through writing songs, recording songs and CDs, or enjoying the pertinent lyrics in songs. Sometimes when I heard you playing guitar and singing in the hospice in the patients' rooms with families, I think it's so comforting and it breaks the clinical feel to the environment. It really adds to the atmosphere as a place of sensitivity and joy. You said it's about holding in that space, living and finding meaning in the present. It seemed you weren't getting to an end point, or a realisation of a goal. Music therapy crossed generations which I hadn't expected – children to grieving teenagers going through a journey through family illness. You used current songs, rap music, and decades back for adults to remember their younger selves. I would like to be able to introduce music therapy to patients in a more strategic way. I couldn't actually say what they were going to get out of it. If you can't intrigue the patients they might miss out because they won't realise how they're going to benefit.

In terms of therapy, I think it has a beginning and an end, and a process that you can measure for success. I'm not sure how you'd do that with music therapy. I have thought in the past, how do you address a situation if a feeling comes up through the music? Hospice offer holistic care and spiritual care. We have the priest, and nurses sometimes struggle with how we address the spiritual issues of patients? Music therapy indirectly supports spiritual care very well. It evokes the subconscious and touches people on a deep level, it has a rapid response that might take hours of talking therapy, it helps to invoke and express emotions and it acknowledges the uniqueness of the person. It promotes quality of life – singing is a celebration. It helps families connect with each other, and reminds patients of their core self. You find music that's important to patients and music is separate from the

illness. Songs that the patient enjoyed can be used as reminders once the patient has died. So music therapy tends to be more tangible than other aspects of spiritual care. I've written some notes because I knew I'd never remember to tell you. I saw you the other day with your guitar walking round the place and it just feels like home.

Jill's story – 2nd interview

I was speaking with a patient and I mentioned music therapy and I still couldn't relay to her what the benefit would be. I assumed she would have the same assumptions I had that it was in the background rather than an actual therapy. The only thing I could say was I know people enjoy it and get a lot of benefit from it. I don't want to set the expectation with the patient because of the unexpectedness of music therapy. As a personal example, in the weekend I went to a folk festival to listen to music and be entertained pleasantly. I heard a song sung by an English girl, and when she finished I was in tears. What it brought up for me was that I thought I was fine; I was in a happy setting. So I wondered what it's like for patients who are facing end-of-life issues. How the music would be more poignant for them. We're taken to that space in music and it becomes 'where am I?' [laugh]. You might lose the essence if you try and verbalise or explain it away. It's got to be an experience. If we could offer music therapy to everyone, I would if it's appropriate. I hadn't considered how music therapy would benefit the nurses and the medical staff. We have focused on the benefits to the patients, but I think everyone recognises that music therapy is very much a part of the team. And it isn't something that's in the background as people may have thought originally. It's something central.

Jill interpretation

Jill initially thought music therapy might involve background music and then asking patients how they felt. She was surprised later to discover the professionalism of music therapy, including the way that music was chosen strategically for a range of techniques. Jill discovered that the music therapist used a wide repertoire of songs and a variety of musical styles. Jill recognised that music was used as a tool to engage with people, break down barriers and build relationships. She understood that music therapy could be used to support people to express a wide range of emotions and to evoke memories through

musical life review. Jill also understood that music could comfort patients and create a calm atmosphere in the hospice environment making it feel 'like home'. She recognised techniques used by the music therapist such as focusing on the meaning of song lyrics and song writing. Jill believed that music therapy could 'indirectly' support the spiritual care of patients, reminding people of their 'core selves' and promoting their quality of life. She recognised the power of music to affect people deeply and subconsciously. Furthermore, she suggested that, in contrast to verbal therapies, non-verbal patients might respond to musical stimuli. Jill's remembered experience with folk music, alongside her shared experience with the music therapist in the hospice, seemed to have shaped and broadened her perception of music therapy. The folk music had taught her about music and emotions – crying to an English folk song had perhaps brought up memories of her home country. Although Jill appeared to have reached some understanding of the benefits of music therapy, she still felt she could not convey this to a patient. In the second interview Jill acknowledged that there might be 'unexpected' benefits for the patient and that the 'essence' of music therapy might be lost in trying to explain or verbalise the experience. This insight of Jill's uncovered the challenge facing music therapists and other professionals who attempt to describe music therapy to patients.

Jane

Jane has been working as an Art Therapist at the hospice for over ten years.

Jane's story

My understanding of music therapy was shaped by my experience of a music therapist in hospice. Prior to her I had a vague idea that music was therapeutic and an expectation that music would be useful. The power of art was that people could find meaning in art and I thought music would be like that – the ability to put meaning into music or sound which was created. I thought music therapy could provide songs and sound that would help give expression to feelings or thoughts. Music therapy would be a non-verbal language. I worked alongside the music therapist [MT]. So I was aware of the value of music therapy and how it could be integrated with art therapy to create a supportive environment and to support families to express their feelings and thoughts in bereavement. My understanding of music therapy has been shaped by seeing it work. What I witnessed the MT doing was: Life review with patients ‘Finding songs that tell my story’, expressing grief through musical instruments, writing songs with children to express feelings and singing or playing these back to adults. We haven't had a MT here for many years. I thought music therapy might provide an environmental experience for patients and families that they could have some control over, and that would be provided as a background. My perception hasn't changed a lot [laugh]. I didn't know that MTs didn't have to be fully trained performing musicians. I now recognise your repertoire and facility working with sound and song, creating music on guitar. There's some flexibility – music therapy comes from wherever the music therapist is coming from. So a music therapist doesn't have to be a performing drummer, but they do have to have understanding of the elements of working with rhythm and working with percussion, to understand the creative process and develop a relationship with the client. A personality of warmth and empathy, empathic response and the way that you are with people, that's a part of music therapy. Seeing that just affirms what I already believe. Music therapy supports patients by reflection, providing distraction, supports patients with their feelings

and expression and supports families to make connections with each other. Music or music therapy can allow a family to relax and be less focused on the patients' condition, and focus on being there with them. Music therapy has helped the Day Group share more intimately about themselves and their lives, their life review, and increasing opportunities to be socially interactive. Music has supported patients' quality of life by giving them stimulation when they need it. For 'L' it's been an opportunity to express her creativity and the situation she's in, in quite a spiritual way, connecting her to what is meaningful. So with structures and concepts that are guiding in her life, she is able to more directly align herself with what she believes in through music. I've seen that making music as a background has created an environment that felt caring, loving and comforting. The guitar is quite soft with the kinds of music that you play and you can enter into it or not – it's not too intrusive. You've focused on developing the resources that are available for patients – Māori music, and instruments available for people and their families to use has been a huge contribution. I think ongoing education is really important. At the Multi-disciplinary Meeting you've given little scenarios talking about specific interventions. It gives them staff a perspective on how music therapy works. Exposing people would be good in the working environment. I think the presentation that you did should happen at least once or twice a year. The presentation where you gave people instruments and asked them to make a sound that related to something in their life – that made it very real how powerful music can be, how it works. You could disseminate articles to all staff or make publications available on the article board – like how to make a referral for music therapy. Music therapy might raise awareness and support the fund raising efforts in the hospice. Art therapies had an exhibition of art that was made in art therapy sessions. That got a lot of interest and public responded really positively. I would like to see an endowment of money set aside earning interest invested and the interest support the employment of music and art therapists in hospice. At the moment we have to fund raise in the community every year for this. The District Health Board does not pay for any of the support therapies. Music therapy has *definitely* had an impact on staff. Staff are excited about music and there's been much more expression around music. There was a spontaneous desire for a regular singing group. People want more music in their working environment. I think it's been really uplifting. They feel happy, comforted and cared for.

People don't realise how important art, music or creativity is to them until they experience it. They become more aware of their own capacity to be expressive through music or listen to music that has an effect on them. If their awareness is raised they're more likely to think about patient's needs. There have also been some reactions, people saying 'I don't want music near my office because I don't think I can concentrate' [laugh]. When you've been playing for the patient's, staff really like that. For myself I've thought about how much music supports my well-being. I thought about bringing more music into my life to support me and my work here so when I'm on my way home I have something in the car I'm listening to that's uplifting.

Jane's story – 2nd interview

The time that you've been at the hospice has provided colleague support and stimulation for me. So having a music therapist and art therapist there's a lot of cross over and synchronicity in the kind of work that we do. That's been a great pleasure for me as a practitioner. I know about songwriting but just to see how you did the songwriting, how you used music to comfort, and support, working very intuitively with people's feeling. I'm just wishing that we would have a music therapist ongoing [laugh].

Jane interpretation

Jane had a broad understanding of music therapy formed from her time working with a music therapist in the past. She had also formed a deeper understanding through her collaborative work and discussions with the student music therapist and through her own use of music to support her. She recognised the commonalities in the arts therapies and how this supported her in the work she was doing. More specifically, Jane was aware that music therapy could create a supportive environment for families to 'express their feelings' in bereavement. She also observed that music therapy created a caring environment in the hospice. She understood that music could provide comfort, stimulation and distraction to patients. In addition, she noted that music therapy could support family connections and help families to refocus by allowing that family to 'relax and be less focused on the patient's condition.' Jane recognised that music therapists needed to have therapeutic skills such as listening, reflecting and being intuitive and that

they needed to have flexible musicianship skills to respond to patients' and families' needs. She understood that music therapists used a variety of musical instruments for their different dynamic qualities which allowed the patients to 'enter into the music or not.' Jane used universal themes such as connection, meaning, guidance, and belief to describe how music therapy might provide spiritual support to patients in palliative care. She felt that music therapy provided structure to patients to 'connect to what is meaningful in a spiritual way.' Jane recognised that music therapy created opportunities to interact socially, and was a catalyst for group sharing. In addition, she commented on the 'power' of music to uplift people, to support their well-being, and to help them to experience their own creativity. Similarly to other participants, she had formed these perceptions through her own experience of music, combined with her shared experience of music with the music therapy student. In the second interview, Jane takes the narrative in another direction by mentioning the colleague support she has felt through working with another therapist in the arts. This perhaps hints at the feeling of isolation that comes from working in relatively unknown and sometimes undervalued arts therapies in New Zealand / Aotearoa.

Cherie

Cherie is an occupational therapist at the hospice. She also coordinates the Day Group, which is a social meeting group for people on the hospice program.

Cherie's story

We had a music therapy student here several years ago and she was involved regularly in the Day Group. She was a nun so she probably did her [music therapy] report from the spiritual perspective? She did a lot of work with patients in the inpatient unit looking at songs that were important to them and songs they wanted at their funeral. She didn't take any group activities. She explained music therapy to individuals in the group and they could choose to become more involved. So there wasn't an official referral system as far as I know. I thought music therapy was really useful for some of the people. I could definitely see its role here at the hospice. There were some clients that I think were struggling with their illness and she worked with them allowing them to reflect through music.

When you first started I didn't know what you were intending with the group, so my perception was based on what had happened before. I expected that in the same way you would come in and quietly mix with the group. To begin with I was a bit dubious about how it was going to work with the group. We've both learnt a lot since then [laugh] and over time I've come to understand the *different* skills that music therapists bring to their work. That has led to me developing my understanding of music therapy. The group needs to develop contact with somebody before you can develop a therapeutic relationship. We didn't have a chance to discuss each others' roles before you had your first session in the day group. In hindsight it might have been better to have had a day meeting the group first. In the Day Group people come here and want to forget that they're sick. They find support in the group by doing things together and being normal. Even though a lot of things we do are quite therapeutic, we do it in a way that the patients don't see it as being like that. I understand 'therapeutic' as having a specific plan for the

purpose of that group or that person's progress or goal. The patients see 'therapy' as you trying to make them do or see something [laugh]. They don't always want to face things amongst other people. The 'Round the World' activity went well because your relationship had been established with the group by then. The patients were involved and it gave them the opportunity to sing and talk about the places they'd been to and things they'd done. That was a very therapeutic activity for them, and yet it was done in a way that they coped with. Without being challenged, they could give what they wanted to. An activity works really well if it's aimed at a special day or theme where music can be introduced into the activity. When we have sessions here we want them to be bright and jolly. I think some of the songs on St Patrick's Day were lovely, but they weren't bright, jolly songs. Christmas Day carols go well. One thing the volunteers are asking for is more quizzes – so perhaps a musical quiz. The 'Round the World' activity was good because it allowed them to talk in between the songs. The staff and patients all love the involvement of the music, whether it's with you, the 'Happy Wanderers' [choir] or the kids doing ballet to music. I think music is so much a part of everybody's life and you associate songs with good things and bad things that have happened in your life. You can sing a song that to you is bright and happy and you can have somebody else in tears 'cause that was so-and-so's favourite song. The whole group can be involved in music – it's cross-cultural, cross-everything really. We used to have the radio on or the tape deck on playing CDs all the time. It's very haphazard what music is played. We had a patient who was music 'mad' so he bought all his CDs and played them for us. I think we need to have different types of music available, perhaps on one CD, used as background music. Or have a CD that we can put people's favourite music on to. I don't know whether the group would prefer there not to be music in the background, whether it's actually important to them?

Cherie's story – 2nd interview

I think that I might have come across more negative about your role than I meant to. I am so much more aware of how you do have to build those relationships first before we can achieve other things. One of the benefits in the Day Group, of having the same consistent

staff all the time, is because those relationships are very strong and very strong within the people in the group as well.

Cherie interpretation

Cherie recognised that music therapists identify and use songs that are important to patients. She was also aware that music could be used for a patient's life review and for reflection. She initially thought that all music therapists would work in the same way but had since realised that they bring different strengths and techniques to the work they do. She ascertained that music therapists might work with individuals or with a group of people. Cherie suggested that relationship building was an essential part of the therapeutic process in music therapy. She understood that music could be used to uplift patients by using 'bright and jolly' music. However, she acknowledged that music could evoke different emotional reactions from different people. Cherie suggested that songs were often associated with a spectrum of emotions associated with musical memories and that perceived 'bright and happy' songs might 'have somebody else in tears.' Cherie also recognised that music therapy might meet some of the goals for patients in palliative care such as transcending sickness, eliciting positive memories and socialising in a supportive environment. She observed that music therapy was inclusive of all the patients and that it gave them opportunities to sing and to reminisce. Cherie understood that music crossed boundaries – social, cultural, 'cross-everything really.' Cherie thought other music therapist roles for groups of palliative care patients might include building up a library of familiar CDs, creating compilations of favourite songs and encouraging people to bring along their favourite music to be played. In the second interview Cherie observes herself as 'being more negative...than I meant to.' It is significant that at the end of her story she appears to have shifted in her understanding and is acknowledging this.

Tessa

Tessa is a palliative care nurse who has worked at a number of hospices in New Zealand / Aotearoa.

Tessa's story

I don't really think of music therapy being in the spiritual domain. Of course if you're playing gospel music and that sort of thing then obviously it's entering into the spiritual domain, but I wouldn't put spirituality and music therapy together automatically. I see music therapy more in the therapeutic domain, for healing and relaxation. Music can be a good distracter too, and can diffuse tense situations. Although I wouldn't invite a music therapist in if there was tension in the room because a new person they didn't know could increase the tension. I would invite the music therapist in for people who are in a fairly stable place in their journey. The ultimate decision for referral to music therapy is with the patient, not with me. But I can facilitate if I think there would be benefits in seeing a music therapist. It has fascinated me that you brought cultural music into your work as a way of striking up a rapport with people. You had instruments from other places that sometimes had that link with a person from another country, like the drum from South Africa. I hadn't thought of music therapy in that light before.

The healing is partly the thinking that is processed while the music is being played. Classical music with no words allows room for thinking. For example, the other night we had a patient who was dying. She was alone and she was quite restless and music did help her to settle. Music gives company when there's not company. When the patient is semi-conscious and I can't ask what sort of music they like, I choose music that I like and that I think the patient might like as well. The other nurse knew this patient liked classical – just nice 'floating away' music to go to another place in. It would be good to have quick access to the CDs if we had a mini-library catalogue system. Having regular education sessions to educate staff about music therapy has been a good starting block. I'm not sure what the library upstairs has on music therapy. I have looked it up on the internet myself

about music therapy in palliative care. The conversation we had when we both started was helpful in my understanding of your role. It was recommended that we make contact with other staff when we started. I'm pretty trusting in what you do and I think what you are doing is good. But I'm unsure about whether music therapy should always be done in seriousness because sometimes I know it can be a fun thing as well. There is a lot of sadness and emotions but sometimes people are in quite a good space and you can introduce things in a light hearted way. Like with 'N' – I've worked with her so many times, I knew she liked Elvis and the pink pyjamas song. Her daughters were playing her favourite music through the night. I think music was fairly important to her. We've touched on quite a bit which we didn't touch on earlier about the emotional side of music and its role in the well-being of patients.

Tessa's story – 2nd interview

I think that music therapy has been well received. Plus, I think that nurses who work here every day are more likely to use it. I've heard of other nurses singing to patients and not just me. Whereas before I hadn't seen nurses using it as much as they are now. I think the forum that you've created here allows that music involvement more. It's not seen as silly, but lightens the mood in more serious situations.

Tessa interpretation

Tessa drew the distinction between the 'spiritual domain' and the 'therapeutic domain' and felt that music therapy was primarily therapeutic for 'healing and relaxation'. However, she acknowledged that both religious and classical music might be representative of the spiritual domain. She also appreciated that healing occurs during the processing of thoughts in music therapy. Tessa was surprised to discover that music therapists would use specific music or resources to make cultural connections with patients. She also suggested that music therapy could contain an element of fun 'when there is a lot of sadness and emotions but sometimes people are in a good space'. Whilst she understood that music generally could provide distraction and 'diffuse tense situations', she had not experienced music therapy in a situation where there was tension in a patient's room and she could not imagine inviting a music therapist in to diffuse a

tense situation. However, she later shifted ideas by acknowledging that music could be used to 'lighten the mood' in difficult situations. Tessa appeared to be forming some of her ideas in the process of the interview, and she acknowledges the power of conversation as a learning tool. In addition, she observed that music therapy could support a patient who was in a 'stable place in their journey.' Tessa used the metaphor of 'floating away music' as a description of using music therapy for relaxation and transcendence. She also appreciated that music could provide comfort by 'offering company when there's not company' and she acknowledged that music could access emotions and support the well-being of patients.

Answer/s to the research questions

How do staff members perceive the use of music therapy, particularly with regard to the spiritual needs of patients, in palliative care in a New Zealand / Aotearoa hospice?

General perceptions

One of the most notable things to emerge from the interviews was that each participant had a different focus on their perceptions of music therapy which were not overtly related to spiritual care. Interviewees mostly had a positive attitude towards music therapy in the hospice. However, two staff members questioned whether music therapy may be intrusive to the patients, particularly in relation to the power of music to evoke sad memories. Four of the participants talked about music used *in* (therapeutic) care rather than music *as* therapy. They thought that music therapy might be using music to create a background of soothing, calming music for patients in the hospice. For example, one participant said ‘nurses have instinctively been doing quite musical things’ to describe music in the care of patients.

Further, the early perception of three participants, who had not encountered a music therapist before my arrival, was that music therapy was largely background music used to create calm, soothing environment. Descriptions of the background use of pre-recorded music included: ‘create a mood; soothe a patient; create some space; breaks the clinical feel; music in the background; feels like home.’ The other three other participants, who had experienced the work of a music therapist before my arrival, all had some understanding of music therapy generally and in hospice care. Their early perceptions of music therapy included: ‘a non-verbal language; to express feelings; create a supportive environment; musical life review; exploring hope and meaning; children with mental disabilities and development goals.’

Multi-disciplinary collaboration – a synergistic approach

Four of the participants stressed the importance of understanding the roles of the music therapist so that they could work effectively as part of a multi-disciplinary team.

Comments that were made included: ‘colleague support and stimulation; cross over and synchronicity; the need to not dilute by having too many therapists; defining roles; working alongside; a synergistic approach; sharing information; don’t have the skills to see that; communication by team members.’

Music to bring a sense of stability, calm and comfort and to uplift patients

All of the participants had noticed the comforting effect of music on the patients, one even suggesting it could help them to ‘float away’. Participants suggested music can uplift, energise, soothe; relax; create an environment; generate feelings of being cared for, loved, comforted, and supported. It helped to settle patients, regulate their emotional states, and diffuse tense situations. People could enter into music or not. The different qualities of instruments were recognised, for example ‘the guitar is quite soft’.

Emotions evoked by ‘sad’ or ‘happy’ music – contrasting attitudes

There was a lot of discussion by all participants on the emotional effects of music on patients in the hospice. Participants also noted their own experiences of feeling emotions in music which were at times quite powerful. Some of their understanding came from their own experience of music to evoke emotions. For example, one participant used the blues to ‘illustrate grief and bereavement’ and another heard a folk song and reflected ‘when she finished I was in tears’. Some participants mentioned the qualities of music describing various types as either ‘sad’ or ‘happy’ music. There was a general recognition that music may have different effects on different people at different times.

Three participants commented on the potential effect of music to bring out ‘sad’ emotions, and voiced concerns over this. One participant was unsure how a music therapist would respond if music brought up emotions in the patient. The other two said that they believed the music played in music therapy should be ‘happy’ music in a hospice setting. The types of comments made included: ‘bright jolly songs’; it can be a

fun thing'; 'in a light hearted way'; 'bright and happy'; 'feel like they're enjoying it'; and 'think about wonderful memories'.

Conversely, other participants believed that music therapy was not always about cheering someone up. They thought that it was also about allowing emotions to be expressed. These participants used analogies such as: 'memories of not so happy times'; 'not always about being happy'; 'allowing tears to flow'; 'she chose sad songs for her funeral'; 'expressing feelings'; and 'expressing grief through musical instruments'.

Impact on staff of music therapy in the hospice environment

Most of the participants mentioned the positive impact on staff of having music in the hospice. One participant mentioned spontaneously, after one of the music therapy seminars, the desire for a staff choir. Other comments made by participants were that they felt staff wanted more music in their working environment and that universally people respond to music because it is non-threatening.

Participants responded with various comments on the effects on staff of music therapy in the hospice: 'staff feel happy, comforted, cared for, and uplifted'; 'music supports my well-being'; 'it's so comforting'; and 'it just feels like home'' One participant believed that experiencing music therapy was a great learning for all the staff. She believed that staff's musical awareness is raised through experiencing music therapy and that they become more aware of their own capacity and are more likely to think about patients' needs.

Another participant thought that guitar playing and singing by Māori and Pacific Island families around the patients' beds in the hospice, was particularly powerful. He believed that everybody loved this form of music in the hospice and he made links to spirituality and music therapy.

Perceptions of spirituality and music as a pathway to spiritual care

The quality of language used by the participants to describe spirituality had powerful metaphors relating to their own experiences. Metaphors included: ‘floating away’; ‘opening up’; ‘finding the core self’; and ‘evoking the subconscious’. All of the participants in the study used language throughout the interviews that might be used to describe the spiritual care of patients, yet only three stated specifically that music therapy could be effectively used as a pathway to the spiritual care of palliative patients. One respondent said that she didn’t see music therapy as being in the ‘spiritual domain’.

All of the participants used language that suggested they were talking about the spiritual care of patients who had experienced music therapy. Three of the participants referred to the religious aspects of spirituality. Religious language used in the interviews included: ‘priests’; ‘gospel music’; ‘organ playing’; ‘hymns’; ‘angelic choirs’; and ‘nuns’ Since encountering music therapy at the hospice, the participants’ understanding of the practice seemed to have expanded. In their interviews, they suggested music therapy was related to ‘being present’; ‘finding meaning’; ‘connecting families’; ‘expressing emotions’; ‘reflection through music’; ‘energy levels’; ‘being present’; and ‘connecting’.

All of the participants seemed to value the use of music in the spiritual care of patients in the hospice. Four people mentioned their own use of music for spiritual care of patients in their work at the hospice. Others discussed their personal use of and relationship to music in their own lives which included spiritual care.

Education and resources are ongoing

‘Music can reach the depths of human experience. Music can also raise awareness of this experience, which enables it to become shared’ (Davis, 2005, p. 137).

Personal learning and new understanding emerged for participants during the process of discussion during the two interviews. This highlights the idea of ‘educio’ or the ‘drawing out’ of understanding. The presence of a music therapist in the hospice playing music in

the patients' rooms was seen as important to the participants growing awareness of music therapy. Conversations with individual staff members were also perceived as crucial to staff understanding the music therapist's role in hospice work.

The participants had some useful ideas on how to up skill people about music therapy in hospice care. There was a general agreement that ongoing education is important and that the seminars on music therapy could be run a few times to capture all the various shifts that staff worked. Some participants mentioned that involving staff in making music during seminars was a very effective way to engage them and interest them musically.

Also the provision of musical instruments (guitar and ukulele) for hospice visitors was perceived to have made staff more aware of the use of music in the hospice and generated more talk about music generally. There was agreement that contributions to the Multi-Disciplinary meetings were invaluable in imparting information on specific music therapy techniques, strategies and outcomes.

There was a suggestion to supply publications to staff about specific topics related to music therapy in palliative care as a way to disseminate information. Also, a music therapy fund-raising project was suggested as a way to raise awareness of music therapy in the community.

Live musical demonstrations to staff were perceived as valuable by some participants to show techniques and methods used. Also, live music was seen to cross cultural boundaries and to break down any barriers between staff and therapist.

Informed referrals – a need to understand the applications and benefits of music therapy in hospice care

Staff participants had varied levels of confidence in making informed referrals for music therapy. Three staff members implied that they felt comfortable with making referrals. One participant gave some detail on when she would refer for music therapy – ‘people

who start to articulate around music or talking about the place of music in their lives, especially if they're very unwell or have less energy.'

There was also some confusion around music therapy referrals. One participant commented that if she was introducing music therapy to a patient, she wouldn't know how to describe to them how they might benefit from music therapy. Another participant believed that the decision to take part in music therapy was with the patient and she said she would make a referral if she thought there would be benefits in seeing a music therapist. One participant suggested that the music therapist could disseminate an article to staff on how to make a referral for music therapy.

Discussion

Introduction

Brooks and O'Rourke (2002) suggested a lack of knowledge concerning music therapy's clinical and therapeutic status and success in hospices, may hinder initial acceptance in New Zealand / Aotearoa. My background in education influenced my curiosity about how staff perceptions might change when opportunities are presented for increasing knowledge.

I know of only one music therapist currently employed in a New Zealand hospice, and I therefore assumed that staff working in hospice care would be unlikely to have encountered a music therapist. I therefore also initially assumed that many staff at the hospice I was practicing at might not have much understanding of how music therapy might support the spiritual care of palliative patients. From my early journal recordings of people's perceptions at the hospice, it seemed that many people thought that music therapy was background music played in the work environment.

However, I discovered that the hospice where this research took place was unique in New Zealand / Aotearoa in that both a registered music therapist and a student music therapist had worked there previously. Half of the participants interviewed had therefore experienced music therapy in a hospice before. This was a surprisingly high number of people for a hospice in New Zealand / Aotearoa (Brooks & O'Rourke, 2002). It may be that those participants had come forward to be interviewed expressly because they had experienced the work of a music therapist previously. This provided rich data as it gave a comparison of perceptions of those who had experienced music therapy in a hospice and those who had not.

In my Reflective Journal dated the beginning of May 2011, I recorded that the staff appeared generally open to and interested in music therapy with the exception of a few

staff members who seemed to be more cautious at first. Factors that may impact on team work include differences in philosophy and language and limited opportunities for dialogue between professionals (Kuebler, Davis & Moore, 2005). In the current study, participants came from four different cultural backgrounds and five different health professions, which may highlight differences in perceptions towards music therapy.

All of the participants showed that they had developed their understanding of music therapy in the spiritual care of hospice patients over the time I was at the hospice. Furthermore, my original assumptions about staff understanding of music therapy in spiritual care shifted during my research. I became aware that the participants appeared to be talking *around* the subject of spiritual care at times but that they were using language that could be deemed as reflecting spiritual concepts. Taylor (2003) recognises that the spiritual dimension is often hidden beyond language and is, therefore, integrated within everyday palliative care. Byrne (2002, p. 73) says, 'It could be said that nurses are involved with spiritual care without necessarily being conscious of having the language to articulate the nature of the experience.'

My personal belief guiding the interpretation of the interviews was that hospice work is intrinsically related to spiritual care and that the two cannot be separated. McSherry (2005, p. 100) says: 'Spirituality has a fundamental and central (often hidden) role to play within the context of palliative care in that we cannot have one without the other.' My philosophy of spiritual care follows that of music therapists interviewed in a study by Marom (2004). These music therapists explain that they 'engaged in all music therapy sessions in a state of attunement and openness to a spiritual reality, which they believed was always present.' (Marom, 2004, p. 60)

My emerging assumption during the analysis process was that spiritual care may be hidden beyond language, and may be integrated within daily care in the hospice setting. Thus, many health care professionals may be providing 'spiritual care' not under the banner of 'spirituality' (Nyatanga & Astley-Pepper, 2005; McSherry, 2005; Taylor, 2003; Byrne, 2002). It may be that the vocabulary of 'spiritual care' that professionals were

comfortable with was hidden behind more common concepts such as loss, grief, fear and holistic care (McSherry, 2005). Taylor (2003) also describes the hidden aspects of spirituality as kindness, connectedness, prayerfulness and physical support.

I used an open interview technique, which included not giving too much direction or limiting the participants' responses to set questions so that the stories of the participants emerged. Whilst I was particularly interested in answering the research question related to music therapy in spiritual care of hospice patients, I also wanted to hear the participants' unfolding stories of their understanding of music therapy in hospice over time. I was comfortable with the wide scope of the study as this reflected my broad concept of spiritual care in hospice music therapy.

The language of spirituality and music therapy – an art beyond words?

'How can we begin to translate the untranslatable?' (Bunt, 1994, p. 183)

One of the most notable things to emerge from the interviews was that although the language of spiritual care (as I have discussed in the literature review) was used by all participants – meaning, purpose, relationship, reflection, connecting, core self, subconscious (Dileo & Loewy, 2005; Magill, 2005, 2002; Aldridge, 1995, 2003; Hartley, 2002) – participants did not necessarily use this language to describe what they were observing of my work, but substituted other words which might also relate to spirituality. Byrne (2002) states that language can be a barrier to promoting spiritual care to patients in palliative care.

Understanding of the relationship between music therapy and spiritual care in the hospice varied for each of the participants and at times I needed to look deeply to interpret the meanings behind the words of the participants. My interpretation of their words is therefore situated in my own personal and holistic practice of spiritual care in music therapy as reflected by Magill (2002) – that the heart of what we do in music therapy is spirituality. An approach to palliative care is therefore intrinsically embedded in spiritual

care to enable music therapists to fully understand and respond to the patient's needs (Hepburn, 2006; McSherry, 2005; Marom, 2004; Magill, 2002; Hartley, 1999; Aldridge, 2003, 1995).

The participants' general perceptions of music therapy in hospice did relate to themes of spiritual care; however the language of spiritual care was perhaps different for each participant. Some participants may not have thought about what spiritual care meant to them personally. Or perhaps the participant's knowledge of music therapy was related to care which they did not perceive as being spiritual care. The participants' perceptions may have revolved around what they felt most comfortable with or knowledgeable about. This may have been due in part to staff positions and varying experiences of music therapy in the hospice. Further, I did not specifically ask for the participants' perceptions of the word 'spiritual'. Although this may have put the interviews more firmly in the context of spiritual care, I felt it may also have lengthened the interviews considerably and detracted from the focus of music therapy. In hindsight, I believe that it may have added more unexpected and personal connections to spirituality in the participants' stories.

In order to have a discourse on spirituality, the language and meanings associated with spirituality need to be defined so that they accurately represent people's perceptions (Hepburn, 2006; McSherry, 2005; Taylor, 2003; Amir, 2002; Byrne, 2002; Bunt, 1994). There has been much debate in the palliative care literature over what is considered 'spiritual' and how to conceptualise it (Włodarczyk, 2003). McSherry (2005) believes many health care professionals may be providing spiritual care not under the guise of 'spirituality'. He says that concepts of 'spirituality' and 'spiritual care' may be communicated under another language – 'that of loss, grief, fear and "holism" ' (McSherry, 2005, p. 101). Taylor (2003) described the hidden aspects of spirituality as the provision of kindness, connectedness and prayerfulness. Byrne (2002) furthers this by saying: 'It could be said that [they] are involved with spiritual care without necessarily being conscious of having the language to articulate the nature of the experience' (Byrne, 2002, p. 67).

Following McSherry (2005), Taylor (2003) and Byrne's (2002) theories, one could argue that many of the perceptions of music therapy in palliative care that were covered in the interviews in this study fell under the proviso of 'spiritual care'. 'The provision of spiritual care is [about] a realisation that this dimension is often hidden beyond language, and thereby integrated within the care that is already provided in a palliative care setting' (Taylor, 2003, p. 118).

Participants referred to the hospice philosophy of care which includes spiritual care. The World Health Organisation (WHO) definition of palliative care also integrates the psychological and spiritual aspects of patient care (WHO, 2009). The participants commented that the hospice philosophy is around spiritual care so the implication is that staff members are looking at a person as a whole. I felt Dana spoke for her co-workers when she said 'The spiritual care is something we all dip in and out of.'

Some participants appeared to view religious concepts synonymously with spirituality. Some of the language used in the interviews linked to religion included: priests, gospel, hymns, angelic and nuns were all mentioned in descriptions of spiritual care in music therapy. Music therapists working in this field have attempted to distinguish between spirituality and religion (Wlodarczyk, 2003; Aldridge, 2003; Amir, 2002). Wlodarczyk (2003) explains that spirituality is a personal connection outside the self, whereas religion refers to a denomination. 'It could be said that spirituality is the experience, while religion attempts to further name that experience' (Wlodarczyk, 2003, p. 2). Aldridge (2003) explains his perception of the differences between spirituality and religion: 'If spirituality is about the individual, ineffable and implicit; religion is about the social, spoken and explicit' (Aldridge, 2003, p. 1). Music therapy may support the religious faith of some patients by creating a 'sacred space' for the patient who can no longer attend spiritual services Salmon (2001). By playing religious music to the patient and their family, the music therapist might support the patient by providing an opportunity for prayer, worship and transcendence through music.

Before I arrived Jill thought music therapy might include ‘angelic choirs’ or someone playing hymns on an organ. She went on to say that the hospice had a priest for spiritual care and that nurses can struggle with how to support the spiritual care of patients. Jill appeared to be saying that spiritual care could be a confusing area for someone not trained in this area. This view is supported in a survey of nurses which suggested confusion over the role of the nurse in providing spiritual care (Narayanasamy & Owens, 2001).

Dana regarded simply being present in the moment with someone as being spiritual care. Being relaxed, centered and fully present with patients is an important part of relationship building in palliative care music therapy (Hepburn, 2006). It has been suggested that providing comfort to a patient, to lend strength and to hold a hand can be regarded as spiritual care (Randall & Downie, 2006). In palliative care just being friendly and at ease with a patient might offer strength and boost the morale of a frightened patient (Randall & Downie, 2006). This might be seen as spiritual care that can be offered without the need for any special understanding, training or spiritual inspiration (Wlodarczyk, 2003).

Barry appeared to be personally comfortable with the concept of spiritual care for patients. This may reflect Barry’s years of professional experience, his particular training and his role as a doctor in palliative care. He believed that palliative care staff needed to be comfortable with issues of spirituality when they arise, to reflect back, and to have thought about what spirituality means to them personally. This view is shared by other professionals working in the field of palliative care (Egan, 2009; Sekeles, 2007; Hepburn, 2006; Amir, 2002). Sekeles (2007) also believes it is important for therapists working with death-grief issues to be aware of their own attitudes towards death, dying, spiritual aspects of death, euthanasia and life after death.

Participants appeared to have experienced their own sense of spirituality through their relationship with music. They suggested that listening to music opened up other kinds of energy in them and that it was uplifting. Some participants used music for their own sense of well-being and to support them in their professional work. Healthcare

professionals have reported their own sense of well-being through spiritual care interventions with their patients (Narayanasamy & Owens, 2001).

General attitudes towards music therapy

All interviewees had a positive attitude towards music therapy in the hospice. Even if a participant had commented that they did not fully understand how music therapy could benefit terminally ill patients, they remained open to the concept. Munro (1974) asserted that in general, at the time of her study, hospice care professionals were unfamiliar with music therapy and music therapists were unfamiliar with terminal care. In the current study, three of the participants had encountered music therapy and were therefore relatively well informed.

At times the participants interspersed their discussions of music therapy with examples of how nurses used music in their practice. This led me to wonder if there was a misconception that music therapy included musical interventions undertaken by other staff such as nurses providing recorded music to patients. This also opened up possibilities for collaboration and support from nurses in providing carefully selected pre-recorded music for patients. Many professionals use music to comfort patients or create an atmosphere of calm (Daykin, Bunt & McClean, 2006; Hilliard, 2005). Although music therapists might also use carefully chosen music for the same effect, music therapy in palliative care draws on a wide range of music interventions as an agent for therapeutic change. These might include songwriting, listening to lyrics of known music, leading the patient in music-making such as singing or improvisation, collating music as a life review and sing-a-longs with family and friends (Dileo & Loewy, 2005; Hilliard, 2005; Włodarczyk, 2003; Aldridge, 1999; Pavlicevic, 1999).

Music therapists use music as the main method for therapeutic change and techniques will vary. Techniques might include the music therapist playing carefully chosen music which is adjusted in rhythm, tempo and volume to suit the patient's condition and preference (Magill, Levin & Spodek, 2008). Music *in* therapy is when music is just one

of the techniques used in therapy. This is more commonly used when a patient can benefit through modalities other than music, such as when there is a high need to verbalise his/her insights (Bruscia, 1987). The distinction is drawn here between ‘music in medicine’ and ‘music therapy in medicine’. In the first, music is the primary therapeutic tool, whereas in the latter, the therapist-client relationship and the *music experience* are central (Bruscia, 1998).

Music therapy in the background of the hospice environment

Participants who had not experienced music therapy appeared to perceive at the time of my arrival that music therapy might be background music in the hospice to create a comforting environment. In my journal I recorded that my informal discussions with staff led me to believe that this was a common perception of what music therapy was – creating a soothing musical background to make people feel good. Playing both live and recorded music in a patient’s room to create a feeling of calmness is one of the applications of music therapy in hospices (Hepburn & Krout, 2004; Włodarczyk, 2003; Magill, 2002; O’Callaghan, 1996; Curtis, 1986).

The nurses in this study talked about providing CD players to play music in the background or playing the organ or piano in the hospice. Nurses quite intuitively used music to support patients. Jill thought music therapy might be ‘playing tapes in the background and asking patients how it made them feel’. With carefully chosen music, a music therapist might use this technique to help a patient to express emotions or to reminisce about their lives. Listening to music that a patient associates with significant events, people and places may help them to reminisce positive memories and feel re-connected to the life they led before they became ill (Hogan, 2002).

Hospices have the potential to become environments where illness and suffering dominate (Aasgaard, 1999). An improvement to the general environment was recorded by supportive care providers in cancer care in a survey of music therapy (Daykin et al, 2006). O’Kelly and Koffman (2007) describe the perceptions of staff towards

environmental music in hospices. Rather than playing taped music, they referred to the live musical performances by the music therapist in the hospice. These events were considered by staff to be relaxing and able to ‘lift’ the atmosphere in the hospice. This has been referred to as ‘environmental music therapy or EMT’ (Schneider, 2005; Aasgaard, 1999). Schneider (2005) says EMT can alter the ‘emotional landscape’ of a medical setting and aims to soothe and relax those within earshot of the music. It has also been suggested that the environmental effect of music therapy can provide humanising qualities to medical settings and create a ‘healthy environment’ (Aasgaard, 1999).

Dana talked about music ‘creating some space’ in a medical environment. She also commented that patients can ‘enter into music or not’. I felt she may have been referring to the effect that music can have when it fills an environment and cuts out other external stimuli. Kenny (1989) talks about ‘musical space’ which is an environment created through the relationship between the therapist, the client and the music. Some patients may benefit from the containment of a ‘sacred space’ (Wlodarczyk, 2003; Salmon, 2001). This sacred space could include important items to the patient and special music or art. Salmon (2001) describes this ‘sacred space’ as a metaphorical space where the patient can feel safe enough for meaningful experiences to happen. Kenny (1989) reports on a conversation she had with renowned music therapist Helen Bonny, during which the latter described the field of sound as ‘sound presence’ or ‘envelope of sound’ (Kenny, 1989, p. 32). Bonny reportedly suggested the phenomenon is a field of sound in which people feel supported in the process of healing.

Jill believed that music in the hospice environment could break the ‘clinical feel’ to the place and she said that it ‘feels like home’ when music is playing. I felt that Jill was referring to a stereotypical clinical environment which may be noisy, busy and sterile whilst her perception of home is more nurturing with the use of music. Clark et al (2007) refer to the job satisfaction that comes from the integration of spiritual care in the workplace. The hospice philosophy of care where this study took place was reflected in the physical environment. It was intended to be home-like with bright coloured quilts on

beds, pictures on walls and carpeted rooms. Jill seemed to feel that music completed this picture of the hospice being a 'home' for the patients.

Jane felt that music therapy in the hospice had provided patients with comfort and had created an environment that felt 'caring, loving and supportive.' She talked about the choice of guitar to support patients and commented, 'The guitar is quite soft and you can enter into it or not.' Dana also mentioned the concept of 'entering into music'. In addition, Jill mentions the use of guitar – 'Sometimes when I hear you playing guitar in the hospice...I just think it's so comforting.' The benefits of using the guitar in music therapy include the guitar's portability, familiarity and dynamic range of sound (Castelino, 2008), which makes it a particularly suited instrument to palliative care (Ricciarelli, 2003).

Cherie gave insight in to the use of pre-recorded music in the Day Group environment. She comments: 'We used to have the radio or the tape deck on all the time'. She felt that the style of music played may not have suited all of the patients in the Day Group. She said, 'I don't know whether they would prefer there not to be music in the background.' Music therapy with groups can generate positive social interaction (Pavlicevic, 2003; Aarsgaard, 1999). However, the more diverse the environmental population is, the more varied or even contradictory their individual needs might be.

The making of a socially stimulating but secure environment, is a challenge for institutions where patients and families are experiencing an extremely insecure and unpredictable time of life, as is often the case in hospices (Aarsgaard, 1999, p. 39).

Pavlicevic (2003) believes that group 'musicking' is about more than just having music in common – culture, ethnicity, socio-economic status and values can all either alienate or bond a group. She believes that it is the actual act of group 'musicking' – a phrase coined by a New Zealand / Aotearoa musicologist (Small, 1998) – that forms the distinct culture of a group.

Experience with music therapy in hospice prior to the research music therapist arriving

Three of the participants had experienced the work of a music therapist before my arrival. My original assumption was that it would be unlikely that staff had experienced a music therapist in hospice care. Contrary to my assumption, two music therapists had worked at the hospice in this study previously – one was a registered music therapist at the hospice in the 1990s and the other was a student music therapist at the hospice in 2005.

Prior to my time at the hospice, these participants had developed a broad understanding that music therapy could be applied for a range of therapeutic uses. They recognised that music therapy was a way of communicating that could be used as a ‘non-verbal language’ to express feelings and find meaning. There was also an understanding that music therapy could be used for a musical life review with patients. Jane said that the music therapist she worked with had used the phrase ‘finding songs that tell my story’ to describe life review and memories through music. Cherie had worked alongside a student music therapist and understood that ‘songs that were important’ to patients in their lives allowed them to ‘reflect through music’. Barry used music for his own musical life review and understood that terminally ill patients involved in music therapy might also do this.

The various therapeutic uses of music therapy that are discussed by participants who had experienced a music therapist – providing hope and meaning (Aldridge, 1995), expressing feelings (Hogan, 1999), reflecting through music and life review (O’Callaghan, 1996), non-verbal language (Kenny, 1989) – may be found in the literature related to music therapy in palliative care (Dileo & Loewry, 2005; Hilliard, 2005; Magill, 2005; Hogan, 1999; O’Callaghan, 1996; Aldridge, 1995). Palliative care literature also refers to patients’ life review and the search for meaning and purpose (Kuebler, Davis & Moore, 2005).

Barry had developed his earliest impressions based on his knowledge of music therapy with children with mental disabilities and development goals. After a previous music therapist arrived at the hospice in 2005, his understanding broadened into palliative care.

He says he started to think about ‘using music as a way of exploring hope and meaning’ and he began to use music himself as a teaching tool to illustrate grief and bereavement in palliative care practice. He had touched on themes of music therapy and spirituality that are common in the literature (Magill, 2005; Krout & Hepburn, 2004; Hogan, 1999).

These three participants’ early perceptions of music therapy illustrate the value of experiencing music therapy first-hand as a pathway to understanding (O’Kelly & Koffman, 2007; O’Rourke & Brooks, 2002). By the time of my arrival they had already developed an understanding of some of the applications of music therapy in hospice care.

Multi-disciplinary and inter-disciplinary collaboration – a synergistic approach

Hospice care involves a group of professionals working together to care for an individual. The team available to a new patient in palliative care may include doctors, nurses, a counsellor, art therapist, music therapist, family / whānau support and a touch therapist. This can potentially be overwhelming or confusing for a patient, especially if they have led a relatively private life before their terminal illness. One study participant alluded to the notion of intensity – ‘to not dilute by having too many therapists.’ It is therefore important that teams of professionals work together to assess and then address patients’ needs (Twyford, 2007; Kuebler, Davis & Moore, 2005; Krout, 2004).

Twyford (2007, p. 22) defines multi-disciplinary collaboration: ‘Professionals provide separate treatment...seek expertise of other professionals, are aware of each other’s goals...and liaise regarding client needs and progress’. She defines inter-disciplinary collaboration as: ‘A team of professionals work[ing] collectively to determine goals and implementation plans however still deliver[ing] treatment independently, respecting professional boundaries’ (Twyford, 2007, p. 23). A typical multi-disciplinary hospice team was represented amongst the study participants – two nurses; one art therapist; one doctor; one occupational therapist; and one counsellor. Each brought different

perspectives and knowledge to their interviews related to their various backgrounds and professions.

The art therapist Jane talked about working alongside a music therapist. She felt that art therapy and music therapy were complementary in their approach and in the support of patients and their families. Jane also felt that working together strengthened the value of the arts therapies. People can find meaning in both art and music and both are creative processes which can support the process of grieving (Hartley & Payne, 2008). Jane said, 'I was well aware of the value of music therapy and how it could be integrated with art therapy as a way of supporting families to express their feelings in bereavement.' Music therapy with bereaved families can allow them to explore their feelings and begin the journey through their own grief process (Krout, 1999).

Barry, the doctor in this study, talked about the importance of sharing information in the multi-disciplinary staff meeting. He used the example of a boy who was severely disabled due to his terminal illness and had very low responses. He said, 'I think that's quite important that it's discussed that he is responding in this way to this music therapy – all of us [staff] don't have the skills to see that interactiveness.' In this example, information about a client's positive response to music therapy is discussed with the team. Twyford and Watson (2007) state that multi-disciplinary team sharing gives a more holistic picture which ultimately benefits the client.

Cherie, the occupational therapist, was aware of the need for communication between team members when working with groups of terminally ill patients. When I first arrived she was not sure how music therapy was going to work with the Day Group who came in once a week. She said that after meeting and discussing the group music therapy, she realised the different skills that each music therapist brought to their work, highlighting how perceptions change as knowledge increases.

Dana focused on the notion that a counsellor and a music therapist may both use similar therapeutic approaches with a shared patient. She recognised that foremost it was

important for each therapist to define their roles as counsellor and music therapist so as not to confuse the patient. Other allied health professionals have commented that their discipline has been enhanced by working alongside music therapists (O’Kelly & Koffman, 2007).

In my journal I reflect on my feeling of being the ‘new person’ in the hospice. I was aware that others may have been working with long-term patients and I did not want to undermine any of the work that they had done. Nor did I want to replicate any other therapeutic work. I was aware of the issues Dana had highlighted and believed that collaboration was essential in a multi-disciplinary palliative care team.

Dana also recognised the differences between therapies. She said counsellors rely on verbal communication and they often had a ‘window of opportunity’ to work with terminally ill patients while they were lucid. She thought that a music therapist might be able to work with a patient who had low energy or had entered a non-verbal stage of their illness. Dana said, ‘I might see [music therapy] as a way they can be met that would be quite powerful but more gentle in some ways.’ Dana appeared to be referring to what Singh (2000) calls the ‘Nearing Death Experience – moving beyond the separate sense of self and the increasing experience of spirit and grace.’ Callanan & Kelly (1992) call this ‘Nearing Death Awareness’ and say that a patient’s attempts at communication can be dismissed as confusion due to medication and illness. They assert that to assist the patient in a peaceful death, families and caregivers need to be particularly attentive to the patient during this time. Music therapists may be present playing music during this time in a patient’s dying phase (Krout, 2003). Munro (1974, p .89) says: ‘In communication through symbols, music will reach far beyond human interaction. It can allow us to travel to the edge of their life and back again, to experience transition, a moment of change and the mystery of transformation.’

Music to bring a sense of stability or to uplift patient

‘Music is the balm to all my troubles’ (quote from a hospice patient, in Hilliard, 2004).

Most of the participants had commented on the relaxing and stabilising effect of music on the patients and their families. They also recognised that music played to a patient could uplift or energise them. Dana mentioned the physical lack of control that terminal patients experience and how this can be distressing to them. She said, 'Music can be soothing and helpful to people when a lot of things aren't in their control.' Music can connect with emotions, thoughts and feelings and music therapists use different techniques to either stabilise or uplift patients (Magill et al, 2008; Hogan, 2002; O'Callaghan, 1996). A music therapist will adjust rhythm, tempo, volume, timbre and lyrics to suit the needs of a patient (Magill et al, 2008). Therapeutic outcomes include alleviation of distress, increased relaxation and increased sense of control (O'Callaghan, 1996).

Through her own use of music in her nursing practice, Tessa believed that music could help support a patient's emotional state and help to diffuse tense situations in a room. She describes a situation with a restless patient where she said 'music did help her to settle.' Barry referred to Kerslake (2006) who had written about using music to help himself through depression when faced with cancer. Kerslake would use songs that he knew would help his emotional state when he got sad or depressed.

For a music therapist working with the terminally ill, there is a balance between using music to uplift a patient, to soothe them, or to allow them to be supported to experience a range of emotional reactions. By recognising what the patient might need in a moment there is the constant challenge in trying to meet those needs. As one participant in this study commented, 'it's not always about cheering someone up'. Munro (1974) comments on the risk of presuming that a patient might need music therapy for reasons such as 'it will cheer them up'. She discusses the balance between the therapist being in tune with patient's needs and taking risks in communicating with the patient. 'Only when I forgot about expectations, dared to be patient and to leave choices and initiative to the individual, did music become an effective treatment mode in this kind of care.' (Munro, 1974, p. 78)

Impact on staff of music therapy in the hospice environment

Most of the participants mentioned the positive impact on staff of having music therapy in the hospice. There were comments that staff and patients all loved the involvement of the music in the hospice as music was a part of everybody's life and universally people responded to it. Jane commented that she was sure people wanted more music in their working environment. She mentioned the spontaneous desire for a choir after one of the music therapy seminars and that there had been much more expression about how staff felt about music. In a United Kingdom study of staff perceptions of music therapy, one participant commented that environmental music therapy resulted in both patients and nurses 'dancing round the day hospice' (O'Kelly & Koffman, 2007, p. 238).

Participants believed that having a music therapy student at the hospice had been a great learning for all the staff. Jane believed that as the staff's musical awareness was raised through experiencing music they became more aware of their own capacity in their work. She was also reminded of the value of music in reducing her own work-related stress. In one of the music therapy seminars I ran, I invited staff to choose an instrument for a group improvisation. This hands-on experience generated discussion amongst staff on the beneficial effects of creating their own music. In a workshop designed for music therapists to reduce work-related stress, one participant commented: 'The workshop reinforced my understanding of the value of music to reduce stress, even when used for short periods of available time' (Booth, 1998, p. 54).

Cultural concepts in the hospice environment

Barry commented on the effect on staff of guitar playing and singing around the patients' beds by Māori and Pacific Island families in the hospice. He said that he had never heard anybody complain about that singing and he felt that everybody loved it. He asked the eloquent question: 'Is there some music therapy connection with that form of music?' There is a perceived need for intercultural collaboration in future studies of multicultural music and spirituality.

There are important cultural issues to discuss here: the way in which Māori and Pacific Island people use music in their everyday lives; the way in which they might use music in times of stress and when people are dying; and the interface between their various forms of musical expression and Western music therapy. New Zealand / Aotearoa is a multi-cultural country and an understanding and respect for other cultures is vital in music therapy (Croxon, 1996; O'Rourke & Brooks, 2002).

Māori concepts of death are reflected in the songs sung by the people (Kirby, 1990; Durie, 1985; McIvor, 1988 & 1998). Waiata (chants, songs and dance) are an important part of the *karakia* associated with death and dying in Māori culture (Ngata, 2005; Black, 2001).

‘A waiata is a compelling, remembered story giving us the opportunity to be at the centre of our universe for brief moments – and to share our heartfelt feelings with others...you begin to recover, and discover, something that belongs to your soul’ (Ponika, 2001, p. 10).

McIvor (1988) studied Māori chant and waiata and their implications to music therapy. She found that the rhythm and ritual of Māori music supported group solidarity, enhanced identity and served as a source of emotional release (McIvor, 1988). Beliefs that waiata had healing properties and were connected to the spiritual world were culturally embedded in Māori *tikanga* or philosophy (McIvor, 1998). She says, ‘For the terminally ill facing death, music has a role to play in diverting the mind from pain, relaxing stiffened limbs and muscles, and enhancing the quality of life.’ (McIvor, 1988, pp. 7–8)

It could be that European/Pakeha music therapists and people from other cultures have much to offer each other if the music therapist works sensitively and appropriately alongside a skilled person from the other culture. ‘Through music the disturbed and disoriented person can once more make contact with their *mauri* – the source of spiritual vitality and creativity’ (O'Rourke & Brooks, 2002, p. 11).

Emotions evoked by ‘sad’ or ‘happy’ music – contrasting attitudes

There was much discussion on the emotional effects of music on patients in the hospice. The qualities of music were described variously as either ‘sad’ or ‘happy’ music, but people’s understanding or expression of what might constitute ‘sad’ or ‘happy’ music varied. This was partly due to a general recognition that music may have different effects on different people at different times. As Pavlicevic says, ‘A piece of music can suddenly propel us inwards to retrieve a forgotten event in our life’ (Pavlicevic, 2003, p. 104). One participant shared her perceptions of ‘sad’ and ‘happy’ music when she said that people can associate songs they know with both positive and negative experiences in their lives. She said, ‘You can sing a song that to you is bright and happy and you can have somebody else in tears cause that was so-and-so’s favourite song.’ This illustrates one of the difficulties faced by any music therapist when choosing music for clients. Music therapist Susan Weber says: ‘I have been and still am collecting gentle music with lovely melodies which offer emotional support. However, it is not always so easy to find gentle music that is not also sad and/or melancholy’ (Weber, 1999, p. 99).

Several nurses in the study by O’Kelly and Koffman (2007) expressed fears regarding the emotional effects of music therapy. The researchers found that when they interviewed staff for their perceptions on the roles of music therapy in palliative care, three nurses raised concerns about the potentially intrusive nature of music therapy. Responses suggested that the music might ‘hit the wrong spot’ or ‘expos[e] people to feelings that are too painful’ (O’Kelly and Koffman, 2007, p 237). Staff appeared to be concerned about the sensitivity of the music therapist – would the music therapist really *listen*?

Three participants in the current study also wondered whether music therapy could potentially be intrusive to patients. One nurse was unsure about how a music therapist would respond if music therapy brought up emotions in the patient. She said: ‘What happens if a feeling comes up through the music, how do you address that? ...you have to respond appropriately.’ I felt that this concern came from the perceived power of music to evoke sad memories and emotions (Pavlicevic, 2003). This highlights the issue of trust between disciplines and the importance of relationship building in the team.

Another participant provided insight into the way a music therapist might work with this. She said, 'Music talks to people in a different way, [the music therapist] tunes in to, and reads how the music's affecting people.' Part of a music therapist's role is that they will support a patient who appears to be distressed by feelings that a piece of music might have evoked. Munro (1974) asked herself the question: 'Will I ever know how to respond adequately and appropriately in the many awkward moments?' She goes on to discuss the depth of emotional impact music can have in palliative care. She says, 'We should not presume that music will or should reach these patients nor simply impose live or piped in music on them for reasons such as "it will cheer them up" ' (Munro, 1974, p. 77). Munro suggests that music therapy needs to be carried out with immense sensitivity and respect for the vulnerability of the terminally ill patient.

Cherie talked about a music therapy activity with the Day Group on St. Patrick's Day playing and singing Irish ballads. She commented that the songs weren't 'bright jolly songs.' I felt she was implying that music should be used to create a cheerful social atmosphere. She went on to say that patients do not necessarily want to be challenged in a group situation to share feelings that arise if 'sad' music is played. She acknowledged that people might react differently to the same piece of music.

This once again highlights the challenges of working with groups and addressing the different needs of people. Simultaneously a music therapist needs to tune in to each group member's musical responses, thoughts and feelings whilst also staying engaged in leading music making (Pavlicevic, 2003). Cherie's comments could also be linked to the patient-centered nature of palliative care whereby the needs and requests of the patient are central. In a group situation when a number of caregivers – family, therapists, volunteers – are all caring for patients, there may be a tendency for caregivers to forget to focus on the individual and at times assume they know what the needs of the patient are (Randall & Downie, 2006).

Conversely, Jill mentioned the challenges of working with groups when she said that she had worked with Day Groups before and she felt it was difficult to ‘make people feel like they’re enjoying it.’ She displayed a deeper insight into group music therapy when she said, ‘You get them to think about wonderful memories of happier times and maybe not so happy times but they were all relevant. It wasn’t always about being happy. It was about allowing tears. You think music therapy is always going to be about chivvying [cheering] somebody up but it was actually about allowing tears to flow as well.’

This highlights how staff may have contrasting views on the roles of music therapy which may be equally valid. I think the participants recognised that there is some power in the choice of music played in music therapy and that the music therapist has great responsibility to practice in a patient-centered fashion, with attuned sensitivity to the patient’s needs (Munro, 1974). These issues can be addressed through supervision, careful self-reflection and building trust in the team.

A brief case study in emotional responses to music

Three of the participants mentioned the music therapy I had done with one particular patient. Music was important in this patient’s life and the staff had recognised that music therapy had evoked varied emotional responses in her. When two participants commented on the patient’s choice of music, they had different ideas of how music might have affected her. Dana commented: ‘Music has been very important in her funeral planning and music is something that buoys her up.’ Conversely, Barry said, ‘The songs she chose were always sad songs for her funeral.’ Munro (1974) says that in her experience as a music therapist in a hospice, patients and their families often associate music with happy social occasions rather than sad occasions such as funerals. Barry was interested that this patient had been supported in music therapy to do a musical life review of songs related to positive experiences in her life – songs Barry called ‘happy songs’.

Perceptions of spirituality and music as a pathway to spiritual care

Each of the participants reflected personally on how they thought music and music therapy might link to spirituality in patients. Each of them at times used different language to describe how they perceived music had affected people. However, I felt that the meanings behind their words were linked to core themes of spirituality. Increasingly, music therapists have opened the discussion about the connections between music therapy and spirituality, especially in relation to palliative care patients (Dileo & Loewy, 2005; Magill, 2005, 2002; Amir, 2002; Hartley, 2002; Aldridge, 1995, 2003).

Three participants describe their perceptions in the following excerpts:

‘Music evokes the subconscious, touches people on a deep level, it helps to express emotions, it aids the family in connecting, and it reminds patients of their core self.’

‘I can have a sense of spirituality through music. It opens up other kinds of energy, takes it to another level. Music might touch that spiritual side of patients or be a vehicle that may access that for people.’

‘For this patient, music therapy has given her an opportunity to exercise her creativity and express her situation in quite a spiritual way, connecting her to what is meaningful.’

Participants personalised their own music experience in an attempt to describe music in the context of spirituality. One participant who personalised the music experience felt that through music people might enter into different parts of themselves. Another participant began the interview by saying that she didn’t see music therapy as addressing spiritual needs unless it is gospel music. Later in the interview she described how she used music in her own nursing care to settle restless patients and patients who had entered the dying phase. She believed that music could ‘give company when there’s not company’. Although she does not refer to this as spiritual care, she does seem to be aware through her own experience, that music can be used effectively in the care of dying patients.

Barry also described his personal use of music in his work to introduce themes of spirituality in palliative care. He used music as a way of exploring hope and meaning and as a teaching tool to illustrate grief and bereavement. He said doctors can be embarrassed about concepts of spirituality and that the songs he uses can bring the academic literature to life. Kearney (2003) furthers this idea when he describes medical professionals who project their own fear onto concepts perceived as esoteric or not rational.

Another common theme mentioned by participants was transcendence through music. Participants used the following phrases to describe transcendence: ‘People want to forget that they’re sick’; I play nice ‘floating away’ music to go to another place’; and ‘Music will perhaps transcend the verbal.’ Transcendence from suffering is a common theme in the music therapy literature related to spiritual care (Magill, 2002, 2005; Hepburn & Krout, 2004; Aldridge, 2003; Salmon, 2001). Hepburn and Krout (2004, p. 59) believe that music can help to facilitate transcendence – ‘a going beyond time, distress and suffering’. Magill (2005) says that transcendence occurs through music as the consciousness journeys beyond the ego and the physical body. Music can calm and soothe and through music therapy a patient may also be helped to transcend their suffering of the body and mind (Salmon, 2001; Magill, 2005). Aldridge (2003) describes transcendence as ‘going beyond current awareness to another level of understanding’. He believes music-making, along with prayer and meditation, help patients to transcend the body and mind which are failing them and may be causing pain and distress. ‘So much of what we do is beyond words and it is really because of this transcendental nature of music that important healing in music therapy can and does occur’ (Magill, 2002, p. 1).

Referrals – a need to understand the applications and benefits of music therapy in hospice care

‘How we recognize experience and its varying forms, and interpret those expressive forms emotionally, is a cultural activity’ (Aldridge, 2006, p. 166).

Staff participants expressed different levels of confidence regarding their abilities to make informed referrals for music therapy. Participants all realised that in order for them

to make a referral for music therapy they needed to have some knowledge of how music therapy might support a patient in palliative care. One participant understood that the decision to take part in music therapy was with the patient and that she would make a referral if she thought there would be benefits in the patient seeing a music therapist. This inferred that she and the patient are armed with knowledge and understanding of the benefits of music therapy for the patient. One participant suggested dissemination of an article to staff on how to make a referral for music therapy. The effectiveness of this would rely on staff reading the article but it is nonetheless a useful way to get information out to a wide audience of professional healthcare staff.

A survey of UK music therapists (O’Kelly, 2006) highlighted that amongst multi-disciplinary teams (MDT’s) there was some lack of understanding related to the roles of the music therapist. These interviewees thought that the music therapist was the best person to introduce music therapy to patients to answer the initial questions of ‘what is it you do and how do you do it?’ (O’Kelly, 2006)

Jill felt that there might only be one window of opportunity to describe to a patient how music therapy might benefit them but she was not sure she could do this herself. She felt that patients may think music therapy is ‘a bit of music in the background and that’s therapy.’ She realised that she needed to understand music therapy herself so that she could ‘intrigue the patients into wanting to join’. However, she felt that she couldn’t actually say what they were going to get out of music therapy.

Jill says, ‘You talked about holding someone in that space, at that time and it isn’t always about an end result. My perception was that you have a certain thing in mind and you help the person to reach that point, but it isn’t always about that.’ Jill appears to be referring to the ‘moments’ that can happen in music therapy which are not necessarily planned for. Her interpretation may also have arisen from the unique situation that arises with music therapy in palliative care – that there is not necessarily a ‘goal’ to be reached.

Indeed, the patient's involvement in music therapy may be very brief. Barry comments: 'the speed with which your interaction with that family could happen – that's how palliative care has to work because the time frame for our patients can be so short.' In my view, this creates a whole new reshaping of the concept of 'therapy' which usually follows a process of assessment, planning and goal setting. In palliative care the assessment, the process and the goal may all happen in one session if the patient is near death. Hartley (1999) comments on the different length of time he has with people before they die. He may work once a week for a few years with one person and for one session only with another.

There is a quickness about our work together, because you get to the heart of the matter much more quickly... So instead of delving into what the music meant, what it was about, I simply stayed with the music and trusted it (Hartley, 1999, pp. 84–85).

Jill's comments highlight the need for basic knowledge and confidence amongst staff so that opportunities for patients to partake in music therapy would not be lost. Jill demonstrated in the interviews that she had a sound understanding of music therapy in the care of hospice patients, and yet she still seemed unsure of how to introduce music therapy to patients. It may have been that the language to describe music therapy was not available to her.

Indeed, the literature refers to the difficulty even amongst music therapists of describing what happens in the music therapy process (Magill, 2002; Hartley, 2001; Kenny, 1989). Kenny (1989) highlights the difficulties in objectively describing what happens in a musical improvisation which she says is largely due to the non-verbal nature of music therapy. 'Trying to describe it or explain it in the 'terms' of verbal language, in a sense, must sacrifice some of its essence' (Kenny, 1989, p. 17). Magill (2002) says that as music therapists we need to be able to define, describe and verify our work. However, Hartley (2001) says how frustrating it can be trying to talk and write about musical experiences he has shared with patients. He asks how a language is to be found to describe the unique musical experience that happens in music therapy.

Dana felt comfortable with making referrals, although she said there was always a place for more information. Dana explained who she might refer for music therapy:

Often around people who start to articulate around music...talking about the place of music in their lives. Especially if they're very unwell, have less energy. I always think this is another way they can express themselves...music will perhaps transcend the verbal.

As a counsellor, she said her work was a 'talking therapy' and that if a patient slipped into a lower physical state and could no longer express verbally, she might refer the patient for music therapy at that point. People who are entering a less verbal, more subconscious level in the dying phase may indeed benefit from music therapy (Bunt, 1994; Kenny, 1989) as Dana has indicated, Conversely, early referrals in the disease trajectory allow for relationship building between the patient and therapist (Becker, 2004).

Other reasons for referral to music therapy in palliative care are discussed in the literature and might include: a need to facilitate positive interaction with the patient and family, facilitating relaxation skills, increasing communication and socialization, elevating mood, decreasing isolation, reducing perceptions of pain and addressing emotional issues (Wlodarczyk, 2003). All of these interventions could be said to fall under the broader definitions of spiritual care adopted in this study (McSherry, 2005; Marom, 2004; Magill, 2002; Hartley, 1999; Aldridge, 2003, 1995).

Education and resources are ongoing

My journal records the many times I ran educational seminars and grasped any opportunities for discussions with staff in the hospice corridors to answer questions about music therapy and to generally discuss music they had overheard or observed in a session. Multi-disciplinary Teams (MDT's) are usually exposed to music therapy in a variety of ways which will increase their understanding and awareness of the benefits (O'Kelly & Koffman, 2007).

Cubitt (2005) humorously describes how a music therapist in a new work place is faced with the challenges of how to introduce music therapy into such a complex environment: ‘She is keen to tell everyone all about music therapy, but in her somewhat evangelistic fervor she forgets that perhaps not everyone wants to know’ (Cubitt, 2005, p. 162). In my journal I reflected that it was important to listen first when a staff member wanted to discuss music therapy. My impulse was to take over the discussion and try to give a ‘text book’ definition of music therapy. By stepping back and listening to staff perceptions and personal stories first, I could learn more about the general perceptions of music therapy in the hospice.

Hepburn (2006) shared the challenges she faced when she first started as a music therapist at a hospice:

I was both concerned about promoting the role of music therapy and at times diffident about doing so... I was grateful for referrals and ongoing discussions...I have been challenged with establishing the role of music therapy...It is a challenge that is ongoing to show that music therapy can have a valued role in hospice. (Hepburn, 2006, pp. 96–100)

The need to demonstrate the value of music therapy in environments where resources are limited is ongoing (O’Kelly & Koffman, 2007; Daykin, Bunt & Stuart, 2006; Hepburn, 2006; Wlodarczyk, 2003; Brooks & O’Rourke, 2002; Magill, 2002). In O’Kelly and Koffman’s (2007) study of multi-disciplinary perspectives of music therapy in adult palliative care, interviewees said that collaborative work and educational workshops led to more understanding of the roles of the music therapist.

There was general agreement amongst participants in this study that ongoing education is important and that music therapy seminars could be run more than once to capture all the various shifts that staff work. Participants had some useful ideas for imparting information about the roles of music therapy in hospice care. In particular, the participants mentioned that involving staff in making music was a very effective way to

engage them and interest them musically. In the seminars I included a hands-on musical experience as a way to demonstrate music therapy techniques to staff. Jane said, ‘You gave staff instruments and asked them to make a sound that related to something in their life. That made it very real how powerful music can be, how it works.’

A participant also commented that providing musical instruments in the hospice made staff more aware of the use of music in palliative care. There was agreement that music therapy contributions to the multi-disciplinary meetings were invaluable in imparting information on specific music therapy techniques, strategies and outcomes. In my journal I note that staff members often approached me after these meetings and discussed music therapy with me. One participant suggested supplying publications to staff about specific topics related to music therapy in palliative care as a way to disseminate information. She also mentioned a fund raising project as a way to raise awareness of music therapy in the hospice and in the community. She said that this could have a flow-on effect for funding for music therapy in the hospice. Jill felt that the introduction to music therapy at the nurses meeting on St Patrick’s Day was effective in breaking down barriers with staff who may not have encountered music therapy before. Singing in Gaelic and beating an Irish drum was a technique I used to engage staff and to create a lively, fun atmosphere.

Staff all agreed that the presence of a music therapist in the hospice, playing music in the patients’ rooms and in the corridors, was important to their growing awareness of music therapy generally. Often staff would apologise for interrupting or leave if they came in to a room during a session. In my journal I reflect that I found myself at times leaving the door open to a patient’s room when I ran a session so that staff might have some experience of music therapy firsthand. I would always assess if leaving the door open was appropriate for the situation in the room and condition of the patient and their family.

When I first started at the hospice, I had a one-on-one talk with Tessa, one of the study participants, to describe my role as a music therapist in the hospice. Tessa commented later during the interview that the conversation we had when we both started was helpful in her understanding of the role of music therapy. This illustrates that taking the time to

have brief conversations in corridors, at tea breaks or after music therapy sessions is important in increasing understanding amongst staff.

I have discovered in the process of analysing this research that interviews may be educational in themselves as they invite the respondent to think about the topic more deeply and to self-reflect. I feel that more education and collaborative work could be encouraged to integrate music therapy more fully into New Zealand / Aotearoa hospices. More trained music therapy educators may be needed to raise awareness of the roles of music therapy in the palliative care setting.

Future research might examine the specific role of music in spiritual practices and specific spiritual needs of different cultures represented in New Zealand / Aotearoa, in particular Māori and Pacific Island cultures. This may help to inform future music therapy education programs.

Strengths and limitations of this study

The author understands that there are limitations to this type of research which should be identified from the start. Riessman (1993) says, ‘The stories we tell, like the questions we ask, are all finally about value’. Discourses are dependent on the values and interests of the narrator. There could be power relations depending on the setting of the story told. For example, a student music therapist researcher may be seen to be inexperienced and therefore not valued as highly as an experienced therapist. It may be limiting that the researcher is at times the subject of her story – this may lead to important omissions in the stories which are unknown to the researcher.

In the interview process, it emerged that the language used was at times different for each participant in describing spirituality in music therapy. This implies that verbal expression through interviews may pose limitations as a research tool in this study. Future research might draw from other non-verbal mediums of expression such as drawings or live music that links with the participants’ experience.

Three of the participants in this study may have come forth expressly because they had previously encountered a music therapist. This could be considered one of the strengths in the research by providing a more balanced and wider view of music therapy in a hospice setting. Open recruitment of a cross section of staff professions provided a mixed sample of viewpoints. Conversely, the small number of participants may be considered a limitation in this study as it gives only a partial insight into hospice staff perceptions. Although Māori and Pacific Island representation amongst the participants would have been ideal, the participants did come from four different cultural backgrounds and five different health professions.

It was beyond the scope of this paper to focus on the many effective techniques in adult education. And yet continuing a discourse on the roles of music therapy in New Zealand / Aotearoa hospices is a crucial undertaking if the value of music therapy is to become recognised in palliative care (Brooks & O'Rourke, 2002).

Conclusion

All the staff members in the study illustrated a basic understanding of music therapy in the spiritual care of palliative patients as suggested in the literature. There was a universally positive attitude towards music therapy in the hospice especially towards the social and environmental benefits. Even if a participant had commented that they did not fully understand how music therapy could benefit terminally ill patients, they remained open to the concept. An emerging focus during the research process was the language used by staff to describe their perceptions. It became clear that although the language used to describe spiritual care in music therapy was at times different for each participant, common meanings were drawn from the participants' stories. It emerged that spiritual care may have been hidden beyond language.

A common perception was that music therapy in the hospice was valued by the participants and that the benefits of music therapy for the spiritual care of hospice patients' were recognised by participants. In addition, staff understanding appeared to have increased over time partly due to educational seminars, sharing at team meetings, actual exposure to music therapy and informal conversations with staff.

This study provided an insight into the importance of education in integrating music therapy into the spiritual care of patients in a New Zealand / Aotearoa hospice. It is evident from the interviews that staff understanding did change over time, and that this may have been attributable to a number of factors including educational seminars, informal discussions, experiencing music therapy directly and the participant's personal research. I felt the staff response to education at the hospice illustrated how open staff are to learning, and this was evident in the many discussions I had with staff recorded in my reflective journal. However, some participants felt they needed more knowledge to make an informed referral which illustrates that education needs to be ongoing.

I began my study with the idea that I needed to ‘teach’ staff about music therapy. It emerged that I was both the learner and the teacher, and that the participants’ understanding often emerged through their own experience, observation and conversation.

I have found in my years of experience as an educator and a learner that the challenge is to communicate new ideas in a creative, engaging way which is accessible to everyone. The difficulty in finding the language to describe spirituality in the music therapy process does not make this task any easier for a music therapist. Consequently, a common language for both ‘spirituality’ and ‘Music Therapy’ will be an ongoing discourse in palliative care music therapy.

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Appendices

APPENDIX 1: RECRUITMENT NOTICE

Are you interested in Music Therapy research at x Hospice?

Hi, Keryn Squires here. I am the music therapy student residing at x Hospice until November this year. I am now recruiting staff at x Hospice for interviews relating to the study:

“Staff perceptions of how music therapy can support the spiritual care of palliative patients.”

The aim of my research is to uncover the perceptions of hospice staff, regarding the use of music therapy in the care of palliative patients and to determine whether and how their perceptions might change over time. My background is in education so I am interested in what resources or educational seminars might be needed to support staff understanding.

Participants should:

- Have a minimum of one years experience in palliative care;
- Preferably, but not compulsory, have either been in contact with patients who have experienced a music therapy session, or have referred a patient for music therapy;
- Give informed consent to be involved in the study.

If you are interested please contact:

Keryn Squires

kerynsquires@gmail.com

0210 2375620

04 384 3349

APPENDIX 2: CONSENT FORM



Staff perceptions of how music therapy can support the spiritual care of palliative patients in a New Zealand / Aotearoa hospice.

1. I have read the information sheet dated _____ for a staff members to take part in the study to investigate staff perceptions of the role of music therapy in supporting the spiritual care of palliative patients in hospice care and to discover what resources may be needed to support staff understanding.
2. I understand that it is my choice to be part of this study and that I can withdraw from the study at any time.
3. I understand that any information relating to my participation in this study is confidential and that no material that could identify me will be used in any reports on this study.
4. I have had time to consider whether I will take part in this study.
5. I know who to contact if I have any questions or concerns regarding this study.
6. I understand that the study will be presented by the researcher as a project towards the qualification of a Masters of Music Therapy, New Zealand School of Music.
7. I give consent for the interview to be audio-taped: YES / NO
8. I wish to receive the audio-recording from the interview after it has been transcribed: YES / NO
9. I wish to receive a copy of the results of the study: YES / NO

I _____ (full name of staff member), hereby give consent to participate in this research project.

Signature: _____ Date: _____

Signature of witness: _____

Full name of witness: _____

APPENDIX 3: INFORMATION SHEET FOR STAFF MEMBER



Staff perceptions of how music therapy can support the spiritual care of palliative patients in a New Zealand / Aotearoa hospice.

Researcher:
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You have been invited to take part in a study that will explore how music therapy can support the spiritual care of patients in palliative care. This study is being undertaken as part of a Masters in Music Therapy at the New Zealand School of Music.

Through interviews with staff and my Reflective Journal, this study aims to uncover what hospice staff know and understand of music therapy in the spiritual care of palliative patients and to determine whether and how staff perceptions might change over time. In addition, this study aims to find out what professional development and resources might need to be provided for staff to help them to understand music therapy in palliative care.

In my time at the x Hospice, I have used my skills as an educator (Diploma in Teaching) to become an advocate for music therapy, giving mini-talks and presentations to staff to help them to understand the potential for music therapy in palliative care.

If you decide to take part, your participation will involve two individual half hour interviews a few months apart in July and November 2010. The interviews will be recorded in order to get an accurate transcript. You may request to have the recording after it has been transcribed. You may also request a copy of the transcript before it is analysed and you may correct, edit or add to it.

Participants selected will be 4-6 nurses, doctors, therapists or other staff who work with patients at the Hospice. Semi-structured interviews will involve the researcher gathering the participants 'stories' about working alongside a music therapist in palliative care.

Data will also be gathered from the researchers' reflective journal of observations and practice.

The first interview will aim to uncover early perceptions of staff towards music therapy before and in the first few months that the music therapist started at the hospice. This interview will focus on the question 'What do the participants know already?' An analysis of the initial interview will aim to determine what is needed to support staff understanding of music therapy in the spiritual care of palliative patients.

The second interview, approximately three months later, will aim to uncover perceptions of music therapy after the music therapist has been working at the hospice for nine months. An analysis of the latter interviews will aim to provide further understanding of what is needed to support staff understanding of music therapy in the spiritual care of palliative patients at the hospice.

No material which could personally identify you will be used in any reports on this study. The records will be stored in a secure room at the New Zealand School of Music for ten years after which time they will be destroyed. Only the researcher and the supervisor will have access to the data. Your name will not be used in the thesis/report to ensure privacy and confidentiality. A copy of the thesis will be held at Massey University Library on completion in 2011.

Participation in this project is entirely voluntary, and you will be able to withdraw from the project at any time. You have up to two weeks to decide if you wish to take part.

A report on the results of the research will be available on request after the study is complete. This study has been approved by the Central Regional Ethics Committee. If you have any queries regarding this study, please contact Keryn Squires.

Keryn Squires
Music Therapy Researcher

APPENDIX 4: INTERVIEW GUIDELINES FOR STAFF PARTICIPANTS

Note: this is a semi-structured interview which will use open-ended questions which the interviewer may adapt when necessary to obtain rich data.

Research question: Staff perceptions of how music therapy can support palliative patients in a New Zealand / Aotearoa hospice with a particular focus on spiritual care.

Questions:

Can you tell me your understanding of music therapy before I arrived at the hospice?

What are your perceptions of music therapy now?

How do you think music therapy has supported the spiritual care of patients in hospice care?

Are there any resources that you think might support your understanding of music therapy in the hospice service?

Is there anything else you would like to add regarding the music therapy service at the hospice?

APPENDIX 5: Verbatim Transcript Example

Transcript – Tessa

26-08-2010

K – My overall question is staff perceptions of how music therapy can support the spiritual care of palliative patients and the first thing I want to know is, before I came what was your perception, if any, of music therapy?

T – my perception of music therapy in general is not in the spiritual domain. It is more a therapeutic domain for me – relaxation and those sorts of things. Of course if you're playing gospel music and that sort of thing, then obviously it's entering into the spiritual domain. But I think if you're just playing general classical music, then to me, I can sort of see there may be a spiritual link but I wouldn't conclude that automatically. Before you came I had done a little bit of work at x Hospice where there was also a music therapist functioning, so I did know that there was music as a means to healing and relaxation.

K – So leaving the spiritual aside for a moment, we can go into that a bit more later but if you're just thinking of music therapy and the care of patients, what's your perspective, aside from what you've learnt now from me, have you ever used music? What is your general feeling on the use of music in the care of patients? So that could include how you felt before you knew about music therapy.

T – music can be a good distracter and in the past I have used music as a distracter and a diffuser in tense situations, obviously in this setting when you're a nurse caring for someone you can pick up those tense situations, but as a music therapist generally I wouldn't be inviting music therapists into the room if there was tension going on because with tension already in the room and maybe a new person that they didn't know, then I think that would accumulate the tension if you know what I mean. So I would have to read the situation to see whether I invited a music therapy, therapist into that situation. I generally invite the music therapist in on people that are in a fairly stable place in their, recovery's not the right word, in their journey.

K – so since I've been here and you know I've spoken a little bit about what I do in the Clinical Meetings and, did you go to my seminar?

T – I didn't go to the 3.30 seminar but I went to the seminar you gave at the Cultural Day (K – ah yes) so I've had a little bit of one-to-one with you, plus I've also had group

education on a short span. Yes, and it has fascinated me that you did bring culture and those sorts of things in, cause it's a different way of tapping into and striking up rapport with people (pause).

K – So if you were to for example, make a referral now, would you feel comfortable that you have enough knowledge of what I do to be able to make a referral based on, you know, what your feeling about what I do is?

T – Yes. I think that the ultimate decision for referral is with the patient, not with me (K – of course, yes) but I can facilitate if I think there would be benefits in seeing a music therapist, in what I'm reading the situation is in the room (pause).

K – Are there any, you know smaller, finer things that you've seen or heard me talk about that you've thought 'oh yeah, ok that's something I hadn't thought about, you know a way that music can be used that I hadn't thought about.' Have you had any ideas about that?

T – the cultural aspect where you had the drum from South Africa, you know you had instruments from other places that sometimes had that link with a person that may be from another country. I hadn't thought of music therapy in that light before this setting. I'd thought of it more, as I said the relaxation and therapeutic side more than the actual spiritual.

K – So if you're looking at the therapeutic side, what do you mean by that, or what's your understanding of the therapeutic side of using music?

T – Just healing and relaxation and the healing is partly the thinking that is processed while music is being played. I mean obviously if you're playing classical music where there's no words, it allows room for thinking. And I mean the other night we had a patient here that was dying and was alone, and although I put another nurse in that room, she was quite restless and music did help her to settle. Just to give company when there's not company.

K – How did you choose the music that you used for that patient? What went through your mind when you were choosing the music for her.

T – It's a bit of both I guess. When I'm looking at music to play – and obviously I've chosen music in settings when in the bath and patients are in the bathroom and that sort of thing – I choose things that I quite like plus that I think the patient might like as well.

So it's a bit of both and it was a bit of variety cause obviously the person was semi-conscious at that time so we couldn't really say 'what sort of music do you like?' But the other nurse did know this patient and knew what her taste was. But it was more around the classical, relaxation, and just nice floating away music to go to another place in.

K – And in your use of music in the hospice, or...no we'll stick with that first actually. In your use of music in the hospice, do you feel there's enough resources for you here to be able to...for example if I wasn't here, are there enough resources here – tapes, tape decks, information about how music can be used for patients (pause).

T – I think there are enough resources but I still think that it could be improved. Like you could actually have quick access to the CDs, like a mini-library sort of catalogue system where you know you could actually...at the moment you're just manually hunting through. So that may be a beneficial thing that could happen. Generally the resources are pretty good I think. There's plenty of tape recorders and CDs around.

K – If you were wanting to broaden your knowledge of music therapy now in the hospice, is there anything more that you think I could do as a music therapist to help you to understand more, if you thought that you needed it.

T – I think just the regular education sessions is a good starting block. Obviously if there's an interest there, then people will pursue it. I'm not too sure what the library upstairs has in the way of information about music therapy. But I have actually looked up on the internet myself about music therapy in the palliative care session because I've done assignments and I just wanted to have a look at a bit of research around music therapy in palliative care sessions.

K – Is there anything else from me other than the verbal seminars. Have you ever thought, I'm not really sure what she's doing there or, I'm not sure how she could help this patient? Has there ever been any of those kinds of questions (T – not really) going on that you want to know about.

T – I'm pretty trusting in what you do with the people and I think what you are doing is good and (pause), really sometimes you can find out the answers to your questions yourself rather than asking people. I know we did have a big conversation when we both first started and I mean that was helpful and in my understanding of your role.

K – Was that something that you did on your own initiative or was that something that the staff...?

T – Well, it was recommended that you make contact and make close links (K- yeah, that's interesting) but I don't know that everyone that starts does that if you know what I mean.

K – I'm not sure either, I'm not sure whether anyone else has started, anyone else new since you... (T – no, not since me) no ok, so you're the only one that's approached me. I thought at the time actually you were doing it off your own back and I was pretty impressed. I thought (both laugh). But that's good to know that it's a hospice policy (T – yes, yeah). Cause you went round all the different people didn't you?

T – The yeah, the wraparound services around the medical.

K – Did you have a list of people? (T – yes, yes)

K – Ok, I might try and get one of those. Good to see that the music therapist was on it cause I'd only just started myself.

T – Yeah, well I, I think it had been.

K – Ok, well is there anything else that you want to say about music therapy in hospice or palliative care or any ideas that have come up for you that you want to talk about now?

T – (pause) the mood and stuff around it, does that really matter? You know should it always be done in seriousness because sometimes I know it can be a fun thing as well, do you know what I mean? That's the sort of thing that I'm unsure about and what slant, you know...

K – So are you asking me that question? (T – yeah, yeah) Ok, so let's have a discussion around it then rather than me just answering it for you. So you know music can be used lots of different ways. It can be used to uplift people and also to help them to access sad feelings that they might have. So are you thinking more about in what situations would you use each type of music? Is that what you're question is? Or *whether* you would do that or not?

T – No, I'm just saying is it ok to introduce music in a fun way (K – oh yes, ok) in the palliative care setting? (K – absolutely) when you know there is, as you say, a lot of sadness and emotions but sometimes people are in quite a good space and you can introduce things in a lighthearted way.

K – Yes, a lot of the music I use I try for it not to be sad actually. There may be situations where the music is beautiful so by definition it becomes sad because it's everyone's perception of music isn't it? Something that isn't sad to me may still be sad to someone else because it triggers them in a way that I can't foresee. So my perception of what's uplifting music might be quite different to someone else's. So I have to gauge that, I have to as a therapist, I have to gauge that in the situation. But our Pastor talks about 'silly music' (laugh) and he has quite a few you know, silly songs up his sleeve that make people laugh. And definitely you know, there is a call for that kind of music. And children's music too is often really helpful in that way to just bring the light, the lightness I think, is maybe the word I'm looking for (T – to...yes). So you know happy music, sad music, that's quite a difficult one to assess because of the quality of music. And I can cry at a beautiful song too (laugh) that isn't necessarily saying anything sad. But generally, light children's music, lullabies and silly songs where the lyrics are silly, work really well if you're aim, or my aim, is to help to uplift a patient. So is that what you expected?

T – Yes, it just clarifies for me you know because sometimes with 'N' – I've worked with her so many times, and the pink pyjamas song, and I knew she liked Elvis, you know it was just quite appropriate. And because she'd been with us a good month at that time.

K – Yeah, she was one of those patients who seemed to, I think you noticed that didn't you, she responded very well to music. She loved it and she loved being uplifted by music, and you and one of the nurses, you really used that and synched in with her. Can you tell me anything more about your experience with 'N'? Musically?

T – Umm, (pause) you know her daughters' were playing music on that computer, some of her favourite music through the night. I mean I wasn't in charge of the computer but I knew that music was being played, particularly in her early days here. And basically we were unsure how long she was going to be here at that stage cause she was quite sick on entry to the hospice, and she sort of stabilized out a wee bit and maybe she was even going to go to a placement in a home. But then all of a sudden things turned around and she went downhill fairly quickly. So I think music was fairly important to her. Cause how many times would you have seen her? Three?

K – At least three – musically probably three. There were other times when I popped in and just discussed music with her, so probably five all up.

T – And patient response overall to the music therapy here? What would you say if you had to sort of generalise the role of the music therapist in the hospice setting? Would you say that it's pretty good, well received? Orrr...

K – Very well received (T – very well received) for the people who want music. I mean there's people who (T – aren't musical or yes...) just say no I don't want any music thank you and I have to respect that. But the people who do let me in, yeah, it's (T – well received yeah...) yes, it is.

T – So percentage wise would it be about 60% of people that want music here would you say?

K – Ahh, yes probably. Maybe higher it depends on the week and the day actually. And also depends on what state the patients are in, as you've mentioned you know, whether you would let another person into the room be it music therapist or whatever therapist. So yeah it varies. Anything else you need to add?

T – No, I don't think so. But I think through our discussion we've touched on quite a bit which we didn't touch on earlier about the emotional side of music and its role in the well-being of patients.

K- That's right. And what you brought up about music uplifting patients, that it doesn't always have that effect. You know it can go both ways.

Well thank you very much.

T – You're welcome.

Teresa transcript – 2nd interview

K – this is a catch up just to clarify that the transcript I did of your first interview was the way you intended it to be and also I'll ask you if you've had any other thoughts since that interview if you want to add them to what you've said already.

So first of all did you have a look at the transcript and were you happy with that?

T – yes the transcript was accurate of what I remember the recording to be and I'm happy with what went in there.

K – and there hasn't been much time since the last interview...

T – that would have been about the end of August?

K – that’s right.

T – so that’s close to two months.

K – yes that’s right. And have any other thoughts come in to your mind about your perceptions of music therapy or is there anything you want to add to what you said in the beginning?

T – basically the only thought I’ve had on reading my transcript, and of thinking about the hospice, is that I think since you’ve worked this year here that music therapy has been well received. Plus I think that people who have been here every day are more likely to use it. Cause I’ve heard of other nurses singing to patients and not just me. So I think it is ... I think the forum that you’ve created here I think allows that more. And where it’s not seen as silly but lightens the mood in more serious situations to the ones that we’re dealing with. That’s basically all I have to add.

K – when you say people might use it more do you mean staff might use it more?

T – yes nurses. People who are in the every day contact with patients, cause I mean, you’re only here two days a week but I think that you know, whereas before I hadn’t seen nurses using it as much as what they are.

K – so in what way do you think nurses are using it, you mean music in their room?

T – just in their cares, in their cares yes.

K – ok, that’s everything you need to add? Thankyou T.