The Impact of a Clinician’s Mourning on Music Therapy Treatment

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Janelle S. Junkin

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Soli Deo Gloria – To God Alone be the Glory
God, who is my Comforter and my source of Strength For I know the plans I have for you, Plans to prosper and not to harm you. Jeremiah 29:11
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ABSTRACT
The Impact of a Clinician's Mourning on Music Therapy Treatment
Janelle S. Junkin

The purpose of this study is to explore how a clinician's mourning impacts music therapy practice. The design of the research included interviewing music therapists and data analysis using grounded theory. Subjects included nine music therapists who reported meeting the inclusion criteria. Subjects answered questions regarding their work with patients who have died; how the music therapists mourned that death and the impact that death had on their continued therapeutic relationships. There is currently limited research detailing the impact of a clinician's mourning on their continued clinical work. Death is a natural process that closes the life cycle; therefore, it behooves therapists to begin to consider their own responses and fantasies about death and the impact of this on their future therapy relationships. There are an ever-increasing number of music therapists entering the area of hospice care according to The American Music Therapy Association (AMTA) Member Sourcebook. Through developing research in this area future music therapists working with this population may have additional resources to integrate within their practice. The data may assist in the development of practice models that seek to reduce stress and burnout for clinicians in this area. Seven general categories of therapists' experience of meaning in music and mourning emerged from the data analysis: Connections, Prophylactic Use of Music, Kinesthetic Experiences, Boundaries, Rituals, Closure, Musical Beliefs and Concepts, and Clinical Impact. Across the board, subjects reported a desire to maintain connections with others to keep from being isolated in their work.
CHAPTER 1: INTRODUCTION

The purpose of this study is to explore how a clinician’s mourning impacts music therapy treatment. Death is a natural process that closes the life cycle; therefore, it behooves therapists to consider their own responses or fantasies, defined by the researcher as thoughts or ideas about how they reflect upon death, may affect them. There are an ever-increasing number of music therapists entering the area of hospice care. According to The American Music Therapy Association (AMTA) Member Sourcebook, as of 2003, 61 music therapists were working in the area of hospice care; this number increased to 102, according to the 2005 AMTA Member Sourcebook, approximately a 68% increase.

This study will explore the music therapist’s process of mourning and investigate its impact upon clinical work in subsequent music therapy sessions. The conclusions drawn from this research may provide an important basis for clinicians to explore their own ideas regarding death and its potential impact on the work within their area of expertise.

There is a need for increased emphasis on the clinician’s, specifically the music therapist’s ideas and experiences in death and the impact that this has on continued clinical work. Therapists can learn from one another’s experiences. It is, therefore, important to share what is learned and the lessons that can be provided through Benedikte qualitative analysis of such experiences.

This researcher believes that the impact of a patient’s death could possibly manifest itself musically because of the powerful impact of death. Scheiby, a music
therapist, provides a powerful clinical example in her article of how her personal mourning was initiated by a client’s mourning, “...my counter transference manifested itself in the music by a heavy articulation and a sudden faster tempo, and was elicited by my unconscious identification with the client’s strong emotional expression” (2005, p. 9).

The music therapist may, in fact, purposefully choose inauthentic music as a way to avoid issues related to loss and death when working with new clients. Inauthentic music occurs when the music therapist, either consciously or unconsciously, chooses music that ignores, avoids or overlooks the issue of the client or patient. The therapist may play music differently or s/he may have images that come to mind while playing music that manifests pertinent in unconscious ways.

Although the clinically astute therapist explores counter transference, there appears to be a gap in the literature regarding the impact that a patient’s death has on the therapist and the impact of grief that holds in the therapist’s continued clinical work. Since there is little research available and virtually not a single music therapists’ case study of this experience, it is possible that music therapist’s wonderings or ideas about the impact of a patient’s death may lead them to either an over indulgence, defined by the researcher as a narcissistic musical relationship to the intense feelings about their desire to provide good care, in this work or a complete avoidance of the important issues that accompany those who are dying.

The potential impact on a patient is unknown. However, a therapist may miss signs of transference – counter transference that could be explored within the therapeutic relationship. Unclear boundaries may also result from a therapist’s over indulgence in the
work, particularly if treating the dying feeds a narcissistic tendency the treatment may become about the therapist’s needs versus the needs of the patient.

In a recent national Report on Bereavement and Grief Research, (Genevro, et al 2004, p. 494) bereavement and grief are a universal human experience. Sadock and Sadock define bereavement as the state of being deprived of someone by death and refers to being in the state of mourning (2003, p. 61). Sadock and Sadock define grief as the subjective feeling precipitated by the death of a loved one (2003, p. 61). This updated report was first commissioned by the 1984 Institute of Medicine report, Bereavement: Reactions, Consequences and Care. The following are the reasons for the update.

- Most deaths in the United States occur in health care settings – about 60% are estimated to occur in hospitals or medical centers, and an additional 16% occur in other health care institutions, such as nursing homes or hospices (APA Online, 2003)
- Research on grief and its effects, and on the care provided to bereaved individuals and families, has increased greatly in both frequency and scope over the past 20 years
- Advances in biomedical research in the past 20 years have the potential to improve substantially our understanding of how the experience of grief may translate into biological changes that then translate into poor health
- Demographic trends, including the aging of the large “baby boom” generation, are likely to place greater service and economic demands on the health care system, including increasing needs for care related to end-of-life issues (Genevro, 2004, p. 495)

As therapists begin to explore their thoughts about death, they might consider their personal ideologies related to loss, in addition to considering the definitions of bereavement and grief, which were previously defined. Wordreference.com defines loss as, “…the experience of losing a loved one…” This feeling of loss may precipitate the expression of the process of mourning. Genevro, et al (2004. p. 550) report that “…many health care providers experience grief – sometimes profound grief when a patient dies”.

They report “…bereaved health professionals may alternately focus on and avoid feelings of grief as they seek to balance these often intense feelings with their desire to provide good care to other patients” (Genevro, et al, 2004, p. 550).

However, it is possible that a therapist may have resilience when working with the dying. The term resilience has been defined as “the capability of a strained body to recover its size and shape after deformation caused especially by compressive stress or an ability to recover from or adjust easily to misfortune or change” (Merriam Webster’s Collegiate Dictionary, 1996, p. 996). In an article, authored by Karen-leigh Edward a faculty member of Health and Behavioral Sciences at Deakin University, she discusses the resilience of crisis care mental health clinicians. She states, from her findings that mental health workers reported:

Debriefing with the team/with colleagues is important to keeping my anxieties down. Keeping work and home separate is important to keeping stress down. I can leave work and its gone most of the time and I find this keeps my anxieties down. The other way I continue to try to deal with stress and crisis pressure is the use of humor. I remember that consumers are also human and that if I was in their position I would like it and so I try to include in the conversation some more light-hearted conversation to help the person feel happier. It is also a good way to release the anxiety in the situation and the stress you or the client are under to talk about something good and share a bit of a laugh. I think on a personal level resilience is about building up your credibility and confidence in a team (2005, p. 146).

Even though, Edward’s accounting of resilience does not specifically relate to a clinician treating the dying, the statements made by the health clinicians are transferable to how a music therapist might have a positive interaction and experience working with those who are dying.
Michael Bonicello, LSCSW wrote an article detailing his grieving for patients who had suffered losses, in this particular case, the loss of innocence was the subject. While treating his patients, Bonicello mourned their loss of innocence. In this article, Bonicello looked at loss “as a universal experience” (1990, p. 367). He states that, “within every creature, there resides the innate knowledge that life is time limited and that death is as natural a phenomenon as resting after extensive exercise” (Bonicello, 1990, p. 367). According to Bonicello, death is as natural to life as breathing or resting. It can be inferred from his statements that he believes that the act of dying or experiencing a loss is not a mysterious act, but one in which all people engage.

He defines three factors that emerge as someone experiences death or a loss:

1) A cycle of resistance, exhaustion, acceptance, and renewal involved in a natural grieving process; 2) the intensity and time limit of one’s grief is influenced by past experiences, the degree to which the loss affects one’s daily life, one’s personality, and the support one receives from external sources when a loss is experienced, and 3) remaining unresolved for extended periods of time with dramatic consequences in one’s ability to function effectively in future endeavors (Bonicello, 1990, p. 368).

This is a personal account of a therapist as he experienced the grieving process while treating patients who had been sexually assaulted. The above statement describes Bonicello’s conclusions reached after experiences and analysis of his grief.

Generally, the literature reflects caregiver’s or survivors’, usually family members’, feelings of mourning and the processing of those feelings in a variety of ways. Dalton and Krout, music therapists who treat bereaved adolescents, explain:

The songwriting process involved in working with bereaved adolescents to facilitate the creation of lyrics and music that expressed their core concerns regarding the death of their loved one and how they were coping since the death. Lyrical themes within the songs were identified and organized by the music therapist into five grief process areas described as understanding, feeling, remembering, integrating, and growing (2005, p. 132)
Dalton and Krout, using the songwriting technique, developed a grief scale from the identified five grief process areas stated above. Using this scale, Dalton and Krout help the adolescents to move through their grief to come to a resolution in the final grief process area, all through songwriting.

In *Dying, Death and Bereavement*, Sally Baily, Director of Support Services/Arts in the Connecticut Hospice reports that the artist, though not specifically an art therapist, may have a positive impact on the dying patient, which then brings the artist a positive feeling regarding the mourning process. Bailey (1994, p. 334) states in her chapter *Creativity and the Close of Life* that “...artists make a unique contribution in enabling people in the grief/celebration process”.

As this topic of research is fairly new to the field of music therapy, this researcher opted to allow the data to suggest a theory of how the death of a patient impacts a music therapist both musically and interpersonally. It was thought that the grounded theory method would provide the most expansive means to examine this important topic.

Grounded theory is an inductive technique developed by Glaser and Strauss (1967) and refined by Glaser and Strauss and Corbin the 1980’s. It emerged from the discipline of sociology. “Grounded theory is a general approach of comparative analysis linked with data collection that uses a systematically applied set of methods to generate an inductive theory about a substantive area. Its purpose is to discover theory from data” (Wheeler 2005, p. 365). “In grounded theory, research questions are generally open-ended, flexible and broad initially and then become more focused and refined as analysis occurs” (Sprenkle & Piercy 2005, p. 46).
“Grounded theory methodology builds theory that emerges flexibly over time from data collection and analysis. In grounded theory the researcher becomes the primary instrument of data collection and analysis” (Sprenkle & Piercy 2005, p. 45). Therefore as the researcher interviews the subjects, in listening to their responses, the data is analyzed through coding, memoing, sorting and finally writing (Grounded Theory: A Thumbnail Sketch Retrieved 11/28/2005).

The underlying premise of this research is the belief that music therapists may experience intense responses to loss or death. It is likely that music therapists may experience their role in the dying process as an integral participant in the patient’s completion of the cycle of life (Bailey 1994). An exploration of the possible images that music therapists may have associated with the work of a deceased patient was also investigated. In addition, there was inquiry as to whether or not there are any subsequent musical changes or variances, within the created music of subsequent sessions that are related to the mourning of the deceased patient.

This study is delimited by the small number of subjects that were recruited. Therefore, the results may not be generalized to the population at large. Five-to-ten music therapists were recruited to participate in an in-depth interview about the impact of the mourning process on their continued clinical work. The results of this interview may not be generalized since it does not include those music therapists who do not report a process of mourning for deceased patients. The limitation of the study includes the following: music therapists who experience mourning do so in such a personal way that consistent conclusions may be difficult to draw. An apparent assumption is that music
therapists grieve. Accepting this as a given, this research will illuminate ways in which
the music therapists’ mourning may effect continued clinical work.

This research may lead therapists to self discovery about their lack of
consideration that they may, in fact, mourn the death of their patients. In an article by
Phillip Kleespies and Elizabeth Dettmer, psychologists in Boston, MA they state,
“Unfortunately, the same trait that allows individuals to be excellent clinicians, the ability
to empathize, can also leave the clinician vulnerable to personal emotional distress which
lingers long after a critical clinical event” (2000, p. 1357). It may not occur to therapists
that they may experience an impact on their emotional state from the death of a patient.
In addition, therapists who experience an impact on their emotional state after the death
of a patient, may burn out as they are not intentionally working through the death or
deaths. This research may provide, at the very least, examples of how to process the grief
of a death of a patient and begin to point to methods to begin to come to a resolution of
grief and mourning.
CHAPTER 2: LITERATURE REVIEW

2.1 History of Bereavement and Grief

It is important to know how other researchers have looked at the terms: mourning, bereavement and grief, and how these concepts and their contexts have had an impact on caregivers and mental health workers. The last four decades have seen an increase in literature addressing the issues surrounding bereavement, grief and loss as it relates to the survivors of those who are deceased. Recently, the literature has begun to address the impact of death on caregivers and healthcare workers.

For the purposes of this thesis, the researcher chose to incorporate the definitions of mourning, grief and loss presented by Ruth Bright, a music therapist. In 1986 Bright edited a book aimed at presenting a highly practical approach about how to assist people in coping with psychological problems associated with grief. In this book the author almost always uses the word "grief" to describe the inner psychological struggle that responded to the loss (a response which we are capable of hiding even from ourselves), and the terms "grieving," "grief-work," and "mourning," to refer to the visible manifestations of that inner event.

In “The Psychological Aspects of Bereavement”, Birtwistle shares her concern that there is a need to develop an intervention for health care providers to alleviate the impact of loss or bereavement. She states that “those that are bereaved may suffer both physical and mental health problems as a consequence of their loss” (2001, p. 91). She
argues that it is this physical and psychological impact that needs to be identified and addressed.

According to Genevro, et al (2004), many health care providers experience grief – sometimes profound grief when a patient dies. Bereaved health professionals may alternately focus on or avoid feelings of grief as they seek to balance these often intense feelings with their desire to provide good care to other patients. Health professionals need to intentionally seek a balance between being the giver of care and the receiver of support.

Genevro, et al, cite two separate studies that interviewed nurses who work with dying children. Papadatou (2000) reported findings that the “grieving is individual and social-interactional and that it involves a process of ‘fluctuation’ between focusing on the experience of loss and moving away from the grief reactions associated with loss” (Genevro, et al 2004, p. 550). Kaplan (2000) highlighted “the ‘emotional tension’ providers experience as they struggle to balance intense feelings after patients’ deaths with their desire and need to provide competent care to other patients and families” (Genevro, et al 2004, p. 550).

### 2.2 Current Trends in Caring for the Caregiver

In the last ten years, the current trend in grief, bereavement and mourning research has focused on caring for the caregiver. Professionals have begun to voice their concerns about the need to take care of themselves emotionally, physically, and in some cases spiritually. In her chapter Social Support and Mutual Help for the Bereaved, Phyllis Silverman states that the death of a loved one is something that all of us experience at
some point (2003). She focuses on the availability and use of social supports among communities, when death occurs. This is important for the clinician to realize as it provides an example of utilizing the support systems that surround them. Silverman believes that the importance of connection to others, and being involved in caring relationships, cannot be underestimated, especially at times of stress in people's lives.

Kristen Stewart, a music therapist, echoes the above sentiment in “Models of Caring for the Caregiver”. She writes that “the shortage of clearly defined approaches for the caring/coping of professionals in the fields of psychology, social work, and music therapy may be due to the fact that the topic has not been adequately researched” (2002, p. 10). Stewart, in her search for models of caring, finds some approaches that are community-based but also finds ones that are existentially-based, too. She references Sapienza (2000) and Bugental (2000) who view the practice of self-care as connecting to the life force that resides in each individual. Stewart adds a dimension to Silverman’s ideas of caring for the caregiver by adding a connection, not only to a community, but to oneself as well.

2.3 Clinical Experiences of Loss

Researching the subject of mourning may lead one to explore the stories of clinicians, both music therapists and other mental health workers. Their personal experiences of grief, bereavement and mourning certainly impact their continued clinical work. “Analysts are not alone in experiencing death” (Buechler 2000, p. 77). Sandra Buechler, an analyst, who wrote Necessary and Unnecessary Losses: An Analyst’s
Mourning, relates her story of experiencing both necessary and unnecessary losses through her experiences of planned and abrupt terminations.

Baily, Director of Support Services/Arts in the Connecticut Hospice, states in Creativity and the Close of Life that “...artists make a unique contribution in enabling people in the grief/celebration process” (1994, p. 334). Baily states that in her time at Bellevue, she was able to witness the grief of three patients, who were also artists - two poets and a painter, who worked through their despair, fear and anger within their artistic talent. She states about one of the poets, “…she, who had raged against her ‘lot’ and against those who cared for her, moved out into transcendence with a spirit of compassion for those about her – and then quietly died. She lived as she was dying- and she died while she was living” (Baily 1994, p. 328). She stated that the artists who continued to volunteer time and time again believed that death is a completion, as opposed to a break, in the life cycle.

The psychologist Michael Bonicello describes his process of traveling through the stages of grief: denial, bargaining, anger, depression, and resolution while treating a patient who had suffered sexual abuse. Bonicello’s grief came as he vicariously experienced the loss that the patient had suffered, the loss of innocence. He provided an example of how his grieving was triggered by a patient’s loss, the stages of grief that he passed through and finally the resolution which he came upon 18 months later. He discusses the painful moments, but also discusses his acceptance of the loss. He warns of the danger, for the therapist, about not reaching a resolution about death and how this might result in suspended depression.
A social worker, Judith Mishne provides a personal account of how the effect of two unanticipated deaths of her patients affected her. She tells of how she never had any desire to work with those who were dying, so she treated those who were “well”. She informs the reader that she was faced with her own immortality and fears of death when two of her patients were diagnosed with life-threatening illnesses. She discusses how the therapy process continues upon death and how the impending and eventual loss of her patients allowed her to experience the grieving process, both within herself and with the patient and the family.

Mishne quotes the *Comprehensive Textbook of Psychiatry* stating that “the common denominator of psychological trauma is a feeling of ‘intense fear, helplessness, loss of control and threat of annihilation’” (1998, p. 42). In a case vignette, Mishne eloquently relates the story of her first experience of losing a patient and its effect upon her.

During the last seven months of Martha’s life, denial, hope, terror and apprehension ultimately were replaced by withdrawal and emotional numbness and we all experienced the classic symptoms of Post-Traumatic Stress Disorder. My original counter transference responses of pride and satisfaction about Martha’s progress in therapy were ultimately replaced by sorrow and pity which Eissler (1955) states, provides trust, courage and consolation, and a belief in the indestructibility of the patient’s soul, in contrast to grief and despair which undermines the patient’s morale. I believe that I have not wavered in my conviction that Martha is immortal, and that many years after her death, I write about her with my memories as clear as though all occurred yesterday. She is the first patient I ever lost, and I continue to mourn her and think of her (1998, p. 49).

One may suspect that upon a current loss, that a therapist’s mourning may appear in subsequent sessions with other patients. Often, the therapy relationship mirrors one of a parent-child, increasing the potential for transference – counter transference regarding mourning. In an article by A. Alexandris, a psychoanalyst; he discusses how a patient, in
psychoanalysis, delves into his inability to mourn and the defensive measures against losses that are transmitted from one generation to another through the parent-child relationship.

This brings up the possible definition of the role of the clinician. In an article in *Music Therapy Perspectives*, music therapist Joanne Loewy states, “A developing quest within the past twenty years has been the music therapists’ desire to understand their relationship with music and how that relationship might move us into a stance of open and more complete accessibility in forming relationships with our clients” (Loewy 2005. p. 5). This statement supports the researcher’s quest to explore the impact of a patient’s death on continued clinical work, specifically, as revealed through the musical intention of the work.

### 2.4 Uses of Music Therapy in the Mourning Process

Searches in the field of music therapy have provided several examples of clinician’s experiences with death and music. Scheiby shares her personal experience of a counter transference, within the musical context, when confronted with a client’s personal mourning. Scheiby states, “...my counter transference, that manifested itself in the music by a heavy articulation and a sudden fast tempo, was elicited by my unconscious identification with the client’s strong emotional expression. My own father died when I was three months old, and I had experienced feelings of loss and sadness that were related to missing the strong masculine holding at an early age” (Scheiby 2005, p. 9). This demonstrates an example of a clinician’s insight into how unconscious material, in this case past grief, can become present within subsequent sessions.
In an article in *The Arts in Psychotherapy*, a music therapist relates a story of working with bereaved adolescents and the use of songwriting as a technique that may be useful in beginning to address the issue of bereavement. Dalton and Krout provide a basis for analyzing the grief of the bereaved adolescents: “...understanding represented (by) lyrical statements of adolescents. Clarifying that they were ‘normal’ in what they were experiencing. The process area of ‘feeling’ described through lyrics: sadness, anger, guilt, frustration, numbness, fear, and resentment. The process of ‘remembering’ their loved ones and finally ‘integrating’ – how the adolescent would be able to continue and cope with life activities” (Dalton & Krout 2005, p. 132). Possibly, music therapists may find that music serves as a processing of their own emotions regarding dying or deceased patients.

Staying with this thought of using music as an intentional or unintentional means of catharsis for addressing grief, one must consider the book *Caring for the Caregiver: The Use of Music and Music Therapy in Grief and Trauma*. This book provides a look into music therapists’ and professional and personal caregivers response to the 9/11 tragedy and its impact on them personally and professionally. This book takes the reader into the musical world of grief, shock and the working through of the trauma from the perspective of the music therapists and other allied professionals. Benedikte Scheiby writes that it is difficult to find meaning in loss. She describes her use of community music therapy as a model for self-care. She used vocal improvisation and varying instrumental experiences, connected with the movement of the body as part of her interventions with the participants.
Another person to consider is Stein who wrote an article in the *Journal of American Psychoanalysis Association*. The attacks of September 11, 2001, prompt a consideration of the role of music in mourning and trauma. The intrapsychic functions of music in the mourning process are explored, as is music as a unique response to trauma and as a special aesthetic expression of a range of affects connected with grief.

Finally, one might begin to consider personal experiences with grief, not only clinical experiences with grief. Personal experiences may provide a schema for the clinician as they face clinical grief. Sister Donna Marie Beck has begun to investigate her own grief and the use of music as servant source that served to being addressing it. Initial research about the use of music, specifically of listened to music, and how it affects the mind, body and soul of humans (Beck 2005).

This research was born out of Sister Beck’s personal mourning at the death of her mother and how she used music to begin to work through her grief. She also discusses how the grieving process is on-going; it does not necessarily have an ending, but changes over time where it can becomes less pressing on the soul. She quotes William Durant, “Music is so powerful because rhythm and harmony find their way into the secret places of the soul, bearing grace in their movements and making the soul grateful” (Beck 2005).

### 2.5 Understanding Grounded Theory

This researcher has chosen to use grounded theory to analyze the data collected from the interviews with music therapists. Dorit Amir, author of the Grounded Theory chapter in *Music Therapy Research* (2005, p. 366), states that “grounded theory was originally developed by Barney Glaser and Anselm Strauss, two sociologists with
different philosophical backgrounds who worked in a close collaboration. Glaser and Strauss viewed grounded theory as a whole method. Their basic theme was ‘the discovery of theory from data systematically obtained from social research’.

Anselm Strauss and Juliet Corbin further explain the use of grounded theory in *Strategies of Qualitative Inquiry* (1998, p. 161). They state “certain other general procedures have made this methodology effective and influential. Besides constant making of comparisons, these include the systematic asking of generative and concept-related questions, theoretical sampling, systematic coding procedures, suggested guidelines for attaining conceptual (not merely descriptive) ‘density’, variation and conceptual integration”. In terms of identifying a theory through the results, Strauss and Corbin state that “…the conceptualization and diagramming of a ‘conditional matrix’ helps toward specifying conditions and consequences, at every level of scale from the most ‘macro’ to the ‘micro’, and integrating them into the resulting theory” (1998, p. 161).

Amir also states that, “inductive methods must be thoroughly grounded in the data after the researcher has reached theoretical saturation of the sample selected for analysis. One needs to evaluate theoretical sampling, depth of research, and clarity of methods in order to assure validity, reliability and credibility of the research” (2005, p. 367). In other words, trustworthiness of the data must be established. Amir quote Liu (1996) who states, “for internal validity, triangulation (multiple data collection methods), informant verification, and explicit clarification of the researcher’s bias are used” (2005, p. 367). John Creswell, author of *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches* states, too, that in “verifying data, the following strategies will be employed:
Triangulation of data – Data will be collected through multiple sources to include interviews, observations and document analysis…” (2003, p. 204).

Donna Mertens (2005, p. 240) states that “the intent is to understand and describe an event from the point of view of the participant. The key characteristic of phenomenology is the study of the way in which members of a group or community themselves interpret the world and life around them”. These are two very important concepts to this researcher as it addresses the issue of bias and preconceived notions. It is important for this researcher to remember that the collected data will be the “experience” of the music therapists’ sense of mourning; this will be an individual experience, therefore remembering to present the information from the perspective of the subject is vital.

In Research Methods in Family Therapy Silvia Echevarria-Doan and Carolyn Tubbs (2005) provide the researcher with the history and uses of grounded theory of the past thirty years, approximately in the chapter Let’s Get Grounded. Ultimately, this chapter assisted the researcher in understanding the design methodology and how to fully use this method to begin addressing the research statement of this study.

Robert Weiss author of Learning from Strangers: the art and method of qualitative interview studies (1994) provides this researcher with some background information about conducting interviews, especially providing ideas on how to structure questions, so that the data can be collected. In addition, this book provides a chapter on how to analyze data. The chapter on data analysis provides the reader with several options on structuring the data analysis. This is a great resource for identifying the best possible way to collect and analyze data.
CHAPTER 3: METHODOLOGY

3.1 Design

The design of this research was qualitative, specifically utilizing grounded theory. The term grounded means that the theory developed from the research is "grounded" or has its roots in the data from which it was derived” (Ways of Approaching Research: Qualitative Designs Retrieved 11/28/2005). “In grounded theory, research questions are generally open-ended, flexible and broad initially and then become more focused and refined as analysis occurs” (Sprenkle & Piercy 2005, p. 46). “Grounded theory methodology builds theory that emerges flexibly over time from data collection and analysis. In grounded theory the researcher becomes the primary instrument of data collection and analysis” (Sprenkle & Piercy 2005, p. 45).

3.2 Subjects

A sample of nine music therapists was chosen through purposeful sampling, used in qualitative studies, as subjects. “Purposeful sampling is a method of selecting participants for the study who are identified as being expert informants who can help the researcher best understand the research question” (Creswell, 2003, p. 185). The sample size was determined as a result of the nature of the grounded theory method, which does not require a large subject sample in order to generate a theory. The subjects’ ages ranged from 28-53 years old. There were eight females and one male subject. There were eight Caucasian subjects and one Japanese subject. All subjects signed an approved informed consent form before beginning the interview process.
Subjects who participated were chosen when they responded to a phone call or email. The subjects were identified from the AMTA 2005 Sourcebook, as working in either a hospice care facility or a nursing home or a hospital facility, including an oncology unit or by word of mouth. Those subjects who responded self-reported that they matched the inclusion criteria. Subjects worked in nursing homes, hospices, or hospices located on the east coast of the United States and Canada.

The subject inclusion criterion is as follows:

- Board certified music therapist who has been practicing for at least 4 years
- Therapist reported having experienced a process of mourning upon the death of a patient, either expected or unexpected
- Therapist reported that s/he experienced a moment, while working with another patient, when the music triggered a memory of a deceased patient
- Therapist works at either a nursing home or a hospice site or hospital facility.

The exclusion criterion is as follows:

- Music therapy intern
- Music therapist does not report having experienced of mourning or grieving upon the death of a patient.

Those who do not report mourning for a deceased patient will not be able to share what impact the mourning had on the musical process within continued clinical work.
Confidentiality was maintained by the researcher on behalf of the subject. All identifying information about the subject and his/her responses to the interview questions was only heard by the researcher. Each subject was informed to not reveal specific identifying information about the deceased patient, in order to guarantee privacy of the patient and the surviving family. The recordings will be destroyed one year after the completion of the thesis – November 2006, as per the Office of Research and Compliance. Before signing the consent form, the subjects repeated his/her rights as a subject in his/her own words. The subject signed two Informed Consent forms, one for their records and one that the researcher securely stored in the Drexel University Creative Arts in Therapy office.

3.3 Data Collection

The researcher participated in a practice pilot procedure to become more comfortable with the interview process in the grounded theory method. Open-ended response questions were used to collect the data. Each subject participated in an hour-long interview with the researcher. Each subject had an individually scheduled time with the researcher to participate in the interview. Before beginning each interview, the subject was informed about his/her rights as a subject. The interview was audio taped and this audio tape was labeled and securely stored in the Drexel University Creative Arts in Therapy office.

The data collection was separated into three parts. The first part of the data collection included demographic information: age, board certification, number of years in the field, type of facility working in, etc. This took approximately 10 minutes. The
second part of the data collection included the pre-determined questions prepared by the researcher. The interview questions were developed in a process. Initially, questions for the interview began to emerge from the readings in the literature. The researcher developed a set of initial questions which were then discussed and refined by the thesis advisor. In addition, to these questions specific questions emerged from each subject as the researcher listened to their stories and began to explore their experiences with death and its musical impact. This took approximately forty-five minutes.

The open-ended questions included were:

1. Can you talk to me about the music that you created with the deceased patient?
2. At the death of the patient, did you create any music; listen to music, or play known music as a way to remember the patient or to acknowledge the loss?
3. Did you experience any changes in the music that was created with your subsequent patients – use of different modes, timbres, tempos?
4. Can you describe any musical associations you experienced about the deceased patient?
5. Did you notice any changes in your interactions, either musically or in general, with your other patients?
6. Did you ever experience a desire to avoid or remain involved in work with patients who are dying?
7. When explaining to others your work as a music therapist, do you ever reference the deceased patient as an example? In what way?
8. Finally, thinking of your musical experience with the patient before s/he died, are there any things you would have done differently in the music or in your interactions?

The subjects were given processing time to ask any clarifying questions or add any comments they felt were not addressed by the researcher. This took approximately 10 minutes. While conducting the interview, acknowledging the role of the researcher was important. (See Discussion chapter for detailed account of the role of researcher.) The researcher was interested in the subjects not only to tell their experiences, but to provide
practical knowledge for other therapists to learn about what it involves to work with the dying.

The researcher also looked at what the subject did musically, if anything, when processing feelings of mourning. The researcher identified what affect the mourning may have had on subsequent clinical sessions. For this aspect, the researcher identified what musical qualities, songs, or interactions changed, remained the same or if the subjects developed alternative ways of interacting with patients.

The possible risks or discomforts to subjects were minimal. The possible risks included re-experiencing feelings of sadness or loss or possible anxiety about the study topic. To minimize the risk, the researcher encouraged the subject to take his/her time and to answer the questions as s/he feels comfortable. The researcher assumed that the subject would relay any methods of self-soothing and process any disturbing emotions that surfaced.

In grounded theory, data analysis begins as soon as a researcher begins to collect data. The constant comparative method of analysis is a continual process of categorization, sorting and resorting, and coding and recoding of data for emergent categories of meaning. In order to develop theory, interrelationships between categories are analyzed until the researcher finds the one that is complete enough to encompass all that has been described in the story – this is the phenomenon at the heart of grounded theory (Sprenkle & Piercy 2005, p. 49).

3.4 Data Analysis

Initially each interview was transcribed. As the researcher interviewed the subjects and listened to their responses, the process of coding, memoing, and sorting started immediately, culminating in the narration of the data. (Grounded Theory: A Thumbnail Sketch. Retrieved November 28, 2005). The researcher chose to create a chart
for each subject, identifying category headings to organize the information gleaned from
the transcripts (See Appendix A). The chart system made it easier to focus on the music
without the distraction of secondary information. In general, the researcher identified
categories for each subject; however, there were times when categories overlapped. The
next step included looking at the constructed categories and identifying general
categories that include smaller sub-categories.

As discussed in the literature review section, the researcher used triangulation,
data collected from multiple sources, to ensure validity and trustworthiness of the theory.
In addition to the interviews, the researcher contacted the subjects after the interviews to
clarify statements and to gain further understanding of their experiences. In defining the
categories and sub-categories, it became important to increase the emotional distance,
from the information. Transcribing the data assisted in this as this ensured that the
statements were read, not heard.

3.5 Operational Definitions of Terms

The following terms emerged from the literature and from the subjects
themselves.

1. Mourning: process by which grief is resolved; it is the societal expression of post
bereavement behaviors and practices (from Sadock & Sadock 2003, p. 61)

2. Loss: the experience of losing a loved one (from WordReference.com Retrieved
November 28, 2005)
3. Grief: the subjective feeling precipitated by the death of a loved one (from Sadock & Sadock 2003, p. 61)

4. Bereavement: the state of being deprived of someone by death and refers to being in the state of mourning (from Sadock & Sadock 2003, p. 61)

5. Music Therapy: an established healthcare profession that uses music to address physical, emotional, cognitive, and social needs of individuals of all ages; improves the quality of life for persons who are well and meets the needs of children and adolescents with disabilities or illnesses; interventions can be designed to: promote wellness, manage stress, alleviate pain, express feelings, enhance memory, improve communication, and promote physical rehabilitation (from the American Music Therapy Association Retrieved November 28, 2005)

6. Counter transference: the therapist’s identification with unconscious feelings, self-parts (instinctive self, rational self or conscious), or internal objects of the client, which, being conscious in the therapist, can serve as a guide to the client’s hidden life (from Scheiby 2005, p. 8)

7. Death: the absolute cessation of vital functions (from Sadock & Sadock 2003, p. 58)

8. Dying: the process of losing these functions (from Sadock & Sadock 2003, p. 58)

CHAPTER 4: RESULTS

The major findings of this research view two areas. The first area is the intentional use of music. This was reflected both in sessions with dying patients as well as how a therapists’ personal use of the music might come to a resolution related to their sense of grief upon the loss of the patient. The second area looked at how the death of the patient continued to impact the therapists’ continued clinical work, both musically and interpersonally. Subject’s responses to the open-ended set of questions were varied with similar themes occurring, occasionally. As stated in the data analysis section of the methodology chapter, the researcher used triangulation – multiple sources of data collection to develop the identified categories.

The general categories of therapist’s experience of meaning in music and mourning identified are

I. Connections

II. Prophylactic Use of Music

III. Kinesthetic Experiences

IV. Boundaries

V. Rituals

VI. Closure

VII. Musical Beliefs and Concepts

VIII. Clinical Impact
The descriptions of the Therapist Musical Experience in End of Life Issues are as follows:

I. Connection defined as referring to the therapists’ responses about their relationships with the music, the patients being treated and the patients who died, and their relationships with others. Within this category, several sub-categories emerge

1. Live Music refers to music created in the patients’ room which include
   a. Interactions between Music Therapist and Patient
   b. Interactions between Patient and Family

2. Memories refers to the associations or remembrances of patients who have died when a certain song or musical interaction happens

3. Creative Connections refers to a belief that there is a larger cosmic community that the living and the dead are part of; the idea that there is something greater than the humans present within the moment

4. Community Support refers to spending time with co-workers and friends which includes remembrances of patients supporting the grieving process

II. Prophylactic Use of Music defined as referring to the therapists’ responses about their personal use of music as a form of self-care. Within this category, several sub-categories emerged

1. Music not in Therapy refers to music not used within therapy sessions, but used in the subject’s personal life

2. Music in Therapy refers to the therapist playing and/or singing the music that is used in therapy sessions
III. Kinesthetic Experiences defined as referring to the therapist’s desire to feel the music within their bodies including in their fingers or in their hearts. Within this category, several sub-categories emerged

1. Patient’s Physical Response to the Music refers to changes within the breathing, providing a sense of comfort and letting go for the patient in the music

2. Music Therapist’s Physical Response to the Grief refers to the desire to have physical contact within the music made with the deceased patient

3. Music Therapist’s Physical Response within the Session refers to the sense of feeling the music in a part of their body, e.g. the heart

IV. Boundaries defined as referring to the therapist’s desire to have a clinical distance from the music and patient, while remaining present in the session. Within this category, several sub-categories emerged

1. Distance between Patient and Therapist refers to being intentional about the role as a music therapist

2. Distance between Therapist and Music refers to consciously remembering that the music is for the patient, not the therapist

V. Rituals defined as referring to the therapist’s desire to incorporate standards and consistency in working with patients and mourning. Within this category, several sub-categories emerged

1. Personal refers to the therapist’s desire to have a consistent grieving process and resolution
2. Cultural refers to the therapist’s desire to be sensitive to the musical preferences of the patient and the implications and identification with songs and music that may be present for the patient

VI. Closure defined as referring to the therapist’s acceptance of the death of the patient and the resolution of the grieving process, including the acceptance of how long the process takes. Within this category, several sub-categories emerged

1. Music and Patient refers to the use of music to support or guide a patient to acceptance of their mortality

2. Therapist refers to the therapist’s use of music to bring a sense of conclusion to the musical and interpersonal relationship between them and the patient

VII. Musical Beliefs defined as referring to the therapist’s notions or ideas about the uses of music in the therapeutic environment. Within this category, several sub-categories emerged

1. Music Therapist and Patient refers to the role of the music in this relationship

2. Music and the Environment refers to the role of the music in creating, setting, and holding the therapeutic space

VIII. Clinical Impact defined as referring to the therapist’s continued work and the experiences lived up to the identified point that molds the current therapeutic relationships and uses of music. Within this category, several sub-categories emerged

1. Continued Music refers to the changes or consistency in musical interactions and the use of songs created with deceased patients with current patients

2. Personal Grief refers to the therapist’s losses manifesting themselves in their work
a. Musically

b. Desire to work with dying patients

It is important to note that the categories do not encompass all of the subjects, meaning some subject’s experiences had their own category, not fitting into others. In addition, some of the responses fit into several categories and it became necessary to decide which category was the best fit.

Subject 1

Subject 1 is a fifty-three year old woman who has worked in a nursing home for the last four years. In reviewing the subject’s responses, it became clear that several categories were applicable. The first category is Connection, the sub-categories that she provides musical examples of are the Live Music where a connection was strengthened between a husband, who was dying and his wife. Subject 1 relates the musical example of providing music therapy to this couple. “The woman was crying, sitting next to her husband who, in the musical space, opened his eyes. The wife stated that she found comfort in the music used and the connection she was able to have with her husband in the musical environment”. Another musical example of this occurred during a funeral service for a patient who had died. “He had enjoyed Irish music and I played ‘Oh Danny Boy’ for the funeral and the family appreciated this as they found this a fitting tribute to their loved one”.

A final sub-category identified for this subject is Community Support. Subject 1 reports that she and the staff have used the Shiva, a sitting ritual, in Jewish tradition. In this ritual the mourner is not left alone, people are encouraged to come by and talk to the mourner. Subject 1 relates an example of staff and occasionally patients using this ritual
and that sometimes during this ritual, the group will sing whatever the person’s favorite song was. The idea is to be surrounded by others, to have a community to rely on during the initial mourning period.

In the Prophylactic uses of Music, subject 1 identified how she uses music not associated with therapy in her personal life. She stated that she sings in a choir, plays music at home, that she uses music for her own enjoyment and wants her experiences in the music to be associated with fun. In the Kinesthetic Experience, subject 1 provided several musical examples of how she views the connection of music to the patient’s body. In one of her examples she discussed singing a song form - opera for a patient whose family member requested it because this was her mother’s favorite style of music. While listening to the song, the patient opened her eyes, even though she had not opened her eyes in weeks – allowing for a visual connection to occur between patient, therapist, and daughter. In a second story, subject 1 stated that she is there to provide comfort, to help ease the patient’s breathing through the music listening. Finally, she informed the researcher that, in her view, music can help control a patient’s anxiety.

In the Boundaries category, subject 1 discussed having clinical distance between self and patient. She stated that she focuses on the fact that this a job and she has to be professional and provide what the patient needs, but she needs to remain objective in her musical interactions. She stated that there is a need to compartmentalize – “you can be emotional in the moment, but you can not keep carrying that emotion with you”. In the Rituals category, she discussed the importance of knowing the culture of her patients, the importance of playing Jewish songs and playing them in the keys that they are written in if possible as, in her view; this provides added comfort to the patient.
In Closure, she told about entering a patient’s room and playing whatever comes to mind, typically in a folk style, to provide comfort and allow them to breathe more deeply. In subject 1’s experience, there have been times when this has assisted in allowing the patient to “let go”. In Musical Beliefs, subject 1 discussed the importance of quality of life which relates to the relationship between the therapist and the patient. She believes that if a person is able to respond, in hearing music or the voice or seeing a smile, to this stimulus not in pain or agitation, then she has succeeded in contributing to this patient’s quality of life.

Considering the idea of the relationship between music and the environment, subject 1 stated that she believes in the importance of not giving off tension to the patient. This translates to her using the music to provide a warm, comfortable, soft musical space without jarring sounds or sudden changes in her playing or singing. Finally, she also believes that there is a musical phenomenon, special to music therapists’ relationships to their patients. She states that the musical connection, though at times intense, is brief therefore making it a different connection with the patient than s/he has with the nurse or caregiver who provides the physical care.

Finally, considering Clinical Impact, subject 1 did not identify specific areas that she saw how her work with dying patients impacted her continued work. However, inferring from her above responses, this researcher believes that there is a pattern of consistency that emerges in her work. It appears that she continues to have an awareness of her patients, their environment and the music’s role in the interpersonal and environmental relationship.
Subject 2

Subject 2 is a forty-five year old woman who has worked in hospice care for the last year and a half; her related experiences to this research topic come both from her work in hospice and in nursing homes. In reviewing her responses in the interview, several categories were identified. In Connections, subject 2 reflected on how she remembers patients through songs. She talks about playing a song that reminds her of the patient, especially if the patient has taught the song to her – she associates that patient with the song, always thinking of that one patient when that song is requested. She also relates working with families creating legacy songs, so that the family not only has a physical remembrance of their loved, but a musical connection to him/her.

In Creative Connections, subject 2 described “receiving a message” or an instinct to play a song and it is this song that unites others and creates dialogue. Subject 2 related the story of this Creative Connection occurring in a staff memory share which ties in with the community support sub-category. Subject 2 with other staff, including nurses and chaplain staff, join together every other Friday to participate in a memory share for all patients who have died. Subject 2 incorporates music into this time either by playing the deceased patient’s favorite song, or by playing a song on the piano or sometimes using chants and at times using silence to mediate while playing a Tibetan Bowl. She also encourages other staff members to initiate the musical remembrances.

Subject 2’s Prophylactic use of music emerges in participating in music not used in therapy sessions. She sings in a choir and emphasizes that it is not a good idea to give up one’s own music. One can also infer that the use of the patient’s favorite song, during memory share, is another way that she musically takes care of herself.
Subject 2 spent much time discussing the importance of Rituals, both personal and cultural. Subject 2’s personal rituals include singing at patient’s memorial services, and initiating and participating in the staff memory shares. Culturally, subject 2 shares about her experiences of creating Shabbat services for patients with dementia. She informed the researcher about the importance of being sensitive to the cultural importance of music. The desire to create the Shabbat services stemmed from the awareness that the Jewish patients, although demented, were still Jewish and deserved to have that part of their lives honored.

She stated that she has a theory that music is as much a part of family origin as ethnicity. She told of patients dying who requested songs from their childhood, be it lullabies or songs they had learned in their religious community regardless of whether or not they were still religious. Subject 2 believed that patients requested these songs because they were seeking comfort, seeking a sense of being held which can, potentially, be achieved in returning to their musical roots.

In the Closure category, there appeared to be an overlap from the ritual category. Subject 2 explained that she sometimes uses singing at memorial services as a way to come to closure about her relationship with the patient. In this same sub-category, she also described taking the time to go into the room of the deceased patient, regardless of whether or not the body had been removed and playing music in that room as a way to clear the energy and to honor the space of the deceased patient.

In Musical Beliefs, subject 2 described the role of music as a way to honor the space of the person who died. She believes that in many cases, music, specifically song lyrics are metaphors for what is actually occurring in the life or death of the patient.
Subject 2 also stated a belief in music as being spiritual and transcendent; music impacts the space and “speaks to the spiritual essence of patients when they can no longer speak”. She believes that music is a source of strength for the patient.

Environmentally, subject 2 shared that there is much sonic intrusion in the life of those living in hospices, nursing homes, hospitals, etc, and it is important to honor the sonic space. Part of the hospice facility’s honoring of this sonic space is to invite volunteer musicians to come and play at the site, allowing the music to drift into the rooms of patients.

Finally, considering the Clinical Impact of subject 2’s work, one can infer that all of her experiences up to this point have molded her beliefs and views about the role of music in her sessions. One can infer that it was her experience in the nursing home that made her sensitive to acknowledging cultures and rituals, both for the patients and for herself. One can also infer that it was the experience in the nursing home that contributed to her being aware of sonic noise and how music can impact noise both positively and negatively.

**Subject 3**

Subject 3 is a thirty-two year old woman who is working in bereavement counseling and has worked in the hospice care setting for three and half years. In terms of Connection, subject 3 related stories of how connections were strengthened and in one case initiated in families through the use of song writing. Subject 3 told a clinical vignette of working with a mother, who was dying, and her daughter. The daughter was struggling to accept the fact that her mother was dying. So, subject 3 chose to do song lyric substitution to allow the daughter and mother to dialogue in the music. Later, the
daughter expressed gratitude at being included in her mother’s dying process. In a second case vignette, subject 3 related a story about a dying woman who was isolated from her children. Subject 3 and the woman wrote a song, which they then recorded and mailed to the children. The children were able to come and say good-bye to their mother before she died.

Connecting interpersonally with a patient, subject 3 told of a time that she was sitting beside a dying patient. While sitting beside this patient, there was live music playing downstairs that was drifting into the room. She spoke about being moved by the intensity of the moment as both she and the patient were receiving the music, indirectly. Subject 3 also described experiencing moments where she had memories of patients who had died. She stated that she would play a song and think that this was "so and so’s" song. This musical association carried over into her sense of Creative Connection. She related that she sometimes feels a patient’s energy in the room with her as she is playing their song.

Before beginning her full-time career in music therapy, subject 3 related that she did use music prophylactically by writing songs when she felt emotionally overwhelmed. She stated that she would use music as a way to process her emotions through song writing. However, upon being a full-time music therapist she ceased this practice. Having two years away from this work, she says that she would, in the future, make the space to use music for herself, not just for her patients.

When considering Boundaries, subject 3 spoke about the need to disconnect clinically. She made the conscious decision that music is for and about the patient, so she did not make an emotional connection to it. She stated that she has a purpose, musically,
to facilitate the patient’s ability to help themselves. Subject 3 reported that she did not feel an emotional intensity in the moment with patients, but upon reflection, she would begin to have room to feel the emotion that had been blocked in the session.

Musical Beliefs held by subject 3 include being a facilitator to the patient, using the music as a “tool” in terms of creating a musical bridge for connections between family and patient or bringing about closure for the patient and family.

Finally, subject 3 spoke about how she believes her experiences have impacted her continued clinical work. She stated that when she has the memories of patients who have died while playing a song, she sometimes plays that song with more “gusto”, more energy than she normally does. Her parting thought is that she would be more intentional in creating musical space for herself. Specifically, she would include using music to process her feelings of grief as opposed to solely using other non-musical methods to deal with these emotions.

Subject 4

Subject 4 is a thirty-seven year old woman who has worked in hospice care for the last two years. In reflecting on the subject 4’s responses several categories emerged. In terms of Connections, subject 4 expressed that she has moments when she remembers patients who have died while doing music with current patients. She clarified that she does not have an emotional response to this remembrance, but more of recognition that this patient had been a part of her music therapy life. In terms of a Prophylactic use of the Music, she informed the researcher that she uses themed mixed tapes that she has created for herself. Each tape has a different title and she listens to them as she leaves work, in her car.
In terms of Boundaries, subject 4 related that she is conscious that she has emotional distance in her musical interactions with patients. She intentionally chooses to distance herself from her patients and their music when she goes home at the end of day. She explains that she returns to work each day feeling refreshed for the day because she has not born the grief of the patient during the night. She believes that this assists in her ability to be present and engaged in each session with each patient. In addition, she created physical distance between herself and remaining patients upon learning that a patient has died. She creates emotional space to not be with patients at that time.

Regarding Closure, subject 4 uses the technique of song lyric substitution with her patients for the purposes of processing and closure both for them and for herself. Considering the category of Musical Beliefs, subject 4 believes that music is a safe environment, that it fills the space when there are no words available. She believes that it is her tool and stated that she is thankful to have it every time she enters a patient’s room. She believes that the music benefits the dying patient, even if the therapist is not able to know exactly what that benefit is. Finally, she believes that what she brings to sessions, the music, far outweighs the grief and pain being experienced either by her or by the patient.

The Clinical Impact identified by subject 4 is that all of her musical experiences up to this point have been preparing her for this moment in her life. She believes that she carries each experience inside of her and that the combination of all experiences contributes to her work as a music therapist in hospice. She stated that it is a continuing cycle – that there is always something new to learn, not only from the patients encountered, but everybody.
Subject 5

Subject 5 is a twenty-eight year old woman who has worked in hospice care for the last three years. Looking through the data collected from subject 5 several categories are identified. Considering Connections, subject 5 related that she has memories of patients who are deceased when she sings songs with other patients. She illustrated this in a story about remembering a woman who had inspired her to substitute song lyrics in “Amazing Grace” and as she continues to use that substitution, she always remembers the patient.

Regarding the use of music Prophylactic ally, subject 5 stated that she intentionally uses music to take care of herself. She continues to play the songs, from therapy sessions, remembering the patients and allowing her emotions to surface. In addition to using the songs from therapy sessions to deal with emotions, she also said that she sits at the piano and plays music, not necessarily related to her clinical work, using that time to process what she is feeling. She also stated that she will participate in her husband’s music; this music being unrelated to her emotions and her work.

Subject 5 described a Kinesthetic Experience to music. When a patient dies, especially one that she had a strong connection to, subject 5 removes that patient’s music from her song list. She takes that music home with her to sit and physically feel it in her fingers while playing the piano. Subject 5 stated that, in order to handle her grief, she “needs to hear the wobble in her voice”, meaning she needs to feel the grief that she is experiencing through singing, to feel the pain and grief while playing the music. Once she comes to a resolution, she returns the music to her play list. This also fits into the
Rituals category as this is how subject 5 chooses to grieve for the deceased patient and it is a consistent method for her grief.

In the Boundaries category, subject 5 said that her boundaries are fluid. She does attempt to be intentional about her role as a music therapist and what that entails. However, she is aware that sometimes her boundaries are weaker than at other times. She stated that when she has strong boundaries, she loves both the music and her job, but when her boundaries are weak, she avoids the music, particularly sitting with the music of deceased patients and must force herself to return to the music.

Subject 5’s Musical Beliefs include using music as a transitional object. She likens taking the songs of her deceased patients out of the song list to the use of them as transitional objects – these are what she holds onto as she begins to work towards a resolution of her grief. In addition, she keeps mementos, including recordings of songs of deceased patients and any handwritten notes in a special drawer. She does clarify that it is not enough to hear the recording, but to play the music that makes it a transitional object for her. She also stated that it is an honor to play music when someone is dying. When she remembers her patients she cherishes those memories as they give her “warm fuzzy” feelings of gratefulness, love and compassion.

Closure is another category that overlaps in subject 5. Her closure occurs when she takes the music of the deceased patient, using it as a transitional object. Subject 5 is intentional about using music; both music from therapy sessions and music played at her home on the piano, to experience and resolve her grief. Finally, considering Clinical Impact one can infer that subject 5 continues to be intentional about her use and treatment of music, both her personal music and that music created in sessions. Subject 5 stated that
it is her relationship to music that assists in her ability to continue working with dying patients allowing her to not have a sense of burn out.

Subject 6

Subject 6 is a twenty-nine year old woman who has worked in pediatric hospice care for four years. Looking at the category of Connections, subject 6 uses music to create a bridge of communication between the patient and the family. In a specific case example she told of a child who was dying and how she used the music as a time for the family to emphasize what they have instead of what they were losing. She used the music as a “tool” for her patient and for the patient’s family to come to a level of acceptance about the patient’s death. In terms of her connection with patients, subject 6 stated that it is rewarding to be able to witness how alive the patients are and how communicative they are in the music. Remembrances of dead patients do surface from time to time while subject 6 is working with current patients. She stated that she regards these memories as positive occurrences, not feeling traumatized by the remembrance.

For her own Prophylactic use of Music, subject 6 stated that she uses music and imagery as a way to process her emotions. She also improvises on her piano, sings so that she has a connection to her body, as well as occasionally including some body movement in her musical expressions. In addition to using the piano, she also plays the harp. This use of music, specifically the use of her voice and her inclusion of movement speak to a Kinesthetic Experience in the music as well. She views this use of music and her body as a way to be aware of her inner world and/or to visualize what is going on inside; she believes that this assists her bereavement process to reach a resolution.
It appears that for this subject, Rituals and Closure are intertwined. She intentionally creates space for her music to process her bereavement each time she experiences grief. In addition, through her job, she has the opportunity to talk to the families of the deceased patient and, on occasion conduct a musical closure session with the surviving family. It is the combination of her personal music and the visit or phone call to the family members that she values and believes allows for a sense of closure.

Subject 6’s Musical Beliefs include the use of music as to stimulate the imagination to create a greater awareness of what is going on inside, both for the therapist and for the patient. She believes that having an intimate relationship with music is of utmost importance. She places value on the connection between music and communication; on music’s ability to create a non-verbal communication between the patient and the family and the patient and the therapist.

She also believes that it is an honor to be a part of her patient’s lives and that the “music assists the patient in really, truly living; that it is a way to honor the life that patient still has left within them”. Subject 6 believes that the musical experiences supersede the traumatic experiences and that, for her, it is most important to focus on the positive resources of the patient, using music as a supportive therapy.

Finally, in terms of Clinical Impact, subject 6 states that everything she has experienced has meaning and that will stay with her for as long as she lives. From this statement one can infer that subject 6 takes each experience, each mourning process and learns something about herself and her music that she then takes with her to the next patient. It appears that her musical interactions are a constant lesson building on each other to mold her as a therapist.
Subject 7

Subject 7 is a forty-two year old woman who, until recently has worked in hospice care for the last nine years, but decided after a one year sabbatical that it was time to take a break. She is now working on a pediatric oncology floor of a children’s hospital. Taking the category of Connections, subject 7 stated that she uses the music as a way for the patient and the family to increase their communication. She stated that music is the bridge for the communication between family and patient. She related a story about a seven year old patient who was dying and was disoriented and unresponsive, but the family invited her into the room to play violin for the patient as a way to communicate with the patient. This created a musical, non-verbal space for the patient, therapist and family to have a unique experience and connection in. In addition, subject 7 referenced patients who blink their eyes or smile at her as she is playing music for them explaining that this is a way for the patient to make contact with her when they are unable to verbally express themselves.

In terms of a Creative Connection, she says that being with a patient who is dying guides her to use the music differently. She stated that it is her feelings associated with the music, made with the patient, that stay with her and this feeling surfaces again when she is playing for a patient who is dying in a similar fashion to the deceased patient. She states that it is spiritual to have this feeling remain with her and surface, musically, with other patients. Subject 7 also has Community Support. She is a member of a string quartet with other mental health workers, not from the same hospital, who gather together every Tuesday night to play music together, to have fun and to support one another in
their work. Again, the use of her music in the Community Support overlaps with Prophylactic use of Music.

In terms of Kinesthetic Experiences, she uses the music as a way to connect with the body of the patient. She provides an example of using music to help the patient’s breathing – to create a sense of calmness, of comfort and peace. She also stated that, in some cases, this connection between the body and the music can allow the patient to “let go” to assist the patient in dying. She intentionally matches her music to the patient using elements of the music, such as softer dynamics to relax the patient.

When considering the category of Boundaries, subject 7 stated that she is conscious of the role of the music in the space. She is aware that she only has a brief time with the patient and she is conscious of this as she works with the patient. In terms of Closure, she takes the time to grieve those patients who had a significant impact on her, those whom she worked with longer. She uses her larger community as a way to deal with her grief, talking about it and receiving support. When she learns of a patient’s death, she will take time to spend on her own music or choose to see a patient who is not actively dying, seeking ways to manage her work for that day.

Her Musical Beliefs include the fact that she is there for whatever time the patient has left and desires to use the music to enhance their quality of life. She also believes that seeing the beauty, including music outside of the therapy sessions is a way to appreciate and realize the intensity of the work that she does. She believes that she must be clear in her role as a music therapist, going inside of herself to find out why she is having reactions to patient’s sadness. She views the musical space as a unique and unusual
space, a special and intense space where connections are made and emotions are revealed and worked on.

In terms of Clinical Impact, one can infer that subject 7 values her personal relationship with her music and uses this as a way to both be apart from her clinical work and to process the emotions associated with her clinical work. One may also infer that she honors the musical space of her patients allowing them the opportunity to communicate both with her and with family members and with themselves.

Subject 8

Subject 8 is a thirty-eight year old man who currently has a private practice, but has previously worked in a hospital with children dying from AIDS during his undergraduate internship. Thinking of Connections, subject 8 related that he had an experience with dying boy where the musical environment was not only holding the patient, but him, as well. He stated that there was this moment of “connection” between himself and the patient and he was able to improvise a good-bye song for the patient.

Another story that he told included two patients, both young boys dying of AIDS. One was more alert and requested to go into the other’s room, who was not as alert, and make music with him. In this instance the connection was between two patients and the therapist. In terms of patient and family connection, subject 8 allowed families to sit in the room and experience the musical environment with the patient.

Subject 8 acknowledged that he thinks of the musical space and the interactions with the dying patient in a “Creative” way; almost in a sense that there is something greater out there, whatever it is. In certain circumstance, he views the music as a bridge for the patient between the here and where ever the patient is going. In addition, subject 8
stated that he continues to feel a sense of the dead patient being with him as he sings the good-bye song that they created together, with other patients.

In terms of Memories, he remembers certain patients that he associates with songs. He referred to the young boy who inspired the creation of the good-bye song and another moment when a young girl whom he remembers whenever he hears or uses madrigals. His Prophylactic use of Music includes having and maintaining an intimate relationship with music to process his emotions.

Referring to the Kinesthetic Experience in music, subject 8 revealed that he feels grounded in his body when he is not worrying about the music, but concentrating on being present for the patient. He remembers an instance where he felt held by the music as he worked with a patient. He demonstrated this physical sense of being in the music, in his body by holding his hands in front of his chest several times during the interview.

Subject 8’s views of Closure include the experience of improvising a good-bye song and then continuing to use it with other patients. He was aware that his time was limited with the patient and in the music, so he focused on the music. He related the story of the young girl who was dying. They listened to madrigals allowing images to emerge, including the sun and the moon coming and going. To subject 8 this signified that she was using this time as possibly seeing the days of life passing and that time was coming to a close for her.

Subject 8’s Musical beliefs comprise the belief that if he stays in the music, everything else is going to be alright. He believes that the children are going to die regardless of whether he is there or not, so he wants to use the time and the space to help
the patients while he has it. He believes that continuing to remember, in the music, those who died is a way of honoring and celebrating the person.

Finally, the Clinical Impact occurred when he continued using the improvised good-bye song created with the dying patient with other patients. He viewed this song as a gift from the patient to continue sharing with others. He believes that this first patient’s death opened up something emotionally in his body. It helped his voice to be more in his body, providing a sense of grounding for him as he continued his clinical work, particularly in allowing him to not focus on the mechanics of the music.

**Subject 9**

Subject 9 is a thirty-two year old woman who has worked in a hospital for the last five years, but relates her grieving experiences from her work at a nursing home. She worked there for two and a half years. In terms of Connections, subject 9 stated that she has remembrances of patients in the music. A specific example of this is when she hears “Annie’s Song” and remembers the patients who wrote a good-bye song to her using that melody. Subject 9 told of using the music as a “tool” for communication between the patient who was trapped inside of her body and her nurses and her mother. She also believes that when she remembers patients, in the music, it is an ever-expanding community of people who like that song or have a connection to it; a cosmic network of people.

Her Prophylactic use of Music occurred when she sought out a Guided Imagery in Music (GIM) therapist to assist her in processing her feelings of grief over the loss of the patient. She also plays the piano, at home, as a way to stay in touch with her music and emotions. In terms of Closure, subject 9 stated that she found song lyrics to be a good
metaphor for issues. Specifically, she recalled a patient who chose a song that reflected her acceptance that she was dying soon. She also stated that the patient wrote her a good-bye song as the sessions ended. The subject still has the copy of the song that was written for her.

Her Musical Beliefs include a sense of burnout when the music becomes only about the patient. It is during these times, that the subject must re-enter into a personal relationship with music to receive her own nurturing. In addition, she views song writing as a form of communication between the patient and the outside world. She believes that lyrics can be a metaphor for life issues and that she is connected to a larger, cosmic community in her music therapy work.

Finally, the Clinical Impact must be looked at. For this subject one can infer that she is conscious and intentional about keeping boundaries between her personal use of music and the use of music clinically. One can also infer that the sense of a cosmic connection is something that she takes with her as she sees patients, inviting them into the connected space, musically.

In reviewing the data there are times when subjects’ responses were similar, except for wording allowing for similarities in categories to emerge. However, there are times that each person’s responses required a different category. There were three identified categories that contained similar responses and each category appeared in all nine subjects. These included the categories of Connections, Musical Beliefs and Clinical Impact. Within each category, certain sub-categories were more applicable than others, but the general theme appeared.
One can draw the conclusion that having a connection to the music, to the patients, and to a larger community is of utmost importance when working with dying patients. Having an understanding of what an individual’s beliefs are about the role of the music and the role of the therapist help keep clear boundaries in the therapy sessions. And finally, spending time in reflection about past experiences can assist in gaining insight into how those experiences impact continued clinical work, either positively or negatively.
CHAPTER 5: DISCUSSION

5.1 Overview

This study looked at two distinct areas related to the relationship of music to the therapist and the patient, first it explored the role of music in a clinician’s mourning deaths of patients, including the role music played prior to the patient’s death. Second, taking into consideration the role of music both prior to and during the mourning process, the study investigated the impact this had on the clinician’s continued clinical work. Viewing the collected data in its entirety, common themes unfolded. In addition, to the common themes, it became clear that the data did not always fit neatly into one category, but could be placed into several categories. One of the main ideas that emerged in the data is the idea that music has a specific role or function in the grieving process of the music therapist.

There were virtually no accounts, in the literature, of a music therapist’s experience of a mourning process, specifically relating to a patient’s death and its impact on the continued clinical work. Therefore, the data collected for this study uncovered elements unforeseen, particularly in the creation of categories for coding purposes, referenced above. It is from these categories that the researcher was able to identify some common ideas among the subjects. This was illustrated by the subject’s use of music in the therapy session with the dying patient, in the use of music or the lack of music in the processing of the emotions and in the continued use of music in subsequent sessions.

In 2002, Deborah Salmon, a music therapist who works in palliative care, conducted a study that provides a snapshot of stressors and coping mechanisms experienced by music therapists working in the intense area of end of life care. In
Salmon's study, she reported, "84% of the sample responded that they played music, 74% listened to music, 22% sang, 16% composed and 8% danced" (2003, p. 56) as uses of music for self care. In addition, non-musical coping mechanisms were also cited, "creative expression, involvement in spirituality or religion, exercise, seeking support both of colleagues and others, and socializing" (Salmon 2003, p.55). In her discussion, Salmon states options for therapists who are seeking to prevent stress and burn out.

Experienced therapists might benefit most from periodic small-group retreats emphasizing spiritual, emotional, and physical renewal, while those newer to the field may prefer workshops or conferences focusing more on skill building and support. Palliative care music therapists should consider forming small working groups for mutual support, ongoing training, and renewal (2003, p.58).

For this study, nine subjects, all practicing music therapists, were interviewed using an opened-ended response technique. Each subject’s responses were unique to their personal experiences with death and their relationship to music. Initially, subjects answered questions relating to how they used music while working with a dying patient. This, too, provided varied responses including song writing, lyric substitution, improvisation, reflective listening, song singing, and imagery and music. There were similarities among subjects in their use of music experiences.

Through analysis of each subject’s responses, the researcher transcribed the data, identified general categories of therapist’s experience of meaning in music and mourning and specific sub-categories that organized the raw data. Organizing the data in this manner assisted the researcher in identifying both differences and similarities in the data collected. The identified categories included Connections, Prophylactic uses of Music, Kinesthetic Experiences, Boundaries, Rituals, Closure, Musical Beliefs, and Clinical Impact.
As previously stated in the literature section, by Sally Bailey in her chapter *Creativity and the Close of Life* (1994), there is a concept that artists who continue to work with the dying have a belief that the process of dying is a completion of the life cycle, as opposed to a break in the life cycle. It is this concept that continued to surface for the researcher while analyzing the data. This appeared significant to the researcher because the researcher held the belief that death was indeed a break in the life cycle and this research challenged that belief and forced a re-evaluation of the belief associated with dying. All nine subjects have a personal belief about what death is and how a patient lives on, after death. For therapists considering work in this field, it would benefit them to evaluate their beliefs associated with death and the potential impact this might have on their ability for sustained work with the dying.

Most subjects reflected a belief about the role of the music – including providing moments of connection, comfort, peace, or a sense of “letting go”. Coupled with this, the subjects also had a definition of their role as a therapist including being a facilitator, honoring and celebrating the life of the patient through music, and having an awareness of what was happening inside them, so that interactions seemed genuine.

One concept that continually appeared is that there is a spiritual or Creative connection in the music between the therapist and the patient. Each subject related a story of remembering patients after they had died and that this was a positive experience for them, that this was a remembrance that they appreciated, honored or cherished. They viewed the remembering as the patient continuing to live on through the music.

A third area idea that emerged in this study was self care which includes the mourning process. For each subject this appeared different, however, a constant in this is
the relationship that they have with music. Each subject, even the ones who did not identify a specific use of music in their self care or mourning, maintained that they had a relationship, outside of work, with music.

Regardless of whether or not they used music to process their emotions in the present time, there was a time that they used music as a servant source to facilitate the process to explore their emotions, including their personal grief. It is possible that this intimate relationship with music has a direct link with how the therapist uses the music for the patient. Perhaps, because there is an intimate relationship and a belief in the power of music, therapists are able to have distance in their work as there is a third entity in the room – the music.

The concept that music is like a third entity in the room appeared to emerge in all nine subjects’ experiences. Each subject made a statement or provided an illustration of how they relied on the music to hold, not only the patient, but the therapist. Music, being the third entity in the room, became the container for the therapeutic environment. The therapist brought the container, the music, into the session. This concept is best illustrated by subject 8’s example of how he used the music in one of his therapy sessions. He told of an example when he was treating a young boy dying of AIDS and how “…the music held the process – the fear came in passing, the minute I kept singing it was like this is why I want to be here and why I’m supposed to be here and the music just said that and I was okay and I left that session feeling quite grounded and moved in a good way” (2006).

Finally, considering the impact that the mourning process, coupled with music, had on continued clinical work, the researcher identified that this, too, is a process. It appeared from the subject’s responses that each person’s experiences added something to
their personal style renewing it each time they saw a patient. The subjects stated that they spent time, not constantly, but occasionally reflecting on their music and their interactions with patients to learn about themselves, the music, and the patients. The time spent in reflection assisted them in their continued clinical work, helping them to more clearly define their role and the role of music in their work.

All but one subject identified one specific patient, initially, that had made a lasting impression on them. It was this patient that the subject focused on when discussing the experience of mourning and the role of the music. Several subjects stated that it was this patient that enabled them to reconnect with their personal music or enabled them to use music to process their emotions or empowered them to feel more fully present in their bodies and, ultimately, in their other sessions. This is not to imply that each subject limited their memories to one patient, but that each subject had an immediate remembrance of one patient when approached to do this study.

In Silverman’s chapter in *Dying, Death, and Bereavement: A Challenge for Living*, he extols the importance of caregivers having connections with others. He believes that it is important for caregivers to be involved in caring relationships (2003). From the data, the idea of having a community connection is echoed by each subject. Again, each subject’s personal experience was varied, but the general belief in a connection with a larger community, be it a cosmic network, a connection with staff or a connection with friends and family assisted the therapist in working through their emotions. Having a shared experience appeared to assist in the therapist’s ability to process emotions.
Each subject had his/her own personal experience with death and loss either before entering the field of music therapy or during their practice. It is important to note that this personal loss and grief also impacted the therapist’s continued clinical work. In some cases, it was this personal experience of loss that encouraged the therapist to work with the dying. There did not seem to be a narcissistic quality to this, but a general idea that the personal loss was special and intense and there seemed to be a desire to share this kind of moment with someone else that is dying.

For some subjects, their clinical work was a way to remember their own personal loss as they assisted a patient in the completion of the life cycle. In one case, the therapist found that he reconnected with his emotions about loss when he experienced his first patient’s death. In addition, several subjects reported experiencing personal loss and grief during the time they were practicing. It was these subjects who reported having musical associations or memories of their loved ones in the music while treating a patient. Again, the researcher felt this sense that the therapist was remembering their loved one in their continued clinical work, not in a narcissistic way, but in a desire to be a part of the completion of life, hoping to provide a sense of quality of life, however small.

5.2 Clinical Applications

From the research, it can be inferred that therapists, in general, place a high value on understanding their inner selves and having an awareness of their experiences both in the music and interpersonally with their patients. Subject’s 6, 7 and 9 stated, explicitly, that they believe that one should always examine their reactions to sessions and the music, to spend time inside themselves to find out what is going on for them. Subject 9
stated that she is conscious of questioning her emotional responses to the music and the interactions with patients, so that she can be aware of herself and not impose herself on the role of the music or her role in the interpersonal relationship. A second concept that correlates to this idea of insight is the clear definition of the role of music and the role of the music therapist, already previously mentioned.

It is personal insight about a therapist’s emotional responses that assists in having a clear definition of the role of music and the role of the music therapist. When considering working with dying patients, one must beware of imposing personal beliefs upon others. As subject 2 stated, “everybody goes into this work for their own reasons, but it is important to allow the patient their own space to define for themselves how they want to die and the role that music and others will play in it” (2006). Understanding that a therapist will make clinical judgments about encouraging growth in a patient; it is also important to allow the process to happen naturally.

Subject 6 stated that she does not focus on the fact that the patient is dying, rather she chooses to support the life that the patient has remaining. Sometimes this encompasses acknowledging that the patient is dying, but not making the impending death the main focus of the therapy. Each subject, in their own way, is informing others that, when working with the dying, it is important to have insight and clear definitions about the role of the therapist and the role music plays in the work. This will not look the same for every therapist and it will probably not remain stagnant, but having this insight and role definition will assist in keeping boundaries.

Boundaries were also important in each subject’s approach as a therapist. Each subject had their own boundary definition, but each subject had a boundary. Subject 1
and 4 both stated that they are intentional about having clinical distance with patients. Both subjects stated that they thought of patients not as family members or friends, but that this is the job, their chosen profession and what they loved to do, but it is still a job and they could not carry continuous grief home every night.

Subjects 1, 2, 3, and 4 each spoke about being intentional about leaving work at work. These subjects did not bring the music from their sessions home with them, instead they either chose to not use music or they chose to participate in musical activities unrelated to clinical work. Again, they separated themselves, physically and emotionally, from the music created with patients. So, as therapists work with patients who are dying, it is important to define boundaries; they do not have to be rigid, but boundary definitions not only help the patient, but assists the therapist in taking care of themselves.

For therapists working with dying patients, it is recommended that one have a means to achieve closure. From the data collected, it almost appears as the though the terms closure and rituals are intrinsically intertwined. For example, each subject spoke about having techniques to achieve closure, using these techniques each time a death occurred that had a significant impact. This has the feeling of being a ritual. Some subjects, such as subject 2, had very specific rituals that she used to have closure. Her most significant examples of this included participating in a memory share with staff and playing music in the room of the deceased patient as a way to honor that space. Therapists might consider examining what their rituals are and how they impact their sense of closure and continued work.

Finally, one must consider this larger concept of connection. Subject 6 explicitly stated that “it is not good for a music therapist to be isolated”. Each subject echoed this
opinion, in their own way, as well. Each subject had their own way of maintaining a
collection to a larger community; this ranged from being involved with their staff in the
work environment, to having an involvement in outside musical activities, to having an
involvement in non-musical activities, to having an involvement with other music therapy
professionals. Each subject spoke of the virtues of having these connections, one subject
even referred to this connection as a way to nurture herself. Being a part of a team, not
only nurtures the therapist, but it can impact how the therapist responds to sessions –
from a refreshed standpoint versus an overwhelmed one.

5.3 Limitations of the Study

This study explored the grieving and musical experiences of nine different music
therapists working in various settings, including hospice, hospital, and nursing homes.
While this study begins to explore and describe the experience of the music therapist
when treating a dying patient, the results do not yield completely generalizable concepts.
Each subject’s experience with death ranged from working with children, as young as
two months old, to the elderly. Therefore, one must consider the developmental stage of
the patient who died. Taking into account Erik Erikson’s developmental stages, a
patient’s end of life might look different, especially from childhood to late adulthood.
And this may effect a clinician’s ability to accept that death.

Incidentally, there was only one male music therapist who participated in this
study and there is a possibility that gender might play a role in how a therapist handles
their emotions and the impact that may have on their clinical work. In addition, all
subjects interviewed were from the East coast and Canada. It is possible that regional differences may play a role in the grieving process and the use of music.

5.4 Role of the Researcher

Initially, this researcher believed that her role would be one of an active participant in the data collection process; specifically, in asking the pre-determined set of questions of each subject. However, the researcher found that the role evolved into one of reflective listening, where the researcher asked questions and listened to the responses and then, identified areas or terms that needed further clarification. In this, the researcher found that it was useful to listen very carefully to the word choice of each subject and to reflect the exact word back to the subject in order to remain focused on the study topic, but to also encourage further disclosure on the part of the subject.

Paying attention to self, particularly relating to pre-conceived notions of what the researcher expected to happen in the interviews, became of utmost importance. Listening to the subjects required that the researcher had an internal dialogue about what was being learned. This dialogue included checking the self from jumping to conclusions when statements were made that the researcher assumed she knew what the conclusion of the subject would be. At times, the researcher would attempt to sum up what had been stated by the subject in a phrase or word, but this was not always accurate which allowed for the subjects to further clarify their experiences, so that the researcher had the correct impressions and understanding.

The researcher found that it was necessary, at times, to stray from the pre-determined questions because the subject would bring up an area that the researcher had
not considered, but wanted to explore that area in order to determine its relevance to the study. In this, the researcher found that it was often better to allow the subject the space to talk, uninterrupted and then to ask for further clarification or discussion about words or phrases. In this, the researcher needed to listen carefully to what the subject was discussing to determine whether or not the statements were relevant to the research. Occasionally, subjects would veer off topic requiring the researcher to determine if there was a common thread of thought in the statements or to re-direct the subject back to the topic at hand.

The most difficult interviews were with subjects that the researcher found she really enjoyed talking with the subject. In these cases, it required more effort on the part of the researcher to remain on the task at hand and to not become caught up in conversations that did not have relevance to the research. Discipline and focus became important for the researcher, as she had to work harder to not ask questions to “get to know the subject”, but to interview the subject.

Often times, when the researcher asked specific, pointed questions, there was little information provided in the responses. So, it became evident that more information about the subject’s experiences was disclosed when open-ended questions were used or by allowing the subject to tell their story. In this, the researcher also found that, at times, it was appropriate to use personal disclosure to encourage the subjects to talk about their personal experiences.

Several times, the researcher chose to disclose her personal losses to the subject. This had the effect of encouraging the subject to open up more freely about their personal experiences of loss and the impact that that had on clinical work. The researcher also
discovered that there was a greater level of disclosure by treating the interview more like a conversation as opposed to an interview determined to get the needed information. By relaxing and treating the interview as more of an opportunity to learn about the clinical life stories of the subjects, it allowed the subjects to respond in more natural and detailed ways.

5.5 Implications for Further Research

Music therapy research involving clinical work with the dying population is extremely limited. There is virtually no account of a music therapist’s experience in working with the dying, especially exploring the role that music is used in the work and grief process and how this continues to impact the clinician. It may be useful to continue this research by exploring the connection of a patient’s developmental stage and that impact on the music and the therapist.

Another avenue of research might be to expand this study beyond clinical grief to explore the impact of the personal grief and how that affects the continued clinical work. It was recommended, by one of the subjects, that this be explored as she believes that the impact of personal grief might be greater than clinical grief. One might also consider exploring the relationship between culture, ethnic origin and music as this may play a role in a therapist’s and/or a patient’s belief about the dying process and its role in the completion of life.

Finally, one may expand this research by including the impact of unresolved mourning related to burn out. Samantha and Keith Marriage in Too Many Sad Stories: Clinician Stress and Coping, inform the reader that clinicians can experience
burn out defined by Maslach (1982) as “a syndrome of emotional exhaustion, depersonalization and feelings of reduced personal accomplishment that occurs in response to the chronic emotional strain of dealing extensively with human beings, particularly when they are troubled and having problems”. Clinicians may experience secondary post-traumatic stress defined by Figley (1983) as “the emotional duress experienced by persons having close contact with a trauma survivor – a natural response to the survivor’s traumatic material with which helpers may identify and empathize. Finally, clinicians may also experience vicarious traumatization defined by Pearlman (1995) as “the permanent transformation of the inner experience of the therapist that comes about as the result of empathetic engagement with a client’s traumatic material” (2005, p.114).

Therapists who ignore or disconnect from their emotions relating to mourning or grief may burn out sooner than those who take the time to experience their emotions relating to the death of a patient.

Subject 3, of this study, discussed how she chose to not use her music for herself, but to have “mini break downs every three months” believing that this was enough. She burned out in hospice care after three and a half years. In hindsight, she stated that “I would really try to do more processing at home, musically. I thought that I was doing fine, but I didn’t have that big breakdown, so if I went back, I’d definitely process the mourning differently and realize that even if I don’t think it’s there, there’s more there” (2006).
CHAPTER 6: CONCLUSION

This study explored how a clinician’s mourning of a patient impacted subsequent music therapy sessions. The literature presented in this study gave an overview of current issues surrounding caregivers, typically familiar ones, and the impact of grief, personal accounts of clinician’s, specifically a social worker’s accounting of her experiences of death and the impact on their continued clinical work, and evidence of the benefits of using music therapy in the grieving process (client-focused).

The methodology used in this study was grounded theory, specifically utilizing the open-ended response interview as the means of data collection. For this study, being a new area of research, grounded theory was the best methodology choice as it allowed for the data to emerge from the subjects. Nine subjects were identified as meeting the inclusion criteria of the study, through self-report. Each subject participated in an hour-long interview either by phone or in person.

Each interview was transcribed. Taking the transcriptions, the researcher chose to focus on the music discussed, both the musical interactions with patients and the therapists’ personal musical relationship and then to explore what impact this had on their continued clinical work. The researcher chose to create a chart for each subject, identifying category headings to organize the information gleaned from the transcripts. The chart system made it easier to focus on the music without the distraction of secondary information. Categories were identified for each subject; however, there were times when categories overlapped. The next step included looking at the constructed categories and identifying general categories that included smaller sub-categories.
In presenting the results of this study, a definition of each category and sub-category was included, and each subject’s responses were presented in narrative form. All subjects were practicing music therapists working in hospice care, a hospital, or a nursing home. There were eight female subjects and one male subject. Eight subjects have a master’s degrees and one is enrolled in a master’s degree program currently. Each subject had a personal relationship to music and each subject had a definition of the role of music and the role the therapist in their clinical work.

Subjects had unique experiences with the death of patients, however, general categories were identified that assisted in defining these experiences. In general, subjects reported a desire to maintain connections with others, be it personal relationships or work relationships. There was a sense that subjects did not want to be isolated in their work.

Each subject reported a time when they remembered the deceased patients in the music; all reported that they appreciated or cherished these memories. Insight played an important role in each subject’s music and grieving process – subjects were able to gain perspectives, set boundaries, and come to resolutions by remaining in contact with their inner selves.

Each subject reported being open to learning; learning about themselves, learning about the music and learning from their patients. One might consider that it is this openness to learning that has the most impact on subsequent sessions. It is this sense of continued learning that brought freshness, change or consistency in the continued clinical work.
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# APPENDIX A: THERAPIST MUSICAL EXPERIENCES IN END OF LIFE ISSUES

**KEY:** □ Therapist Use of Music in Therapy Sessions  
* Therapist Post-Treatment Use of Musical Processing Resulting from End Stage of Life Therapy Experiences

## SUBJECT 1

<table>
<thead>
<tr>
<th>□ MUSIC &amp; BODY</th>
<th>□ HUMAN CONNECTION</th>
<th>□ CLOSURE</th>
<th>□ MUSICAL TECHNIQUES USED DURING SESSIONS</th>
<th>* MUSICAL REMEMBRANCES</th>
<th>* □ CONCEPTS</th>
<th>* PERSONAL USE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Therapist sings a song with patients, holds their hands, strokes them, so that they are comforted; so they can breathe more deeply, so they can relax and sometimes let go</td>
<td>Therapist related a story about two women who entered the facility together attended music together and died within week of one another</td>
<td>Example of man who died and they sang “Oh Danny Boy” at funeral service because family thought it was a good tribute</td>
<td>“I play arpeggios, not with a pick on the guitar to avoid sharp edges – I want the music to be warm, comfortable and soft”</td>
<td>This is “so and so’s” song</td>
<td>“I compartmentalize – shut down a little bit because I can’t carry emotion of the moment with me”</td>
<td>“I sing in a choir”</td>
</tr>
<tr>
<td>Therapist stated, “I’ve been out in the living room singing with the group and had a resident’s family member come out and say that their mother really loved opera and would love to hear you sing – that’s what I’ll sing and”</td>
<td>Therapist stated, “I believe music creates a very powerful connection”</td>
<td>Clinical example about a man, with cancer, who’s wife was sitting next to him – during the music he opened his eyes, but wouldn’t talk. His wife was crying and she stated that she found it comforting to know that he heard Jewish music at the end of</td>
<td>Play arpeggios both ascending and descending</td>
<td></td>
<td>Her personal belief that the musical connection is different from physical connection of other caretakers – brief vs. long term</td>
<td>Play music at home</td>
</tr>
<tr>
<td>Sometimes the person will open their eyes even though they haven’t opened their eyes for a week”</td>
<td>His life</td>
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<tr>
<td>“I’m there to provide comfort, to help ease breathing, to comfort them or their family; to the family member watching them relax – the value is immeasurable”</td>
<td>During the Shiva, a Jewish mourning ritual, “I will sometimes sing whatever the person’s favorite song was”</td>
<td>Clinical story about therapist and social worker going to a patient’s hospital bed because they were unsure if she was going to make it. “I grabbed the guitar and we went over there to sing to her. Her daughter was with her and the woman moved to the music with her daughter’s assistance”</td>
<td>Stay within the key to avoid any jarring sounds</td>
<td>“Quality of life: person is able to respond by hearing music or voice or seeing smile and can respond to you not in pain or agitation”</td>
<td></td>
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</tr>
<tr>
<td>Therapist will go into someone’s room and just start to play – usually in a major key in a folk style tends to help breathing – Therapist chooses the folk style and keys to enable her desire to be free vocally</td>
<td>“I work on units with Alzheimer’s – total chaos, but in 10 minutes they will be fine and singing and part of the group – they will be calmed down”</td>
<td>Limit change harmonically, melodically, and rhythmically</td>
<td>Play familiar music to contain both</td>
<td>“Music for my own enjoyment”</td>
<td></td>
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<tr>
<td>Therapist chooses her musical</td>
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<tr>
<td>interactions with patients to keep from passing on tension, musically</td>
<td>myself and the patient</td>
<td>Play Jewish songs in the key written in, but will move the key if patient needs this</td>
<td></td>
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</tr>
</tbody>
</table>
**KEY:** □ Therapist Use of Music in Therapy Sessions  
* Therapist Post-Treatment Use of Musical Processing Resulting from End Stage of Life Therapy Experiences

**SUBJECT 2**

<table>
<thead>
<tr>
<th>INTERPRETATION THROUGH SONG/SONG LYRICS</th>
<th>POST MORTEM</th>
<th>GROUP PROCESSING</th>
<th>PROFALACTIC USES</th>
<th>PERSONAL GRIEF</th>
<th>CULTURE AND RITUALS</th>
<th>IMPACT OF MUSIC ON ENVIRONMENT</th>
<th>MUSICAL REMEMBRANCES</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Hey Jude</em> (Lennon and McCarty) – song related to person tying up life – life review process</td>
<td>Cleansing music example of playing music in the rooms of deceased patients in order to move out the old energy and clear the room for the next patient</td>
<td>Staff memory share times – incorporating music as a way for the staff to remember the deceased patients; example is to use caregiver quotes, patients music, or the Tibetan accompanied with silence</td>
<td>Singing in the choir</td>
<td>Used music at father’s bedside when he was dying</td>
<td>Started a shabbat program at a nursing home – creating a sacred space</td>
<td>“Music impacts and speaks to spiritual essence of patients when they can no longer speak”</td>
<td>Remembrances of patients through songs</td>
</tr>
<tr>
<td>“Lyrics are metaphors for life”</td>
<td>“Honoring the space of the person who died”</td>
<td>“Spoke of receiving a ‘message’ to play a song during these share times and it’ll be the song”</td>
<td>Being intentional in not giving up own music</td>
<td>Memorials for patients – provided closure for the music therapist, residents and staff</td>
<td>“Sonic intrusions occur in the medical world all the time – part of combating this is to provide music that can be heard throughout the facility”</td>
<td></td>
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<tr>
<td>Story of patient who used chant even though he felt</td>
<td>Use of song, prayer, chant, and</td>
<td>Other staff will lead song or chant</td>
<td>Connection to Jewish music and</td>
<td>Sonic intrusion – “part of dying is withdrawing and</td>
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</tbody>
</table>


<table>
<thead>
<tr>
<th>Abandoned, he still found strength in Jesus</th>
<th>Silence when remembering patients who have passed, with other staff</th>
<th>Cultural identity – the deep tradition, sense of faith to sustain and lift them</th>
<th>Letting go, so allowing the sound environment to leave space for this, both through the music and through decreased intrusions</th>
</tr>
</thead>
<tbody>
<tr>
<td>“I believe that music has a transcendent and spiritual quality” - example of <em>Somewhere Over the Rainbow</em></td>
<td>“It is a release of energy – kind of healing – it is an iconographic entity”</td>
<td>“Finding right song could open the door to origin of person’s family and country”</td>
<td></td>
</tr>
<tr>
<td>Lullabies – “the sense of being held, rocked, being put to sleep”</td>
<td></td>
<td>“Culture is a source of strength”</td>
<td></td>
</tr>
<tr>
<td>Metaphors – songs have a spiritual quality – example of patient who used <em>Hey Jude</em> to come to grips with the end of his life</td>
<td></td>
<td>“Personal theory that, at the end of life, people revert back to their origins – family and religious to include lullabies and songs from religion”</td>
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<td></td>
<td></td>
<td>Singing at memorial services for a sense of closure</td>
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</tr>
</tbody>
</table>
**KEY:**  □ Therapist Use of Music in Therapy Sessions  
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**SUBJECT 3**

<table>
<thead>
<tr>
<th><em>PERSONAL USE</em></th>
<th><em>DISCONNECT</em></th>
<th><em>BELIEF – REFLECTION AFTER LEAVING JOB</em></th>
<th><em>PERSONAL MOURNING</em></th>
<th>□ CONNECTION</th>
<th>□ SESSION IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 years after leaving the field, therapist is starting to make own music again</td>
<td>“Music became for the patients only – I turned off the radio; stopped making music at home”</td>
<td>“I didn’t leave enough space for the music to be for me and for the patient”</td>
<td>Use of live music with grandfather dying</td>
<td>“Bridging family through lyric substitution” – example of daughter who expressed gratitude at being included in the music therapy experience because she felt included in her mother’s dying process; she felt that she had been heard and validated</td>
<td>“Songs that triggered memories were sometimes played with more gusto”</td>
</tr>
<tr>
<td>Hindsight – “I would have done more musical processing at home”</td>
<td>Music was only for work</td>
<td>Enjoyed music done with patients – it was very rich and emotional</td>
<td>“Intensity of the experience comes later in the processing”</td>
<td>Use of song writing with a dying woman to reach out to her children – gave the patient a sense of closure</td>
<td>“Felt that deceased patient’s energy was still with her in the sessions”</td>
</tr>
<tr>
<td></td>
<td>“All the music I had, I gave to the patients”</td>
<td>“Didn’t feel loss of music, at the time”</td>
<td>Listened to music while sitting at the bedside of dying patient – emotionally involved in this experience because receiving the music</td>
<td>Remembrances of patients through songs</td>
<td>“Occasionally feels that musical elements could have been better, but for the most part looks back and finds good elements to the musical interactions”</td>
</tr>
<tr>
<td></td>
<td>When playing music – it</td>
<td>“Musical moments”</td>
<td>“Song that sang at”</td>
<td>Reflective listening to</td>
<td></td>
</tr>
<tr>
<td>was not emotional – it was for and about them</td>
<td>become intense after the moment is over, upon reflections’’</td>
<td>grandmother’s funeral made me tearful the first time I played it a session</td>
<td>help family to have a positive experience with the patient</td>
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<tr>
<td>Therapist role definition: “I have a musical purpose; I’m a facilitator helping them to help themselves”</td>
<td>“Music brings out the emotions in people”</td>
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</tbody>
</table>
KEY:  □ Therapist Use of Music in Therapy Sessions  
* Therapist Post-Treatment Use of Musical Processing Resulting from End Stage of Life Therapy Experiences

SUBJECT 4

<table>
<thead>
<tr>
<th>* MUSICAL REMEMBERANCES</th>
<th>□ BELIEFS</th>
<th>□ MUSICAL TECHNIQUES USED DURING SESSION</th>
<th>* PERSONAL</th>
<th>* HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flash back in sessions to deceased patients – more recognition than emotional</td>
<td>“Music is a safe environment – fills spaces when there are no words”</td>
<td>Sing songs</td>
<td>Use of themed mixed tapes: Top of Lungs, Calm, Inspirational – use of these tapes to help create distance from the day</td>
<td>“All musical experiences up to this point have been preparing me for this moment in my life”</td>
</tr>
<tr>
<td>“It is my tool”</td>
<td>Create new song lyrics for the purposes of processing and closure</td>
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<tr>
<td>“What I bring in music outweighs the grief and pain”</td>
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<tr>
<td>“The music is a benefit to the dying patient”</td>
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**SUBJECT 5**

<table>
<thead>
<tr>
<th>□ SONG GENRES</th>
<th>* PERSONAL</th>
<th>* KINESTHETIC</th>
<th>□ MUSICAL TECHNIQUES USED DURING SESSION</th>
<th>□ BOUNDARIES</th>
<th>* MUSICAL REMEMBRANCES</th>
<th>* BELIEFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of Memories with a patient who loved Broadway musicals</td>
<td>“Music as a transitional object – pulls deceased patient’s music out of her song list to play it at home before using it with other patients”</td>
<td>“Desire to feel the music, the grief and sadness on the keyboard and in her voice”</td>
<td>Song writing</td>
<td>Strong boundaries – love music and job</td>
<td>“Experiences remembrances of past patients in the music example of lyric substitution in Amazing Grace Praise God changed to name of patient you are loved – always comes back to this patient when does this substitution”</td>
<td>“It’s an honor to play music when someone is dying”</td>
</tr>
<tr>
<td>Uses music to process emotions – sits at keyboard</td>
<td>Keeps created song lyrics and recordings in a special drawer in her desk</td>
<td>Lyric substitution</td>
<td>Weak boundaries – avoidance of music and have to force self to return to the music</td>
<td>“Memories of past patients are warm fuzzies – feel gratefulness, love and compassion”</td>
<td>“Intentionally uses music to take care of self – extremely important”</td>
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<tr>
<td>Used music to process personal experiences with death</td>
<td>Cherish above memories</td>
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<td>Participates in music outside of work</td>
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</tbody>
</table>
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**SUBJECT 6**

<table>
<thead>
<tr>
<th><strong>PERSONAL</strong></th>
<th>**AND ** <strong>BELIEFS</strong></th>
<th><strong>MUSICAL TECHNIQUES USED DURING SESSION</strong></th>
<th><strong>MUSICAL REMEMBRANCES</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Use of music and imagery to deal with grief, loss</td>
<td>“Music used to honor life of patient that is left”</td>
<td>Use of improvisation with children</td>
<td>Remembers patients in song choice – “feels that this is positive not traumatic”</td>
</tr>
<tr>
<td>Use of music to stimulate imagination and what’s going on inside self</td>
<td>Music used to increase communication between patient and family</td>
<td>Use of improvisation with patient and family</td>
<td></td>
</tr>
<tr>
<td>Improvise on piano, use of voice and harp to process emotions</td>
<td>Music used to emphasize what they have as opposed to what they’re losing</td>
<td>Music and imagery with patients</td>
<td></td>
</tr>
<tr>
<td>“Music is the center of my life – it is important to have a personal relationship with my music and how I communicate through it”</td>
<td>Focus on positive resources – supportive level of therapy</td>
<td>Music-centered approach</td>
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<tr>
<td>“Closure is important, especially using music to achieve this”</td>
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<tr>
<td>“Musical experience supersedes the traumatic experience”</td>
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<tr>
<td>“It is really rewarding to witness how alive the patients are and how they are able to communicate in the musical environment”</td>
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<tr>
<td>“It is an honor to be a part of the patients’ lives”</td>
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<tr>
<td>Use of music to help patients really, truly live</td>
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</tbody>
</table>
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### SUBJECT 7

<table>
<thead>
<tr>
<th><strong>MUSICAL TECHNIQUES USED DURING SESSION</strong></th>
<th><strong>BODY CONNECTION</strong></th>
<th><strong>COMMUNITY CONNECTIONS</strong></th>
<th><strong>BELIEFS</strong></th>
<th><strong>PERSONAL</strong></th>
<th><strong>MUSICAL CONNECTIONS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s songs known to patients</td>
<td>Use of music to get inside patient – adjust breathing of patient</td>
<td>“I create the ability for family to communicate to dying patient – music is a bridge for the communication between family and patient”</td>
<td>Role of MT – present to do music for time that the patient has left – desire to increase quality of life through musical interactions</td>
<td>Play music for self</td>
<td>“It isn’t the music, but the feeling associated with the music that brings past patient’s to mind”</td>
</tr>
<tr>
<td>Use of improvisation</td>
<td>“Adjust dynamics to create focus, relaxation, and peace for patient”</td>
<td>“I guide family to witness physical responses to increase communication between them and patient”</td>
<td>“Seeing beauty outside of hospice; increase my awareness of intensity of the work as an MT”</td>
<td>“I am a member of a string quartet with other health professionals and friends; get together every week to play music and to have fun”</td>
<td>Sometimes these are personal remembrances of losses</td>
</tr>
<tr>
<td>Teach patient to play violin – pizzicato while singing</td>
<td>“I played violin for patient who was unresponsive, but in listening to the music there was a visible change in her breathing”</td>
<td>“The impact of what’s inside of me while creating music is most important”</td>
<td>“Upon patient’s death I will use my personal music or will work with a patient who is not actively dying to have distance and time to process”</td>
<td></td>
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<tr>
<td>See patient blink eyes or smile in the music</td>
<td>“Music may help patient to let go and die”</td>
<td>“Be clear about your role as MT when making music with patients”</td>
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</tr>
</tbody>
</table>
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### SUBJECT 8
#### TABLE 1

<table>
<thead>
<tr>
<th>Musical Techniques Used During Sessions</th>
<th>Closure</th>
<th>Session Impact</th>
<th>Feeling Associated with Patient</th>
<th>Personal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Singing familiar songs with patients</td>
<td>Improvising a good-bye song</td>
<td>Continued use of chord progression and melody of improvised good-bye song with other patients – viewed as a gift from dying patient that he is able to share with others</td>
<td>“Felt comfortable with patient – mellow, comfortable, fun – calm”</td>
<td>Intimate relationship with music – used music to process emotions</td>
</tr>
<tr>
<td>Kids played instruments with therapist</td>
<td>“Awareness that time is limited with patient”</td>
<td>“Patient’s death opened up something emotionally – helped my voice be more in his body – not worrying about mechanics of the music”</td>
<td>“Rocking sensation – being held by the music – both therapist and patient”</td>
<td>Always has songs running in head</td>
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<tr>
<td>Music and imagery</td>
<td></td>
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</tbody>
</table>
### SUBJECT 8
**TABLE 2**

<table>
<thead>
<tr>
<th>BELIEFS</th>
<th>CONNECTION</th>
<th>PERSONAL LOSS</th>
<th>MUSICAL REMEmBRANCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Stay in the music – keep singing – things will be okay”</td>
<td>“2 kids who were friends and dying, one was more aware than another and asked therapist if they could go to other’s room and make music with him”</td>
<td>Music therapy friend died – sang at funeral and remembers him whenever hears or sings a specific song</td>
<td>Thinks of friend every time plays Sugar Mountain</td>
</tr>
<tr>
<td>Kids will die regardless of his presence or not, so use the time and space to help the patient</td>
<td>Carrying sense of dead patient with him every time sang the good-bye song</td>
<td></td>
<td>Remembers specific patient when plays Papa Is a Rollin’ Stone</td>
</tr>
<tr>
<td>“Music not only holding patient, but therapist”</td>
<td>“Felt still singing in front of the deceased patient”</td>
<td></td>
<td>Madrigals always remind him of a young girl whom he worked with in music and imagery</td>
</tr>
<tr>
<td>Musical connection</td>
<td>Bridge, for patient, between here and where ever patient was going (afterlife reference)</td>
<td></td>
<td>Singing kids songs with his own family will sometimes trigger memories of past patients, but believes that this adds to the experience</td>
</tr>
<tr>
<td>Music held the process – felt grounded and moved in a good way</td>
<td>“Allowed family to sit and experience the musical environment with the patient”</td>
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<tr>
<td>Got a chance to be with a kid and to do music</td>
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<tr>
<td>“Thinking of music and interaction with dying patient in Creative way”</td>
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<tr>
<td>Just bring in the music and all else will be okay</td>
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<tr>
<td>“Honoring and celebrating person who died when continue to remember them in the music”</td>
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</tbody>
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#### SUBJECT 9

<table>
<thead>
<tr>
<th>□ MUSICAL TECHNIQUES USED DURING SESSION</th>
<th>□ &amp; * COUNTER TRANSFERENCE</th>
<th>□ MUSICAL MEANING</th>
<th>□ CONNECTION</th>
<th>* MUSICAL REMEMBRANCES</th>
<th>* PERSONAL</th>
<th>* BELIEFS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Song writing with ALS patient – use letter chart to spell words</td>
<td>“Difficulty in supporting patients decision to accept death”</td>
<td>“Lyrics are metaphors for issues example: ALS patient using Elvis song to accept end of life”</td>
<td>Patient wrote goodbye song to therapist</td>
<td>“Remembers ALS patient every time hears Annie’s Song”</td>
<td>Kept song written to her by patient</td>
<td>Sense of burnout when music becomes only about the patient</td>
</tr>
<tr>
<td>Music listening</td>
<td></td>
<td>Patient able to assert self, musically, even though trapped in her body</td>
<td>Patient wrote songs to others, including her mother</td>
<td>Remembrances do not produce bad feelings</td>
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<tr>
<td>Song communication – patient wrote songs to nurses to ask them to talk to her, change her outfits, to not continue to isolate her</td>
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<td></td>
<td>Plays piano at home for personal enjoyment</td>
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</tr>
</tbody>
</table>

"Feels that it is a bigger community, a cosmic network of people who like the same song and that they are all connected through the music"