A Music Therapist's Use of Her Voice in End-of-Life Care: A Heuristic Self-Inquiry

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ABSTRACT

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Samantha M. Borgal

The purpose of this research was to examine the author's beliefs, attitudes, and emotions related to her voice and to gain insight and self-awareness about how this might affect her work as a music therapist in end-of-life care. The data collection and analysis procedures were conceptualized within Moustakas' six stages of heuristic inquiry and were delimited to include only self-reflection components. Sources of data included a self-reflexive journal and audio recordings of the researcher's voice. Open coding was used to identify themes related to the research question. These themes were organized using axial coding and layers of meaning were examined and clarified. The research process culminated with a creative synthesis in the form of an original song that was composed, sung, and recorded by the researcher. Personal implications as well as implications for clinical, educational, and research activities are presented.

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Chapter 1. Introduction

Significance of Inquiry

The voice can be an important therapeutic instrument for music therapists working in end-of-life care (Cadesky, 2005; Clements-Cortés, 2013; Dileo, 2011; Loewy, 2005; Nakkach, 2005 & Summers, 2011). There are many ways that music therapists use their voices in this setting. For example, vocal qualities should be fluid, warm, with no tension and have a moderate vibrato (Dileo, 2011), as well as a slow, soothing, soft, strong, grounded, and with a concentrated tone (Cadesky, 2005). Music therapists' voices can be a non-verbal, sensitive communicator to support, hold, and lull the patient and/or caregivers through: (a) matching a client's breathing patterns, (b) changing vocal timbres, (c) opening one's voice, (d) changing vocal placement, (e) varying rhythms and dynamics, (f) singing on vowels, (g) singing improvised or pre-composed lyrics, and (h) the use of reflexive improvisation where the therapist vocally reflects loved ones' sentiments to the client (Cadesky, 2005; Dileo, 2011). Humming, repeating familiar melodies, vocal sounds (such as toning), and chanting may also be used to shift, share, or release emotions; decrease pain and can accompany the patient by communicating an unconditional sense of presence, healing, and comfort (Summers, 2011; Nakkach, 2005).

Given that music therapists need to use their voices in both knowledgeable and therapeutic ways, one might assume that they would need to work toward achieving a certain type of vocal quality. However, some literature suggests that the quality of the therapist's voice is not as important to the therapy process as is one's skill in the use of specific vocal techniques and/or the quality of the therapeutic relationship (Austin, 2011; Cadesky, 2005). These ideas seem to conflict with music-centered models of music therapy where the aesthetic quality of the music is believed to be inextricably linked to the therapeutic process and outcomes (Aigen, 2005; Lee, 2003). Summers (2011) indicates that proper vocal technique must be well established using diaphragmatic breathing and vocal placement in resonators with an open and relaxed airway when working in end-of-life care. She also maintains that one must sing from the heart with intention and awareness as the voice carries the sound ambiance, represents the *hello* space, and adds to the dimension of beauty that is necessary for therapy to occur. These various positions seemed somewhat contradictory to me, which in turn led me to wonder about the role of voice in end-of-life care and more specifically, about the role of my own voice in this context.

Personal Relationship to the Topic

I am a certified Canadian music therapist (MTA) who has nurtured my passion for classical and operatic singing through fifteen years of vocal lessons, participation in competitions and performances, and mentoring young vocalists. Before my undergraduate degree, while nurturing my classical voice, I was also listening to R&B, country, and popular music. My passion for classical and opera was further ignited during my music therapy undergraduate degree when I was able to attend professional opera performances, perform as a soloist in a concerto competition, compete for scholarships based on academic achievement in voice, and received supportive feedback from professors and fellow students. Upon completing my degree, I began a full time 6-month music therapy internship in palliative care. During my internship, I was reunited with various genres such as Broadway, pop, country and jazz, and found joy in new genres such as rock and roll and the blues. During this time, patients, staff, and volunteers made numerous comments about the "unique" quality of my voice. Some of these comments included: "You have a beautiful voice," "Your voice sounds like honey," "You're a great singer," "You should be recording somewhere," and "Where do you perform?" While I appreciated these compliments, they also led me to wonder how my voice in particular affects my practice as a music therapist in end-of-life care. Although others may perceive my voice in a certain way, are there underlying assumptions or perceptions that I have about my own voice and/or about my vocal identity that subconsciously affect my work? I began to address this question during my internship by exploring this topic with my supervisor. Since finishing my internship two years ago, this issue remained in the back of my mind. Writing a research thesis within the context of my graduate music therapy training has allowed me to explore this topic with much greater focus and depth.

Statement of Purpose and Research Question

Given how voice appears to be an important therapeutic tool in end of life care and how my own voice is a central component of both my clinical work and my musical identity, the purpose of this research was to examine my beliefs, attitudes, and emotions related to my voice and to gain insight and self-awareness about how this might affect my work as a music therapist in end-of-life care. Heuristic self-inquiry was deemed to be an appropriate methodology to address this purpose. The primary research question was: What are the experiences and insights

of an end-of-life care music therapist when she engages in self-reflective practices that are related to her own singing voice?

Assumptions and Delimitations

As a music therapist in end-of–life care, whose primary instrument is voice, and who had done some prior reflection on the research topic during her internship, I had a number of assumptions about my voice that needed to be acknowledged. I assumed that my voice and the way that I used it in my clinical setting had the capacity to *break the ice*, establish rapport, and create connections with clients and their families. I assumed that my voice had the capacity to hold a nurturing space. I assumed that my voice could calm, comfort, soothe, inspire, and surprise people as well as allow them to cry. During data collection, I tried to write as authentically as I could to allow new insights and ideas to emerge.

In order to work within the time frame of a Master's thesis, a number of delimitations were imposed upon this study. Specifically, with the exception of two journal entries, data collection was delimited to a four-week period. There were three sources of data: (a) audio recordings completed after sessions of the sung material that had emerged in sessions, (b) journal entries about my experiences of using my voice in end of life care, and (c) journal entries about my observations, thoughts, and feelings while listening back to the audio recordings. Mandalas were completed after each recording session to help provide me with closure but they were not analyzed as data per se as this was beyond the scope of this research. Mandalas are circle drawings that "mirror the Self as the container for the psyche's striving toward self-realization or wholeness" (Fincher, 2010, p. 20). Audio recordings were not made in the therapy sessions themselves so as not to affect patients' therapeutic processes at a potentially sensitive time in their (and their loved ones') lives. See chapter three for additional details pertaining to these delimitations.

Key Terms

In my work setting, *end-of-life care* falls under the definition of palliative care. According to the World Health Organization (2014):

> Palliative care is an [holistic] approach that improves the quality of life of patients and their families facing the [challenges] associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable

assessment and treatment of pain and other problems, [including those that fall under] physical, psychosocial and spiritual domains. (p. 5)

Within the context of this research my *singing voice* is defined as musical sounds that I create with my voice including humming, singing pre-composed, original and improvised songs; vocal improvisation, and vocal entrainment/matching. *Vocal improvisation* includes singing or vocalizing words, vowels, hums or sounds in inventive, spontaneous, extemporaneous, and resourceful ways (Bruscia, 1987). *Vocal entrainment/matching* is a form of vocal improvisation where I match a patient's baseline respiratory rate with my voice alone or sometimes accompanied by instruments such as guitar, gradually slowing/changing the rhythm of the improvisation in order to slow and/or regulate the patient's breath (Baker & Uhlig, 2011; Dileo, 2011; Summers, 2011).

Finally, *self-reflective practices* are defined as those that involve contemplation or reflexive study for the purpose of understanding one's own attitudes, beliefs, and emotions as a music therapist who uses her voice in end-of-life care (Bruscia, 1998).

Chapter Outline

I have organized this heuristic self- inquiry into five chapters. Chapter One describes the significance and purpose of the inquiry as well as my personal relationship to the topic. Assumptions, delimitations, and key terms are defined. Chapter two reviews relevant literature in the areas of: (a) music therapy in end-of-life care, (b) use of voice in end-of-life care, and (c) self-inquiries contained in the music therapy literature. Chapter three describes how the heuristic self-inquiry methodology was conceptualized in this research. Chapter four includes the results that emerged from the illumination and explication phases of the inquiry. Lastly, chapter five presents my *aesthetic* representation of the results (in the form of an original song) and essential meanings revealed in the explication phase outlined in chapter four. This final chapter also includes limitations; personal, clinical, and academic implications of the results; and suggestions for future research.

Chapter 2. Related Literature

Music Therapy in End-of-Life Care

One of the first articles to address Canadian music therapy in palliative care was written by music therapist Susan Munro and Canadian palliative care founder Dr. Balfour Mount, and was published in the Canadian Medical Association Journal in 1978. This publication spawned a response from a physician who asked if the publication was "some kind of joke" (Amies, 1979, p. 110). Amies (1979) concluded his letter saying "is it necessary to publish such articles in the guise of learned scientific thought when they are merely common sense made muddy and obscure by jargon-ridden balderdash?" (p. 110). In the original article, Munro & Mount (1978) aligned music therapy with palliative care philosophies of the time, indicating that:

> In the hands of a trained music therapist, music has proven to be a potent tool for improving the quality of life. The diversity of its potential is particularly suited to the diversity of the challenges – physical, psychosocial and spiritual—that these patients present (p. 1029).

In response to the letter to the editor written by Amies, Mount (1979) wrote:

> As we stated in our article, the term "music therapy" has often provoked irrational enthusiasm or unjustified skepticism. Between these extremes lies the fact that music therapy has, within the last 20 years, emerged as a rational discipline. Our experience in palliative care suggests that the diversity of its potential is particularly suited to the diversity of the challenges these patients present (p. 112).

Since that time, the body of music therapy literature in end-of-life care has continued to grow, reflecting the evidence-based use of music by trained music therapy professionals within a therapeutic relationship to effectively support and manage end-of-life challenges for patients and their caregivers (Aldridge, 1999; Bradt & Dileo, 2010; Clements-Cortés, 2013; Dileo & Loewy, 2005; Gallagher, Huston, Nelson, Walsh, & Steele, 2001; Gallagher, Lagman, Walsh, Davis, & LeGrand, 2006; Hilliard, 2001, 2005; Krout, 2003; Magill-Levrault, 2009; O'Callaghan, 2010; O'Kelly & Koffman, 2007; Rykov, Weeks, Cadrin, Pringle, Salmon, & Montgomery, 2008; Tung, 2014). However, the literature also indicates that more research is needed to see if specific types of music and/or instrumentation have implications for symptom management in various domains of palliative care (Groen, 2007; Gutgsell et al., 2013).

The physical domain. Within the physical domain, music therapy may be used to support pain relief, lower perception of pain, divert attention away from pain, and increase physical comfort, relaxation and contentment—even within a single music therapy session (Curtis, 1986; Groen, 2007; Gutgsell et al., 2013; Krout, 2001; O'Callaghan, 1996). In a study that examined the self-reported effect of a single music therapy session on anxiety experienced in palliative care (measured by the standardized Edmonton Symptom Assessment Scale [ESAS] and a pulse oximeter), Horne-Thompson and Grocke's (2008) findings indicated that music therapy was effective for reducing pain ($p = 0.019$), tiredness ($p = 0.024$), and drowsiness ($p = 0.018$). In a study conducted by Gallagher et al. (2006), 159 music therapy sessions that took place in a palliative care context were analyzed ($N = 200$). This was one of the first quantitative studies within the end-of-life milieu to include such a large sample size. They found that music therapy was effective for improving body movement, pain and shortness of breath as measured by various standardized scales including the Riley Infant Scale (adapted) and the Nursing Assessment of Pain Intensity. A study conducted by Kerr (2004) on the effect of music on non-responsive patients within the hospital found that physiologic measures of heart rate, $F(2) = 0.017$, $p = 0.983$, and respiration rate, $F(2) = 0.403$, $p = 0.674$, were improved (lowered) for participants ($N = 10$) following two types of music: classical and new age styles with no preference for one type over the other. Although the results did not achieve statistical significance, they showed consistency over a two day period, $F(2) = 0.413$, $p = 0.668$ (heart rate), and $F(2) = 2.12$, $p = 0.149$ (respiration rate). In a study ($N = 80$) conducted by Krout (2001) on the ability to address pain in a single music therapy session, significant statistical results were found for independently observed pain control, $t(158) = 6.48$, $p < .001$ (observed by four trained volunteers), self-reported pain control, $t(18) = 4.02$, $p < .005$ (rated by the patient), independently observed physical comfort, $t(158) = 6.54$, $p < .001$, and self-reported physical comfort, $t(18) = 3.37$, $p < .005$. Groen (2007) reported that 93% of music therapists use music listening techniques (live or recorded) to address pain and stated that "more research is needed to evaluate specific music therapy techniques on pain in the hospice setting" (p. 111). Specific music therapy interventions that may be used to address physical issues in palliative care are outlined below.

The psychosocial-emotional domain. Within the psychosocial-emotional domain, music therapy may help relieve anxiety, fear, depression, withdrawal, and tension (Bailey, 1986) as well as to facilitate expression of grief and exploration of loss (Clements-Cortés, 2004). Horne-

Thompson and Grocke's (2008) study found anxiety to be significantly reduced in a single music therapy session for individuals who had end-stage terminal disease as measured with the standardized ESAS and a pulse oximeter. Gallagher et al. (2006) found that music therapy was effective for improving facial expression and mood, decreasing anxiety, and improving verbalization as measured by Rogers' Happy/Sad Faces Assessment Tool and visual analog scales.

Salmon (1993) described the relationship between music and emotion, explaining that both involve vast complexities, are multidimensional and contain huge breadth and depth within the human experience. She indicated that music can enable a person to express that which cannot be spoken while the music therapist is present within the figurative and literal music therapy space using his/her music to support, encourage, reflect, and accept the varying expressed emotions within the music therapy session. She directed the music therapist to use intelligence and sensitivity; balancing openness and respect to the infinite possibilities of music, emotion and human spirit.

Clements-Cortés (2010) studied the value of relationships between patients, their family, friends, themselves, and to the spiritual at the end of life. She assessed music therapy case studies using the Dileo and Dneaster (2005) model of music therapy in end-of-life care, which utilizes the supportive, communicative/expressive, and transformative levels of music therapy practice.[1] She found that working within these levels of intervention can facilitate relationship completion with one's self (intrapersonal), with others (interpersonal) and with the spirit (transpersonal). This model can also help people express the five global sentiments: *I love you, will you forgive me?, I forgive you, thank you,* and *goodbye* which are very important in order to facilitate the developmental landmarks of death, including meaning making of life's accomplishments,

[1] Each level of music therapy practice within the music therapy Levels of Practice Model has specific goals in mind: The supportive level is allocated to palliate physical, psychological and cognitive symptoms common at the end of life, the communicative/expressive level is allocated to provide a means for the patient to express feelings which he or she may or may not be aware, and the transformative level is allocated to facilitate insight and growth at the end of life which can include reviewing and coming to terms with his or her life, resolving conflicts and feelings, forgiving self and/or others, addressing spiritual/existential issues, exploring after-life beliefs and/or finding peace. Levels do not have to be inclusive, consecutive, or exclusive (Dileo & Dneaster, 2005, p. xxiv).

completing worldly affairs, and relationship completion (Byock, 1997). Clements-Cortés (2010) stressed how the last days and weeks of a person's life can be a valuable time for a person to heal and grow and that a music therapist assisting with life review can facilitate closure, reconciliation, peace and a good death. In a phenomenological study, Clements-Cortés (2011), worked with four participants and two co-participants (spouses of two of the participants) in order to observe music therapy and its ability to facilitate relationship completion at the end of life. Six major themes emerged: (a) love—the expression to themselves, to a loved one or to God, (b) loss—of life as they knew it, a loved one, previous losses, (c) gratitude—the celebrations of who the participant was to another, (d) growth/transformation—the participants' use of their final days to live as opposed to waiting for death to come, (e) courage/strength—the ability of the participants to proceed through this process and felt pleased with the outcomes, and (f) good-bye—the realization that one must say goodbye to their family, friends and life as they knew it, and that music therapy assisted with the expression of good-bye despite the difficulty of saying good-bye (p. 35).

The spiritual domain. Aldridge & Aldridge (1999) stated that challenges faced by those with terminal illness are associated with identity. Fundamental questions such as *Who am I?* and *What will become of me?* are themes of existence contained in every spiritual tradition. "Concepts of hope and transcendence are drawn from spirituality and in music therapy the transcendence is realized through the creative act" (p. 85). Wlodarczk (2007)'s self-report study on the spirituality of persons in inpatient hospice who acted as their own control (N=10), receiving both session A, 30 minutes of music therapy and session B, 30 minutes of a non-music visit found that spirituality was an important topic for these persons at the end of their lives (75% of participants requested spiritual music within the music visits, 35% initiated discussions related to spiritual issues within the music visits, and 80% of people in the non-music visits were disappointed to not have had music. Findings include that music therapy supported them in achieving feelings of spiritual well-being as compared to the non-music group. Wlodarczk (2007) indicated that future research should include a larger sample size and participants with a broader range of spiritual beliefs in order to reach more generalizable conclusions.

Quality of life. Aldridge (1995) explained that music therapy can be an influential supporter and facilitator of growth and change at the end of life thus affecting individuals' overall quality of life. In a 2010 Cochrane Review, Bradt & Dileo cross-analyzed two quality of life

studies pertaining to end-of-life care by Hilliard (2003) and Nguyen (2003). They found that music therapy had a positive effect on psychophysiological well-being, functional well-being, and social/spiritual well-being. Hilliard (2003) also found that while the physical status of all participants (in the experimental and control groups) declined over time, those who participated in music therapy (the experimental group) had higher quality of life scores, $F(1, 72) = 8.437$; $p < 0.05$, which increased over time with further music therapy sessions as compared to the standard care group who did not receive music therapy.

Caregivers. Caregivers can play an invaluable role assisting in the care of the patient at the end of their life and music therapy can play a valuable role supporting physical, emotional and spiritual distress among caregivers during the dying process (Magill-Levreault, 2009). Music therapy can facilitate enhanced communication (Hilliard, 2003; Magill-Levrault, 2009) and facilitate relationship-completion (Magill-Levreault, 2009; Clements-Cortés, 2013). Authors have indicated that more research is needed on music therapy with adult caregivers who support people at the end of their lives (Clements-Cortés, 2013; Tung, 2014).

Music therapy interventions. A patient's relationship to music when admitted to palliative care can vary. The patient may have previously worked with music or as an amateur or professional performer, they may never have picked up any instrument or sang, and/or their musical listening habits can vary widely. Also, symptoms such as delirium, confusion and/or disease progression may determine their ability to experience music therapy and the music therapists' level and type of music therapy intervention. Therefore, musical applications cannot be generalized within the palliative care context (Clements-Cortés, 2013). It is important to consider patients' preferred or self-selected music (Clark et al., 2006; Hogan, 1999; Mitchell & MacDonald, 2006; O'Callaghan, 1996; Salmon, 2001), as well as the benefit of live music versus recorded music (Bailey, 1983; Clements-Cortés, 2011). Regardless of the intervention used, it must be applied within a comfortable and safe environment and in the context of a therapeutic relationship (Salmon, 2001; Summers, 2011).

Music therapy in end-of-life care includes a broad range of experiences or interventions in order to address the domains of functioning outlined above. Receptive music therapy techniques (where one responds to music interventions in a non-musical way) such as listening to live or pre-recorded music is common due to the physical limitations of patients in this setting (Bradt & Dileo, 2010). These interventions can help to decrease tension, stress, anxiety, pain, and pain

intensity as well as help to regulate breathing (Grocke & Wigram, 2007), relieve insomnia and promote sleep (Schulberg, 1981), and provide a sense of peace and nourishment (Salmon, 2001).

The Bonny Method of Guided Imagery and Music (BMGIM), a receptive method also referred to as GIM,[2] has been used to reduce psychological stress in end-of-life care contexts (Short, 2002). Cadrin (2005-2006) described the use of GIM with a 47-year-old woman at the end of her life. Within 10 sessions, this patient was able to express her emotions surrounding shame, family relationships, spirituality, faith, fear, acceptance, gratitude, ownership of her role in her family relationships and was able to die peacefully with her mother at her side.

Music for reminiscence is another receptive technique in music therapy and is used to assist patients with memory retrieval and life review for the purpose of supporting identity, self-esteem, making further connection with family members across generations (O'Callaghan, 2004), and refocusing one's attention away from unpleasant feelings and thoughts (Bailey, 1984). Patients may participate in song choice interventions where they are asked to select songs based on a specific criteria such as how they are feeling on that day (Dileo & Dneaster, 2005) or within that session (Salmon, 2001). The therapist may sing the chosen song for the patient, or the therapist and patient may sing it together (Clements-Cortés, 2004). It has been found to be a non-threatening way to facilitate expression for those who feel hesitant to share feelings openly for various reasons (Hogan, 1999). Song choice can bypass habitual defenses, transforming past unresolved issues or pain into a sense of meaning, of beauty and the divine (Salmon, 2001). This resolution may lead to further interventions such as reminiscence or relaxation techniques (Clements-Cortés, 2013). Furthermore, it may increase self-esteem, help patients to re-gain self-identity and help increase social interaction (Clements-Cortés, 2004). Song stories, musical autobiographies, musical life review and music collages (all forms of music for reminiscence) may also be used in order to facilitate relationship completion according to Clements-Cortés (2013).

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[2] A model of music therapy developed by Helen Bonny which involves the conscious use of imagery elicited by specific classical music programs in order to uncover explorative levels of consciousness not usually accessed within normal awareness (Bruscia, 2012, First Paragraph).

Song (lyric) discussion or lyric analysis may provide a means of expression for many feelings (Clements-Cortés, 2004). It provides a non-threatening way for patients to express their feelings and can help to facilitate the loss/grief process and regain self-identity (Clements-Cortés, 2004). O'Callaghan (1996) presented a case where song discussion facilitated an additional song request from the client and subsequent verbal processing. It also motivated this client to speak with his sister concerning her vision of his death and his reality of his dying process.

Music therapy in end of life care can also involve more active musical participation on the part of the client. For example, a patient may improvise a thought or feeling musically, or the therapist and patient may make up music together (Clements-Cortés, 2013). Some music therapists believe that music improvisation is a form of meaningful self-expression that goes beyond verbalization (Lee, 1996, 2003). Others believe that improvisation is the facilitator for additional exploration through words and music (O'Kelly & Koffman, 2007). Music therapists use improvisation to support, reflect, and encourage a client's musical creativity and expression (Clements-Cortés, 2004; Salmon, 1993). Salmon (1993) used improvisational music therapy techniques with a client named Steven, who with the support, reflection, encouragement, and acceptance of his therapist was able to express his sadness, anger, spirituality, and hope related to his illness. Clements-Cortés (2013) distinguished three types of improvisation used in end of life care. *Empathic* improvisation is when the music therapist uses compassionate music making to match the person's current state of physical or mental being to provide emotional relief and comfort. *Referential* improvisation is the naming of a story, topic or symbol to be improvised upon to enable the projection of emotions onto the identified story, topic, or symbol in order to clarify difficult and/or misunderstood emotions. *Active* improvisation involves the patient's free musical exploration using musical instruments to facilitate emotional awareness and insight to emerge from the act of improvising (Clements-Cortés, 2013).

Song composition (with words or instrumental*)* is the re-creation of words to an already existing song, or it is the complete creation of a new song (Clements-Cortés, 2004, 2013). Salmon (2001) assisted a patient to include her own words within a pre-existing song which incorporated themes of their expression of love for husband, hope for the future, belief in a higher power, and possible doubt of her future. Song composition may also work as an effective tool in the bereavement of the caregiver(s) accompanying the patient on their journey (Salmon, 2001). Hilliard (2011) discussed an effective songwriting process where David (the client) expressed his

feelings for his friends and family, explored his relationships as they were before music therapy and how they evolved to be during his time working with the music therapist. Songwriting helped David's communication with his wife, his family, his friends and his church and contributed to his quality of life up until his death. His eight songs also provided a legacy for his loved ones after he died. Similarly, O'Callaghan (1997) indicated that song composition in music therapy at the end of life can facilitate the expression of emotions and re-focus attention away from uncomfortable symptoms. The song can also serve as a support to care givers during their time of bereavement. More specific ways of using the voice in end of life care will be presented in the following section.

Singing and Voicework in End of Life Care

According to Austin (2011), music therapists rely heavily on vocal interventions in their clinical work. Voice has commonly been recognized to have a strong connection to one's inner self (Baker & Uhlig, 2011). "Vocal expressions have been described as magical, extraordinary, very personal, and an extremely sensitive form of emotional and social communication" (Baker & Uhlig, 2011, p. 25). *Voicework* is a term used to address the music therapist's interest working with the voice in personal, clinical, and research contexts (Baker & Uhlig, 2011). Voicework in music therapy has been used with a wide array of populations including end-of-life care.

Magill (2001) investigated how music therapy addresses suffering at the end-of-life and although it was not coined *Voicework* at the time, several vocal techniques were explicitly indicated. These include: toning (vowel sounds sung at different pitches with or for a patient in order to release tension and enhance awareness; first written about by Keyes, 1979), chanting (the repetitive singing of meaningful words chosen by patient or therapist in simple melodies to encourage communication and relaxation), singing songs (pre-composed, to ease expression of thoughts and feelings or for reminiscence), singing composed songs (through word substitution in pre-composed songs or the newly created to reflect meaningful events or themes), melodic improvisation using the voice (to provide contact with the patient, to foster relaxed breathing and/or to decrease feelings of isolation), and imagery in music using the voice (the singing of pre-established and preferred images to promote relaxation, re-focus thoughts and enhance mood). She suggested that the human voice is intimate and through the singing of gentle melodies and

tones, can increase comfort and that there is a "natural association between the human voice and nurturing" (p. 169).

Dileo (2011), talked about five different voices used with people who are imminently dying which can include their family members. They include: (a) the *Synchronized Voice* which is a modified entrainment technique used to decrease shortness of breath, (b) the *Nurturing Voice* which focuses on an open, moderately vibrated, fluid, warm, use of voice to sing pre-composed songs with a lullaby rhythm, (c) the *Accompaniment Voice* which is used to accompany the person or family by chosen songs which are meaningful, (d) the *Dialoguing Voice* where the music therapist communicates with an unconscious person or person with dementia and (e) the *Emoting Voice* which expresses the five sentiments explained by Dr. Byock (2004) which are *I love you*, *thank you*, *forgive me*, *I forgive you* and *goodbye*.

Summers (2011) created a *Hello* Space Model in end-of-life care which includes three phases of intervention. The first phase is to entrain with the person's body using breath and the E-string of the guitar to connect the voice with the client and therapists' *hello* centres. The music therapist alternates between two chords. In the second phase, the music therapist hums, sings on syllables and breathes into the pain and relaxation. The third phase consists of vocal improvisation with lyrics when appropriate.

Nakkach (2005) proposed vocal yoga including a six-step process which includes the use of soft voice, humming simple repetitive melodies, droning long tones, use of familiar song and invitations to meditate. This process is used to distract and to promote healing and well-being. According to Nakkach (2005), music therapy within the context of Eastern spirituality, which includes toning, chanting, yoga, and the incorporation of songs from various cultures across continents could be used in end of life care to allow music therapists to grow and deepen the connection to their core therapeutic intent, and to assist patients to quiet the mind, convey positive feelings toward detachment and to enhance spiritual insight.

Other music therapists have proposed other models and interventions that are also relevant to end-of-life vocal practices in music therapy. Cadesky (2005) used vocal improvisation to "be with" the person, to contain and match as well as entrain with breathing. Dileo & Parker (2005) sang songs to aid in relationship completion. This type of singing can involve family members and the patient. Lowey & Stewart (2005) proposed the use of lullabies to ease transitions, to communicate safety, accompaniment, reduced fear and love. Lullabies, they found, have also

been helpful for sleep induction and sedation. They proposed a four-step process to evoke sleep and sedation. Lowey (2011) created a Tonal Intervallic Synthesis method used to help with pain management in medical settings. Here, the music therapist works with the person in a therapeutic relationship and uses the voice to provide a *blanket of sound* with the intention of using the energies and vibration from toning and the movement between intervals to release a pain block. Toning is the singing of long tones for healing purposes (Keyes, 1979). Cadesky (2005), Clements- Cortés (2013), Dileo (2011), Hilliard (2005), Loewy & Stewart (2005), and Summers (2011) all stated the use of voice for music therapy entrainment, by way of creating/improvising sounds as closely related to patient's pain and/or breathing with a gradual shift toward healing sounds appeared to reduce the patient's perception of pain and/or could promote easier breathing experiences. Song dedication is an intervention where a patient or loved one selects a song for the other that expresses a chosen feeling or sentiment which is sung and performed by the music therapist (Dileo & Parker, 2005). Similarly, song legacy is an intervention where a recording of a specific song or composition is designed to be given to intended recipient(s) during the dying process or after the death of the loved one (Hilliard, 2005; O'Callaghan, 2004). Song legacies often include the patient's sentiments or suggestions for how the patient would like to be remembered and can be purposefully composed by the therapist and patient together or can emerge through the act of vocal improvisation (Hilliard, 2005; Dileo & Dneaster, 2005; O'Callaghan, 2004). Finally, in music therapy in end-of-life care, the therapist's voice can be used with combined approaches such as music and meditation, music and massage, music and movement, and/or other creative arts (Dileo & Dneaster, 2005).

According to Clements-Cortés (2004) singing can facilitate articulation, fluency, and breath control in speech, it can facilitate new ways of breathing, which can result in enhanced physical comfort and increased relaxation. Singing can also increase self-awareness and provide a sense of belonging, facilitate expression, and reminiscence; and family members can also sing at the bedside to the patient. Songs may be pre-composed or created spontaneously.

In end of life care music therapy, according to Cadesky (2005), the singing voice is a metaphor and vehicle for musical and non-musical qualities of the therapist. The raw materials produced by the voice equal the raw materials created in the therapeutic process. The human voice is a *primal* musical instrument which identifies the person's current states of neurological, emotional and spiritual functioning. It has the ability to act as an activator on deeper brain

structures and can *join* the client. Nakkach (2005) said that the voice communicates healing and comfort, and allows expression and the release of emotion like no other instrument. Summers (2011) stated that the voice provides space for giving and receiving between the therapist, client and music. "Our voice is the audible expression of our own unique energy" (p. 307). She views the voice as a healing force to help healing, promote harmony within one's self and the world, as a representation of our true selves, and a spiritual channel between emotions and spirituality.

In order to facilitate the previously presented *Voicework* techniques in end-of-life care, Nakkach (2005) used the combination of the quality of voice (delicate, intimate, open, simple and repetitive) and sacred syllables such as *OM* to effect the atmosphere of the patient and therapist to provide calm, transcendent, and spiritual connection for both the music therapist and patient at the end of life which can communicate healing and comfort. She stated that the effectiveness of toning depends on the quality of the attack, texture of voice, volume, and clarity of intent. Summers (2011), stated in relation to her *Hello* space model, that the quality of voice of the music therapist is influenced by diet, fatigue, emotions and their life (Summers, 2011).

Interesting and central to this research perspective, Summers (2011) stated that when using his/her voice, the music therapist must be aware of his/her vocal qualities and how these are potentially linked to therapeutic outcomes. Cadesky (2005) stated that the therapist's use-of-self acts as a therapeutic vehicle. In order to use the self as a music therapist, there must be *awareness* of the self and an understanding of how the voice may impact the session vocally and non-vocally. The music therapist must have clinical expertise in order to be spontaneous and client-directed and should know the vocal qualities which help to meet patient needs. The therapist must *hold* and *contain* the session with the voice and there must be an eagerness for *living* one's music therapy work in the positive and negative senses. Nakkach (2005) spoke to the awareness of the therapist's own inner states also and suggests vocal exercises and practices to help the music therapist become more aware of their inner states. Furthermore, Summers (2011) spoke about bringing an awareness of the whole self into sessions, which seems almost paramount to her *Hello* space model. Bringing the whole self or *hello* including one's whole voice into the music therapy session means to incorporate the therapist's lifetime of vocal experiences. There must be an identification of vocal skills and abilities, plus the music therapist must competently read the ambiance of the room and make assessments of the patient, their relationships, and their potential needs. The therapist must monitor counter transference and must possess proper vocal technique,

vocal support, diaphragmatic breathing, singing with intention and awareness of the voice. The music therapist should become aware of the person's musical identities and to tap into styles that relate to client's experience.

Self-Inquiries in Music Therapy

Self-inquires in music therapy involve the music therapist-researcher studying his or her own encounters with a music therapy related phenomenon of interest and analyzing and interpreting the data (Bruscia, 2005). Bruscia (2005) described several self-inquiry methods used by well-known music therapists. For example, Priestley (1994) utilized embodied phenomenology to study manifestations of her own countertransference within her own body as a way of understanding the client's experience with the therapist and with themselves. Bonny (1993) also used embodied phenomenology to better understand Guided Imagery and Music (GIM) programs through affective-intuitive listening. Bruscia (1982) himself conducted an autobiographical study where he analyzed how he related to music at various points in his life in order to generate 14 hypotheses about one's relationship to music.

Heuristic self-inquiry research in music therapy is scant. In a chapter on first person research in music therapy, Bruscia's (2005) referred to Fenner (art therapist)'s heuristic study (1996) where she determined the value of her own drawings, and reflected upon them to promote self-knowledge and change. Schenstead (2012) (a music therapist) conducted a heuristic self-inquiry using flute improvisation and reflexivity through journaling, poetry and artwork. The research culminated with an arts-based performance piece. This research process enhanced her inner awareness and helped her to connect with her primary instrument (flute), which one can surmise would have ultimately benefit her work as a music therapist.

McCaffrey (2013) studied the music therapist's experience of self in clinical improvisation in music therapy using a phenomenological approach and stated that the resistance to self-inquiry by music therapists may be due to music therapists' focus on improving the well-being of the client and that they may regard their own self-awareness practices analyzed within a research paradigm to be less valuable. To address this type of misconception, Aigen (1993), stressed the "importance of the therapists' creativity, intuition, flexibility, and self-awareness in determining therapeutic efficacy" within qualitative, naturalistic research paradigms. Wheeler (1999), after conducting a self-inquiry about her pleasure in working with severely disabled

children also stated that conducting this type of research can yield valuable insights into one's job satisfaction and level of burn-out. It was her hope that her study would inspire more music therapists to conduct first person, reflexive research.

Summary

The use of music therapy as an intervention in end-of-life care has evolved since it was established in the 1970s. Although several studies have been published that address the efficacy of music therapy interventions within the physical, psychosocial-emotional, spiritual, quality of life, and caregiver domains, more research is needed. A diverse number of music therapy interventions have been developed for end-of-life care including those that specifically involve singing and voicework. The music therapist's use of her voice in end-of-life care can be a very personal endeavour. Although very few heuristic self-inquiries have been published in music therapy, they can lead to valuable insights, which may not only resonate with the researcher but also with other practitioners thus impacting practice. It is hoped that the current study will have this effect.

Chapter 3. Methodology

Heuristic Self-Inquiry

The development of heuristic research methodology is credited to Clark Moustakas beginning with his extensive investigation of the experience of loneliness (Moustakas, 1990). The word *heuristic* comes from the Greek word *heuriskein*, which means "to discover or to find" (Moustakas, 1990, p. 9). The current study only includes the self-reflection components of Moustakas' approach, which traditionally included the perspectives of other participants. Heuristic self-inquiry begins with the inner searching of one's self in order to discover the full meaning of an experience. It evolves through the development of greater self-awareness and self-knowledge, which in turn helps to generate further methods and procedures of investigation and analysis. The ultimate goal of heuristic self-inquiry is to discover and portray the qualities, meaning, and essence of a unique experience by the person (i.e., the current researcher) who is experiencing the phenomenon (Moustakas, 1990).

Validity

Moustakas (1990) defined validity as the effective representation and authentic depiction of the meaning of experience that is studied through the gruelling, committed, and courageous self-searching and explication of the heuristic researcher. The researcher herself must ascertain validity, as she is the one who is living and studying the experience. I addressed the issue of validity in my study by acknowledging and bracketing my assumptions to the best of my ability during the data analysis process and by returning often to the raw data and constantly judging it against itself. I also engaged in verbal and written dialogues with my research advisor who challenged me to strive for clarity and consistency within my writing and the in which ways I expressed my thoughts and ideas. The intent of heuristic self-inquiry is not to discover generalizable truths but rather to create a comprehensive and honest depiction of one's own subjective experience.

Participant

I was the sole participant in this heuristic self-inquiry.

Materials

The materials used in this study were a self-reflexive journal and recordings of my voice.

Data Collection and Analysis Procedures

The data collection and analysis procedures were conceptualized within Moustakas' (1990) six stages of heuristic inquiry:

1. *Initial Engagement* is "discovering an intense interest, a passionate concern that calls out to the researcher, one that holds important social meanings and personal, compelling implications" (p. 27). This step was realized by: (a) conducting a literature review, (b) examining my personal relationship to the topic, (c) identifying my assumptions, (d) discussing the topic with professors, peers, and my supervisor; and (e) writing the research proposal.

2. The *immersion* phase occurs when the terms of the inquiry are defined and clarified and the researcher lives with the question in all facets of their life from conscious, everyday states to unconscious states. In my research, this phase employed self-reflective, experiential techniques that took place over a one-month period. The first source of data was a reflexive journal where I wrote personal reflections about my voice. Sometimes these reflections were written shortly after music therapy sessions had occurred and sometimes they were written spontaneously—whenever a relevant reflection came to mind within the month designated for data collection. The second source of data was recordings of my voice. For three days, after coming home from working on the palliative care unit, I recorded excerpts of vocal interventions that I had used with patients on that day, keeping in mind what had happened in the session as I made the recording. After each recording session, I drew a mandala to help bring a sense of closure to my experience. Given that the topics and experiences were highly emotional, I needed to find a way to bracket these experiences and separate them from my everyday life. The day after I finished my last of three recording sessions, I began the last phase of data collection, which was to listen back to the recordings, reflect upon them while listening, and write these reflections in my journal.

3. The *incubation* phase is a period of time when the researcher discontinues her concentration on the inquiry to allow for distance and the understanding to re-emerge with new developments. In this phase, I stopped gathering data, took a break from my job for 17 days and went on a family vacation. This phase was extended due to the unforeseen circumstances of an immediate family member's illness and death. I returned to my family home to be with my family and honour the life of my loved one. Subsequently, this phase was extended by an additional five days.

4. The *illumination* phase allows for the emergence of conscious awareness in two ways: (a) through the activation of new components of the experience which may produce more knowledge and (b) the correction of distorted knowledge (i.e., previous perspectives that may need to be re-considered or interpreted in a different way). I reviewed my journal and added new perspectives, trying to interpret the meaning of my experiences and self-reflection processes while at the same time noting my current feelings and reactions. I also tried to challenge my own interpretations and previous assumptions by committing to journaling freely about my experiences without censoring my thoughts and/or feelings in order to provide an honest and accurate account. I then used Newman's (2006) first phase of coding analysis. This involved re-reading my entire journal several times and using open coding to identify themes that related to the research question.

5. In the *explication* phase, the themes were organized, and layers of meaning were examined and clarified. Here, I used the second phase of Newman's coding analysis, referred to as axial coding. Themes that emerged from the open coding procedure were organized into categories using colour coding. Selective coding procedures returned to the initial themes and important topics. Quotes from my journal were included to ground the generated themes and categories in the data.

6. The final phase, *creative synthesis,* is defined as an aesthetic representation of the themes and essential meanings. This may take different forms such as a story or other art form. Rather than pre-determining a creative modality, I allowed the most comfortable and appropriate medium to emerge as my inquiry evolved. Ultimately, I wrote a song and recorded it. This process is further described in Chapter Five.

Chapter 4. Explication

The primary research question guiding this inquiry was: *What are the experiences and insights of an end-of-life care music therapist when she engages in self-reflective practices that are related to her own singing voice?* Using the heuristic self-inquiry methodology described in Chapter Three, the following themes and categories emerged in response to this question. Direct quotes from my journal are used throughout (in *italics)* to help ground the results in the data.

Theme 1: Ways I Use My Voice in End of Life Care

There are various ways that I use my voice as a music therapist in end-of-life care. Four categories emerged within this theme: vocal techniques, therapeutic effects for family members, ways of singing therapeutically, and vocal awareness. Although I use many vocal techniques within my music therapy practice, it appears that during data collection, I most often used vocal improvisation techniques. Vocal improvisation helps me to meet my patients where they are at—especially during their most challenging moments. Although I observed the therapeutic effects that one human's voice can have for another, I believe that this goes beyond the mere application of techniques and must also involve my ongoing awareness of how my voice and I are interacting within a music therapy session. This is consistent with the theoretical writings of the four authors referred to in Chapter Two: Cadesky (2005), Dileo (2011), Nakkack (2005), and Summers (2011).

Category 1: My vocal techniques. I found that I used vocal improvisation techniques many times in an attempt to match the patient's mood or model the mood the patient was seeking. When singing familiar and favourite music (of the patient), I would at times, depending on the patient and his or her needs, adapt songs by singing on open syllables to increase his or her level of comfort and enabled them to focus on one musical element—the melody. I would also invite the patient's family members to share their feelings with me, which I would then express through improvised song. *If I feel the family has enough ego strength, I will ask them if there is anything they would like me to sing for them…any words, phrases, wishes.* This is similar to a technique explained by Dileo (2011) called the emoting voice that is used to facilitate relationship completion. Here, the music therapist vocally improvises expressions and sentiments wished for by the patient and/or caregiver(s). When listening back to recordings of my voice, I felt like it not only reflected the inner feelings of my patient but also my own inner feelings. It became clear that I am not a blank screen, and that when using my voice and its unique vocal qualities in this

therapy context, it may simply not be possible to fully separate the patient's experiences and my experiences—they are interwoven. This is similar to directives found in Summers' (2011) *Hello Space Model* where she indicated that music therapists working in end of life care need to be aware of the potential for this type of vocal countertransference. *Listening back made me realize just how subtle the message can be and that what I might be experiencing within the session may be evident just in the way I sing and the way I frame my face and my vowels. Is my mouth open? Is my palate raised? Is my jaw tense? Are my words clear?* Lastly, I noticed that I was adapting qualities within my voice in order to facilitate patient goals. The audio excerpts revealed how different each of my vocalizations sounded based on each patient. For example, when I was reproducing the music from one patient's session, the singing was *up tempo, joyous sounding with a clear moderate vibrato* while the sung material based on another patient's session was *soulful to be in sync with the patient's preference and overall identity.*

Category 2: Therapeutic effects for family members. This category includes therapeutic effects that my voice and the way that I sang songs may have had for family members. My journal revealed several instances where I noted that a loved one had cried after I began singing a meaningful song. *Sometimes, when I begin singing and playing softly on guitar, the family members of the patient will begin to cry.* These individuals sometimes stated (prior to crying) that they did not want to be emotional in front of their loved one. They sometimes expressed that they cried because of the song itself, because of the sound of my voice, or the beauty they felt within the music, lyrics and/or its delivery. I found that singing a meaningful song and/or the unique, personal sound of my voice singing the chosen song(s) may act as a gentle therapeutic container for family members to emote in a socially acceptable way, especially while they are in the direct presence of the dying family member.

Category 3: My ways of singing therapeutically. When listening to the recordings of my voice, I began to note what felt like therapeutic qualities of my voice. When using my voice to increase feelings of comfort for patients and/or families, I sang softly, in the middle of my range, on open vowels such as *ahh.* The sound was round and open within my mouth and it felt comfortable for me. When trying to be very soft, I could hear my sound cutting off at times, and the vibrato could shift from being even to uneven. The tempo was slow and consistent within a familiar meter such as 3/4 or 4/4. In other sessions where I felt the patient was seeking straightforward, high quality aesthetic diversion, I described my voice as sounding *soft and*

strong with a slow tempo and natural/even vibrato. I had good control over the melody and a strong conscious delivery. In another session where the patient was seeking up tempo music, my vocal dynamics were louder. I did not feel the need to hold back vocally as the patient was open to receiving this type of offering. My singing was clear with a moderate, consistent, and even vibrato. I could hear joy and envision smiling. Conversely I sang *with medium dynamics, strongly, putting my sound into the song and its delivery and bringing it home in the last verse, [not holding back the emotional delivery of this song and singing from the heart]* for another patient who had expressed a preference for soulful music. In conclusion I wrote: *there seems to be a direct relationship between how I feel in relationship to the patient's [needs] and the type of singing I produce.*

Category 4: My vocal self-awareness. My journal contained reflective notes on inner dialogues that I had with myself during sessions concerning how I was using my voice and my intent around the use of my voice. *My thought was to sing to soothe;* [while vocalizing] *I felt like I entered a musical space surrounding the patient's need for comfort while the patient's daughter massaged patient's legs and feet*" and [my vocalization had] *long legato lines and* [was] *very piano in dynamics.* It was not just my vocal qualities or how good or bad the sound was but an increased awareness of my voice's purpose in the music therapy sessions. *Thus me sharing a part of me* [through my vocalizing]*, whether for someone who values the classical sound or someone who is from a different culture than mine can be moved* [by my vocalizing] *and that I can promote change and possible healing. Even if I am attempting to integrate a foreign music in a respectful, compassionate way, the aesthetics transcended me, my voice, and the person I am working beside.*

Theme 2: My Innate and Unique Singing Voice Combined with Therapeutic Intent

There are ways in which I think of my own voice and these combined with the needs of the patient influence how I sing in music therapy sessions. This feels like vocal authenticity, my innate style, and the timbre of my voice all combine with the ways I adapt my voice to sing therapeutically. I feel committed to being both vocally authentic and flexible but I also recognize that there are particular ways in which I like to sing and that I have my own vocal aesthetic standards. The awareness of these assumptions and preferences contribute to my effectiveness and confidence as a music therapist in end-of-life care. Awareness of my preferences and

assumptions, helps me to gauge when it might be appropriate to capitalize on my assumptions and preferences versus when they should be bracketed and set aside to meet the needs of the patient.

Category 1: My vocal authenticity. As a vocalist, I have always tried to be as authentic as possible in my delivery of the music, whether it be on stage at a performance or in a music therapy session. To be vocally authentic for me means to deliver the musical elements of melody, harmony, and lyrics by singing my honest interpretation of the sentiments I feel the composer has defined through the musical structures he or she has written. In my life, and as a person, I also value honesty and transparency to others and by others; therefore, the vocalizations I make within a session are no different. *As a vocalist/performer, I am used to and believe in giving my all musically, to wear my heart on my sleeve as it were. To be connected to another's* [the patient's] *story, identity, past, present and future means for me the authentic, goal oriented use of my voice.* I believe that this authenticity can help to foster a trusting therapeutic relationship with my patients in end-of-life care. Although complete authenticity (being fully aware of all of my countertransference in the moment) at all times is not possible, I believe that this is what I must consistently strive for in my work.

Category 2: My innate ways of singing and unique vocal timbre. Core aspects of my singing and overall timbre are innate no matter which genres/styles of music I am singing. I perceive my vocal sound as having a clear, even tone, precise tuning, and an even vibrato when that is called for, for example, when a patient requests a song from the classical repertoire, I will allow my vibrato to reflect the style. If I am singing a blues genre or style, I will naturally use a different vibrato, and vocal colour/timbre that I feel represents the stylistic qualities of musicians I have heard performing within that particular genre or style. My vocal timbre is a combination of my unique vocal chords, my resonating chamber inside of my mouth, and my many years of training and practice. My vocal quality has been developed through my training, my personal definition of beauty, and what I think is acceptable within Western genres of music. As my patients' generally feel most comfortable with the music they grew up with, I too feel most comfortable with my vocal sound being a certain way, which involve singing openly, freely, flexibly without tension, and with the joining of vowels and consonants that produce a continuous, open legato like sound. I feel that this is my default sound but this does not mean that I will not produce other sounds/tones if I feel that it is therapeutically warranted for patients. *It is*

soft in dynamics, it rises and falls. The melody is often slower tempo, moving up (ascending) and down (descending) as much with the breath of the patient. I believe that knowing my default vocal quality or timber is essential as it helps me to know when I need to move away from it in order to meet or match the patient I am working with and/or the reflect the unique essence of a session.

Theme 3: Living with Inner and Outer Perceptions of My Voice

Perceptions of my voice by myself and by others are something I have to constantly live with as a therapist who uses her voice as a primary therapeutic instrument. Reviewing the data helped me to see more clearly what my own inner perceptions are, what outer perceptions I feel are placed on me by others, and the inner conflicts I experience navigating all of these perceptions within my psyche. This was one of the primary motivators for this inquiry and through this process I have found that I love to sing, I love to perform, I love being music therapist, and that doing music therapy can be challenging yet very rewarding. In my music therapy practice, I am highly focused on my patients and their needs, and how I can help them by using my voice. This involves a commitment to vocal authenticity, awareness of myself as a therapist, and vocal self-awareness. I believe that this enriches rather than detracts from my practice in end-of-life care.

Category 1: Outside perceptions. A very common experience that I have had in the workplace or when performing in public (after being identified as a music therapist), is being faced with comments regarding the quality of my voice in relationship to the fact that I work as a music therapist. It is sometimes my impression that I am automatically deemed to be a highly competent music therapist because those who heard me singing felt that I was an accomplished singer. It feels that they are sharing an assumption with me—that if one is a good musician, one will also be a good music therapist. After one such experience occurred in a performance context during the data collection period, I noted the following in my journal*: I felt respected by fellow professional musicians in the classical world and felt proud to be a music therapist respected by the classical music world.* Furthermore, in the workplace, I also received comments, which I responded to in my journal. *I have had co-workers ask me why I am not "recording music somewhere else."* Patients also made comments: *"You have a really beautiful voice"* and *"Your*

voice is so beautiful, you shouldn't be here singing, you should be somewhere else singing on stage."

When these comments (which I perceive as assumptions) are shared with me, it produces an inner conflict. I feel proud of my voice and grateful that I may use my voice in my work with others, yet I am told by some (e.g., those within my social circle) that they know the best and more acceptable way for me to be using my voice. I wish to be representing the profession of music therapy and what I do in the most truthful, clear, and respectful way. It feels like when people hear my voice, I gain professional credibility as a music therapist: *"I gain credibility to some when I open my mouth to sing. It can help my initial goal areas, it can form the therapeutic rapport quickly. Perhaps this self-disclosure and my belief about performing as necessary for the given moment perpetuates the "you sound good" and can be the catalyst for the therapeutic relationship."* This might mean that the person could determine that through my vocal skills they trust that they are in *good* hands. However, my ability to sing is not the only determinant for being a competent music therapist, and being a music therapist does not mean that I am missing out on opportunities to be a performer.

Category 2: Inner conflict. I have always been the type of person who listens to the comments, opinions, advice, and assumptions of others. I process this information, I may even choose to experience these things for myself and then I decide what behaviours, interactions, and experiences I feel resonate most with me. When I have tried to assimilate outside perceptions (e.g., others comments, opinions, advice, and/or assumptions) related to my voice and my work as a music therapist I have at times felt a combined sense of worry, shame, and pride. I have felt a sense of pride when I have felt that I was being deemed a *good*, *credible*, or *worthy* performer and/or music therapist. On the other hand, I feel worried and sometimes even shame that I might be perceived as not doing the *right* thing in my work as a music therapist because I love to perform and I actively pursue this passion. I have worried at times that compliments related to my voice and my performance skills and abilities may make me seem less credible as a music therapist because we are supposed to focus on improving the quality of life of our patients and not focus on ourselves as performing musicians. *I am afraid that being regarded as a good singer can make me vulnerable to scrutiny by my music therapy peers, that what I do might be deemed performing and thus makes me susceptible to altering my credibility as an effective music therapist.* I have also feared that perhaps I perpetuate the *performer* stereotype that society often

has about music therapy (i.e., music therapy is not perceived as a health profession but as an activity where one performs for others to cheer them up or make them feel better) by having a voice that has been deemed to be of high quality by other respected musicians and members of the public.

Category 3: Inner confidence. Despite the emerging categories of inner conflict and navigating outside perceptions, my journal also contained several different entries about my inner confidence. I have confidence in myself regarding the capacity for me, my skills, and my voice to work effectively to help others. *I believe when I see someone in distress that my voice can calm them if it's matched appropriately.* In another entry I wrote: *I use my voice because I feel confident that I can reach targeted outcomes with it. That I can control it for what I want* and *I feel at times like my voice gives me confidence. Perhaps not because of what my voice sounds like, but how my voice can affect others. I gain confidence that if we decide that to do relaxation- that my voice can get the person to a relaxed state.* I feel that I have developed my vocal skills well enough to be able to use my voice flexibly and use it as a tool to help others. I also feel a sense of altruism and gratitude from sharing my voice with others and working toward bettering their lives. *I feel that singing—being the last singer a person may hear, having my voice on recording that could be the transitional object in their grief is huge and something beyond me that I find difficult to even fathom. I give selflessly with my voice and that feels good.* It appears that feeling a sense of confidence in my vocal instrument relates to my feelings of being effective as a music therapist and thus my ability to help my clients accomplish targeted goals at the end of their lives.

Theme 4: Reasons for and Ways of Handling *Nice Voice* Comments and Perceptions from others in a clinical context

Through my own inner conflict and through the process of this study, I have learned ways in which I can manage the *nice voice* comments and I feel better able to try and understand what they might mean for my clients and their families. At times, it may not matter what I think of my own voice but rather what others get from it or think of it and what I do with that. *It doesn't seem to matter what they think about the timber of my voice as long as I'm singing with intent.* Overall, the timber of my voice seems less important than my ability to sing with intent. I have noticed a flow within some music therapy sessions where I am no longer fully aware of the quality of my

voice, but immersed in the connections among patients, loved ones, the music, and myself. After one session I wrote: *Using patient's choice of words and reflecting them to try to enhance their experience.* [I was told] *there were sirens going off around* [in another section of the hospital]*, and I don't remember noticing them.*

Category 1: Possible reasons for value statements on the quality of my voice. Within my journal, I reflect upon the meaning of the comments made by others about my voice. I write: *The comment "what a great voice" putting on it- a great value statement. Two sides: Either valuing it as an enhancement to their person or as a separation between them and me: you are/possess something beautiful and I do not. In a society with* [a common] *attitude that perfect is best and when one places value on an object, there is a connection made to the object from the person to the object. How does that impact the role and position of a music therapist? Perhaps it is their way of giving something back to me, or trying to express their reactions/how it made them feel. It could have moved them, touched them spiritually. They could have perceived many things from it.* Furthermore, my reflective journaling revealed the idea that people may give me credibility based on their opinion of the quality of my voice. *I gain credibility to some when I open my mouth to sing.*

Category 2: How to manage or use value statements on the quality of my voice. Within my reflective journal are entries concerning how I may choose to accept the comments from the outside (how patients, co-workers, the member of the public see the use of my voice). *I know in my mind that my reasons for singing are steeped in goals and ways I would like to promote healing in my patients and families. My purpose is not to get a critique on my voice, however, it seems to be the by product.* Three strategies emerged from my journal that I can possibly use to manage value statements (i.e., *nice voice* comments) that occur in my music therapy sessions: (a) listen therapeutically (openly and inquisitively) to the comments being made and include them in my assessment of each patient; this could allow me to know more about the value that each patient places on music qualities, (b) assess the role that music has in patients' lives and their definition of aesthetics (i.e., music is for entertainment therefore it must have a certain aesthetic which I feel you possess) and/or (c) assess the possible reasons for the *nice voice* statements (i.e., is there a possibility that they are complimenting my voice in order to create a connection or barrier between me and them; as if they are implying that I have something [a *nice voice*] that they do not have and so they can separate themselves from me or like me more

because of this and desire my company). In other words, are there ways that I can incorporate *nice voice* comments into my assessment to enhance and assist with the therapeutic process and therapeutic change? *Perhaps it is their way of giving something back to me, or trying to express their reaction/how it made them feel.*

I understand that the definition of meaning can vary from person to person and that assessing his or her judgment on the quality of my voice can tell me a lot about the person I am working with which in turn can be used to accomplish goals within the music therapy session. *When people say "you have a nice voice" that is their opinion or experience. It could reflect their opinion, feelings toward it.* In response to people placing credibility judgments on my voice and in turn my effectiveness as a music therapist I wrote: *It can help my initial goal areas. It can form the therapeutic rapport quickly.* I may exhibit gratitude to the person and re-focus the session back to the therapeutic goals of the sessions. I have had to accept whether I like it or not, that sometimes people will make a value judgment on my vocal quality and share their thoughts within the session. This is something that I can use to assess the person's relationship to music and accommodate this knowledge within my work.

Theme 5: Assimilating My Performance Skills and Experience within the Therapeutic Relationship

I have been balancing my identities as a performer and as a music therapist since I began my first year of my undergraduate music therapy training. At one time, I thought I had to choose between the two. This inquiry has helped me to understand how I can balance both identities comfortably within my professional life. I have identified ways that I have adapted the skills I acquired in my performance life into my techniques as a music therapist.

Category 1: Differences between performer and therapist. I feel that I always knew intuitively from my music therapy training that there are distinct differences between my lived experiences as a music performer and as a music therapist. As a young professional, gaining real world experience, I feel that I did not know how to balance these differences in my work and in my personal life in ways that felt appropriate, respectful, authentic, and representative of both identities. In my journal, I wrote: *When a performer performs on stage they represent a global message, personal experience or societal experience. It's not generally personal or individual, though to a fan it might feel like that. In music therapy, the therapist is making [an] assessment,*

they learn and acquire information about a patient that a performer would not necessarily ever know. The music therapist knows the situation and gets to know the person they are working with in a very intimate way. In receptive techniques the music therapist brings the person's music to them, they bring the situation above that is personal to the person… to help them. Or they create music with the person based on their [the patient's] *experience… this adds a whole new and powerful position for the therapist and a powerful/novel experience for the person. I feel deep down that I am a performer as well as a music therapist. I am cautious and through insight* [reflection] *know the difference between the two. There seems to be a beautiful ability to capture a moment from a therapist's eye and deliver the healing/music through a performer's/therapist's spirit.*

Category 2: Valuing my skills as a performer within the music therapy context. Receptive music therapy techniques involve aspects of performance, whether it is through singing and playing a familiar song, singing a composed song, or improvising for the patients/family members. The overall purpose of these *performances* is not the same as a performance on stage. In therapy contexts, I can choose which elements to emphasize to address a treatment goal area. *As a performer on stage: my goals are different then they would be in a therapy session. As a performer, there is a persona that one puts on. Yes it is clear to me that not every music therapist identifies as a performer and has opted for music therapy because they do not want to perform, however, in my work and whenever a song is sung there is a performance and your role as a performer could be to facilitate others to sing along, etc…"*

Category 3: My role as a catalyst for the emotional expression of my patients and family members. As a music therapist, I am often facilitating the emotional expression of another. At times this means the shedding of tears or expression of other meaningful emotions by the patient, family members, friends or others who are present. In order for me to be an effective therapist, it is not beneficial for me to begin expressing my own deep emotions as this would take the emphasis away from the patient and not be helpful. It does not mean, however, that I do not feel deep, intense empathetic emotion for my patients. I have learned within my years of performing how to emote deep and intense emotions without completely allowing myself to enter them. This performance *persona* can assist me in my quest to help another emote without falling into the experience of my own deep emotions during the music therapy session. To be able to access different emotions, I have learned how to categorize my emotions and allow myself to

become aware of them at the appropriate times and express them for my personal and professional well-being. *As a performer, there has to be a delivery of intense emotion in a contained way. The closer a performer gets to emoting while maintaining the music seems to move the audience the most.*

Category 4: Maximizing my skills as a performer within the therapeutic intervention. For me, as a music therapist, I am emoting through a song what might be happening in the room to either allow the emotions to be released in a contained way or to foster/drive a change of emotion (improving mood). Either way, I have to embody that for the patient so they can get there too, in the receptive. Within my performance practices, I have learned how to embody a certain emotion or feeling. Embracing and maximizing these skills as a music therapist can be a useful tool for me in my ability to reflect the situational and personal emotions and foster/drive a needed change or release of emotion.

Category 5: Interplay between the music therapist and performer identities within my work. Because I value the skills I have acquired through my performance experience and the skills I have acquired through my music therapy practice, it has been natural for me to take what I need from the performance skills and translate it to the music therapy session context. In the past, I have done this intuitively but can now more readily identify the elements that I use. Discovering these various skills has allowed me to identify that it is more than just my vocal quality at work. It is a combination of all of the skills I have acquired to date. *No wonder these are such intense moments, beyond words, beyond description, beyond regular earthy realities. The performer gives without ever truly knowing what the experience was for that person… sure they can hear snippets but there's no follow-up. The music therapist can give a performance of the person's requested song/piece and may learn, and knows/possesses the skills to support the person through the experience when the tears begin to flow! It seems that it's not just my vocal quality at work.*

Category 6: Balancing music therapist and music performer/vocalist identities. I do not believe that I can be completely fulfilled in my work as a music therapist without having vocal performance opportunities that occur outside of this context. I have had to learn how to balance these two identities and feel that I will need to remain aware of how a shift in balance may occur as I continue to grow and evolve. I currently balance both identities by staying committed to using the performance outlets that I feel enrich my performance identity, and I take

opportunities that help me acquire more skills and knowledge for my music therapy practice (which can include vocal performing). By staying committed to developing and practicing both performing and music therapy, I feel that my two identities are enriched and this decreases my need to choose one or the other. *I can't take my love for singing out of me… I was born with it. But I can be highly aware of how it affects my patients and use it to their advantage. It is also important for me to have a singing outlet… where I can sing just to sing or be working toward using my voice in a more traditional way such as performing classical* [or other] *works.*

Theme 6: Music Therapist Using Her Own Voice as a Self-Care Tool Outside of Music Therapy. After I became aware of the ways in which I balance and use my identities to maximize my work as a music therapist, I became aware that I also use vocal performance in my personal life as a self-care tool. I felt a sense of gratitude being able to use my voice both professionally and personally to nourish myself and then in turn, nourish my work as a music therapist in end of life care, a place that can be vulnerable and highly emotional. In this way I can feel connected to my identity as a performer, without compromising my work as a music therapist. *How lucky and privileged I am to be able to earn my livelihood from music and singing and get to use it as a self-care tool. How fortunate. This is another way for me to stay very aware and healthy as a therapist.*

Chapter 5. Discussion

As noted in Chapter Three, the last step in Moustakas' stage of inquiry involves a creative synthesis of the essential meanings revealed in the explication phase. This final chapter contains a brief description of this creative synthesis process as well as an audio recording of the final product. Limitations of the study as well as personal, clinical, and academic implications of the results are presented. Suggestions for future research are provided.

Creative Synthesis

As I began analyzing and extract meaning from my data, the urge to make and create music became greater and greater. I could not imagine drawings, poetry, or any other art forms that would allow me to express this heuristic research process in a more authentic way than the use of my own voice. After living with the challenge of balancing my identities, I had to return to the source (my voice) and do something with it. I also felt that this was an opportunity to synthesize my skills and qualities and have them all contained in one forum—my skills as a music therapist to create meaning, to compose a song, to express myself, to explore the depths of my psyche, and to come out with something creative that would tie everything together. Therefore, I began to write. I wrote about myself, about how I see myself in the eyes of my patients, and about the values I have as a citizen in the world.

You'll Know That Someone's Near

There was a pretty voice put inside this girl
With a big old heart on top
She had a big old will to help to help out a lot
And a strong will not to stop

Chorus

Listen to your heart
And all that's there
And when you lose your faith
I'll be right there
With a listen ear to shed some fear
You'll know that someone's near.

Verse 2

Frustrated by the narrow views of the human's first impressions
There's a lot more to see, come close, take heed,
give yourself some lessons

Chorus

Bridge

The world will come and tell you what's right
And you might take a listen
But never forget, never forget
The last truth
You're to give the final permission

Chorus

On the day that I had planned to both write and record the song, I woke up with a dry and sore throat. I felt comfortable singing and felt I would not damage my vocal chords but I knew that that vocal quality that I pride myself on was not quite there—but that did not matter to me. The experience of having creative ideas fluttering around in my head and wanting to make them a reality was a much stronger urge than worrying about how great my voice was going to sound on that particular day. The words flowed, the creative musical ideas to reflect my words flowed, and I began to sing. I recorded my song and listened back to it. Although I could make many statements about the quality of the music, this was not as important as actually going through the creative process and expressing myself. I knew deep down that I could always rehearse the song should I want to do it *better* but the mere act of creating it at the time was all I needed to feel that I synthesized my experience. The style of song that emerged was an easy-listening pop like ballad. I did not intend to create a song in a certain style. I wrote the words first and let the tones and melody come which helped me express myself to the degree I was searching for.

Limitations

The heuristic self-inquiry can take a large amount of time. In order to stay within the confines of a Master's thesis, the duration of the data collection and analysis period was delimited. This may have imposed limitations on the results in that further insights and clarity may have been gained with more time. The themes and categories might even be further consolidated. This was also the first research project that I had ever conducted. In addition to learning about the methodology as I went along, I struggled with maintaining trust in the emerging data and resisting the desire to generalize the results while attempting to decipher my own writing may have affected the results. I also experienced the unexpected loss of a loved one while conducting this research. Although I did not feel that this experience would affect my process, it is possible that my feelings may have inadvertently affected how I interacted and interpreted the data.

Implications

Personal and Clinical. I had surmised that I might gain enhanced understanding about the use of my own unique voice in music therapy in end-of-life care through careful reflection upon my lived experiences. Analyzing my written reflections and listening back to my voice through audio recordings allowed me to identify differences between my *real time* perceptions of my voice as they emerged during a session and how I perceived them post-session when listening back. I noticed through the process of recording and listening back, that my perceptions of what I sound and feel during a music therapy session (in terms of my voice) may be different than what the patient perceives. Acknowledging these different perceptions has allowed me to better understand what seems to truly matter within a session—authentic, goal-oriented, client-focused intent which I can realize with my voice when it is deemed clinically appropriate to do so. Identifying the ways that I adapt my voice within my end-of-life care music therapy practice has enabled me to become more aware of unique components of my voice and bridged a gap between the intuitive and the theoretical ways I may use my voice. This inquiry has also helped me to better navigate my dual life as a vocal performer and music therapist. Subsequently, I feel better equipped to use my performance skills within the end-of-life care music therapy context. I

feel I have enhanced personal insight with regard to my relationship with my voice as I feel that it lives authentically within both my roles as a music therapist and vocal performer..

My enhanced personal understanding has led to other changes in my practice. I have acquired new confidence and sensitivity in the ways I address patients' and others' comments about my voice. I now try and assess where the comments may be coming from, express gratitude, and think about how best to focus the session in that moment. The more in tune I feel with a patient's needs and identity, the more comfortable I am to navigate (and use, when clinically appropriate) comments they make concerning the quality of my voice. Any uncomfortable feelings I have in response to a patient's comments may signal transference or countertransference, which when identified, can be an important source of information on how I should proceed with the patient and his/her family members.

This research could inspire other music therapists to study and reflect upon how they use their voices in clinical contexts. They may identify their own assumptions and personal or professional experiences and apply their insights into their work and/or personal life in a way that suits their comfort level, lifestyle, and the best interest of those they are working with. I have learned a great deal from recording my voice, listening back, and reflecting upon it. Others may find this exercise helpful, as one may be able to hear discrepancies between what they intend to do versus what is actually coming across. Through greater insight comes a greater capacity to maximize therapeutic presence with patients, and to help navigate the potentially life altering changes yielded from the relationship between music therapist, patient, and music. Deliberately identifying differences between identities, (i.e., music performer versus music therapist) can be useful as there continues to be societal confusion between a performing musician who plays music to make people feel good (whether on stage or at the bedside) and a music therapist who uses music with therapeutic intent to promote, maintain, or restore mental, physical, emotional, and spiritual health (Canadian Association for Music Therapy, 1994). Acknowledging and working through one's professional and personal concerns related to one's work as a music therapist can lead to new discoveries and insights which in turn can enhance one's personal and professional growth.

Education and Research. This study could provide a viable framework for students who want to conduct a heuristic or first-person inquiry within an academic or other context where a limited time frame is a consideration. It may inspire others to conduct similar inquiries, which in turn could lead to enhanced personal and professional understandings.

Further research could be done to learn more about the experiences of other end-of-life care music therapists who identify as singers. Qualitative analysis of these experiences could yield global themes that may be applicable to work in this clinical context. Other music therapists who identify as performers in other musical mediums could also conduct similar inquires. All of these studies could potentially include other participants in addition to the self-inquiry component. It would be interesting to examine similarities and differences between the experiences of male and female music therapists or the similarities and differences among the experiences of music therapists of different cultures who also identify as performers.

In this research, mandala drawings were used to bring closure to my reflection processes and they were not used as a source of data. However, this could have yielded some unique insights and may be a good approach to use in future self-heuristic inquiries conducted by myself or others.

Finally, if logistically and ethically possible it would be interesting to examine patients' and families' perspectives on their experiences of vocally centered music therapy sessions that occurred in end of life care contexts.

Closing Thoughts

Accepting the heuristic self-inquiry methodology took courage and faith in order to embrace the unknown and to be open about my own researcher-participant process. My resolve to follow-through with this methodology came from my commitment to becoming a more effective music therapist for those I work with, to improve the use of my voice within the music therapy context, and to embrace the unknown like so many of my patients have graciously done.

Summers (2011) stated that a music therapist should be fully authentic. By taking a closer look at my experiences with my voice, I was able to embrace my dual identity, become more

authentic, gain further confidence in navigating my worlds as a music therapist in end-of-life and a performing musician. I look forward to continuing to reflect so I may achieve further insights as I continue on within these complex yet fulfilling roles.

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