

# ‘The MusiQual treatment manual for music therapy in a palliative care inpatient setting’

## Abstract

This article 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 Northern Ireland. The MusiQual study considered the feasibility of a multicentre randomised trial to evaluate the effectiveness of music therapy in improving the quality of life of hospice inpatients (protocol: McConnell et al. results: Porter et al.). The procedures in the manual are based fully on those implemented by the Music Therapists during the feasibility study, and it also incorporates the theoretical model defined and published following the realist review of the literature (McConnell and Porter). The manual is presented in the format in which it would be used in the potential future phase III multicentre randomised control trial. It represents a flexible approach to provide enough scope for practicing therapists to adapt their interventions to individual clients as is best practice in music therapy. It aims to provide stable guidelines both to ensure treatment fidelity in a future trial of music therapy for palliative care inpatients and to act as a relevant guide for Music Therapists practicing in this field.

**Keywords** [feasibility](#), [music therapy](#), [palliative](#), [quality of life](#), [theoretical model](#), [treatment manual](#)

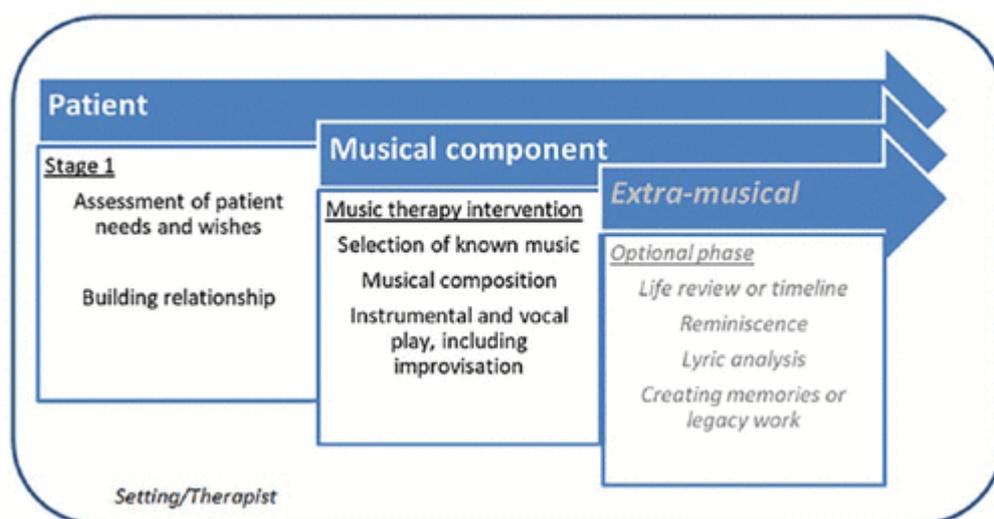
## Background to the MusiQual treatment manual

This article 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 Northern Ireland (NI). The study, completed in June 2017 ([McConnell et al., 2016](#); [Porter et al., 2018](#)), 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. It sought to test the processes and procedures to be used in such a study. This treatment manual has been developed in preparation for this potential multicentre trial to ensure treatment fidelity across the sites.

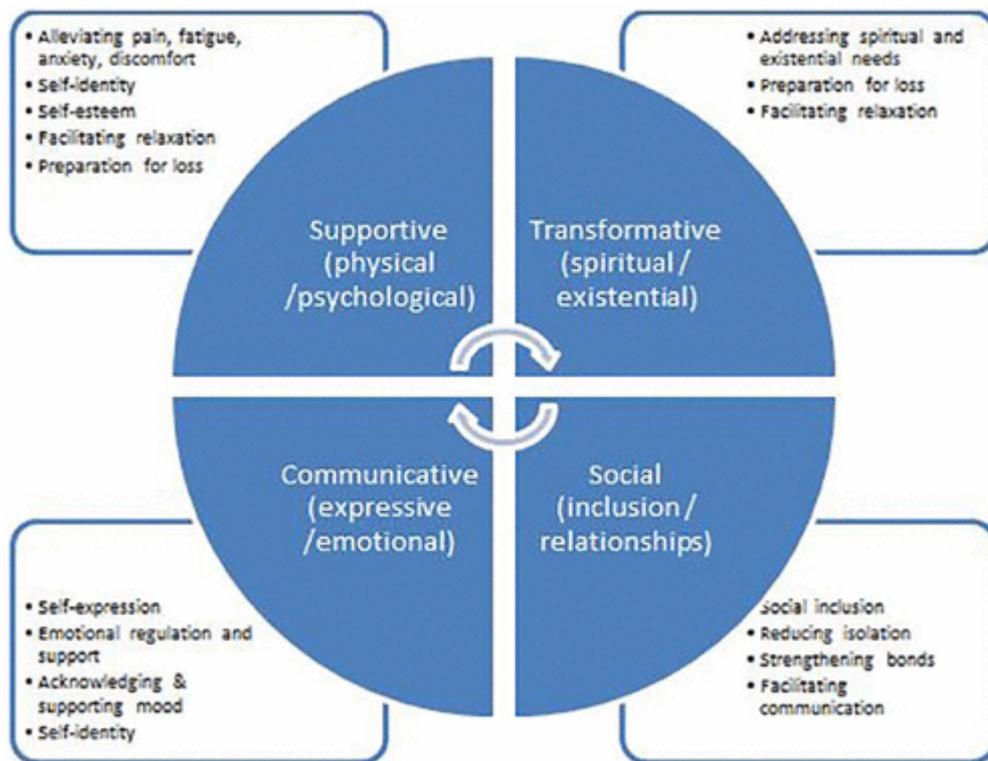
In the preparation of this manual, it was found that little information was available publicly regarding the preparation of such a document. The MusiQual team therefore decided to publish this manual as a standalone piece of work in the hope that, in addition to its potential function in their future 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 et al., 2011). Details from the therapists’ clinical documentation were 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, 2017). 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). Thus, the manual is structured in line with the four domains outlined in the theoretical model that has been developed.



**Figure 1.** Visual outline of the process of the music therapy intervention.



**Figure 2.** Four-domain theoretical model for music therapy in palliative care inpatient settings (McConnell and Porter, 2017).

The manual has been reviewed and agreed as an accurate representation of music therapy by a number of music therapy professionals to ensure that it properly reflects approaches and techniques commonly adopted in palliative care. The manual is intended primarily for both Music Therapists and researchers as a guideline 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. The interventions described are intended to be carried out by qualified Music Therapists 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). This 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, focusing on 'noticing, acknowledging, and making use of the client's resources through the fostering of a collaborative relationship' (Rolvjord, 2010: 66, cited in Ross, 2017). Indeed, in this approach the collaborative therapeutic relationship is seen as a core component, and it is considered to be suited to the unique, individualised, sometimes rapidly changing and short-term nature of palliative care inpatient settings 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.

## General music therapy principles

Prior to outlining the specific music therapy process for the study, the general music therapy principles to be followed are outlined. These are the key therapeutic principles identified for music therapy in palliative care inpatient settings. These are considered to be 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.

### 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 facilitates this process for the client, 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

An appropriate therapeutic environment is provided through which clients can express themselves and communicate. The therapeutic environment and approach is adapted to suit each client with appropriate support and guidance. Within the safe environment established and managed by the therapist, clients often find they can express themselves in new ways. 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 within the patient and whatever they bring to sessions, and space is allowed for negative emotions.

### Givens

The following should be considered as essential to 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 approach – focusing on patients' strength and potential

Tailored therapeutic objectives

Fostering positive interactions

Collaborating with the client to select 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 focusing 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 a particular avenue if it becomes clinically evident that this may not be in the client's best interest (e.g. focusing 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).

## The music therapy intervention

### Context of the intervention

For reference, the target population of the clinical trial is adult hospice inpatients, irrespective of diagnosis. Inclusion criteria are hospice inpatients above the age of 18, who have given informed consent. 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, and 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 these procedures can equally apply to the broader spectrum of hospice inpatients.

### ***Protocols of the 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 information session/s for staff prior to the start of the music therapy service, and should signpost relevant literature to staff as required. These sessions should be offered on at least two or three occasions during the initial period at different days/times to enable attendance by as many members of staff as possible. Their purpose is to make all staff aware of music therapy and what it entails, 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***

A protocol length of 45 minutes for each therapy session is planned to ensure equality of dosage as far as possible, 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. This decision is based on the wishes of the patient themselves, participation in previous sessions and their own assessment, and therapists should act and advise accordingly as they would in any clinical setting.

### ***Equipment***

Musical instruments as required to include harmony instrument/s (piano/keyboard/guitar/ukulele or similar), voice, and a range of small, accessible instruments, including culturally diverse instruments where available and appropriate (i.e. standard music therapy instrumentation)

Multi-sensory items (e.g. sensory scarves) that might at times be utilised by the therapist to support the music therapy intervention

A songbook 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 General Data Protection (GDPR) regulation (EU) 2016/679 and dependent on full explicit consent

Patient's and therapist's own instrument if applicable.

## The music therapy process

The aim of this section is to outline the form that the basic therapy process takes. After 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.

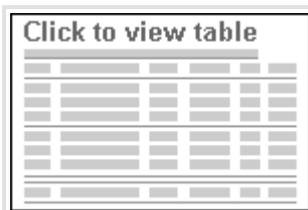
Stage 1 represents the standard process that forms the initial phase of music therapy work in most clinical contexts ([Bunt and Hoskyns, 2002](#): 24–37 and 251). In the palliative care inpatient setting, this process will largely be concentrated within the initial session given the potentially short-term nature of the work. Following this stage, the remainder of the intervention is made up of two parallel sections (stage 2), focusing on its musical and extra-musical components.

### Stage 1

Before beginning the intervention, the Music Therapist should ensure that they have received an adequate handover from venue staff with medical history as required, an update on current health and well-being, 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 Music 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 and reflected upon 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.



Table

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	
2A Musical components	2B Extra-musical components
Selection of known music	Life review/timeline
Musical composition	Reminiscence
Instrumental play, including clinical improvisation	Lyric analysis
	Legacy work/creating memories

[View larger version](#)

### ***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.

### ***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 relationship is sought and established from the beginning, but also remains an ongoing process throughout the intervention.

### ***Presentation of possible types of intervention***

Following the client's lead, the therapist presents possible forms of treatment intervention, giving a brief description of options (as listed in the subsequent section), and what they might entail, and a presentation of 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 adapted 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.

### ***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 as follows:

Client directly expresses their preference verbally or gives clear non-verbal indication → therapist proceeds in this direction.

Client hesitant but gives some indication → therapist suggests this intervention/asks for confirmation/facilitates an exploration of this possibility → 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 → therapist assesses reason for this (e.g. emotional reasons or inhibitions) → Therapist can continue general approach and seek further indication from client, or may suggest possible interventions based on what they have observed → therapist sensitively initiates intervention when required.

### ***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 time frame 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. These should be stated appropriately in clinical notes in accordance with documentation requirements of the setting, their employer and also with HCPC Standards of Proficiency for Arts Therapists<sup>1</sup>. 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.

## Stage 2: Clinical 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, and 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 song parodies (where the music of a pre-existing, usually familiar, song is used and the lyrics replaced with the client's own lyrics). This type of intervention will typically involve its own lyric development and analysis, and often involves reminiscence and life review work, and it may involve or lead on to free instrumental play (improvisation) as part of the composition process.

#### **Instrumental play**

The client may play a known instrument alone or with the therapist, may choose to learn instrument techniques, or share their instrumental playing with family members present. The 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, and 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, for example, 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 for the music therapy sessions**

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 the overall therapeutic arc, plan sessions accordingly and support patients in doing same. The therapeutic arc is broadly considered to mean the structure and outline of the therapy intervention as a whole and, especially in this setting, of the individual sessions themselves, that both should have a beginning, middle and end where a therapeutic alliance or relationship is established, the main body of therapeutic work is carried out, and the intervention is drawn to an appropriate closure. As it is not possible in this setting to predict with certainty the pattern of upcoming sessions, therapists should structure and guide each individual session so that it has its own therapeutic arc 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, 2017](#)), and further confirmed via the critical realist evaluation which followed ([Porter et al., 2017](#)). 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, representing the main areas of focus for palliative care work in music therapy, are the supportive domain (physical and psychological), communicative/expressive domain (emotional), transformative domain (spiritual/existential) and social domain. These are outlined in [Figure 2](#).

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 the following:

- Reducing or alleviating pain, fatigue, distress, discomfort, anxiety, tension, fear, feelings of insecurity

- Facilitating relaxation (to 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, preemptive grief, working with current loss and existing 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' Clements-Cortes, 2004; O'Callaghan, 1996; O'Callaghan and Hiscock, 2007; O'Kelly and Koffman, 2007) and a release of frustrations felt about their situation (Leow et al., 2010). 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 (Dimaio, 2010; Krout, 2003; 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 and Lings, 2012). When music therapy is delivered as a group therapy where visitors can also partake, research suggests this lowers levels of symptoms of bereavement for families and caregivers (O'Callaghan and Barry, 2009).

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

Self-expression, emotional regulation and 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, preemptive grief, working with current loss and existing 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 (Heath and Lings, 2012; O'Kelly and Koffman, 2007).

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

- Social inclusion, reducing isolation (involvement of significant others)

- Strengthening relationships and strengthening bonds:

  - Spending time and (re)connecting with loved ones, defining and reflecting on important relationships

  - 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, songwriting 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 (McClellan 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, 1999:107). 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 (Cadrian, 2006).

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

Relaxation (meditation, mindfulness, grounding)

Preparation for loss, pre-emptive grief, working with current loss and existing 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 should be maintained at all times of the person-centred nature of this work and the overriding aim of improving quality of life. This is particularly important given the short-term nature of the work. It is vital that any contraindications be acknowledged and addressed by the therapist, seeking the support of other professionals/supervisors whenever needed.

## Conclusion

Both the musical components and the extra-musical components can be adapted by the Music Therapist to address all of the treatment foci outlined, and to put the therapeutic principles described into practice. 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 four areas 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 requires skill and experience. 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 as well as support networks for therapists working in this field. Finally, two key traits that must be acknowledged in these Music Therapists are self-awareness and grace (in the sense of bringing honour, dignity and respectfulness). These are of utmost importance, and will form the bedrock foundation upon which a successful music therapy intervention based on the manual presented here can be built.

## Appendix 1

### Suggested 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.

[Google Scholar](#)

---

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. Available at:

<http://search.informit.com.au/documentSummary;dn=150313160753920;res=IELHEA> (accessed 12 March 2019).

[Google Scholar](#)

---

Bowers, TA, Wetsel, MA (2014) Utilization of Music Therapy in Palliative and Hospice Care. *Journal of Hospice and Palliative Nursing* 16(4): 231–239.

[Google Scholar](#) | [Crossref](#)

---

Gallagher, LM, Lagman, R, Walsh, D. (2006) The clinical effects of music therapy in palliative medicine. *Supportive Care in Cancer* 14(8): 859–866.

[Google Scholar](#) | [Crossref](#) | [Medline](#)

---

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*(2) 40:113: 37.

[Google Scholar](#)

---

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): 582–590.

[Google Scholar](#)

---

Korczak, D, Wastian, M, Schneider, M (2013) Music therapy in palliative setting. *GMS Health Technology Assessment* 9: Doc07.

[Google Scholar](#) | [Medline](#)

---

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.

[Google Scholar](#) | [SAGE Journals](#) | [ISI](#)

---

McConnell, T, Scott, D, Porter, S (2016) Music therapy for end-of-life care: an updated systematic review. *Palliative Medicine* 30(9): 877–883.

[Google Scholar](#) | [SAGE Journals](#) | [ISI](#)

---

Renz, M, Schutt, MM, 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): 961–966.

[Google Scholar](#) | [Crossref](#) | [Medline](#)

---

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

[Google Scholar](#) | [Medline](#)

---

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.

[Google Scholar](#)

---

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

[Google Scholar](#)

## Acknowledgements

Jenny Kirkwood drafted the primary version of this manual and subsequent versions received input from members of the MusiQual team from Every Day Harmony Music Therapy, Chroma, and Queen's University Belfast.

## Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship and/or publication of this article.

## Funding

The feasibility study described herein which led to the development of this manual was funded by a Northern Ireland Public Health Agency Research and Development Enabling Award.

## Notes

1. <http://www.hpc-uk.org/standards/standards-of-proficiency/arts-therapists/>

## References

Abernethy, AP, Shelby-James, T, Fazekas, BS. (2005) The Australia-modified Karnofsky Performance Status (AKPS) scale: a revised scale for contemporary palliative care clinical practice. *BMC Palliative Care* 2005(4): 7. [Google Scholar](#) | [Crossref](#)

---

Aldridge, D (1999) *Music Therapy in Palliative Care – New Voices*. London: Jessica Kingsley Publishers. [Google Scholar](#)

---

Ansdell, G (2016) *How Music Helps in Music Therapy and Everyday Life*. London; New York: Routledge. [Google Scholar](#) | [Crossref](#)

---

Bradt, J (2010) The effects of music entrainment on postoperative pain perception in pediatric patients. *Music and Medicine* 2(3): 150–157 [Google Scholar](#) | [Crossref](#)

---

Bunt, L, Hoskyns, S (2002) *The Handbook of Music Therapy*. Hove, East Sussex: Brunner-Routledge. [Google Scholar](#)

---

Cadrin, ML (2006) Music therapy legacy work in palliative care: creating meaning at the end of life. *Canadian Journal of Music Therapy* 12(1): 109–137. [Google Scholar](#)

---

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): 255–260.  
[Google Scholar](#) | [SAGE Journals](#)

---

Dileo, C, Dneaster, D (2005) Music Therapy at the End of Life State of the Art. In: Dileo, C, Loewy, J (eds) *Music Therapy at the End of Life*. Cherry Hill, NJ: Jeffrey Books.  
[Google Scholar](#)

---

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.  
[Google Scholar](#) | [Crossref](#)

---

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.  
[Google Scholar](#) | [Crossref](#) | [Medline](#)

---

Heath, B, Lings, J (2012) 'Creative songwriting in therapy at the end of life and in bereavement'. *Mortality* 17(2): 106–118.  
[Google Scholar](#) | [Crossref](#)

---

Krout, RE (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.  
[Google Scholar](#) | [SAGE Journals](#)

---

Leow, QHM, Drury, VB, Poon, WH (2010) A qualitative exploration of patients' experiences of music therapy in an inpatient hospice in Singapore. *International Journal of Palliative Nursing* 16(7): 344–350.  
[Google Scholar](#) | [Crossref](#)

---

McClean, 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.  
[Google Scholar](#) | [Crossref](#) | [Medline](#)

---

McConnell, T, Porter, S (2017) Music therapy for palliative care: a realist review. *Palliative and Supportive Care* 15(4): 454–464.  
[Google Scholar](#) | [Crossref](#) | [Medline](#)

---

McConnell, T, Graham-Wisener, L, Regan, J. (2016) 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).  
[Google Scholar](#) | [Crossref](#) | [Medline](#)

---

O'Callaghan, CC (1996) Lyrical themes in songs written by palliative care patients. *Journal of Music Therapy* 33(2): 74–92.  
[Google Scholar](#) | [Crossref](#) | [ISI](#)

---

O'Callaghan, CC, Hiscock, R (2007) Interpretive Subgroup Analysis Extends Modified Grounded Theory Research Findings in Oncologic Music *Journal of Music Therapy* 44(3): 256–281.  
[Google Scholar](#) | [Crossref](#) | [Medline](#)

---

O'Callaghan, CC, 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). Available at: [www.voices.no/mainissues/mi4000999053.php](http://www.voices.no/mainissues/mi4000999053.php)  
[Google Scholar](#)

---

O'Kelly, J (2002) Music therapy in palliative care: current perspectives. *International Journal of Palliative Nursing* 8(3): 130–136.  
[Google Scholar](#) | [Crossref](#) | [Medline](#)

---

O'Kelly, J, Koffman, J (2007) Multi-disciplinary perspectives of music therapy in adult palliative care. *Palliative Medicine* 21(3): 235–243.  
[Google Scholar](#) | [SAGE Journals](#) | [ISI](#)

---

Porter, S, McConnell, T, Clarke, M. (2017) A critical realist evaluation of a music therapy intervention in palliative care. BMC Palliative Care 1670.

[Google Scholar](#) | [Crossref](#)

---

Porter, S, McConnell, T, Graham-Wisener, L. (2018) A randomised controlled pilot and feasibility study of music therapy for improving the quality of life of hospice inpatients. BMC Palliative Care 2018: 17125.

[Google Scholar](#)

---

Raglio, A, Attardo, L, Gontero, G. (2015) Effects of music and music therapy on mood in neurological patients. World Journal of Psychiatry 5(1): 68–78.

[Google Scholar](#) | [Crossref](#) | [Medline](#)

---

Robb, SL, Burns, DS, Carpenter, JS (2011) Reporting guidelines for music-based interventions. Journal of Health Psychology 16(2): 342–352.

[Google Scholar](#) | [SAGE Journals](#) | [ISI](#)

---

Rolvjord, R (2004) Therapy as empowerment. Nordic Journal of Music Therapy 13(2): 99–111.

[Google Scholar](#) | [Crossref](#)

---

Rolvjord, R (2010) Resource-oriented Music Therapy in Mental Health Care. Gilsum, NH: Barcelona Publishers.

[Google Scholar](#)

---

Ross, M (2017) A resource-oriented and relationship based music therapy approach for persons living with dementia. Masters Thesis, Concordia University. Available at: <https://spectrum.library.concordia.ca/982324/>

[Google Scholar](#)

---

Sato, Y (2011) 'Musical life review in hospice'. Music Therapy Perspectives 29: 31–38.

[Google Scholar](#) |