

Title of submission: “The MusiQual treatment manual for music therapy in a palliative care inpatient setting”

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Abstract:

This paper presents the treatment manual developed during the MusiQual feasibility study carried out in Belfast by Queen's University Belfast, Every Day Harmony Music Therapy, and Marie Curie NI. The MusiQual study looked at the feasibility of a multicentre randomised trial to evaluate the effectiveness of music therapy in improving the quality of life of hospice inpatients. The procedures and processes described in the manual are based fully on those implemented by the music therapists during the feasibility study in Belfast, and it also incorporates the theoretical model defined during this study and published as a result of the realist review of the literature (REF). The manual is presented here in the format that it has been developed in for use in the potential future phase III multicentre randomised control trial. It represents a flexible approach in the hope of providing enough scope for practicing therapists to appropriately adapt and tailor their interventions to individual clients as is accepted best music therapy practice, but also to provide sufficiently stable guidelines both to ensure treatment fidelity in a future large-scale trial of music therapy for palliative care inpatients and also hopefully to provide a useful and relevant guide for practicing music therapists working in this field.

Keywords: music therapy, palliative care, theoretical model, procedures, guidelines

Background to the MusiQual treatment manual

This paper presents the treatment manual developed as part of the MusiQual feasibility study which was carried out in Belfast by a partnership between Queen's University Belfast School of Nursing and Midwifery, Every Day Harmony Music Therapy, and Marie Curie NI. The study, completed in June 2017, looked at the feasibility of carrying out a multicentre randomised pragmatic effectiveness trial, to evaluate the effectiveness of music therapy in improving the quality of life of hospice inpatients and the impact on those close to them, and sought to test the processes and procedures to be used in such a study (McConnell et al., 2016a). This treatment manual has been developed in preparation for this potential multicentre trial to ensure treatment fidelity across the sites.

In the preparation of this manual, it was found that little information was available publicly regarding the preparation of such a document, and so the MusiQual team decided to publish this manual as a standalone piece of work in the hope that, in addition to its potential function in their future RCT, it might prove to be of interest or use to music therapists working in palliative care to use as a reference and potentially support their work in this field.

Introduction

This manual has been based fully on the procedures and processes used by the music therapists during the feasibility study in Belfast. No treatment manual as such was followed in the feasibility study itself to allow the therapists to carry out their interventions in a manner that was as true to 'real-life' clinical practice as possible. A standardised model for clinical documentation and reporting was followed (Robb, 2011). Details from the therapists' clinical documentation thus recorded was collated and cross-checked with the theoretical model defined as a result of the realist review completed by the study team in 2016 (McConnell and Porter, 2017a). This realist review examined a total of 51 articles from the literature and resulted in a theoretical model consisting of four domains of intervention for music therapy in a palliative care setting (shown in Figure 2 below). Thus, the manual is

structured in line with the four domains outlined in the relevant theoretical model that has been developed.

The manual has been reviewed and agreed as an accurate representation of music therapy by a number of music therapy professionals (JK, NC, CD, CG, DT, AV) to ensure that it accurately reflects approaches and techniques commonly adopted in palliative care. The manual is intended for both music therapists and researchers as a guideline first and foremost for the replicability of the music therapy intervention in this study, but also as a guide for music therapists working in this field in a wider context. It is understood that the interventions described herein are only intended to be carried out by qualified music therapists duly registered with the Health and Care Professions Council (HCPC). Music therapists participate in regular supervision in order to ensure that they are working safely and in the best interests of service users, but we also recommend in this manual that, due to the nature of palliative care work, music therapists working in this context have access to additional counselling and support as required.

The theoretical background predominantly adopted in this work is that of a person-centred and resource-oriented approach where the patient's capabilities are maximised (Ansdell, 2016; Rolvsjord, 2004; Rolvsjord, 2010). **The person-centred approach, from Carl Rogers, is an empathic approach that empowers the individual in the co-design of the therapy process. Resource-oriented music therapy makes use of the personal resources and potential of the individual, focussing on "noticing, acknowledging, and making use of the client's resources through the fostering of a collaborative relationship" (Rolvsjord, 2010, p. 66). Indeed, in both of these approaches a collaborative therapeutic relationship is seen as a core component, and they are considered to be suited to the unique, individualised, sometimes rapidly changing and short-term nature of palliative care inpatient care where we work with the person in the 'here-and-now' of their clinical condition.**

Furthermore, the procedures outlined herein are intended to be adhered to within the boundaries of a flexible approach, tailored to the requirements of the person in question at any given time. While the manual is in place to ensure treatment fidelity and the validity and replicability of a trial, it is understood that the procedures are intended to be followed pragmatically and with such flexibility of therapeutic approach in mind.

Context of the therapeutic intervention

For reference, the target population of the clinical trial is adult hospice inpatients, irrespective of diagnosis. Inclusion criteria are hospice inpatients over the age of 18 who have given informed consent, and exclusion criteria are: patients with an Australia-Modified Karnofsky Performance Scale (Abernethy et al, 2005) of 20% or less, patients who have been deemed by the clinician responsible for their care not to have sufficient cognitive functioning to participate, patients about whom the clinician answers the following question in the negative 'Do you expect this person to live for more than a few days?'. However, it is considered that the procedures herein can equally apply to the broader spectrum of hospice inpatients.

Setting:

- The therapy setting is usually the client's own room or an alternative private space within the hospice, chosen in accordance with client's needs, wishes, best interests, the practicalities of the venue, and risk assessment.
- The scheduling of session times should be kept as flexible as the service can permit in order to best facilitate patients' attendance and participation.
- Before starting sessions, the therapist should agree with hospice staff how best to avoid unnecessary interruptions (e.g. light or sign on door), and be prepared to appropriately and tactfully handle these should they occur so that music therapy sessions are not disturbed where possible.
- The music therapist, together with trial investigators, should hold informational session/s for staff prior to the start of the music therapy service, and signpost relevant literature to staff as required. These sessions should be offered on at least 2/3 occasions during the initial period at different days/times so as to enable attendance by as many members of staff as possible. This is to make all staff aware of music therapy and what it entails, and also to contribute to the building of relationships between the music therapist and staff members, agree referral processes and day-to-day handover and exchange of information about individual patients.

- These early contacts should also address the prioritisation of services (music therapy vs other health professionals) so that there is a situation of mutual respect and interruptions in future sessions are minimised.

Duration:

- Therapy session length should be protocolised to 45 minutes to ensure equality of dosage, although it can be ended sooner at the therapist's discretion if clinically appropriate to do so. An additional 15 minutes should be allocated to each session to enable clinical note-keeping

Participation of others in sessions:

- A patient's 'significant others', such as family members and friends, may also participate in sessions and this is an important part of the trial. It is especially important that the therapist is able to maintain a patient-centred approach, while still giving value to the presence of these significant others. Patient needs must come first, but the strengthening of bonds and facilitating of communication with these others are important factors and are among the main therapeutic principles of the study.
- Patients are asked at the consent stage regarding the participation of such people in the sessions. While the patient can freely express their wish to have a significant other participate in any individual sessions, the therapist must also assess, on an ongoing basis, whether their participation is and remains in the patient's best interests, based on the wishes of the patient themselves, participation in previous sessions and their own assessment, and act and advise accordingly as they would in any clinical setting.

Equipment:

- Voice
- Harmony instrument/s such as piano/keyboard/guitar/ukulele
- An accessible range of small musical instruments, including culturally diverse instruments where available and appropriate (standard music therapy 'kit')
- Multi-sensory items (for example 'sensory scarves') such as might at times be utilised by the therapist to support the music therapy intervention

- A song book to be developed by the therapist/s covering a wide range of genres and culturally diverse material appropriate to their setting. This can act as a reference tool, aide-memoire, and supporting material for clients to use when selecting and participating in known musical material. It is at the therapist’s discretion when its use is clinically appropriate. For the purposes of the trial a single songbook will be developed by therapists for use across all venues.
- iPad (or similar) to access music listening and lyrics/chords (YouTube, Spotify, Ultimate Guitar or similar), Wi-Fi connection where possible, speakers
- Recording equipment and secure storage for any recording in line with GDPR legislation and dependent on full explicit consent
- Patient’s own instrument if applicable
- Therapist’s own instrument if applicable

The music therapy intervention

The aim of this section is to outline the form that the basic therapy process takes. After the initial ‘Stage 1’, the steps are not intended to be linear – the choice of approach used should be patient-led and is at the therapist’s discretion based on their clinical judgement, the patient’s indicated preferences, and the treatment foci being addressed at a given time.

‘Stage 1’ represents the standard process that forms the initial phase of any music therapy work in most clinical contexts. In this setting, this process will take place in a condensed period of time within the initial session/s. Following this stage, the remainder of the process is divided into two super-imposing sections focussing on the musical and extra-musical components of the intervention.

Stage 1: Music Therapy introduction
Introduction to music therapy
Personal introductions – building relationships
Possible types of intervention in music therapy
Client’s indication of preference for intervention
Therapist assessment of patient needs

Stage 2: Music Therapy intervention	
<u>2A Musical components</u>	<u>2B Extra-musical components</u>
Selection of known music	Life review/timeline
Musical composition	Reminiscence
Instrumental play, including clinical	Lyric Analysis
improvisation	Legacy work/creating memories

Stage 1:

Before beginning the intervention, the therapist should ensure that they have received an adequate handover from venue staff with medical history as required, an update on current health and wellbeing, and a musical history if possible.

The four elements of this stage take place simultaneously (representing ‘contracting’ in this setting), but the order and level of detail required will be judged by the therapist based on the needs and indications of each individual patient. These elements are present most explicitly and to greater depth during the first clinical session, but should also be revisited at least internally by the therapist in every session to ensure that all remain securely in place. The aims of this stage are to establish the beginnings of the therapeutic relationship, the setting, therapeutic boundaries, a sense of safety, and to put the client at ease and reassure them of any doubts.

1.1 Introduction to Music Therapy

At this stage clients will already have given informed consent and been briefed in detail on what the trial and music therapy intervention entails. However, it will usually be necessary for the therapist to revisit this in order to ensure understanding and answer any questions clients or family members may have, using their judgement as to the level of detail or complexity appropriate for each individual patient.

1.2 Personal introductions – building relationship

Based on the therapist's assessment of the client and their openness to musical interaction, the therapist may spend some time building the initial relationship before therapeutic musical interaction begins. The therapist should use their sensitivity and therapeutic skills to seek a point of contact or connection (musical or otherwise), establish rapport and thus set up the beginnings of the therapeutic relationship. This is sought and established from the beginning, but remains an ongoing process throughout the intervention.

1.3 Presentation of possible types of intervention

Following the client's lead, the therapist introduces the possible treatment interventions, giving a brief description of options (as listed in the subsequent section below) and what they might entail, and an introduction to the instruments available. These options may also be presented in simple written form for the client to keep and refer to in future if considered appropriate. This presentation may be curtailed at any point depending on the client's responses. The therapist can also inform clients of the potential aims of interventions if considered appropriate. The therapist will ask the client what they would like or hope to achieve in the sessions, and if they have a preference for which type of musical intervention to use. The therapist must always reassure the client that they can choose whether, when, how, and for how long to engage, that they are under no obligation whatsoever to play/sing, there is no right/wrong way to engage and no need to perceive themselves as "musical". Thus the therapist seeks to manage any inhibitions or anxiety in this respect. Therapists should encourage curiosity and interest wherever it is expressed, in order to facilitate exploration of a musical experience that will resonate with the person in a context of safety.

1.4 Client's possible expression/indication of preference for intervention

The therapist observes whether the client expresses a preference to engage in a particular type of intervention (expressed verbally or non-verbally). The possibilities for this are:

- Client directly expresses their preference verbally or gives clear non-verbal indication ⑦ therapist proceeds in this direction.
- Client hesitant but gives some indication ⑦ therapist suggests this intervention/asks for confirmation/facilitates an exploration of this possibility ⑦ therapist proceeds in this direction watchful for indicators to confirm that this is in fact a suitable process for this client.
- No clear or observable indication of preference ⑦ therapist assesses reason for this (e.g. emotional reasons or inhibitions) ⑦ Therapist can continue general approach and seek further indication from client, or may suggest possible interventions based on what they have observed ⑦ therapist sensitively initiates intervention when required.

1.5 Therapist assessment of client need

Therapists assess how the client engages both verbally and non-verbally, their mood, approach to the sessions, and relational abilities, specifically the client's cognitive and emotional ability to engage in the various forms of intervention, and how these might address their specific needs. The therapist should identify the needs that can be addressed effectively in the timeframe available for each individual patient in order to improve their quality of life. At this point the therapist is setting their clinical aims for the work which should be stated appropriately in clinical notes in accordance with standard documentation requirements. The therapist's assessment should be continuous and adaptive throughout the intervention, in particular in relation to the client's emotional state and perceived needs in music therapy.

Clinical music therapy intervention

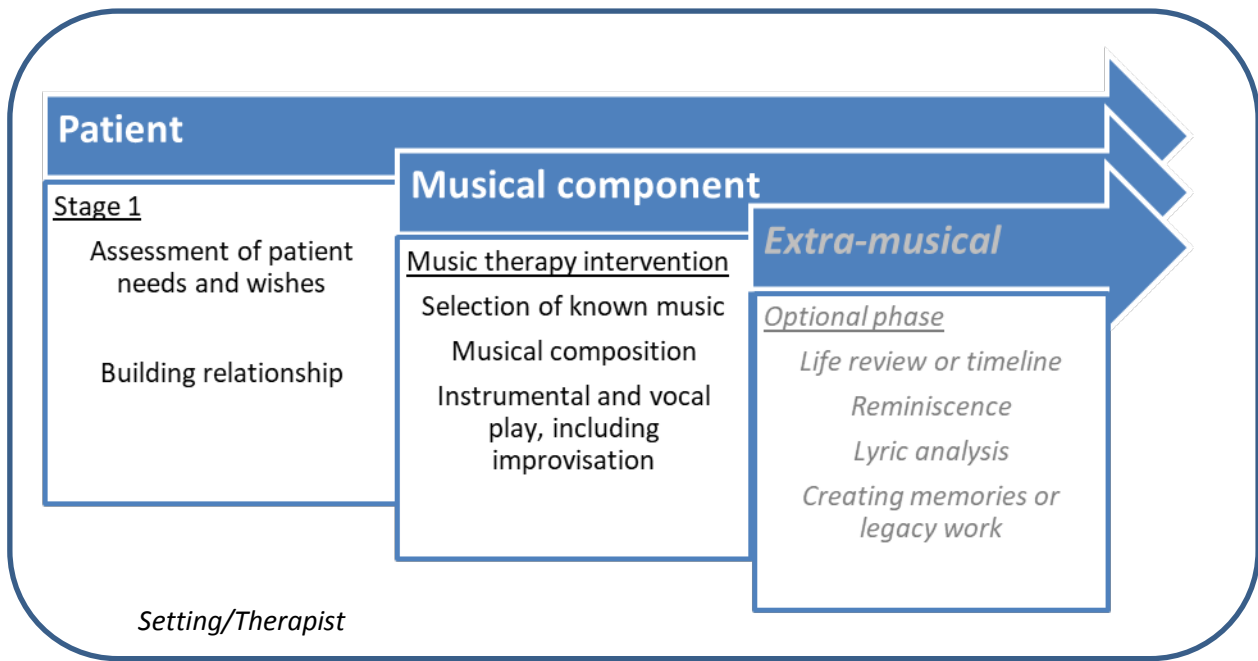


Figure 1 – Visual outline of the process of the music therapy intervention

Possible musical components of the intervention:

Selection of known music

- A choice is made for particular music previously known to the patient which is either played live (preferable) or listened to. This can be through client's choice, choice of client with other person participating, choice of other person (with client's approval), or guided by the therapist using appropriate clinical judgement.
- Client engagement can be through listening only (active or passive), singing alone, singing with therapist and others, or instrumental playing.
- This type of intervention may subsequently develop into songwriting, composition or improvisation if clinically beneficial and appropriate.
- This type of intervention may result in lyric analysis, reminiscence or life review work if clinically beneficial and appropriate.

Musical composition

- This can be the composition of original music, songwriting, or composition of parodies.
- This type of intervention will typically involve its own lyric development and analysis, and often involves reminiscence and life review work.
- This intervention may involve or lead on to free instrumental play (improvisation) as part of the composition process.

Instrumental play

- Client may play a known instrument alone or with the therapist.
- Client may choose to learn instrument techniques, or share this with family members present.
- Client may engage in improvised music using the instruments provided. This can be free improvisation or an improvised extension based on previously chosen/known music.
- This intervention may involve or lead on to musical composition or songwriting.
- This type of intervention may involve or lead on to reminiscence or life review work.

Possible non-musical intervention components

Life review/timeline

The therapist may support the client (and/or significant other) in using the musical interactions as a vehicle or stimulus to engage in looking back over their lives, possibly constructing a musical 'timeline'.

Reminiscence

The therapist may support the client (and/or significant other) in using the musical interactions as a vehicle or stimulus to engage in remembering events/people/places from their past, discussing and reflecting on these with therapist or significant others.

Lyric Analysis

The therapist may support the client in using the lyrical content of music as a vehicle or stimulus to reflect on or relate to themselves, something important to them or their significant other.

Legacy work / Creating memories

Sessions may create a 'legacy' and possibly tangible or intangible 'takeaways' for significant others. The processes outlined above can be informal or formal, and may result in a tangible product, e.g. song/music written, lyrics created, recorded music produced. Sometimes material in sessions may be spontaneously recorded by patients or significant others. The therapist must ensure that appropriate consent is obtained from all parties for this, especially when it may be shared publicly.

General guidelines

- Assessment must be an ongoing process throughout the intervention, especially with regard to clients' emotional state and perceived needs. The therapist should refer back frequently to the 'Stage 1' processes to ensure that all elements remain in place.
- Appropriate time and space should be left both during sessions and between sessions to give clients (and therapist) time to reflect, make decisions and guide the course of the therapy process.
- Given the short-term nature of intervention, the therapist should sensitively initiate if necessary. Be client-centred, but also be ready to lead and guide.
- Maintain awareness of the possibly limited length of intervention and this overall 'therapeutic arch', and plan sessions accordingly and support patients in doing same.
- At the same time, as it is not possible in this setting to predict with certainty the pattern of upcoming sessions, therefore therapists should structure and guide each individual session so that it has its own 'therapeutic arch' as far as possible, especially as regards the emotional state of the client. Therapeutic aims should be set realistically in this respect.

Treatment foci

This section of the manual **outlines the** theoretical framework developed in a realist review of the literature on music therapy for palliative care (McConnell and Porter, 2017a). **This framework was based on a palliative care model for music therapy developed by Dileo and Dneaster (2005), with the addition of a fourth domain encompassing social aspects of care.** The four domains of intervention include the supportive (physical and psychological) domain, communicative/expressive (emotional) domain, transformative (spiritual/existential) domain, and social domain, which are considered to be the four areas of focus for palliative care work in music therapy, and are outlined in Figure 2.

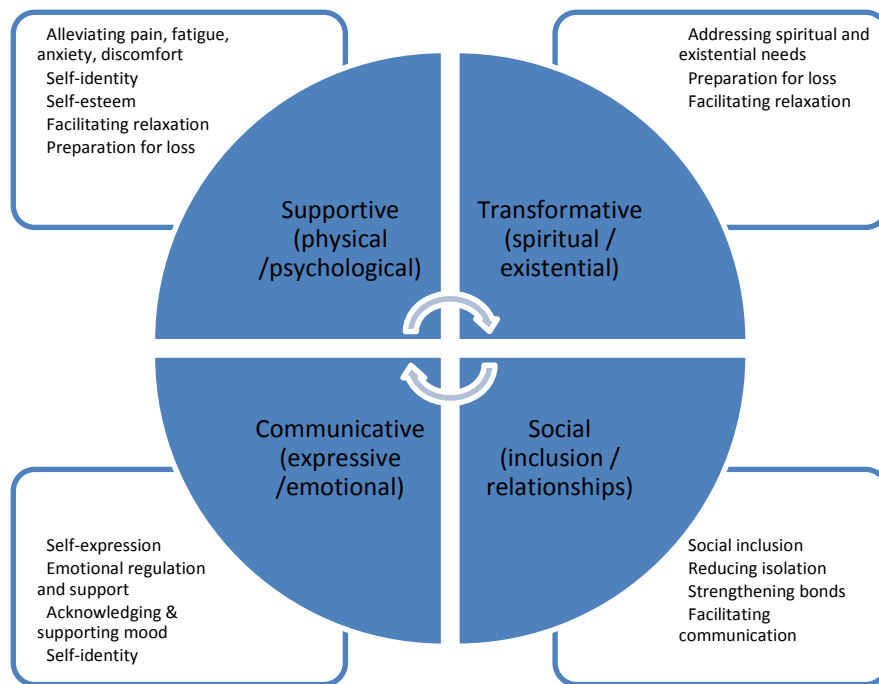


Figure 2 – Four-domain theoretical model for music therapy in palliative care inpatient settings

In the context of this manual, this theoretical framework and the four domains should act as a guide for therapists during assessment, setting of treatment aims and co-creation of the therapy intervention itself. The content of the therapy sessions created will align itself to

one or more of these domains. Aspects of the theory relating to each domain are provided below.

Supportive domain (physical and psychological)

Research has increasingly demonstrated the synergistic effect of both physical and psychological factors on levels of pain perception (Bradt, 2010). Negative psychological states, such as fear, anxiety and emotional distress can result in higher levels of pain, while pain can in turn result in higher levels of psychological distress. A number of studies have demonstrated the positive impact of music therapy on brain structures that control anxiety and stress levels (Fachner et al., 2013; Raglio et al., 2015). Furthermore, music therapy can alleviate psychological and physical distress through a number of therapeutic mechanisms, such as helping the individual transcend their identity as a 'dying' patient to reconnect with themselves as an empowered individual, by helping them reconnect with happy memories, open up about their feelings and so on.

In the 'supportive domain', music therapy interventions in palliative care therefore focus on:

- Reducing or alleviating: pain, fatigue, distress, discomfort, anxiety, tension, fear, feelings of insecurity
- Facilitating relaxation (could potentially include meditation, mindfulness, grounding)
- Self-identity – exploration, confirmation or reframing of identity as 'people' rather than 'patients'
- Self-esteem – providing new experiences, sense of purpose or achievement, hope
- Improving mood - uplifting, stimulating, relaxing, strength, hope, comfort, energising, enjoyment
- Preparation for loss, pre-emptive grief

Communicative domain (expressive / emotional)

An underlying mechanism of music therapy for palliative care patients can be the cathartic effect of relief from repressed emotions (O' Callaghan, 1996; Clements-Cortes, 2004; O'Callaghan and Hiscock, 2007; O'Kelly and Koffman, 2007) and a release of frustrations felt about their situation (Leow, 2010b). Communication between patients and loved ones is improved through the simple act of choosing songs together that had meaning for both, memories are shared, and feelings of loss can be explored together with the

support of the therapist (Krout, 2003; Diamaio, 2010; Sato, 2011). With therapist support, music can be a safe channel for the expression of emotions and therapeutic songwriting can help patients communicate thoughts and feelings, thus opening channels of communication. Musical improvisation can help patients identify and express difficult or painful emotions, aided and supported by the therapist (Heath, 2013). When music therapy is delivered as a group therapy where visitors can also partake, research suggests this lowers levels of bereavement for families and caregivers (O'Callaghan, 2009).

In the 'communicative domain', music therapy interventions in palliative care therefore focus on:

- Self-expression, emotional regulation, emotional support where range of both positive and negative emotions can be acknowledged and processed
- Self-identity – exploration, confirmation or reframing of identity as 'people' rather than 'patients'
- Acknowledging and supporting mood and mood disturbances, 'being with' the patient in their current mood state - stimulating, relaxing, giving comfort and hope if and when therapeutically appropriate
- Preparation for loss, pre-emptive grief

Social domain (inclusion / relationships)

The 'legacy' function of music therapy can contribute to the strengthening of social bonds. By providing a space for the expression of difficult emotions, either verbally or non-verbally, music therapy can help reduce the isolation often experienced by palliative care patients. Music therapy can contribute to creating a sense of community in palliative care settings (O'Kelly, 2002), softening and humanising the setting, lifting the mood of patients, families and staff, and improving communication with staff therefore improving patient care, and it can contribute to improved relationships with families (O'Kelly & Koffman, 2007; Heath and Lings, 2012).

In the 'social domain', music therapy interventions in palliative care therefore focus on:

- Social inclusion, reducing isolation (involvement of significant others)
- Strengthening relationships and strengthening bonds :
 - (Re)connecting with loved ones, defining and reflecting on important relationships, 'spending time with'
 - Identifying and reflecting on key moments in lives
- Facilitating communication

Transformative domain (spiritual/existential)

In relation to spirituality and health, facilitating the search for meaning appears to be one of the key mechanisms by which music therapy influences improved outcomes. Music chosen by clients, song writing, or music improvisation helps patients gain insight into their past, address past unreconciled events, find meaning in their present experience, and share their values and beliefs. Music therapy can help palliative care patients to transcend suffering by enjoying simple pleasures such as laughter, positive energy, relaxation, and having fun with the music (McClean et al., 2012). Through a process of cognitive reframing the patient can move from the perception of themselves as a sick, dying patient to an empowered individual. Music enables end-of-life patients “to extend beyond the immediate context to achieve new perspectives” (Aldridge, 1999 p. 107).

‘Legacy’ work in the creation of songs or music expressing their values, beliefs, or communicating a message to loved ones can contribute to the reduction of existential anxiety and can provide comfort and a sense of continued connection for loved ones during bereavement (Cadrin, 2006).

In the ‘transformative domain’, music therapy interventions in palliative care therefore focus on:

- Relaxation (meditation, mindfulness, grounding)
- Preparation for loss, pre-emptive grief
- Addressing spiritual or existential needs and providing support

Contraindications

It is for the therapist in their clinical judgement and professional responsibility to assess and appropriately address any possible contraindications of undertaking work that might involve stimulating, processing or expression of potentially difficult emotions with patients and/or significant others, or work where reflections are made on relationships and communication

with significant others. Awareness must be maintained at all times of the person-centred nature of this work and the overriding aim of improvement to quality of life. This is particularly important given the short-term nature of the work. Any contraindications must be acknowledged and addressed by the therapist, seeking the support of other professionals/supervisors whenever needed.

Main therapy principles

These are the key therapeutic principles identified for music therapy in palliative care inpatient settings. **These are considered to be the general therapy principles to be adopted and adhered to in any music therapy intervention in this setting, regardless of the specific focus or treatment aims of any particular session or sessions.**

Relationship-building

Establishing a positive therapeutic relationship – this enables the therapy process to take place effectively and must be achieved in a short space of time. The act itself of sharing and creating music together allows a deep connection to be quickly established. Of importance are the therapist's ability to 'be with' the patient, their quality of companionship, their ability to support and maintain this relationship, to adapt to each client (following their lead and also being ready to lead them when necessary) and to adjust language and musical input to the client's cognitive and emotional capabilities at any given moment.

Therapeutic listening – the therapist is listening and interacting empathically, making the client feel listened to, and letting them be themselves fully and uniquely.

~~*Strengthening bonds with others (whether present in sessions or not) – the therapist supports and facilitates communication between clients and significant others where this is deemed appropriate and beneficial (which may include working in the context of less harmonic family relationships), also providing opportunities for legacy work and creating memories where appropriate.*~~

Shared creative experience

Facilitating shared creative experiences of varying levels of complexity - Making music together instantly connects those involved, and results in a process or experience that

would not have existed without the presence of those involved. The therapist engages the client in shared musical interplay - scaffolding, adapting and structuring the shared creation to facilitate their engagement, and therefore increase shared creativity. The music therapist 'carries' and facilitates the client in this journey, providing guidance and support as required. The shared creative experiences can range from more predictable (e.g. re-creation of known songs), to use of parody, through composition, to entirely unknown musical play in improvisation.

Facilitating communication and self-expression

~~Emotional expression and communication in music~~—a safe channel is provided through which clients can express themselves and communicate. This is done in a way that is adapted to suit each client with appropriate support and guidance. Within the safe environment established and managed by therapist, clients often find they can express themselves in ways they never thought they could. Music –whether improvised or pre-composed – as uniquely human and universal to all despite illness, will connect with and naturally tend towards the things that are most meaningful to each person. Within this the clients' musical identity can be explored and affirmed, bringing an increased sense of meaningfulness. The focus is on the person behind the patient and whatever they bring to sessions, and space is allowed for negative emotions.

Givens:

The following should be considered as “givens” in this therapy approach, and as such are the starting premise of any intervention. If they are not in place, action should be immediately taken to rectify this:

- Safe and containing therapeutic space
- Person-centred and resource-oriented - focussing on patient's strength and potential
- Tailored therapeutic objectives
- Fostering positive interactions
- Collaborating with the client re. therapy goals and type of intervention adopted
- Working with whatever the client brings to the therapy space

The following should be considered as contraindicated in this therapy approach:

- avoiding emerging problems and negative emotions
- neglecting client's strengths
- overtly focussing on illness or pathology unless patient-led
- directive approach
- ignoring client's indicators of preferred therapy course or directing course of intervention towards therapist's own preference
- pursuing with a particular avenue if it becomes clinically evident that this may not be in the client's best interest (for example, focussing on a person's musical skills if these now prove difficult due to fatigue or poor concentration). The client may express an interest in pursuing such an avenue, but therapists must be aware that therapeutically this may not be in their best interests)

Conclusion

Both the musical components and extra-musical components can be adapted by the music therapist to address all of the treatment foci outlined, and also to operationalise the therapeutic principles described above. Thus the intervention stages, treatment foci and therapy principles are superimposed and simultaneous. The therapist's role and skill in palliative care work lies in continually evaluating and identifying which of these are to be addressed at any given moment in order to improve the quality of life of their patient. In other words, the music therapist makes observations, clinical judgements and adapts their clinical 'offerings' accordingly based on client indicators throughout every session in line with the person-centred approach. This is a complex and dynamic process and can be a difficult one to master. At this point it seems important to reiterate the absolute necessity that this type of work be carried out by HCPC-registered arts therapists and the need for sufficiently robust and regular supervision and support networks for therapists working in this field. Lastly, two key traits that must be acknowledged in these music therapists are self-awareness and grace (in the sense of bringing honour, dignity, respectfulness). These are of the utmost importance, and will form the bedrock foundation upon which a successful music therapy intervention based on the manual here presented can be built.

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Bibliography

Abernethy, A.P., Shelby-James, T., Fazekas, B.S., Woods, D. and Currow, D.C. (2005) 'The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice' *BMC Palliative Care* 2005 (4):7

Aldridge, D. (1998) *Music Therapy in Palliative Care – New Voices* London: Jessica Kingsley Publishers

Ansdell, G. (2016) *How Music Helps in Music Therapy and Everyday Life*. London and New York: Routledge

Cadrin, M. L. (2006) 'Music therapy legacy work in palliative care: creating meaning at the end of life' *Canadian Journal of Music Therapy* 12(1), 109-137

Clements-Cortes, A. (2004) 'The use of music in facilitating emotional expression in the terminally ill' *The American Journal of Hospice and Palliative Care* 21(4), 255-60

Dileo, C., & Bradt, J. (2005). *Medical Music Therapy: A Meta-Analysis and Agenda for Future Research*. Cherry Hill, NJ: Jeffrey Books.

Dimaio, L. (2010) 'Music therapy entrainment: A humanistic music therapist's perspective of using music therapy entrainment with hospice clients experiencing pain' *Music Therapy Perspectives* 28(2), 106-115

Fachner, J., Gold, C., & Erkkela, J. (2013) 'Music Therapy Modulate Fronto-Temporal Activity in Rest-EEG in Depressed Clients' *Brain Topography* 26(2), 338-354

Heath, B., & Lings, J. (2012) 'Creative songwriting in therapy at the end of life and in bereavement' *Mortality* 17(2), 106-118

Hilliard, RE. (2003).The effects of music therapy on the quality and length of life of people diagnosed with terminal cancer. *Journal of Music Therapy*, 40(2),113–37.

Krout, R.E. (2003) 'Music therapy with imminently dying hospice patients and their families: Facilitating release near the time of death' *American Journal of Hospice & Palliative Care* 20(2), 129-134

Leow, Q. H. M., Drury, V. B., & Poon, W. H. (2010b) 'A qualitative exploration of patients' experiences of music therapy in an inpatient hospice in Singapore' *International Journal of Palliative Nursing* 16(7), 344-350

McClellan, S., Bunt, L. & Daykin, N. (2012) 'The healing and spiritual properties of music therapy at a cancer care centre' *Journal of Alternative and Complementary Medicine* 18(4), 402-407

McConnell, T., Scott, D., & Porter, S. (2016a) 'Music therapy for end-of-life care: an updated systematic review' *Palliative Medicine*, 30 (9), 877-883

McConnell, T., Graham-Wisener, L., Regan, J., McKeown, M., Kirkwood, J., Hughes, N., Clarke, M., Leitch, J., McGrillen, K. and Porter, S. (2016b) 'Evaluation of the effectiveness of music therapy in improving the quality of life of palliative care patients: a randomised controlled pilot and feasibility study' *Pilot and Feasibility Studies* 2(70)

McConnell, T. and Porter, S. (2017a) 'Music therapy for palliative care: a realist review' *Palliative and Supportive Care* 15 (4): 454-464

O'Callaghan, C.C. (1996) 'Lyrical Themes in Songs Written by Palliative Care Patients' *Journal of Music Therapy* 33(2), 74-92

O'Callaghan, C.C., & Hiscock, R. (2007) 'Interpretive Subgroup Analysis Extends Modified Grounded Theory Research Findings in Oncologic Music Therapy' *Journal of Music Therapy* 44(3), 256-281

O'Callaghan, C., & Barry, P. (2009) 'Music therapists' practice-based research in cancer and palliative care: creative methods and situated findings' *Voices: A World Forum for Music Therapy*, 9(3), Retrieved from www.voices.no/mainissues/mi4000999053.php

O'Kelly, J. (2002) 'Music therapy in palliative care: current perspectives' *International Journal of Palliative Nursing* 8(3), 130-6

O'Kelly, J., & Koffman, J. (2007) 'Multi-disciplinary perspectives of music therapy in adult palliative care' *Palliative Medicine* 21(3), 235-243

Porter, S., McConnell, T., Clarke, M., Kirkwood, J., Hughes, N., Graham-Wisener, L., Regan, J., McKeown, M., McGrillen, K., Reid, J. (2017b) 'A critical realist evaluation of a music therapy intervention in palliative care' *BMC Palliative Care* 16:70

Raglio, A., Attardo, L., Gontero, G., Rollin, S., Groppo, E., & Granieri, E. (2015). Effects of music and music therapy on mood in neurological patients. *World Journal of Psychiatry*, 5(1), 68-78.

Robb, S.L., Burns, D.S., Carpenter, J.S. (2011) 'Reporting guidelines for music-based interventions' *Journal of Health Psychology* 16 (2):342-352

Rolvsjord, R. (2004) 'Therapy as Empowerment' *Nordic Journal of Music Therapy* 13 (2): 99-111

Rolvsjord, R. (2010) *Resource-Oriented Music Therapy in Mental Health Care* Gilsum, NH: Barcelona Publishers

Ross, Margaux (2017), 'A Resource-Oriented and Relationship Based Music Therapy Approach for Persons Living with Dementia' *Masters thesis, Concordia University*, retrieved from <https://spectrum.library.concordia.ca/982324/>

Sato, Y. (2011) 'Musical life review in hospice' *Music Therapy Perspectives* 29, 31-8

Recommended supplementary reading

Amadoru, S., & McFerran, K. (2007). The role of music therapy in children's hospice: Both unique and necessary. *European Journal of Palliative Care*, 14(3), 124-127.

Baxter, C., & O'Callaghan C. (2010). Decisions about the future use of music therapy: Products created by palliative care patients. *The Australian Journal of Music Therapy*, 21, 2-20. Retrieved from <http://search.informit.com.au/documentSummary;dn=150313160753920;res=IELHEA>
ISSN:

Bowers, T.A., & Wetsel, M.A. (2014). Utilization of Music Therapy in Palliative and Hospice Care. *Journal of Hospice and Palliative Nursing*, 16(4), 231-239. doi: 10.1097/NJH.000000000000060.

Gallagher, L. M., Lagman, R., Walsh, D., Davis, M. P., & LeGrand, S. B. (2006). The clinical effects of music therapy in palliative medicine. *Supportive Care in Cancer*, 14(8), 859-866.

Horne-Thompson, A., & Grocke, D. (2008). The effect of music therapy on anxiety in patients who are terminally ill. *Journal of Palliative Care*, 11(4):582-90.

Korczak, D., Wastian, M., & Schneider, M. (2013). Music therapy in palliative setting. *GMS Health Technology Assessment*, 9, Doc07. doi: 10.3205/hta000113, URN: urn:nbn:de:0183-hta0001139

Magill, L. (2009). Caregiver empowerment and music therapy: through the eyes of bereaved caregivers of advanced cancer patients. *Journal of Palliative Care*, 25(1), 68-75.

Renz, M., Schutt, M.M., & Cherny, T. (2005). Spirituality, psychotherapy and music in palliative cancer care: research projects in psycho-oncology at an oncology center in Switzerland. *Supportive Care in Cancer*, 13(12), 961-6.

Salmon, D. (2001). Music therapy as psychospiritual process in palliative care. *Journal of Palliative Care*, 17(3), 142-146.

Tsiris, G., Dives, T., & Prince, G. (2014). Music therapy: Evaluation of staff perceptions at St Christopher's Hospice. *European Journal of Palliative Care*, 21(2), 72-75.

Wlodarczyk, N. (2007). The effect of music therapy on the spirituality of persons in an inpatient hospice unit as measured by self-report. Master's Thesis: Florida State University, Florida.

Appendix 1 - Music therapist co-authors

Naomi Craig is a music therapist working for Every Day Harmony Music Therapy, Belfast and provided the music therapy intervention for the MusiQual feasibility study which was carried out in Belfast in 2016/17.

Conall Dunlop was a music therapist working for Every Day Harmony Music Therapy, Belfast and provided the music therapy intervention for the MusiQual feasibility study which was carried out in Belfast in 2016/17.

Catherine Gordon is a music therapist working Every Day Harmony Music Therapy, Belfast and has previous extensive experience in delivering music therapy to both inpatient and day hospice settings in Northern Ireland.

Daniel Thomas (Joint Managing Director, Chroma, UK) Daniel qualified as a music therapist in 2002. His work focuses on children and families, especially supporting attachment, bonding and resilience. Daniel has worked in prisons, mental health settings and in special and mainstream schools with children with a range of brain injuries and other conditions He certified in the APCI assessment in 2014, and as a Neurologic Music Therapist in 2017. He is also the Joint Managing Director of Chroma.

Jo Godsal (Clinical Director, Chroma, UK) Jo is a dramatherapist who has specialised in working with children and young people who have experienced early trauma. He qualified in 2006 and has worked in mainstream primary schools and a residential therapeutic

community. He is the Clinical Director at Chroma, supporting and overseeing therapy. He completed the Neurologic Music Therapy training in 2017

Aisling Vorster (Music Therapist, Chroma, UK) Aisling is a music therapist and clinical supervisor, specialising in work with children and families. She works in a variety of settings, including schools, the NHS, justice services, residential settings and charities. Aisling also has a certificate in family therapy and works with a range of needs including attachment, learning and physical disabilities and autism. She also works in adult mental health and dementia services. She also certified as a Neurologic Music Therapist in 2017