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Music therapy in palliative care

Chapter: Music therapy in palliative care

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Music is intricately woven into the fabrics of life and takes on deeper significance during times of transition, loss, and grief.

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Music therapy in palliative care

Introduction to music therapy in palliative care



Music therapists offer musical experiences to improve comfort and enhance the lives of palliative care patients and their families. Music's helpful role in dealing with transition and loss is long evident in tribal rituals and religious and community practices (Laderman and Roseman, 1996). In the 1970s, pioneering music therapists Lucanne Magill and Susan Munro respectively brought live music to patients at Memorial Sloan Kettering Cancer Center, New York, and The Royal Victoria Hospital Palliative Care Unit, Montreal. Music therapists now contribute to holistic patient care in palliative inpatient and home-based services, and other settings caring for people with degenerative conditions, throughout the world.

In palliative care, music therapy can be defined as the creative and professionally informed use of music in a therapeutic relationship with people identified as needing physical, psychosocial, or spiritual help, or desiring further self-awareness, to enable increased life satisfaction and quality. Music therapists, who are university trained and accredited by national registration committees, can often extend the way that music enhances patients' well-being and their connection with who and what matters in their lives. The musical elements and evolving therapeutic relationship can underlie helpful, sometimes transformative experiences. The focus is on therapeutic process rather than musical products and participants do not have to have musical backgrounds to benefit. Music therapists invite patients and families to explore and choose music therapy methods. The therapeutic relationship informs how the music is shared and created. It can be distinguished from music thanatology which is the provision of 'prescriptive music, using harp and voice at bedside' with the compassionate musician's presence (Cox and Roberts, 2007, p. 80). This chapter will describe ways in which music therapists work in palliative care, clarify research supporting its efficacy, and offer strategies for how caregivers may offer music to support palliative care patients when music therapists are not available.

Music therapy in adult contexts: assessment, methods, and effects



Various descriptions of music therapy in palliative care with adult patients, families (including anyone significant in their lives), and staff carers are available (Munro and Mount, 1978; Munro, 1984; Dileo and Loewy, 2005; Hilliard, 2005). Music therapists typically receive referrals from staff, patients themselves, or their families. As patients' conditions fluctuate, sessions may be flexibly scheduled, range from minutes to over 1 hour, and can be offered occasionally to almost daily. Therapists can visit patients at bedsides in hospitals and homes bringing accompanying instruments, sheet music, or recorded music. The author often brings sheet music with up to 7000 songs and classical pieces that she can spontaneously play on an electric piano. Music therapy groups may also be conducted in day hospices, inpatient palliative care, or nursing home settings. Many music therapy departments incorporate extensive recorded music libraries, audio equipment, and tuned and untuned instruments.

Upon meeting patients, the music therapist's assessment includes determining the patient's music preferences, the relevance of music throughout their lives, and biopsychosocial needs or spiritual and aesthetic interests that may be addressed through music therapy. Music therapy methods offered to patients and their families can include (a) replaying the music of their lives, including live performance (by therapist and/or participant), music listening, music and life review, and lyric substitution in familiar songs; (b) exploring 'new' music, including therapeutic song writing, music improvisation, and unfamiliar music; (c) guided use of music, such as relaxation inductions with live or recorded music; and (d) music-based gift or legacy creation, such as song compositions and music-based audio-visual recordings. Ways in which music therapists can support patients and families are listed in Table 4.7.1.

Table 4.7.1 Some music therapy aims in palliative care

Supportive validation	One's feelings and thoughts
	Of a life that has been and is still being well lived
	One's self-worth; spiritual way of being
	Contemplation; a time to 'be'
Increased self-awareness to aid coping	Self-discovery

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	Reawakening or reworking of an earlier awareness
Symptom relief and relaxation	Including pain, tension, dyspnoea, nausea, insomnia, restlessness
Connectedness	Those with cognitive impairment
	Those with language barriers and communication difficulties
	Expanded opportunities for interactions with family members, friends, other patients, staff
Aesthetic and spiritual experience	Pleasure
	Diversion; normalcy
	Creative expression
	Transcendence
Support expression of grief, bereavement	Dealing with loss: acceptance of one's own way; reframing regret; helpful catharsis
	Increasing confidence and strength for moving forward

Replaying the music from one's life



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Patients often choose to experience music that elicits emotions, messages, or memories of places, events, and people that they want to feel connected with, and supported or inspired by. One patient, for example, consistently asked the music therapist to sing '(You are the) Wind Beneath My Wings'^a because, she said, no one had ever told that they loved her. Identifications with lyrics associated with themes such as adversity, loss, and hope, and singers who have lived with life-threatening conditions, can enable one to feel understood and part of a wider human experience. People project into music and take from it what is needed because music is polysemous: it can be interpreted in multiple ways. For example, while 'Sailing'^b may simply evoke happy youthful memories for one patient, another may repeatedly request the song to connect with the lyrics. Music can nurture or sustain in unexpected ways. The day before he died, a patient requested that the music therapist play 'The Prayer'^c on the electric piano, and then asked for the lyrics so that he could sing it sometime. Although unable to outwardly sing, the invigorating and life-affirming properties of music still allowed him to connect with his non-patient musician identity: he could imagine singing until he died, and possibly felt hope 'singing' the song's lyrical plea of guidance to a safe place.

Patients often request songs once sung by parents or other important people, which can evoke supportive feelings of nurturance. They may also request songs sung at school, that signified courtships, were enjoyed at dances, parties, musical theatre, or concerts, or have spiritual meaning, affirm faith, and enable prayerful contemplation. Music can powerfully elicit emotions and images associated with earlier times. Patients may listen, sing along, or share memories, laughter, and tears, sometimes with their families, other patients, and staff. Elicited stories about their musical memories can reflect the important 'dignity-conserving perspective', 'continuity of self' (Chochinov, 2012, p. 14). Music-based reminiscence can improve communication between patients and those close to them, validate their lives, enhance insight, ethnic and cultural affirmation, and improve self-esteem, sense of worth, and identity (Forrest, 2000). Regrets may also be reframed and reconsidered. Through computerized music scrapbooking, young cancer patients have also arranged meaningful song fragments into new musical works which validate and express important sentiments (Robyn Booth, personal communication, 1 November 2006). Patients' life stories and favourite musical pieces can also be audio-recorded as legacies, perhaps combined with accompanying photo albums. Patients who cannot verbally communicate, for example, through motor neurone disease, can especially find this a meaningful way of sharing their non-patient identity with visitors and staff.

Physical reactions to music therapy may also reveal vital parts of a patient's personhood, arguably reflecting 'dignity-conserving care' (Chochinov, 2012, p. 36). This was evident, for example, in day hospice music therapy groups when one patient held onto a glass of wine

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in one hand, her wheelchair with the other, and stood up and danced while others waltzed to recorded band music; a seated 90-year-old whose feet could still manoeuvre Scottish highland gigue steps; and when a patient could sing perfectly despite expressive aphasia due to a brain tumour. Music therapy experiences can affirm one's life roles, community contributions, and extend self-awareness and ability to meaningfully express. This is especially evident when patients engage in song lyric substitution, as the music can give impetus to one's creation of personal lyrics, and the hearing of one's meaningful expressions mirrored back through song can soothe, affirm, and inspire self-pride. A particularly useful song for inviting patients to substitute lyrics to is 'One Day at a Time'.^d When experiencing music one's non-discursive (non-verbal) level of awareness may also be accessed and experienced as a felt, mindful, or a symbolic sensation, possibly enabling longed-for relaxation or peacefulness. This often seems apparent when patients ask for a favourite piece of music to be played repeatedly, or when patients comment, 'You can stay here all day' when the music therapist softly plays their preferred music at their bedsides. The balance of music, discussion, and counselling is therefore monitored and variable in sessions because initiating verbal reflections may shift a patient's focus from a restful or transformative 'feelingful' mode to a less helpful cognitive state.

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Patients and families

Music therapy can enable an intimate and comfortable context for patients and families to convey supportive and validating messages through choosing music to enjoy and relax with together and share elicited memories. Affirming messages may also be non-verbally expressed through 'knowing' looks and smiles, hand-holding, massaging touch, embraces, shared singing, and dancing rhythmically with the music, which can involve kicking legs or holding and moving hands together, even when one is in a bed or bed-chair. Music therapy may also help to sustain family members maintaining long vigils at patients' bedsides at the end of their lives. When barely rousable, patients may still smile or squeeze their loved one's hand to acknowledge a significant song and statement, and when non-rousable, family may continue to communicate with their loved ones through asking for meaningful songs (e.g. 'Love will Go On'^e) and hymns (e.g. 'Amazing Grace'), and singing or sharing memories. Such good memories of how patients are cared for can ease distress in bereavement (Reid et al., 2006). Music therapy in multi-bed rooms can also inspire shared involvement of patients, families, visitors, and staff in uplifting ways, and through singing together or sharing music-based stories, acknowledge each other's value.

Combining music with allied therapies may also broaden therapeutic benefits of both modalities. For example, patients can use music with physiotherapy exercises, and art therapists have helped patients to create CD covers for songs composed in music therapy and to integrate important aspects of patients' musical backgrounds into their art legacies. Music therapy alongside art therapy in an aesthetically tranquil hospice setting connected with surrounding bush-land contributes to a 'generative community environment' which can enable patients to feel 're-empowered', to creatively regain a sense of identity, and to connect with their faith in a 'sacred place' (Glenister, 2012, p. 91).

Exploring 'new' music



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Therapeutic song writing

Through therapeutic individual or group song writing patients and families can express important sentiments in a contained and quick way. People can express what may be difficult to verbalize, and the creative effort may bring pride, spiritual comfort, self-affirmation, or cathartic relief (O'Callaghan, 2005). A music therapist also found that helping cancer patient to create an opera helped them to feel calm, healed, proud, and express fears and grief (O'Brien, 2006). Patients with cognitive impairment can also write songs as therapists provide necessary structure such as multiple choices of lyrics, melodic fragments, harmonies, and tempos. Adding musical accompaniment may extend the therapeutic effect of verbal expressions, because music is a mnemonic and can reinforce emotional meaning. To help palliative care patients write songs: (a) the music therapist invites a patient or family member to consider a topic and then helps them to brainstorm lyrical ideas through encouraging free association or offering prompts and questions; (b) the therapist and patient then group and transform the ideas into a song lyric structure; (c) the therapist invites suggestions for musical elements (melody, harmony, rhythms speed, genre, volume) or offers musical alternatives, line by line, for the patient to choose from, and (d) the therapist, patient, or an extended group record the completed song (O'Callaghan et al., 2009).

Palliative care patients may write songs about their illness journey, for someone important, the general community, or their faith, and experience relationship closure, self-expression, spiritual enhancement, and life review (Dileo and Magill, 2005). Analysis of lyrics of 64 songs written by 39 palliative care patients in music therapy revealed that the patients used song writing to express messages, self-reflections, compliments, memories, imagery, prayers, and reflect about adversity and their significant others, including pets (O'Callaghan, 1996a). Another analysis of 35 songs written by 27 cancer inpatients for their children found that parents' song lyrics included their memories of times spent with their children; messages of love, compliments, and/or hopes for the children; existential beliefs, such as being available for the children now and in the afterlife; and supportive suggestions, such as who the children can turn to for future support (O'Callaghan et al., 2009). Arguably, these findings indicate that therapeutic songwriting may support parent-child connectedness during the parents' illnesses (O'Callaghan and Jordan, 2011) and, if the parent sadly dies, the child's coping through bereavement as positive associations with the deceased help the bereaved (Raphael, 1984). This is important given the scant information about how to support parents and their children through palliative care (Saldinger et al., 2004).

Improvisation

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In music therapy improvisation, the music therapist and participant/s may improvise together on tuned (e.g. keyboard, metallophone, xylophone) or untuned (e.g. drums, rain sticks) instruments, with or without vocalizations. A simple, often effective way of introducing tuned instrument improvisation to patients is through the pentatonic scale. This is a group of five notes which always sound harmonious when the notes are played together. Within this musical relationship, the client musically expresses aspects of their creative self, and the therapist's improvised musical reflections (mirroring) can affirm and extend the participant's musical and holistic way of being. These creative musical experiences can be enjoyable, 'freeing', and transform one's way of cognitively and feelingfully experiencing the world. The ongoing musical dialogue can affirm that the client has been heard and is known, inspiring further creativity, which may lead to further adaptive self-awareness. This has been illustrated in work with a gentleman with motor neurone disease (Salmon 1995) and with HIV-positive men (Hartley, 1999).

Concerts, music appreciation

Music therapists may also organize concerts and music appreciation sessions, where the therapist presents information about singers, bands, or musical genres in response to patients' requests, for those seeking to pursue novel, interesting, and educative experiences for as long as they can. Concerts may include patient, family, or staff performers or good musicians from the community.

Guided use of music



Relaxation inductions and music, and instructions for the use of music, may be used to help patients manage symptoms and feel less stress, including when undergoing scans or procedures. Good relaxation induction scripts are widely available and some include suggestions for music usage (Grocke and Wigram, 2007).¹ When patients are tense and very ill the author sometimes finds that a short relaxation induction followed by about 5–15 minutes of live music can be helpful, for example, 'The Swan',^f 'Watermark',^g the *Deer Hunter* 'Cavatina',^h the *Moonlight Sonata* first movement and *Sonata Pathétique* second movement by Beethoven, and Nocturne in E flat by Chopin. Musical elements need to be steady without extreme variations in tempo, rhythms, and dynamics (loud/soft).

Preferred music is most associated with relaxation response (Stratton and Zalanowski, 1984) and pain reduction (Mitchell and MacDonald, 2006). Music alters mood through activating neural areas involving arousal, pleasure, dopamine production, and opioid transmission, more broadly than those elicited by language (Levitin, 2006). Theoretical rationales for pain reduction in music therapy include direct physiological response to music stimuli that alter neural components of pain sensation, as well as cognitive and emotional changes aligned with increased self-awareness, thereby altering one's sense of the meaning, and thus perception, of pain (O'Callaghan, 1996b). When playing music to distract from symptoms, therapists often use the isoprincipal, musically matching patients' physical and emotional states, and gradually shifting the musical elements as patients move into more desired states, for example, slowing music down as breathing rate slows with relaxation. When participants have control over the music experienced in sessions, adverse effects are rare.

Specific populations



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Children and adolescents

Music is often a central part of children's and adolescents' lives. It enables young cancer patients a connection with 'normalcy' and offers a vehicle for releasing emotions and energy, connecting with family and friends, and identity development (O'Callaghan et al., 2011, 2012). Music therapy can also help to alleviate young patients' distress and symptoms (O'Callaghan et al., 2011), improve coping with aversive procedures like radiotherapy (Barry et al., 2010), as well as improve their mood (Barrera et al., 2002), coping, and initiation behaviours (Robb et al., 2008). Music therapists tailor interventions to the young patients' cognitive abilities and emotional states. Those unable or unwilling to discuss feelings may symbolically express and find self-understanding, such as when a 'miserable and depressed' 8-year-old child was able to express grief and give a message to her best friend through song writing shortly before her death (Daverson and Kennelly, 2000), and when two 13-year-old-patients with brain tumours undergoing radiotherapy required less anxiolytics after experiencing improvisation, song writing, or therapeutic music lessons (O'Callaghan et al., 2007). Families may also have normalized and 'fun' experiences, for example when 4-year-old Peter smiled after a blanket was put on and gently pulled from his face during a Swedish playsong the day before he died (Aasgaard, 2001), and when a grandmother said that the happiest she had ever seen her 14-year-old grandson with AIDS was when he received a trumpet from a hospice on which the music therapist gave him lessons (Hilliard, 2003).

Cognitive impairment

Cerebral areas and neural systems activated during some musical activities are 'relatively independent from the areas used for verbal tasks' (Sergent et al., 1992, p. 108). Furthermore, long-term memories of music are relatively preserved in people with cognitive impairment. Therefore, the therapeutic use of both language and music are more likely to activate preserved neural function in palliative care patients who have brain impairment than when caregivers use language alone. Using both music and verbal language with people with brain impairment expands opportunities for them to have an aesthetic experience and meaningful connections with others. This includes patients with brain cancer and dementing conditions who can sometimes still sing, play instruments, write songs, and share music related interests, reminiscences, and humour with patients and families.

Music improvisation and familiar music can also provide a highly interactive medium for working with patients in low-awareness states following profound brain injury who display minimal and inconsistent spontaneous responses. The diagnosis of 'vegetative state' in one patient, following a severe anoxic brain injury in a cardiac arrest, was revised to a 'minimally conscious state' following purposeful, non-verbal responses in music therapy. Her family, who 'knew she was in there', then worked with

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the music therapist to find ways that they could leisurely share music with her (Magee, 2005). This work is described as ‘neuropalliative rehabilitation’.

Ethnic minorities

Music therapists try and offer a wide variety of musical styles from many cultures. Patients unfamiliar with the dominant language in their care setting may experience reduced isolation, validation, and joy as they experience songs from their language of origin. Culturally significant music may also help patients to reconfirm their identity within their wider socio-historical and ethnic heritage, assist their expression of pain, grief, and memories, and support their preparation for death and their family members’ grieving (Forrest, 2000).

Bereavement

Caregivers’ music therapy memories shared with deceased family members indicates pre-loss music therapy’s role for healthy grieving (Lindenfelser et al., 2008; Magill, 2009). For example, a grandmother caring for her four grandchildren said that memories of family song writing sessions before their mother (her daughter) had died allowed them to remember ‘some good feelings, not all sad’ (O’Callaghan et al., 2013).

Music therapy groups for 18 bereaved adolescents incorporating song writing, improvisation, or song listening and discussion gave the participants permission to grieve which helped them to feel better (McFerran et al., 2010). Therapeutic song writing also helped six bereaved children to accept loss, and express emotions and memories connected with their loved ones (Roberts, 2006).

Music-based care and the relevance of music therapists



Palliative care workers are encouraged to invite patients and families to consider using music for self-care whenever possible and music-based care suggestions are outlined in Box 4.7.1. Employment of music therapists is, however, recommended for extending music’s capacity to enhance life quality. This is enabled through the therapeutic relationship and music therapists’ knowledge of theoretically informed and evidence-based methods.

Box 4.7.1 Suggestions for staff caregivers offering music in palliative care

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- ◆ Patient choice is imperative, including type of music, its volume, when and where it is listened to, and for how long. Ensure patients can control volume and turn their music off whenever possible; regularly offer to help music access (or to turn it off) when patients are unable to operate music systems when they have a disability. Once a person with anarthria and physical disability from motor neurone disease spelled out on the e-tran board (with eye movements) that the music therapist needed to take her CD player away because busy staff put headphones on her ears and did not inquire about the volume before leaving.
- ◆ One's preferred music is most associated with relaxation. Hence music therapists do not advocate the indiscriminate use of 'piped' music in palliative care settings: what one person finds helpful may be aggravating for another.
- ◆ Suggest that patients bring their own music, labelled with their name when coming for inpatient stays or procedures (e.g. iPods/ CDs) and have CD players and headphones available as necessary.
- ◆ When patients intend using music for aversive procedures, suggest that they consider how they would feel if the experience contaminated their enjoyment of that same music in the future. Some people find using preferred music to help them through an unpleasant experience does not impact upon their future enjoyment of that music, while others need to avoid it in the future.
- ◆ Encourage 'normal' family interactions through sharing music as appropriate. For example, parent inpatients may play children's music CDs/playlist during young children's visits; families can bring instruments to play into inpatient settings; hospices may have guitar, harmonica, or keyboard available for patients and families to play. Suggest that family members and friends bring in patients' favourite CDs into hospital and listen to music together, or offer to buy a favourite CD instead of flowers. In home-based palliative care, suggest that patients and families consider listening to old music collections; help them consider ways of getting to concerts/ bands if they are concert goers (e.g. borrowing a wheelchair; contacting concert venues about wheelchair access and convenient car parking availability).
- ◆ Encourage the development of music libraries with diverse music choices in hospital settings that patients/families can access. Perhaps include CD 'samplers' or playlists on MP3 players which offer a range of music styles so that patients and families can explore unfamiliar types of music that may be

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helpful. As people become more unwell music preferences may change.

- ◆ Invite patients, perhaps with their families, to consider making CDs or playlists of the musical highlights of their lives. Memories or messages related to the music can be also put on the CD. These 'musical life reviews' can elicit affirming conversations and can be given as gifts.

- ◆ Inquire about and talk to patients about their music interests which indicates interest in the 'person' beyond the patient. Sometimes talking about music can be just as enjoyable as listening to it.

- ◆ Consider the presentation of live concerts or background music sensitively in public palliative care settings. Live concerts in palliative care settings, including accomplished musicians and music students, and even patients and families themselves, can be normalizing, interesting, and enjoyable. Performers may suggest that patients and families need to feel free to leave the concerts as needed. Live acoustic ambient music to enhance the environment may be offered in areas where people can move to and from (e.g. foyers). Volume should not be too loud: normal conversations need to be still audible. Avoid presenting music with loss and death themes in this context. Instrumental music, for example, acoustic classical guitar or piano, may be good. Inviting anonymous written feedback to be placed in strategically located feedback boxes can help with understanding what music is appropriate for the context.

- ◆ When patients have cognitive impairment (e.g. adynamic, memory loss) regularly offer music.

- ◆ Some patients with memory loss find listening to the same music repeatedly enjoyable.

- ◆ If patients and families appear 'sad' listening to music this is often ok, especially if they have requested the music. It is important that they can feel free to turn the music off (or leave a concert) if they wish. Consider whether to inquire about the emotion and offer support or leave them to contemplatively be. If a patient or family member is concerned about their music reaction perhaps reassure that varied (and different) responses to music can be normal when one is dealing with serious illness. It is possible that the person is experiencing the 'pleasurable sadness' paradox, that is, enjoying listening to music that evokes sadness alongside positive feelings.*

- ◆ Consider the potential effects of your personal music usage on the wards on overhearing patients and staff.

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◆ When patients are unarousable at the end of life, family members may be invited to put soft music on in the room that they believe that patient would like, and softly hum or sing one of their favourite songs, hymns, or melodies. Reassure them that it does not matter if they don't remember the words.

* Source: data from Vuoloski, J.K., Thompson, W.F., McIlwain, D., and Eerola, T. Who enjoys listening to sad music and why? *Music Perception*, Volume 29, pp. 311-317, Copyright © 2012 by The Regents of the University of California. All rights reserved.

Therapeutic relationship in music therapy

The music therapist's supportive presence may be conceptualized as providing a 'sounding board' or a musical 'human mirror'. Winnicott suggested that in psychotherapy the therapist 'reflects back' aspects about the patient, enabling the person to exist 'as an expression of I AM, I am alive, I am myself' (Winnicott, 1971, p. 56). In music therapy, the patient may be 'reflected back' in a multisensorial manner, that is, musically, verbally, and non-verbally, expanding the potential for creative reintegration and new awareness. Improvisations and familiar music in music therapy are always experienced anew, creatively perceived and expressed, potentially transducing into helpful ways of viewing and coping with illness experience. The therapeutic impetus encapsulated in live musical involvement with a trained music therapist cannot be underestimated as the therapist validates and often improves people's experiences through reflective listening and supportive musical and verbally insight-oriented dialogue.

As patients move closer to death, however, expecting significant psychotherapeutic changes may be inappropriate. The therapist may still softly play the music that has previously enriched the patient's life, and assist family members and friends to continue their supportive presence or expression of messages. This is especially evident, for example, when the music therapist accompanies a spouse singing a favourite courtship song to their dying partner, when children of dying patients ask for songs that they remember their parents loved watching them dance to in school concerts, and when the therapist accompanies family members sing hymns during bedside vigils, such as when one patient's favourite, 'Here I am Lord',¹ was being sung by her children as she took her final breath.

Research and evidence

Extensive music therapy research has been conducted within this field, exemplified by three Cochrane reviews² in music therapy palliative care (Bradt and Dileo, 2010), oncology (Bradt et al., 2011), and dementia (Vink et al. 2011). There is also a review, spanning 1983-2009, of 61 research

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projects in music therapy, cancer, and palliative care encompassing 32 objectivist (quantitative), 26 constructivist (qualitative), and ten mixed methods publications. This latter review found considerable evidence for music therapy improving the life quality of patients and family and staff caregivers in myriad ways. For example, randomized controlled trials (RCTs) and non-controlled quantitative studies showed findings of improved mood, relaxation, spiritual well-being, comfort, and reduced pain, distress, depression, anxiety, isolation, and boredom. Qualitative research findings revealed that music therapy can be a positive social, emotional, and spiritual experience, which provides opportunity for creativity, healing, aesthetic meaning, expanded identity, and it can affirm one's sense of aliveness. Family and staff caregivers also find witnessing and experiencing music therapy's effects personally helpful. (See O'Callaghan (2009) for summaries of these studies and references.)

A Cochrane review meta-analysis on five end-of-life care studies (175 participants) found statistically significant findings in three studies for improved quality of life scales in three domains: functional, psycho-physiological, and social/spiritual well-being (Bradt and Dileo, 2010, p. 2). For example, in one RCT, which examined music therapy's effect on 25 hospice inpatients, anxiety, pain, tiredness, and drowsiness were significantly reduced in the music therapy intervention group compared to the volunteer visitor control group (Horne-Thompson and Grocke, 2008). Another Cochrane review, which examined the effect of music therapy and pre-recorded music listening interventions on physical and psychological outcomes in cancer patients, included 30 trials (1891 participants) (Bradt et al., 2011). The meta-analysis findings also suggested that music may improve life quality and mood, and reduce anxiety and pain. In one RCT, for example, which included 62 patients receiving autologous stem cell transplants for haematological malignancies, the music therapy group scored significantly lower on the anxiety/depression and total mood disturbance score compared with the controlled standard care group (Cassileth et al., 2003). The authors of both these Cochrane reviews, however, warned that the findings need to be viewed cautiously as most of the studies included high bias risks (Bradt and Dileo, 2010; Bradt et al., 2011). Within Cochrane reviews, findings of 'high bias risk' can mean that one of four criteria for dealing with internal risk domains were not met, that is, (a) adequate randomization, (b) allocation concealment, (c) detail about incomplete outcomes, and (d) blinding of participants, service providers, and assessors (Higgins and Altman, 2008). As, 'it is not possible in music therapy studies to blind participants and those providing the interventions' (Bradt and Dileo, 2010, p. 5), perhaps if the first three mentioned criteria are met (randomization, allocation concealment, and incomplete outcomes addressed) and the assessor is blinded, music therapy trials should be rated as producing high enough quality findings.

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Arguably, RCTs and other quantitative studies included in these Cochrane reviews do not produce superior findings to well-conducted qualitative research when investigating music therapy's effect on subjective experiences in palliative care. In RCTs, alongside the problem of non-blinding potentially biasing outcomes, the control of variables is also difficult because (a) music therapy is not a standardized treatment, (b) patient-carer relationships are associated with therapeutic gain (Kain et al., 2004), and (c) conducting studies on representative samples with even distribution of confounders in treatment groups is difficult, especially with small samples. Hence it is suggested that quantitative research only allows logical or conceptual rather than predictive generalizations, just like qualitative research does. Qualitative research on music therapy research questions in palliative care is preferred by some researchers because (a) it can be unethical to withhold (or delay) potentially supportive care through RCTs when patients are assigned to non-experimental groups (Keeley, 1999); (b) RCTs include standardized measurement scales which may provide information important to the researcher but not patients (McGrath, 2000); (c) RCTs do not necessarily support palliative care principles of patient- and family-centred care (Kvale and Bondevik, 2008): patient-centred practice emerges from listening to patients' reflections; and (d) existing outcome tools are not sensitive enough to detect many of the benefits reported in qualitative studies.

Constructivist (qualitative) research approaches can collect patients' and caregivers' idiosyncratic voices, identifying what they find important. Grounded theory methodology, for example, informed a multisite study which uncovered how 100 oncology staff members, who witnessed music therapy on their wards, were often incidentally supported by music therapy and, as a result, perceived improvements in their care of patients (O'Callaghan and Magill, 2009). Grounded theory methods were also used in a study conducted with six patients with chronically progressive multiple sclerosis. Music therapy provided opportunities for the patients to challenge their disabled identities. Improvisation either validated or reminded them of physical loss, and songs supported coping strategies to deal with the condition's emotional impact (Magee and Davidson, 2004).

Closure



Previously, people lived with shared understandings and ways of how to die and mourn. In contemporary, more individualistic societies people use more privatized ways of dealing with loss (Walter, 1994). Music therapists invite palliative care patients and caregivers to explore how musical attachments from their lifetimes and creative experiences with less familiar music can alleviate physical and emotional distress; nurture and sustain; validate one's unique contribution; restore or continue meaningful connection with who and what is important; and enable new realizations and joy through aesthetic or transcendent experiences. Some of the most profound moments in music therapy are

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when people apparently experience 'happiness' and 'sadness' in an alternate or simultaneous manner as they relive and reintegrate memories alongside a knowing that their mortal end is near. Almost always, patients want the music to continue. Music can 'carry mourning too heavy for words and preaching' (Roy, 2001, p. 132), provide a familiar 'holding space' (Berger, 2006), and be a vehicle for release. Music therapists are vital members of palliative care teams who are helping to enrich people's lives transitioning from corporeal existence, and the family members, friends, and caring staff accompanying their passage.

References for songs/music mentioned in chapter (piano versions)

- a 'Wind Beneath My Wings' (1982), by Jeff Silbar and Larry Henley.
- b 'Sailing' (1972), by Gavin Sutherland.
- c 'The Prayer' (1998), by David Foster.
- d 'One Day at a Time' (1974), by Marijohn Wilkins and Kris Kristofferson.
- e 'Love Will Go On' (1997), by James Horner and Will Jennings.
- f 'The Swan', by Saent-Saens (1835-1921).
- g 'Watermark' (1988), by Enya.
- h *The Deer Hunter* 'Cavatina' (1978), by Stanley Myers.
- i 'Here I am Lord' (1981), by Dan Schutt.

Online materials

Complete references for this chapter are available online at <http://www.oxfordmedicine.com>.



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Notes:

1. Some music therapists with specialized training offer patients with good energy and cognitive capacity the Bonney Method of Guided Imagery and Music. After a relaxation induction clients describe their imagery during musical listening, and then verbally or artistically process their reactions in order to increase self-understanding and personal growth.

2. A Cochrane review is a systematic assessment of a health-care intervention consisting of a systematic review of literature related to the intervention and, if appropriate, a meta-analysis of eligible trials (Higgins and Green, 2008). Cochrane reviews are widely regarded as providing gold standard research findings in health care.

