Music and healing in cancer care: A survey of supportive care providers

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Abstract

This paper explores the role of music activity and music therapy in health care drawing on a survey of UK cancer care providers offering music interventions and music therapy. The survey examined the extent and type of music provision and explored providers’ views about the role and contribution of music and music therapy in healing. As well as music, the survey organisations offered a range of supportive therapies including complementary and alternative therapies (CAM) and creative therapies such as art therapy. The results provide insight into the way in which music and creative therapies are viewed by those responsible for care provision in this sector. The data point towards some of the challenges facing music therapists in the changing world of cancer care. These include responding to changes arising from developments in treatment and the organisation of care as well as increased collaboration with a diverse range of supportive care practitioners. These include providers of music and arts for health activity as well as complementary and alternative therapy practitioners who are increasingly involved in cancer care provision. We discuss the implications of these changes for the development of music therapy in cancer care.

Keywords: Music; Music therapy; Cancer care; Creative therapies; Arts and health; Complementary and alternative therapies (CAM)

Background

This paper reports on a survey of music therapy provision within UK cancer care organisations. While there is a growing body of research exploring clinical outcomes and effects of creative arts in health, relatively little research has focused on the organisational and policy contexts in which these are provided or the impact of these on service development. Our study aimed to gain an overview of factors shaping the current provision of music therapy in order to inform future developments in the UK and other countries where music and creative therapies are increasingly incorporated into cancer care provision. Our particular focus is on the way in which music therapy and music activity are viewed by those responsible for care provision. This is important because of the role that this group may play in an increasingly complex division of labour surrounding supportive cancer care. The study therefore sought to establish the extent and type of music provision as well as providers’ views about the role and contribution of music and music therapy in supportive cancer care settings.

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Music therapy in cancer care

Music therapy is a growing profession and, worldwide, includes diverse practices and models (Bunt & Hoskyns, 2002; Hanser, 2005; Wigram, Perdersen, & Bonde, 2002). Music therapy can encompass a wide range of music activities including individual and group listening, guided imagery and music and improvised individual and group music making. Whatever the therapeutic intervention, trained music therapists draw on, amongst others, psychodynamic, humanistic and transpersonal approaches (Bunt & Hoskyns, 2002).

Within developed countries music therapy in cancer care is an emergent field. In a survey of US music therapists by Kruse (2003) the majority of music therapists working in oncology were relatively new to this subspecialty. This reflects the position of music therapy in cancer care in other developed countries (Aldridge, 2003). Similarly, cancer care is a relatively new field for UK music therapists, with the majority of music therapists having traditionally worked within the fields of psychiatry and learning disabilities, and to a lesser extent, general medicine, neurology and the prison and probation services (Bunt & Hoskyns, 2002; Hanser, 2005).

Nevertheless, music therapy is increasingly used in cancer care: in his literature review of music therapy references relating to cancer and palliative care Aldridge (2003) cites papers from as far afield as Australia, Canada, China, Europe, Israel, Japan, New Zealand and the US. This growth in provision has been accompanied by increased regulation and systematisation of activity, with increasingly formal requirements for maintaining ethical practice. The survey by Kruse (2003) revealed a highly educated profession, with 43% of respondents having completed masters’ degrees and 11% doctorates. These trends towards professionalisation are reflected in the UK where music therapy has since 1997 been included within the regulatory framework for health professions. It is likely to influence patterns of provision of music therapy in future, resulting in enhanced working conditions, pay levels and career structures (Bunt & Hoskyns, 2002) all of which may contribute to increased provision.

Music therapy in cancer care focuses both on physiological and psychological needs arising from the disease process as well as from chemotherapy medications and radiation treatments (Aldridge, 2003; Bunt & Hoskyns, 2002; Burns, Harbuz, Hucklebridge, & Bunt, 2001; Hiliard, 2003; Kruse, 2003; Porchet-Munro, 1995; Rider, 1987; Standley, 1995). A starting point for music therapy in cancer care is a recognition that cancer involves not just chronic pain but can represent a serious challenge to identity, necessitating both physiological and psychological resources (Aldridge, 2003).

A wide variety of music activity takes place in cancer care settings, not all of which is undertaken by professional music therapists. Hence unpaid carers, volunteers and performing musicians may all be involved in music activity in cancer care. As Aldridge (2003) points out, music has been championed as a nursing intervention even when music therapists are not available. Pothoulaki, MacDonald, and Flowers (2005) distinguish between music therapy interventions undertaken by professional music therapists and music interventions undertaken by other clinical staff. Bruscia (1998) distinguishes between music in therapy and music as therapy. The former exists in a variety of settings, as many professionals might use music to contribute to the care environment and create an atmosphere conducive to healing or the reduction of anxiety. Formal training in music therapy is not necessarily a requirement for this type of provision. In contrast, music as therapy entails music as the agent of therapeutic change. Bruscia’s definition of music therapy encompasses several levels including didactic, medical, healing, psychotherapeutic, recreational and ecological. In a typology that may be helpful in distinguishing creative practice that requires formal therapy training he also identifies four levels: auxiliary (functional use for non-therapeutic/recreational use); augmentative (enhancing other treatment modalities); intensive (in which music therapy occupies a central and independent role); and primary (with music therapy in a singular and indispensable role) (see also Wigram et al., 2002). In recognition of this diversity our survey encompassed a wide range of music interventions as well as music therapy provision by professional music therapists. Within the UK this latter group gained in 1997 the status of state registration with the UK Health Professions Council, and the term State Registered Music Therapist (SRMT) is adopted in this paper to capture this distinction.

The changing world of cancer care

Within the UK cancer care provision is organised within a mixed economy that includes National Health Service (NHS) organisations as well as non-statutory organisations including charitable and independent hospices and hospitals. Services are also offered by a range of community organisations including cancer help centres as well as patient support and campaigning groups (Macmillan Cancer Relief, 2002). While this organisational framework may be specific to the UK there are general changes in cancer care in developing countries that affect music therapists. These are identified
by Kruse (2003) and include changes in treatment and care provision. For example, as cancer treatments have become more effective, leading to increased life expectancy following some types of cancer diagnosis, there is a trend towards shorter hospital stays and a corresponding need for extended community-based facilities to meet the needs of cancer patients. These trends are reflected on the focus of the current research, which is on supportive care as opposed to acute and curative cancer treatments. These trends affect the work of music therapists both in acute and supportive care. For example, survey respondents working in hospitals reported spending shorter amounts of time with patients and an increasing importance of music therapy techniques addressing psychosocial needs such as relaxation and self-help as opposed to some clinical needs such as the relief of nausea (Kruse, 2003).

A further trend arising from the changing needs of cancer patients is the increased involvement of a diverse range of practitioners including community organisations, volunteers and a range of complementary and alternative therapy (CAM) practitioners (Kruse, 2003). There are some parallels between music therapy and CAM in the changing context of cancer care. For example, while to some extent controversial, theories from psychoneuroimmunology, in which psychosocial, neurological and immunological responses are related, have influenced both disciplines (Kruse, 2003; Pert, 1997; Sollner et al., 2000; Spiegel, 1996; Watson, Haviland, Greer, Davidson, & Bliss, 1999).

Music therapy may share other features of CAM, particularly those that are highly valued by patients in the changing world of cancer care. Studies show that patients who use CAM do not necessarily seek clinical outcomes in the form of a cure; rather they seek to ameliorate the effects of treatment and gain psychological support in order to feel more “in control” of their situation (Downer et al., 1994; Sollner et al., 2000; Sparber et al., 2000). Research suggests that CAM patients value the non-invasiveness of these treatments in comparison with orthodox medicine. The emphasis by CAM practitioners on the psychosocial impact of disease is particularly valued by service users and use of CAM may therefore be seen as part of an active coping style (Coward, 1989; Douglas, 1994; Furnham & Vincent, 2000; Sharma, 1992, 2000). The therapeutic encounters between patients and healers can offer important opportunities for individuation (the ability to distinguish one’s sense of self and identity from others), which seems to be an important aspect in the search for hope and meaning (McClean, 2005).

Within the UK, the growth of the broader arts for health movement has added to the complexity with a diverse range of arts practitioners and organisations increasingly engaged in supportive care provision (Daykin, 2007). In relation to music, for example, a wide range of interventions is seen as falling under the arts for health umbrella including music therapy, music performance by professional musicians, community music, participatory patient arts and music and use of music by health care staff. Government sponsored bodies such as the Arts Council England and its regional divisions have shifted attention towards social models of health as well as issues of participation and arts, these organisations have shifted attention towards social models of health as well as issues of participation and social exclusion (Daykin, 2007), reinforcing a trend away from traditional clinical priorities towards patient centred psychosocial care.

Within the UK, the need to distinguish the particular contribution of different supportive care disciplines has been identified as a concern for policy makers (DH, 2006). This need for greater understanding of the differences between music and arts therapies and other approaches that use creative arts within health care is related to calls for a stronger evidence base to support these interventions (DH, 2006). This requirement for evidence-based practice has been a strong influence on music therapy (Davidson, 2005), with a growing evidence base for this form of provision (Edwards, 2005; Gold, 2004; Staricoff, 2004; Vink & Bruinsma, 2003). A recent systematic review of music interventions in oncology settings by Pothoulaki et al. (2005) identified 24 studies from USA, Canada, Australia and Europe. Over half of these used experimental methods including two randomised control trials. These studies report a range of outcomes, a major focus being physiological effects of music on the immune system (Bartlett, Kaufman, & Smeltekop, 1993; Burns et al., 2001; Kuhn, 2002). A recent qualitative study of the relevance of music therapy in a cancer hospital, O’Callaghan and McDermott (2004) reviewed accounts of patients, visitors and staff members across five studies. Many of these accounts affirmed a sense of “aliveness” in the face of “vulnerability” (see also O’Callaghan, 2002), confirming the view of the needs of cancer patients as psychological and spiritual as well as physiological (Aldridge, 2003).

As well as the ongoing need to demonstrate the value of therapy in environments where resources are limited, there is a recognised need to identify risks and limitations of particular therapies (Daykin, 2007; Edwards, 2005; O’Callaghan, 1996). Distinguishing music therapy from other interventions using music, or from CAM therapies, may be important in the future. Within the UK, where music therapy is relatively new to cancer care providers, these distinctions may not be well developed. Hence music therapy is sometimes viewed as a CAM, as is reflected in the inclusion of music and
art therapies in a recent directory of CAM provision in UK cancer care (Macmillan Cancer Relief, 2002). However, music therapists may draw on different frameworks from those used by CAM practitioners. Distinguishing these approaches may be central to arguments about the specific role of music therapists in cancer care, as well as to the identification of benefits and risks of the other supportive care interventions. This can be illustrated in relation to debates about psychosocial benefits and risks of CAM. As well as offering opportunities for individual expression and agency (McClean, 2005, 2006), CAM therapies have been characterised as promoting simplistic perceptions of personal responsibility for health, creating risks of failure and blame and adding to the existing stigma of illness (Cant and Sharma, 1999; Coward, 1989; Lee-Treweek, 2001; McClean, 2005, 2006).

As well as the continuing need for research to identify the clinical effects of music therapy and other supportive care interventions, there is a need to explore further the impact of the organisational contexts in which these interventions take place. These contexts can influence the development of care provision as well as the results of clinical evidence. It is to this area of the debate that our study contributes. Our study did not seek to evaluate the clinical effects of music therapy; rather we sought to map the extent and type of music therapy provision within UK cancer care and to explore the ways in which music and music therapy are perceived by those responsible for providing care.

Methodology

This paper reports the results of a survey of cancer care organisations providing music therapy. The survey sought to gain a comprehensive picture of the extent and current role of music and music therapy in cancer care. A postal questionnaire was distributed to the CAM managers of 80 UK cancer care organisations. These organisations were identified from directory of complementary therapy providers in cancer care published by a Macmillan Cancer Relief in 2002. This lists over 300 organisations providing CAM therapies. These organisations can be divided into three broad groups: hospices, hospitals and cancer help centres/support groups in the community. The majority of CAM providers are non-statutory organisations, although approximately 90 National Health Service (NHS) organisations are identified as providing CAM therapies. The directory reveals that music therapy is provided in 52 of these centres across 34 regions of the UK. These centres include 46 non-statutory sector and six statutory facilities (including NHS hospitals, hospices and specialist units). Hence almost 90% of music therapy in UK cancer care is provided within the non-statutory sector.

The survey sample included all 52 organisations providing music therapy. For purposes of comparison, we also included 28 organisations randomly selected from the directory. This latter group included 18 non-statutory organisations and 10 NHS organisations not currently providing music therapy. Table 1 describes music therapy provision by facility within the sample organisations.

Table 1
Music therapy provision by facility

<table>
<thead>
<tr>
<th>Facility</th>
<th>Hospice</th>
<th>Cancer care</th>
<th>Children’s hospice</th>
<th>Hospital</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MT</td>
<td>29 (55.77%)</td>
<td>14 (26.92%)</td>
<td>6 (11.54)</td>
<td>3 (5.77%)</td>
<td>52 (65%)</td>
</tr>
<tr>
<td>No MT</td>
<td>10 (35.71%)</td>
<td>9 (32.14%)</td>
<td>0 (0.00%)</td>
<td>9 (32.14%)</td>
<td>28 (35%)</td>
</tr>
<tr>
<td>Total</td>
<td>39 (48.75%)</td>
<td>23 (28.75%)</td>
<td>6 (7.50%)</td>
<td>12 (15.00%)</td>
<td>80 (100%)</td>
</tr>
</tbody>
</table>

Table 2
Sample characteristics and response rates by sector

<table>
<thead>
<tr>
<th>Overall response rates</th>
<th>Non-statutory sector</th>
<th>Statutory sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responses</td>
<td>Non responses</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>Responses</td>
<td>Non responses</td>
</tr>
<tr>
<td>67 (83.75%)</td>
<td>13 (16.25%)</td>
<td>80 (100%)</td>
</tr>
<tr>
<td>55 (85.93%)</td>
<td>9 (14.06%)</td>
<td>64 (100%)</td>
</tr>
<tr>
<td>12 (75%)</td>
<td>4 (25%)</td>
<td>16 (100%)</td>
</tr>
</tbody>
</table>
The questionnaire was sent to a named individual identified in the directory after a brief telephone conversation to check the accuracy of the data. These preliminary calls revealed instances where the named individual was no longer working at the centre, and also allowed a more appropriate representative to be identified if the named individual did not feel able to respond to the questionnaire. Questionnaires were sent in a stamped addressed envelope and after 3 weeks non-respondents were sent a repeat questionnaire followed by a further telephone reminder. Respondents were assured of the confidentiality of the process, assured through anonymity in data reporting, and they indicated consent by signing the questionnaire.

The questionnaire sought to elicit information about a number of issues. Questions explored the extent of music provision and the different types of music activity taking place, including listening to live and recorded music and active music making by service users. They also explored the format of music therapy, including individual and group therapy. For purposes of comparison, questions about the extent of art therapy and other creative therapies were included. There was a specific question about whether the music therapy offered was provided by a state-registered music therapist and there were also questions about the frequency and format of music therapy this group provided. A question about funding sources for music therapy was included. Finally, the structured part of the questionnaire focused on future plans for music therapy, asking whether there were any plans to expand this provision and whether these plans included employment of a state registered music therapist. The quantitative questionnaire responses were analysed using the software package SPSS for windows. The results are presented below.

An open-ended question sought brief written statements describing the perceived role and contribution to music therapy in cancer care. Qualitative responses to the open-ended question “what do you think are the main benefits of music therapy to people with cancer?” were analysed using a thematic content analysis. This involved drawing out key themes from the statements and developing these into a typology of music provision. This is discussed in more detail below.

**Results**

A total of 67 questionnaires (84%) were returned (see Table 2). Response rates varied by sector and type of provision. The organisation of supportive cancer care in the UK reflects a complex mixed economy that includes statutory bodies such as National Health Service (NHS) hospitals and, to a lesser extent, local authority care facilities as well as voluntary, charitable and independent organisations. These are funded through a range of means include private donations, fees and contracts with government and local authorities. There are also a range of user led support and campaigning groups that provide some care. We have drawn a distinction between statutory and non-statutory organisations, although this to some extent obscures the complexity of the situation.

Tables 2–4 provide details of response rates by sector and facility. Table 2 shows that the response rate to the survey was higher within the non-statutory sector than within the statutory sector (86% and 75%, respectively). Response rates were highest amongst hospices (mostly non-statutory): 96% compared with 70% for other non-statutory cancer care organisations and 67% for statutory NHS hospitals (Table 3). Finally, response rates were weighted towards music therapy providers: 87% compared with 79% for organisations not providing music therapy (Table 4).
The quantitative analysis reveals that the use of music in some form was widespread, with almost two thirds of respondents reporting use of more than one type of music activity within their organisation (see Table 5). Only six organisations reported no music activities taking place. The most frequently cited activity was that of listening to recorded music, and the use of live music was reported by 60% of the sample. Music making by service users was reported in 21 organisations.

Provision of formal music therapy was reported by just under half of respondents (n = 31). While our focus was on music, we included questions about art therapy in order to see whether experience of this more established form influences music provision. In general, art therapy was more likely to be offered than music therapy. Where music therapy was provided, it was more likely to be offered in conjunction with one or more therapies than on its own, whereas art therapy was almost twice as likely than music therapy to be provided as a sole therapy (see Table 6). Hence music therapy is less established than art therapy in cancer care. Nevertheless, the fact that music therapy is often provided alongside art therapy but seldom on its own indicates that a positive experience by care providers of art therapy provision may encourage provision of music therapy as a natural development.

As we have discussed, music therapy has relatively recently gained the professional status of state registration. Table 7 indicates the extent to which state registered music therapists (SRMTs) are involved in the music activities provided by the organisations. A total of 16 organisations (24% of respondents) employed a SRMT. All the children’s hospices included in the sample used SRMTs but the presence of SRMTs in adult care settings was less strong. The employment within the children’s hospices is closely connected to the work of Jessie’s Fund, a charity established in 1994 in memory of Jessie by her parents, both of whom are professional musicians committed to music therapy. The fund supports the employment of music therapists in children’s hospices and also organises short training courses for care workers in children’s hospices on therapeutic music making (http://www.jessiesfund.org.uk). Overall, the data

<table>
<thead>
<tr>
<th>Music activities provided</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than one music activity</td>
<td>42</td>
<td>62.68</td>
</tr>
<tr>
<td>Listening to recorded music</td>
<td>44</td>
<td>65.67</td>
</tr>
<tr>
<td>Listening to live music</td>
<td>40</td>
<td>59.59</td>
</tr>
<tr>
<td>Music making by service users</td>
<td>21</td>
<td>31.34</td>
</tr>
<tr>
<td>No music activities</td>
<td>6</td>
<td>8.96</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Creative therapies provided</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Music therapy as sole creative therapy</td>
<td>9</td>
<td>13.43</td>
</tr>
<tr>
<td>Music therapy in conjunction with one or more other creative therapies</td>
<td>22</td>
<td>32.84</td>
</tr>
<tr>
<td>Art therapy and no other therapy</td>
<td>16</td>
<td>23.88</td>
</tr>
<tr>
<td>Neither music nor art therapy</td>
<td>17</td>
<td>25.37</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>4.48</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>100.0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Music therapy provided by state registered music therapist</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>16</td>
<td>23.88</td>
</tr>
<tr>
<td>No</td>
<td>32</td>
<td>47.77</td>
</tr>
<tr>
<td>Not applicable</td>
<td>13</td>
<td>19.40</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>8.95</td>
</tr>
<tr>
<td>Total</td>
<td>67</td>
<td>100.0</td>
</tr>
</tbody>
</table>
suggest that over half of organisations providing music therapy in adult cancer care do not employ a SRMT for this activity.

Tables 8–10 give a more detailed breakdown of the characteristics of music activity within these organisations, including frequency and type of provision, funding sources, methods of referral to music therapy and evaluation practices. Weekly provision was the commonest form, with over half of music therapy provided by a SRMT taking this form. Group therapy was more commonly provided than individual therapy although three quarters of the group provide therapy in both group and individual formats. Funding sources for music therapy varied, with external funding reported by seven organisations. External funding sources included the NHS and charities such as Jessie’s fund. Three organisations reported using more than one source of funding, while four reported subsidising music therapy internally. In a small number of organisations service users were expected to pay for music therapy. Other sources cited included permanent employment of a music therapist in a Children’s Hospice and a temporary residency by a SRMT in an adult care hospice. Methods of referral to music therapy were also explored. No formal patterns seemed to emerge from these data, although a common approach seemed to be that of incorporating music therapy into a general programme of therapeutic activity. Fourteen of the organisations reported that they evaluated the music therapy they provided, with nine reporting that evaluation data were available. Informal verbal feedback was used in 10 organisations and this was used more frequently than formal or written feedback, which was only mentioned by five organisations. Evaluation was equally likely to be undertaken by the music therapist as another member of staff, and in most cases by both. One music therapist reported using discussion with other staff of video recordings of music therapy sessions as an evaluation technique.

Respondents were asked about their plans for future provision of music therapy. Almost a third of organisations were planning to expand music therapy provision in future (Table 11). Further analysis reveals that this group is made up of established music therapy providers using SRMTs, including children’s hospices as well as organisations that were established providers of art therapy: only three had no experience of using creative therapies. This further suggests that there are links between patterns of provision, with successful provision of art therapy paving the way for expansion of creative therapies including music.
Table 11
Likely use of SRMT in organisations planning to expand provision of music therapy

<table>
<thead>
<tr>
<th>Organisations planning to expand music therapy provision</th>
<th>Future expansion</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>State-registered music therapist</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Not applicable</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>22</td>
<td>19</td>
</tr>
</tbody>
</table>

Table 12
Likely use of SRMT in music activity in future

<table>
<thead>
<tr>
<th>Likely future use of state registered music therapist</th>
<th>Likely use of SRMT in future</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>State-registered music therapist</td>
<td>11</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Not applicable</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>19</td>
</tr>
</tbody>
</table>

Respondents were asked about the likely employment of SRMTs in the future (Table 12). Fourteen respondents stated that they were likely to use SRMTs in future provision. In most of these organisations (11) use of a SRMT was already established, hence a further three organisations were planning new provision using a SRMT.

Of those planning to expand music therapy provision, only eight stated that their plans included employment of a SRMT, while 12 planned to increase therapeutic music making without use of a SRMT. Hence organisations seemed to be using a pluralistic approach, with the case for employment SMRT in the provision of music therapy not necessarily widely accepted.

Thematic content analysis of qualitative data

Respondents were asked an open-ended question:

“What do you think are the main benefits of music therapy to people with cancer?”

A thematic content analysis of these data revealed several overlapping approaches to music provision. These approaches can be viewed as belonging to a continuum, with the background use of music at one end and music as the main agent of therapeutic change at the other. In between these polarities, music was seen as having a range of roles including providing enjoyment, diversion from illness and adjunctive in relation to other therapies. This notion of a continuum of therapeutic music echoes the distinction made by Bruscia (1998) between music in therapy and music as therapy. While music therapists who have undergone formal training in the UK may use elements of music at all these points on the continuum, they are much less likely to engage with notions of music as providing a background than they are with those of music as providing the potential and means for healing. On the other hand, the providers in this study did not seem to make clear distinctions, embracing all points on the continuum as being of benefit.

Music as background

Several responses emphasised what might be termed the secondary and background aspects of music including improvements to the general care environment. Issues such as relaxation and a calming atmosphere were emphasised in these accounts and no further therapeutic claims were made for music:

Music provides a tranquil atmosphere, and is all part of the service we offer in the day hospice.
Entertainment and enjoyment

Other responses emphasised the role of music as enjoyment and entertainment. Again, these responses did not necessarily draw on notions of healing or therapeutic process:

Our musical evening drew in many people - they enjoyed what they did and were surprised by how good it sounded.

Other accounts emphasised enjoyment in ways that addressed issues relating to illness more directly. For example, the potentially joyful qualities of music were seen as of real value when other opportunities for expression were limited:

Many of our service users cannot see so hearing music is a great joy to them, they enjoy making music.

The above example highlights the fact that there may be overlaps between music in therapy and music as therapy. Many cancer care providers are aware of the challenges to identity that cancer diagnosis and treatment can represent. In the following example, another way in which music was seen as contributing to healing was through the opportunity to restore a sense of identity.

Music provides an opportunity to pursue an interest from pre-cancer days when fatigue and other symptoms prevent more physical occupations.

In some responses, music is seen as having a compensatory function in relation to the losses associated with cancer. This function was seen as working at physical, psychological and social levels and within it is difficult to distinguish the healing from the non-healing aspects of music.

Music as a tool: communication and healing

In other statements, the distinctions were clearer, as in those expressing the notion of music as a tool that could support another identified healing process, rather than having healing properties in its own right. Hence the role of music in enhancing communication between professionals and patients during cancer treatment, as well as between individuals and families was stressed.

When notions of healing entered the accounts, these centred on a range of processes in which music was seen as supportive, even essential, but not necessarily central. Hence several practitioners of visualisation, meditation, massage and other therapies drew on music as a resource for healing:

I’m afraid I know nothing about music therapy in professional terms. I used gentle therapeutic music for my touch therapy work and it is an ESSENTIAL tool.

In some accounts, music as a tool was well worked into the particular healing discourse used:

I use music and sounds in relationship with my work in traditional Chinese medicine to help balance the energies. Types of music relate to different elements - to relax or motivate as needed.

As we move through the continuum, music begins to be endowed with more power. Although the accounts begin to emphasise music as therapy, the discourses upon which they do not necessarily draw on the therapeutic traditions emphasised in formal music therapy training: more recognisable in these accounts are the notions of mind body healing often used by CAM practitioners. Hence in the following example music not only aids relaxation but also offers a form of immunity, blotting out any intrusive thought patterns while the music lasts, in a manner akin to focused meditation:

Music aids relaxation. It calms the mind, helps stop invasive thoughts for the period the music is playing.

The power of music: exploration, expression and release as healing

Many of the responses also highlighted music processes as linked more directly to healing and therapeutic processes. Respondents offered a wide variety of ways in which music is seen as healing. These seemed to be clustered around notions of exploration, expression, release and evoking healing processes. Music was also seen as providing opportunities for exploration through reflection, reminiscence and self-awareness. A number of different
discourses influence the accounts but, perhaps understandably given the context of our study, the CAM discourse of mind-body medicine is strongly recognisable. Hence in the following example music was seen as offering release and a means of accessing and bringing into present consciousness a range of emotions lying hidden under the surface:

Music provides a medium for expressing thoughts and emotions which otherwise may be kept hidden.

As well as accessing such dormant emotions music was seen as having the capacity to stimulate a healing response:

Music can create the right atmosphere and evoke reactions - either on a physical, emotional, spiritual or psychological level or altogether.

Discussion

This study has identified some of the issues facing the development of music therapy in countries like the UK where this form of provision in cancer care is emergent. The research only attempts to address some aspects of this extensive area: further studies are planned, including those drawing on the views of service users and music therapists themselves. Nevertheless, by exploring the views of providers of music therapy in cancer care, as opposed to therapists, we can draw some useful insights. While our survey was relatively small, the high overall response rate suggests that we were able to capture a reasonably accurate picture of music therapy provision as well as attitudes to music and creative therapies among managers of UK organisations providing supportive cancer care.

The context for our study is that of a complex division of labour in which music therapists as well as a wide variety of music, arts and CAM practitioners are involved. This diversity has been encouraged by trends in treatment that have resulted in shorter hospital stays and shifted the focus towards psychosocial and community-based care. Within this context music therapy is a relatively new profession: many care providers have greater experience of other forms of art and music activity as well as CAM therapies than they do of music therapy. A key question therefore arises as to the role of different specialities within supportive cancer care. In this study we have noted the absence of a strongly developed discourse among care providers articulating the value of therapeutic music or music therapy as distinct from other interventions. Our data suggests that care providers may draw on eclectic notions and metaphors in their descriptions of their use of music. Our data are limited in this respect: in-depth exploration of the similarities and differences between perceptions about CAM, creative therapies, music interventions and music therapy is warranted. Such research should address the question of whether perceptions of music therapy in certain contexts are influenced by risks associated with CAM, such as individual responsibility for illness or the potentially burdensome expectation of ‘success’ in the performance of healing rituals of expression and release.

The need to distinguish the benefits and risks of specific approaches so that their respective contributions might be better understood has been raised as a key concern for policy development (DH, 2006). Arguments in favour of professional training emphasise not just the high standard of creative practice that therapists bring but their formal training in therapeutic frameworks as well as the benefits of professional regulation (Bunt & Hoskyns, 2002). These include requirements for ethical practice and an assessment of risks as well as benefits of therapy. We have explored healing discourses surrounding music, drawing on Bruscia’s (1998) distinction between music in therapy and music as therapy in order to develop the notion of a continuum of music and healing in cancer care. Nevertheless, our study suggests that the specific contribution of the professional music therapist is not necessarily well understood by those responsible for providing care. This may account for our finding that despite growing evidence of music activity in supportive cancer care, employment of SRMTs in this field is relatively rare.

While these trends may be to some extent attributable to the specific context of UK cancer care, our study also reflects wider trends. These include the shift in focus towards psychosocial care and the greater availability of CAM, recognised in research the US (Kruse, 2003) and likely to be generalisable to other countries where music therapy provision in cancer care is emergent. Hence the questions raised by our study resonate with current issues for music therapists working in cancer care at both national and international levels. How are the specific contributions of a music therapy intervention to be developed and demonstrated alongside other CAM therapies? How are music therapy programmes likely to be affected by flexible and collaborative working in this context? Should music therapy training offer a stronger focus on techniques for psychosocial support, such as song writing and receptive techniques alongside the customary active improvisatory techniques? With the emergence of the arts in health and community music movements, how
does the professional music therapist work alongside other musicians and professional colleagues in the delivery of a comprehensive range of musical and music therapeutic interventions?

While the views of care providers represent an important area of research, we would not suggest that these operate as a single influence on the development of care. Further research that addresses the views of policy makers, therapists and patients is also needed to strengthen understanding of the development of music and creative therapies. While the evidence-based health care movement has led to increasingly high-quality clinical studies of music therapy, it is important to acknowledge the impact of broader policy and organisational processes on the development of supportive care interventions. A final question arises from our study concerning the most appropriate research methodologies for addressing these complex organisational and process issues. Further integrated and collaborative research, including qualitative research, is needed to explore these issues and contexts in the global setting.

References


