

A Narrative Exploration of the Music Therapist's Experience
of Patient Voice in Hospice

by Cathleen M. Flynn, MT-BC

A Thesis Submitted in Partial
Fulfillment of the Requirement
for the Master of Arts Degree

Master of Arts in Music Therapy Program
in the Departments of Graduate Studies
and Music and Theatre
Saint Mary-of-the-Woods College
Saint Mary-of-the-Woods, Indiana

August, 2016

Abstract

Little is known about how music therapists experience the music, particularly the voices, of patients in hospice care. Using narrative inquiry, a research method in which the form or the analysis of story is used to understand qualitative data, this researcher examined four participant experiences with patient voice. Participants were music therapists working in hospice care, were purposefully selected based on diversity of professional experience and theoretical orientation, and submitted in their own narrative style a significant clinical story involving patient voice. Narrative data were analyzed using contextual and categorical methods (Kenny, 2005; Maxwell, 1996); pre-determined categories used for categorical analysis were situation, interaction, and continuity, the three elements that comprise stories according to Clandinin and Connelly (2000). Based on contextual and categorical results, this researcher's findings validated the current literature related to voice in hospice music therapy and clinician experiences of patient music and psychospiritual state. The findings also highlighted the clinical relevance of clinician and patient experiences of time.

Keywords: voice, hospice, narrative, clinician experiences

Acknowledgements

To Lauren DiMaio, MMT, MT-BC, for fueling my passion for this mysterious work and always cheering me on; Yasmine Iliya, PhD, MT-BC, LCAT, FT, for your contagious love of good research, good writing, and genuine curiosity; and Tracy Richardson, PhD, MT-BC, for your unwavering guidance and belief in my process.

To the research participants, who told their stories with courage and compassion, and to the patients who inspired these stories.

To Mom, Dad, and Jill, for always being there in moments of inspiration and exhaustion.

To my graduate school cohort and my boss, Deb, for sharing in my excitement and struggle throughout this process.

To Frances Flynn for her love of music.

To Jim and Buddy, whose voices I won't forget.

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Introduction

The voice expresses humanity in our living and our dying. Through music, speech, sighs, and silence, a hospice patient's voice can play an integral role in music therapy. Few music therapy studies explore patient voice in hospice care, yet voice is an important mode of human expression that has therapeutic meaning and value within music therapy practice (Austin, 2008; Uhlig, 2006; Uhlig & Baker, 2011). The vast majority of hospice music therapy research about voice discusses techniques for the clinician's therapeutic use of voice (Cadesky, 2005; Dileo, 2005; Dileo, 2011; Nakkach, 2005; Summer, 2011). No hospice music therapy research to date exclusively investigates hospice patients' use of voice. This lack of literature may be due in part to the reality that disease and dying processes limit patients' capacity for active music-making or vocal communication. The deficiency in literature may also indicate a need for clinicians and researchers to broaden our understanding of what *voice* means for dying persons, and to consider how clinician experiences of being in music and relationship with a patient who cannot communicate the lived experience of dying may shed light on the experience of the patient. Notwithstanding the reason for the current lack of literature, it is evident there is much to be explored in the realms of patient voice and clinician experiences in hospice music therapy.

While a handful of music therapy researchers explore clinician countertransference in disparate ways, relatively few studies investigate the phenomena of clinician experiences of music therapy work. No studies to date explore how hospice music therapists experience, perceive, and describe the voices of dying patients. Narrative inquiry is a viable method for exploring how hospice music therapists experience patient

voices. This method uses the written voice of a storyteller to richly describe a particular event, person, or object; this primacy of aesthetics and context aligns the method with the artistic medium of music therapy and the patient-centered philosophy of hospice care and meets the demands of this study's purpose and research question (Kenny, 2005; National Hospice and Palliative Care Organization, 2015).

Research Question

This researcher explored the question, "How do the participating music therapists describe a significant experience with patient voice in hospice care?"

Purpose Statement

This research investigated the music therapist's experience of a hospice patient's voice through the narration of participant-selected significant story. Narrative inquiry was used to investigate the meaning of participant experiences. In each story, individual context and categories of shared or common experience were explored.

Definitions

It is helpful to define terms integral to this study. According to Bruscia (2014), *music therapy* is "a reflexive process wherein the therapist helps the client to optimize the client's health, using various facets of music experience and the relationship formed through them as the impetus for change" (p. 36). A *music therapist* is a person who has completed an approved collegiate music therapy program and received national board certification (AMTA, 2015).

Voice is a multi-dimensional word with various meanings in hospice literature. Sometimes voice refers to the patient's speech. Sometimes it is a metaphorical reference to the patient's ability to express their lived experience and to be heard (e.g. Does the

patient have a voice in the decision-making process?). In music therapy literature, voice often refers to patient singing. This author's conceptualization of voice is based on Austin's (2008) definition, which encompasses singing, natural expressive sounds (e.g. moaning, crying, laughing, sighing, audible breath), and toning or vocalization.

For the purpose of this study, the music therapist's *experience* was inherently self-defined by each participant during the storytelling process. These experiences may include but are not limited to the clinician's identification of nuanced musical qualities (e.g. vocal texture, timbre), allegorical thinking (e.g. respirations like waves), empathic physiological responses (e.g. feeling restful as a patient sleeps), and manifestations of the clinician's psyche in relation to the patient that are defined within traditional psychodynamic approaches as countertransference.

Review of Literature

Music Therapy in Hospice

Hospice care has been a part of the United States healthcare system since the 1970s (National Hospice and Palliative Care Organization, 2014). The National Hospice and Palliative Care Organization (2014), or NHPCO, defines hospice as a “...model for quality compassionate care for people facing a life-limiting illness that provides medical care, pain management, and emotional and spiritual support. Hospice focuses on caring, not curing” (p. 3). Patients are eligible to receive hospice care through Medicare Part A if a primary care physician confirms a terminal illness prognosis of 6 months or less. Every person receiving hospice care has an interdisciplinary care team, which includes a physician, nurse, social worker, chaplain, nurse aids, and companionship volunteers (NHPCO, 2014). Additional services like music therapy may also be available.

Music therapy has been an established profession in the United States since the mid-20th century (American Music Therapy Association, 2015). According to the American Music Therapy Association (AMTA), board-certified music therapists in the United States currently serve people at community centers for youth, seniors, or people with disabilities; psychiatric and medical hospitals; schools; chemical dependency programs; physical rehabilitation centers; outpatient clinics; correctional facilities; nursing homes; private practices and hospices (2015). Although the hospice movement in the United States began approximately two decades after music therapy became an established profession (AMTA, 2015; NHPCO, 2014), music therapists in the States worked with veterans of war and, thus, may have treated persons at the end of life even before the 1970s. Hospice music programs expanded in the latter part of the 20th and

early 21st century, and were an expanding market at the time of this study, perhaps in part because of music's ability to promote quality of life in various domains of a person's life.

The music therapist's role within the hospice interdisciplinary team includes direct patient care, music therapy education and resourcing, and bereavement support (Mandel, 1993), and hospice music therapists utilize various theoretical approaches. Salmon (2001) proposed a psychospiritual theoretical approach for music therapy with patients experiencing life-limited illness, suggesting psychology and spirituality are interconnected and simultaneously influenced and supported by music therapy experiences. Hilliard (2001) illustrated the use of a cognitive-behavioral theoretical approach in hospice, and DiMaio (2010) described her work within a humanistic approach. Hospice music therapists of many theoretical orientations use receptive, re-creative, compositional, and improvisational music experiences to address patient goals in physical, psychological, social, emotional, and spiritual domains.

According to Hilliard (2001), music therapy objectives for patients in hospice care include support for anticipatory grief, pain management, family interaction, and opportunities for life review and insight. Music therapy interventions utilized in hospice care include singing and listening to meaningful songs, songwriting, music imaging, lyric discussion, music-assisted relaxation, entrainment, life review, ritual drama, and improvisation (Aldridge, 1999; Baker & Wigram, 2005; DiMaio, 2010; Hilliard, 2001; Lee, 2006; Marr, 1998; Potvin, 2015; Salmon, 2001; Sato, 2011; Wylie & Blom, 1986). The voice is an instrument frequently used by the music therapist and/or the patient in many of these interventions.

Voice in Music Therapy

Voice and singing are important in music therapy work. Every music therapist and music therapy client has a voice, and our voices can reveal information about our psychological and physical wellbeing (Austin, 2008). Because the voice comes from within the body and is perhaps the most basic means of expressing thoughts and feelings on a daily basis, sharing it through song can feel vulnerable and intimate.

Uhlig (2006) described a multi-cultural approach to the use of voice in music therapy. After compiling voice-centered case studies from music therapists around the world, she described themes and important distinctions among participants' uses of voice, and deemed these emergent tenants authentic singing. Uhlig and Baker (2011) used the term voicework to describe "the use of the human voice within the therapeutic approach to achieve health and well-being" (p. 32). Austin's (2008) Vocal Psychotherapy is an analytic music therapy method based on three primary techniques – vocal holding, free associative singing, and chanting. Outside these methods, music therapy clinicians develop voice-based experiences in the field to meet the specific needs of patients, including those in end-of-life care. That there is limited foundational research on the use of voice in music therapy despite the reality that voice is a pervasive instrument within the field demonstrates the need for more research in this area of practice.

Voice in Hospice Music Therapy

Most research related to voice in hospice music therapy examines the music therapist's use of voice to facilitate various patient goals. Dileo (2005) described a relationship completion intervention in which the music therapist uses voice to represent the voice of a dying patient or a loved one of the patient. The music therapist uses five

relationship completion statements – “Thank you,” “I forgive you,” “Forgive me,” “I love you,” and “Goodbye” – as the basis for vocal improvisations that support interpersonal resolution for the dying patient and loved ones. In addition, Dileo (2011) described the therapeutic use of the therapist’s voice for synchronizing, nurturing, emoting, and dialoguing with imminently dying patients. Summer’s (2011) *Vocal Hello Space Model* is a spirituality-based approach to vocal work with hospice patients that utilizes familiar songs, song-form improvisations, and toning on vowels to establish compassionate presence with a dying patient. Nakkach (2005) described a contemplative, yogic philosophy-informed approach to the therapist’s use of breath, voice, and intentional silence with dying persons. Cadesky (2005) offered a case example and suggestions for the effective use of vocal improvisation to meet hospice patients’ therapeutic needs.

Patient stories woven into hospice music therapy literature and witnessed by this researcher suggest the significance of the dying patient’s use of voice, and of the clinician’s intrasubjective awareness of the patient’s voice within music therapy. Yet at this time of this study is no available systematic research investigating how music therapists experience hospice patients’ voices. Each of the interventions above has the potential to be a rich, demanding experience for the music therapist as well as the patient, and the music therapist’s experience of the patient impacts the flow of therapeutic work.

Music Therapists’ Experiences of Clinical Work

Music therapists’ experiences of the musical and interpersonal interactions that comprise clinical work may help illuminate the efficacy and meaning of music therapy practice. While music therapy case studies often include subjective information from the clinician, little literature systematically investigates clinician experiences of music

therapy work. In her phenomenological exploration of music therapists' intuition, Brescia (2005) stated, "Music therapists' use of their subjective experience can be important when attempting to understand the dynamics of their relationships to clients, particularly in how one comes to understand the music of another" (pp. 64-65). Her study of intuition investigated how music therapists receive intuitive information and how this information is formed into intuitive knowledge.

Several studies have investigated the experiences of clinicians utilizing the Nordoff-Robbins Music Therapy (NRMT) approach. Forinash (1992) interviewed eight music therapists undergoing NRMT advanced training about their experiences of clinical improvisation, and found their enigmatic experience of the work was impacted by natural ability, musical biography, and conscious choice, and involved similar experiences of the unknown, vulnerability, pressure, spontaneity, creativity, intuition, and rationality in the relationship between self, music, and client. In a doctoral dissertation, Fidelibus (2004) conducted in-depth interviews with 10 NRMT clinicians about their experiences of flow and mindfulness in clinical improvisation. Finally, Cooper (2010) interviewed five NRMT clinicians about their clinical-musical responses during a self-selected memorable session and extracted shared units of meaning related to the clinician's intrapersonal awareness in addition to perceptions about the client and music. Shared interpersonal awareness experiences among participants included empathy for the client, intuition, awareness of feelings, awareness of a transpersonal/inner guidance, and faith in music/oneself.

Studies by Muller (2008) and Kwan (2010) further investigated music therapists' intrapersonal awareness during clinical work. In 2008, Muller investigated music

therapists' experiences of being present to clients and found that each participating clinician described the phenomenon as one of giving space, opening up, gaining access to the client's experience, sharing awareness and pain, and allowing the music to inform and influence the therapeutic presence. Kwan (2010) investigated music therapists' experiences of being with adults experiencing pain and found six themes in the interviews that described the therapeutic interactions between clinician and patient – trust, presence, caring, physical empathy/sympathetic resonance, empowerment, and facilitation of communication/expression. Muller (2008) and Kwan (2010) both suggested further phenomenological investigation of music therapists' subjective experiences of clinical work.

While music therapy with dying persons can be deeply moving and challenging for the therapist, most music therapy and related discipline hospice literature mentions little about clinician experiences of patient care. DiMaio (2010) reflected on her experiences utilizing music therapy entrainment with patients experiencing pain in hospice care. Marom (2008) described her experiences of hospice patients declining music therapy services, noting that hospice music therapy literature tends to disproportionately highlight positive and rewarding patient-therapist interactions as opposed to uncomfortable or challenging interactions. Potvin (2015) illustrated in detail his experience of engaging in music therapy ritual drama with an imminently dying patient's family. In addition, Dorris' (2015) graduate thesis explored the experiences of music therapists working with imminently dying hospice patients. Each of these authors mentioned the importance of understanding and exploring the clinician's countertransference responses as manifested in hospice music therapy.

Countertransference in music therapy. Countertransference is an aspect of music therapists' experiences that several researchers explore. However, the varying descriptions and definitions of countertransference within music therapy literature make it difficult to gain an integrated understanding of the theory of countertransference as understood within the music therapy community. The most comprehensive examination of countertransference in music therapy to date is Bruscia's (1998) edited work entitled *The Dynamics of Music Psychotherapy*. Various authors discuss transference and countertransference as understood and experienced within different approaches to music psychotherapy, including Vocal Psychotherapy, Analytical Music Therapy, Nordoff-Robbins Music Therapy, and the Bonny Method of Guided Imagery and Music (BMGIM).

Wildman (1995) studied his experiences of countertransference related to termination of music therapy sessions and services within the context of music therapy with a young child. In 2006, Dillard interviewed eight music psychotherapists with varying theoretical frameworks about their experiences of musical countertransference, exploring signals of musical countertransference, reactions by the clinician and client, and response to the awareness of countertransference. In 2015, Wilkerson, DiMaio, and Sato explored countertransference in hospice music therapy by offering an overview of current theories, characteristics of countertransference with dying persons, and suggestions for coping with countertransference. More research is needed to understand the countertransference and other intrapersonal experiences of hospice music therapists.

Narrative Inquiry in Music Therapy

Clinical stories, or narratives, have the capacity to illustrate the complex beauty of music therapy in a poignant and accessible matter. Narratives engage our hearts and our minds. They can convey our past, root us in the present, and help us imagine possibilities for the future. And, while clinical stories are often woven into the fabric of data presentation in music therapy literature, very few studies to date utilize narrative inquiry as the primary method of qualitative music therapy research. Clements-Cortes and Klinck (2016) used a narrative style in describing patient cases that illustrate the use of humanistic music therapy techniques for grief and loss with palliative care patients and bereaved families, but the qualitative research method they use is case study, not narrative inquiry. Hadley (2003) used narrative form to explore the life of influential creative music therapy pioneer Clive Robbins. Bruscia (1995) applied a reflexive narrative process to describe his use of BMGIM with a client with a life-limiting illness. While Kenny (2005) offered several examples of narrative elements within studies that utilize other qualitative methodologies, her own writings related to indigenous and field theories in music therapy, particularly *The Field of Play* (1989) and *The Mythic Artery* (1982), offer what is perhaps the most extensive conceptual groundwork for the use of storytelling in modern music therapy research.

Summary

Because the whole person – the physical, psychological and emotional, neurological, social, and spiritual or existential aspects of self – experiences music, music therapy can creatively support the living and dying processes of the hospice patient. Preceding this study, hospice music therapy literature has focused largely on treatment

methods, outcomes, and theoretical models. Anecdotal evidence suggests hospice music therapists' experiences of patient music are a significant phenomenon in music therapy (Heath & Lings, 2012; Hilliard, 2001; Kidwell, 2014), yet no systematic research to date has explored these experiences.

Voice is important to the therapeutic process and offers opportunities for patients to express their conscious and subconscious realities. Because of the therapeutic potency and accessibility of many hospice patients' voices throughout the dying process, qualitative research exploring music therapists' experiences of their hospice patients' voices is a meaningful place to begin. The therapist's intrapersonal awareness and narrative description of patient voice may provide important clinical information, particularly in work with hospice patients who, due to disease processes, may not have the cognitive or communicative capacity to verbalize their own experiences of using voice. The purpose of this research was to explore the music therapist's experience of a hospice patient's voice through narrative inquiry, the art of storytelling.

Method

Research Design

Qualitative researchers investigate questions of experience and meaning, and explore in-depth the nature of certain persons, situations, written and spoken language, artifacts, or artworks. Unlike quantitative research, which is based on positivist philosophy where data must be scientifically verifiable or logically proven, qualitative research is characterized by the inclusion of tacit and reflexive knowledge in investigations, reliance on multiple data sources in the form of images and text, the human person as an instrument for data collection and analysis, and a natural rather than controlled environment throughout the research process (Creswell, 2014; Lincoln & Guba, 1985). Kenny (2005) stated music therapists in particular might have a “natural affinity” (p. 421) toward storytelling as a qualitative research methodology because the artful, highly contextual nature of this style of inquiry is similar in nature to being in music and a therapeutic relationship.

This narrative inquiry consisted of four stories written by music therapists working in hospice care and a process of meaning-making through this researcher’s analysis and integration of the narrative data. In perhaps the oldest method of inquiry, narrative researchers utilize either the form of story or the analysis of stories to understand an individual or event (Kenny, 2005). The former approach is closely related to phenomenological inquiry and the latter approach is closely related to hermeneutic inquiry. Most, if not all, narrative researchers in music therapy literature have utilized the form of story; this study utilized the analysis of participant’s written stories. An important factor in selecting this methodology to explore experiences with patient voice was the primacy of participant voices throughout the narrative inquiry process. Utilizing their

own narrative voices, participants described their experiences with patient voice. Kenny's assertion that "voice plays an important part in this type of research" (p. 421) illustrates the method's applicability to this study's research question.

A challenge for researchers in narrative inquiry is determining the extent to which a story should remain whole to present its coherent meaning or be intentionally fragmented to support analysis of meaning units. Narrative researchers tend to choose either a contextual approach that emphasizes coherence (e.g., wholeness) in the story or a categorical approach that emphasizes content (e.g., significant fragments) in the story (Kenny, 2005). This researcher chose to dwell in the middle of these two interpretations, balancing coherence and categorization, by utilizing the single-question element of Wengraf's (2001) highly structured approach to narrative inquiry, but diverged from Wengraf's approach for the remainder of the data collection and analysis period in order to allow participant stories to coalesce and meaning to emerge organically throughout the research process.

Participants

This researcher examined the experiences of a small sample of board-certified music therapists working full-time in hospice care in the United States. Prospective participants were identified based on membership in a closed Facebook group for music therapists working in hospice or palliative care. The group has over 700 members, and this researcher announced study recruitment through the message board visible to all group members (see Appendix A). Prospective participants were required to have access to email and the ability to write a significant clinical story in English. Seven prospective participants expressed interest within the one-week recruitment period and were provided

a thorough description of the nature of the study in an informed consent document (see Appendix B) and the opportunity to discuss questions or concerns with this researcher; six of those who expressed interest gave informed consent to be screened for participation.

Of those who met inclusion requirements and provided informed consent, this researcher purposefully selected participants with the intention of including a diverse sample. The target number of participants was three, though more participants were included to involve the most diverse sample possible. Prospective participants who completed informed consent were selected for diversity using a sample selection screening tool (see Appendix C).

Diversity factors considered by this researcher were years of professional and hospice work, hospice facility type (i.e., home-based care, inpatient, or hospital), theoretical orientation, and geographic region of the American Music Therapy Association, though membership in AMTA was not required. One participant was from the Southwestern Region, one was from the Mid-Atlantic Region, and two were from the Great Lakes Region. One participant had two years of professional experience including one year of hospice experience, one participant had four years of professional experience including three years of hospice experience, one participant had sixteen years of professional experience including eight years of hospice experience, and one participant had two years of professional experience including two years of hospice experience. One participant identified as a cognitive-behavioral music therapist, two identified as humanistic and/or existential music therapists, and one identified as eclectic.

Procedure

Each participant was asked by this researcher to write a story utilizing the following prompt: “Tell me a story of a significant experience related to a hospice patient’s voice in music therapy. What was the experience to you?” Participants were encouraged to take adequate time to reflect, write with thick description, mask any client identifying information, and use their own narrative voice/style to tell the story, but were not given further directives such as required story length or suggestions of what constitutes a significant experience.

After this researcher received the stories, the researcher immersed herself in the stories for several days then determined whether any follow-up questions were needed from each participant to get a clear textual image of the participant’s experience. Each participant decided whether data shared in follow-up questioning would be woven into the original narrative or included outside the original narrative in the results section. The researcher’s follow-up questions were recorded in the results section.

Data Collection

Participants submitted their original narratives and any follow-up data to the researcher in the form of a Microsoft Word document or the body of an email. After being notified of their selection for the study, participants had one week to submit their narrative. Similarly, participants had one week to submit follow-up data after being notified of the need for clarifying questioning. Participant data was saved on a password-encrypted flash drive that was stored in a locked cabinet when not in use by the researcher. This researcher determined all raw data would be destroyed two years after completion of the study.

Data Integration

Qualitative data analysis is emergent, so methods of analysis are flexible. According to Maxwell (1996) and Kenny (2005), narrative data can be analyzed through consideration of inherent meaning in the story's gestalt, known as contextual analysis, or by deconstructing parts of the story to find multiple categories of meaning, known as categorical analysis. The most basic form of contextual analysis is the presentation of data in its entirety, which enables the reader to engage in the innate analytic process of text comprehension. As the researcher and reader encounter each story, the story is contextually analyzed in the subjective, moment-to-moment phenomenon of comprehension. However, categorical analysis requires the identification of pre-determined or emergent categories by which data can be understood. This researcher chose to do both contextual and categorical analysis and, for the categorical analysis, used pre-determined categories based on Clandinin and Connelly's (2000) statement that all narratives occur in a three-dimensional space. The dimensions of *interaction*, *continuity*, and *situation* are inherent in any narrative, and help storyteller and researcher make meaning of the story; interaction relates to the personal and social elements of the narrative, continuity relates to the temporal elements, and situation relates to the context or the sense of place.

After receiving each participant narrative in the form of a Microsoft Word document or the body of an email, this researcher printed each story to enable easeful visual analysis. This researcher read each story individually upon receiving it, then read them one after another several times when they were all collected to familiarize herself with each narrative. These beginning stages of immersion in the data took place during

focused time with minimal environmental distractions to allow the researcher's full attention. During initial back-to-back readings this researcher underlined distinctive elements of each story, or elements that set the story apart, and also underlined uniting elements of each story, or elements from one narrative that connected it with one or more of the other narratives.

Data integration began when this researcher immersed herself in the narratives to determine whether follow-up questions were needed for clarification of each participant's lived experience. Considering each narrative in its three-dimensional wholeness while categorically examining each dimension opened this researcher to various perspectives by which meaning can be understood. In this study, the research question was less an analytic inquiry than an opening for creative integration. Thus, this researcher's intention was not to reductively analyze participant narratives for the purpose of meaning-making, but rather to integrate data in a way that represents the inherent meaning in the individual and collective experiences of hospice music therapy clinicians.

Ethical Considerations

The Institutional Review Board of Saint Mary-of-the-Woods College approved this study. Each prospective participant gave informed consent to be screened for participation, and those who were not selected because they did not contribute to the diversification of the sample as outlined by the researcher were given an opportunity to ask questions about the researcher's decision-making in the sample selection process. Participants were informed of anticipated educational uses of the data.

Because of its relativist nature, qualitative research presents unique ethical challenges. The process of collecting and analyzing narrative data in this study was fluid

and open to adaptations based upon the idiosyncrasies of each participant's engagement with the story and with the researcher. To promote data trustworthiness this researcher utilized member checking, allowing participants to read the study in its entirety and make comments or clarifications after the data integration period to ensure the presentation of the stories accurately represented their lived experience. This researcher incorporated into the data integration process breaks from data immersion to avoid mental saturation and decreased ability to meaningfully analyze data. In addition, this researcher upheld participant confidentiality by eliminating participant names, password-encrypted protection of digital participant data, and a locked desk drawer to store hard copies of each story during the data integration stage, which required printing the narratives. Two years after the completion of the study participant data will be digitally destroyed.

Role of the researcher. Because of the subjective nature of qualitative research, it was important to openly consider areas of potential researcher bias. This researcher approached the topic of study and each participant as an existential-humanistic music therapist with a feminist clinical worldview. In addition, this researcher identifies as a vocalist with a professional interest in aesthetic considerations and the use of voice in end-of-life care. This researcher had worked as a music therapist in hospice care for over a year at the time of this study, and believes patient voice and clinician experiences play a significant role in end-of-life music therapy. Therefore, this researcher brings an understanding of the topic as well as professional bias to the research process.

Criteria for evaluation. This researcher's consideration of evaluative criteria and readers' engagement in critically evaluating this research upholds the overarching purpose of research, which is the search for truth and understanding. Narrative inquiry is

criticized by some researchers and theorists because it seemingly exists outside the privileged epistemological spheres of positivist, empirical scientific research (Kenny, 2005). The quantitative research evaluation criteria of reliability and validity are not applicable to qualitative research. Fortunately, theorists have developed evaluative criteria for the narrative approach to qualitative inquiry in order to uphold research integrity and ethics. Mishler (1990) suggested trustworthiness (i.e. evaluation of the story by other researchers) and authenticity (i.e. believability and integrity of the story) are the criteria for evaluating narrative research. Lieblich, Tuval-Mashiach, and Zilber (1998) suggested the following criteria: (a) width, or comprehensiveness of the story; (b) coherence, or completeness of the story; (c) insightfulness, or originality in the storytelling; and (d) parsimony, or satisfactory and aesthetic analysis and presentation of data.

Results

The purpose of this study was to investigate the music therapist's experience and perception of a hospice patient's voice through the narration of a significant story. The research question was, "How do the participating music therapists describe a significant experience with patient voice in hospice care?" Six prospective participants completed informed consent and the sample selection screening questionnaire (see Appendix C). Based on the demographic information obtained in the screening process, this researcher selected a sample of four participants with the goal of including music therapists from various geographic regions whose levels of professional experience and theoretical orientations differed.

Story One

When I came into his room, there were two things that were quickly made clear - the first was his love of his farm, and the second was how dearly loved he was. Several family members crowded into the nursing home room, scattered between images of running horses and photographs of barn scenes. His family reported that he hadn't communicated with them in days and, indeed, the sound of his breathing made it clear he was actively dying.

At this point, I'd been with so many actively dying people that I thought I knew what to expect. I admit that this prior experience got the best of me and left me with some assumptions. I did believe that he could hear and benefit from what was going on around him. However, I expected not to see any sort of intentional reaction. Any possibility of meaningful communication seemed remote at best.

Nevertheless, his family was excited about having music present that might be special to him. They brainstormed about the old cowboy songs he loved. Many came to mind. As they invited me to begin playing, I strummed my guitar and sang a popular cowboy tune: "Oh give me land, lots of land under starry skies above - don't fence me in... Let me ride through the wide open country that I love - don't fence me in."

A few family members chimed in from afar, but some by the bed had a look of surprise on their faces as they heard a soft sound come from his mouth. It was quiet - so quiet I almost missed it at first. It didn't sound like a groan of pain. From the lens I was working from I at first took it to be a mere biological side effect. Now looking back, it didn't sound like a random moan from a disconnected body. This loving family's reaction opened my eyes to a new possibility – in fact, one of his children looked up with delight in their eyes and whispered, "He's singing with you!" Other family members crowded around to hear him. He continued to sing a wordless, gentle sound.

His voice was quiet, airy, smooth. It was a sound that brought bright eyes, tears, smiles, and even laughter to his loved ones.

There was no sign on his face of any change, no movement from his body, no words that made any sense in any language known to man. Yet his family heard him. Though his body could no longer speak as it once had, his family felt that he was communicating with them. He could still engage with music, still engage with his family even when all of his body systems were beginning to shut down.

Witnessing this experience surprised and gently humbled me. Later on, his family described how "amazing" it has been to see this moment. I can't help but agree. It was a beautiful reminder that meaningful communication might be found in surprising ways

when we look for it. It need not be in ways we expect. I hope that I will always remember this one quiet note that I almost missed - the voice that spoke comfort to a grieving family in ways that words could not.

Story Two

She sang in such a way that music was the only constant in her life. She sang with spirit, resolve, and disregard for anyone else in the house. E insisted we sing, even when her condition started to limit her to the point of making singing slightly unsafe, as she would so easily become short of breath.

“I have cancer of the NIPPLE!” She reminded me of this for at least the first six months of treatment. Her inflection in this statement mimicked the melody and punctuation of when she wanted me to understand the struggles of her life. “They said I couldn’t go there because I was BLACK.” It would hover around a tonic near the beginning of the statement with the last three words crescendoing and arpeggiating up to the last punctuating word, as if to hang on the V-chord without resolution. In this way, she expected a response. This was when I turned back to music.

She welcomed these responses and perhaps knew that I had little to offer her as a white, young woman never experiencing the Civil Rights Movement either directly or ancestrally. And so we sang, her with her spirit and strength and determination – I with my guitar and the hope I was supporting a voice that had known so much silencing. She loved the idea of making a CD for her family and chose all religious songs, all with the message of liberation and freedom from whatever may trap us. Her wide vibrato and attempts at extended phrasing are forever captured on recording and in my memory – “I’lllllll fly aWAAAAAYY.”

E lived quite some time past her prognosis. “I have to make it to (get ready for the upward motion in pitch and volume) one HUNDRED.” After such energized statements, she literally made sounds “Ho...hum...ho” to help her catch her fleeting breath. I offered that she listen. Only a few measures into a hymn, she was there with a voice that could be heard across town. And that’s what she wanted – to be heard. So, E asked me to help her perform at her 100th birthday party.

Her son introduced us as “the new ebony and ivory,” to which E leaned over to lovingly remind me that’s because she is black and I am white. While she was still as sharp as ever, that day, I heard her voice for the first time as weakening. Yes there was still strength in her effort and determination. However, in that room of mixed company but mostly seemingly healthy people, I felt as though I could hear the bodily betrayal of her spirit. That is, I heard her desire to sing being dimmed by her physical capability. We sang only two songs, not the five we had planned. She needed much help from me, as those who had gathered in her honor remained quiet to hear her. I tried to tell myself it was the excitement and hustle bustle of the day. Though there was probably some truth to that, in hindsight, this birthday was the beginning of the end.

I saw E twice more after her birthday party. The first of these visits, she requested to just listen. I knew this was best for her health, even though I found myself trapped in sadness upon not hearing her. The next and final visit would be her final minutes alive. In spite of being told E was failing, I fought to keep myself together as she fought for each breath. As I sang one of her favorites to sing, “I’ll Fly Away,” she exhaled her last with a sigh that fell in pitch. I couldn’t help but sense the poeticism in this. She had always

wanted to offer some kind of punctuating statement with her upward inflection, yet here her last breath fell in pitch, relief, and cadence.

Though I am over six months removed, I continue to revisit the recordings she made. I have used her voice and her case to discuss liberation psychology in music therapy. E continues to be a source of rich reflection for me – who holds the power in music therapy? What does it mean to sing beyond one’s means? At any given moment, what role did singing and/or the music play? On my bad days, I listen to her recordings to be reminded of singing through the injustices of this world, which for E were largely racial. On my good days, I recall being there for her punctuating moment in all of her 100 years and 1 month to hear the last of her living voice. By this, I am most humbled.

When the shadows of this life have gone, I’ll fly away. Like a bird from prison bars has flown, I’ll fly away.

Story Three

Last month I received a call to see one of my people experiencing severe pain. I walked into her room and heard her crying - my heart felt heavy as soon as I heard her. I knew she had been experiencing this pain, so hearing her cry out made it too real.

She stated that she didn’t want visitors, but she did need a nurse. After calling the nurse, I told her I’d wait with her until the nurse got there. I held her hand and began humming. She asked me to sing for her - something she doesn’t do often, so I was excited to jump on the opportunity - so I grabbed a drum and mallet, and told her to hit the pain away while I sang. After a few moments, she began screaming out, “Ahh” because of the pain - the small amount of relief I had for her was then gone. We always want to take our

peoples' pain away, and when what we're doing doesn't work, a part of the pain, I think, becomes ours.

I took the drum away and grabbed her hand again. I began improvising a vocal melody to match her and bring her back while she squeezed my hand. I started experiencing that old familiar feeling of, "What do I do next? How can I help her? How can I take this pain away?" I kept singing and matching her - this just felt as though it was the right thing to do. As our sounds matched, I could tell we were starting a meaningful connection. Our breathing synchronized and I could tell she was calming down based on the length between yells and her breathing deepening.

When she stopped screaming, she whispered, "Dear Lord, please take me. Please come and take me. Take me now." This was one of the hardest things I've had to hear in my hospice work. You want your people to be comfortable and get what they want, but it was defeating to hear her so defeated. There is a distinct difference between giving up on life and acceptance of the next phase. This sparked me singing "I'll Fly Away", one of her favorites. She smiled, looked away, and began crying out again because the pain worsened. I said, "Let this be your prayer." Each time she screamed, "Ah", I began singing "I'll fly away", utilizing the Iso principle. She caught on and we started sing/screaming together. This continued for a few minutes, until she laughed and began improvising words to make the prayer her own. "I'll fly away, Oh Glory, to a land where I will not feel pain... I'll fly away, Oh Glory, to a land where I'll find peace and rest...". I was so glad she was making it her own. This brought back the idea of acceptance of the end that she expressed before. This continued until she once again

calmed down. I kept singing as she began to fall asleep. Her breathing slowed, and I knew she had found peace, if only for a moment.

A few weeks later the nurses told me that they still hear her singing “I’ll Fly Away” while she’s waiting for her medicine. I was blessed and honored to be a part of this experience. It was a time for growing for me - moving with someone on their journey. Her voice is shaky and she isn’t proud of it, but she continues to sing. We joked later that God tells us to make a joyful noise... It doesn’t have to be perfect, it just has to happen.

Story Four

R. was a 45-year-old African American female, married with 3 children. She had an aggressive cancer for which she had been in treatment for approximately 2 years. R. was a very faith based individual, and did not believe the cancer would take her life; rather, that she would be healed.

Initially, my work with her met brick walls; she did not want to discuss legacy or feelings about what was happening to her. On my third visit, she was excited, stating she had seen a show on TV where someone had written a song for her family. Even though I broached the idea of songwriting with R. initially, this was the day that fire was in her eyes about engaging in it.

My view of R. until this point was that she was very passive. I was unsure of whether she had a cognitive deficit (maybe from chemo?), as her view of her situation seemed quite simplistic. When she spoke, she often averted her gaze and her voice trailed off, yet she spoke quickly and in a very soft voice, overall. There was not much energy behind her voice and normally I would have talked with a patient about that, but

R. was so sure she would be healed; she could not acknowledge any perceived “weakness”.

The course of her treatment involved song writing and recording it as a legacy project. She also performed the song “live” for 8 family members.

At the third session she was utilizing oxygen and was much more short of breath. As we worked on ideas for her song, her voice was animated and happy sounding in a childish way. She would say “yeah!” with the vocal contour higher and more energized at the start. A more energized thing with a falling line and very melodic.

Her voice was always soft, and always sounded carefree and childlike, which did not match her prognosis, in my eyes. The ends of words/phrases dropped off and consonants were soft, creating a non-percussive and smooth way of speaking that was sometimes difficult to understand, but similar to other African American patients I have worked with.

R.’s voice seemed to have barely enough air behind it to keep it in the correct register. As a flute player, I am aware that if you do not have enough air speed behind a tone, it drops to the lower octave and is fuzzy. This is what happened with R. She did not seem to have the energy to push enough air through to let her voice reside in its regular place, dropping often to a hoarse, under-air-funded voice with the tone breaking. She seemed to be aware of this. She tried to present to everyone that her condition was temporary; she would push the air more forcefully to buoy up her voice, but could only do so for short periods. We had to take frequent breaks.

As R. was trying to create the idea that she would be healed for her family, it appeared to me that her voice was the mechanism she could use for this, since she could

not demonstrate this physically due to limitations. Her voice was always happy, animated (in the degree she could be) and infused with as much energy and enthusiasm as she could impart, based on oxygen needs. It appeared to me that R. was using her voice to show that she could, indeed, be healed.

When we recorded her song it was obvious that R. had an understanding of pitch placement – her placement was generally good, but floated downward maybe due to energy and oxygen needs, and occasionally upward. When we sang together, as on the chorus, she oriented easily to my pitch. R. easily laughed softly and enjoyed the recording process, creating familiarity as she responded without hesitation to my verbalizations.

Generally speaking, her voice was childlike as was her approach to her illness (what I witnessed). Her most often vocalization was “yeah” as she averted her gaze, with an initial attack that was higher, followed by an approximate octave leap down.

On the day R. sang the song she had written for her family “live”, she was 4 days from her death. She still presented her belief that she would be healed and this struggle was temporary. Even though I knew her physiological state, I would not have known that from being with R. that day. She found enough energy to present the song live to her family with energy and warmth. We took several instrumental breaks to allow her time to regroup, but she seemed to have a sense of urgency to “do this thing” for her family. Her voice was stronger than the last 2 times I had worked with her, and my sense was that she viewed this as a very important event, wanting to make sure her message of gratitude was heard.

R. was a very interesting client; I felt her voice gave me a clue as to her emotional age, however, I never had enough conversation with her to validate that. She seemed so childlike and trusting to me. She seemed to understand that her vocal strength would communicate a certain “something” to her family and was able to push past physical limitations to portray strength to them when needed.

Contextual Results

While one principle of the narrative inquiry method is honoring the tacit meaning in the reader’s inner contextual analysis, this researcher also offers a summary of her own contextual analysis in Table 1. The two-sentence summaries in Table 1 respectively present the following: (a) the lingering essence of the story as understood by the researcher; and (b) the participant’s experience as described in the story and as understood by the researcher. The result of this contextual analysis is a distilled description of each narrative, similar to news bylines.

Table 1

Contextual Results of Narratives

Narrative Number	
One	A dying farmer's wordless sound was singing to the ears of his loved ones. The music therapist heard the patient's music through his family's delight.
Two	The new ebony and ivory sang with spirit and strength until ebony's voice was freed from her body in death. The music therapist made space for the patient's punctuating, poetic voice.
Three	A woman crying in pain invited singing and made the song her own. The music therapist synchronized with the patient in the presence of faith and uncertainty.
Four	A faith-filled mother maintained childlike hope in the face of death through songwriting. The music therapist pondered the soft, youthful persistence of the patient's performance.

Categorical Results

Categorical findings were organized into the following three themes: (a) Situation; (b) Interaction; and, (c) Continuity. Situation relates to sense of place, interaction relates to interpersonal events, and continuity relates to passage of time.

Situation. Most situational data were located at the beginning of each participant's narrative. In Story One, the participant described arriving in the patient's nursing home room and understanding an aspect of who the patient was based on environmental surroundings – images that portrayed the patient's sense of place in the world, a place rich with farmland spotted with barns and horses. In Story Two, the participant suggested a sense of place when stating the patient sang with “disregard for anyone else in the house,” and mentioned the “room of mixed company” filled with

“excitement and hustle bustle” on the patient’s birthday. The participant also referenced elements of cultural situatedness when describing racial elements at play in the therapeutic relationship and process, recognizing herself as “a white, young woman never experiencing the Civil Rights Movement either directly or ancestrally.” This suggestion of sociocultural place as a situational consideration beyond physical and environmental place was also evident in Story Four when the participant mentioned aspects of the patient’s cultural identity – age, race, and spiritual background. The situation in Story Three created a unique sense of immediacy, having taken place “last month” in a facility where the patient was alone rather than at home or with family.

Interaction. Perhaps the most meaningful and idiosyncratic content of each narrative relates to interpersonal and social elements, or interaction. Categorizing interactional data in a narrative about experience within a therapeutic relationship is challenging because vast portions of each narrative describe, explain, or reflect on interactions between the participant, the patient, other significant people, and the larger sociocultural world. Because this researcher investigated the experience of the participant, the interactional data deemed most relevant to the research question were data describing how the participant experienced encounters with the patient.

In Story One, the family, who comprised the larger social context of the session, impacted the participant’s interactions with the patient. At the beginning of the session the participant noted, “Any possibility of meaningful communication seemed remote at best,” and when the patient made a sound “I [the participant] at first took it to be a mere biological effect.” Yet the “loving family’s reaction opened my [the participant’s] eyes to a new possibility – in fact, one of his children looked up with delight in their eyes and

whispered, ‘He’s singing with you!’” The family’s response to the patient’s music during the dying process altered the participant’s musical interaction with the patient. “There was no sign on his face of any change, no movement...no words.... Yet his family heard him.... His family felt that he was communicating.”

In Story Two, the participant described in detail musical interactions – and the musical qualities of verbal interactions – with the patient. The participant utilized music to engender meaningful interpersonal encounter despite significant cultural differences. “...she [the patient] expected a response. This was when I turned back to music. She welcomed these responses and perhaps knew that I had little to offer her as a white, young woman never experiencing the Civil Rights Movement.... And so we sang.” Initially, the patient’s interaction with the music and the participant were external and expressive. “I offered that she listen. Only a few measures into a hymn, she was there with a voice that could be heard across town. And that’s what she wanted – to be heard.” As the patient’s disease progressed, the musical interaction changed. The participant stated, “The first of these [final three] visits, she requested to just listen.... I found myself trapped in sadness upon not hearing her,” acknowledging the grief that can occur in professional interactions with dying persons.

In Story Three, the participant describes interaction with the patient in moments of synchronization both creative and painful. The participant reflected on the interpersonal power of pain and discomfort, stating, “My heart felt heavy as soon as I heard her,” “We always want to take our peoples’ pain away, and when what we’re doing doesn’t work, a part of the pain, I think, becomes ours,” and “You want your people to be comfortable and get what they want, but it was defeating to hear her so defeated.” In

addition to interactions with the patient in pain, the participant described creative interactions with the patient during which the patient connected with her music and the participant and perhaps disconnected momentarily from her pain. The participant stated, “I held her hand and began humming,” “As our sounds matched, I could tell we were starting a meaningful connection,” and “Each time she screamed, ‘Ah’, I began singing.... We started sing/screaming together.” Synchronization in creativity and in pain characterize the interactions in Story Three, yet the participant also delighted in the patient’s interpersonal independence, stating about the patient’s improvisation, “I was so glad she was making it her own.”

In Story Four, the participant discussed how verbal and vocal interactions with the patient provided insight into the patient’s interpersonal world. Initially, “[the patient] did not want to discuss legacy or feelings.... There was not much energy behind her voice and normally I would have talked with a patient about that, but R. was so sure she would be healed; she could not acknowledge any perceived ‘weakness.’” The participant described the patient’s voice as “always soft, and always sounded carefree and childlike,” which represented to the participant the patient’s “passive,” “childlike and trusting” manner of interacting with the world. The patient’s determination to present as someone who was not dying – “It appeared to me that R. was using her voice to show that she could, indeed, be healed” – combined with her carefree demeanor shaped the interactions of the therapeutic process. Though the patient seemed passive, she actively engaged in the therapeutic process and the participant created opportunities to enable shared engagement. “When we sang together, as on the chorus,” the participant stated, “she

oriented easily to my pitch. R. easily laughed softly and enjoyed the recording process, creating familiarity as she responded without hesitation to my verbalizations.”

Continuity. Continuity, or the element of time, shapes and structures story. At the time each story was told, the experiences recounted by each participant were in the past and, thus, told as a memory in past tense rather than as a real-time account or a time-ambiguous myth. Each narrative illustrated the progression of time differently, yet a similarity emerged. Each participant included a retrospective reflection, not only recounting the memory of the lived experience of being with the patient but also evaluative insight of their current experience of the memory while removed from the situation. The participant in Story One stated, “Now looking back, it didn’t sound like a random moan from a disconnected body.” The Story Two participant stated, “Though I am over six months removed, I continue to revisit the recordings she made,” and “E continues to be a source of rich reflection for me.” The Story Three participant reflected about the patient’s plea for the Lord to “take” her, “This was one of the hardest things I’ve had to hear in my hospice work.” At the end of Story Four, the participant stated, “R. was a very interesting client” and summarized a current understanding of this past experience.

Several distinctions exist in the way participants described the passage of time within narratives. In Story One, the participant’s use of temporal language illuminated differences in the patient’s and the family’s experience of time. The phrases related to passage of time for the patient – “...he hadn’t communicated with them in days,” “He continued to sing a wordless, gentle sound,” and “Though his body could no longer speak as it once had” – suggest ambiguity or fluidity of time, which seems appropriate for a

dying person. Thus, phrases that reference the patient's experience of time do not move the story forward. It is the participant's and family's engagement with time that structures the narrative, and this also seems appropriate since the family and participant continued living and became tellers of the patient's story after his death. The family "brainstormed," "invited me [the participant] to begin playing," "heard him [the patient]," "felt that he was communicating," and "Later on...described how 'amazing' it had been to see this moment." The story began when the participant "came into his [the patient's] room," and ended with an expression of the participant's desire to integrate this past memory into the future ("I hope I will always remember this one quiet note that I almost missed."). In addition, the Story One participant reflected on how clinical experiences of the past impacted the participant's initial approach of the patient. The participant's and family's experience of time structured Story One's continuity.

In Story Two, the participant guided the reader through the patient's treatment process using temporal language, beginning with a reference to "the first six months of treatment." After the retrospective reflection "...in hindsight, this birthday was the beginning of the end," the temporal language in Story Two quickens – "I saw E twice more," "the next and final visit," and "she exhaled her last with a sigh" – indicating the patient's quickening decline. After the patient's death, temporal language no longer referenced the patient's treatment but, instead, referenced the participant's continued experience of time without the patient – "Though I am over six months removed, I continue to revisit the recordings she made," "On my bad days I listen to her recordings to be reminded of singing through the injustices," and "On the good days, I recall being there for her punctuating moment." In addition, temporal language in Story Two

demonstrates the patient's end-of-life psychological work of processing the past and considering the future. The participant described the patient processing the past – “she wanted me [the participant] to understand the struggles of her life” – and how the participant's own past “as a white, young woman never experiencing the Civil Rights Movement either directly or ancestrally” impacted their interaction in the moment. Yet while the patient processed her past, she also looked toward the future. “E lived quite some time past her prognosis. ‘I have to make it to...one HUNDRED.’” Temporal elements of the music therapy treatment process and of the patient's therapeutic content shaped Story Two.

The acute pain management needs of the patient in Story Three and the immediate responsiveness required of the participant rendered a more concentrated use of temporal language in the narrative. Throughout the first half of the story the participant recounted a quick, detailed description of time that illustrates the focused urgency of a music therapist responding to someone in pain crisis – “Last month I received a call,” “After calling the nurse, I told her I'd wait,” “After a few moments she began screaming out.... The small amount of relief I had for her was then gone.” Then the participant retrospectively reflects in the moment, “I started experiencing that old familiar feeling of, ‘What do I do next?’” A shift in the use of temporal language in Story Three took place when the participant described synchronization with the patient and the use of the ISO principle; the progression of time within the narrative slowed, and the participant recounted singing “as she [the patient] began to fall asleep.” After this statement, the participant described interactions with staff and the patient “a few weeks later” and made retrospective

statements about the experience as “a time for growing for me – moving with someone on their journey.”

In Story Four, the participant’s use of temporal language highlighted the patient’s struggle with time and the disease process. This struggle was evident when the participant recounted, “She had been in treatment for approximately 2 years,” and “initially, my work with her met brick walls.” Given time, the patient’s engagement with the participant shifted – “On my third visit, she was excited.... Even though I broached the idea of songwriting with R. initially, this was the day that first was in her eyes.” The participant suggests the patient’s “carefree,” “childlike” vocal tone throughout the therapeutic process demonstrated that the patient “tried to present to everyone that her condition was temporary.” This incongruence between the patient’s perception of her remaining time alive and the truly time-limiting nature of her disease is evident in the participant’s description of “the day R. sang the song she had written for her family ‘live’” – “she was 4 days from her death. She still presented her belief that she would be healed and this struggle was temporary.... We took several instrumental breaks to allow her time to regroup.... Her voice was stronger than the last 2 times I had worked with her, and my sense was that she viewed this as a very important event.” The participant’s descriptions of the musical and interpersonal manifestations of the patient’s belief in the temporary nature of the disease shaped Story Four; thus the story’s continuity is attributed to the patient’s belief that her disease would not limit her lifetime.

Discussion

This researcher investigated the following question through narrative inquiry: how do the participating music therapists describe a significant experience with patient voice in hospice care? Through categorical analysis, this researcher approached the research question by exploring three essential parts that create the sum of the story – situation, interaction, and continuity. Situational data demonstrated how each participant's experience was shaped by the environmental and sociocultural places in which the clinical encounter(s) occurred. The location of the session (e.g., home, skilled nursing facility, geographic region), patient's cultural identity, and patient's stage in the dying process were all situational factors that influenced participant experiences.

Interactional data revealed that participant experiences were impacted by the patient's family, symptoms and biopsychosocial processes of dying, music created in each clinical encounter, quality of verbalizations and vocalizations, and the participant's capacity to empathize and synchronize. Continuity data illustrated the complex and fluid nature of time in storytelling as well as in the phenomenon of dying. Each narrative conveyed the past through participant retrospection, the present through references to the participant's ongoing internal perceptions of the relationship with the patient, and the future through the participant hopes for continued remembrance and insight related to the experience.

If each narrative is its own ocean teeming with many parts, contextual analysis is an aerial view, a look at the summation of the narrative's parts. In this aerial view, it is evident that the hospice music therapist's experience of patient voice is (a) steeped in uncertainty, (b) impacted by the patient's spontaneous or unexpected creative expressions, and (c) influenced by the patient's cultural identity and relationships with

others. The participating music therapists heard, made space for, synchronized with, and pondered these patients' voices.

These four narratives beautifully illustrated Hilliard's (2001) end-of-life music therapy goals of pain management, family interaction, and life review. Furthermore, the Story Three patient's plea with a higher power during her pain experience demonstrated the relevance of Salmon's (2001) theory of psychospiritual music therapy treatment for dying patients. Each participant observed glimpses of the patient's inner psychological world through the external expression of voice, as described by Austin (2008). The clinician's synchronization described in Story Three aligned with Dileo's (2011) research finding that vocal synchrony is therapeutic for the dying patient, and when the Story One participant stated, "His family felt that he was communicating," Dileo's (2005) suggestion that voice in hospice music therapy can facilitate relationship completions was exhibited. While Dileo described the use of the clinician's voice to achieve relationship completion, in this narrative a sense of completion was achieved through the family hearing the patient's vocal sounds.

Some participant experiences mirrored the music therapy literature written about clinician experiences. Information about the patient's culture (e.g., race, spirituality, age, geographic region, and family background) impacted the way the participant approached musical interaction with the patient. That vocal expression is influenced by culture is the assertion of Uhlig's (2006) multi-cultural voicework model for music therapy, and an adaptation of the present study that gathers more information about participant culture could be structured so qualitative data is interpreted through the lens of Uhlig's model. Furthermore, in Story Two, the participant described what Cooper (2010) called faith in

music and oneself to bridge the space between the participant's and the patient's life experiences. The Story Two participant's statement that the patient sang loudly to feel heard is related to Brescia's (2005) suggestion that the clinician's subjective experience of the patient's music can illuminate the nature of the relationship. The participant in Story Three illustrated that empathy and inner guidance (Cooper, 2010), shared awareness of pain (Muller, 2008), sympathetic resonance and facilitation of expression (Kwan, 2010), and ability to be in the unknown (Forinash, 1992) are required for the clinician to effectively work with hospice patients in pain.

While some results of this study echo and further validate the current literature in hospice music therapy, an aspect of the dying experience that has not received attention in the literature but was brought forth in this researcher's categorically analysis of each narrative's continuity was the patient's and the clinician's experiences of time. As a temporal modality, music is an aesthetic manifestation of time as the person creating or hearing the music experiences it; one's affective, cultural, and interpersonal world is governed by perceptions of the past, the present moment, and the future. The participant narratives demonstrated the clinical relevance of (a) retrospective reflection, or examination of the past, for both patient and clinician, (b) differences in the dying versus the living person's experience of time in the present moment, (c) differences in participant descriptions of time based on urgency of patient need and therapeutic technique, and (d) the clinician's continued processing of time spent with the patient even after the patient has died.

Limitations and Reflections

It became evident after I collected all four narratives that more specificity in the narrative prompt may have ensured each participant's submitted narrative contributed to addressing the research question, "How do the participating music therapists describe a significant experience with patient voice in hospice care?" The prompt utilized was "Tell me a story of a significant experience related to a hospice patient's voice in music therapy. What was the experience to you?" Some participant narratives described their experience of one session while others described their experience of many sessions over the course of treatment; because the number of music therapy sessions conducted with hospice patients is highly variable, the narrative data may have been more consistent and conducive to categorical analysis if all narratives described just one significant session. Furthermore, an additional reminder that the study's purpose was to understand the quality of the first-person experience of the *participant*, not to analyze a descriptive play-by-play of what happened with the patient, may have eliminated the need for follow-up questioning so some participants could expand on their own experiences.

While participants were diverse in terms of professional background, I did not include cultural diversity factors such as ethnicity, gender identification, sexual orientation, spiritual affiliation, and age in the participant selection process or paperwork. Prior to recruitment I considered including these factors in participant selection, but decided against it out of concern that more diversity selection factors would limit the pool of participants. However, cultural information about the hospice patients was present in each story and provided meaningful contextual information to participants, so having participant cultural information would have provided me with another plane upon which

to analyze narrative data. Patient culture impacted the telling of each story and could have more fully impacted the analysis of participant data if I had collected participant cultural information.

One of the most challenging aspects of this research process was choosing an approach to data analysis and integration, or meaning-making. Few examples of narrative inquiry exist in creative arts research; of those in existence, even fewer analyze stories submitted by participants or explore participant experiences. In related human service fields, many examples of narrative inquiry are almost indistinguishable from ethnographic inquiries (Clandinin & Connelly, 2000). Thus, finding examples of approaches to data analysis was evasive. It did not occur to me until a post-analysis conversation with my father, who is an historical researcher, that exploring methods of historical data analysis, particularly primary source analysis, may have helped shape the data analysis process in this narrative inquiry. Similar to narrative researchers, many historical researchers seek to uphold the inherent aesthetic and meaning within self-described experiences of participants without distilling or de-contextualizing data.

Unexpected ethical questions emerged for me during data collection and analysis. As a clinician working in hospice, I approached each narrative through the lens of my own experiences, biases, and beliefs about music therapy with dying persons. Though it is impossible for me to fully know the context of each clinical decision and interaction from my position outside the patient-participant relationship, some parts of the narrative data described situations in which I would have acted differently or perceived the situation differently than the participant. I struggled to maintain my role as a researcher

trying to understand and analyze qualitative data without allowing my beliefs and biases to skew the presentation and integration of the narratives.

The months-long process of conceptualizing, developing, and executing this research was intense and involved many adaptations. In retrospect, keeping a journal of my timeline, frustrations, and small successes beginning from the first topic idea to the final paper submission would have been a helpful outlet and enjoyable to review after completing the study. I am reminded that my own story as a budding researcher is worth telling, and regret not keeping a reflexive journal during this research process.

Recommendations for Future Research

More research is needed to explore the music, particularly vocal expressions, of hospice patients. The current lack of research in this area may exist for a variety of reasons, including music therapists' theoretical approaches or challenges in identifying and articulating the musical expressivities of dying persons. Regardless of the reason, qualitative methods offer avenues by which researchers can study the music of hospice patients. This researcher believes narrative inquiry is an underutilized method of qualitative inquiry. The aesthetic nature of stories may make narrative data a meaningful addition to art-based research and a viable alternative to traditional case study in music therapy. In addition, exploring the relationship between narrative, phenomenological, and hermeneutic inquiry may expand researchers' conceptual resources for qualitative data analysis.

The hospice music therapy patient's experience of time within music therapy and within the larger context of their dying process deserves greater exploration, as music can be a meaningful way both to structure or to transcend time. In addition, more research

investigating the experiences and perceptions of music therapy clinicians, particularly related to their experiences of time in end-of-life settings, would help the professional community deepen our understanding of the roles, challenges, tendencies, and differences we collectively experience. Research investigating how demographic factors such as the clinician's cultural identity, theoretical orientation, clinical population/facility, primary instrument, and geographic region affect the clinician's experience and perceptions of therapeutic work could be useful for educators, supervisors, and clinicians alike. Finally, research in which the experiences under investigation are participant-described rather than observed and inferred by the investigator has the capacity to diversify the pools of knowledge available to our professional community and lift up voices that may otherwise be unheard.

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Appendix A

Research Participant Recruitment Verbiage

MT-BCs working in hospice at full-time status: I am a graduate student conducting qualitative research to explore clinician experiences and perceptions of patient voice in hospice MT. I will use narrative inquiry; after being given a prompt, each selected participant will write a story about a significant clinical experience involving a patient's voice and will submit the story to me. Stories will be presented in their entirety in the study and any identifying clinician or client information will be masked. If you are interested in learning more and/or being screened for participation eligibility, please contact me at cflynn@smwc.edu.

Appendix B

A NARRATIVE EXPLORATION OF THE MUSIC THERAPIST'S EXPERIENCE OF PATIENT VOICE IN HOSPICE

You are being asked to participate in a research study conducted Cathleen Flynn, graduate student at Saint Mary-of-the-Woods College (and Tracy Richardson, Ph.D., MT-BC, faculty sponsor) from the Department of Music and Theater. This research is being conducted as part of a thesis. Your participation in this study is entirely voluntary. Please read the information below and ask questions about anything you do not understand before deciding whether or not to participate. You have been asked to participate because you are a board-certified music therapist working full-time in a hospice setting.

PURPOSE OF STUDY

This research will investigate participating music therapists' experiences and perceptions of hospice patient voice through the participant's written narration of a significant story. This researcher will consider meaning related to participant experiences and perceptions by exploring both individual context and categories of shared/common experience. Results from this study will be used to fulfill the thesis requirement for the Master of Arts in Music Therapy program at Saint Mary-of-the-Woods College.

PROCEDURES

If you provide consent, you will complete a screening questionnaire that provides this researcher with information necessary to select a purposeful, diverse sample of participants. Within one week of the deadline for screening questionnaire completion, you will be notified whether or not you will be selected for the study. If you are selected as a participant, you will be asked by this researcher to write a story utilizing the following prompt – "Tell me a story of a significant experience related to a hospice patient's voice in music therapy. What was the experience to you?" You will have one week after selection notification to submit the initial narrative, and will submit all narrative data to this researcher in the form of a Microsoft Word document or the body of an email. After this researcher receives the stories, she will immerse herself in the stories for several days then determine whether any follow-up questions are needed from you to get a clear textual image of your experience. You will have one week to submit any follow-up data if notified by the researcher of the need for clarifying information, and will decide whether they would like the data shared in follow-up questioning to be woven in the original narrative or included outside the original narrative in the results section. Any follow-up questions will be recorded in the written study's results section.

POTENTIAL RISKS OR DISCOMFORTS

The procedure involves no known physical, legal, social, or economic risks for participants. You may find participation feels emotionally vulnerable because of the personal nature of the research question and the extent to which participant's clinical experiences and perceptions are shared in the narrative written report.

POTENTIAL BENEFITS

There are no anticipated benefits for taking part in this study. Possible benefits of participation may include increased self-understanding, clinical awareness, and gratification in sharing a significant story.

CONFIDENTIALITY

This study was approved by the Saint Mary-of-the-Woods College Human Subjects Institutional Review Board on 3/13/2016. Participant identities will be protected through the use of pseudonyms to maintain confidentiality, and the key to the pseudonyms will be kept on paper in the locked cabinet with the consent forms. Participant data will be digitally stored on a password-encrypted flash drive that will be stored in a locked cabinet when not in use by the researcher. Two years after completion of the study, all raw data will be destroyed.

PARTICIPATION AND WITHDRAWAL

You can quit the study at any time prior to the data analysis/integration stage without any repercussions. Once this researcher begins data analysis/integration you will no longer be able to withdraw your data; however, this researcher will utilize a member checking process by which participants can make changes to their submitted narrative data throughout the study. If you would like to withdraw participation, please notify this researcher or academic advisor at the contact information listed below.

COST AND COMPENSATION

There is no cost to participate in this study and participants will not be compensated.

ALTERNATIVES TO PARTICIPATION

Participation in the research study is voluntary.

IDENTIFICATION OF INVESTIGATORS

<p>Principal Investigator: Cathleen Flynn, MT-BC 3 Lynnette Dr. Fairview, NC 812-870-4973 cflynn@smwc.edu</p>	<p>Faculty Sponsor: Tracy Richardson, Ph.D., MT-BC Department of Music & Theater Saint Mary-of-the-Woods College Saint Mary-of-the-Woods, IN 47876 812-535-5154 trichardson@smwc.edu</p>
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RIGHTS OF RESEARCH PARTICIPANTS

If you have questions, please contact Cathleen Flynn or Dr. Tracy Richardson at the information listed above. If you have concerns about the study, please contact Dr. Lamprini Pantazi with the Institutional Review Board at Saint Mary-of-the-Woods College at (812) 535-5232 or lpantazi@smwc.edu. For a copy of the completed study, please contact Cathleen Flynn. Results will be available after December 2016.

I understand the procedures described above. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

Printed Name of Participant

Signature of Participant

Email Address

Date

Signature of Person Obtaining Consent

Date

Appendix C

Sample Selection Screening Questionnaire

Name:

AMTA Region* (highlight/circle):

Mid-Atlantic	Western	Southeastern	Southwestern
Great Lakes	New England	Midwestern	

Years practicing as MT-BC:

Years practicing as full-time** MT-BC in hospice setting:

Type of hospice organization (highlight/circle):

Home-based Hospice unit at hospital Inpatient Other: _____

Professional theoretical orientation (select ONE with which you most closely identify):

Cognitive-Behavioral Humanistic-Existential Music-Centered Psychodynamic
 Transpersonal Other (please describe): _____

**Regardless of your membership status with the American Music Therapy Association, please identify your geographic region.*

***Full-time status at your place of employment, or 32+ hrs./week of independent hospice contracting.*