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MUSIC THERAPISTS' EXPERIENCES
WITH ADULTS IN PAIN:
IMPLICATIONS FOR CLINICAL PRACTICE*

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ABSTRACT

The purposes of this study were to explore the lived experiences of music therapists with adults experiencing pain, to describe the themes that emerged from the accounts, and to connect these themes back to clinical music therapy contexts. Though many music therapists are involved in healthcare settings according to the American Music Therapy Association (AMTA) Member Sourcebook, there is limited current research about music therapists' experiences when treating clients in pain. Hence, there is a need for inquiries and additional resources for clinicians to access and integrate within their practice. Three music therapists were interviewed regarding their work with clients who were in pain. The data was analyzed using modified grounded theory methodology. Six themes emerged from data analysis. The themes were trust, presence, caring, physical empathy and resonating sympathetically, empowerment, and facilitating communication or emotional expression. In addition, potential implications for clinical practice were drawn from five inferences within the therapists' accounts of i) experiencing the needs of persons experiencing pain, ii) experiencing varied roles, iii) experiencing pain and healing music, iv) experiencing client-therapist-music relationships, and v) experiencing the therapeutic process.

* I wish to express my heartfelt appreciation and deepest gratitude to the three therapists who gave their time and openly and vividly shared personal experiences of their work with clients in pain—the interviews were the highlight of this challenging yet enriching research project.

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INTRODUCTION AND RELATED LITERATURE

When I first began this inquiry, I was a graduate student seeking to understand more about the impact of music therapy on clients' pain symptoms. This interest was rooted in a vivid first-hand experience of using music and toning to work through dental pain from having a molar tooth extracted. As a music therapist, I naturally became fascinated with how various disciplines and professions approached and dealt with pain, and how music could alter and positively impact the experience.

Pain is commonly understood to be a complex and subjective experience that has deep rippling effects on other functional aspects of life. Chronic pain is often difficult for the sufferer, their carers and for members of the medical team because pharmacological treatments had their limitations. Hence, I was particularly interested in how music supported or helped persons in pain cope with their discomfort. After reviewing the literature, questions surfaced that motivated this exploration of music therapists' experiences—their expectations, beliefs, and relational dynamics—as they worked with clients who were in pain.

As evidenced with each annual report by the American Music Therapy Association, the fields of Music Medicine and Medical Music Therapy have grown significantly. Each year, an increasing number of music therapists are employed within healthcare settings, hospitals, and hospices. In the area of pain treatment, however, there are relatively few studies on music therapists' experiences of working with clients, or conversely, on clients' experiences of music therapy.

As I worked on a music medicine database as a graduate research assistant, I observed that much of music therapy and pain literature reflected the contingent use of music as procedural support (Walworth, 2003; Thompson, 1995) and as a form of distraction (Roberts, 2002; Kwekkeboom, 2003). Documented approaches ranged from passive listening, to music-facilitated relaxation, to active vocalization and toning (Whipple & Glynn, 1992).

As the complexity of pain reflected in the literature suggested that music therapy in pain treatment might not easily be reduced to a set of procedures, and the perception and interpretation of pain cannot easily be reduced into a single or a few valid "truths" because of the unique and subjective nature of the pain experience, a descriptive, non-positivistic paradigm seemed more appropriate over empirical, quantitative approaches to address the questions I was mulling over: What do music therapists bring to clients who are in pain? What are some of the beliefs that influence their work? How might music therapists reflect on their work? How do music therapists deal with pain personally? How do music therapists perceive the effect and impact of music therapy on their clients and the latter's pain?

Studies of clinician (Comeau, 1991) or patient/client experiences (Beitz & Goldberg, 2005; Racette, 1989; Santy & MacKintosh, 2001; Walshe, 1995) have historically served to inform the field of music therapy. The dearth of published studies on therapists'

(Edwards & Kennelly, 2004) or pediatric patients' (Muller, 1997, 2004) experiences in medical contexts or pain treatment support the findings of Michel and Chesky (1990) that many clinicians who worked with clients who were elderly, or who had medical conditions, neurological impairments, or physical disabilities were not directly involved in pain work, perhaps due to a lack of knowledge. The latter's survey of 348 music therapists showed that many music therapists indicated a desire to work with clients in pain, and suggested a need for further information and assistance through pertinent research and support.

Muller (1997, 2004) used phenomenological methodology to study the experiences, philosophies, and practices of music therapists who worked with children in pain. Muller identified a need for more case studies on the use of live music with children in pain and also for inquiries into how music involvement and engagement affects the course of a crisis or treatment. He cited case studies as more relevant clinically because therapists could adapt or apply the information to their practice as appropriate. He also noted that there were gaps in terms of information and resources related to techniques or approaches for pain treatment in the literature.

Like Muller's, my research explored music therapists' "lived experiences" with clients in pain. However, the focus of this study differed from Muller's in two ways: first, I was interested in examining the work of music therapists with adults who were experiencing pain, and second, grounded theory was applied to analyze the data that had been gathered from a phenomenological approach of interviewing. The intent of phenomenological research, as explained by Mertens (2005, p.240), is to "understand and describe an event from the point of view of the participant . . . (and explore) the way in which members of a group or community themselves interpret the world and life around them." Grounded Theory, on the other hand, as described by Robson (2002), is a process of action research where the researcher goes back and forth to the field to collect data in order to generate theories of practice—"throughout the process, one is trying to understand what it means to those who created it and to integrate that meaning with its meaning to us" (pp.197–198).

My faculty advisor, Dr. Kenneth Aigen, suggested a grounded theory approach in order to explore more globally the perceptions, approaches and techniques, experiences and decision-making processes within therapists' experiences (Ruud, 1997; Moe, 2000). As the on-going processes of music therapy and pain are not understood by simply gathering the facts, a grounded theory was useful because it provides a framework within which the day-to-day experiences can be viewed in their complexity (Glaser, 1993).

Several other researchers had also used the modified grounded theory method to explore an area within music therapy: Edwards (2004) had identified eight categories of techniques employed by a music therapist in work with three children who had neurological or spinal injury: cueing, synchrony, choices, orientation, preparation, feedback, incorporation and humor; and O'Callaghan (1996) had found eight themes in the lyrics of 64 songs written by 39 palliative care clients: messages, self-reflections, compliments, memories, reflections upon significant others including pets, self-expression of adversity, imagery, and prayers.

To this end, in the present study an inquiry using modified grounded theory (Glaser & Strauss, 1967) was framed to answer the “how,” “what,” and “how to” questions of working with adults in pain, by analyzing clinician experiences of providing music therapy pain treatment—how music therapists perceived their work and their perceptions of the impact of music processes and clinical protocols, treatments, and music experiences on their adult clients who were experiencing pain. My approach was also informed by the writings of Aigen (2005), Bruscia (1998), Wolcott (2001), Ely, Arul, Downing, and Vinz (2001), and Amir (2005).

METHOD

Grounded Theory

According to Sprenkle and Piercy (2005), “grounded theory methodology builds theory that emerges flexibly over time from data collection and analysis” (p.45). Finlay and Ballinger (2006) described the process of constant comparative analysis within grounded theory framework as “involving coding a unit of data and comparing it with all the other units of data coded in that category.”

Sprenkle and Piercy (2005) further described how research questions in grounded theory were broad, flexible, and open-ended initially, but became more focused and refined with analysis. The researcher needs to approach the field of study with an open mind without preconceived ideas about what may be uncovered. Hence, there is a danger posed by conducting a literature review in advance as the latter may influence the researcher to project existing ideas onto the process, which may interfere with creative discovery. Glasser (2001) held the view that the specific purpose of the literature review was to minimize literature distortion of emergent categories. Strauss and Corbin (1990) clarified that restricting the literature would reduce the likelihood that the data will be manipulated to support existing theory and findings.

Participants

The nature of grounded theory does not require a large participant sample in order to generate theory. After IRB approval was gained, emails were initially sent to clinicians with clinical expertise and a publication record in pain treatment. While greatly limiting the sampling frame, my rationale for including only those clinicians who also had a publication record was that I knew that they would have expertise in the area of working with clients in pain. These clinicians were invited to participate in the study, or to refer other experienced clinicians in a “snowballing” effect. This method of purposive sampling was a means of “selecting participants for the study who were identified as being expert informants who could help the researcher best understand the research question” (Creswell,

2003, p.185). Hence, the music therapists who were interviewed had to have at least three years' work experience in various pain settings.

Out of seven potential respondents, three music therapists voluntarily completed interviews—two females and a male. The three North American clinicians were actively practicing in the field and providing pain treatment at the time, and their combined experience was more than two decades. Two of the interviews were conducted face-to-face and one was completed via long-distance telephone call. Each interview averaged an hour. Four other music therapists who initially expressed interest in the study were not interviewed because they did not return a signed consent form or failed to respond to follow-up emails. All participants signed a consent form before beginning the interview process.

Background of the Participants

At the time of the interview, Participant 1 worked at a hospital that specialized in palliative care for adults with advanced cancer. The average stay was 28 days. He provided support mainly at the hospital, and also went out to the homes of a handful of clients.

Participant 2 had focused her doctoral studies on pain management with pediatric clients. After becoming intrigued with the stories and perspectives told by adults with chronic pain, she started services on her campus for persons in the community with chronic pain and chronic medical conditions utilizing active music interventions. Over three years, she worked with a variety of students, many in their forties and fifties. All her clients were female. These clients engaged in music therapy for at least one to two semesters.

Participant 3 refined her strategies with adult clients from working with hospitalized children who were in pain. After more funding became available, services were expanded to include adults, including those with sickle-cell anemia.

Interviews

While the participants were being interviewed, their responses were digitally recorded. Before the interview, details about maintaining client confidentiality and interviewee anonymity were reviewed.

The interviews were conducted as *conversational partnerships* (Rubin & Rubin, 2005). These conversations were structured with combinations of main and follow-up questions, as well as probes to elicit depth and detail, vividness, nuances, and rich narratives or descriptions. Each participant was asked to describe, define, and experience the different material they brought up, as they felt comfortable, in order to gain a rich sense of their experience. The music therapists were asked to refer to their clients using pseudonyms. The opening questions were, "Have you worked with a person who was in pain? What was it like?"

This style of interviewing was adapted from various phenomenological approaches used by Comeau (1991), Racette (1989), and Muller (1997). Some patterns discussed by Rubin and Rubin (2005) include “opening the locks” (or broadly talking about the topic), “tree and branch” (following each link of association), and “river and channel” (following an idea to its remotest tributary). My role as the researcher was acknowledged in the interview process as well. I was also interested in gleaning practical knowledge for other therapists to learn about what may be involved in working with adult clients who were in pain. Hence, the focus of questions was to gather descriptions of three music therapists’ experiences and their perceptions of how music therapy unfolded, along with their thoughts, feelings and reflections that related to each specific encounter.

The possible risks or discomforts to participants were minimal and included re-experiencing uncomfortable feelings or possible anxiety about the study topic that might surface during the interview. To minimize the risk, I encouraged each participant to leisurely self-pace while talking about the experiences s/he felt comfortable exploring or processing.

After each interview, the audio recording was transcribed verbatim using Express Scribe software on a Macintosh computer. The interview and subsequent data checking were transcribed verbatim and were not edited for grammatical or other language technicalities. Data analysis began after the first interview and involved coding, organizing, and classifying material.

Data-Analysis: Modified Grounded Theory Method

Finlay and Ballinger (2006) described the process as involving coding a unit of data and comparing it with all the other units of data coded in that category. Any given unit of text was assigned to as many meanings as were seen in it. Inductive open coding was used with existing codes, or if new data emerged, a new code was created. As the data collection and analysis progressed, the codes were compared with each other and organized into clusters according to fit. These clusters were then labeled as categories.

Through this process of constant comparative analysis, key issues and recurrent events were coded as categories for deeper exploration. Patterns, consistencies and inconsistencies in the data were analyzed to build a pattern of relationships or “themes.”

Sprenkle and Piercy (2005) summed up the process: the interrelationships between categories are analyzed until the researcher finds the one that is complete enough to encompass all that has been described in the story. In this way, adequate sampling is achieved when the data becomes saturated and no new codes are generated through interview narratives.

Integrity

A chart was created for each participant to organize the information coded from narratives. These codes were organized as clusters that were then grouped as categories. When categories overlapped, general categories were identified that could filter down into sub-categories.

This method of working answered the question of integrity and “truthfulness” within this approach of qualitative inquiry. Memos of ideas were kept to preserve emerging ideas and hypotheses about the data as analysis was conducted. These memos were used extensively in the final discussion.

Member checking was conducted as a means of triangulation to verify the themes generated. This process involved having each participant review the transcript of their interview, and to clarify the information and the themes that had emerged from the data analysis. Participants also confirmed the consistency of the general themes with their unique experiences.

In addition, emotional distance through reading of the statements was helpful in the defining of the categories and sub-categories, before it was possible to understand and then integrate the different levels of experiences, processes, and stories for relevant information and themes.

Validity

Questions about validity and trustworthiness—that the researcher’s biases and preconceptions may influence data collection, analysis and reporting (Patton, 1990)—were considered as well. Plager (1994) proposed a hermeneutic phenomenological perspective to explain that the researcher, as a human being, will always be in a ‘circle of understanding’ in which pre-existing beliefs and personal experiences influence one’s grasp of the particular phenomenon. Beattie (2001) discussed Strauss and Corbin’s ideas about reciprocal shaping due to researcher-participant rapport, advising that insights gained through involvement and experience with the research were an important and rich source of data themselves. Hence, during this whole inquiry process from literature review to the actual interviews, a journal was kept where thoughts, questions, ideas, and interpretations were jotted down.

Awareness of Personal Contributions to the Findings

At the time of this study, my professional identity, ideas about music therapy, and role as a music therapist were being reshaped by the experiences of being in graduate school. Having trained and functioned through a predominantly behaviorist framework to this point, I felt challenged to explore and view music therapy through naturalistic and non-positivistic lenses to better account for and understand the larger picture of pain contexts,

and how music was relevant. I knew that certain aspects of the pain phenomenon were not easily explained away nor reducible, and that considering every aspect raised for its potential relevance to the clinical setting would be a monstrous task and impossible to complete in master's level research. Yet, I felt that such an approach was important to gain a rounder or fuller picture in order to communicate to other professionals about how and in what ways music therapists contributed to the care of clients in pain. I also wanted to equip myself to work more effectively with clients who were in pain.

Hence, I shifted between two states of mind while working through the data: letting the narratives speak for themselves, as well as weighing the relevance of the material for clinicians. Of most interest to me was the question, "*What (from the therapists' perspectives) was meaningful and important in music therapy within the pain setting?*" During the interviews, I not only steered the therapists to focus on the what, where, who, when and how of their encounters, but to also elaborate on their thoughts, feelings and reflections while with their clients who were in pain. During the music therapy session, what was going on in terms of the client, the therapist's observations, the music, the therapist's clinical judgment? What was the therapist's role? How did their role change? What happened to the music? How did the client respond? What changed? How did they feel?

The overly broad question meant that the pain topic was not narrowed down. The motivation was to ask everything there was to ask about the material brought up by the participants that related with pain encounters. Hence, the themes that later emerged provided a means to navigate toward a level of personal understanding about music therapy as a process with essences that were describable rather than explained, evaluated, or proven. The wide range of experiences that were recounted were not disappointing and made me more interested in the subject. The challenge came with navigating through the process to filter and sieve out what was relevant, and to integrate the material while considering its clinical implications.

I struggled, sorting through strong feelings that resonated with certain of the therapists' comments. For example, as a new clinician, I had quickly realized the inadequacy of being trained to work with "plugging in behavioral objectives like a wall to a screwdriver" (Participant 2). I wanted to convey the importance of assessment in terms of "feeling it out" and the importance of "just being present." At a deep level, I felt that music therapy had an important contribution to healthcare and the quality of life of clients who were in pain, and further, that communicating about the impact of music therapy needed to be articulated across many levels. I wanted to give music therapists a voice about their work with clients in pain. I felt it would be an important contribution for our profession and for other professionals to understand beyond cold, hard facts or clinical statistics, how music therapists processed their experiences, feelings, and approaches/techniques. As abstract and intangible as it seemed, it was important for me to understand more about process and the lived experience while I was researching about pain-music therapy experiences from therapists' perspectives.

Organization of Report

The focus of phenomenology was to capture the essence of the experience in the participants' own words. This was done with one change following Wolcott's (2001) recommendation: the tense was shifted from present to past. Hence, the stories and accounts were left intact even as they were coded. The final organization of the report was in two tracks. This evolved from pulling together common categories as themes and formulating tables and diagrams to illustrate the dynamic interactions that were involved in the participants' accounts.

The experiences of music therapists' were seen to fall across three broad categories: of clients' pain, of clients' pain and healing music, and of "being" with the client. These overlapped within six emergent themes detailed in the participants' own words: *trust, being present, caring, physical empathy and resonating sympathetically, empowering, and facilitating communication and emotional expression.*

Following this, I explore potential implications of these findings for music therapy clinical practice with adults in pain. Four functions of music were described—resonating, release and organizing, reconstituting and integrating, and resting, relaxing and containing.

There were five inferences that were conceptualized from the participants: 1) "experiencing the needs of persons experiencing pain" (their perceptions of what clients in pain needed, and their ideas about pain rating and pain assessment), 2) "experiencing varied roles" (therapists' descriptions and definitions of various roles, techniques, methods and their philosophical orientations), 3) "experiencing pain and healing music" (their ideas about the role of music as a major change agent for relief and release), 4) "experiencing client-therapist-music relationships" (how therapists negotiated their relationships within music, and their perceptions of what they brought to the therapeutic relationship), and 5) "experiencing the therapeutic process" (participants' general reflections on anything that was relevant to their work with clients in pain).

EMERGENT THEMES AND RELATIONSHIPS

Six themes emerged from coding and categorizing the participants' accounts: *trust, presence, caring, physical empathy and resonating sympathetically, empowerment, and facilitating communication and emotional expression.*

The six emergent themes were by no means hierarchical or fixed categories, but described fluid interactions of the participants with persons experiencing pain. The music therapists' stories were reported in their own words (in past tense).

Trust

She had such a need to tell me this story . . . it was clear that she wanted me to know her life story before we could do anything. It was almost like she wouldn't trust me before we knew how bad her life had been. (Participant 2)

Trust, one of the themes that emerged from participants' accounts, served as an opening springboard for communication and for other processes within and without music to unfold.

She said, "Maybe I was just checking if you were judgmental at all—if I had to defend myself towards you. As I was telling my story, I wanted to check how safe I was with you." (Participant 2)

Trust allowed for clients to share their story and experience. Trust broke through defensive walls in order for music to be offered, experienced, and taken in.

There's this trust that develops where they just relax when they see [us] because [we're] not bringing in a needle . . . I don't bring that type of news . . . So when [we] walk in, it's just like ahhh! [sharp intake of breath], something friendly, something familiar . . . I knew her ins and outs—she had shared her life's history and story and all. (Participant 1)

So there was a trust there, a growing trust that happened through the song. And that led to his openness. (Participant 3)

A lot of times they have got such a trust in you [confiding voice] they'll tell you all the dirty garbage—the things that you didn't really need to hear. (Participant 1)

For the participants, trust involved instinct or going by their gut-feeling, and understanding and having confidence in their skills, knowledge and abilities in music, and of their clients.

Sometimes, they're polite (not forthcoming or trusting) . . . If they can't make decisions, if they're in such pain and groaning [or] not responding, I had to just trust my instinct and go in with guitar or with voice and see if they were starting to react. (Participant 1)

The participants were then able to maintain an open stance and remain non-judgmental.

So, keeping an open stance, and then providing [music experience] once I have her trust, because if we can shut our mouths and listen, people will then grow and trust us, especially when they realize we are not going to make them do anything—we're not out to change their anger, or their experience. (Participant 3)

For trust to build, the participants described a non-judgmental stance, being unhurried, listening patiently to the client's life story and not imposing any expectation or value to the relationship until it had been developed and the therapy process had been established. Prior successful experience with the therapeutic process also facilitated this awareness and ability to step-back until this aspect unfolded.

I thought later how powerful this was because men are so stoic and strong, and to hold someone's hand, especially a man you've only known for two or three weeks, you know, in MT context. And I'm thankful he felt that safe with me, and was able to voice that—his need [for hand-holding]. (Participant 1)

Presence

And so she felt that being together like that in the music was just the ultimate peace for her. (Participant 2)

[There are some patients] when I come in, who say, "have a seat." Then, they don't say a word, and I don't say a word—they just want your presence. (Participant 1)

Presence was succinctly defined as "just being there one hundred percent—eye contact, listening, a gentle stroke on the shoulder, maybe rubbing the forehead—just them knowing you are truly with them (Participant 1). Presence involved "feeling it out." Participant 3's experiences led to this elaboration:

[Feeling it out] means that you play music with this person . . . from a kinesthetic or cultural to a cognitive, emotional and spiritual level—All these things are working at once in music [and it's a matter of] responding to all those different levels.

Along with trust, music therapists described "being present" in their musical interactions and ways they related with persons who were in pain—how they conveyed empathy and understanding through posture, attention, listening, affect and response—as a process of continual assessment within and tailoring the music context so that clients felt supported through their presence. In their words:

And I could hear that she was waiting for me to change tone . . .
(Participant 2)

I'm here. I'm not going to leave. (Participant 1)

I'm going to hear her words and I'm going to do the best I can to integrate music therapy in her culture, in her language, and in her time . . . I want to understand Sternberg's (2007) definition of pain—while I can't be ignorant of the physical component, I want to also understand the emotional and cognitive components of the pain. (Participant 3)

Think about it—it won't be happening if the therapist wasn't there on that level . . . And so not only through the music, it's a matter of being present. To me, are we through music relaxing someone? Or is it because we have such good rapport with someone? (Participant 1)

The participants' accounts also highlighted how they struggled over the paradox of the need for “doing” over “being.” For Participant 1, “being” went beyond musicality or knowledge of techniques to “being present.”

And in that moment, I did not understand (then), that the best way I could help her in those initial sessions was to shut up, sit back, and just . . . just be with her. (Participant 2)

So I felt like I didn't do anything but at least I did—I was present. (Participant 3)

It's like I tell my students, “That's great that you play guitar; it's great that you play piano. It's great you have a beautiful voice. If you can't be present with someone, and just be with them, then it's not the right thing”
(Participant 1)

Participant 1 made a distinction about “being detached” (from overwhelming and conflicting feelings that comes from being human) and yet still “present” in supporting Sarah. The latter, who was dying, had written a song for her daughter and husband and he was singing it for them.

I had a knot in my throat and I couldn't sing because right when I had started the music, the husband sobbed. He wasn't crying—it was “huh . . . aaahhh!” and it was so intense. And I got through verse, chorus, and verse. I was trying to pull away because now his parents were crying.

She's crying. The husband's crying. And then the third verse and I'm almost a basket case. So detached, and I was still a part of it. (Participant 1)

Caring

I wanted to protect her. I wanted to heal her. (Participant 2)

I stopped and squeezed his hand, then went back to playing. (Participant 1)

And nobody was judging her—we were just being together in the music and she really felt the music was embracing her. (Participant 2)

Caring was conveyed through music, through physical gesture, words of understanding and presence.

I was really intrigued by the stories that were behind the pain—the perspectives that were given related to (patients') pain stories. I also began to see these patients very differently. (I found that) when I really sat down with them and heard their life stories, and saw and witnessed all the suffering they went through, that it made me more compassionate and want to try and help them. (Participant 2)

And they're like, you can't imagine what this is like! And I can take somebody's hand and say, I can imagine what it's like because I've been on the inside of it. And that's what I say. I'm here with you, and I'll be with you all the way. (Participant 1)

“Caring” was charted as a “continuum of care”—of clients feeling neglected by others and neglecting to care for self, to feeling cared for, to caring for self and others (Table 1). “Care” music was described as “comforting,” “embracing,” and “supporting.” The continuum also extended into the participants’ accounts of their own need to balance self-care with their care-giving responsibilities.

Table 1: Continuum of Caring

Music caring: “music was embracing her”				
“Uncaring” Neglect of self (disconnect)/ Neglect by others (feeling judged)	Feeling cared for (connection, not judged)	Caring for self	Caring for others	Over-caring for others/ Over-caring by/of others

BALANCE

Self-care strategies:

(squeezing it out, unwind after work, break between sessions, distance, grounding, bodywork, toning, checks and balances, visiting other professionals, and personal music therapy process)

Therapists' Reflections on Self-Care while working with Adults in Pain

The participants were deeply moved by their encounters with many of their clients, especially the younger clients. There were times when they connected with particular individuals or stories. They stressed the importance of balance as they juggled the continuum of caring and care-giving with the need for self-care and awareness of countertransference issues.

I've had times where I do fine. Then I'm like, I'm going down to my office for a little bit and I sob, because it's devastating. I do, sometimes I cry—sometimes [I'm] like we'll process this later, this is intense; need to visit with the chaplain or social worker, or make sure you're running after work—you do have to have your checks and balances. (Participant 1)

I was feeling tension in my middle. I do absorb energy. I use it. Then I squeeze it out before I leave. (Participant 3)

The need to maintain balance and healthy boundaries was significant because it had repercussions on the client's process. For example, Participant 2 acknowledged:

I'm not perfect. I don't always keep it in check . . . sometimes I will prevent a client from going into a more painful space because I can't . . . I can't deal with it.

Self-care strategies that were discussed included bodywork, physical exercise, toning, visiting with the chaplain, social worker or other professionals, and a variety of grounding techniques to refocus energy, and check emotional relations with the client, creating a healthy distance to continue the work.

Well fortunately with Chris, I had an hour ride back to our hospital so I could unwind a bit. (Participant 1)

I need to check in with myself during sessions to monitor this and to create some distance. I could never do two sessions consecutively—I may need to ground myself, refocus my energy, and check into my emotional reactions

to the client. I usually do this through some bodywork and toning. (Participant 2)

I'm in my own music therapy, you know—I work with it, for myself. (Participant 3)

Physical Empathy and Resonating Sympathetically

The participants also described physical sensations of resonance and empathy, of “soaking up” the client’s energy, pain, or experience. This awareness and ability to use their senses to tune into the client’s energy or symptoms of discomfort moved beyond a detached, clinical assessment. It involved the therapists extending themselves into the client’s world in order to work with it.

At times I resonate physically with the client’s pain—my body may feel very heavy; I may feel greatly reduced energy, or a headache. (Participant 2)

[you were almost doubled over?] I felt mid-body tension with him—it made me feel like crouching over . . . I felt, when I was playing guitar for the warm-up, I was feeling tension in my middle. (Participant 3)

I would have the sensation of her being very scattered, like all over . . . I get a lot of visuals when I work. Sometimes I pick up on the pain, like I feel my neck stiffen (Participant 2)

His breathing was very sporadic . . . I matched it and then I started slowing down. And then his breathing started to smooth out just a little bit. And so when he would inhale, if he held it just a little bit, I would do rubato. And then when he would exhale, I would come back in on the inhalation . . . on the IV or V chord, and on the exhalation, always come back to tonic. (Participant 1)

And it’s not like I’m cotton. I’m more like a sponge. I absorb it [energy]. (Participant 3)

Empowerment

Empowerment was described as a three-prong stand:

Empowering is sort of a three prong stand—between people, music and the body, and then as a dynamic element of inter-relating. (Participant 3)

Various elements of music were enlisted within psychodynamic frameworks to address clients' sense of powerlessness and lack of control, and to shift helplessness.

I saw her speech was clipped. I saw some resistance—I'm fine, I'm trying to get out of here; been a very, very frustrating 24 hours—frustration, and sort of I can do it all myself, which means that she is pushing away help because she really didn't want help from anyone but her husband. I get that. So I didn't want to come in too helpful. So I immediately back off. My stance is usually neutral, even if I know she's not going to go home (Participant 3)

It has become [more] about helping them find their voice again, and empowering them. (Participant 2)

We're using aspects of rhythm to empower the patient and also to provide a channel, a drive for which they can release the pain. (Participant 3)

Facilitating Communication and Emotional Expression

And she turned to me, and she took both my hands, and she said [barely audible whisper], "You, my Soul Mama!" [breath out] (Participant 2)

The therapists felt a sense of disintegration or disconnection in their clients, and shared their experiences with bringing connection to the client's experience through facilitating communication and emotional expression.

Music therapy provided a non-verbal means:

- To sound out or listen to their pain

They might have told five doctors they have pain in the knee. But maybe by the time they come to us, because we're not asking [them to] give us the one to ten, they tell us where it hurts. [There's also] a body selection of instruments—what they would want to hear us play, or what they might

want to play for their pain—because they might not want to play anything.
(Participant 3)

- To grieve (through poetry and song-writing)

I had a patient who is 45 who had a brain tumor and a 13 year old daughter and she could not figure out how to say goodbye. And she was very stressed. She wanted to write a poem and that didn't seem right. She wanted to do something, to say something about "I'm here with you always." And she would cry tremendously and it was her grieving process too. She was grieving for herself and then she was grieving for all these losses—that she was never going to have; and the losses of her daughter—not going to have mom. (Participant 1)

- Through improvisation

I used our warm up context song and his response each time would be spontaneity—he'd sing verses about how he was doing—his frustration. [Did he improvise on the spot?] Yes, he was very musical. (Participant 3)

- So that a variety of emotions could be shared.

It's a balance. There are times when it's sad. There are times when you have ten people in the room, all laughing and sharing. (Participant 1)

Significance of the Themes

The six themes appeared to be the building blocks for more complex interactions and dynamics that moved and shaped the process of therapy for coping with or relieving pain. Each was a piece of the whole, and each piece comprised a whole within itself.

The participants' accounts showed *trust* was crucial before any work could begin. Further, *presence* through "being with" over "doing" was a necessary factor for trust-building and to support the work once the process was initiated. *Caring, physical empathy and resonating sympathetically, empowerment, and facilitating communication and emotional expression* were also recurring elements. These themes co-existed alongside each other and interplayed as other factors shifted.

CLINICAL IMPLICATIONS

Five inferences that were drawn from the narratives may have relevance for clinical practice and will be detailed in this section. 1) From the music therapists' experiences of the needs of clients in pain, we may infer that pain assessment needs to be holistic. 2) Through their experiences of various roles in pain treatment, we see that the whole self is flexibly brought in to address identified needs. 3) From their experiences of clients' pain and healing music, we gain insight into the latter's ameliorating and therapeutic effects. 4) Within music therapists' experiences of "client-therapist-music relationships," we observe a continuum of interactions from subtle to dynamic. In addition, 5) the therapists' experiences of the therapeutic process in the context of working with clients in pain provides us with a skeletal framework to conceptualize the flow of the session(s) from encounter to active work or refusal, and from assessment to evaluation of outcomes or termination.

Experiences of the Needs of Clients in Pain: Implications for Pain Assessment

That's a real pain that's affecting every part of her life—that's affecting her movement, her legs, and her capacity to function. (Participant 3)

Every human being is faced with a hierarchy of physical, psychological and spiritual needs (Maslow, 1943; Koenig, Cohen, Blazer, Pieper, Meador, et al., 1992). Kuhl (2002) discussed how "physical needs include food, clothing, and shelter; psychological needs include the sense of self and relationship to others; and spiritual needs include the awareness of and connection to a source of power or strength bigger than oneself" (p.204).

Need to Assess Pain Holistically

Participant 3 discussed the importance of holistic pain assessment, not for diagnostic purposes, but to contextually understand the client's condition ("how it feels"), and to "learn about the ripples of how their pain is penetrating through different aspects of their life":

I'm not an art therapist [or] seeking to analyze in a deep Freudian way. I kind of just want to know . . . "I'm interested in the red you drew on the forehead—what's that?" "That's the headache my husband causes me" (Participant 3)

The participants' views of the client's needs and their approaches to address those needs were often different from that of other medical professionals.

The staff wanted to diffuse pain. In the hospital, they think it's supposed to go away . . . and not many people say that to a patient, "I'm interested in your pain." Most staff just go ahead and say, "Is your pain better?" "Has it gone away?" "Are you all better?" I think of five different things that have worked over twelve years that I can offer. Bad pain—is it anger? Fear? Lack of nurturance? Lack of integration? And what are (the client's) needs? And how is pain manifested? And where is it coming from? (Participant 3)

The mind and body were described to be inseparable in pain work—effective pain assessment and treatment needed thoughtful consideration of the physical response and how it manifests, as well as one's emotional response to the former. In this regard, participant 3 cited Tabor's *Cyclopedic Medical Dictionary* definition of pain because it included both physical and emotional elements:

An unpleasant sensory and emotional experience arising from actual or potential tissue damage or described in terms of such damage . . . not only the perception of an uncomfortable stimulus, but also the response to that perception" (Entry on Pain, ¶1).

In addition, clients may be experiencing stress from lack of support from family members and loved ones. This led to simple requests for gestures such as hand-holding.

Client: "Could you just hold my hand?"

That's all he needed and he relaxed so quickly. It was just amazing. Stopped crying. Closed his eyes. His whole body just completely relaxed. And that's what he needed. (Participant 1)

Further, other medical care providers may not be validating of their pain perceptions or experiences.

So the doctors are telling them that the pain is caused by something physical, and that this pain is a red light [sort of warning signal]—it sets up sort of a cycle—there's pain, then there's the reaction to the pain, and the third part of the circle is, "What does it mean for me?" "What does this indicate is wrong with my body?" So this can set off a fear or emotional response. (Participant 3)

I observe the body language a lot, breathing also. So, I would just ask them to describe in detail their pain. That aspect by itself is already very validating to them because usually no medical professionals, no health-care professionals sit down and talk that extensively about their pain—the

questions are usually more about the functional aspects—are you able to do this? Are you able to do that? (Participant 2)

Only by vividly understanding and contextualizing was it feasible to organize music therapy interventions and explore various techniques appropriately to work with and alleviate the pain. Participant 3 elaborated that appropriate interventions were not a mechanistic application of techniques but involved understanding where the client was coming from and wanted or needed:

Another problem with our field is that people make the wrong intervention—they go into these schools and they get these behavioral objectives and try plugging it in like a wall to a screw-driver. Everyone has a mechanism of response and you have to feel that out in the assessment. (Participant 3)

For participant 2, the use of formal numerical scales felt dehumanizing when she gained insight that rating scales may cause some clients to experience a lack of validation for their pain experience.

One woman said, “I feel”—forget the correct words—it’s something like, “I’m being in court, being judged, and I’m also in the witness chair, talking about it, trying to explain to them how much pain I am in—making them believe. But when I look around and I see their faces, it’s in vain. It doesn’t matter, because they have all made their judgments. They don’t see my pain, so it cannot be this bad—I’m exaggerating it.” Not sure if right after that, I stopped asking for pain ratings—I heard that constant pattern of judgment, judgment, judgment. (Participant 2)

Participant 2 subsequently dropped the use of pain-rating scales, favoring a humanistic, psychodynamic orientation to her work with clients in pain instead.

They [administrators] were upset that I was not taking any data, and I told them it just, it did not feel right: “Are you 7, 8 or a 5?” They just are; it’s irrelevant in our work. It was irrelevant whether I knew they were a 9 or a 5. We just were together in the same space so it didn’t matter about being able to put some value on them. I really started working with them as women . . . I felt protective of them as women. (Participant 2)

Along the same vein, participant 3 used the body-coloring tool as a means of whole pain assessment:

And we do a whole pain assessment—we use the naked body and the crayon—it's found in the Dileo Medical MT book [attributed to Loewy, 1999] and is a figure of the naked body. We're giving them the opportunity to color in (body work doesn't just diagnose) so the assessment is critical . . . that we learn about the ripples, about how their pain is penetrating through different aspects of their lives. (Participant 3)

In this way, holistic pain assessment was therefore seen as a validating component of the treatment process.

Music Therapists' Experiences of Various Roles in Pain Treatment

We play a lot of different roles—we play listener, we play musician (Participant 2)

The participants described functioning in many roles as they actively reached out to connect with the client, patiently building trust and wearing down negative attitudes or resistance. This was accomplished through a posture of being helpful and understanding, in other words, “I hear, I'm listening, I want to understand. How can I help?”

I think I enticed her. I was able to have her say, “Yeah, let's give it a try,” by being very transparent about it—nothing mystical about what we were doing. I helped her open up more. (Participant 2)

Assessing

Assessing was described as a continuous process of watching the client's breathing, color, and energy during music.

His breathing was very sporadic . . . and so in trying to go in where he was at, I could see the pulse on his neck and that's where I started the tempo of the music. (Participant 1)

Participant 3 highlighted the importance of not pre-supposing or assuming, but simply “meeting” the client.

Well the most important thing is not to presuppose anything before you meet the patient, and to listen around—to hear what everyone says with a grain of salt; stay away from the chart and just go in and face-to-face meet the patient as an equal. As in, “What kind of music are you hearing?” That's really important—your receptivity to the potential of music. It's important not to come in with the “shoebox” of techniques—leave

everything outside and go with what you, yourself are getting—What are your countertransferences? What are the patient's desires? What's been left out? Those kinds of things. (Participant 3)

Actively Reaching out to Connect or Relate

In reaching out, the therapists were open, transparent, centered, and located—trusting of self and the music therapy process. They were fully present with all their senses, and balanced—having addressed their own needs through healthy practices and strategies (Figure 1). The participants were intuitive and sensing, paying attention to visual and other sensory perceptions. This level of attentiveness facilitated entrainment. It was important to tune into and understand what the client needed from moment to moment, to use the iso-principle to match or resonate with clients' affect and energy, and to match music to physical signs such as breathing or heart-rate when clients had acute pain, or were having a difficult time with falling asleep (insomnia) (Figure 1).

I provide the experience for her. During the assessment, it's figuring out what's going to help this person most musically, and sometimes, I don't have to do anything. Like, if someone's sleepless and tired—if they are in so much pain they can't get to bed, I might work with integration—which would be deep breathing. Particularly with someone that's dying who thinks every time they go to sleep that they are going to die and there's the whole ambivalence thing that's going on—so each time I can help them sleep and achieve a deep sleep, that's physically good for their body and that also means they are trusting the environment enough to go to that strange place (which is an unconscious place). (Participant 3)

The participants described actively intervening to tailor music that matched the client's state. They were active listeners to clients' life stories and were intuitive and validating of feelings that were not directly expressed—they listened for disparities and contradictions in the various accounts. They were mediators (Figure 1).

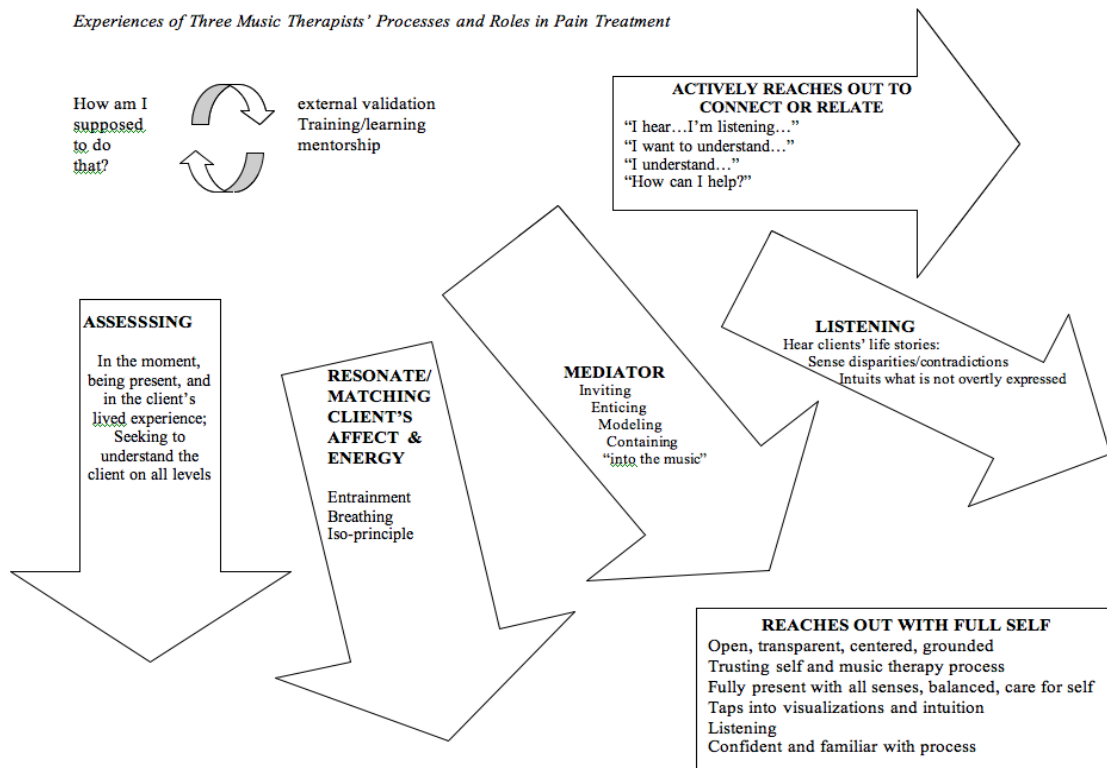


Figure 1: Therapists' roles

Mediating and Facilitating Music Experiences

I was able to incorporate some singing and such with her. So, I'm usually able to get her to allow me to bring the music in. But sometimes, she just wanted quiet. We have to meet them where they are at. (Participant 1)

As mediators, the participants were inviting, enticing, modeling, supporting, and containing. The participants articulated various ways they "brought in the music" (Participant 2) to their clients and how they anticipated or projected outcomes from various methods or interventions. They reflected and affirmed the clients' physical and emotional state. Mediated music experiences facilitated short-term pain relief through distraction. This involved entraining with different chord progressions paired with open vocal tones that resonated with the clients' moans and groans.

I often paced my music on their breathing. When the pain music was played, their breathing was heavier and [I could] feel them tense up—like "When is this going to stop?" And really pick up on the tempo of the breathing and slow down the music . . . I played the pain music rather

shortly because it caused more pain for them. Then we slowly altered, or I would slowly alter, the music into healing music. (Participant 2)

Music experiences were mediated and modulated to match shifts in clients' pain experiences—grating, unmusical sounds might become more open or melodious, with breath spaces introduced. Where the release of pent-up feelings was imminent, the participants described facilitated emotional expression by heightening the intensity of the music through guitar (Participant 1), voice work (Participant 2) and drumming (Participant 3), serving as a catalyst. As both therapist and client became more familiar with the other, deeper emotional needs were then made known and addressed within music experiences. Participant 1 experienced bringing a positive note to sadness:

There are times when ten people in the room are all laughing and sharing. And [I was] giving memories that will come back later, maybe on the anniversary of the death—"And do you remember we were all in the room and we were playing drums, and we were laughing!" [I knew I was] adding a positive experience to a very sad time. (Participant 1)

Experiences of Clients' Pain and Healing Music: Music's Ameliorating Effects, Functions, and Roles

For Participant 1, time was experienced as being suspended during music:

The time [stood] still—I didn't know I had been in there an hour and a half. (Participant 1)

Music was described by Participant 3 as a dynamic of relating between people, music and the body, for empowering:

One is the effect—the element of music on the body. This blended with the therapy part (which is the second prong and involves the therapist, the patient, but it could also be the construction of a family or friend). Then when you put those two elements together, you have the medical music-psychotherapy—using music as the behavioral element of change but in a psychotherapeutic context—it's empowering between people, between music and the body, and then empowering, as a dynamic element of inter-relating. (Participant 3)

All the experiences with persons in pain recounted by the music therapists involved some aspect of live music that was entrained to the client's output, such as breathing, body movement, or vocalizations. Participant 1 elaborated on the value added from

live music over recordings: live music became part of the process that could be tailored, “guided,” and shifted to “engage” the client and other significant persons, and to bring about connection amongst other outcomes, for example, palliation.

You know you could put the CD or the radio on, but there's no tambourine, or no drum, and there's no one there to start the process and engage it, or guide their process, also together (with other significant persons in their lives), and giving or allowing them to have an opportunity to connect. (Participant 1)

Music served four functions: Resonating (entrainment), Release and reorganizing, Reconstituting and integrating, and Resting, relaxing and containing. (Table 2)

Table 2: Uses, Functions, and Roles of Music

RESONATING	RELEASE, REORGANIZING & RECONSTRUCTING	RECONSTITUTING & INTEGRATING	RESTING, RELAXING, & CONTAINING
<i>“Ironing out ripples” (P3)</i>	<i>Primal scream; unaesthetic release (P3)</i>	<i>“Syncing with breathing” (P1, P2, P3)</i>	<i>“Putting to sleep” (P1)</i>
<i>Vibrating (P2, P3)</i>	<i>drumming; Ketow beat (P3)</i>	<i>Visualizing (P2)</i>	<i>Overtones; balancing the body (P3)</i>
<i>Gonging (P3)</i>	<i>Purging (P2)</i>	<i>“Gathering the sparks” (P3) “Pulling tree branches together” (P2)</i>	
<i>Sounding over the body (P3)</i>	<i>Spitting (P2)</i>		
<i>“Musical massage” (P1, P3)</i>	<i>Cleansing (P2)</i>		<i>“peaceful, allows me to just be without sobbing throughout” (P2)</i>

Resonating

If you listen carefully to how people describe their pain, very often the descriptors that they use are musical descriptors—it's pounding pain, or it's stabbing, it's sharp, it's dull. A lot of that can be translated into musical elements. And basically I just play on lots of different instruments, lots of different styles to find an auditory image that would satisfy them, that they would feel expresses clearly their pain, that resonates with their pain, then we would create an image or music that sounds very healing to them, very soothing. (Participant 2)

Through entrainment, Participant 1 found he was able to offer music to a client who was in a coma:

I had a patient in a coma one time, and she would rrrahhhhh (rattly sound) all the time. And when I would play music, she would become quiet and the sound would cease. Her breathing was always so fast, and within thirty seconds to a minute every single time I would have a session with her, (every time I started playing), everything would just slow down, almost instantly. (Participant 1)

The participants also spoke about active entrainment and “pain” versus “healing” music. In their pain state, the clients’ music was reflected with descriptors as “dis-jointed,” “unharmonious,” and “discontinuous,” without melody or phrasing.

In entrainment what we do is try to let the music resonate as much as possible with the pain that the person is feeling . . . So basically we create an auditory picture of the pain then we slowly alter the music into healing music. We usually work on slowing down the music together with making the timbres less sharp—usually they choose very sharp timbres. And then I would start inserting in a melody because the pain wouldn’t have melody—it’s dissonant clusters on the piano or sharp sounds on the maracas. (Participant 2)

Participant 1 shared about how he entrained musically:

In palliative care especially, the way I do entrainment is for the patient’s relaxation—a walk down pattern say from G F# E D C and I have a simple way of holding the finger pattern so it sounds nice with a little touch of dissonance. And maybe I’ll repeat a phrase four times and then switch to a C and do some embellishment there then go back to tonic G. The I and IV chords are amazing and very powerful. It’s a cadence and it works very well . . . to try to refocus someone’s attention so they can start to relax. And my voice is going to change too. (Participant 1)

The range of music experiences recounted was extensive. For example, Participant 2 found herself feeling “naked” (unsupported) and brought in the piano to provide Lillian with more support in her voice work.

I brought in the piano to try to support us more. Two, because at times I felt kind of naked, just being with our voices alone, because her voice was so unstable and trembling, and I felt my voice was not enough to support her. (Participant 2)

Release, Reorganizing and Reconstructing

Pain and its “release” music were often a-musical and non-aesthetic. Release of intense emotions, such as anger, was characterized by disharmony and non-beauty. In contrast, for patients who are dying, release may be quiet—disassociating and withdrawing from life (Participant 1).

And with pain you want to have an un-aesthetic release. You don't want it to work—you don't want it to be pretty; you want it to be noise, and it's not musically intelligent. It's musical release . . . People need to know they can smear. And they can break up the form, that they can have the power to control and destroy especially when their bodies have been destroyed. They need that power back—to destroy. (Participant 3)

Participant 3 elaborated on the relevance of the polarities of beauty and non-beauty with pain, and of decomposition and composition.

Music therapists are obsessed with the aesthetic (form). But when you look at beauty you have to look at the polarity, the other side of the coin. The whole deconstruction, the whole noise—because, without noise, there's no music and without going into the darkness and deep tunnel of someone's pain with them and being in that chaos which is not aesthetically beautiful, you're never going to get to that level you need to get to as music therapists, which is decomposition. (What do you think that does?) It gives them assurance—they then have the ability to construct their own life. (Participant 3)

Participant 2 related an emotionally powerful session with Lillian who was “birthing her pain” and described a “cleansing” function with release music:

I said, “How about if we just try to get it out of our body?” So, we started doing things like spitting, “WhahhayhhHYAHHH!” She did it a couple of times and then she started laughing. I was like BlaahccchaAAAH but it felt so good for her to be able to . . . (She called it) “birth her pain” and then kind of get rid of it. Then she became very sad because she immediately realized that she wanted to give birth to a child, but then she was giving birth to this horrible pain. (Participant 2)

The music experiences involved voice, guitar, piano, drumming and gonging. Techniques described included relaxation techniques, distraction and diversion, vibration, active listening, music improvisation and “release” experiences through drumming.

Voice

I was drawn to do voice work, just because of her voice quality. And her story was about having lost her voice—she did not have the strength to fight . . . she had literally given up her voice. And we moved from singing in unison to singing in harmonies. She says, “You’re asking something I can’t do. And it’s too hard for me because this is what my life is about. I’m trying to get my voice heard. I’m trying to climb up the ladder, trying to go up, and the ladder goes up, and I can’t. I’m stuck.” So there was so much symbolism in what she said, in what the music was representing. (Participant 2)

Drumming

Probably the best experience I can tell you, of drumming for me, was with this man in his 50s who had cancer of the bowels. He was in hospital for four months. And he had not gone to the bathroom—only through a catheter for three of those four months. And after drumming, he was able to urinate without a catheter. I was very proud. Some of the doctors were asking, “What did you do?” I was like, we drummed. (Participant 3)

Piano

And what the piano allowed me to do then . . . was give us ground, and I could be figure with her. I could then, with my voice, help her to go up. And sometimes, we would just do little vocal exercises where I would sing just on a triad or so, an arpeggio, a three-step melody, and I would ask her to imitate me and then we would do it together, with the piano. Sometimes, I would keep the ground, I would ask her to provide the melody, but I would have the piano help her with the melody, so she would feel more supported . . . (Participant 2)

Guitar and Vocal Entrainment

I quickly got my guitar out and right away started out with vocal improvisation. And I was starting to slow the music down and I was starting to get softer with my voice. Finally I took my voice out of it. And she went “Ohhhh . . . [pause] Ohhhh . . .” And I gently said, “Bea, you know I see your facial tension just a little bit. Let’s just relax your forehead just a little bit, just focus on that. Try and take a breath with me. Do some breathing . . .” (and) she got quiet. I kept playing and I got softer. And I noticed—I looked up at the clock and it had been 25 minutes that I had

been playing. But all of a sudden (I couldn't believe it), she started snoring. (Participant 1)

Vibrations

We'll warm up with the ocean disk and get the breathing deep and going, especially breathing through the nose and out through the mouth. Sometimes we use a visualization like a shape or place. (Participant 3)

Participant 3 further related the use of bells and gongs as pain diagnostic tools, with one caution—to check in with the client:

I'll use the gong all over the body and work with ironing out the pain. I'll actually see and feel the pain as wrinkles, where someone's really holding out and the vibrations can really iron out, and balance, working with pain on one side of the body or the other, using vibrations then to iron or even out and balance the body . . . We'll beat the gong once and kind of scan the body and see what happens to the sound. (Participant 3)

We also use Suzuki bells. When they are played together, like a perfect fifth, around the body, the overtones go in and out of tune. And I think that's based on the energy of the pain. So, it's a real listening process. The tones seem to change when you are in an area where the pain is . . . But, it is important to ask what the patient's experiencing after a few minutes of gonging because the vibration is very powerful, especially to the vulnerable person who's had no stimulation, who's been sitting in their bed, turned off to their body. (Participant 3)

Participant 3 also detailed the use of African drumming using the “ketow” beat to facilitate emotional release, or “a cry response,” and how the act of playing the drum using a certain technique does allow emotions that are held in to bubble up.

I think there's a cry response that comes, when someone's really upset and they're actually releasing that cry to the point when they are [sounding] like a croaking sob, sort of like a primal scream. I also actually think there's something that happens in the body when they are at the release point, that's really therapeutic and that's good for the body. (Participant 3)

This “ketow” beat involved a moderate tempo of 80 to 90 beats per minute. Participant 3 explained:

I usually start any kind of drum experience I do in this basic beat pattern, in the life rhythm—meaning 80 to 90 beats per minute and then eventually accenting the ONE of a four-beat measure. And naturally there's some sort of propensity to your instinctual anger where you want to kick someone, or punch something—it will come out when you accent the ONE. Eventually, when you add the FOUR, it sets the momentum for release. It gives the rhythm a pocket of a place . . . After 60 or so measures, we worked into building the momentum—we did what I call a roll'em (where we use both hands and totally let it out like you're kind of killing someone, and do the ketow beat)—it's the hardest kind of drum beat to play—it's a slap . . . and it's like an accented 16th—tee-tee-tee-tee-tee-tee-tee—and you're slapping with both hands. (Participant 3)

Reconstituting and Integrating

For some clients, after experiencing cathartic release, there was a process of “reconstituting and integrating” a new sense of self, with access to a more healthy part. Participant 3 described Julie's process of “gathering up the sparks”:

Once that tension is released, it's like gathering up the sparks and pulling yourself together, but it's a new you, because the materials that you pull back are accessing a new place, often a vulnerability. The shift meant that the client wasn't trying to fight to the full. She was back in bed and giving in to people that were caring about her, around her. She wasn't projecting as much anger on staff. She was able to look at the crisis and let go of all the responsibility, and take time for herself. (Participant 3)

Participant 2 turned a visualization of a tree into a helpful metaphor for her client, who she had sensed as needing “grounding.”

She said, “I closed my eyes and I heard your music and I saw my tree, and I was able to ask what I had to ask for.” (Participant 2)

Resting, Relaxing, and Containing

The client's comfort was a foremost consideration and the music therapists worked actively to use music and to engage the client in shifting from feeling dis-ease and disharmonious to a more harmonious state of being, so that rest ensued.

And she said, “The music seems to make me peaceful and allows me to just be without sobbing throughout.” (Participant 2)

I kept playing repetitively using a very simple structure. But all of a sudden, I couldn't believe it, she started snoring. (Participant 1)

Experiences of Client-Therapist-Music Relationships

The dynamic interactions of client, therapist, and music often led to shifts of physical and emotional energies. The effects were far-reaching, even extending to significant others. Participant 1 witnessed music bringing an estranged husband and wife together—reconciling through musical dialogue:

And they had a rocky marriage. They loved Beatles. She agreed to play tambourines and he wanted to try the drums a little. And I sang With a Little Help from my Friends and I vamped. She was doing tambourines and he was doing the drums, and they had a conversation—she would do something; he would do something. They went back and forth. This was a new experience for them—they are creating new memories in their marriage. It was magic because it was so intimate! They were estranged, yet connecting with each other. We had completely forgotten that he was dying and we were just reconnecting to the music we grew up with. (Participant 1)

Both music and therapist were seen by Participant 1 to function as a catalyst during this encounter.

So, I just recognized that (I was) a catalyst—a catalyst for giving them an opportunity to have non-verbal communication for fifteen minutes. [So is the music or the therapist the catalyst?] Well it's both. You know you could put the CD or radio on, but you don't just push the button and say, uh, the music therapist said to play the tambourine together when your wife comes. There's nothing there. It's partly us (therapists) also, guiding their process together, giving and allowing them to have an opportunity—I look back on that thinking that they at least had a moment where there was no hatred to each other, and they were able to relax and probably had a glimpse of who they were when they first got married (Participant 1)

In and out of music contexts, the music therapists encountered clients in denial—disconnected in how they thought about their pain, their lives, their experiences—with their physiological states and their feelings. The disconnection or over-connection was sometimes connected with mourning or grieving (Figure 2).

When you're sick in the hospital (sometimes on an unconscious level), you're either holding onto extremes, to certain parts of your body that you think are going wrong, or you're giving up on it, and you're totally repressed and pushed away from anything that's going on . . . so it's either overconnect or disconnect, depending on the person. (Participant 3)

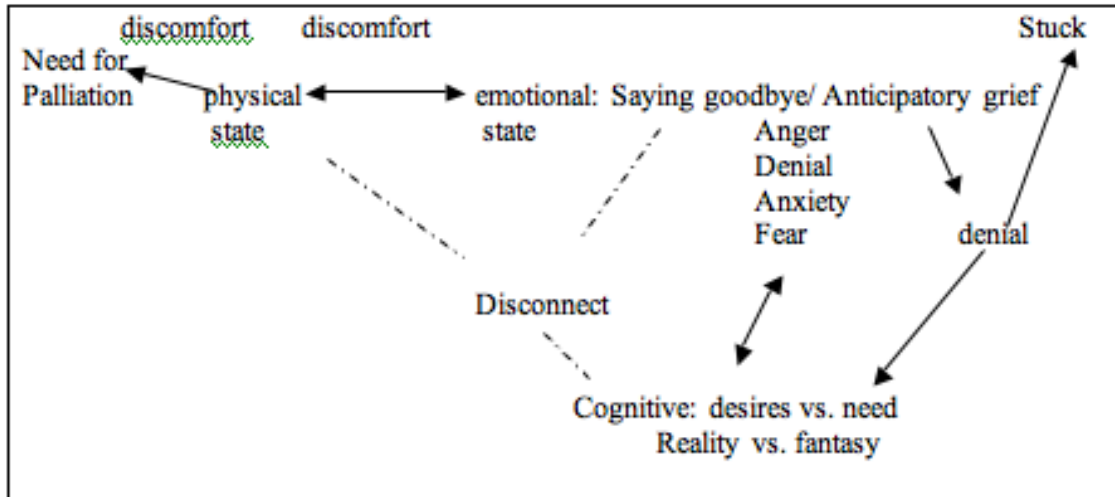


Figure 2: Disconnection

Clients were described to be in states of being angry or frustrated. This anger masked deeper feelings of anxiety, denial, fear and sadness (Figure 2).

Often [people with chronic pain] are trying to disconnect from their body because it is too painful. So, they are trying to escape from it. By doing so, I guess there becomes, or, it develops into a “disconnect” from their emotions. And they are trying to be strong because that’s the only way they can survive. So they are definitely not going to go into the emotions of past trauma. Or you get the anger a lot—they are not disconnected from their anger often, but from all the sadness that comes with it. (Participant 2)

I was observing that he had difficulty breathing . . . he was really trying to be in good spirits (so a strong basic beat [on the drum]). But his body failed him and that’s where the topic of conversation [centered]—there were so many things he wanted to do and his body was failing him. So, sort of a mourning, a disconnect . . . when you mourn something, you’re disconnecting from it, or seeking to [disconnect]. (Participant 3)

Participant 2 became aware of the need to empower her female clients and adopted a subtle, low key approach, offering her clients opportunities to regain control. For example, she recounted experiencing the shifts in Lillian's process, from "I'm stuck," to voicing assertiveness and then moving to connection with "Soul Mama." For the therapist, the process shifted from feeling frustrated, to wanting to empower the client.

And she said, "Yes, why don't you sit next to me with a xylophone?" So, I just played the xylophone, and I was humming. And something in me felt like I just wanted to rub her back. And I stopped playing the xylophone. I kept on humming and I rubbed her back. And I got very much in a kind of gospel kind of mode. And I remembered being so aware of that shift and thinking, "Am I being very inappropriate? Is this very stereotypical—because she's African American that I'm going into this?" But it felt right . . . it felt so right . . . and she would go hhhhh, (breath), hhhh, (breath), so I just kept on.

She turned to me and she took both my hands, and she said [barely audible whisper], "You, my Soul Mama!" Then she said (more seriously), "Somebody protects you and would not let anything happen to you." She said there was no soul mama—because her mother hadn't protected her. So, what a shift—from our being together as little kids on the xylophone, to me becoming her soul mama. (Participant 2)

In his account of "Saying Goodbye," Participant 1 talked about the reward of taking the creative risk of vulnerability, in the sharing or gifting of personal creative resources. The account reflected the experience of song-writing with a patient who was dying, and also explored the therapist's inner and personal investment with the process.

So, we talked about putting those things to music and coming up with a song and so we came up with a style. She wanted rock 'n roll and so I said, "Let's play some styles on the guitar." And the style she chose ended up being a most gentle waltz, beautiful, simple, and innocent from the R&R she [initially] wanted to do. She had quotes that she wanted [to include] so we put those down. And together we came up with the first verse and the chorus. And she said, "I want you to do the rest." So, I worked on it and I did it in about two days. Then, because it involved (my) creative side of (my) personal being, I was like what if she did not like it? Then (I've) got to start over. It takes a lot of energy to be creative for someone else. It's not like (I was) writing a song for myself to have fun with. And so, I had written the music with her words. And I played different things. And then she picked the waltz style. And when I sang the song for her, she just [whispering] sobbed and sobbed. She said, "It's just perfect." (Participant 1)

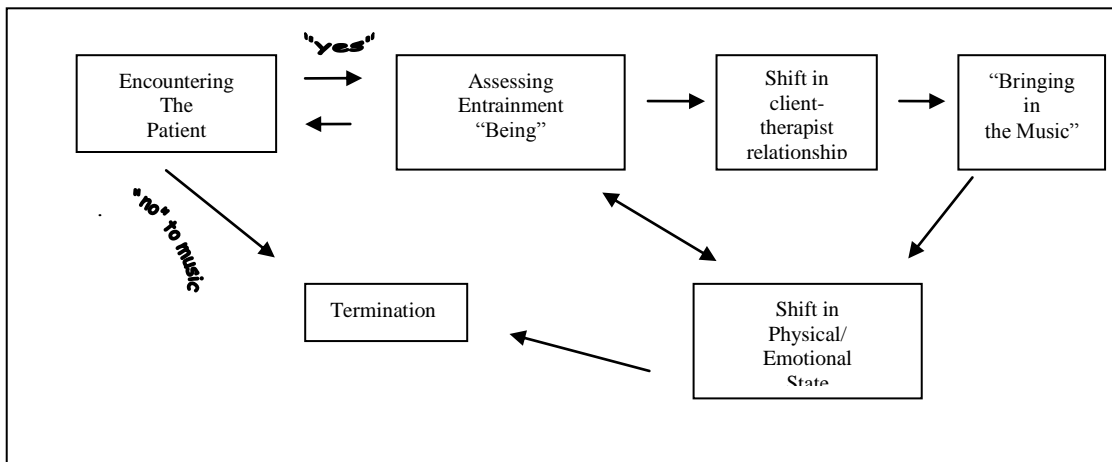
Experiences of the Therapeutic Process

I said, “I just wanted to let you know that you can also take me in a different direction, you know, if you want to go high or low.” She was singing very low—I’d started off low because her speaking voice was extremely low and part of that was because of the pain medication. (Participant 2)

Consistent in the three accounts were three common stages: the initial encounter where there was need for the client to be heard, shifting to trust-building and rapport, before culminating in the response of commitment to being in relationship with the therapist and music, to therapy and to the process, or refusal and termination (Figure 3).

That was really the second phase. The first one was my [feeling how] frustrating . . . and we moved into music just unison. The second [was] her reflecting how the music represented how stuck she was. And then it moved more into vocalizing and toning. Sometimes she would come in, and she said, “You know, I feel like singing a song today. Can we sing?” And I felt that was another shift So, she would direct the sessions much more. And then a lot later on, talking about problems between her husband and herself—she wants children, he thinks it’s not a good idea; her struggle about so badly wanting a baby and not getting support from her family. (Participant 2)

Figure 3: Experience of the Music Therapy Process



In the initial encounters, clients needed to express, “I don’t feel safe” and tell their life story, scream or moan and be heard. They needed to break through resistance and being defensive, to be in touch with disconnected feelings.

With a lot of people with chronic pain (especially the ones that I work with at least), I notice that often they are trying to disconnect from their body because it's too painful, right. (Participant 2)

The client's subsequent commitment was seen to play out in a few minutes, over the course of a session, or over a span of several sessions or years.

I felt she was not allowing me to help her the best way I could—because the best way I could in my opinion, was with music—was to be in the music with her. (Participant 2)

Participant 1 found a moment of connection to be a meaningful experience.

But the fact that he had taken my hand, and said I couldn't have done this without you—(I) actually made a difference while he had that procedure done. It was great because (I saw) the power of how effective (music therapy) can be. (Participant 1)

The participants also underwent their own process as they negotiated various roles. They sensed that clients had a need to tell their life story and that trust had to be developed in order to break through the protective walls put up by defenses such as talking or anger. Once the rapport of “feeling safe” had been established, the clients were able to share deeper, inner pain—usually of an emotional nature. The range included the chaotic mixture of sadness and grief, fear, anxiety, distrust and numbness. As the relationship with therapist and music developed, the clients made concrete commitments to being in relationship, to therapy, and to the music therapy process.

The phases experienced by the music therapists were encountering the client, continuous observation and assessment of the client's state and needs and building trust, bringing music into the session, followed by the constant monitoring of the music and relational processes as the client's physical and emotional state shifted.

And you notice their locus of control—are they codependent in their beat and wanting you to drive? Are they responding to the tone, rhythm, harmony, melody, and then what is their musical desire—from a kinesthetic or cultural to a cognitive, emotional, and spiritual level? All these things are working at once in music. So, it's responding to all those different levels. (Participant 3)

For participant 2 (as well as 3) within long-term treatment settings involving chronic pain, the work often shifted into exploring clients' emotional worlds (using psychotherapeutic or other approaches).

Initially, the frustration was really with, I guess, I can't say myself alone, also with her. I felt powerless—you know, she wouldn't allow me to go to the music. (This particular client had a need to keep talking and tell her story). And in retrospect, it's very interesting that she made me feel powerless, because how did she feel? There was so much transference and countertransference going on right there. (Participant 2)

The work then, was not simply to manage or “take away,” or in other words, distract from the pain, but also working toward gradual integration of mind, body and spirit.

So by doing the voice work [which brought all the emotions out], (I was) physically connecting her back with her body, through her voice The work really went on from just helping her identify and find her voice, to really trying to use her voice to go to painful places in her body and trying to give the pain different shapes and trying to have some control over her pain. Eventually the work really became about her coming up and asserting herself. So, after a couple of months, we were almost never working directly on her pain. It was about anger. She would move into screaming—about her husband, her doctor, sometimes just at her world. She had to grieve so much, and that helped her with her pain. When we stopped, she would say “Oh, I feel so much better.” (Participant 2)

The participants actively reflected or elicited responses, and intuited when to allow emotions to build and climax in music to a point of cathartic release. They were there to support as the music and the client's process shifted. Music shifted from “painful,” “diseased,” “disharmonious” to “release,” “resonating,” “integrating,” and “resting” (Figure 4).

This flow, tied in with the continuum of care, was thus conceptualized:

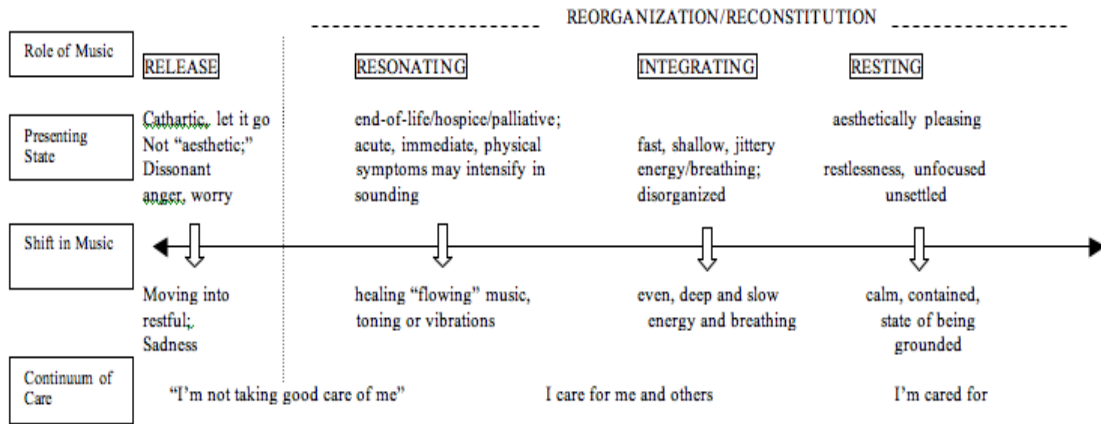


Figure 4: Summary flowchart of processes

Other Reflections

Each of the participants' final reflections on the topic was directly related to their experiences at their respective work settings and philosophical approaches.

Reflecting on the strength and resiliency of her clients: *Working with this population—allowing myself to step out of my boundaries, my box, and my idea of how to work with pain—has been so enriching. And working with them has just empowered myself a lot and has given me a completely different perspective on life—because in their weakness, in their physical weakness, they are so strong . . . They are SO STRONG [firm voice]—They have been beaten up over, and over, and over again. And they, they are able to keep on going—just gives me a lot of inspiration. So, I want to thank all the women I worked with and hopefully will keep on working with.* (Participant 2)

You know, before you can help someone reconstruct, you have to be willing to go through the deep trenches of death and loss, these sort of real dark places, going into (my) own shadow as Jung would say. (Participant 3)

Sharing with interns about caring and the need for boundaries: *If you're crying every day, it's the wrong profession to be in. If you never cry, it's the wrong profession—in working with palliative care. If something doesn't touch you and shake you to your core, you're too detached. But if you're crying every day, you're too attached. You have to realize you're there for a purpose, and that's to, as we're talking here, help with pain.*

Refocus—refocus anxiety, agitation, and restlessness. If you can't bring that to someone because, "they are dying and oh my goodness . . ." and you're having struggles with that yourself, then it's not the right place.
(Participant 1)

SUMMARY AND CONCLUSION

The goal of exploring music therapists' perspectives was to increase awareness of the topic of pain treatment within the field of music therapy—to uncover some of its different meanings and diverse manifestations, as well as to consider the implications for live music therapy interventions when working with clients in pain.

The number, or quantity, of interviews in no way negatively impacted the quality of material—a broad description of the phenomenon studied was gained from three in-depth interviews. From these interviews, an overview and understanding of various interactions and relationships (therapist-client-music) within music therapy with clients in pain was gained. I found that the lengthy and informally-structured interviews drew out from participants a wide variety of experiences with clients in pain and there was ample material for the method to be applied effectively.

The decision to use a grounded theory approach was in order to uncover common themes when working with clients in pain and add to the existing knowledge base of such a complex phenomenon. The aim was not to generalize observations or standardize applications, but to enrich understanding by discerning what the data might suggest or imply.

Challenges and Limitations

Research constraints included the timing of the study (towards the busy end-of-year holiday season) and lack of follow-through by others who had expressed interest in the study, for instance, not answering email communications, not returning signed consent form, or difficulty in scheduling the interview. In the end, only three therapists completed interviews.

This inquiry was limited to the inclusion of experienced therapists with a publication record and clinical expertise with clients in pain (minimum three years practice in the field). An inquiry into the experiences of new therapists may offer other perspectives.

The interview process, transcribing, and coding process, which were time consuming, flowed smoothly and were enjoyable. The software worked well and I was able to pause and rewind as many times as needed in order to type out the narratives. The writing process was challenging to me personally. I found it difficult to emotionally separate and tear the stories apart because they had been powerfully and emotionally conveyed. The stories overlapped and illustrated different aspects of the themes, ideas related to mu-

music therapy, and pain. Time and distancing was helpful with processing all of the information.

Moreover, applying phenomenological methodology with grounded theory method created a dilemma about leaving stories intact—that is, capturing the phenomenon through the interviewee's eyes versus pulling the narratives apart to generate themes and ideas. This was reconciled somewhat by dividing the report into two parts. I kept the focus question foremost in mind when I felt I was coming to an impasse while writing up the discussion: What do music therapists have to know (individually and collectively) in order to work with clients in pain?

Categorizing during data analysis was not a tidy process of organizing bits of data or information as expected. Often, certain aspects were described or alluded to in various ways—for example, trust was described by participant 2 as a relational process formed over a series of sessions, by participant 3 discussed trust as a three-pronged stand, and again by participant 2 it was alluded to when recounting holding a client's hand. In this way, multiple codes were generated and the data was filtered under both broad as well as specific categories. When participants verified through email as to the accuracy of transcribed portions of their interview, they confirmed that the themes and essences generated were relevant to their specific accounts.

During the follow-up process of member-checking, participants merely confirmed that the transcripts of their narratives were accurate and did not expand on questions that were tagged or raised. Only one participant expanded on the follow-up questions emailed after the initial interview. I had hoped for more follow-up material during this process.

When sifting through the data, a fundamental question constantly arose. While participants supported clients through the range of music experiences, was it the therapist, was it the music, or was it the dynamic interaction of both that impacted the client's process? While no clear answer was plainly evident, the data suggested all three scenarios at play. Hence, the data was also triangulated to account for these relationships. It was beyond the scope of this study to do more than chart the implied interactions and processes that were described.

Role of Researcher

I learned how to treat the interview more like a conversation than a formal question and answer session. After the first few minutes of the initial interview, the role shifted to listening reflectively to the language and narratives of participants in order to identify terminology and topics that needed clarification, as well as to further encourage their disclosure.

It became quickly evident that pointed questions led to limited information compared to freely encouraging participants to talk about their experiences with open-ended questions. When participants strayed into areas that I had not considered, but was interested in exploring further for potential relevance, they were encouraged to talk freely. Another level of awareness emerged—that of an inner dialogue about information that

was being shared, new learning, and to check myself from making assumptions or jumping to conclusions. On a few occasions, participants would veer off topic requiring me to redirect the participant back to the topic.

Future Research Considerations

Pain, as an experience, is personal and subjective. Hence, there was no intention on my part to draw any final conclusions from this research into music therapists' experiences working with clients in pain.

Future inquiries could be directed toward in-depth exploration of therapists' experiences with specific medical-pain populations, cultures, or music approaches/mediums within pain treatment. It might also be interesting and beneficial to study the use of vocal versus instrumental music experiences with clients in pain, or to explore the use of composed versus improvisational mediums.

Increased attention could also be directed toward music therapists' self-care strategies, the multicultural aspects of music therapy pain treatment, cultural aspects of pain (alluded to by Participant 3), and empowerment work with female clients (recounted by Participant 2 and 3).

Finally, the client's perspective of their experiences in music therapy while in pain has not yet been explored. The wealth of information that we could gain as music therapists by hearing the clients' stories would bring rich insights into the benefits and limits of our work.

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