INFORMATION TO USERS

The most advanced technology has been used to photograph and reproduce this manuscript from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI
University Microfilms International
A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor, MI 48106-1346 USA
313/761-4700  800/521-0600
A phenomenology of music therapy with the terminally ill

Forinash, Michele, D.A.

New York University, 1990

Copyright ©1990 by Forinash, Michele. All rights reserved.
Sponsoring Committee: Professor Barbara Hesser, Chairperson
Professor John V. Gilbert
Professor David W. Ecker

A PHENOMENOLOGY OF MUSIC THERAPY
WITH THE TERMINALLY ILL

Michele Forinash

Submitted in partial fulfillment of the requirements for the degree of Doctor of Arts in the School of Education, Health, Nursing, and Arts Professions New York University 1990
I hereby guarantee that no part of the dissertation which I have submitted for publication has been heretofore published and (or) copyrighted in the United States of America, except in the case of passages quoted from other published sources; that I am the sole author and proprietor of said dissertation; that the dissertation contains no matter which, if published, will be libelous or otherwise injurious, or infringe in any way the copyright of any other party; and that I will defend, indemnify and hold harmless New York University against all suits and proceedings which may be brought and against all claims which may be made against New York University by reason of the publication of said dissertation.

5/14/90

Michele Fominet

Date
In memory of

KYLE FORINASH, JR.

July 14, 1920 - January 7, 1989

My father
ACKNOWLEDGMENTS

A most heartfelt acknowledgment is extended first and most importantly to the patients and families at Cabrini Hospice who agreed to participate in this study. Their willingness to share such intimacy at this time in their lives is inspiring. This project would have been impossible without their openness.

There are many others to whom I am deeply indebted for their support, understanding and guidance. My committee, chaired by Professor Barbara Hesser with Professor John V. Gilbert and Professor David W. Ecker as members, was very helpful in guiding me through this project. In addition to chairing the committee, Barbara has gone above and beyond the call of duty as both an advisor and friend.

I extend my thanks to the wonderful staff with whom I work at Cabrini Hospice. The staff, led by Mary Cooke, Director, and Barbara Miller, Assistant Director, provided me with encouragement at every step. I deeply appreciate the Hospice Team’s ongoing support of my clinical work.

A very special thank you goes to the NYU music therapy community. Dorit Amir, David Ramsey, Noah Shapiro, Judi Rubin-Bosco, and Alan Turry truly
inspired me during our late night talks at Eddie’s. Roseann Kasayka, David Gonzalez, and Ken Aigen have also been most supportive and caring.

My friends have also been invaluable in this process. Jenny A. Martin provided endless support and encouragement as well as much needed editorial services. Steve Schneider, Caryl-Beth Thomas and Elizabeth Funghini have all been both patient and understanding.

A heartfelt thanks to Dr. Robert Kuisis for being the one to hear my many concerns and questions and for being willing to push me when that was necessary.

A thank you is also extended to Dr. Tom Cloonan and Dr. Carolyn Kenny for their advice and fresh perspectives at crucial moments.

A very special acknowledgement goes to my mother Ruth E. Forinash and my brother Dr. Kyle Forinash for always believing in me.

Thanks also to Dr. John Richie and Lin Zoeller for having the wedding and celebration which enabled me to have so much fun that I was ready to get down to work and get this done!
Thirty Three

Knowing others is wisdom;
Knowing the self is enlightenment.
Mastering others requires force;
Mastering the self needs strength.

He who knows he has enough is rich.
Perseverance is a sign of will power.
He who stays where he is endures.
To die but not to perish is
to be eternally present.

Lao-Tsu
Tao Te Ching
# TABLE OF CONTENTS

DEDICATION iii

ACKNOWLEDGMENTS iv

EXCERPT FROM TAO TE CHING vi

CHAPTER

I INTRODUCTION 1

II RELATED LITERATURE 7
  Music Therapy 7
  Thanatology 15

III METHOD 21
  Phenomenology 22
  Method 28

IV PARTICIPANTS IN THE STUDY 34
  Discussion 44

V RESULTS OF THE STUDY 48
  Relationship 50
  Music 61
  Process 70

VI CASE EXAMPLE 79
  Transcript 80
  Process Note 95
  Data Analysis 99
  Discussion 101

vii
VII

CONCLUSIONS AND
RECOMMENDATIONS FOR
FURTHER RESEARCH

Conclusions 105
Description of Music Therapy 106
Summary of Method and Recommendations for Further Research 107

BIBLIOGRAPHY 110

APPENDICES

A  HUMAN SUBJECTS STATEMENT 118
B  STATEMENT TO THE SUBJECTS 119
C  CONSENT FORM 120
CHAPTER 1
INTRODUCTION

The motivation for this doctoral dissertation has grown from my experience as a music therapy clinician with the terminally ill and from my frustration in trying to relate my clinical experiences to other professionals in an articulate and meaningful manner. As I became more experienced in the clinical setting I was drawn to the idea of pursuing research, yet traditional research methods did not seem to fit my clinical experiences. Research articles on music therapy frequently left me with the sense that although a point may have been proven in a given article, at the same time something essential was missing.

In analyzing this "something" I found that the research I read often dissected the clinical work and offered a reduction of the experience that bore little resemblance to actual clinical practice and consequently had little meaning for me as a clinician. Paradoxically, my experience with clinical work in music therapy was not based on this dissection or reduction, but rather on complex, multidimensional human interaction, the working together of patient and therapist in the context of the therapeutic
environment.

In pursuing a doctorate in music therapy at New York University and contemplating my clinical work as a music therapist with the terminally ill I realized that I must employ a research method that would not reduce the patients to unrecognizable statistics. I became determined to discover or adapt a method that would allow the music therapy experience to be seen and heard as whole, one that would take into account the complexity and richness of the patients with whom I work and the sessions in which we interact.

The music therapy presented in this dissertation is taken from my clinical practice with terminally ill patients at Cabrini Hospice in New York City. Hospices provide palliative and supportive care for terminally ill patients and their families. The past forty years have brought major changes in our present health care system. Advances in science and medicine have enabled us to provide better care for the medically ill in our society. Patients who once might have been considered hopeless can now receive treatment and perhaps a cure. Along with our ability to prolong life have come difficult philosophical questions about choices between quantity of life and quality of life.

Sanctity of human life has been moved from its central place to compete with quality of life issues.
As health professionals and potential patients, we all have an obligation to reflect on these issues and develop a reasoned ethical position (Davis and Slater, 1989, p. 39).

The hospice movement has developed from these quality of life issues.

The growth and development of Hospice in the United States from three programs in 1975 to over 1800 in 1988 shows the interest and concern of people in taking control of this aspect of their lives in a highly technical health-care system (O'Connor, 1989, p. 79).

Although the present practice of music therapy with terminally ill patients originated with Susan Munro in the 1970s at the Royal Victoria Palliative Care Service in Montreal, the connection of music to dying and death is not new. Rather, music has been used near or at the time of death for thousands of years. American Indians learn a death chant while young and sing it in any event that might be life threatening. In doing this they learn to recognize the nearness of death while becoming prepared to meet death with power and clarity given them by their personal chant. It serves to keep "the heart open and the mind clear" (Levine, 1982, p.26). In India the death ritual involves chanting as the family carries the deceased to the cremation ground (p. 6).

The Tibetan Book of the Dead, whose roots are suspected to be pre-ninth century, provides a thorough examination of chanting as an aid for the newly deceased in their afterlife existence. This book
states that a priest, trained in the specific task of directing a recently deceased being into the "bardo", or afterdeath world, is to be called at the time of death. This priest conducts a service which "consists of a mystic chant containing directions for the spirit of the deceased to find its way to Paradise" (Evans-Wentz, 1960, p. 18). Milarepa, a Tibetan yogi who lived in the twelfth century, spontaneously composed a song at the time of his death. This song served as a final teaching to his students to guide them toward their own Enlightenment.

If ye tread the Secret Path, ye shall find the shortest way;  
If ye realize the Voidness, Compassion will arise within your hearts; . . .  
If ye lose all differentiation between yourselves and others, fit to serve others ye will be; And when in serving others ye shall win success, then shall ye meet with me; And finding me, ye shall attain to Buddhahood (Evans-Wentz, 1928, p. 262-273).

More recently the musical setting of the requiem has served as a form for composers to musically reflect thoughts and feelings that accompany the idea of death and afterlife. Certainly one of the most famous is the requiem of Mozart. It is reported that while writing it he said to his wife, with tears in his eyes, "that he was writing his requiem for himself. 'I feel it too well, . . . my end is drawing near'" (Burke, 1959, p. 353). The afternoon before his death Mozart and his friends sang part of the requiem. In the midst of
this, "Mozart, with the feeling that it would never be finished, burst into a violent fit of weeping, and laid the score aside" (p.356).

In present day Western society music is used at wakes, funerals and memorial services. Hymns or songs are sung and verses are chanted as families and friends gather to remember the deceased. It provides the survivors with an opportunity to grieve the loss of their loved one as well as feel the support of others who share in this grief.

These examples are the forerunners of the present practice of music therapy with the terminally ill. Music therapy has existed as a profession since after World War II when music was found to be therapeutic in treating war veterans in psychiatric hospitals (Gaston, 1968, p. 5). It has since branched out to include work with a variety of 6 populations including mentally retarded, emotionally disturbed and geriatric patients. Music therapy used specifically with the terminally ill is even more recent. The first article on this subject was published in 1978 (Munro and Mount), at a time when only a few clinicians were practicing with the terminally ill. In the ensuing years, more music therapy clinicians have begun to work with this population, but there is still very little literature

---

1 Munro has more recently published under the name Porchet-Munro.
that defines and describes the practice of music therapy in this setting.

A symposium on music therapy with the terminally ill was held at Calvary Hospital, Bronx, New York, in June of 1988. This international gathering of over forty music therapists working with the terminally ill addressed the present state of clinical work and made recommendations for future directions. One of the needs cited at the symposium was for a deeper and clearer understanding of clinical work. Jenny Martin, in her introductory welcome, stated that to enhance understanding of music therapy we must "conduct research which both accurately and adequately describes the music therapy experience" (1989, p. 3). Susan Munro also to tackle challenging questions such as, "What is meaningful research for music therapy in cancer care/hospice care?" (1989 p. 12). The idea for this dissertation has come from the growth of facilities providing palliative care, the increasing number of music therapy clinicians practicing in these facilities, and their expressed need for further appropriate research as applied to clinical work. This dissertation will serve to determine and describe the essences of the phenomenon of music therapy, specifically with the terminally ill. It will hopefully provide insight and understanding into the work while respecting the wholeness and complexity of the phenomenon.
CHAPTER II
RELATED LITERATURE

Music therapy began as a profession when music was found to be therapeutic for World War II veterans in psychiatric hospitals. Since that time it has been used with a variety of populations including, psychiatric, mentally retarded, emotionally disturbed and geriatric. In the past fifteen years music therapy has found application in medical settings with patients facing a life-threatening or terminal illness.

Though not in its infancy, this segment of music therapy is largely undeveloped. There is little literature on this specific topic and very few research studies. An examination of the present state of clinical work in music therapy with the terminally ill, as seen in publication, is presented. As the literature on thanatology is closely connected to the literature on music therapy with the terminally ill, a brief summary of this is included.

Music Therapy Literature

One of the most recent publications on music therapy with the terminally ill is the proceedings from the 1988 symposium at Calvary Hospital (The Next Step Forward: Music Therapy with the Terminally


In this seminal gathering of international music therapists, ideas were shared and issues explored relating to both the present practice and the future direction of music therapy for the terminally ill. Special topics in these proceedings are on skills and competencies (Bright); group work (Salmon); grief and bereavement (Curtis; Loyst); isolation (O’Callaghan); challenges for the music therapist (Porchet-Munro); and research (Lane; Whittall; Forinash). The proceedings are significant because the participants are clinicians who are presently shaping the field through both practice and research of music therapy.

The research papers in the proceedings describe different approaches to understanding the music therapy event. Lane (1989) adapts a quantitative approach to research in discussing the implications of measuring speech pause time as an indication of the effectiveness of the music therapy intervention with oncology patients. Her purpose was to provide a baseline of speech pause time in a control group (of non-hospitalized adults) and an experimental group (of hospitalized adult cancer patients). This baseline could then be contrasted with future control and experimental groups to determine the effectiveness of music therapy in treating depression. Although "because of the uneven sample sizes the data results
may have been skewed" (p. 67) this article "suggests that there are some observable differences in speech pause time scores in hospitalized and non-hospitalized adults" (p. 67).

Whittall (1989) presents a quantitative pilot study on "The Impact of Music Therapy in Palliative Care." She uses "non-invasive biofeedback equipment" (p. 70) to record patients' responses to music therapy sessions. In her conclusions she states that "anticipated results were seen to some extent" in that "a decrease in heart and respiration rates was seen indicating a lower level of anxiety" (p. 72). However, because of the small sample size and the lack of control for other factors, the results are difficult to generalize.

"Research in Music Therapy with the Terminally Ill: A Phenomenological Approach" (Forinash, 1989) is the tracing of my own initial interest in research. It outlines beginning thoughts about the philosophical perspective of phenomenology as a possible method for study of music therapy with the terminally ill and only begins to delineate a method.

At this time there is only one book on music therapy with the terminally ill (Munro, 1984). It was written by Munro, while she was working on the Palliative Care Unit of the Royal Victoria Hospital in Montreal, Canada. It is essentially descriptive in
nature; she focuses primarily on case material from her clinical work and discusses important considerations and observations from each session. Munro identifies not only the patient's area of need, such as pain, anxiety and isolation but also considerations for the therapist, such as length and frequency of sessions, music therapy activities, selection of patients, taped versus live music and bereavement follow up.

Aside from these two major documents only a handful of articles on music therapy with the terminally ill exist and of these only a few are about research.

Bailey (1983) addresses the effects of music on tension and anxiety in adult cancer patients in "The Effects of Live Music Versus Tape-Recorded Music on Hospitalized Cancer Patients." 2 She uses traditional experimental design in her study, establishing two groups: One which received live music and the other taped music. "The live music subjects reported significantly less (p < .05) tension-anxiety and more vigor than did the taped music subjects" (p. 17). Additionally "live music subjects reported significantly more changes in physical discomfort (p < .05), changes in mood (p < .01), and changes in mood for the better (p < .001); and recommended music

---

2 Bailey has more recently published under the name Magill.
therapy sessions for others (p < .01" (p. 17).

Curtis (1986), also employing an experimental design, studies the effect of music on pain in terminally ill patients. This study fails to show significant results. However, the "graphic analysis of individual responses indicated that music may have been effective" (p. 10).

Munro and Mount's "Music Therapy in Palliative Care" (1978) sets forth a theory of clinical music therapy with the terminally ill. According to this theory, terminally ill patients exhibit needs in four major areas: physical, psychological, social and spiritual.

In the area of physical needs, the authors found that music can reduce the chronic cycle of physical pain by encouraging muscular relaxation. Music can also alter the perception of pain by reducing anxiety and depression.

In the area of psychological needs, the authors found that music can reinforce identity, link patients to their pre-illness life, aid in life review, ease anxiety and depression, express emotions, aid in anticipatory grieving, reinforce reality and provide hope.

The authors found that music can address the area of social needs by providing a means of socially acceptable self-expression, act as an aid in bonding
the community of caregivers, as well as bonding the patient and family to others sharing a similar experience.

In the area of spirituality, the authors found that music provides the opportunity to examine the meaning of life and death, link patients with their spiritual beliefs, and aid in the transition from life to death (pp. 1042-1062).

In her article "Treatment of Anxiety and Fear in Terminal Pediatric Patients," Fagen (1982) discusses specific issues of anxiety and fear in working with children and demonstrates the effectiveness of music therapy in alleviating these issues.

Fagen (1982) identifies the times when a pediatric patient's anxiety is usually highest: at the time of diagnosis; at the death of a peer; and at the time of a personal medical crisis. She discusses the dying patient's fears such as drug-induced hallucinations, isolation and death itself. In each case she provides case examples that specify these anxieties and fears and demonstrates how music therapy is an effective intervention.

Bailey (1984) addresses the technique of song choice in her article entitled "The Use of Songs in Music Therapy with Cancer Patients and Their Families." She examines the meaning of the patient's choice of songs in the music therapy session. Bailey lists nine
theme areas in song choice. They are hope, pleasure, the world, needs and desires, reminiscence, relationships, loss and death, feelings, and peace. Bailey also delineates three stages in the therapeutic process. They are contact, awareness and resolution (p. 6).

She uses songs choice to first engage the patient and family. This is followed by the emergence of a theme that once expressed in the music, can be brought to the patient's and family's awareness. Resolution, which occurs when the theme is acknowledged and expressed, is considered the final stage of therapy.

Bailey (1986) later published an article entitled "Music Therapy in Pain Management," which addresses specific goals of music therapy as an intervention in the control of pain. Her emphasis here is on the patients and their participation in the music therapy sessions. She devises categories of patients: the music performer, music listener and music "eventer" (one who associates music with events such as weddings, holidays, etc.). For each type of patient she indicates specific involvement in music therapy that can be effective as an intervention in pain management.

Wylie and Blom (1986) discuss a specific music therapy technique in "Guided Imagery and Music with Hospice Patients." This article focuses on music therapy with two hospice patients, specifically
describing how music and guided imagery are used to "facilitate pain control and help patients reminisce about their lives" (p. 25).

Nelson and Sidenberg (1986) address the potentials for music therapy in palliative care in a presentation at the 13th Annual Conference of the Canadian Association for Music Therapy. They list nine objectives to which music therapy can be applied: enhancement of time remaining, providing an outlet for self-expression, aiding in evoking memories, providing a means of communication, aiding in maintenance of self-esteem, aiding in reality orientation, altering moods, relieving isolation and promoting physical relaxation.

Slivka and Magill (1986) discuss clinical interventions through the conjoint use of social work and music therapy with children of cancer patients. Case examples are used to highlight this collaboration and specific results.

Of the four actual research studies that are presented here (Lane, 1989; Whittall, 1989; Bailey, 1983; and Curtis, 1986) only one (Bailey, 1983) shows significant results in the use of music therapy with the terminally ill. Bailey’s results indicate only that live music is more effective than tape recorded music with hospitalized cancer patients. That other quantitative research approaches suggest certain
findings but fail to show significant results indicates the need to pursue alternative research projects with this population.

Thanatology

With the advent of the medical model and advanced technologies in the United States, the event of death was moved out of the home and into the hospital. Death became an event to be hidden. The family of the dying person was expected to carry on an existence that denied the reality of the illness and its effect on the family and community unit (Aries, 1982, p. 570-571).

Throughout the 1960s a subtle change in the opposite direction began to occur. The event of dying began to be examined.

Hundreds of books and articles appeared . . . describing and analyzing the process of death, dying, mourning and bereavement. Improved communication with the terminally ill and enlightened care of their needs has become a topic of ever-increasing public interest (Stoddard, 1978, p. 7).

The thanatological literature at present is quite extensive and far too vast to be covered completely in this dissertation. To provide an overview of the literature and for discussion purposes, it has been categorized in four major groups. These are:

historical perspectives of death and mortuary ritual;
philosophical and psychological perspectives on death and dying; spiritual approaches and perspectives to
dying; and fictional and non-fictional accounts of dying. Literature on the physical aspects of terminal illness, i.e., medical material, has been omitted.

**Historical Perspectives**

The literature in this category addresses the various ways humankind has viewed death throughout history. This historical context provides a background from which we can better understand our present rituals surrounding death.

One of the most extensive and exciting works in this area is *The Hour of Our Death* by Philip Aries (1981). He offers insight into our views and attitudes to death as they have changed over the past thousand years. Aries discusses not only the physical issues of death and burial, but also the religious rites that have evolved around death. He provides an overall view by examining funerary rites, deathbed visions, last rites, embalming, burial, cremation and cemetery art.

Other notable pieces of literature in this category include *The Tibetan Book of the Dead* (Evans-Wentz, 1960); *The Egyptian Book of the Dead* (Budge, 1972) and *The American Book of the Dead* (Christie, 1981). These describe how death and afterlife are understood in specific cultures, as well as provide insight into spiritual practices and cultural rituals surrounding death.
Philosophical and Psychological Perspectives

As the events of dying and death have been closely scrutinized, we have learned to better understand how the human being, as dying patient, as family member and as caregiver, responds to death. These analyses have produced literature that addresses the philosophical and psychological issues surrounding death.

One of the early cornerstones of this category is Kubler-Ross’s On Death and Dying (1969). Kubler-Ross addresses the psychological aspects of impending death from the perspective of the dying person. She describes stages of coping with a terminal illness: denial, anger, bargaining, depression and acceptance. Though she has received some criticism for what readers took to be an ironclad formula of stages of illness, her initial analysis continues to be very influential.

Other books in this category include: Explaining Death to Children (Grollman, 1967) and What Helped Me When My Loved One Died (Grollman, 1981); Counseling the Dying (Bowers, 1964); Facing Death (Kavanaugh, 1972); The Denial of Death (Becker, 1973); The Deepening Shade: Psychological Aspects of Life Threatening Illness (Sourkes, 1982); Grief, Dying and Death (Rando, 1984); Grief Counseling and Grief Therapy (Worden, 1982); Living Your Dying (Keleman, 1974) and The Meaning of Death (Feifel, 1959).

Each of these provides insight into the
psychological impact that a terminal illness and subsequent death have on patients and families.

**Spiritual Perspectives**

All religions and spiritual paths outline certain beliefs and doctrines about the passing from this life, and the life hereafter. Christianity, Judaism, Buddhism, Hinduism, Islam, Anthroposophy and Theosophy are just some of the existing spiritual paths, and within these there are a multitude of books from which to choose.

**The Tibetan Book of the Dead** (Evans-Wentz, 1960); **The Egyptian Book of the Dead** (Budge, 1972); Levine’s **Who Dies?** (1982), **Meetings at the Edge** (1984) and **Healing Into Life and Death** (1987); **Life Between Death and Rebirth** (Steiner, 1968); and Ram Dass and Paul Gorman’s **How Can I Help?** (1985) are only a few examples of metaphysically thought-provoking literature. They explore the spiritual dimension of death, afterlife and reincarnation.

Also in this category are the recent books on transpersonal psychology. These books address psychology and psychotherapy with the inclusion of the spiritual element of humanity. Books such as Ken Wilbur’s **No Boundary** (1979) and Boorstein’s **Transpersonal Psychotherapy** (1980) deal with death as both a symbolic transformation in the process of
therapy and with the physical experience of death. This literature puts traditional spiritual concepts such as reincarnation and the "higher self" presented in books such as The Tibetan Book of the Dead (1960) in a present-day, Western psychological perspective.

Fiction and Non-Fiction

The literature in this section often gives a vivid account of one particular person's death and the personal impact of dying on both the dying individual and the family.

Examples in this category include A Death in the Family (Agee, 1938); The Death of a Woman: How a Life Became Complete (Wheelwright, 1981); And a Time To Die (Pelgrin, 1962); As I Lay Dying (Faulkner, 1938); The Death of Ivan Ilyich (Tolstoy, 1960); and The Plague (Camus, 1972).

These are often the case examples of how people face their own impending death or the impending death of a loved one. These are essentially descriptive in nature and do not necessarily explain why people are reacting in certain ways, but rather the focus is on how they are reacting.

In general some of the most influential books on thanatology included here (Kubler-Ross, 1969; Keleman, 1974; etc.) are descriptive. The authors have formulated theories, or ideas, from the descriptions of
their clinical work or the clinical work of others. For this author as researcher, this descriptive process and its effectiveness again indicates the direction for further research in a qualitative manner.
CHAPTER III

METHOD

Terminal illness is a complex and many-faceted disease process. Some of its facets can be easily studied through traditional quantitative analysis; while other facets are difficult to measure by such methods. Quantitative studies on effectiveness of treatment protocol on disease process (White, 1984), studies relating patients' pre-illness nutritional habits to disease diagnosis (Luke, 1977), or studies on the role of genetics in the disease process (Giblett, Chen, & Osborne, 1981) undoubtedly yield significant results. These results affect our present health-care practices and allow us to provide more advanced treatment for the medically ill in our society.

The style of research cited above tends to attempt to objectify knowledge. It holds that knowledge acquired is independent from the person who experiences the "knowing." It makes the assumption that knowledge is "impersonal, explicit and permanent: the ideal of total objectivity" (Greene, 1966, p. 17). This paradigm, known as logical positivism, and its primary research approach, known as the scientific method, though indispensable, have been criticized for their failure to address intricate social and environmental issues
Over-emphasis on this style of research can result in neglecting other complex facets of terminal illness. Conscious and symbolic processing of emotional reactions, contemplation of the meaning of life, the use of ritual and the use of music for the terminally ill will only be partially understood from this quantitative perspective.

Phenomenology

In examining the phenomenon of music therapy with a terminally ill patient, we are attending to the complex interactions that occur between the music therapist and the patient. This relationship is dynamic and flowing. The therapist and patient move in a dance that is their interactive relationship. They are partners in this dance, and one partner (the therapist) cannot be removed in order to study the other partner (the patient). A music therapy session is the result of the interplay of the two persons.

Therefore, to study this phenomenon appropriately, we must seek a philosophy of knowing that does not remove the experiencer from the experience. This idea is explored by M. Grene in her book The Knower and the Known (1974). She attempts to rediscover the "knower" as an aspect in the process of the acquisition of knowledge. Grene’s writing is based largely on Michael
Polanyi's ideas that knowledge is based on one's direct, personal experiences. In his book, *Personal Knowledge*, Polanyi (1958) seeks to bring to our awareness the impact of the "personal" knower in the acquisition of knowledge.

Ferrara (1984) supports the acquisition of knowledge as a dynamic process: "from Kant through Gadamer, two centuries of writers have clearly demonstrated that knowledge is grounded in our interaction with things, not from things as separate objects" (p. 199).

In his article "Richness or Chaos?: Toward a Phenomenology of Musical Interpretation" Ferrara (1984) presents a convincing rationale for the use of phenomenology in musical interpretation. He writes of our tendency to regard music in objective analysis as an object devoid of the aesthetic and dynamic qualities that we experience as musicians (p. 197). He presents phenomenology as a means of addressing the complexity of the musical situation, giving importance to the listeners and their orientation to the work, as well as to the potential meanings of a musical work.

Phenomenology, as a "style of thinking which concentrates an intense examination upon experience in its multifaceted, complex and essential form" (Thde, 1976, p. 17), is an appropriate method for studying music therapy with the terminally ill. It will provide
a rigorous and thorough framework in which to study and further understand this phenomenon while respecting the integrity of the event.

The first problem then of this dissertation project is to discover which methods of phenomenological research might be appropriate for application to the phenomenon of music therapy with the terminally ill. The history and development of the philosophy of phenomenology is beyond the scope of this paper; however, certain writers are reviewed as they have directly influenced the development of the philosophy and model presented in this dissertation.

In addition to those cited earlier, the philosophies of Heidegger (1975), Husserl (1984), Gadamer (1976), and Merleau-Ponty (1964) have helped create a foundation. This foundation is a perspective from which to view our attempts at understanding. These writers have a desire for a method that operates from the perspective of the "lived world." This concept refers to the experience of understanding and studying the world as lived or as experienced as opposed to the world as it exists in the laboratory setting. This theme is important in phenomenology and prompted this study of the "lived world" of music therapy, not the dissected components of the phenomenon but the actuality of the practice.

The specific applications of a phenomenological
research method as developed by Colaizzi (1982), Gendlin (1982), Giorgi (1975, 1984), Spilman (1975), and Stevick (1971) were also of great value. These served both to introduce methods of research as they are applied and to verify that phenomenology can bring deeper understanding and insight into phenomena. The verification takes the form of a sense of groundedness, a returning to the experience to verify that the results are grounded in the experience, that they exist in the experience.

Colaizzi (1968), in an unpublished doctoral dissertation, studies the phenomenon of learning. He uses a descriptive method seeking to articulate a phenomenologically based psychology. Gendlin (1982) and Stevick (1971), in separate articles, focus specifically on a phenomenology of the experience of anger. Spilman (1975) presents an holistic approach to the study of a patient with Chron's disease through phenomenological analysis. Giorgi's article (1975) will be discussed in more fully later in this paper because the method developed here is greatly influenced by his work.

describes the creative process involved in music making. He writes that "making music is an expressly human endeavor, and yet, musical activity is strangely wonderful, awesome, and mysterious" (p. 116).

In his article "Phenomenology as a Tool for Musical Analysis," Ferrara (1984) develops a method of phenomenological analysis for application to music. He outlines a five step process which allows the research to both listen to the "whole" of the musical piece, i.e., open listenings and isolate specific components, i.e., sound as such, syntax, semantic meaning, ontology of that piece for closer scrutiny.


The recent direct use of phenomenology in music therapy has proved to be especially exciting (Kenny, 1984; Forinash and Gonzalez, 1989).

phenomenological method she sets out to discover the essences of the music therapy experience, design a framework to describe the process of music therapy and then express these essences in a language which can be understood by professionals in other fields (p. 64).

Kenny does this by defining essences as she sees them emerge from reflections on a videotaped music therapy session conducted with a patient in the rehabilitation center where she worked as a music therapist. A panel of various professionals (art therapist, philosopher, musician, etc.) then viewed the same video tape and responded to Kenny's questionnaire which began with the essences from the session as she defines them. The panel members worked with these essences to further clarify their meanings. Kenny concludes with revised definitions of the essences.

A colleague and I took Ferrara's (1984) method and adapted it for the study of a music therapy session (Forinash and Gonzalez, 1989). We varied the methodological steps as outlined by Ferrara so that they more fully captured the music therapy session. Our steps focused on different aspects of the music therapy session including: patient background, the session itself, musical and verbal syntax, sound as such, semantic or referential meaning, ontology, and metacritical evaluation. Writing this article was extremely useful in helping me begin to articulate
philosophical ideas as used in a phenomenological method. I came away knowing that phenomenology is a useful approach because it uncovered aspects of the session that were critical (images, my personal feelings while leading the session, etc.) to the process of the therapy session. I also felt the method to be still somewhat limited and that it neglected some important aspects of the session (i.e., therapist-client relationship, the presence of the music as a growing and responsive force). Talking with Dr. Tom Cloonan, of New York University, aided significantly in articulating the aspects that were omitted by this study and in directing me toward other research.

**Method**

This chapter has been a discussion and search for a method of research. As we move closer to the establishment of a method there are additional considerations to be discussed.

One consideration is the question of which patients to include in the study. Terminally ill patients are often weak, sometimes so much so that speaking is difficult or impossible. Some patients are comatose or actively dying at the time of a session. Yet if the "lived world" of music therapy with the terminally ill is to be studied, a method must be developed that allows the inclusion of these patients. The method must not be
demanding on the patient in the session; no questionnaires or interviews about their experience are possible. A criterion then for the research method is that the patient’s or their families need only consent to the session and participate in the manner they would if the session were not being studied. For example it must be possible for the nonverbal, unresponsive or actively dying patient to be included.

Another consideration is that of developing a method that will minimally influence the session itself, a method that is minimally intrusive. Again, the session studied must be as close to the "lived world" of music therapy as possible. Sessions can be an intimate sharing of thoughts and feelings, consequently the inclusion of a video camera or an additional researcher in the room may alter the session.

At the same time there is a need for some hard data to be analyzed, data which could potentially be analyzed by any researcher familiar with the method. Audiotaping the sessions and providing a written transcript of each session will be the basis of this hard data as it will be minimally intrusive and will minimize the subjectification of the data.

The method developed here is most strongly influenced by the work of A. Giorgi (1975, 1984) as presented in his articles "Convergence and Divergence of Qualitative and Quantitative Methods in Psychology" and
"A Phenomenological Psychological Analysis of the Artistic Process." In the 1975 article he provides a convincing rationale for the development of an appropriate method for use in psychology.

Psychology should not emulate the practice of the natural sciences, but rather it should turn to its indigenous phenomena, describe them faithfully and interrogate those descriptions; the researcher should let the unfolding of the phenomenon itself guide the logic of his inquiry (p. 72).

A basic philosophy and method of application are woven beautifully into this one statement.

Giorgi goes further by actually describing a method of phenomenology as applied to the experience of learning in the 1975 article and to the experience of the artistic process in the 1984 article. In both he outlines five steps. The first step is the reading of a description of the phenomena to "get a sense of the whole" (Giorgi, 1975, p. 73). In this step the researcher is present to more than simply the words on a page but also to the meanings "he apprehends through written language" (p. 73).

The second step is a slower rereading of the description with the intention of discovering the meaning of the event. Step three is a process of eliminating redundancies and clarifying and elaborating the meaning by "relating them to each other and the sense of the whole." The fourth step is one in which the researcher reflects on the meanings gleaned from the prior steps and works with what is revealed about the
learning process. Step five is a synthesis and integration of the "insights achieved into a consistent description of the structure of learning" (Giorgi, 1975, p. 74-75).

For application to the music therapy session some adaptations of this method have been made. The researcher conducted ten music therapy sessions with ten different terminally ill patients. These patients were from the Cabrini Hospice program in New York City where the researcher works as a music therapist. The first ten patients who agreed by written consent to take part in this study were accepted without regard to their diagnoses or prognoses.

In the event that a patient was unable to agree to participate, a family member was allowed to make the decision on the patient's behalf. Each session was audiotaped and a transcription was made of each audio tape. A process note was written by the researcher after each session from the perspective of the music therapy clinician. These three components formed the data base which was studied.

Step one was the collection of data; conducting and taping the sessions, rendering transcriptions and writing process notes.

Step two was the first analysis of the data. Each session was taken in its entirety: tape, transcription and process note. The assumption was
that the data collected described music therapy with the terminally ill. The researcher then reflected on the data. Reflecting is the state in phenomenology known as "bracketing." This state is one in which we suspend our "previous knowledge or beliefs concerning the existence of the (phenomenon)" and "refer to what appears in (the) phenomenal field, as a structured set of appearances either sensuous or conceptual or both" (Kaelin, 1981, p. 50).

In this reflective process the researcher made notations in the margins of the session transcript and the process note, and on a blank sheet of paper for the audiotape. In this step the researcher transformed the description of music therapy with the terminally ill into "meaning units" or "constitutents" of the experience as described by Giorgi (1975, p.75). These "meaning units" then form the basis for the translation of descriptive material into essences of the music therapy experience with the terminally ill.

Essence is taken here to mean the "repeatable characteristics of human experience considered as necessary for the constitution of an object's meaning" (Kaelin, 1981, p. 51). Essence can also be described as "the invariants within phenomena" (Ihde, 1986, p.38). In application here it implies "that which makes a music therapy session a music therapy session, and without which the music therapy session would cease to exist"
(Forinash, 1989, p. 74). The essence sought here is that in the music therapy session which is crucial to the existence of the phenomenon.

Step three was a second reflection. This was a reflection on the essences that emerged in step two. The emphasis here was to integrate and synthesize these essences into "a consistent description of the structure of" (Giorgi, 1975, p. 75) music therapy with the terminally ill.

Step four was a second reflection of the data in its entirety, with the researcher seeking to verify the groundedness of the essences obtained in step three.

The fifth step was an integration and synthesis of these essences into a final description of music therapy with the terminally ill.
CHAPTER IV
PARTICIPANTS IN THE STUDY

As stated previously, the purpose here is to study the "lived world" of the music therapy experience with the terminally ill patient. This lived world refers to the complete experience of music therapy with the patients presented here. Following the research method adapted, one session with each of the ten patients who participated in this study is included. Yet, before a meaningful discussion of the essences that emerged from those sessions can take place, the reader must become acquainted with both the overall concept of music therapy in hospice as practiced by the therapist studied here as well as with the patients who participated in the study. The reader must be familiar with the lived world of music therapy as it exists at Cabrini Hospice.

Cabrini Hospice is a program for terminally ill patients and their families. To be considered appropriate for the program, a patient must have a life expectancy of six months or less and need palliative rather than curative care. Supportive care provided is provided to the patients and their families.

Most of the patients in the Cabrini program are seen at home. Services such as nursing, social work,
pastoral care, creative arts therapies and volunteers are available in the home environment. Cabrini has a 15 bed inpatient unit that is used by home care patients for symptom management or respite care. All services available to the patient and family at home are also available to the patient and family in the inpatient unit. The program serves approximately 50-60 patients at any given time.

Music therapy, as practiced at Cabrini Hospice, is the intentional and compassionate use of the elements of music to meet the psychological, spiritual and physical needs of the hospice patients and their families. The music therapy sessions take a variety of forms though are always individually tailored for each patient and family. Sessions most frequently takes the form of live music, using a variety of instruments including guitar, voice, electronic keyboard, piano, omnichord, percussion instruments, etc. The music selected includes precomposed music in most styles and periods as well as improvised music. Taped music is also used with some patients and families. The type of music can be requested by the patient and family or suggested by the therapist. Referrals can be made by any staff member, patient, family or the therapist.

Typical therapeutic goals for hospice patients and their families are: increasing appropriate self expression, increasing self esteem, strengthening
appropriate coping mechanisms, reducing anxiety, reducing the perception of pain, finishing unfinished business, and providing closure.

In discussing the specific patients who participated in the study it is important to note that the analysis provided in this document is based on one music therapy session with each of the ten patients. In some instances the session studied was the only session that took place; in others it was in of a series of sessions that occurred while the patient was on the hospice program.

Before a discussion of essences can take place the reader must also have some understanding or awareness of the patients and their process in music therapy.

Session 1 Samuel

Samuel was an 82 year old man with metastatic colon cancer which had been diagnosed two years prior to his admission to the hospice program. Samuel was an outgoing, versatile man who had had many careers in his lifetime, including chicken farming, restaurant management and attending law school. He had recently been working as an apartment building superintendent. Samuel was an independent person and liked to take care of himself. His relatives lived out of state though they telephoned regularly and made frequent visits. He had several very close friends who were committed to
helping him during his illness.

I met Samuel while he was on the inpatient unit, having been admitted for pain control. The direction of therapy with Samuel moved from increasing self expression and self esteem to finishing unfinished business and providing closure.

Samuel was aware of his diagnosis and prognosis though he did not discuss it. We had a total of nine sessions together, both at his home and on the inpatient unit. The early sessions were often very energetic and active, friends and family were often involved and we did much singing, playing and even some dancing. The session included in this study was the seventh session and occurred when Samuel was on the inpatient unit. He was much weaker, less responsive, and had no visitors at that time. The final two sessions with Samuel were conducted on the inpatient unit. The last of these done with Samuel, his niece and a close friend on the day before Samuel died.

Session 2 Ricky

Ricky was a 52 year old man with AIDS which was diagnosed two years prior to his hospice admission. Initially he had received chemotherapy, but when he showed little response to it refused any further medical intervention. Ricky had no family listed in his hospice chart and only one friend who was minimally
involved with his care. He had a 24 hour private nurse who cared for him in his Manhattan apartment.

Ricky was unable to communicate verbally due to his disease process (toxoplasmosis) and was referred for music therapy by the social worker. The direction of therapy was on increasing self expression and self esteem. The session included here was the third out of seven, all of which took place in Ricky’s apartment. Ricky died at home and in the last two sessions we did no music; I simply sat and held his hand.

Session 3 Pat

Pat was a 64 year old woman with metastatic breast cancer which was diagnosed three years prior to her hospice admission. She had received chemotherapy but had steadily deteriorated. Pat had never married and was being cared for by her sister who was visiting from Puerto Rico. She spoke primarily Spanish, but did use some English.

The direction of therapy centered on reducing her perception of pain, reducing anxiety, and increasing self expression.

The session included here is the fifth out of a total of six, all of which were conducted on the inpatient unit. Pain control continued to be an issue for Pat though the hospice team tried very hard to keep her comfortable. Pat died on the inpatient unit.
Session 4 Alice

Alice was a 47 year old woman with metastatic breast cancer which had been diagnosed five years prior to her hospice admission. Though initially she had good results from the chemotherapy, in the more recent months there had been a slow but steady deterioration in her physical condition.

Alice was a very active and engaging woman who had worked as an actress and had been a director for a children’s theatre in New York City. Alice lived alone though her mother had moved to New York from California to help care for her during her illness. Alice also had many friends involved in her care.

Alice knew her diagnosis and prognosis and discussed this openly. She was referred for music therapy by the social worker at hospice who felt that Alice’s previous connection to music might help strengthen her ability to cope with her terminal illness. The direction of therapy focused on this, though the session included here, which was conducted at her home, was our only session. Alice began to deteriorate very rapidly within a week of this session and she died on the hospice inpatient unit with her mother and several friends at her side.

Session 5 James and Sara

James was a 54 year old man who was diagnosed with
a brain tumor four years prior to his admission to the hospice program. He had received active treatment for his disease during those four years. James was an artist and his wife Sara a psychotherapist. They had one adult daughter as well as many close friends and relatives involved in his care.

James and Sara were very open and honest about discussing his diagnosis and prognosis and shared many thoughts and feelings about their internal process of facing his illness and impending death. They were referred to music therapy as both had an interest in music and enjoyed creative expression through the arts. James and Sara were seen for a total of 20 sessions, most of which took place in their apartment. The direction of therapy focused primarily on increasing self expression, increasing appropriate coping and providing a sense of closure. The session included here is number ten.

James died at home. At Sara’s request she and I sang several of the songs we had done in the sessions at the Memorial service for James. I maintained contact with Sara throughout her bereavement process.

Session 6 Arthur

Arthur was a 56 year old man with a brain tumor which was diagnosed one year prior to his hospice admission. He had initially refused treatment, hoping
to cure himself through exercise and diet. Arthur lived alone and had never married though he did have a niece who lived nearby and visited frequently. He had a 24 hour private nurse to aid in his home care.

Arthur was very active and had enjoyed travel a great deal prior to his illness. He knew his diagnosis and prognosis and discussed this, though he still held out some hope for remission.

Arthur was referred for music therapy by the social worker to aid in self expression as his brain tumor made verbal communication somewhat difficult. The direction of therapy focused initially on providing means of self expression and increasing self esteem and later moved to providing support and closure.

The session included here is the third out of a total of fifteen, most of which were conducted in Arthur’s apartment. Arthur died on the hospice inpatient unit.

Session 7 Marilyn

Marilyn was a 45 year old woman with AIDS which had been diagnosed one year prior to her hospice admission. She had contracted this from her husband who had died in the previous year, also from AIDS. She had three daughters and several grandchildren who were minimally involved.

Marilyn was only on the hospice program for two
days and was referred for music therapy by the nursing staff as she was very close to death and her family was unable to stay with her. Consequently, the session included here was the only one conducted and the focus of the session was simply to provide support and closure. Marilyn died on the inpatient unit on the day after this session.

**Session 8 Roy**

Roy was a 66 year old man with cervical node cancer diagnosed ten years prior to his admission to the hospice program. He had initially responded well to treatment but when complaints of weakness and fatigue required a further medical work-up, metastatic disease was revealed. Roy was a very outspoken, independent man whose wife, an artist and teacher, was very committed to caring for him at home. They had no children or family nearby.

Roy was referred for music therapy by the social worker as he had been a musician and craftsman of musical instruments. The direction of therapy was to increase self esteem and self expression.

The session included here is the second of a total of four, all of which were held in his apartment. Roy died at home with his wife at his side.
Session 9 Sadie

Sadie was a 67 year old woman with a diagnosis of cancer of the appendix which was discovered two years prior to her admission to hospice. At the time she was admitted Sadie had greatly deteriorated. She was only on the hospice program for one week, all of which was spent on the inpatient unit. Sadie was married and had children though her family was minimally involved.

Sadie was referred for music therapy by the nursing staff as she was close to death and did not have much family support. The direction of therapy focused primarily on providing closure and decreasing anxiety through providing a connection in the music to Sadie’s strong sense of spirituality.

The session included here is the second of a total of three. Sadie died on the inpatient unit at hospice.

Session 10 Essie

Essie was a 70 year old woman with cancer of the larynx which had been diagnosed three years prior to her hospice admission. Essie was married and had several children though they all lived out of state. Essie was outgoing and assertive and though she could speak only in a whisper due to her tracheotomy, she was perfectly capable of making her exact wishes known.

Essie referred herself for music therapy after hearing me work with the previous patient (Session 9
Sadie) in the bed next to Essie. The focus of the therapy centered on increasing her self expression.

The session included here is the only one that took place with Essie as she was discharged home the following day and died there two weeks later.

**Discussion of participants**

From these introductory descriptions a summary of characteristics can be provided. This is done to simply validate for the researcher that these sessions studied are reflective of the lived experience of music therapy at Carlini Hospice. This is not meant to be a statistical analysis but rather a general overview of participants.

A total of ten sessions were conducted with a total of eleven participants in addition to the researcher. Five sessions were with female patients, four with male and one session was with a couple. Of those participating nine were white, one black and one Hispanic. Religious affiliation included four Protestant, four Catholic and three Jewish participants.

The primary diagnosis included two patients with cancer of the breast, two with cancer of the brain, two with a diagnosis of AIDS, one each with cancer of the prostate, larynx, appendix and colon. The ages of participants ranged from 47 to 82 years old with the
average age being 61.

The session sequence for each patient can also be summarized.

Session Sequence:

Pt. 1 (Samuel) - 7th session of 9
Pt. 2 (Ricky) - 3rd session of 7
Pt. 3 (Pat) - 5th session of 6
Pt. 4 (Alice) - 1st session of 1
Pt. 5 (James and Sara) - 10th session of 20
Pt. 6 (Arthur) - 3rd Session of 15
Pt. 7 (Marilyn) - 1st session of 1
Pt. 8 (Roy) - 2nd Session of 4
Pt. 9 (Sadie) - 2nd Session of 3
Pt. 10 (Essie) - 1st session of 1

Total number of sessions conducted with each patient varied from a total of one to twenty sessions, with the following breakdown:

3 - 1 session (Alice, Marilyn, Essie)
1 - 3 sessions (Sadie)
1 - 4 sessions (Roy)
1 - 6 sessions (Pat)
1 - 7 sessions (Ricky)
1 - 9 sessions (Samuel)
1 - 15 sessions (Arthur)
1 - 20 sessions (James and Sara)

The following session sequence indicates that most frequently there were three or fewer sessions.

1st session - 3 clients (Alice, Marilyn, Essie)
2nd session - 2 clients (Roy, Sadie)
3rd session - 2 clients (Ricky, Arthur)
5th session - 1 client (Pat)
7th session - 1 client (Samuel)
10th session - 1 client (James and Sara)

The range of session sequence is wide and reveals diversity of time of working with each patient.

Another observation to be made is of the actual instruments used in the session and specifically who
used the instruments, therapist or patient.

Instruments: (Therapist) (Patient)

Pt. 1 Samuel - guitar and voice -
Pt. 2 Ricky - guitar, voice -
chimes
Pt. 3 Pat - guitar, voice, voice,
casio, omnichord omnichord
Pt. 4 Alice - piano voice
Pt. 5 James - guitar, voice voice
Sara - guitar
Pt. 6 Arthur - guitar and voice voice, percuss.
Pt. 7 Marilyn - guitar and voice -
Pt. 8 Roy - ukelele, guitar ukelele
Pt. 9 Sadie - casio and voice -
Pt. 10 Essie - casio and voice voice

Written another way we see the distribution of instruments between therapist and patient.

Guitar-Voice-Casio-Ukelele-Omnichord-Piano-Perc.

Th. 6 8 3 1 1 1 1
Pt. 1 6 0 1 1 0 1

The level of participation is also important to note. Below is a continuum showing each patient’s participation.

<table>
<thead>
<tr>
<th>Very Passive</th>
<th>Moderately Passive</th>
<th>Moderately Active/passive</th>
<th>Moderately Active</th>
<th>Very Active</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marilyn</td>
<td>Sadie</td>
<td>Essie</td>
<td>Arthur</td>
<td>Alice</td>
</tr>
<tr>
<td>Ricky</td>
<td>Pat</td>
<td>James</td>
<td>James</td>
<td>Sara</td>
</tr>
<tr>
<td>Samuel</td>
<td>Roy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The researcher’s clinical experience confirms that the data collected represents the clinical music therapy at Cabrini Hospice. Both male and female patients are seen and ages and diagnoses of patients
are varied. Because of their advanced illness patients are often seen for fewer sessions, (three or less) though occasionally longer term work (ten or more) does occur. Patients most often participate by using their voice, which is often the least taxing physically, but participation varies, and some patients use other instruments, especially percussion. Clinical experience indicates that most patients fall in the moderately passive to moderately active/passive category. Only occasionally do patients participate at the very active or very passive ends of the continuum.
CHAPTER V
RESULTS OF THE STUDY

The second step of the research method utilized was one of reflecting on the data collected in an effort to reveal or allow the essences of the experience of music therapy with the terminally ill to emerge. This process involved a reflection on the three components of each session: the session transcript; the therapist's process note; and the audiotape. While doing this reflection notes were made by the researcher in the margins of the session transcript and the therapist's process note, and on a blank sheet of paper for the audiotape. These notations were the "meaning units" (Giorgi, 1975, p. 75) that then formed the basis for translation into essences.

At this level the essences that emerged were specific to the session being studied. One session revealed a patient's personal or internal struggle in coming to terms with their illness. Another session focused on a patient's relationship to family members, friends and to the therapist. One session demonstrated a particularly powerful direct expression of feelings in words and music, while another revealed music as a vehicle for thoughts and feelings.

After all data were analyzed in this manner and
these session-specific essences revealed, the researcher's task was to do a second reflection. This level of reflection was on the essences that had emerged in an attempt to synthesize them into groups or categories. This second level of reflection was done to obtain a sense of the general essential structures of the music therapy experience which would lead to a description of the music therapy experience.

In this reflective process the researcher found that three general groups of essences emerged. They are: Relationship; Music; and Process. The unique nature of each session is not lost while synthesizing the essences into groups. The following discussion will highlight both uniqueness of each session and will show the session-specific essences which were synthesized into the three general groups.

In keeping with the idea stated earlier of the "unfolding of the phenomenon" (Giorgi, 1975, p.72) the reader will be first presented with excerpts from each of the ten sessions in which the essences emerged. A discussion of the essences will take place after the excerpts are presented. In this way the reader can follow the researcher's process in uncovering the essences as well as synthesizing them into the general groups.
**Essence of Relationship**

Relationship takes many forms in these sessions. In the Session 1 (Samuel) there was a strong sense of the presence of the relationship between therapist and patient that had evolved during the preceding sessions. This session took place near the end of the therapist-patient relationship, only a few days before Samuel died. As therapist, I felt very connected to Samuel and felt this connection was the basis for the establishment of trust which allowed Samuel to let me be with him at this intimate time. This was especially significant in light of Samuel’s independent personality which often precluded anyone helping or being there for him.

**Session Transcript**

M: is there anything in particular we should start with today?  
S: The sound of your voice.  
M : Oh-h. (Silence then M sings)

"It had to be you, it had to be you.  
I wandered around and  
Finally found somebody who  
Could make me be true,  
could make me feel blue  
And even be glad, just to be sad,  
Thinking of you..."  
Jones and Kahn, 1924).

Later in the session S opens his eyes.  
M: I’m sending you off to sleep aren’t I?  
S: Yes, it’s wonderful.

---

3 IT HAD TO BE YOU (Isham Jones, Gus Kahn) © 1924 Warner Bros. Inc. (renewed) All Rights Reserved. Used By Permission
The therapist reflected this relationship by choosing music with lyrics that expressed relatedness and acceptance. Samuel said very little during the session but one of the few statements that he did make indicated his sense of relatedness to the experience. When asked what he wanted to hear he replied simply "The sound of your voice."

In the Session 2 (Ricky) there was again the strong sense of relationship between therapist and patient. Several times during the session Ricky, who had great difficulty speaking, reached out to hold the therapist’s hand and simply murmured "Oh" or "wonderful." Ricky maintained eye contact throughout the session and seemed very engaged in this contact. This also seems significant in that Ricky had no family and only one other person involved in his life at this time.

Process Note

"I feel a very strong connection to Ricky in the music. I feel that we communicate clearly, though few words are actually spoken. He watches me intently throughout the session with a very wide open expression on his face. I feel that he is drinking in the contact from our time together."

"He responds by watching me and when the song is over he groans "Oh..." and takes my hand. He squeezes it and looks into my eyes. There is no turning away from Ricky. He is so present and so there."

In addition this session also offers another aspect of the essence of relationship. There is the
sense of the relating of Ricky to his pre-illness life which is shown in his choice of music. The one song that Ricky chose in our sessions was "The Way We Were" (Bergman and Hamlisch, 1973). It served as a contact song for us and was used at the beginning of most of our sessions together.

Process Note

"Memories, light the corners of my mind, Misty water color memories, of the way we were. Scattered pictures of the smiles we left behind Smiles we gave to one another For the way were.

Can it be it was all so simple then? Or has time rewritten every line? If we had the chance to do it all again, Tell me would we, could we?

Memories, may be beautiful and yet, What's too painful to remember, We simply chose to forget. So it's the laughter, we will remember Whenever we remember, the way we were. The way we were" (Bergman and Hamlisch, 1973) 4

This sense of evoking memories is reflected by the therapist, both verbally and in other music used in the session.

Though it is impossible to completely clarify what memories were being evoked for Ricky in the session or what his reaction to these memories was, it was a significant part of the music therapy experience. The potential beauty of music therapy is present here in

4 THE WAY WE WERE (Alan and Marilyn Bergman, Marvin Hamlisch) © 1973 COLGEMS-EMI MUSIC INC. All Rights Reserved. Used By Permission
that the therapeutic work takes place on a symbolic level. The power of music therapy is coupled with a sense of mystery.

Session 3 (Pat) expresses relationship in a very present and obvious manner. The relationship centered on the therapist and patient in the here and now. Pat spoke primarily Spanish and due to her disease process was intermittently confused, thus making verbal communication quite difficult. Pat was also very weak at the time of the session, yet the musical improvisations served as a means of connecting in the here and now in a manner that was accessible to Pat.

Process Note

"I bring out the omnichord as in the past Pat has actively participated on this instrument. She seems so weak that I am not sure she will do it today. Yet when I play that first chord, she looks directly at me, smiles and reaches for it. We play together for some time. Pat seems to come in and out of awareness while doing this. At times she is very engaged and then in mid-strum she simply slows down or stops. Sometimes I gently assist with hand over hand while at other times I begin to play and this re-engages her."

The essence of Relationship with Alice (Session 4) is different in that it primarily focuses on Alice’s explorations and expression of her relationship to herself at this time. Alice explored the changes that had occurred in her life since her diagnosis and how these changes are evident in her present musical limitations in the session.
Session Transcript

After singing "Look to the Rainbow" (Harburg & Lane, 1946).
A: It (the cancer) is all in my lungs now. It's a spray across.
M: Is it painful?
A: No, it is just that there is no wind there. I have no control. But it just feels so good to do it. I have the feeling that part of it is simply just disuse. But if we could meet once or twice..

After singing a section of "Belle nuit" (Offenbach, 1936).
A: Oh, I just can't. Normally I can sing it effortlessly. It's actually low in my natural tessitura, but I guess in my cancer tessitura it's not.

She also chose music from her theatrical career which seemed to provide for a symbolic exploration of issues surrounding her illness. In this symbolic exploration, the focus of relationship seemed to be of an inner nature. Alice seemed to be exploring the differences between her present self as terminally ill and her pre-illness physically healthy self.

One example of this is a Christmas song entitled "Are My Ears On Straight?" (Levin, 1953). This song is sung from the perspective of a doll who has been dropped and broken by her young owner. The doll is asking the dollmaker to repair her and make her well enough to go home on Christmas Day.

James and Sara, in Session 5, show several different dimensions of Relationship. (Chapter VI explores this session in depth.) An obvious one is between the patient and his wife in the here and now. They openly shared their feelings with each other both
verbally and symbolically in the music. Their relationship was strong. They supported each other’s expression of feelings of anger and sadness as they evolved in both musical improvisation and in Sara’s singing to James.

Also evident is the relationship of the patient and his wife to their past and their early years together. The music they chose throughout the session was primarily from the 1960’s when they met. The music seemed to take them back to that time in their lives and helped to strengthen their bond as husband and wife.

The relationship of the couple to the therapist was also present. The session included here is the tenth session and the depth of exploration that occurs in this session and their ability to express deep feelings indicates a level of trust had been attained.

Session 6 (Arthur) is similar to Session 4 in the essence of relationship. In this session Arthur was exploring the relationship of his present life to his pre-illness life. Arthur had been a strong, physically active man who appeared to be wrestling with his loss of strength and stamina from his illness. Arthur explored this relationship through very direct attempts in the session to improve his verbal skills. The session centered around Arthur’s musical accomplishments. Through musical call and response
both in percussion rhythms and vocal lyrics he strove to echo phrases and music correctly and explored his present abilities.

The session transcript highlights this issue of succeeding and getting better.

Session Transcript

After singing "Summertime" (Gershwin, 1935).
A: Good! We are getting better.
M: Yeah, we are aren’t we?
A: I have some good days...
M: Uh huh. Some that are better than others?
A: Yeah.
M: And what is this day? Is this a good one or...
A: It’s a good day!

Though in this stage of our work together Arthur often succeeded, he did maintain a sense of humor about his less successful attempts.

Session Transcript

M and A in responsive singing of "On Top of Old Smokey" (Public Domain).
M: On top of old Smokey
A: On top of old Smokey
M: All covered with snow
A: On top of old snow...Smokey...all covered with snow.
M: I lost my true lover
A: I lost...(Spoken) I lost a few words!
(A and M laugh)

The session served as a place for exploration of his sense of self and abilities.

Marilyn, in Session 7, was a patient who was actively dying at the time of the session. She was unresponsive, breathing in a rapid and shallow manner, her eyes were open, but she did not seem to see.
Though she did not respond to her name being called, she would moan when the nurses positioned her. As therapist, I had gone in to simply be with her and provide support for her as Marilyn's family was unable to stay on the hospice unit with her. The process note reflects the therapist's attempt to sense a relationship either between the therapist and patient or between the patient and some aspect of her life. This attempt at connecting or relating in the present moment seemed unsuccessful.

Process Note

"I begin to improvise, basing the rhythm of my music on her breathing, using a simple chord progression. I use "ah" and "oo" sounds. At this point I am really looking to connect with her. To make some kind of contact with her, or to let her know that I am here. I don't feel that I achieve it."

This changes somewhat as the session progresses.

Process Note

"After a brief silence I improvise a rocking rhythm in common time alternating between two major seventh chords. I continue to vocalize in rhythm on "oo" sounds. I feel at this point that my intention changes. I had been offering the music as an opportunity for Marilyn to perhaps let go a little. Yet after this improvisation I feel that I want to support Marilyn where she is rather than try to move her."

In Session 8 (Roy) there were again several relationships present. The first and most obvious was the relationship of Roy to his life prior to his illness when he had been a musician and craftsman of
musical instruments. This essence of relationship is similar to that of both Session 4 and 6.

Due to the progression of his illness Roy was somewhat confused and could stay focused on a particular subject for only a short period of time. There was little actual music in this session; the therapist and patient both hold and occasionally strummed instruments that Roy had rebuilt.

Session Transcript

(Referring to a Martin Ukelele that Roy worked on)
R: Well that has the...it has the antique quality.
M: Right. And if you've had it for a while...
R: It is a good quality.
M: Uh huh. I would assume if you've had this one for a while, it must have some memories attached to it.
R: More than you know.
M: More than I know. (R showing instrument)
R: The uh...the edges of this along here...the fact that they don't scratch anymore. I had to use a fingernail file.
M: So you filed it down to make it smooth.
R: To bring it down to where it would be usable. Uh...without losing the sound. You still want to play it.
M: So you want to keep the sound.

Roy's expertise as a craftsman was a significant part of his life. Additionally we took the roles of teacher and student in the session. Roy instructed me and related to me as a person to whom he was passing some of his musical knowledge. As I knew very little about ukeleles I played this role well.

Audiotape

"Roy seems to be the teacher, sharing knowledge of music and especially of instruments with the
therapist as the student. He also refers to his
teacher and mentor further setting up the teacher-
student relationship."

Session 9 (Sadie) focused on the relationship
between the patient and her concept of spirituality.

In the previous session with Sadie she had
requested spirituals and this music seemed to
strengthen her in an inner way and help reduce her
perception of her pain. At the time of this session
she had deteriorated considerably and appeared very
close to death. I mentioned several spirituals and she
nodded yes to "Nobody Knows the Trouble I’ve Seen"
(Public Domain). Later in the session she complained
of pain and I focused a simple improvisation of
"Standing in the Need of Prayer" (Public Domain) on
asking God for comfort and relief.

Session Transcript

(M singing)
"It’s me, it’s me, it’s me, Oh Lord.
Standing in the need of comfort
It’s me, it’s me, it’s me, Oh Lord.
Standing in the need of comfort"
(Public Domain).

Sadie appeared to rest peacefully at the end of
the session.

Session 10 (Essie) reveals two Relationships; the
first related Essie to her feelings at the moment and
the second focused on Essie’s relationship to her
caregivers on the hospice staff. Essie had a
tracheotomy so speaking was difficult and done only in
a whisper, though she was able to communicate effectively.

She began by requesting "Sometimes I feel like a Motherless child" (Public Domain). After a verse of this I asked Essie to substitute a word for "motherless" that reflected how she was feeling. She chose "sorrowful" and we sang several verses of this. After this she requested that we improvise a song about her primary nurse on the unit, Marie, who was attending to the patient in the adjacent bed. I began with the chorus.

Session Transcript

(M singing)
"Marie, Marie is Essie's nurse
She comes when she's called.
Marie, Marie is Essie's nurse
She comes when she's called."
M: (Spoken) what else does she do? Does she give you a shot?
(E mimes taking pills)
M: Oh she gives you pills.
(sung)
Marie brings pills for me,
Marie, Marie, Marie.
Marie brings pills for me,
Marie, Marie, Marie.
M: (Spoken) What else does she do?
Marie: I suction her.
E: (nods yes and makes a face)
M: Oh you hate that!
E: (Nods yes)
M: (Sung)
"Sometimes she does things I just don't like.
Sometimes she does things I just don't like. But Marie is Essie's nurse,
Marie, Marie, Marie.
Marie is Essie's nurse,
She comes when she's called."
E: (Whispered) I want to get well fast so I can be her helper.
Essie explored her relationship to her own feelings as well as her relationship with others.

**Discussion of Relationship**

It is apparent from these sessions that the essence of Relationship can take many forms. Prior to this research I would have thought that it was always the relationship between the therapist and the patient, or between the patient and a family member. Upon this closer examination it appears that the relationship can be much more complex. At times it was an inner relationship; the relating of the patients as they are now to some aspect of themselves. This aspect was usually from their pre-illness life. It is my strong sense that this exploration and expression allowed these patients to identify with their strengths and abilities. This positive identification and strengthening of self esteem hopefully improved their ability to cope with facing a terminal illness.

**Essence of Music**

Certainly this essence seemed obvious from the outset of this project but again it unfolds somewhat differently than one might have expected. In Session 1 (Samuel) the music was quiet and gentle, it filled the environment and provided a sense of
atmospheric cushioning.

Audiotape

"The music is easy and mellow, the vocal tones are long and full. There is a sense of rocking that creates a trance-like feeling. Though outside car horns and street sounds drift in, the music seems to soften these while it fills the environment. There is also the message in the lyrics of support and acceptance for things as they are in the moment."

The music seemed to create a space, an enviroment in which therapist and patient were together. In this session the music seemed most important and in fact music might have been one of the only possible ways in which to allow the therapist and patient to be together.

In Session 2 with Ricky the music served a more active purpose of communicating. Ricky requested the song "The Way We Were" (Bergman and Hamlisch, 1973) and related strongly to this. The therapist used music to convey messages and explore meaning.

Transcript

M: I have a song to share with you. Last week we were talking and a lot of the songs we did were about meaning, what's meaningful, what's beautiful and what is important in each of us. This song has that same message in it.

(Sung)
"Oh the dolphins and the mermaids
They'll be coming here tonight.
For they know quite well
That you've been feeling bad.
They've been listening to the seashells, They've been talking to the waves.
And they understand the things
That make you sad.
And they'll tell you they are different,
But they don't even care.
The things that matter,
Aren't the things we see.
It's what we have inside us,
The mermaids you and me,
And the dolphins swimming
deep beneath the sea"  
(Lonnquist, 1986).  

The reflection on the audiotape also shows
this use of music for communication and exploration
of meaning.

Audiotape

"Music is used to reflect the situation. There is
a sense of exploration and communication in the
music."

For Pat in Session 3 the music again served as a
means of communication and expression. The music
engaged her and drew her into the experience. The
music that Pat most strongly responded to was Christmas
music and we used this almost exclusively even though
the session took place in September.

Audiotape

"The music is used to engage Pat. She interacts
primarily on this musical level. There is a
sharing and communication of togetherness in the
musical improvisations."

This observation is also present in the process
note.

5 THE DOLPHINS AND THE MERMAIDS (Ken Lonnquist)
© 1986 KEN LONNQUIST. All Rights Reserved. Used By
Permission
Process Note

"Pat's face often lights up while she is playing (the omnichord) and it seems that the actual act of creating music seems to bring her much joy."

The music in Session 4 (Alice) was a very strong force. Alice sang throughout the session while as therapist I accompanied on the piano.

Audiotape

"Alice's voice is beautiful and there is such a joyous connection in the music. The lyrics of these songs which are obviously familiar to Alice provide a sense of symbolically processing the issues surrounding her present illness."

The music enabled Alice to express feelings of both frustration with her limits, as well as apparent sadness.

Session Transcript

(A singing, M playing piano)
"Our private world is like a play about a pair of lovers. The plot says only we may enter and only we may share the light of love stage center.

Our private world is sweet like this, complete like this. Far beyond the throng, sure and strong We belong together. You opposite me..."
(Coleman, Comden and Grover, 1978) 6

(A begins to cry and M extends her arms to her. A takes a moment and then says: Let 's try it again. The song is half sung and half cried this time through.)

It would again be somewhat presumptuous to make
an interpretation as to exactly what in this song was evoking these feelings of sadness, yet again the ability of the music to provide the opportunity for the expression of these feelings is crucial to the experience.

The music in Session 5 (James and Sara) reveals several musical moods and dynamics. It was also a very musically active session. There was much singing by the three of us while Sara and I played guitars in the session. The music used was both precomposed as well as improvised and provided for an expression of feelings. This expression begins with anger which emerged during the first song of the session. This expression of anger was then more deeply explored through musical improvisation. Once the feeling of anger was fully explored and expressed, a second level of feeling emerged in the music. This feeling was one of sadness and loss and was first explored symbolically in the music. This symbolic expression was then explored consciously and directly by the patient’s wife.

Music as communication was again the theme in Session 6 (Arthur). In this session Arthur began with a spontaneous improvisation on the caxixi shaker that I handed him. I joined on the guitar.

Process Note

"I hand him the caxixi shaker and he immediately
begins playing very rhythmically. Without saying a word I follow his lead and begin strumming the guitar. I add vocal sounds and he follows my lead. We do some antiphonal singing. I notice that the longer phrases seem difficult for him to repeat, so I shorten the phrases. We continue in this way for some time, maintaining eye contact."

The reflection on the audiotape reveals a sense of the music being used to help Arthur practice his verbal communication.

Audiotape

"Arthur works hard in this session to correctly echo the lyrics. The music itself sounds somewhat forced in these attempts. Echoing the phrases correctly seemed to be most important."

The music in Session 7 (Marilyn) revealed a musical matching of the patient’s participation in the session. Marilyn was in a very physically deteriorated condition at the time of the session. The therapist matched Marilyn’s breathing in a clinical musical improvisation.

Process Note

"I spend a few moments sitting with Marilyn, just to get a sense of how it feels to be in the room with her. I watch her breathing and begin to breathe with her. I notice how regular and sharp her breaths are. The oxygen machine provides a continuous hum in contrast to her rapid and shallow breaths. I begin to improvise, basing the rhythm of my music on her breathing, using a simple chord progression. Vocally I use "ah" and "oo" sounds."

In Session 8 (Roy) the essence of music refers to both music that was actually played in the session as well as to the idea of music and the memories of the
music from the patient's past. Ukeleles that the patient had rebuilt were held by therapist and patient and occasionally strummed as background sounds.

Process Note

"Throughout our verbal dialogues are bits of music. Either Roy begins to strum the small uke or I do. In both events the other begins to echo. It feels like a musical dialogue underlying our verbal exchange."

"Our musical dialogue is one of echoing. If Roy starts I simply watch his fingers and echo his melody or chord. Today's session is only my second attempt at playing the uke so I watch him carefully. When I begin to play it seems to reach him immediately and he strums or plucks the strings."

The presence of music as a memory seemed significant to this session. Throughout the session Roy shared memories of the time he spent playing music and rebuilding instruments.

Session Transcript

M: Did you work on these? (referring to the ukeleles)
R: I worked a little bit. But I put the thing back together again, when it fell apart and broke. I had to figure out how to make it go back into themselves.
M: So you learned about it by putting it back together. It looks like it is in really good shape, you showed me where you had the clamps...
R: The clamps...let's see that (reaches for ukelele) The cheaper they are the heavier they are going to be at this end. (Indicating the balance of the instrument.) It is exceptional. It is so far beyond good.

The essence of music here is music as remembered, as well as music as a direct presence.

In Session 9 (Sadie) the music took a supportive
role. This patient was very close to death and the music served to provide a structure for her spiritual beliefs which were important to her as well as to provide a sense of filling the environment with soothing sounds; perhaps alleviating some of her physical discomfort.

Process Note

"I address the music to the task, to see if I can help her to be more comfortable. The rest of the session is really focused on this goal. I choose "Standing in the Need of Prayer" (Public Domain) to express what she seems to need at this time. I can tell during this that she is beginning to relax. Her facial muscles slacken and her eyes begin to close."

Session 10 (Essie) used both precomposed music as well as improvisation. The music helped Essie to express her feelings in the session. Due to her tracheotomy she had difficulty speaking above a whisper though she did sing along and substituted words in the song for me to sing.

Transcript

E has requested "Sometimes I Feel Like A Motherless Child" (Public Domain) and after one verse M while continuing to strum, asks:
M: Essie, is there another word that we can put in this song? Sometimes I feel so...?
E: Sorrowful
M: OK
M sings a verse using this word.

The songwriting improvisation in this session mentioned earlier, in which we sang about Essie's nurse, also exemplifies the use of music to more fully
explore Essie's feelings toward the hospice staff.

Discussion of Music

It is obvious from these examples that the music is unique to each patient. It occurs in many different styles: popular music of the 1900s to the present; classical; religious; and Christmas. It occurs as well in many different moods: anger; sadness; support; and questioning. One of the major functions of music seemed to be the ability of the music, or rather the ability of the patient and therapist to use music, to express feelings and thoughts in a symbolic manner. This symbolic expression appears to be less threatening and at times is more accessible to the patient than a direct confrontation of the feelings. It also lays the groundwork for possible insight into these feelings when the patient is ready.

The presence of music as a dynamic force reaching the patient and therapist is essential. Dynamic here is used to imply a moving, vital force in the music. The music is an entity that engages. It is a catalyst that moves, draws patient and therapist in, and provides a structure in which they can express themselves.

It is evident from these sessions that no one style of music is appropriate. There certainly does not appear to be music that is "correct" to use at any
particular time. The music is unique to the patient and situation. The music is a creation in the moment.

**Essence of Process**

The term process has wide application in the field of therapy. It is most often meant to refer to

the relationship implications of interpersonal transactions" . . . specifically the "'how' and the 'why' of the patient's utterance, especially insofar as the 'how' and 'why' illuminate some aspects of the patient's relationship to others with whom he is interacting (Yalom, 1975, p. 122).

Progoff (1988) uses the term "hypothesis of process" (p.42) to refer to the means by which "something elusive becomes graspable and knowable" (p.42). He goes further in saying that this will allow

us to draw together large amounts of subjective and intangible material while still in their living movement. It is moving, but we perceive its motion and we can relate our inner awareness to the form and vitality of its movement (Progoff, 1988, p.42).

It is this description which most closely reflects the following use of the term process.

In Session 1 with Samuel was a process of reflection, of summing up and bringing to a close both the relationship between therapist and patient and bringing closure to this patient's life.

Process note

"In the silence (that followed the music) I was
just reflecting on the time that Samuel and I had spent together over the past month. For knowing him a short time I felt strongly connected to him. There was a sense of peace in this session as I sat and thought of Samuel and what I knew of his life. His style, caringness and his uniqueness as a human were very clear to me. I was thankful for knowing him."

In Session 2 with Ricky the sense of process was a sense of us being there, together in the moment, in a very present way. The process was the creation of a fully alive moment of being together.

Process note

"He responds to the song with his open gaze. I feel like it doesn't matter what I am singing as much as it matters that I am being there in a very real way with him. I feel very present and not like I am really trying to do anything, just sing. He points to my guitar. I wonder what it is about the music that lets us be there in this way with each other. I have little to say in words to Ricky, but the feeling that we are deeply communicating is definitely there. I play another tune from last session and as soon as I finish he points again to my guitar. It feels good to be doing this with Ricky. I reflect to him the connection I feel to him and the music and I say that I also see his connection too. He nods and I wonder why I bothered to say it. It is obvious. The silences feel peaceful to me."

Session 3 with Pat also demonstrates this essence of process. The music therapy sessions seemed to allow Pat to be fully herself. Throughout the process note on this session I refer to Pat as someone who likes people, likes to be active and engaged in interacting with others. This active personality was coupled with a body that was severely debilitated from disease. The process is one of interacting and relating.
Process note

"Pat is quite striking to see. She is so thin. Her skin is drawn tight over her face and when I enter the room she seems to be asleep. I don’t really think it is sleep but it is that distant place that she goes with her eyes open but looking absentmly ahead and not seeming to be aware of her surroundings. I am always surprised when she does come back to this level of awareness. She seems so far away, I wonder if she can come back. Her illness has weakened her considerably and made interaction difficult, but she clearly prefers to be active."

The session provided Pat with interaction on an accessible level. It allowed her to be heard and for her to receive a response to her interaction.

Session Transcript

Pat reaches for the omnichord and strums.
M begins humming "Silent Night" (Mohr & Gruber, 1964).
M: Pat do you want to play with me?
P: Yes
(Music begins)
M: It sounds good, Pat.
P: Yeah.
(music continues)
M: Pat that sounds really nice.
(Pat smiles)
M: I see by your smile that you like it too.
P: Bonito!
M: Bonito, Si!

At the end of the session, Helene, the Hospice Nursing Care Coordinator entered the room and we performed Pat’s favorite song for her. Pat seems to be really engaged in hearing Helene and I do "Ave Maria" (Schubert, 1964). This too provided for the process of interacting.

In Session 4 with Alice the process was one of exploration. This was our first, and only session
together and Alice used the time to explore on many levels. First there was the exploration of her musical abilities and limits that had changed since her diagnosis of cancer. Second was the symbolic level of processing these changes through the use of music.

Process Note

"I have a sense in this session of Alice being a dam, that long held back, has finally burst. All these conscious and unconscious feelings are flowing out and finding expression."

Audiotape

"The music comes fast and furious. Alice moves quickly from one song to the next. The music is very beautiful. She seems to be exploring limits, possibilites, reality and hope both consciously and unconsciously."

The process in Session 5 (James and Sara) was one of exploring feelings of anger. This resulted in a catharsis and was followed by an exploration of another layer of feeling. This was explored first symbolically and gradually resulted in insight into her feelings.

In Session 6 with Arthur the process was one of accomplishment. Throughout the session Arthur was attempting to correctly echo phrascs of lyrics in the songs that we were singing.

Process Note

Arthur requests a Gershwin tune and I suggest "I Got Rhythm" (1930) to reflect our very rhythmic beginning. I sing a phrase and Arthur echoes me. If I leave a space for him he will repeat the phrases that I sing. He tries very hard to do this and if it is not "correct" the first time he
will try again. We sing several songs in this fashion. He will also use the caxixi shaker for added rhythm and I follow his beat. Arthur maintains a sense of humor and directness in our session while trying to achieve these accomplishments."

At this point in our work together Arthur was trying to improve his verbal skills and used the session to this end. In future sessions as he became weaker, the intention of our work also changed and allowed for expression that was not focused on this theme of accomplishment.

In Session 7 (Marilyn) the process seemed to be twofold. At first there was a sense of the therapist searching for a connection to the patient. This was followed by the sense of the therapist supporting the patient where she was, in a state very near death, but still holding onto life.

Process Note

"I play chord changes to "Perhaps Love" (Denver, 1981) in rhythm with her breathing. After one verse of using "ah" I sing the entire song. It feels soft and gentle to me, just being together. I see the note attached to the side rail of the bed. It is handwritten and says:

'Your grandsons Tom and Jeff
Your son Keith
and your nieces and nephews
love you.'

I use this information for the final improvisation and I sing about these people who are sending their love to Marilyn and encourage her to feel this love being sent her way."

The process in this session began with the working through of my own need to help this patient let go and getting to a place where I could really support where
she was in the process of dying. The process then became our sharing this space on that fine line between life and death.

In Session 8 (Roy) the process emerged as a sense of sharing between patient and therapist. The teacher-student roles that were assumed have been referred to earlier and it was in these roles that the process occurs. Roy was regaining his sense of self through passing his knowledge of music and instruments on to me.

Process Note

"I have a real understanding and appreciation of Roy and his achievements."

Audiotape

"Roy seems to be the teacher, sharing knowledge of music and especially of instruments with the therapist as the student. He also refers to his teacher and mentor further setting up the teacher-student relationship."

Session 9 with Sadie was a process of seeking support and relief from physical suffering. There was a sense of using the session to connect Sadie to her belief in God and thereby increase her sense of comfort. This process was subtle. There is little dialogue yet the process was still very present.

Process Note

"I ask what she wants to do in today's session. She barely responds and I realize how much she has deteriorated since our last session... I choose the song "Standing In the Need of Prayer" (Public
Domain) to state what Sadie seems to need at this time. I can tell during this music that she begins to relax. Her facial muscles slacken and her eyes begin to close. I keep the improvisation going and change to the song "Kum Ba Yah" (Public Domain) and substitute verses that request peace and relief from suffering."

The process in Session 10 (Essie) was one of exploring feelings and then expressing these feelings. This was done very much in the music. It was also significant that this expression of feelings was done in an appropriate manner. Essie’s relationships to the hospice staff had not always been positive in nature and this goal of encouraging her appropriate expression of feelings had been an issue for all those involved in her care.

Process note

"Essie had responded to "Sometimes I feel like a Motherless Child" (Public Domain) so I continued with that. She responded by curling up in her bed and pulling the covers up around her chin. After I sang one verse I asked her what other word we could include. She chose sorrowful. I sang two verses with that word. When I asked for another word she nodded no."

"Essie responds to the songwriting and uses it fully. In addition she is able to use the song to express feelings toward her nurse in a positive manner. Marie, the nurse, is able to respond and also relate positively to Essie."

Discussion of Process

The process in these sessions varies greatly. At times it was a dynamic process of awareness and change.
It provided the patient or family member with insight and self understanding. The process was also subtle; it was the exploration of a single moment of existence for the patient. As seen in Session 7, process can also refer to the therapist’s process of insight and understanding of the events of the session. The reader can see that these essences are very connected and related. They are in fact dependent upon each other. The relationship is the basis for the unfolding process and the music is the vehicle for that unfolding.

**Description of Music Therapy with the Terminally Ill**

Step three of the method in this project called for an integration and synthesis of the essences yielded in step two into "a consistent description of the structure of" (Giorgi, 1975, p.75) music therapy with the terminally ill.

This was done by a process of re-reading the essences and reflecting on them while trying to capture those essences in a concise description. This description is a working definition of music therapy that will be further expanded upon in Chapter VII.

Music Therapy with the terminally ill is the dynamic process of a togetherness of patient and therapist. This togetherness takes place in the
present time but is not bound by it. Music therapy uses the dynamic movement of music to connect, relate and express. It is a creation in the moment of patient and therapist and what they bring of themselves to the moment using music as the vehicle for expression.
CHAPTER VI

CASE EXAMPLE

Step four in the method outlined was a returning to the original transcripts, process notes and audiotape to verify that the essences that emerged are grounded in the data. In doing this second reflection excerpts of one of the ten sessions will be shared in depth with the reader. What follows is the session transcript and the therapist’s note for Session 5. In the left margin of these components of the session are numbers. These numbers refer to the meaning units and essences which emerged from the data as described in step two of the method. They are listed and discussed at the end of this chapter.

James was a 52 year old man with a brain tumor that was diagnosed four years prior to his admission to the hospice program. James was an artist and he and his wife were amateur musicians who enjoyed playing music. James’ wife Sara was a psychotherapist.

This session is number ten out of a total of twenty sessions and took place in their apartment in Brooklyn. James was lying in the hospital bed as he experienced left sided weakness. Sara and I were
sitting at the side and foot of the bed and both of us were playing guitar. Prior to the beginning Sara and James mentioned a friend with whom they were upset because he was "too busy" cleaning his house to come visit.

Music Therapy Session Transcript

J: James
S: Sara
M: Michele

M: Ok. Shall we start with "When I'm Gone"? (Ochs, 1966). (M sets tempo on guitar with strum, S joins in on guitar.)

(sung)
"There's no place in this world,
I'll belong when I'm gone.
And I won't know the right from
The wrong when I'm gone.
And you won't find me singing
On this song when I'm gone.
So I guess I'll have to do it
While I'm here.
And I won't feel the flowing
of the time when I'm gone"
(Ochs, 1966).

1 J: (sings out loudly these improvised lyrics)

And I won't clean my closet at my home when I'm gone.

(J, S and M all laugh loudly)

2 M: (improvises these lyrics, J and S joining in)

3 And you won't go to play bridge when I'm gone.
So you'd better come and visit while I'm here.

(more laughter from all of us)

S: Bravo! (laughter)
M: That was great! (laughter)
(We all sing together as written)

"And I won’t breath the brandy air
When I’m gone.
And I can’t even worry ’bout my cares
When I’m gone.
Won’t be asked to do my share
When I’m gone.
So I guess I’ll have to do it
While I’m here"
(Ochs, 1966).

M: Should we make up another verse?

J: (to Sara) Go ahead.

S: No, you do it. You be the creative one.

I’m too busy trying to keep time.

J: Well start and I’ll see what I can do.

M: Ok.

S: And I’ll see if I can split my neurons

M: Ok

"I won’t be running from the rain
When I’m gone.
I can’t even suffer
(J sings) From the pain
when I’m gone.
There’s nothing I can lose or I can
Gain when I’m gone.
So I guess I’ll have to do it
While I’m here.

Won’t see the golden of the sun
When I’m gone.
The evenings and the mornings will be
One when I’m gone.
Can’t be singing louder than the guns
When I’m gone.
So I guess I’ll have to do it
While I’m here.

My days won’t be dances of delight
When I’m gone
The sands will be shifting from my
Sight when I’m gone.
Can’t add my name into the fight
When I'm gone.
So I guess I'll have to do it
While I'm here.
I won't be laughing at the lies
when I'm gone" (Ochs, 1966).
(S improvises)

I'll be playing bridge instead,
when I'm gone.
(as written)
"Can't live proud enough to die
When I'm gone.
So I guess I'll have to do it
While I'm here"
(Ochs, 1966).  

J: What was that last one?

Can't live proud enough to die,
when I'm gone?

J: Can't live proud enough to die,
when he's gone?

M: Um humm.

S: What a line.

M: let's do the first verse again.
(every one sings out together)
"There's no place in this world
I'll belong when I'm gone.
And I won't know the right
From the wrong when I'm gone.

You won't find me singing
On this song when I'm gone.
So I guess I'll have to do it
While I'm here"
(Ochs, 1966).  

J: Bravo! That is such a great song!

^{7} WHEN I'M GONE (Phil Ochs) © 1971 BARRICADE MUSIC, INC. Administered by ALMO MUSIC, INC. All Rights Reserved. International Copyright Secured
M: That is a great song.
S: Betty said something interesting about this about this song. You know he (Phil Ochs Ochs) committed suicide.
M: Um hum.
S: She wondered about that and this song.
J: I wonder if he commited suicide. I've always wondered about that.
S: You’re not sure? Why do you say that?
J: He was too controversial.
M: He was a man of controversy.
J: Alright. what’s next?
M: Do you want to try this "angry" song?
J and S: Oh sure! Yeah! The angry song! Anything with anger we’ll try!
M: Oh good!
S: (Laughing) It’s running close to sadness sadness, they are neck and neck.
M: (Laughing) Ok we’ll do some anger and then we’ll move to sadness. You won’t know this song, but it only has two chords. (M strums) Once we go on to the chours, we can make up some words. (Strums, showing Sara) OK, so it is A to E. All you have to do is go back and forth between these two chords.
(M sings)
"Another angry stranger exchange. Another angry stranger exchange."
I was yelling, he was screaming,
We were bouncing off the ceiling,
With an angry stranger exchange."

M: That's the chorus, Ok?

(Laughter, then J and S join in)
"Another angry stranger exchange.
Another angry stranger exchange.
I was yelling, he was screaming,
We were bouncing off the ceiling,
With an angry stranger exchange."

M: This is one verse.

"Well he went to wash my windshield
And I did not want it done.
So I said "Please don't"
He didn't listen to me
That's when the trouble first began."

M: Let's do the chorus again.

"Another angry stranger exchange.
Another angry stranger exchange.
I was yelling, he was screaming,
We were bouncing off the ceiling
With an angry stranger exchange."

M: (Strumming chords) OK, what are you angry
about that we should put in?

J: Alright, let's see.

M: (singing)

"Well he would not come and visit,
And he would not say why."

S: um hum!

M: He left me in the lurch

S: sitting on my perch.

M: another angry friend exchange.

S: Great! Ah ha!

(S and M singing)

"Another angry friend exchange
another angry friend exchange
I was yelling he was screaming
we were bouncing off the ceiling
with an angry friend exchange."

S: (sung) Oh what a friend
M: (echoed) Oh what a friend!
M: How could he leave me out?
S: (spoken) I’m trying to play off the word
friend. He ain’t my friend!
M: (sung) He makes me so mad I’d rather have
another!
S: (laughing) I like that!
(Sung) I’d rather have another,
perhaps a blood brother.
M: (spoken) Good! Ok! Now what was your first
line?
J: (spoken) I’d rather have a real friend!
M: (spoken) There we go!
(sung) Well he calls himself
my friend, (S joins) but I’d rather
have another. (M sings) Becuase what I need,
is a friend in deed. Yes one who would be
here with me.

(All sing)

"Another angry friend exchange
Another angry friend exchange
I was yelling he was screaming,
I was bouncing off the ceiling
With an angry friend exchange."

M: Should be do another verse?
S: Got a verse James?
J: I’m thinking.
M: You look like you’re thinking.
S: (Sung) Oh so busy cleaning the attic.

Sorry you’re dying, it’s interfering, cleaning my attic,
M: (sung) don’t give me no static
J: (Spoken) Yeah, don’t give me no static.
S: I’ve got to clean my attic!
M: (Sung) sorry you’re cleaning your attic.
S: What about us? While my husband’s so sick?
M: Don’t give me none of that static. Oh forget your attic.
S: (Sung) and do something meaningful for us!

(We all sing)

"Another angry friend exchange
Another angry friend exchange."
M: (sung) I’d like to yell I’d like to scream
Like to kick you in the bean!
S: (sung) I’d like to lock you in the attic,
so you can clean it forever amd ever. Never leave the attic again!

(We all laugh, for a several minutes)
J: Ok, let’s do something else.
S: That was very creative!
M: I wrote that song...driving down the Brooklyn-Queens Expressway. I was driving home one day and got so frustrated with the traffic and the back up that I just made it
up.

J: One day, when I had my car in a garage right next door. I got caught in a traffic jam...you know one of the New York traffic jams. It was raining and I said "The hell with it!" turned the radio on, took a rag out of the glove compartment, opened the window and began to wash the car. It was great.

(We all laugh)

S: That was a creative solution. Some of your others weren't. The time you got the ticket at 6 am, coming out of the garage.

J: Oh, God.

M: What happened?

S: There was a light on the corner. It was early. It was early in the morning and it is a tricky light. It's kinda going from red to green and it's inbetween. I guess you passed I guess you passed it before it was fully green.

J: Oh.

S: And there were two cops on the corner, having coffee.

J: Yeah, here he comes!

M: Oh dear.

S: I liked the creation of the song, it was a great release.
J: Oh.
S: What should be do next?
J: Uh, let's up date them a little
(S pulls out some music books she had been
been looking through during the week)
S: How about Judy Collins?
J: Sure.
(S sings a capella)
"In the early morning rain,
with a dollar in my hand."
J: Ah..
(S continues to sing)
"with an aching in my heart
and my pockets full of sand."
S: (spoken) interesting James?
(J nods)
(M begins to strum guitar while S sings)
15 "In the early morning rain,
with a dollar in my hand.
With an aching in my heart
and my pockets full of sand.
I'm a long way from home
and I miss my loved one so,
In the early morning rain,
with no place to go."
S: (spoken) It is a lovely song.
(S sings)
"Out on runway number nine,
big 707 set to go.
Well I'm stuck here on the ground,
where the cold wind blows.
Well the liquor tasted good
and the time went fast.
Well there she goes my friend,
there she goes at last.

Hear the mighty engines roar.
See the silver bird on high.
She’s away and westward bound.
Above the clouds she’ll fly.
Where the morning rain don’t fall
and the sun always shines.
She’ll be flying o’ere my home
in about three hours time.

In the early morning rain,
with a dollar in my hand.
With an aching in my heart.
And my pockets full of sand"
(Lightfoot, 1964). 8

J: (spoken) I wonder what that means?

M: What? With my pockets full of sand?

J: With a dollar in my hand and my pockets
pockets full of sand. I can’t get a good
good strong image of that.

S: He didn’t have much?

M: Possibly slept on the beach. All he’s got
is sand.

J: It is lovely. Want to do that again? Or
continue on.

S: Want to do “Thirsty Boots” (Anderson,
1965)? Do you know that Michele?

M: Nope.

S: (teasingly) Oh Michele.

M: But I’m learning...

8 EARLY MORNIN’ RAIN (Gordon Lightfoot) © 1964
WARNER BROS. INC. All Rights Reserved. Used By
Permission
S: Oh you will really like this one.

M: I’ve liked them all!

S: (sung a capella)

"You’ve long been on the open road, you’ve been sleeping in the rain. From dirty words and muddy cells, your clothes are smeared and stained.

But the dirty words, muddy cells will soon be judged in shame. So only stop to rest yourself and you’ll be off again.

Then take off your thirsty boots and stay for awhile. You’re feet are hot and weary from a dusty mile. And maybe I can make you laugh, maybe I can try Just looking for the evening, for the morning in your eyes"

(Anderson, 1965)

M: (spoken) Oh that is beautiful.

S: Do you remember this song James?

J: Yes.

(M plays the guitar and S sings, it is in a low key and we stumble in places.)

"You’ve long been on the open road, you’ve been sleeping in the rain. From dirty words and muddy cells, your clothes are smeared and stained With dirty words and muddy cells will soon be judged in shame. So only stop to rest yourself and you’ll be off again.

So take off your thirsty boots, and stay for a while. Your feet are hot and weary from a dusty mile. And maybe I can make you laugh, and maybe I can try just looking for the evening,
for the morning in your eyes"
(Anderson, 1965) 9

M: That's wonderful.

J: That's right.

M: Now I'll just put it into a key we can both
sing it in and it'll be fine. (We all laugh.)
I like all the images of the traveling and all
of that.

(S reads more titles)

J: (in response to "The Last Thing On My Mind"

(M plays, guitar and S sings)

"It's a lesson too late for the learning,
made of sand, made of sand.
In the wink of an eye my soul is turning,
in your hand, in your hand."

(J joins in singing)

"Are you going away with no words of farewell?
Will there be not a trace left behind?
But I could have loved you better,
didn't mean to be unkind.
You know that was the last thing on my mind.

It's a lesson too late for the learning,
made of sand, made of sand.
In the wink of an eye my soul is turning,
in your hand, in your hand.

Are you going away with no words of farewell
Will there be not a trace left behind?
But I could have loved you better,
didn't mean to be unkind.
You know that was
the last thing on my mind"
(Paxton, 1964) 10
J: Very Good. That was very good Sara.

M: I love all these words. I think that is what I like about folk music in general.

S: "My Ramblin' Boy" (Paxton, 1963) Do you want to hear that?

J: Sure

(S sings, M plays guitar)

"And here's to you my ramblin' boy.
May all your ramblin' bring you joy.
He was a friend a pal always.
He stuck with me through the hard old days.
He never cared if I had no dough.
He rambled round in the rain or so.

So here's to you my ramblin' boy.
May all your ramblin' bring you joy.
Here's to you my ramblin' boy.
May all your ramblin' bring you joy.

In Tulsa town we chanced to stray
and we tried to work one day.
The boss said he had room for one.
Said my old pal, we'd rather bum.

So here's to you my ramblin' boy.
May all your ramblin' bring you joy.
Here's to you my ramblin' boy.
May all your ramblin' bring you joy.

Late one night, in a jungle camp.
The weather it was cold and damp.
He got the chills, and he got them bad.
It took the only friend I had.

So here's to you my ramblin' boy.
May all your ramblin' bring you joy.
Here's to you my ramblin' boy.
May all your ramblin' bring you joy.

He left me here to ramble on.
My ramblin' pal, he's dead and gone.
And when we die, we go somewhere.
I'll bet you a dollar he's ramblin' there.

So here's to you my ramblin' boy
May all your ramblin' bring you joy.
(Sung slowly and with much feeling)
Here's to you my ramblin' boy
May all your ramblin' bring you joy"
(Paxton, 1963) 11

20 J: Oh Sara, that was fantastic. Very lovely. 
Have you been practicing since last time? 
Your tone is so much sweeter. 

21 S: At first I thought this song was about a 
dog, from the first verse. James, did you 
have any...I first...I just thought it was 
about a dog...the loyalty and all. I didn't 
remember the other verses. Until it becomes clear...

(Sara has continued looking through the book)

S: This is a very pretty song. Very simple
Do you remember that James?

J: No. Who is it? Baez?

S: No.

J: Collins?

S: Yeah.

(S sings a capella)

"Now that our mountain is growing, 
with people hungry for wealth. 
How come it’s you that’s a-going, 
and I’m left alone by myself."

22 J: (Softly) Oh, God.

S: My unconscious is making an interesting
choice. I'm sorry but every song that I'm picking...

(Sung)

"We used to hunt the cool caverns,  
deep in our forest of green.  
Then came the roads and the taverns  
and you found a new love it seems.

Once I had you and the wildwood.  
Now it's just dusty roads.  
And I can't help from blaming your  
goin'on the coming, the coming of the roads."

S: Do you want to hear this James?

J: (Nods yes)

(M plays guitar, S sings)

"Now that our mountain is growing  
with people hungry for wealth.  
How come it's you that's a goin'  
And I'm left alone by myself.

We used to hunt the cool caverns  
deep in our forests of green.  
Then came the road and the taverns  
and you found a new love it seems.  
Once I had you and the wildwood  
Now its just dusty roads.  
And I can't help from blaming your  
goin'on the coming, the coming of the roads"  
(Wheeler, 1964) 12

(Silence)

J: That is pretty.

S. What else would you like to hear?

(After several suggestions, J agrees to  
Amazing Grace (Public Domain). M plays  
guitar while S and J sing)

"Amazing Grace, how sweet the sound

12 THE COMING OF THE ROADS (B.E. Wheeler) © 1964  
BEXHILL MUSIC CO. All Rights Reserved. Used By Permission
that saved a wretch like me.
I once was lost but now I’m found
Was blind but now I see.

'Twas grace that taught my heart to fear
and grace my fears relieved.
How precious did that grace appear
the hour I first believed.

Through many dangers toils and snares
I have already come.
'Tis grace hath brought me safe thus far
and grace will lead me home.

When we’ve been here ten thousand years
bright shining as the sun,
we’ve no less days to sing God’s praise
than when we first begun.

Amazing grace how sweet the sound
that saved a wretch like me.
I once was lost but now I’m found
was blind but now I see”
(Public Domain)

M: Ok, I ’ll see you next week.

Music Therapy Session Process Note

James and Sara seemed really ready,
willing and able to use the music for
themselves today. Prior to the session, Sara
stated that she and James were both feeling
frustrated. This frustration was focused on
friends of theirs who were "letting them
James’ illness has been lengthy and they
feel that people are pulling away from them.
This makes them feel angry.

We begin with "When I’m Gone" (Ochs,
1966) which is a favorite of theirs. They
introduced me to it several sessions ago and
it has since become one of our standards. Sara has gotten back into playing the guitar in these past weeks. She had played back in the 60s and has now picked it back up. She has obviously been practicing between sessions as today she is doing very well. Spontaneously, during this singing, James begins to add his own lyrics that reflect his angry mood. I can really hear his anger as he sings sarcastically about what is keeping his friend too busy to come by. Sara really supports him in this and I do also, adding lyrics from what she had told me prior to the session. I have a good, strong relationship with this couple and I am very comfortable adding in lyrics. This provides releif and we laugh heartily as we sing.

We continue with this song, sometimes using the lyrics and at other times improvising. James stongs us on the line "Can't live proud enough to die when I'm gone which we repeat several times. We finish the song and talk briefly about the composer Phil Ochs and his death by suicide. This is a psychologically sophisticated couple who have been struggling with a long term illness. I want to keep the communication open about suicide. I wonder if they ever think about
I sense there is still plenty of "angry" energy so I suggest an "angry" song. Sara responds very strongly, saying that anger and sadness are running neck and neck for her. I support this and say we can do both.

Again James and Sara really use the music. They seem free and at ease in improvising lyrics about how they are feeling. I join in and we have a very expressive exploration of these feelings. James or Sara often start with a line which I echo and work into the music. There is really a nice flow at this point of thoughts and feelings and these are matched in the music. It gets quite heated and we are all quite involved. It ends with lots of laughter and it is clear there has been a real catharsis of this emotion. Sara says this verbally.

I give a little background on the song, how it evolved out of my own frustrations of being stuck in a traffic jam on the Brooklyn-Queens Expressway. James and Sara talk about frustrations and creative solutions to them.

The mood has changed. We are all still very present but there is no palpable mood hanging in the air. James asks to 'update' the music and Sara offers James choices. Sara
has several books of music that they had sung from in the early part of their marriage. They are new to me, so Sara sings them first and then I accompany on guitar.

I am struck by the feeling in these songs. One after another they all seem to deal with moving on, separation, and loss. I find the experience very beautiful and very intense. Sara is at this point performing for James as I accompany. James is very supportive of Sara’s singing and tells her how beautiful she sounds. Her voice has gotten much stronger in these last weeks as she has begun singing again regularly.

After "My Ramblin’ Boy" (Paxton, 1963) Sara begins to analyze the lyrics. She is tentative at first but slowly becomes aware of the losses she is singing about. This theme culminates when Sara begins to sing "The Coming of the Roads" (Wheeler, 1964). After one verse sung a capella James softly utters "Oh, God" as he seemingly becomes aware of the message. Sara then too becomes aware and verbalizes this. "My unconscious is making an interesting choice. I’m sorry, but every song that I’m picking..." It seems that her opening statement about anger and sadness running neck
and neck has been very true for this session. What is significant at this point is that Sara asks James if he wants to hear the song, now that the meaning is explicit, and looking at her he nods "Yes."

I was really touched to be able to share this moment with James and Sara. She was expressing her sadness at his impending death and he was able to really hear her. It was framed by a beautiful and bittersweet song.

Working with James and Sara is a joy. They are very open, articulate and intelligent people. They are actively involved in the process of music therapy.

**Data Analysis**

Below are numbers which refer to the cited transcript and therapist’s process note. In the A column is the "meaning unit" (Girogi, 1975, p.75) extrapolated from the data and in the B column is the essence that emerged from this meaning unit.

<table>
<thead>
<tr>
<th>#</th>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>J’s improvised lyric, self expression</td>
<td>Music - used for expression</td>
</tr>
<tr>
<td>2</td>
<td>M’s matching and supporting J</td>
<td>Music and Process - exploration and expression</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>3</td>
<td>J and S’s improvised lyric</td>
<td>Music and Process - exploration and expression</td>
</tr>
<tr>
<td>4</td>
<td>S’s improvised lyric, self expression</td>
<td>Music and Process - further exploration</td>
</tr>
<tr>
<td>5</td>
<td>J’s exploration of meaning</td>
<td>Process - exploration of meaning</td>
</tr>
<tr>
<td>6</td>
<td>Mutual support of exploration</td>
<td>Relationship - support of each other</td>
</tr>
<tr>
<td>7</td>
<td>Providing opportunity for further exploration</td>
<td>Relationship and Process - Trust allowing for further exploration</td>
</tr>
<tr>
<td>8</td>
<td>Expression of feelings in song</td>
<td>Music - self expression</td>
</tr>
<tr>
<td>9</td>
<td>Further expression through improvisation</td>
<td>Music - self expression</td>
</tr>
<tr>
<td>10</td>
<td>Further expression through improvisation</td>
<td>Music - self expression</td>
</tr>
<tr>
<td>11</td>
<td>Emotional release</td>
<td>Music, Relationship and Process allowing for catharsis</td>
</tr>
<tr>
<td>12</td>
<td>Movement following release</td>
<td>Process - movement to new issue</td>
</tr>
<tr>
<td>13</td>
<td>Awareness of release integration of experience</td>
<td>Process - awareness and integration</td>
</tr>
<tr>
<td>14</td>
<td>Movement to exploration of different level of feelings</td>
<td>Process - movement</td>
</tr>
<tr>
<td>15</td>
<td>S’s unconscious expression of feelings</td>
<td>Music and Process - expression of unconscious feelings</td>
</tr>
<tr>
<td>16</td>
<td>S’s expression</td>
<td>Music - self expression</td>
</tr>
<tr>
<td>17</td>
<td>J and M’s support of S’s expression</td>
<td>Relationship - support for exploration</td>
</tr>
<tr>
<td>18</td>
<td>Further expression of unconscious feelings by S and J</td>
<td>Music and Process - further expression of unconscious feelings</td>
</tr>
</tbody>
</table>
19 J and M's support for S's expression Relationship - support and acceptance for expression

20 J's support for S's expression Relationship - support

21 S's exploration of meaning Process - beginning of insight

22 Further exploration and awareness of meaning by J and S Process - continuing insight

23 Awareness of feelings expression of conscious feelings Process and Music completes awareness and expression

24 Music to provide contact and connection Music - providing connection and closure

25 J's expression of feelings Music - self expression

26 M's exploration of meaning for J and S Process - exploration of meaning

27 M's encouraging further exploration of feelings Relationship - support for exploration

28 J and S's exploration of feelings in music Music - self expression

29 Movement and exploration of new level of feelings Process - movement

30 Music as expression of unconscious feelings Music and Process music as vehicle for unconscious feelings

31 S and J's awareness and expression of conscious feelings Process - awareness and insight

Discussion of the Session

This case study takes the reader through two components of the data base of one of the ten
sessions conducted: the session transcript; and the therapist’s process note. (The audiotape was not included for reasons of confidentiality.) It provides an opportunity to review the session in depth, and as outlined in step four of this method, to reground the essences back into the actual experience.

From this case example we see the session-specific essences that emerge. On the second level of reflection that occurred, these essences were synthesized into the groups: Relationship; Music; and Process.

The essence of relationship in this example occurs on several levels. It encompasses the relationship between the patient and his wife, between this couple and their friend who they feel is letting them down, between the couple and the therapist and between the couple and the music. In each case the relationship supports or provides the basis from which the process occurs.

The music takes a variety of forms and serves different purposes. At times, the music takes the form of precomposed songs, primarily from the 1960’s, chosen by the patient and/or his wife. The first improvisation grows out of one of these songs and is used for the expression of feelings; specifically anger. This expression continues in
the musical improvisation introduced by the therapist and this expression results in a catharsis. Once these feelings have been expressed, precomposed songs are again chosen by the patient and his wife. A theme of loss begins to emerge in her song choices. This is initially an unconscious, symbolic choice. At this point the music is providing the vehicle for the symbolic expression and processing of the wife’s feelings of impending loss. This theme of impending loss is evident in the lyrics of the songs she chooses, yet this theme emerges gradually and it is only toward the end of the session that the wife makes the interpretation of her choices. She observes that the music is reflective of what she is presently feeling. Once this expression is made explicit by the wife, she asks her husband if he wants to hear the song she had begun and he nods yes. The music now provides the structure for the expression of the wife’s feelings about the impending death of her husband.

The music allows the three of us to share in the expression of these intimate feelings. This ability of the music to convey unconscious meanings is very powerful in this session. Even after many listening and re-readings of this session, this particular moment continues to fill me with emotion. It was a profound and poignant moment.
The process in this session is obvious, dramatic and closely tied to the essence of music. The music is the container in which the process occurs. The process begins with the expression of feelings of anger which once expressed are further explored. When the expression of these feelings is exhausted, the process continues revealing another layer of feeling. The process is different than the earlier part of the session in that here, the initial expression of feelings is unconscious, and only through time becomes a conscious expression.
CHAPTER VII
CONCLUSIONS AND RECOMMENDATIONS
FOR FURTHER RESEARCH

Conclusions

The last step in the method then was a final integration and synthesis of the regrounded essences into a description of music therapy with the terminally ill patient.

All of the data was reviewed in its wholeness with a focus on looking for a common thread or existing pattern that ties these sessions together. In doing so one is immediately struck by how different each session is. The patients are unique, the music varies, the process of therapy is never quite the same. This uniqueness and specialness of each session makes it obvious that no one type of music, song, improvisation or intervention would always be appropriate. Each session is comprised of the unique interplay and coming together of patient and therapist.

The therapist's role in these sessions takes many forms but always focuses on serving as a companion on the patient’s journey. It is the patient’s journey, and the therapist is simply sharing in this process during the session. The therapist sometimes reflects, sometimes questions, sometimes directs and sometimes
just listens as the patient travels on his or her journey. The therapist is the sounding board or mirror to the patient’s experience. This places a great demand for flexibility on the part of the therapist. It is not necessary for the therapist be an expert on the patient’s journey, but rather a caring, interested, and compassionate companion. This style of therapy draws upon the therapist as a person and calls upon him or her to bring him or herself to the session and to be present in the experience.

The word exploration also stands out as the data are re-experienced. It is the constant exploration of the moment and whatever it has to offer. Sometimes it is the intense indepth exploration that leads to insight and increased awareness while at other times it is the exploration of where the patient is at the moment without any noticeable change or movement.

**Description of Music Therapy with the Terminally Ill**

The fifth step in this method called for a second integration of the essences: Relationship; Music; and Process into a final description of music therapy with the terminally ill.

Music therapy with the terminally ill patient is the coming together of patient and therapist in a process oriented exploration. This exploration takes place in the present moment yet is also expansive in
that it can include both the past and future. It takes place in the realm of direct human interaction through music and words but also accesses the unconscious and symbolic levels of understanding and relating.

Summary of the Method and Recommendations for Further Research

In utilizing this method certain advantages and disadvantages became apparent.

Advantages

This style of research provides an excellent means for gaining a deeper understanding of and insight into clinical music therapy with the terminally ill. This in depth exploration of the experience in its wholeness has allowed for an intense examination of the music therapy process with the terminally ill patient while maintaining and respecting the integrity of the clinical work. Patients in this study were viewed as whole persons, they were not dissected and reduced; we were able to study them in their complex and multifaceted presence.

It is my opinion that this method of research has yielded meaningful results. Essences of music therapy with the terminally ill patient did emerge, were discussed and were regrounded back into the actual experience. The essences have given me, as a music therapy clinician, further insight into clinical work
with terminally ill patients. This provides direction for me as therapist and a deeper understanding of what occurs in the music therapy session. As a clinician I have become more focused on the relationships I have with patients, as well as the relationships patients have with others and how these relationships are part of the therapeutic process. I have a sense of the possible uses of music in the therapy situation that goes beyond the direct use of music in here and now interaction. I have certainly gained a renewed respect for and deeper appreciation of the patients with whom I work and their unique, complex, multifaceted processes in facing death.

**Disadvantages**

This research has had an impact for me as a music therapy clinician. Yet, after such an in depth study, I am acutely aware of the limitations of this research. Certainly an obvious drawback of this method is the subjectivity of the researcher in also functioning as the therapist. Due to the limited number of music therapy clinicians presently working with the terminally ill this is an unavoidable problem, though the continuing expansion of our field should help eliminate this particular drawback.

In addition, if this research method were to be used again by a researcher studying his or her own
clinical work, one recommendation would be that perhaps another step could be added to the method. The additional step might call for another music therapy clinician, familiar with the population being studied, to review the sessions and essences which emerged. This would bring another perspective into the research findings and limit the subjectification.

Utilizing this method has only been a first step; the results of this research are limited. It is difficult to extrapolate the findings beyond my own clinical experience. Consequently, I can make no global generalizations. This research was necessary first step, but upon completing it I am aware of how small a step it actually is.

To quote Ihde (1976)

I do not claim to have in any way exhausted or even to have reached totally adequate limits of a phenomenology of [music therapy with the terminally ill]. I would hold that the existential possibilities elicited are suggestive of a need for philosophy to examine human experience [music therapy] more deeply than it often has (p. 34).

It is my sincere hope that research of this nature will continue to be conducted on music therapy as practiced with the terminally ill as well as on music therapy as practiced with other populations. This will hopefully both refine the method and provide more information and direction regarding clinical music therapy.
BIBLIOGRAPHY


Jones, I., Kahn G., (1924). It had to be you. CA: Warner Bros. Inc.


APPENDIX A
HUMAN SUBJECTS STATEMENT

Participants in this study will be recruited from Cabrini Hospice in New York City. Patients on the hospice program will be asked if they would like to participate in the study. The first 10 patients that agree will be studied.

The principal investigator will provide prospective participants with the attached Statement to the Subjects and the consent form.

Data collected from the audio taped sessions and process notes will be reported in the dissertation, however names and identifying characteristics will be changed to insure the patients' privacy.

As stated in the consent form, participation in this study is voluntary and each subject has the right to withdraw from the study at any time.

The music therapy intervention does not involve any health risks. There is no potential physical harm for those participating in this study.
APPENDIX B

STATEMENT TO THE SUBJECTS

In this study the principal investigator will be attempting to determine and describe the experience of music therapy with hospice patients. Participation in this study is voluntary and will not adversely affect the patient's rights and welfare. It will involve:

1. Participation in one music therapy session with the principal investigator. The session will be approximately thirty minutes to one hour in length.
2. This music therapy session will be audio taped. Participants may have a copy of the audio tape if they so choose.

Participants may withdraw from the study at any time, and if requested the principal investigator will destroy the audio tape. The music therapy intervention does not involve any health risks. There is no potential physical harm for those participating in the study.
APPENDIX C

CONSENT FORM

NEW YORK UNIVERSITY
SCHOOL OF EDUCATION, HEALTH,
NURSING AND ARTS PROFESSIONS
MUSIC THERAPY PROGRAM
35 West 4th Street
New York, NY 10003

I have agreed to participate in the study seeking to determine and describe the experience of music therapy with hospice patients and hereby give my consent to be a subject.

The principal investigator, Michele Forinash, a New York University graduate student, has explained that my participation in the study is voluntary and involves the following:

1. Participation in one music therapy session with the principal investigator which will be approximately 30 minutes to one hour in length.
2. This session will be audio taped by the principal investigator and I may have a copy of this tape if I choose.
3. I may choose after the session to withdraw my consent. If I so choose the principal investigator will destroy the audio tape.
4. The principal investigator will review my clinical chart for pertinent information.
5. I am free to contact the principal investigator should I have any questions about this study.

Subject’s Signature ___________________________ Date ___________________________

Subject’s Name (Printed) ___________________________

Michele Forinash, MA, CMT ___________________________ Date ___________________________
Principal Investigator (212) 998-5452