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Music Therapy When Death Is Imminent: A Phenomenological Inquiry

Alexa Dorris Economos, MMT, MT-BC

Starshine Hospice, Cincinnati Children's Hospital, Cincinnati, OH

Music therapists have described powerful case examples and personal experiences of providing music therapy for clients who are actively dying that suggest a complex experience that merits further exploration. This phenomenological study was conducted to gain a better understanding of the lived experience of music therapists working with clients who are actively dying. Four music therapists (2 female, 2 male), with an average of 10 years' hospice care experience, participated in semi-structured interviews. Data were analyzed using a phenomenological approach (Moustakas, 1994). Ten themes were distilled from the interviews and grouped into four categories: ongoing assessment, intuitive processes, countertransference, and the role of aesthetics and transformation. Participants described a flexible, dynamic clinical and personal process informed by ongoing assessment. These findings point to the importance of further discussion surrounding the clinical implications of the music therapist's internal experience and the role of assessment, intuition, and aesthetics in hospice music therapy.

Keywords: *Hospice; Music Therapy; Qualitative Research; Aesthetics; Assessment*

Background

The days and hours leading up to an individual's death can be challenging for the client, family, and hospice team. Although the active, or imminent, dying process remains an elusive medical and spiritual concept, it is generally understood to encompass the time measured in days and hours before an individual's death (Hui et al., 2013). Although a large body of evidence cites

Address correspondence concerning this article to Alexa Dorris Economos, MMT, MT-BC, Starshine Hospice, Cincinnati Children's Hospital, Cincinnati, OH, 660 Lincoln Ave, Cincinnati, OH 45206. E-mail: Alexa.economos@cchmc.org. Phone: 3174416808.

the self-reported and observed benefits of offering music therapy in hospice care to reduce anxiety and manage pain (Bradt & Dileo, 2010; Hilliard, 2003; Hogan, 2003; Krout, 2001), there is a dearth of empirical evidence to support the use of music therapy with clients who are actively dying (Potvin, 2015). An increasing number of music therapists have written about their experiences, and although the goals addressed and personal experiences vary across reports, these accounts suggest that providing music therapy at the time of imminent death is a personally profound and intimate experience (Munro, 1984; Zabin, 2005).

Several accounts point to the use of sophisticated and dynamic clinical processes as music therapists provide meaningful experiences for clients and their family members. For example, when family members are present in the room and the client appears minimally conscious with no apparent needs, music therapists have explored the benefits of shifting their focus toward supporting loved ones' needs for emotional expression and connection (Gallagher et al., 2017; Krout, 2003). Hogan (2003) recounted a case where the family was involved in music therapy sessions, and how this helped the client identify and share with his family the song that he wanted played during his death. Gilbert (1977) presented music therapy as a catalyst for facilitating anticipatory grief conversations with loved ones by offering music as a nonthreatening container for the expression of emotions related to separation and loss. Shared listening to a client's personally meaningful music has also been discussed as a way to provide structure in the midst of uncertainty, facilitate emotional and cognitive connections to important memories, and create a peaceful environment in which to honor a client's transition (Martin, 1991; Munro, 1984).

A number of music therapists have described incorporating the *iso*-principle into live music listening experiences in order to reduce symptoms and connect with their clients during the active dying process. In music therapy clinical practice, the *iso*-principle may be defined as the use of musical elements to match a client's emotional or physical state (Wigram, Pederson, & Bonde, 2002). Hogan (2003) and Hilliard (2001) presented case studies in which music listening experiences incorporating the *iso*-principle were used to create a familiar and relaxing environment, manage pain,

reduce anxiety, and support the dying process. Cadesky (2005) and Weber (1999) both discussed the use of vocal improvisation to match clients' moods and respiratory rate in order to serve as a grounding, safe container for clients' experiences of dying. Because clients who are actively dying may offer only subtle or minimal feedback, the content and meaning of these musical experiences are often influenced by the music therapist's perception, necessitating a deeper exploration of the role of countertransference in hospice music therapy.

Countertransference may be broadly understood as a music therapist's personal reactions to a client (Bruscia, 1998). DiMaio, Wilkerson, & Sato (2015) explored music therapists' experiences with countertransference and its influence on their work with hospice patients and identified the following themes: facing one's own mortality, boundary issues, personal grief, exposure to pain and suffering, spiritual issues, and cultural differences. Similarly, Marom (2008) presented four case vignettes in which transference and countertransference dynamics significantly affected the therapy process. In both publications, supervision and self-care were identified as important tools for developing insight about the nature of these dynamics to promote understanding and self-awareness, and as a form of self-care for the therapist (DiMaio, Wilkerson, & Sato, 2015; Marom, 2008).

Finally, narratives describing music therapists' experiences with clients who are actively dying often note the powerful influence of spirituality, with particular attention paid to the experience of transcendence (Kidwell, 2014; Runningdeer, 2013; Sekeles, 2007; Zabin, 2005). Munro (1984) described the experience of shared music listening during the final hours of a client's life to be "precious moments where music transcends emotional, physical and spiritual barriers" (p. 14). Hogan (1999) supported this idea, identifying music therapy as an aesthetic tool to support the dying process by fostering existential resolution between all of the dimensions of human experience. Some authors suggested that spirituality may even serve as a theoretical or clinical foundation for the work (Potvin & Argue, 2014; Zabin, 2005).

In summary, music therapists have written about their clinical and personal experiences of providing music therapy for clients who are actively dying, and these accounts point to a powerful,

complex, and dynamic experience. At this time, the "essence" of providing music therapy for imminently dying clients remains elusive. Therefore, a phenomenological approach was selected to explore the lived experience of music therapists working with clients who are actively dying.

Phenomenological Research

Phenomenology is a philosophical approach derived from the Greek word *phainómenon*, meaning "that which appears" (van Manen, 1990). Phenomenological inquiry strives to understand both the "essence" of experience by gathering rich, detailed description from a small number of sources; and also exploring how we come to perceive and understand experience (Creswell, 2013). Therefore, phenomenology is not concerned with solving problems or making vast generalizations (van Manen, 1990), but instead with allowing themes to emerge from the lived experiences of a few who have experienced the phenomenon in question.

Objective

The purpose of this study is to gain a greater understanding of the experiences of music therapists who have worked with clients who are actively dying. The primary research question was as follows: How do music therapists describe their experiences providing music therapy for clients who are actively dying?

Method

Research Setting

This study was conducted at Appalachian State University and received approval through the Office of Research Protections. In order to communicate with music therapists from a variety of settings, I conducted interviews over telephone and Skype. Participants were encouraged to select a quiet, uninterrupted location.

Researcher

I am a board-certified hospice music therapist. My approach to music therapy is predominantly humanistic, but I strongly value resource-oriented approaches and reflexivity in my work. For this

reason, I refer to myself in the first person since I may not be separated from the knowledge obtained during this research.

Participants and Recruitment

I used the steps for purposive sampling outlined by Tongco (2007). Based on Creswell's (2013) recommendations for sampling in phenomenological research, I concluded that the complexity and depth of the topic necessitated seeking rich, detailed descriptions from a group of fewer than 10 participants who had at least two years of experience working with clients whose deaths were imminent. I identified hospice music therapists with this qualification using the online registry of the Certification Board for Music Therapists (2015), personal communication with music therapy colleagues, and subsequent Google searches to identify clinicians and their places of employment. I obtained e-mail addresses through participants' websites and professional references.

I contacted seven potential participants who met the eligibility criteria. Five participants confirmed their eligibility and agreed to participate; however, one subject ceased communication midway. Because the recruitment time period was limited, I chose to analyze the interviews from the four remaining participants. Two women and two men provided electronic copies of signed informed consent documents prior to their study participation, and chose a pseudonym for use in this research report. Table 1 provides information on each participant's gender, year of experience, job responsibilities, theoretical approach, and clientele. In summary, participants had a significant amount of hospice experience (range 6–16 years; mean 10.3 years) and worked in a variety of settings, including home care, skilled nursing, and inpatient units. Three of the participants saw clients who were actively dying on a regular basis, and one participant saw clients who were actively dying only when it occurred by chance during regularly scheduled music therapy visits. Each participant shared eclectic theoretical orientations informed by humanistic beliefs. Some of these included person-centered, existential, humanist, Gestalt, eclectic, aesthetic, and music-centered approaches. Three participants mentioned a variant of person-centered, including client-centered and patient-driven, approaches. All participants' caseloads consisted of diverse

TABLE 1

Participant Information

Participant pseudonym	Gender	Years of experience	Job responsibilities	Theoretical approach	Clients served
Nathan	Male	6	Caseload of between 30 and 50. Regularly saw actively dying patients	Existentialist-humanist with heavy influence from Gestalt model of therapy	Mostly older adults with chronic illness in both home and facility settings
Ella	Female	11	Caseload of 30–35, internship director, administrator. Regularly saw actively dying patients	Humanistic, existential, music-centered	Mostly older adults in both inpatient and home care settings
Renee	Female	10	Private practice owner. Caseload of 10–12. Only saw actively dying patients if by chance during home visit	Person-centered and music-centered	Mostly older adults enrolled in home hospice
J.C.	Male	16	Program director, internship director, caseload of 30–40 monthly. Regularly saw actively dying patients	Eclectic, incorporating primarily client-centered approaches with cognitive-behavioral interventions as needed	Mostly adults over 50 in inpatient setting. Infrequently, pediatric hospice patients

groups of individuals with unique needs, although the majority of their work was with older adults and their families.

Procedure

After obtaining informed consent through electronic communication, I interviewed three participants by telephone, and one using Skype software. I conducted semi-structured interviews in order to provide ample opportunity for participants to give detailed descriptions of their experiences with the phenomenon in question. The interviews were not time-limited, and lasted between 35 and 50 minutes. Face-to-face interaction may have encouraged more conversation, as the Skype interview lasted longer than the other three phone calls. See Appendix A for a list of the interview questions.

Epoché

In order to reflect on my personal experience and biases, I wrote the following epoché before engaging in the study process:

> When I reflect on what feels important when I am providing music therapy for someone in the dying process, I think first of considering the patient's physical needs from a medical model and planning the session accordingly. Although I trust that music may offer a relaxing and analgesic effect, ultimately I have used individuals' breathing patterns as the rhythmic foundation for improvised music to create a peaceful and supportive environment. I have found that when I truly consider the "why" and "how" of what happens, physical needs seem secondary to more abstract needs. Goals like "hold space" or "offer compassionate presence" come to mind. I find myself invested in the idea of easing the spiritual transition from life to death, a process with which I am, by virtue of being alive and healthy, completely unfamiliar. Communication during these sessions is unique. Some of my patients were alert and oriented until the moment of their death; others showed no physical evidence of responsiveness for weeks. I am sensitive to ethical and spiritual dilemmas. I feel uncomfortable with the idea of unintentionally projecting my developing spirituality onto my clients. My greatest

fear is that my spirituality ultimately informs how I perceive my experiences working with clients who are dying. I have asked myself, why do I want to ease their transition? What does that say about my feelings and introspects about death and dying?

Data Collection

Interviews were audio recorded using the *Voice Recorder* iPad® app. I transcribed three of the interviews, and a graduate student trained in research ethics transcribed the fourth de-identified interview. Transcripts were provided to participants for member-checking to increase validity of the results.

Phenomenological Reduction

Data were analyzed using the steps for analyzing phenomenological data identified by Moustakas (1994). All themes were developed through an inductive, reflexive approach. Before analyzing the transcripts, I reviewed my epoché and reread each interview. Then I engaged in the process of horizonalization, or highlighting significant statements contributing to the understanding of the participants' experiences and treating each statement as equally important. These statements, or horizons, were placed without identifying information into a single document.

I then created clusters of meaning and reconnected each horizon with the participant who relayed it. I then engaged in the process of imaginative variation to consider which clusters contributed or did not contribute to understanding the "essence" of participants' experiences. Ten emergent themes were distilled. I then created a textural description of the participants' experiences organized by theme. These themes were then organized into groups based on their content, which resulted in the identification of four larger categories.

Finally, I maintained awareness of the final steps of Tongco's (2007) steps for purposive sampling, remaining mindful of potential bias in the results due to my selection of participants. This process was strengthened by regular meetings with three research advisors with whom I discussed challenges to my viewpoints and new insights. In addition, I maintained communication with participants during the analysis process to offer opportunities for them

to add their perspectives on the findings. One participant communicated via e-mail to refine his textural descriptions, while the others declined.

Results

Ten themes emerged from the analysis, with each theme later organized across four categories. Nine themes were present in all four interviews, with one theme present in only three interviews but retained due to its stated importance in those interviews. Table 2 summarizes the 10 major themes and corresponding subthemes.

Category One: Ongoing Assessment

Theme 1: It Is Important to Know as Much Information About the Clients as Possible Before Providing Services to Them When They Are Actively Dying. All participants made a distinction between the assessment process for clients with whom they had a preexisting relationship and providing services to a client with whom they had no relationship. For clients with whom participants did not have a preexisting relationship, all four participants stressed the importance of a thorough assessment. Ella shared that she often invited family members into the session in order to gain more information about the client; however, she considered a here-and-now approach to assessment as the most important:

> Ella: For people I don't know, the most important thing is… what is their experience right now? Are they suffering?

The other three participants highlighted the role of consultation with family and the interdisciplinary team as an important source of contextualized information to meet the client's needs. Nathan and J.C. suggested that the music therapist may both gain information from and act as a support for the context of the goals of the interdisciplinary team:

> J.C.: So in a sense we mirror the entire team's interventions in our approach, and goal areas may overlap where we can clinically support the goals of the chaplain or social worker but have a unique approach through music therapy.

Table 2

Music Therapist Experiences Working with Actively Dying Clients: Categories, Themes, and Subthemes

Category	Themes and subthemes
Ongoing Assessment	Theme 1: It is important to know as much information about the clients as possible before providing services to them when they are actively dying.
	Theme 2: Assessing client's physical state can suggest information about internal experience.
	Subtheme 2.1: It is rare for there to be verbal communication with the client.
	Subtheme 2.2: Participants observed respiration and other visible physiological responses to assess their clients' internal experiences.
Intuitive Processes	Theme 3: The music therapist must be flexible and adaptive in the moment to serve both patient and family needs.
	Theme 4: Intuitive processes are extremely important.[1]
Countertransference	Theme 5: Countertransference is deeply influential in both the clinical process and the music therapist's personal life.
	Subtheme 5.1: Countertransference influenced the clinical process.
	Subtheme 5.2: Countertransference influenced personal and spiritual revelations.
	Subtheme 5.3: Supervision and self-care are extremely important.
	Theme 6: The music therapist feels a responsibility to take on a role that transforms the experience and environment in a meaningful way.
Aesthetics, Transition, and Transformation	Theme 7: The central goal is to help the patient transition meaningfully, with as little discomfort as possible.
	Theme 8: When loved ones are present, the music therapist uses a dynamic and collaborative process to facilitate meaningful transition for both client and his or her loved ones.
	Theme 9: Music therapy can reveal deeper meaning in the midst of pain and suffering.
	Subtheme 9.1: The dying process can be musical.
	Theme 10: Music therapy can transform the experience and environment.

[1]Theme present in only three of the four interviews.

Theme 2: Assessing the Client's Physical State Can Suggest Information About His or Her Internal Experience. *Subtheme 2.1: It is rare for there to be verbal communication with the client.* All four participants shared that it was rare for clients to verbally or physically communicate their needs. Renee noted that even when verbal or physical communication was present, the dying process created an overwhelming amount of need that perhaps couldn't be expressed outwardly through words.

Subtheme 2.2: Participants observed respiration and other visible physiological responses to assess their clients' internal experiences. In the absence of verbal communication, all four participants shared that they observed their clients' breathing patterns and other physiological responses in order to evaluate their clients' comfort level.

> Ella: In our hospice, we use the PAINAD scale to give a number and a quality to that experience. But you can hear it and see it, you know, like what kind of sound? Are they moaning? Is it distressing? Are they extremely restless—that terminal agitation? Because that becomes a priority to me.

Respiration was the most commonly mentioned physiological response across all four interviews. J.C. and Renee noted that observing breathing patterns can impart crucial information about a client's experience of pain or anxiety. Nathan noted that rarely, physiological responses can also suggest whether or not the client is experiencing change in the context of the music therapy experience.

> Nathan: Sometimes they will give you some sort of external response; their breathing will change, they'll have turned their head towards the music or they'll have given me a squeeze of their hand, so those moments you know that you've at least reached them. In my experience, that is more the minority.

Category Two: Intuitive Processes

Theme 3: The Music Therapist Should Be Flexible and Adaptive in the Moment to Serve Both Patient and Family Needs. Adaptability and flexibility were identified as important aspects of working with

clients and their families during the dying process. All four participants noted that it was important to engage in continuous assessment, allowing the music therapy experience to reflect the needs of the moment. J.C. stressed that although information about the client was important, pre-planning an experience would not lead to a successful music therapy intervention:

> J.C.: Sometimes everything you might have read about this patient may be non-applicable when you walk in the room. You still need to have the ability to make clinical decisions based on what's presenting in the moment.

When asked about changes in their practice over the years, Ella and Nathan noted that over time, they experienced an improvement in their clinical skills as they embraced a more flexible approach.

> Ella: I'm not as rigid, I think, is what it comes down to. Being able to say well this is what I think or what I thought of that approach… and well, that's changing… and that doesn't fit, so I need to change.
>
> Nathan: Initially I was thinking of myself as "there's the patient, there's the family, there's the medical team, there's the music therapist, there's the hospice team," I was compartmentalizing everybody and all the roles that were present, and what I came to realize is that there's not really, unless that boundary is being explicitly set by the family or by the patient, those compartments didn't really exist.

Theme 4: Intuitive Processes Are Extremely Important. Nathan, J.C., and Renee noted that intuitive processes were an important part of assessing and meeting the client's and family's needs in the moment. I have included this as an emergent theme because of the weight placed on this theme by those who expressed it, as well as my own sense that intuitive processes are embedded in much of the language describing the assessment of imminently dying clients. Nathan highlighted the importance of using focused intuitive processes to assess physical and energetic responses:

> Nathan: I have to say that if it's just me and the clients, more or less, I feel like I really just try to check with my intuition. I feel like if I spend 2 hours with a very active

> client, I leave those sessions much less tired [than] the 15 minutes I spend with my unresponsive client because the challenge there is for me to open up all my empathic sensors; all of my antennas, all my intuition, put all my energy into that. The most subtle movement can communicate so much.

J.C. and Renee suggested that tapping into one's intuition can impart information about the environment and needs of those who are present in the session:

> J.C.: You still need to be in the present and respond appropriately and intuitively to the moment by moment flow of the session. Sometimes I will put my knowledge of a patient/family in the back of my awareness and respond spontaneously but can draw from this information as needed.
> Renee: I'm really also trying to feel what it's like in the room… like feel, you know, what their distress level is. Or if there's family, what's the feeling in there? There's a lot of intuition and clinical judgment that is part of the time in that setting.

J.C. shared his sense that developing intuition and deep listening were, in some ways, at the core of what it means to improve as a music therapist in this setting:

> J.C: I like to think that I've developed a strong clinical sense that will guide me in a good direction with different patients that offers what they need at that moment. I think you develop a deeper level of listening skills and can "hear" between the lines with your patients. Deeper listening and empathy combined with music is a most powerful medicine! It may very well be the essence of this work. Being able to tap into what a person really needs during this critical time is essential.

Category Three: Countertransference

Theme 5: Countertransference Is Deeply Influential in Both the Clinical Process and the Music Therapist's Personal Life. All participants recounted their awareness of countertransference

to significant music therapy sessions. In addition, all participants highlighted the influence of countertransference in both the clinical process and in the context of their own lives.

Subtheme 5.1: Countertransference influenced the clinical process. The participants' belief systems around the use of music therapy with clients who are actively dying contributed to their clinical decisions. Nathan and Renee identified their personal reactions to sessions as not only influential, but as clinical skills they developed to inform interaction with the environment:

> Nathan: …now I think that I'm much more accepting of any sort of emotions I might have. I mean, there are times where you're going to cry with the family because that's the most appropriate response.
> Renee: I've heard people use the phrase using your countertransference as a guide for what you're doing so I think about that as a way that I can work in that setting.

Nathan and Ella expressed awareness of how their own experiences influenced their therapeutic roles:

> Nathan: I think the people who are actively dying, when they're hanging on for that long, they're working stuff out for themselves. I always feel a bit awkward about not wanting to be an uninvited guest in that process. I want to be helpful, but I take whatever cues I can take that indicate if my presence is not desired at the time because they're doing their own work
> Ella: My experience has been that absolutely everything about me influences my relationship with my clients… I happen to love that Beatles song "In My Life" and so I knew it really well. And because I knew it well, it could really reflect and be what it needed to be helpful and therapeutic in that moment.

Subtheme 5.2: Countertransference influenced personal and spiritual revelations. Participants were invited to share a significant experience providing music therapy for a client who was actively dying. Although all participants stressed that all music therapy sessions were uniquely meaningful, these sessions sparked personal and spiritual revelations about universal concepts. Renee shared an

experience in which one of her clients with whom she had a previous relationship died during their time together. For her, this revealed new insight regarding the processes of life and death:

> Renee: That was the first time I had been with a patient by myself that they died… You know, life begins and life ends in a moment. And it just felt so holy. She and I had connected previously, and her faith is very similar to my faith, so I was conscious of that. So I had an idea of what she may have been thinking or feeling about the end of life. I mean, if I think about it longer, that happened a couple months after I came back from maternity leave… so I had just given birth to new life.

J.C. described his reaction to a meaningful session in which his client responded to significant lyrics of a treasured song by making eye contact with her daughter just before taking her last breath:

> J.C.: Needless to say, that experience was very powerful and intense, and it moved me deeply. It reminded me how hearing is often intact till the very end with patients and that even when a patient is seemingly non-responsive, they are still able to hear the music. That was very affirming to know that this patient, who was not responding in any overt way, was actively listening to the song. I wondered if it was a coincidence that she chose that precise moment to open her eyes and have that last moment with her daughter. I don't think so! The session was an emotionally transcendent experience that stays with me to this day.

For J.C., the experience not only validated his beliefs about his clients' abilities to share in music experiences at the end of life, but it also resonated with his spirituality in its transcendent qualities. Nathan and Ella expressed that their experiences both interacted with and informed their spirituality:

> Nathan: I don't have a dogmatic belief system, so I find it's very fluid, and it's very much been shaped by my experiences in hospice, so I absolutely do draw from ideas of transitioning, from ideas of integrating into some sort of larger framework, some sort of larger fold.

> Ella: With the dying process I would say personally it's affected me and my spirituality because I don't have a set of core beliefs around spirituality. I find myself super influenced by what's going on in my work and then going home thinking, how does that fit in?

Subtheme 5.3: Supervision and self-care are extremely important. J.C., Ella, and Renee stressed the importance of supervision and self-care when doing this work. Renee described a significant clinical experience that necessitated further processing time than she had available. Ella described a gradual process of using supervision and self-care as tools for learning how to authentically appreciate belief systems that were contradictory from her own.

Theme 6: The Music Therapist Feels a Responsibility to Take on a Role That Transforms the Experience and Environment in a Meaningful Way. This theme emerged when I revisited each interview after having already organized significant statements by theme. I noticed that embedded within countertransference to sessions was a common sentiment: each participant expressed a sort of calling to this work; at the core of their experiences was the sense that it was their responsibility to react appropriately to important elements of sessions and to provide music therapy experiences in a meaningful way. Renee shared a clear example of this when she noted a significant polarity in her work: on the one hand, she felt called to be a hospice music therapist in her own spiritual life; but on the other, she felt it was important to put her beliefs aside to support her clients in their belief systems.

> Renee: I feel very strongly at the core of my being that I'm called to the work that I'm doing, and I'm particularly called to be with people in their final years of life. So clinically, I've worked very hard to support my clients' beliefs and to not put myself on them.

Nathan shared a similar view to Renee in relation to becoming more flexible in the work in order to support clients' various belief systems and unique dying processes. He shared that the process of both examining and blurring the boundaries and roles made him a more effective vessel of the music and clinical process. J.C. directly addressed what he saw as his responsibilities in the moment:

> J.C.: As a music therapist, I feel a sense of responsibility to try my best to make the most of their dying experience and bring the joy of music and a feeling of comfort and support to the patient and family.

Ella questioned the roles of the music and of herself during a significant music therapy session, highlighting her sense of responsibility to create a "good" death environment:

> Ella: I felt like, this is what music therapy is when someone's dying; this is great. And other times I thought, God, am I an intruder? Does he blame me that she died while I was there? All my core issues came up. But I really felt like it was a good session and a good death, and I was really, really honored to be a part of it.

Category Four: Aesthetics, Transition, and Transformation

Theme 7: The Central Goal Is to Help the Patient Transition Meaningfully, with as Little Discomfort as Possible. All four participants shared a sense that their central goal in providing music therapy for clients who were imminently dying was to facilitate a shift from any visible suffering, anxiety, or pain to a place of minimal discomfort across several dimensions of the dying experience. However, all four also acknowledged that discomfort and pain were sometimes inescapable. Participants agreed that supporting a client's unique process was important.

> Nathan: I think often times you encounter people who aren't ready to go yet. They, in fact, might be actively dying, but they are not in a place yet where they are ready to let go or say goodbye and move on to whatever they're going to be moving on to. I try to gather information around those contexts. For instance, they may be waiting for their daughter to come in from out of town. There may have been some sort of emotional spike of energy prior to them moving into this space. So in that moment I'm thinking, "I'm not going to help this person transition if they're not ready to move." Instead, what I want to be focusing on is, "How can I help hold them in this space? How can I hold both of them in this space together in a way that can help

> fuel this interaction that ultimately can lead to successfully dying in a way that feels rich and meaningful and with value?"
> Ella: … it's really a matter of letting my fingers and my voice meet them where they are and seeing how my music influences their music. And hopefully that can bring some relief, some shift, some change from what I'm hearing from them.

Theme 8: When Loved Ones Are Present, the Music Therapist Uses a Dynamic and Collaborative Process to Facilitate Meaningful Transition for Both the Client and His or Her Loved Ones. All four participants agreed that when loved ones were present, their needs became equally as important in the music therapy process. J.C. and Renee introduced the idea that the family's experience was sometimes incongruent with that of the client's. In this case, the therapeutic process became dynamic: a balancing act between serving both patient and client.

> J.C.: Sometimes family might request seemingly inappropriate songs that are up tempo and lively when a patient may need something relaxing and comforting. So you work to best serve both the patient and family needs. You're always trying to find a way of integrating, adapting and finding a balance where you can best serve the patient and the family. It's an active, collaborative process that we do in music therapy with actively dying patients where you're involving everybody in the process.
> Renee: If there are people in the room, I watch what's going on with them too, so whether people are turning away from the person who is dying or if they're turning toward them. If they're… sometimes people cry… well, sometimes they're tears of release and letting go… there are so many layers to everything; it's hard to pin it down to one thing.

Renee considered the family's experience of the death to be equally as important, as they may carry the meaning of the experience with them. Ella, Nathan, and J.C. agreed, sharing the importance of actively involving loved ones in the music-making experience when possible.

> Ella: My way to involve them in the session becomes what can you tell me about this person and music? What song do you think they would want to hear? What song would they want you to hear in this moment?
> Nathan: You walk into that room and the family's all just kind of sitting there like this, not saying anything, and the moment a familiar song comes on, the moment a familiar spiritual begins to be introduced into the environment, that's when the emotions start to come

Theme 9: Music Therapy Can Reveal Deeper Meaning and Beauty in the Midst of Pain and Suffering. All four participants used the word "beauty" or "beautiful" numerous times when describing significant experiences providing music therapy for a client who was actively dying. The aesthetic quality of experiences in this setting was described as important for the overall effect of the session on both clients and loved ones. Participants shared a sense that music therapy can facilitate a sense of meaning and beauty in relation to the full spectrum of human experience. Ella shared this as motivation for working in this setting:

> Ella: …wanting to go into this work for the desire to help be a part of something that can be beautiful. And realizing that there's great suffering in this world and how you find beauty in their suffering.

J.C., Ella, and Nathan expanded on the function of meaning-making in the midst of human suffering.

> J.C.: I find it meaningful to work with all sorts of patients and families, and because this is a time when they're actively dying, it takes on an importance and significance. To me it has an inherent meaning.

Ella shared her realization that although music therapy had the potential to create beauty in the midst of suffering, this was not always what occurred:

> Ella: Man, we're supposed to make these moments beautiful in hospice, and they're just not. It was really a shocking discovery about this work... How do you find aesthetic in something that is unaesthetic? I think that's just how my

existential self has made meaning of witnessing suffering and great acts of suffering and great moments of suffering and beauty. And sometimes it's both in the same session.

Nathan expanded on this concept, stressing the importance of framing suffering in a larger context:

Nathan: Drawing upon not thinking of the active dying experience as an isolated experience, but really understanding it as the culmination of a much larger and extensive process…
The way that we live is the way that we die, so what is going to make the most sense for this person during this chapter?

Subtheme 9.1: The dying process can be musical. Nathan, Ella, and J.C. offered the idea that a patient's physiological experience can be integrated within the larger experience of music in the environment.

Ella: The dying process can be obviously physical but it's also musical.
Nathan: I don't really make distinctions between receptive or recreative music experiences anymore because I don't feel like you're ever truly just listening. If you're actively listening, then you're breathing differently, you're moving differently, you're thinking differently, so in some way you are contributing to the aesthetic environment.

Theme 10: Music Therapy Can Transform the Experience and Environment. All four participants shared stories as evidence that music therapy had the potential to transform the experience of actively dying for both clients and their families:

Nathan: It ended up being a very beautiful experience because she died almost immediately after they took her off the meds, but we weren't really aware of that. They were really embraced within the music, I think we were all really embraced within the music.
Ella: The daughter was doing a great job playing really soft waves [with the ocean drum], and I was talking to the client during the intro also; moments of reflecting back what I was noticing about this room and these people who loved

> her, and my guesses about her. And then I moved into the lyrics, changing the lyrics. I think I made up a few verses and found a short phrase that became a part of the song. It was something to the effect of, "You are in my life, you are loved," over and over. I expanded that music, watching the client the whole time. And she stopped breathing during the song and died. And it was… that moment was beautiful; she was so surrounded by people who love her.

J.C. observed that he noticed mostly positive changes as a result of music therapy:

> J.C.: Unfortunately, some deaths are very difficult and problematic and as hard as we try, we are not always able to bring the comfort and ease that we strive for to certain patients. But in my experience and with most of the patients that I have seen who are actively dying, music therapy has had a profoundly positive effect in their final hours.

Renee shared this view, pointing out that music had the potential to support a variety of environments depending on the needs of the client and his or her loved ones.

> Renee: Sometimes, people need to leave. Sometimes they need to be there. Sometimes they need it quiet. Sometimes they need it soothing… relaxing with hymns… and there's sometimes something more conversational and upbeat. It's different every time.

Discussion

This phenomenological analysis revealed nine emergent themes present in all four interviews and one emergent theme present in three of the interviews. I grouped the 10 emergent themes into four broader categories to guide discussion of these findings.

Ongoing Assessment

In all four interviews, participants noted some form of ongoing assessment. Existing music therapy literature has extensively explored the features of a music therapy assessment for hospice

clients; however, there is little emphasis on the role of assessment in caring for the actively dying patient. In some cases, this is because the music therapist has already had a chance to have an assessment session prior to the patient entering the dying process (West, 1994). The majority of assessment tools are designed to measure a client's communicative or musical behaviors (Hintz, 2000; Thompson, Arnold, & Murray, 1990). In addition, there is an assumption that assessment tools should contribute to generalizable information informing treatment goals (Lipe & York, 2000). However, the behaviors displayed by actively dying clients are often quite subtle. In addition, many of the factors informing the music therapists' assessment in this study were abstract: Renee described using her intuition to assess the energy in a patient's room. Considering these factors and the unique experiences of dying clients, one might wonder if a formal assessment could ever be generalizable.

All four participants agreed that assessing global pain and/or anxiety was a primary consideration before providing music therapy. A survey by Groen (2007) revealed that hospice music therapists use a variety of numerical tools to assess pain. It is notable, however, that spiritual support was listed in this study as the primary reason for referral in music therapists. A total understanding of pain and anxiety requires an assessment taking other global factors that influence pain into account (Coward & Stajduhar, 2012). Understanding the importance of global assessment, one might wonder: how does a numerical rating help music therapists address the factors contributing to the experience of pain? Maue-Johnson and Tanguay (2006) created a global assessment tool that addressed several aspects of the hospice patient's experience, including physical, psychological, social, and spiritual domains. Although the assessment was geared toward assessing hospice clients before they reached imminent status, the tool largely mirrors the information that was sought from clients' families and the interdisciplinary team by study participants.

With this in mind, all participants embraced flexibility as they developed as clinicians. As J.C. noted, "Sometimes everything you might have read about this patient may be non-applicable when you walk into the room." Participants described continuously assessing each moment using intuitive and musical processes. McFerran and

Shanahan (2011) described an assessment procedure with a child in hospice care that, instead of assessing for future goals and objectives, focused on meeting the child in the moment with music in order to provide presence and focused listening. Lichtensztejn, Macchi, and Lischinsky (2014) discussed the features of assessing clients who were minimally conscious, noting the parallels between creative music therapy and engagement in receptive experiences to assess and communicate with clients. All participants in this study indicated small physical and energetic responses as evidence that there was some level of communication occurring with each client, even in his or her final moments. It is clear that participants valued assessment to gather knowledge about their dying clients; however, whether or not formal assessment is a necessary condition to facilitate a meaningful music therapy experience during the dying process is unclear.

Intuitive Processes

Bruscia (1998) defined intuition as an "inner knowing," a spontaneous process of deriving whole meaning from a seemingly illogical process. Intuition has been identified as a tool that may inform both the clinical and musical process (Forinash, 1992). Three participants indicated intuitive processes as extremely important in the dynamic clinical process. In addition, references to intuition were often included in the literature describing experiences of providing music therapy with clients who were actively dying (Cadesky, 2005; Sekeles, 2007; Zabin, 2005).

It is noteworthy that Brescia (2005) was inspired to conduct a qualitative study examining the role of intuition after her experiences providing music therapy with children in palliative care who were actively dying. Her results suggested that intuition may be a product of the interaction between trust, relationship with the client, deep listening, self-awareness, and previous experience and education. All four of the participants in this study noted the importance of deep listening and self-awareness along with the importance of knowledge and ongoing assessment in the clinical process. J.C. shared that he felt this was the "essence" of the work. Therefore, intuitive processes may play a very large role in music therapists' experiences of music therapy with clients in the dying process, even if their elements are not conceptualized as such.

Countertransference

All four participants confirmed that they experienced rich and influential personal reactions to sessions with imminently dying clients. This finding was consistent with both research suggesting that a music therapist working in hospice may be forced to examine existential issues related to death (DiMaio, Wilkerson, & Sato, 2015) and also that music therapists' countertransference may significantly influence the clinical process (West, 1994). All participants recalled meaningful sessions in which their music-making interacted with ineffable events and feelings, creating a spiritual experience that influenced their worldviews thereafter. Perhaps music therapy is a natural catalyst for spiritual experiences: in a retrospective analysis of family satisfaction data for cancer patients receiving music therapy, Burns, Perkins, Tong, Hilliard, and Cripe (2015) found that family members of hospice patients who received music therapy were more likely to report receiving adequate spiritual support and having spiritual conversations. The consistent presence of spirituality in the literature and in the experiences relayed by participants suggests that it may very well be elemental to hospice music therapists' experiences.

An unexpected finding related to countertransference was the dynamic exchange of meaning that participants experienced. Countertransference to significant sessions influenced their worldviews and became material to be integrated into their spirituality. Scheiby (2005) discussed the phenomenon of intersubjective countertransference, or that which influences the process of the therapist in relationship to the therapeutic process. In the process of being fully "with" and "for" the client in music, the music therapist may experience personal revelations as a result. Birnbaum (2014) further described the concept of intersubjectivity, or the therapist's experiences of transformation and healing as a result of his or her therapeutic relationship with a client. Traditional views of countertransference generally accept that acknowledging this phenomenon is important in order to differentiate between the client's and therapist's experiences. Intersubjectivity does not negate this reasoning; it suggests, however, that it is highly unlikely that a music therapist will enter into an intimate therapeutic relationship with a client without experiencing some aspect of personal transformation as a result.

The last emergent theme—something that was distilled from both countertransference in sessions and also the discussion of the various roles a music therapist might take on during the clinical process—was the participants' feelings of responsibility to transform the environment in a meaningful way. In a personal reflection of her experience with a dying client, Wagner (2015) wrote, "I had served a very specific, important purpose, and the moment was over. I once again felt the strange and unique warmth of giving so much meaning to someone I knew so little" (p. 1077). Marom (2008) discussed a countertransference issue in hospice music therapists as a feeling of responsibility to make something beautiful out of something painful. DiMaio (2010) identified a "desire to fix" as a reaction to her work providing entrainment to address pain in hospice clients. The participants in this study identified the process of transforming painful experiences into beautiful ones as a core element of the work. Perhaps this reflects our American unwillingness to welcome or acknowledge that dying is a natural, and sometimes unfair, aspect of living despite the advances of modern medicine (Webb, 1999). The prominence of this question suggests that the experiences of hospice music therapy and countertransference are inseparable. Participants in this study felt personally moved by sessions in which clients and their families were able to contextualize suffering in relation to something larger.

Aesthetics, Transition, and Transformation

"Beautiful" was a frequently used and important word in this study, as all four participants expressed their sense that music therapy in the dying process could be profoundly beautiful. Beauty may be conceived as a universal concept of the human experience (Kenny, 2006). Salas (1990) defined beauty as "the quality or integrity of form that echoes, to a greater or lesser degree, the grace and elegance of the patterns of existence" (p. 4). Support for this assertion is outlined by Stern (2001), in which he suggested that beautiful music reflects integral dynamics of vitality and existence occurring in physical motion that connect us to universal concepts. Aesthetic experiences in this sense may extend beyond traditional definitions of music and toward the breaths of our clients as they die or the sounds of their loved ones in the room (Abrams, 2011). Three participants in this study viewed their dying clients and their

environments as integral parts of music creation. Salas (1990) supported this idea, suggesting that beauty is always an interdependent process: "Beauty is perceived when the conviction of the creator meets the conviction of the perceiver" (p. 7). Perhaps beautiful experiences serve the purpose of providing evidence of order, affirming both the client's process and the music therapist's role in their lives.

Although the participants in this study recognized the power in beautiful experiences, they also noted that painful experiences were equally important. Nathan expressed a thought echoed by Scheiby (2005): The way that we live is the way that we die; and in this sense, every death is meaningful. Salas (1990) described a broader conceptualization of aesthetics, noting that all artistic creation was full of merit because of its potential ontological affirmations of meaning. West (1994) offered this perspective in her sharing of a clinical vignette, writing, "Changes in the music used and the progression of her art and imagery paralleled her movement through phases and tasks of dying" (p. 123). Therefore, an experience may be unaesthetic and still hold meaning in relation to the client's lived experience.

Aigen (2007) introduced the idea of aesthetic experiences as transformational. All four participants spoke about the power of music therapy to transform the environment and facilitate meaning-making. In some cases, music therapy mirrored preexisting goals. In other vignettes, music therapy provided a transformation in perception of the environment. Transformation may be defined in the context of personal growth; however, there is inherent mystery and spiritual consideration in the process. It is often difficult to pinpoint the exact moment or process behind transformation. In the dying process, it is sometimes difficult to confirm that death has occurred. Supporting transition, or the transformation from living to whatever awaits after death, has become the overarching focus of providing music therapy for hospice clients (Krout, 2003). Aigen (2007) noted that the aspects of tension and release in music mirror a client's process of tension and release. The participants in the current study and other music therapists have noted that facilitating release for both clients and family members is a central goal of providing music therapy when clients are actively dying (Krout, 2001).

Implications for Research and Clinical Practice

Findings from this study reveal powerful concepts that are challenging to define but merit further exploration. Participants' experiences of balancing assessment and intuitive processes highlight the need for music therapists to discuss the role and scope of assessment for clients in the dying process. Music therapists might reconsider their use of numerical pain and anxiety assessment tools and move toward using an informal global assessment process incorporating both their observations and that of client, family members, and staff when possible.

Hospice music therapists may also benefit from increased exploration of the role of personal reflection in their practice, whether this takes the form of intuition, spiritual experiences, or countertransference. It may be helpful to identify how to best nourish the conditions that interweave to create intuitive experiences according to Brescia (2005): trust, deep listening, self-awareness, previous experience and education, and relationship to client. Clinicians should continue to be curious about how they define and experience spirituality, cultivating mindfulness of its influence on themselves and their music therapy practice. These research findings support existing literature stressing the importance of supervision and self-care, as the dynamic exchange of meaning within the clinical process and in participants' lives necessitates careful processing of these concepts.

Conclusion

This study sought to understand the experiences of music therapists who provide music therapy for clients whose death is imminent. Four experienced hospice music therapists described their diverse experiences through semi-structured interviews. Ten emergent themes were identified through a process of phenomenological analysis. Major themes in this research included the role and scope of ongoing assessment, the role of intuitive processes, the intersubjective nature of countertransference in participants' experiences, and the role of aesthetics in facilitating transitional and transformational experiences. Much of what we know about this work is veiled in spiritual and esoteric concepts; and ultimately, as each participant expressed, it is impossible to know the experiences of

our clients with absolute certainty. Perhaps better understanding our own experiences will help shed light on the gray areas in the space between ourselves and our clients as we move, with them and for them in music, toward transition and transformation.

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Appendix A

Interview Questions

1. How many years of experience do you have working as a music therapist in hospice care?
2. Please describe your current job, including number of clients that you see, setting, characteristics of clients, and anything else that feels important.
3. Describe your clinical and/or philosophical approach to music therapy in hospice.
4. Describe your clinical decision-making process when clients are actively dying.
5. Please describe a memorable music therapy session with a client who was actively dying.
6. What feels important to you about that session?
7. Describe your approach now compared to when you first began practicing as a music therapist.
8. What else would you like to discuss regarding music therapy for clients who are imminent?

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