MUSIC THERAPY AT THE END OF LIFE: A CRITICAL INTERPRETIVE SYNTHESIS OF THE LITERATURE

A Dissertation
Submitted to
the Temple University Graduate Board

In Partial Fulfillment
of the Requirements for the Degree
DOCTOR OF PHILOSOPHY

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December 2017

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ABSTRACT

The purpose of this study was to provide a critical interpretive synthesis (CIS) of the literature focused on music therapy at the end of life. The guiding question for this inquiry was, "What is the essence of the music therapy experience at the end of life, as it is explained across the literature?"

Music therapy has been offered in hospice and palliative care in the United States, almost from its inception, when the first hospice in the United States opened in 1974. Since then, hospice has grown to be one of the most common settings for music therapists. The abundant literature addressing music therapy at the end of life demonstrates the meaningfulness of this clinical work, however, little synthesis of this literature has been published. CIS, a research methodology developed in 2006 by Dixon-Woods, et al., offers researchers a method for synthesizing diverse bodies of literature, and explicitly integrates quantitative, qualitative and non-empirical literature. Unlike methods for conventional systematic reviews, researchers using CIS draw from distinctive traditions of meta-ethnography to synthesize, build synthetic constructs, and generate a synthesizing argument. The resulting argument—an integrative, coherent theoretical framework—comprises a network of constructs and the relationships between them.

Through the capacity of music therapy to establish, reestablish, or enhance the connection to self, connection to others, and connection to spirituality for people at the end of life, *Connection* emerged as the synthesizing argument in this study. As such, Connection became the unifying theoretical framework linking existing constructs across

the literature. Within this framework, the role of the music therapist as *companion* emerged, demonstrating the essence of their presence to facilitate those connections, within a therapeutic relationship accelerated and enhanced by the music.

This critical interpretive synthesis of the literature on music therapy at the end of life provides a meaningful resource for music therapists working in end of life care, or for those who aspire to do so. The meaningful work of individual authors is strengthened by the unifying connections made in this synthesis and music therapists are offered a theoretical framework from which to approach clinical work and a potential focus for therapy. This study illuminates some of the subtleties and complexities of music therapy at the end of life and brings to the forefront a deeper understanding of how music therapy impacts the end of life experience.

DEDICATION

To Keith, your devotion, love and support, and faith in me have sustained me

To Luke, and the twins, you have literally been a part of me throughout this journey, and your presence within and surrounding me has inspired me

To my Mom and Dad, for your unconditional love and for always teaching me that I could accomplish whatever I dreamed possible

To my sisters, my life-long companions, for always being exactly what I need

In honor of the memory of my grandfather, Dr. Alan Johnson,

whose pride in me I could never forget

ACKNOWLEDGMENTS

I am deeply and eternally grateful for my dissertation committee chair and longtime mentor, Dr. Darlene Brooks. I want to express sincere appreciation for her companionship on this journey, for her never-ending support, encouragement, tough love, insight and belief in me. Without her, I would not be the music therapist and scholar I am today, and I would never have survived this journey.

I also want express my gratitude for my committee members, Dr. Wendy Magee and Dr. Alison Reynolds for their contributions to this project, and for their patience in seeing me through to the end. Also, to Dr. Helen Shoemark, as a part of the music therapy faculty, I express appreciation for her support and contributions to the music therapy program.

I want to thank Dr. Cheryl Dileo, my advisor in the PhD program. Her dedication to this program and to the students is truly a gift and I have learned so much from her over the years. My first encounter with music therapy at the end of life was in her class and I will never forget the experiences we had; they are a part of my fabric as a music therapist, and now researcher.

I want to thank my Temple family and fellow doctoral students. I am honored to be a part of this extraordinary group of people.

I am truly appreciative of my dearest friends and their support throughout this process. I thank them for knowing when to ask questions, when to push me, when to encourage me, when to listen, and when to pretend like they didn't even know I was writing a dissertation.

A special thank you to my grandmother, who encouraged me and shared about my grandfather's experience during his dissertation writing, how hard he worked, and how much she understood how challenging this process could be for everyone involved. She always made sure to remind me how proud she is and he would be.

I want to express my deep love and appreciation to my Mom, Dad, Lisa and Kaleigh, for always being there, for believing in me, supporting and encouraging me to not give up, to finish what I started, and knowing that I would.

How can I ever find the words to express the gratitude I feel to my amazing husband? Luckily there are songs to help…

"The sweetest devotion, hit me like an explosion, all my life I'd been frozen, the sweetest devotion I know…"

Six years ago I took two leaps of faith: I started this program and we began our new relationship. In those years, as I worked toward this moment, we also became engaged, married, suffered losses, received the most precious gift of our son, and are now expecting the growth of our family with two new babies. My journey in this doctoral program will be forever linked with the beginnings of our life together. You have been the kindest, most patient, devoted and supportive partner to me and father to Luke, and I cannot imagine being able to do this without you.

Finally, I want to express sincere appreciation for my experiences at Samaritan Hospice, and to all of the patients and families who allowed me to enter their lives at such a sacred time. I was forever changed by my experiences accompanying people at the end of life. The irony of being an expectant and new mother whilst being immersed in the experiences of people at the end of their lives is not lost on me. My hope is that I can honor their legacies in the ways in which I live my life to the fullest, with a deep connection to myself, to my loved ones, and to my God.

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CHAPTER 1

INTRODUCTION

Though it is not clear when music therapists began working in dedicated hospice facilities, the field of music therapy originated with the work of musicians at the bedsides of veterans facing life-threatening injuries (American Music Therapy Association, 2017). Music therapists were advocates of *palliative care* from the beginning, understanding that music was capable of having profound effects on the physical and emotional well-being of patients. In 1978, Munro and Mount offered the first literature published on music therapy for patients at the end of life, using the term "palliative care." They presented a compelling rationale for the use of music therapy with patients at the end of life, proclaiming physical, psychological, social and spiritual benefits. Since then, the utilization of music therapy in hospice and palliative care settings has exponentially increased.

I began my career as a music therapist in 2005, and initiated the first full-time music therapy program for a hospice in Southern New Jersey. I had taken one class taught by Cheryl Dileo in my graduate program focused on music therapy at the end of life, and I owned the one edited book available at that time: David Aldridge's (1999) *Music Therapy in Palliative Care: New Voices.* I remember carrying my class notes and that book with me as I traveled around 3 counties to see patients. Between sessions I would desperately search for answers or insights to help me understand my clients and their experiences. These notes are now frayed and coffee-stained; the book is worn and yellowed from the sun.

When I think of these early days of my career, the metaphor of a person with newly acquired blindness comes to mind. I could not see or even envision how to navigate these new experiences. At times there were glimpses of the familiar, but for the most part, I was in uncharted territory. I had to learn to use all of my senses to feel my way through this unique process of music therapy. I read and reread my materials hoping to find some solid ground from which to approach this work.

With some experience, I began to feel confident, instinctively knowing what to do and say with my patients. I was having dynamic experiences—working with dying patients felt particularly meaningful, more extraordinary than work I had done in other settings. I now ask myself "Why?" Was it merely because patients were dying and this moved me, reminding me of my own, or my loved ones' mortality? Was it the persistent sense of urgency, never knowing which session would be the last? Was it the need for a deep energetic connection with patients who were actively dying and for whom the increasing tension and need for release was palpable? Was it because I was in patients' homes, often in their bedrooms, sharing in this sacred time, and feeling a deeper sense of intimacy than I had in other clinical environments? These are simply a few of the numerous questions that came to mind.

After some time in my first hospice job, I began to feel pressure to present on my work, both from my agency and the music therapy community. I struggled to articulate my experiences in any theoretical or scientific way. The only way I felt I was able to capture the essence of the work I was doing was to tell stories. The stories were powerfully moving, and would usually convince anyone listening that music therapy works in this setting. I have attended countless presentations at the local, regional and

national level on music therapy and end of life, and most of these, too, are full of heart-warming, moving stories about this work happening at end of life. So it was not surprising to me when I began to explore the literature that a large number of the hospice music therapy publications included case examples.

The case reports were compelling, but did not explain why music therapy was so effective when working with patients at the end of life. Rarely was there mention of the reasons for choosing particular methods or whether there was some discernible mechanism of action within music therapy experiences. Quantitative studies rarely addressed the therapeutic process, rather focused on outcomes, and qualitative studies were often focused on a specific component of music therapy in hospice care. At that time, I was seeking a more in depth understanding of music therapy with this population. Profound ideas were scattered throughout the literature. Lack of a source unifying those ideas inhibited my ability to grasp and apply them in my attempts to ground my clinical practice.

The idea for my study began to emerge in 2014 while attending a presentation in which Clare Ghetti discussed her process of synthesizing the literature on music therapy as procedural support for invasive medical procedures. As a result of her literature analysis and synthesis, Ghetti (2014) was able to create a working model of music therapy as procedural support and described the outcome as approaching theory. During her presentation, I found myself thinking about hospice music therapy and wondering if there was a way to provide a useful synthesis of this body of literature. Although I knew of many resources that provided common areas of need, goals and objectives, and music therapy interventions, I was not aware of any attempt to form a working model of music

therapy in hospice care, grounded in research and practice. Creating such a model appealed to me.

Research synthesis has become an important methodology for establishing evidenced-based practice and influencing policy (Cooper, Patall, & Lindsay, 2009). To begin my process of inquiry, I conducted a preliminary search, first looking for published systematic reviews or syntheses of end of life music therapy literature. At that time there were three: Krout(2000)Hilliard (2005), and Bradt and Dileo (2009). Krout (2000) conducted a comprehensive literature review that included publications from 1978-1999. Hilliard's (2005) review of empirical research followed and Bradt and Dileo published a Cochrane review in 2009 While Krout's (2000) publication is a useful resource for clinicians, it lacked a synthesis, critical analysis or interpretation of the literature. Bradt and Dileo's review (2009) represented the only synthesis of the music therapy in end of life literature at this time, however, given the stringent quality assessment requirements of Cochrane systematic reviews, only five studies were included in the review.

It may be that systematic review and meta-analysis are not plausible and do not adequately reflect the literature available in this area. Common methods of qualitative research synthesis are unsuitable given the small number of qualitative studies published in hospice music therapy. There is, however, an abundance of literature, i.e. quasi-experimental studies, case studies, theory papers, and book chapters, which contain rich information and exemplify the important work happening in this field of music therapy. I felt that a different type of synthesis was necessary to provide a more inclusive representation of the literature on music therapy for patients at the end of life.

Determining the best synthesis methodology for this body of literature was an extensive process. I first researched the methodology used by Ghetti (2012) and developed by Altheide (1996), qualitative media analysis. Qualitative media analysis is a method involving systematic analysis of documents related to a chosen topic, emphasizing description and discovery through searching for underlying meanings, patterns, and processes. Several elements of Altheide's (1996) method appealed to me. However, my search of studies utilizing qualitative media analysis revealed that it has largely been used for synthesizing ideas, opinions, or beliefs present in television and newspaper media and rarely for synthesizing research; Ghetti's (2012) study was one of the few examples applicable to my topic.

Consequently, I researched other options for approaching a synthesis of the entire body of literature focused on music therapy at the end of life. Meadows and Wimpenny (2016a; 2016b) provided a great resource in their chapters on synthesis of interpretive and mixed methods research. It was in reading those chapters that I learned of the varied synthesis methodologies available. Paterson (2012) was another valuable resource for determining the best methodology for this study. Her chapter provided a historical context for the development of multiple qualitative synthesis methods and an overview of meta-synthesis research, along with suggested considerations for choosing the right methodology.

The methodology described in Meadows and Wimpenny (2016a; 2016b) and Paterson (2012), Critical Interpretive Synthesis (CIS), emerged as the most suited for my purposes. CIS was developed to synthesize diverse bodies of literature and explicitly integrates quantitative, qualitative, and non-empirical literature. While CIS involves an

iterative and reflexive process of synthesis, it offers more structural guidelines than other synthesis models—an asset for a novice researcher (Paterson, 2012). While attempting to synthesize the literature addressing the issue of access to healthcare by vulnerable groups in the United Kingdom, Dixon-Woods et al. (2006) found that conventional methods of systematic review were ill-suited to synthesize the diverse and complex body of literature focused on this topic. CIS evolved from this realization.

CIS is informed by conventional systematic review, but draws on a distinctive tradition of qualitative inquiry and interpretive approaches to review. The subjectivity of CIS is explicitly acknowledged and accepted. Dixon-Woods et al. (2006) make no claims to the reproducibility of their study using CIS, recognizing the 'authorial voice' of the researcher who, as in all qualitative research, approaches the critical analysis with professional and personal sensibilities. While the output of CIS is interpretive, and therefore inherently not reproducible, it is grounded in the evidence and can offer insights consistent with this evidence (Dixon-Woods et al., 2006).

It is important to note that while my initial interest in this topic originated in my practice of music therapy in a hospice setting, I intended to include both hospice and palliative care literature in my study, but limit the inclusion to only those who address people at the end of life. I provide more detail regarding the delineation of hospice and palliative care in Chapter 2, but, essentially, it has only been in the last several years that *palliative care* has become a distinct area of medicine, separate from hospice care. Therefore, it would have been difficult and potentially detrimental to the synthesis to exclude palliative care literature, since many music therapists working in palliative care settings are attending to people at the end of their lives.

I began this inquiry with many questions about the process of music therapy at the end of life. Yet, according to CIS methodology, research questions are not identified *a priori* (Flemming, 2010). To do so would have limited the aim of the study. In CIS, research questions are left relatively broad, without specific hypotheses, and serve not as an anchor, but a compass. This process is explicit in its intention to be highly iterative, allowing the definition of the phenomenon to emerge from the in-depth, reflexive analysis of the literature (Dixon-Woods et al., 2006; Flemming, 2010). Consequently, to begin this study, I identified this relatively broad research question to guide me in my study: What is the essence of the music therapy experience at the end of life, as it is explained across the literature?

Therefore, the purpose this study was to provide a critical interpretive synthesis of the body of literature focused on music therapy at the end of life, in hospice and palliative care. The intent of this study was not to provide a "how-to" of music therapy for hospice practitioners, but a critical interpretation of the theoretical underpinnings present across the literature. The output is a synthesizing argument, which takes the form of a coherent theoretical framework, comprised of networks of constructs and the relationships between them, that links new constructs generated through the synthesis to existing constructs present in the literature (Dixon-Woods et al., 2006). My intent was to provide another resource for music therapists, for clinical practice and research, and further inform the healthcare community.

Personal Stance of the Researcher

I worked in hospice music therapy for over six years. In that time, I experienced tremendous growth as a therapist and as a person. I always felt that one of the most

important messages I communicated to patients was my willingness to accompany them on their journey at the end of life. And it was also music which allowed the relationships I developed with patients to be transformative, cathartic, and create a sense of community amidst the loneliness and despair that dying can bring forth. In our shared musical space, patients experienced themselves, and others in different ways. Patients could reconnect to their bodies, their emotions, their memories, and their spirit through the music we shared. This work was unlike anything I had experienced in other clinical settings but I could never completely understand why.

I had many specific questions initially guiding my approach to this research synthesis: How are music therapists defining the process of music therapy at end of life, the role of therapist, of client, and of music? Are there any distinct themes that emerge within music therapists' depictions of music therapy at end of life? How are music therapists assigning meaning to their work in music therapy and hospice? How do music therapists describe the impact of music therapy on clients at end of life? Why does music therapy work in this setting? Why are certain methods commonly used, and others less so? How are music therapists acknowledging and coping with grief and how does it impact the contextualization of their work? How do music therapists address professional and ethical boundaries in music therapy in end of life?

It was important to me that my curiosities did not confound my data. Yet, I anticipated that some of these topics may manifest in the synthesis. Dixon-Woods et al. (2006) acknowledged the 'authorial voice' present in an interpretive synthesis. As in other methods of qualitative research, the conclusions of this study, though grounded in evidence, were largely influenced by my own experiences, opinions, and beliefs about the

topic. I approached this topic with vested interest in the literature as the majority of my clinical experience as a music therapist has been in hospice and palliative care settings. There can be value in having a heuristic sensibility when approaching topics related to one's chosen professions (Schroerlucke, 2015). And while this was not a heuristic study, I could not remove my professional experiences from my understanding and interpretation of the literature, nor should I have, as they provided additional sources of insight.

CHAPTER 2

REVIEW OF THE LITERATURE

The History of Hospice Care

Modern hospice care originated with the work and vision of Dame Cicely Saunders. Saunders was a nurse during the Second World War, a medical social worker working with patients with terminal cancer in the mid to late 1940's, and also a physician practicing in London from 1958 until she retired in 1985 (Clark, 2002). It was in her work as a medical social worker, that she developed a fateful relationship with a Polish refugee, dying in her care in a large hospital. Many accounts of the history of Saunders and the hospice movement speak of her relationship with this patient as being her inspiration for her life's work in hospice and palliative care. Saunders and the patient dreamed together of creating a home-like place where people could come to die, free of pain. Saunders (2001) described this patient as being a "powerful catalyst for a new world-wide movement" (p. 430). It was her conviction that people deserved to die with dignity, compassion, and respect while receiving expert medical care that led Saunders to pursue medical training and devote her career to the care of terminally ill patients (Lutz, 2011).

In 1958, Saunders began her clinical practice and research as a physician at St. Joseph's Hospice, a Catholic institution in East London. "The introduction of the detailed recording of an oral and regular regimen, and the development of symptom control with the drugs becoming available, led to the change expressed by one of the nuns nursing there as 'from painful to pain free'" (Saunders, 2001, p. 430). While

pharmaceuticals were able to address the physical aspects of pain, Saunders recognized that the spiritual and emotional needs of patients at the end of life were more challenging to address. Though most of the evidence base was anecdotal at this point, Saunders (2001) said that, "the work at the hospice had been enthusiastically welcomed because it had been possible to demonstrate that patients could be free of pain and still alert, responsive and remaining themselves" (p. 431). Saunders coined the term *total pain* which refers to the mental, social, and spiritual distress associated with physical pain, and from the beginning of her practice, she emphasized that patients should have the support they need to live until they die (Saunders, 2001).

This concept of total pain, along with other tenets promoted by Saunders regarding the proper use of opioids to control physical pain and meeting the needs of the family caregivers of the dying, is used in hospices across the world. Saunders lectured at Yale University in 1963, presenting her specialized care for dying patients (Lutz, 2011). In 1974 the first hospice in the United States was opened in Branford, Connecticut in (National Hospice and Palliative Care Organization, 2014). That same year, the first hospice legislation was introduced to provide federal funding for hospice programs. Though the legislation was not passed that year, over the next decade the hospice movement became widely accepted as a viable means of providing quality and cost-effective care. By 1984, Joint Commission on Accreditation of Hospitals (JCAHO) had initiated a hospice accreditation, and, in 1986, a Medicare Hospice Benefit was made permanent and began reimbursing hospices (National Hospice and Palliative Care Organization, 2014).

Hospice and Palliative Care in the United States

Hospice and *palliative care* are words that are often used in tandem, and this pairing likely originates with the evolution of its practice. The "National Hospice and Palliative Care Organization" was once the "National Hospice Organization." In 2000 they changed their name to include palliative care, "as hospice care and palliative care share the same core values and philosophies" and hospices were changing their name to include "palliative care" in efforts to reflect the range of care already being provided (NHPCO, 2014a). While palliative and hospice care are connected, they are distinct levels of care.

Defining Palliative Care

In 1990, the World Health Organization (WHO) first defined palliative care as an approach that "seeks to address not only physical pain, but also emotional, social, and spiritual pain to achieve the best possible quality of life for patients and their families" (NHPCO, 2014a). Palliative care has also been defined as "patient-and family-centered care that optimizes quality of life by anticipating, preventing and treating suffering" and "involves addressing the physical, intellectual, emotional, social and spiritual needs and facilitating patient autonomy, access to information, and choice" (National Quality Forum, 2006, p. VI). A number of definitions have since circulated, but the characterizing features of the palliative care philosophy and delivery are unchanged. Palliative care includes interdisciplinary approaches to care; involves collaboration and communication between patients, families or caregivers, and health care providers; is available concurrently with curative or life-prolonging care; and supports patients' and

families' hopes for peace and dignity throughout the trajectory of the illness (NHPCO, 2015).

Proponents of palliative care advocate for the inclusion of palliative care services throughout an entire course of treatment for an illness, no matter the diagnosis. While the challenges of integrating palliative care into general medical care are acknowledged, there exists a belief that it is the right of all patients to have access to palliative care across all care settings. This need only becomes greater as a patient moves into late stages of illness or injury (National Quality Forum, 2006). Theoretically, anyone receiving medical care could receive palliative care, however palliative care is typically presented as a referral-based program in the hospital setting, reserved for patients with complex medical needs or for patients suffering from poor pain and symptom management. While palliative care is indeed provided at end of a person's life, it is not restricted to this phase; it begins with the onset of a life-threatening illness or injury and continues into a family's bereavement. Palliative care is available through the continuum of an illness; hospice care is only available at the end of life (see Figure 1).

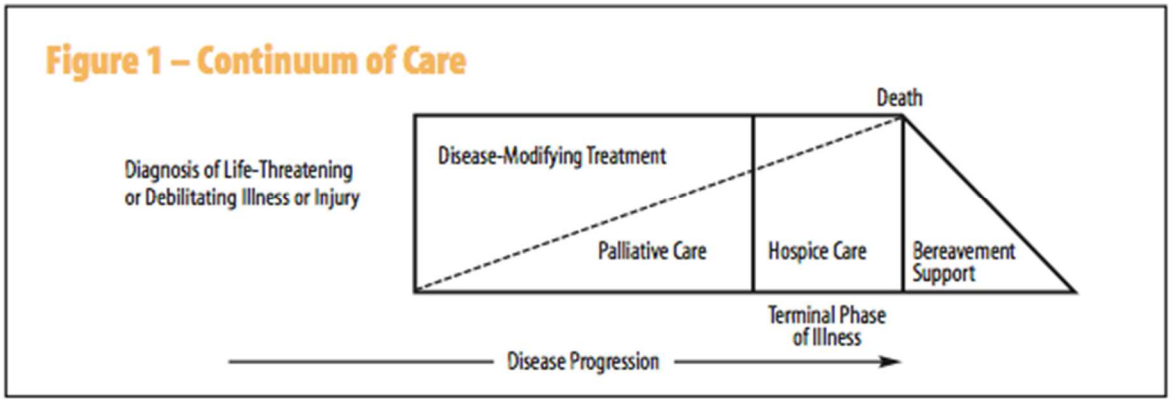

Figure 1. Continuum of Care. Reprinted from "National framework and preferred practices for palliative and hospice care" by National Quality Forum, 2006, (p. 3). Copyright [2006] © National Quality Forum. Reprinted with permission.

Defining Hospice Care

Hospice care is "a service delivery system that provides palliative care for patients who have a limited life expectancy and require comprehensive biomedical, psychosocial, and spiritual support as they enter the terminal stage of an illness or condition" (National Quality Forum, 2006, p. vi). According to the National Hospice and Palliative Care Organization (NHPCO), hospice care offers "expert medical care, pain management, emotional and spiritual support expressly tailored to the patient's wishes," which incorporates multiple disciplines, resulting in a model of quality and compassionate care (NHPCO, 2014a). Patients of all ages and diagnoses receive hospice care provided by an interdisciplinary team, which typically consists of a physician, nurse, social worker, home-health aide (for personal care), and clergy or other spiritual support counselors. Some hospices also offer other services such as music therapy or massage therapy.

In the early days of Cicely Saunders and the hospice movement, the word *hospice* was synonymous with a physical location, a home-like place where people moved to receive end of life care. Now, hospice refers to a philosophy of care as well as a service, which is provided wherever patients can be most comfortable. Though some hospice organizations have inpatient settings where patients are transferred for short-term stays should their needs require a more intensive level of care, most people receive this care in the comfort of their own home.

Hospice eligibility

While anyone could receive palliative care as part of their general medical care, there are strict guidelines for eligibility, which determine when patients are referred for hospice care. Because the majority of patients receiving hospice care are covered under

the Medicare Hospice Benefit, Medicare regulations for hospice eligibility are incorporated into standard practice. A physician refers individuals diagnosed as being in advanced or terminal stages of illness to hospice care. The referring physician must make a determination that their patient has a prognosis of six months or less to live, should the terminal diagnosis run its normal course, without life-sustaining treatment. Of course, end of life prognostication is not an exact science, and many patients can live much longer than six months. There is no limit to the total length of time a patient can receive hospice care, however all patients are re-assessed at regular intervals to determine ongoing hospice eligibility (NHPCO, 2014b).

Medicare has established guidelines for determining an end-stage prognosis. There must be evidence of disease progression as documented by worsening clinical status, symptoms, signs, and laboratory results; a decline in Karnofsky Performance Status (KPS) or Palliative Performance Score (PPS); an increase in emergency room or physician visits, or hospitalizations related to the terminal diagnosis; progression to dependence for activities of daily living (ADL's); or progressive advanced stage pressure ulcers in spite of optimal care (NHPCO, 2014c). Evidence of a patient's decline must be clearly documented throughout the hospice admission to demonstrate that the hospice diagnosis continues to be terminal and hospice-eligible. For example, Medicare provides both non-disease specific and disease-specific guidelines for Amyotrophic Lateral Sclerosis (ALS), cancer, dementia, HIV, stroke, pulmonary, heart, renal, and liver diseases (Jones, Harrington, & Mueller, 2013), and hospices must demonstrate that patients meet these criteria for end-stage advanced illness.

As is the case for other areas of healthcare, hospice organizations are continually adapting and shifting their practice according to the regulations and demands placed upon them from funding sources. Centers for Medicare & Medicaid Services (CMS) regularly revise their Conditions of Participation (CoPs), or "the health and safety requirements that all hospices are required to meet. They include a flexible framework for continuous quality improvement in hospice care and reflect current standards of practice" (CMS, 2013). While there is significant debate regarding the appropriateness of some of these regulations and whether they limit access to hospice care for patients with legitimate end of life needs (Fishman, O'Dwyer, Henderson, Asch, & Casarett, 2009; Harrold, Harris, Green, Craig, & Casarett, 2013; Lynch, 2013; McCluskey & Houseman, 2004; Moore, 2004; Rothenberg, Doberman, Simon, Gryczynski, & Cordts, 2014; Schonwetter, Soendker, Perron, Martin, Robinson, & Thal, 1998), hospice organizations must comply with regulations in order to receive and retain compensation for service rendered. Hospices also have had to adjust to continuous decreases in reimbursement, while providing the same number of services and maintaining quality care.

The Growing Field of Music Therapy in End of Life Care

Despite the challenges hospices may face in the current healthcare climate, many are providing music therapy. In my professional experience as a music therapist in a large nonprofit hospice organization, I found that hospices often use music therapy as a marketing tool and consider it an exemplification of their convictions for providing holistic, patient-centered care. Our hospice physician and medical director often advocated for music therapy to patients, caregivers, and other medical professionals, communicating its value as a worthwhile resource for meeting physical, emotional, and

spiritual needs. This sentiment is echoed throughout the field and hospices are increasingly becoming aware of the application of music therapy in this setting. While not required or reimbursed by Medicare, the inclusion of music therapy in the services available to hospice patients is becoming more prevalent. I believe this speaks to a growing recognition of the relevance of music therapy within the hospice community, given its guiding philosophies and the foundations laid by Dame Cicely Saunders, to allowing patients to live until they die and treating the total pain experiences of patients.

Though it is not clear when music therapists began working in dedicated hospice facilities, the field of music therapy originated with the work of musicians at the bedsides of veterans facing life-threatening injuries (American Music Therapy Association, 2017). Music therapists were advocates of palliative care from the beginning, understanding that music was capable of having profound effects on the physical and emotional well-being of patients. Munro and Mount (1978) offered a compelling rationale for the use of music therapy with patients at the end of life, proclaiming physical, psychological, social and spiritual benefits: "Our experience in palliative care suggests that the diversity of its [music therapy's] potential is particularly suited to the diversity of the challenges these patients present" (p. 1033).

The American Music Therapy Association (AMTA) 2014 Work Force Analysis reported that of the 1,685 music therapists responding to the survey, 109 were working in hospice settings. They were the second largest group out of the 36 work settings represented and they are working in hospices across the country (AMTA, 2014). With increased awareness and utilization of music therapy in end of life care, the opportunities continue to grow. As more music therapists are working in end of life settings, the body

of published literature has also increased. Numerous studies, papers, and several books depict the work of music therapists in end of life care. Together they create in an expansive, diverse body of literature and the need for meta-analyses and summaries has become apparent (Clements-Cortes, 2014, p. 383).

Published Reviews of the End of Life Music Therapy Literature

It has been 17 years since a comprehensive review was conducted on the extant literature on music therapy at end of life. In 2000, Krout reviewed 88 clinical case reports and 23 experimental studies, conducted from 1978-1999. He included published case studies, as well as articles, book chapters, workshops, conference sessions, continuing education courses, and other published and unpublished sources.

Krout's (2000) review organized the case reports according to cited patient goals, clinical techniques using music, and methods of data collection or measurement of effectiveness, and included narrative discussion of some of his findings. Krout (2000) identified and described 21 patient goals or problems. An overwhelming majority of reports (n=72) described expression of feelings as a goal area. Other goals often cited were relaxation (n=58), anxiety reduction (n=48), reduction of pain perception (n=36), insight (n=35), and communication (n=27). Twenty-three techniques were used across case reports. The most often used techniques were music listening (n=42), improvisation (n=26), singing (n=26), songwriting (n=26), music playing (n=21), and song choice (n=19). Finally, results indicated that authors utilized behavioral observation (n=88) primarily, and verbal self-report (n=73) as methods of data collection or measurements of effectiveness.

Krout (2000) found that most clinicians used a combination of techniques to

address multiple patient needs and goals. He concluded that the rationale for this treatment strategy is reflective of the holistic nature of hospice and palliative care. It was determined that whether in one session, or over the course of many, clinicians are not using one treatment intervention to address one clinical goal. The needs of patients vary so significantly within and among sessions, especially with disease progression, that limiting interventions would not be appropriate to meet patients' needs.

For the 23 experimental studies reviewed, Krout (2000) reported on the dependent variables, data collection methods, treatment variables, data analysis, and provided a synopsis of the results of each individual study. He did not offer a synthesis of the information, but discussed each study in narrative form.

Krout (2000) also incorporated a discussion of clinical applications, from the music therapy literature reviewed, and related literature from adjacent fields, which he found to be applicable to music therapy in hospice and palliative care settings. Krout (2000) presented a clinical manual, discussing procedures being used by music therapists, made suggestions for clinicians working in the field, including clinical practice applications, considerations for measuring and evaluating patient progress and outcomes, and conducting research. Many resources were provided, i.e. referral, assessment and evaluation forms and procedures, pain scales, assessment scales, and questionnaires.

In 2005, Hilliard published a review of empirical research literature focused on the use of music therapy in end of life care. The review included 11 studies, with over half demonstrating significant positive effects of music therapy on variables such as pain, physical comfort, fatigue and energy, anxiety and relaxation, mood, spirituality and quality of life. Hilliard (2005) asserted that this review demonstrated "the emergence of

an evidenced-based approach to the use of music therapy in hospice and palliative care" (p. 173). Though existing research at that time included many qualitative studies and perspectives, Hilliard (2005) chose to exclude the qualitative literature from his review, due to the belief that quantitative studies provided greater reliability and were more generalizable.

In 2009, Bradt and Dileo conducted a Cochrane review on music therapy for end of life care. Of the 2964 citations resulting from the search, 23 were considered for inclusion, and only five determined to meet the inclusion criteria and stringent quality assessment requirements of Cochrane reviews were included in the review. The results of the study indicated that "There is insufficient evidence of high quality to support the effect of music therapy on quality of life of people in end-of-life care" and "more research is needed" (Bradt & Dileo, 2009, p. 2). As of March 2014, this Cochrane review was withdrawn from the Cochrane library, after the authors chose not to complete a quantitative update. They argued for a mixed methods systematic review, wanting to include the excellent qualitative research that had been published in this area, but were rejected by the Cochrane Pain, Palliative, and Supportive Care Group as the editor of this Cochrane Review Group could not see the value of adding qualitative data to the review (Bradt, 2017, personal communication). This systematic review/meta-analysis was the only aggregative synthesis of the research on music therapy for end of life care at the time and is no longer available as a reference in the Cochrane library. Since 2014, McConnell, Scott and Porter (2016) have updated Dileo and Bradt's systematic review, though it was not published in the Cochrane database. In McConnell, Scott, and Porter's review, only three studies were included, and like Bradt and Dileo (2009), they were

unable to demonstrate the effectiveness of music therapy on overall quality of life. Their results suggested efficacy on reducing pain, but only minimally, given the high risk of bias found in the included research.

While Krout's (2000) publication is a useful resource for clinicians, it does not provide synthesis, critical analysis or interpretation of the literature. In addition, Bradt and Dileo's (2009), Hilliard's (2005), and McConnell, Scott & Porter's (2016) studies included only a very small portion of the literature which is not representative of the diverse body of literature on music therapy at end of life. Robust quantitative research on music therapy with clients at the end of life is under-represented, potentially because of the extremely vulnerable and fragile nature of this client population. Or, perhaps it is because the usefulness of this research paradigm in this setting is questionable, given the issues of declining health and attrition. As a result, traditional methods of review and meta-analyses are not plausible, since they do not adequately reflect the literature on music therapy at the end of life.

Qualitative research accounts for only a small percentage of the literature, which renders common methods of qualitative synthesis unsuitable. However there is an abundance of literature, i.e. quasi-experimental studies and other research not meeting Cochrane criteria, case studies, theory papers, and book chapters, which contain rich information and exemplify the important work happening in this field of music therapy. Therefore, a different type of synthesis is necessary to provide a more inclusive representation of the literature on music therapy for patients at the end of life. In the current study, I proposed an approach to synthesizing the literature that provides more

synthesis, critical analysis, and interpretation of the diverse texts focused on music therapy in end of life care.

Quantitative Research Synthesis and Evidence-based Practice

Until the last decade, researchers have focused predominately on synthesizing quantitative research, utilizing techniques of meta-analysis and systematic review. Particularly in healthcare, meta-analysis and systematic review have been used to develop standards of practice, inform policy, and have contributed greatly to *evidence-based practice*. Evidence-based practice has been defined as "the combination of evidence derived from individual clinical or professional expertise with the best available external evidence to produce practice that is most likely to lead to a positive outcome for a client or patient…, [and] is now almost institutionalized in most industrialized countries" (Pearson, 2004, p. 46). The Cochrane Collaboration has become an international leader in quantitative research synthesis, with contributors from over 120 countries.

Cochrane's number one goal is "to produce high-quality, relevant, up-to-date systematic reviews and other synthesized research evidence to inform health decision making" (Cochrane, 2013). The main output of Cochrane is the Cochrane Library and mostly consists of systematic reviews of randomized controlled trials (RCTs) of healthcare interventions. This library is accessible to everyone and is intended to inform health care practice and decision-making. Cochrane regards randomized controlled trials as the best approach to generate evidence of effectiveness.

Consequently, this quantitative research methodology rose to "a position of superiority in terms of quality and applicability to practice" (Pearson, 2004, p. 46). The past domination of quantitative research and synthesis in the evidence-base reflects the

values of the dominant research community, where qualitative research is often seen as less credible or rigorous (Pearson, 2004). "The Cochrane Group has created a hierarchy that has been endorsed by many academic institutions, and that serves to reproduce the exclusion of certain forms of knowledge production" (Holmes, Murray, Perron, & Rail, 2006, p. 185). However, Suri and Clark (2009) felt it was limiting to allow syntheses that are exclusively based upon measurable outcomes and statistical integration to exclusively inform policy and practice. They felt it important that the mainstream research community begin to embrace multiple forms of research synthesis to reflect diversity and complexity in existing research.

In 2004, Cochrane initiated the Cochrane Qualitative Research Methods Group, which has more recently become the Qualitative and Implementation methods Group. Their latest guidance project used palliative care as the case study for developing the guidance on choosing qualitative evidence synthesis methods for use in health technology assessments of complex interventions (Booth et al., 2016). Later in 2008 Cochrane included a chapter on qualitative research in their handbook for systematic reviews of interventions. They proposed that qualitative research would

> contribute to Cochrane intervention reviews in four ways: 1) Informing reviews by using evidence from qualitative research to help define and refine the question and to ensure the review includes appropriate studies and addresses important outcomes; 2) Enhancing reviews by synthesising evidence from qualitative research identified whilst looking for evidence of effectiveness; 3) Extending reviews by undertaking a search to specifically seek out evidence from qualitative studies to address questions directly related to the effectiveness review; and 4)

> Supplementing reviews by synthesising qualitative evidence within a stand-alone, but complementary, qualitative review to address questions on aspects other than effectiveness. (Noyes, Popay, Pearson, Hannes, & Booth, 2008, p. 571)

The Cochrane Collaboration does not currently support stand-alone 'supplementary' qualitative reviews; they are constrained by their focus on the 'effectiveness' of interventions. They will only accept qualitative reviews that "inform, enhance, or extend a Cochrane intervention review" (Noyes & Lewin, 2011, p. 2).

Despite Cochrane's influence and the dominance of quantitative research, there are many who advocate for a pluralistic evidence-base for health care practice (Pearson, 2004). While Pearson (2004) agreed that RCT's produce evidence of effectiveness, questions besides those merely addressing cause and effect are also important, and are being pursued in the research community. He argued that qualitative research methods are equally valid, but are largely excluded in approaches to systematic review, which make up the majority of the evidence-base for healthcare practice. At that time [2004], methods for reviewing or synthesizing qualitative evidence were still evolving and had not been given the same attention (as they have in quantitative research) by experts in qualitative approaches to inquiry (Pearson, 2004).

Qualitative Research Synthesis

In the last decade, qualitative research has become more prominent and is growing in acceptance as an important contribution to evidence-based practice. Hannes and Lockwood (2012) recognized growth in the number of published qualitative synthesis papers using several qualitative evidence synthesis methods, as well as in the number of academic and theoretical papers informing these methodologies. In a

relatively short amount of time, methods have been enhanced and refined, increasing not only the quantity, but the quality of qualitative research syntheses. In the health and social sciences literature, authors are proclaiming the need for qualitative synthesis to support clinical practice and identify directions for future research (Paterson, 2012).

In general, research synthesis methods vary according to their goals (aggregation vs. interpretation), epistemological position (realism vs. idealism), degree of iteration (none vs. extensive), and outcomes (theoretical vs. utilitarian). For each trait, methodologies exist along a continuum, and can be defined according to where they fit between each end of the spectrum. Qualitative synthesis methods may include elements of both aggregation and interpretation, but one is generally more prominent than the other. While aggregative methods list findings, combine them into themes, and provide a general description of the phenomena, findings are reported without context. Interpretive methods consider the context of individual studies, and extend aggregative data to produce new models or theories about the phenomena (Paterson, 2012). Epistemological stances range from idealism to realism, wherein idealists assume that all knowledge is constructed and realists assume they see the world the way it is (Spencer, Ritchie, Lewis, & Dillon, 2003, as cited in Paterson, 2012). The degree of iteration used in data collection and analysis further categorizes qualitative synthesis methods. Iteration refers to the process by which the researcher approaches the data, whether highly structured and fixed, or reflective and responsive to the evolving synthesis. Lastly, the intended outcomes can range from theoretical to utilitarian, in that they may be used to directly inform practice or policy. Since 2003, when only five qualitative evidence synthesis methods existed, more than a dozen methodologies have been developed and they are

each unique in their epistemological, methodological, and terminological differences (Paterson, 2012).

Initial interest in qualitative research synthesis focused on the development of methodologies to synthesize qualitative research alone. Though less attention has been given to methodologies that synthesize both quantitative and qualitative research, a few methods have emerged. These mixed method syntheses have mainly followed two broad approaches: multilevel synthesis and parallel synthesis (Flemming & McInnes, 2012). Multilevel synthesis is comprised of three separate syntheses around a particular research question: 1) a synthesis of qualitative evidence, 2) a synthesis of quantitative evidence, and 3) a combination of the products of 1 and 2. In a parallel synthesis, the quantitative evidence synthesis and the qualitative evidence synthesis are conducted as separate or linked reviews. For instance, the qualitative synthesis may be used to aid in the interpretation of synthesized RCTs. The two types lack interface among the quantitative and the qualitative literature during the synthesis process (Flemming & McInnes, 2012). Finding that lack problematic for their research needs, Dixon-Woods et al. (2006) developed a new methodology they call Critical Interpretive Synthesis, more suited for synthesizing diverse bodies of literature to explicitly integrate both quantitative and qualitative literature.

Critical Interpretive Synthesis (CIS)

Critical Interpretive Synthesis was developed by Dixon-Woods et al. (2006) during their attempt to synthesize the literature addressing the issue of access to healthcare by vulnerable groups in the United Kingdom. They found that conventional methods of systematic review were ill-suited to synthesize the diverse and complex body

of literature focused on this topic:

> It includes empirical work using both qualitative and quantitative methods; editorial comment and theoretical work; case studies; evaluative, epidemiological, trial, descriptive, sociological, psychological, management, and economics papers, as well as policy documents and political statements. "Access" itself has not been consistently defined or operationalised across the field. There are substantial adjunct literatures, including those on quality in healthcare, priority-setting, and patient satisfaction. A review of the area would be of most benefit if it were to produce a "mid-range" theoretical account of the evidence and existing theory that is neither so abstract that it lacks empirical applicability nor so specific that its explanatory scope is limited. (Dixon-Woods et al., 2006, p. 36)

They proposed a new method of synthesis, which is sensitized to conventional systematic review, but draws on a distinctive tradition of qualitative inquiry and interpretive approaches to review, especially meta-ethnography.

The original methodology Dixon-Woods et al. (2006) intended to use was, in fact, meta-ethnography. At that time, meta-ethnography had been widely published, but was used solely for the purposes of synthesizing qualitative research, and with small samples. Eventually, the researchers had made so many amendments and additions made to the meta-ethnography methodology, that they felt it more appropriate to create a new methodology, with its own title and processes. They borrowed two major strategies of meta-ethnography: lines-of-argument synthesis and refutational synthesis (see Chapter 3) and aspects of conventional systematic review methods to create an approach to review.

Critical Interpretive Syntheses Published 2006-2015

CIS has primarily been used in health care settings to date. An extensive search of studies utilizing this methodology revealed that 30 works—journal articles, book chapters, and dissertations—had been published just since 2010, in addition to Dixon-Woods et al.'s (2006) seminal study. The use of this methodology increased significantly from 2012 to 2015. While authors varied according to their level of adherence to the methodological procedures set forth by Dixon-Woods et al. (2006), there was consensus among researchers regarding the ability of CIS to synthesize large and methodologically diverse bodies of literature. Table 1 includes characteristics of each published CIS from 2006-2015: country, field of study, focus of the research and/or research questions, and the synthesizing argument/constructs or conclusions.

Based upon the studies retrieved in this search, CIS has been utilized exclusively in Europe and North America, with the majority in the United Kingdom (n=14). Other countries represented are the United States (n=6), Canada (n=7), Norway (n=1), Finland (n=1), Australia (n=1), and Belgium (n=1). CIS has been used to synthesize research in a number of areas. Represented areas of study are general healthcare policy and procedures (n=10), geriatrics (n=3), mental health (n=3), nursing (n=2), cancer care (n=2), end of life care (n=2), social services (n=2), occupational science (n=1), autism spectrum disorders (n=1), library and information science (n=1), higher education (n=1), critical information literacy (n=1), sport psychology (n=1), and music (n=1).

It is not surprising that the greatest number of CISs were conducted to answer questions regarding general healthcare policy and procedures (Boyko, 2010; Boyko, Lavis, Abelson, Dobbins, & Carter, 2012; Entwistle, Firnigi, Ryan, Francis, & Kinghorn,

2012; Heaton, Corden, & Parker, 2012; Kelly & Maden, 2015; Keygnaert et al., 2014; Moat, Lavis, & Abelson, 2013; Wilson et al., 2014), following the focus of Dixon-Woods et al.'s (2006) originating work. Like Dixon-Woods et al. (2006), five CISs were focused on the study of inequalities within the health care system (Entwistle et al., 2012; Gysels et al., 2012; Heaton et al., 2012; Kelly & Maden, 2015; Keygnaert et al., 2013. Others focused on processes informing health care decisions and policy making (Boyko, 2010; Boyko et al., 2012; Moat et al., 2013; Wilson et al., 2014).

Three CISs focused on geriatric care (Manthorpe & Illife, 2010, 2011; Thuné-Boyle, Iliffe, Cerga-Pashoha, Lowery, &Warner, 2012). Thuné-Boyle et al. (2012) synthesized the evidence related to physical activity programs for people with dementia, and its effect on behavioral and psychological symptoms of dementia. Manthorpe and Illife (2010; 2011) dedicated two studies to the incidence of suicide in older adults. While the first study was initiated to shed light on the potential for prevention of suicide in later life and the public health practice surrounding this topic (Manthorpe & Illife, 2010), the second study focused on the role of social work in suicide prevention in older adults (Manthorpe & Illife, 2011). For both studies, Manthorpe and Illife (2010; 2011) praised the subjectivity of CIS: "Given the need to guide practice and policy we see this method as a way of bringing practitioner and policy-maker perspectives to bear on the problem of contextualization in systematic reviews, we consider this subjectivity as a strength, because it promotes debate about practical action" (2010, p. 1235).

Table 1

Characteristics of Critical Interpretive Syntheses Published 2006-2015

Document	Country	Field of Study	Purpose/Aim of Research	Synthesizing Construct/Argument or Conclusions
Dixon-Woods, M. et al. (2006)	UK	General healthcare policy and procedures	To offer a critique of the tendency to use measures of utilization as a means of assessing the extent to which access to healthcare is equitable and to explore alternate ways to understand access to healthcare by vulnerable groups.	Candidacy. Describes the ways in which people's eligibility for medical attention and intervention is jointly negotiated between individuals and health services. Candidacy is a dynamic and contingent process, constantly being defined and redefined through interactions between individuals and professionals, including how "cases" are constructed.
Flemming, K. (2010)	USA	Cancer Care (Pain)	To establish how the recommendations for use arising from the effectiveness literature reflected patients', carers', and healthcare professionals' perceptions of using morphine, and how these perceptions may influence recommendations for practice.	Control of cancer-related pain was a mediating factor through 4 synthetic arguments: 1) opioids and opioid concern, 2) using opioids is a balancing act and trade off, 3) the existential meaning of cancer and cancer pain, 4) the intersubjectivity of pain.
Boyko, J. (2010)	Canada	General healthcare policy and procedures	To develop a model that describes the key features and intended effects of deliberative dialogues used as a knowledge translation and exchange (KTE) strategy and to understand how deliberative dialogues used as a KTE strategy can support evidence-informed health system policymaking.	Capacity building: helps to explain the relationships between key features and intended effects of deliberative dialogues when the aim is KTE.
Manthorpe, J. (2010)	UK	Geriatrics (Psychiatry)	To synthesize the literature addressing suicide in later life, in order to shed light on the potential for prevention and practice from public health perspectives.	While the majority of older people who commit suicide have major depression, suicide seems to be due to a combination of personality factors and co-morbidities, including chronic pain and disablement. There is little information about the involvement of older people in risk reduction or about harm minimization approaches at patient and public participation levels.

Table 1

continued

Document	Country	Field of Study	Purpose/Aim of Research	Synthesizing Construct/Argument or Conclusions
Manthorpe, J. & Iliffe, S. (2011)	UK	Geriatrics (Social Work)	What is the role of social work in suicide prevention in older adult?	CIS revealed three problems: 1) a scarcity of research that takes a system-wide approach to suicide prevention in later life; 2) a dearth of evidence about the social work contribution to reducing the risk of suicide in later life; and 3) a noticeable absence of reference to social work practice in national guidelines for mental health practitioners.
Talseth & Gilje (2011)	Norway	Nursing (Suicide)	To provide an inclusive understanding of nurses' responses to suicide and suicidal patients that can benefit nursing practice and guide research.	Four key concepts—critical reflection, attitudes, complex knowledge/professional role responsibilities, desire for support services/resources—can serve as a useful guide for nurses to understand their own and other nurses' responses to caring for suicidal patients in various settings.
Morrison, L. et al. (2012)	UK	E-health interventions	To develop a conceptual framework to define the range of design features that could be used to deliver the content of health interventions delivered using the Internet. The purpose of developing this conceptual framework is to permit analysis of how specific feature(s) of intervention design may influence health-related outcomes.	Four core interactive design features were identified that may mediate the effects of intervention design on outcomes: social context and support, contacts with intervention, tailoring, and self-management. A resulting proposed conceptual framework provides a guide for systematic research to identify the effects of specific design features on intervention outcomes and to identify the mechanisms underlying any effects.

Table 1

continued

Document	Country	Field of Study	Purpose/Aim of Research	Synthesizing Construct/Argument or Conclusions
Gysels, M. et al. (2012)	UK	End of Life Care (EOL)	To appraise the evidence regarding all stakeholders' views and experiences regarding involvement in palliative care research and to explore whether there are best practices regarding participation in research.	Ethical concerns regarding patient participation in EoL care research are often unjustified. However, research studies in EoL care require careful design and execution that incorporates sensitivity to participants' needs and concerns to enable their participation. An innovative conceptual model for research participation relevant for potentially vulnerable people was developed.
Entwistle, V. et al. (2012)	UK	General healthcare policy and procedures	To identify the range of experiences of health care delivery that matter to patients and produce a conceptual map to facilitate consideration of why they matter.	The characteristics and actions of health care services and staff, and the ways they relate to patients, have implications for patients' experiences of being enabled (or not) to feel, be and do what they value feelings, being and doing, in the course of their health care contacts and beyond.
Heaton, J. et al. (2012)	UK	General healthcare policy and procedures	To confirm or further refine the conceptual model of continuity of care developed and elaborated by Freeman and colleagues.	Patients' and carers' experiences of continuity of care are what counts. Continuity of care is multi-dimensional. Processes and outcomes of continuity of care are both important.
Boyko, J. et al. (2012)	Canada	General healthcare policy and procedures	same as Boyko (2010)	same as Boyko (2010)

Table 1

continued

Document	Country	Field of Study	Purpose/Aim of Research	Synthesizing Construct/Argument or Conclusions
Thuné-Boyle, I. et al. (2012)	UK	Geriatrics (Psychiatry)	To examine the current understanding of the efficacy of physical activity programs for people with dementia in relation to various outcomes: psychological, behavioral, and mood and sleep disruptions.	Exercise appears to be beneficial in reducing some behavioral and psychological symptoms of dementia (BPSD), especially depressed mood, agitation, and wandering, and may also improve night-time sleep. No synthesizing argument reported.
Bales, S. & Gee, C. (2012)	USA	Library and information science	To identify current trends in the subject area to further develop a library collection for students and researchers/What are the characteristics of current research in journalism and popular culture?	Engaging in dialectical praxis—on understanding how institutions act to define realities or how these structures and relationships inform and result in practices of resistance. Related to three major categories: 1) bounding the discipline, 2) constructing social realities, and 3) reconstructing realities.
Daker-White, G. & Rogers, A. (2013)	UK	Mental Health	To examine the processes of engagement and perceived relevance and appropriateness of tele-health interventions for people with a diagnosis of schizophrenia.	People with a diagnosis of schizophrenia or psychosis use the Internet primarily for the purposes of disclosure and information gathering. Empowerment, regulation and surveillance emerged as the key dimensions of engagement (or not) with tele-health interventions.
Hock, R. & Mooradian, J. (2013)	USA	Social work	To increase the utility of the co-parenting literature for application to social work practitioners. Specific aims were (1) to synthesize existing literature into a clear conceptual definition of co-parenting and its components and (2) to provide suggestions for social work practice directed toward enhancing co-parenting in diverse families.	Co-parenting is the process through which two or more adults provide conjoint caregiving for one or more children for whom they share responsibility. Co-parenting encompasses components that include degrees of parental harmony, boundary preservation, parental connection, and reciprocal caregiving.

Table 1

continued

Document	Country	Field of Study	Purpose/Aim of Research	Synthesizing Construct/Argument or Conclusions
Kazimierczak et al. (2013)	UK	Cancer Care	To synthesize the literature related to provision of information in the support of cancer patients and to engage in critical reflection on the concepts underlying approaches to information provision.	A concept of cancer information provision should be seen as a "support for navigating the knowledge landscape," which recognizes the diverse, changing and relational nature of patients' values, needs and preferences. It promotes a view of information provision as an ongoing and flexible process of navigating different resources, which in turn supports the navigation of patients' broader experiences of their health and care.
Keygnaert et al. (2013)	Belgium	General healthcare policy and procedures	To explore the current European policy frame on European Union migrants' sexual reproductive health (SRH) and whether it is consistent with a rights-based approach to healthcare.	There is a discrepancy between a proclaimed rights-based approach to health and actual obstacles to migrants' attainment of good SRH. Uncertainties on entitlements of diverse migrant groups are fuelled by unclear legal provisions, creating significant barriers to access health systems in general and SRH services in particular. No synthesizing argument reported.
Mackenzie et al. (2013)	UK	Social Services	To assess the fit of 'candidacy' (Dixon-Woods et al., 2006) to other public services using a CIS of three case studies literatures relating to: domestic abuse, higher education and environmental services.	High levels of congruence between 'candidacy' and the sampled literatures on access/ utilization of services but the concept needs to be refined. In particular, distinguishing between micro, meso and macro factors play into the identification, sustaining and resolution of candidacy, and demonstrate the plural nature of candidacies.

Table 1

continued

Document	Country	Field of Study	Purpose/Aim of Research	Synthesizing Construct/Argument or Conclusions
Markoulakis & Kirsh (2013)	Canada	Mental Health	To synthesize the literature on the academic challenges and experiences of university students with mental health problems, in order to generate a theory of their difficulties in the university setting.	Three synthetic constructs: internal difficulties, external difficulties, and academic outcomes. Internal difficulties were comprised of physical, psychological and social domains, while external difficulties consisted of those posed by structural difficulties and stigma.
McFerran et al. (2013)	Australia	Music (and adolescent mental health)	To generate an organizing framework that critically synthesizes the literature across the fields of social psychology, music psychology, music therapy, and music education, linking music and adolescent mental health.	Decisions related to research design, assessment of health, and the nature of musical engagement have predictably influenced study outcomes. Studies have been limited by the collection of insufficient detail about the full range of individual's musical behaviors. There has been inadequate triangulation of health outcomes solicited from a variety of perspectives.
Moat et al. (2013)	Canada	General healthcare policy and procedures	To examine the ways in which context- and issue-related factors influence the perceived usefulness of evidence briefs among their intended users.	Many types of "evidence" are viewed as useful content in an evidence brief, along with several formatting features. Contextual factors can influence views of evidence briefs. Polarity, saliency, and familiarity can influence views of evidence briefs prepared for that issue. Influential factors affect the users or the producers of briefs, and they influence views of evidence briefs through a variety of mechanisms.

Table 1

continued

Document	Country	Field of Study	Purpose/Aim of Research	Synthesizing Construct/Argument or Conclusions
Farrelly & Lester (2014)	UK	Mental Health	To determine the current understanding of the Therapeutic Relationships (TRs) between individuals with psychotic disorders and their clinicians in community case management settings.	Three key components of beneficial TRs were identified: mutual trust, demonstration of mutual respect and shared decision-making. Such interactions are difficult to achieve in routine practice.
Kangasniemi et al. (2014)	Finland	Nursing	To synthesize previous studies of environmental issues in nursing science by using Critical Interpretive Synthesis (CIS).	Environmentally responsible nursing can be identified in relation to the: (1) theoretical framework (ecology and environmental health); (2) background arguments; (3) the role of responsible stakeholders; and (4) the targets of environmentally important areas of responsibility.
McDonough (2014)	USA	Critical information literacy	To uncover pedagogy and instructional content to inform personal teaching practice and that of other individual teaching librarians who wish to take a critical approach to information literacy with undergraduate students.	No clear synthesizing argument. Most criticize traditional approaches to information literacy. Traditional information literacy is overly-focused on tools and skills and presents an overly- simplistic model of the research process that is out of synch with the realities of research in this subject.
Schroerlucke (2014)	USA	Sport Psychology	Explored the question of what differentiates individuals whose performance tends to be impaired by pressure (choke artists) from those who are consistently able to perform optimally under pressure (clutch performers).	Critique of the field's positivistic approach, which has produced a fragmented and ambiguous literature pervaded by enduring difficulties across the domains of conceptualization, research, theory, and practice. Synthesis organized around the theme of advocating for a more balanced and integrative approach to both inquiry and intervention that honors the inevitable role of subjectivity in the pressure-performance relationship.

Table 1

continued

Document	Country	Field of Study	Purpose/Aim of Research	Synthesizing Construct/Argument or Conclusions
Raymond et al. (2014)	UK	End of Life Care	To provide a synthesis of the concerns and challenges for carers at the end of life.	No clear synthesizing argument. A range of perspectives provide contrasting views of the heterogeneity of carers and professionals. Themes discussed: wishes and rights, symptom control, place of care, food and drink, elder abuse and neglect, spirituality, traditions and culture, being a family member or carer, and grief.
Sirkis (2014)	USA	Higher Education	To study the role of the college department chair and discern the knowledge, skills, and abilities that chairs should possess and how they are best learned.	Only able to obtain abstract. Findings not reported.
Wilson et al. (2014)	Canada	General healthcare policy and procedures	To gain further understanding about whether, how, and under what conditions health systems decide to pursue disinvestment, how health systems have chosen to undertake disinvestment; and how health systems have implemented their disinvestment approach.	Paper was a protocol, CIS not yet carried out.
Farias & Rudman (2015)	Canada	Occupational Science	To explore how "critical" has been defined in the literature and how critical perspectives are being utilized to inform occupational science.	1) Turning the lens inward: deconstructing foundations and pushing boundaries, 2) Turning the lens outward: Situating occupation in relation to power and fore-fronting issues of inequity and injustice, 3) Pushing for a broader agenda: Expanding beyond knowledge generation and critical questioning to transformation.

Table 1

continued

Document	Country	Field of Study	Purpose/Aim of Research	Synthesizing Construct/Argument or Conclusions
Kelly & Maden (2015)	UK	General healthcare policy and procedures	To explore the literature in relation to health care professionals' beliefs and perceptions of oxygen therapy in order to provide a platform for further investigation.	Synthetic constructs: oxygen for symptom relief, levels of knowledge and understanding and oxygen as a therapy for health care professionals. The literature alludes to deep-seated beliefs that exist and in order to enhance practice, these beliefs and cultures need to be challenged.
Nicholas et al. (2015)	Canada	ASD	To identify studies addressing employment supports in Autism Spectrum Disorders, including studies that examine employment acquisition and retention.	Two domains of vocational intervention in the literature were found: supported employment including community placement and job coaching and media and technology–based augmentative tools.

Another CIS focused on suicide, but from a nursing standpoint. Talseth and Gilje (2011) wanted to provide an inclusive understanding of nurses' responses to suicide and suicidal patients. Though they found gaps existing in the international literature, they felt they were able to contribute a more inclusive view of nurses' responses to suicide and suicidal patients and a way of guiding nurses in clinical practice. According to Talseth and Gilje (2011), the CIS approach moved knowledge beyond aggregate data to a deeper level of understanding, while remaining research-based.

In related fields, the CIS methodology has been used in mental health (Daker-White & Rogers, 2013; Farrelly & Lester, 2014; Markoulakis & Kirsh, 2013) and in social services (Hock & Mooradian, 2013; Mackenzie, Conway, Hastings, Munro, & O'Donnel, 2013). Markoulakis and Kirsh (2013) implemented the first CIS in the methodologically diverse mental health research. They found CIS methodology to be an advantageous method for their review, enabling them to develop a theoretical account of the difficulties experienced by university students with mental health problems and a critique of their representation in the literature. This synthesis provided great insight into the needs of college students with mental health problems, contributing factors to and sources of their difficulties, and encouraged a focus on prevention of student difficulties through mitigating their sources. Markoulakis and Kirsh (2013) believed CIS could be useful in future reviews of mental health research.

Two additional CISs were published in mental health following Markoulakis and Kirsh's (2013) initial publication. In the same year, Daker-White and Rogers (2013) looked at the use and potential of 'telehealth' interventions—interventions involving the use of telephones, networked computers, handheld devices (including mobile phones) and

any experimental 'stand alone' monitoring or communication devices—for people with schizophrenia. Later, Farrelly and Lester (2014) explored the therapeutic relationships between mental health service users with psychotic disorders and their clinicians. Interestingly, following the completion of Daker-White and Rogers (2013) CIS, a related Cochrane review and a narrative review were published. These subsequent studies concluded that there was a weakness of evidence on efficacy of interventions utilizing information technology in mental health services. However, Daker-White and Rogers (2013) found that the results of the CIS were more useful, in that they were able to identify actual factors or issues to be investigated in future studies.

Non-health care related studies were few (Bales & Gee, 2012; Farias & Rudman, 2014; Nicholas, Attridge, Zwaigenbaum, & Clark, 2015; McDonough, 2014; Schroerlucke, 2014; Sirkis, 2014), however their contributions speak to the versatility and advancement of this synthesis methodology. Three of these were doctoral dissertations, which demonstrates that this type of synthesis is an intensive process and ambitious undertaking and scholars are finding utility in CIS and its resourcefulness to synthesize expansive, complex bodies of literature.

Of particular interest to the present study were the CISs focused on cancer pain (Flemming, 2010), end of life care (Raymond et al., 2014; Gysels, Evans, & Higginson, 2012) therapeutic relationships (Farrelly & Lester, 2014), and music and adolescent mental health (McFerran, Garrido, & Saarikallio, 2013). Flemming (2010) was the first author to synthesize a body of literature using CIS following Dixon-Woods et al.'s (2006) initial publication. She used the method to examine the practice of using morphine to treat cancer-related pain. Flemming (2010) found that she was able to integrate 19

qualitative studies with the existing Cochrane effectiveness review on the same topic. Using an integrative grid, she showed how the qualitative findings fit with the recommendations from the quantitative research and found that the qualitative review addressed issues wider than those specifically mapped by the effectiveness review. For this reason, it was important that the qualitative research be incorporated into the overall synthesis. Because of the clear descriptions of the analysis process and the specificity with which she reported results, her study proved to be a useful resource.

Similarly, the two CISs focused on end of life care (Gysels et al., 2012; Raymond et al., 2014) offered an example of how literature synthesis has been approached. Gysels et al. (2012) conducted an interesting CIS on views and experiences regarding involvement in palliative care research. They also explored best practices for research participation at end of life. Concerns regarding the ethics of patient participation in end of life care research are common, however the researchers found that these concerns are often unjustified; "Patients are generally willing to contribute to research and the majority of those who take part in research report it as a positive experience. Patients confirm that it brings them direct benefits" (p. 139). There existed only a small number of people who experienced distress, and for whom extreme sensitivity was required. Gysels et al. (2012) found that research needs to be flexible and equipped with methods that enable patients and caregivers to safely participate in research, and offer a model for conducting 'research with care.' They also contend that assuming patients are too vulnerable and denying their opportunity to participate in research is paternalistic and unnecessary.

Raymond et al. (2014), who focused on of the concerns and challenges for caregivers of persons with dementia at the end of life, did not provide a clear picture of

the process of synthesis, nor did they report synthesizing constructs or arguments. It is possible that their decision to include both professionals' and family caregivers' opinions and experiences of palliative care for a person with dementia proved to be too distinctly different and therefore difficult to synthesize. In contrast, this diversity was not problematic for Farrelly and Lester (2014), who approached the topic of therapeutic relationship and were able to incorporate all stakeholders' perspectives.

Farrelly and Lester (2014) identified synthesizing constructs that represent components of beneficial therapeutic relationships (mutual trust, demonstration of mutual respect, and shared decision-making) and found that these constructs exist in polarities. The polarization was generated by a fundamental ambiguity in the purpose of the therapeutic interaction, creating a synthesizing argument of *goal ambiguity.* In an earlier publication, for which only the abstract was available but the same topic was addressed, Farrelly and Lester (2011) stated that CIS was particularly useful for synthesizing diverse literature involving complex phenomena such as therapeutic relationships. It was clear in this paper that the community mental health setting and therapeutic relationships developed within, are indeed complex. Influenced by policy, norms, and further complicated by mental illness, the development of therapeutic relationships is multi-dimensional and requires careful examination. The same could be said for the therapeutic relationships developed in end of life settings.

As of 2015, the only CIS specific to music therapy research was McFerran et al.'s (2013) study of the literature linking music and adolescent health. McFerran et al. (2013) reviewed the research across the fields of social psychology, music psychology, music therapy and music education to study the relationship between music and youth mental

health. The researchers found value in the characteristics of CIS that allow for integration of "findings from potentially diverse studies and disciplines into a single, coherent framework" (p 2). This process of integration values a range of epistemological stances and attempts to avoid common assumptions and biases. This ability of CIS to challenge assumptions and biases was significant for this synthesis that spanned several disciplines and was focused on a topic provoking much debate. McFerran et al. (2013) initiated the application of CIS to music therapy research and demonstrated its value as a method for synthesis. Since 2015, McFerran has co-authored two additional studies using the CIS methodology (Medcalf & McFerran, 2016: McFerran, Hense, Medcalf, Murphy & Fairchild, 2017), demonstrating her support of the application of CIS to the music therapy literature.

Reviewing the published CISs demonstrated that the method is versatile in its ability to synthesize expansive, complex bodies of literature, as well as complex phenomena. Embedded in this approach is a range of epistemological stances, which may help to avoid common assumptions and biases. CIS is able to move knowledge beyond aggregate data to a deeper level of understanding, while remaining research-based. In addition, coherent frameworks can be constructed from potentially diverse literature and/or disciplines.

Purpose of the Study

The purpose of this study was to provide a critical interpretive synthesis of the body of literature focused on music therapy at the end of life. This study provides an interpretive review of the research published in this area of music therapy practice. The intent was not to provide a how-to or exhaustive summary of music therapy for hospice

practitioners, but a critical interpretation of the theoretical underpinnings present across the literature. The output is a synthesizing argument, which takes the form of a coherent theoretical framework, comprised of a network of constructs and the relationships between them. This framework links new constructs generated through the synthesis to existing constructs present in the literature. The purpose in developing this synthesis was to provide a useful resource for music therapists, for clinical practice and research, and further inform the healthcare community.

Research Questions

As described previously, specific research questions in the CIS methodology are not identified *a priori* (Flemming 2010); to do so would limit the aim of the study. Rather, research questions are relatively broad, without specific hypotheses and are continually refined throughout the study in response to the search results and findings from retrieved literature. This process is explicit in its intention to be highly iterative, allowing the definition of the phenomenon to emerge from the in-depth, reflexive analysis of the literature (Dixon-Woods et al., 2006; Flemming, 2010).

The broad research question to begin this CIS of end of life music therapy literature was:

- What is the essence of the music therapy experience at the end of life, as it is explained across the literature?

CHAPTER 3

METHOD

Procedure

Dixon-Woods et al. (2006) developed an innovative method of synthesis built upon conventional systematic review methodology and traditional qualitative traditions of research inquiry. CIS is distinguished from conventional systematic reviews in its rejection of a linear, fixed stage approach to the review. While there are specific processes in place for approaching the review, the method is intended to be qualitative in its approach: "iterative, interactive, dynamic, and recursive rather than as fixed procedures to be accomplished in a pre-defined sequence" (p. 43). There is a need for flexibility in this type of review, with ongoing critical orientation to the material and emerging theoretical ideas. The procedure included all phases set forth by Dixon-Woods et al. (2006): literature search, sampling, determination of quality, data extraction and analysis, and conducting the interpretive synthesis. The procedure was not linear and sequential, rather interactive and recursive. A brief synopsis of the procedure is provided in Table 2.

Table 2

Synopsis of the CIS procedure

Literature Search: organic process fitting with the emergent and exploratory nature of the review questions; the purpose of the searching phase was to identify potentially relevant papers to provide a sampling frame.
Paper Selection and Inclusion: determined selection (inclusion/exclusion) criteria, used purposive and theoretical sampling to select papers, and assessed quality of empirical literature for potential inclusion
Data Extraction and Analysis: proforma used to extract summary information for each potential document; Open and axial coding used to develop themes/categories; continued until theoretical saturation was reached
Conducting the Interpretive Synthesis: lines of argument synthesis and refutational synthesis (techniques of meta-ethnography) used to build synthetic constructs and produce a synthetic argument, or an integrative, coherent theoretical framework

Search of the Literature

The purpose of the searching phase in CIS is to develop a sampling frame. This approach to searching the literature is a clear divergence from the explicit, reproducible and exhaustive nature of conventional systematic review (Dixon-Woods et al., 2006). Dixon-Woods et al.'s (2006) search generated over 100,000 records. While the end of life music therapy literature is extensive by music therapy research standards, it does not compare to the bodies of literature in other areas of healthcare. Therefore, this search was more manageable and did not require the same amount of scrutiny for initial consideration of inclusion. All literature, including but not limited to quantitative and qualitative research, theory papers, book chapters and case studies, was considered potentially relevant for this synthesis.

The search of the literature combined a number of strategies and was an organic process, fitting with the emergent and explanatory nature of CIS. The search strategy included a search of electronic databases—Medline, CINAHL, Psychinfo via Ebscohost and Proquest—using the following key words: music therapy, hospice, palliative care, end of life, death, and dying, for literature published between 1977 and 2016. I also utilized reference chaining and hand searched the following journals: *Music Therapy Perspectives, Journal of Music Therapy, The Nordic Journal of Music Therapy, The Canadian Journal of Music Therapy, The British Journal of Music Therapy, Music and Medicine, Journal of Palliative Care, American Journal of Hospice and Palliative Medicine, Palliative and Supportive Care, Supportive Care in Cancer, The Arts in Psychotherapy*. Several books are published on the topic (Lee, 1994; Aldridge, 1999; Dileo & Loewy, 2005; Sekeles, 2007), and each chapter within those was considered for

inclusion. Several case study books have been published in music therapy (Bruscia, 1991; Hadley, 2004; Meadows, 2011; Bruscia, 2012), and each case study addressing this population was considered for inclusion. The resulting combination of formal and informal search strategies allowed for identification of multiple and varied sources of potentially relevant literature.

Paper Selection and Inclusion

The search of electronic databases produced over 1,500 results. These results were sorted by relevance and after examining about 90 of the documents, and their relevance was becoming increasingly less appropriate for this study. At this point, I began hand searching the journals listed above and reference chaining. I reviewed the abstracts of 145 relevant papers and entered ones that were of interest to this study into a spreadsheet, later used in data extraction. The following inclusion criteria were applied:

1) quantitative and qualitative research must be conducted by a music therapist;
2) papers, i.e. theoretical, case studies, book chapters, etc., must be written by a music therapist;
3) papers must address music therapy at the end of life, in hospice or palliative care settings; and
4) papers must be originally written in, or have accessible English translations.

The following exclusion criteria were also applied:

1) existing syntheses, literature reviews, and meta-analyses will not be included;
2) abstracts will not be included;
3) music therapy with children at the end of life will not be included; and
4) papers strictly focused on caregivers will not be included.

The final two exclusion criterion were not a part of the initial proposal, but added shortly after my literature search began. I quickly decided that I would not include children in this synthesis, as it was clear to me from my own practice and from the literature that the practice of music therapy with adults at end of life is distinctly different from that of children at end of life. The trajectories of terminal illnesses and treatment approaches, including palliative and hospice care, are markedly different in the cases of children. For instance, children with a cancer diagnosis, though they may be in the end stage of the illness, often will not be admitted to hospice care until days, or even hours before death. Healthcare providers and caregivers are rarely willing to abandon curative treatment until the last possible moment. Consequently, it did not make sense to me to synthesize the literature from these two very different practices.

I also decided to exclude literature that strictly focused on caregivers of patients in hospice or palliative care and only consider papers that discussed caregivers' needs within the context of the music therapy relationship and process with the patient. Music therapy with caregivers outside of the context of the patient, and music therapy in grief/bereavement are very different from music therapy practice with patients at end of life and would not fit with the focus of this synthesis.

Upon initial inspection, twenty-seven documents did not meet inclusion criteria (see Table 3). The 118 remaining documents were considered for inclusion in the synthesis.

Sampling

In lieu of tightly specified inclusion criteria as in systematic review, CIS incorporates sampling. Because the focus of CIS is on the development of concepts and

theories underlying a phenomenon through a critical interpretation of the literature, and not an exhaustive summary of the data, sampling is theoretically warranted. The sampling process is a dialectic one and is conducted parallel to theory generation. Dixon-Woods et al. (2006) incorporated *purposive sampling* to initially select papers and later used *theoretical sampling* to add, test, and elaborate on their emerging analysis.

Purposive sampling is often used in qualitative research. It is a strategic sampling, where choices are made according to the nature of the research objectives and the context in which researchers are working (Palys, 2008). The researcher applies expert knowledge of the subject to select the most representative sample. For studies involving participants, those with particular characteristics may be chosen to meet the needs of the evolving analysis (Morse, 2004). For a literature synthesis, purposive sampling involves choosing a portion of the literature that is broad and representative of the topic, but not necessarily exhaustive (Dixon-Woods et al., 2006).

Theoretical sampling was first significantly explained by Glaser and Strauss (1967) and is considered a part of the Grounded Theory approach to qualitative inquiry. Theoretical sampling involves an analytical process of decision making in data collection. Parameters for the sample are not set at the onset of the research process, but are developed once the researcher has immersed herself in the phenomenon under study. Data which can be compared or differentiated, and contribute to conceptualization of the topic, are chosen for the study. "The use of theoretical sampling forces the researcher into new directions, stretching the diversity of data gathered for the purpose of developing concepts and theories" (van den Hoonaard, 2008, para. 5).

Table 3

Documents Not Meeting Inclusion/Exclusion Criteria

Document	Design	Reason for exclusion
Fagen (1982)	Theory paper	Children
Ridgeway (1983)	Theory paper	Not written by MT
Curtis (1986)	Experimental, single subjects	Not music therapy
Loyst (1989)	Theory paper	Focus on caregivers
Lane (1989)	Theory paper	Hospice or palliative care not mentioned
O'Connor (1989)	Theory paper	Not written by MT
Porchet-Munro (1994)	Theory paper	Not music therapy
O'Neil (1994)	Theory paper	Focus on caregivers
Finlayson (1999)	Theory paper	Not music therapy
Krout (2000)	Literature review	Literature review
Hilliard (2004)	Survey study	Not music therapy
Hilliard (2005)	Literature review	Literature review
Mondanaro (2005)	Theory paper	Children
Hanser (2005)	Theory paper	Hospice or palliative care not mentioned
Edwards (2005)	Theory paper	Children
Lindenfelser, Grocke, & McFerran (2008)	Phenomenology	Children
O'Callaghan (2009)	Literature review	Literature review
Leow, Drury, & Poon (2010)	Qualitative approach using Burnard's thematic analysis	Literature review
McFerran & Shanahan (2011)	Descriptive	Children
Logis (2011)	Theory paper	Not written by MT
O'Callaghan, Hudson, McDermott & Zalcberg (2011)	Grounded theory	Focus on caregivers
Lindenfelser, Hense, & McFerran (2012)	Mixed Methods	Children
Bowers & Wetsel (2014)	Literature review	Literature review
Warth et al. (2015)	Theory paper	Not music therapy
O'Callaghan et al. (2016)	Meta-ethnography	Meta-analysis
Clements-Cortés (2016)	Literature review	Literature review
McConnell, Scott, & Porter (2016)	Systematic review	Systematic review

Following the guidelines set forth by Dixon-Woods et al. (2006), I incorporated both purposive and theoretical sampling to ground the synthesis. Literature searching and sampling continued iteratively throughout the study as I identified themes and categories, and continued until I felt theoretical saturation was reached. Once the data no longer required amendment of theoretical categories, searching and sampling was complete.

Determination of Quality

Relevance takes precedence over quality assessment in CIS methodology. This is not to say that quality is not important in this approach to synthesis, but the strict quality assessment and hierarchical view of evidence in conventional systematic review, which may discount important work, is not seen as desirable. Dixon-Woods et al. (2006) "felt it important, for purposes of an interpretive review, that a low threshold be applied to maximize the inclusion and contribution of a wide variety of papers at the level of concept" (p. 38). Therefore, only papers that were appraised low *and* were determined to be low in relevance were excluded in their review. While some studies may be considered weak according to methodological quality standards, they could have high relevance to the topic, and may be especially important to the synthesis.

To assess the quality of quantitative and qualitative research studies, I applied the quality appraisal prompts utilized by Dixon-Woods et al. (2006). Each study's inclusion in the synthesis was determined both by the quality assessment and its relevance to the analysis and emerging theoretical constructs. The quality appraisal prompts were:

1) Are the aims and objectives of the research clearly stated?
2) Is the research design clearly specified and appropriate for the aims and objectives

of the research?

3) Do the researchers provide a clear account of the process by which their findings were reproduced?
4) Do the researchers display enough data to support their interpretations and conclusions?
5) Is the method of analysis appropriate and adequately explicated?

Papers determined to be of low quality were further considered according to their relevance for the emerging synthesis. Dixon-Woods et al. (2006) stressed the importance of deferring judgments of credibility and contribution until a synthesis is well-developed. For non-empirical literature, the quality appraisal prompts are not applicable, and were considered for their contribution on a conceptual level, as suggested by Dixon-Woods et al. (2006).

Data Extraction and Analysis

I began with a detailed inspection of each paper, using a proforma to document a summary of information for each considered document on: methodology/type of paper, purpose/aim of research/paper, participant characteristics, methods of data collection, methods of data analysis, and main findings/conclusions. Completion of this extraction form was dependent upon the clarity of reporting within the selected papers; fields were left blank when the information could not clearly be articulated in a succinct way. When authors included case examples to demonstrate their ideas, I included the details of those patients in the participant details. When considerable amounts of information were missing, then the relevance and potential conceptual contributions were considered over the quality of reporting. The proforma, for only the included literature and presented in

chronological order, is found in Tables 4 and 5. Table 4 presents the country, setting, proposed/utilized interventions, number and defining characteristics of participants. Table 5 presents the study design, data collection and analysis methods, purpose, and main findings or conclusions.

Several CIS researchers have utilized qualitative data analysis and research software, such as ATLAS.ti (Flemming, 2010) and QRS Nvivo (Boyko, 2010; Boyko et al. 2012; Dixon-Woods et al., 2006; Keygnaert et al., 2013; Kazimierczak et al., 2013; Markoulakis & Kirsh, 2013) to help manage the large volume of text-based data. Because I was most familiar with MAXQDA, I used the most current version of this data analysis and research software. Features of this software assisted in organizing and coding the data.

I have established that each component of this synthesis process was not mutually exclusive. Data analysis began freely with the extraction of data and continued throughout the synthesis, revisited as needed along the way. This process required immersion in the data, reading, re-reading, identifying themes, and constantly comparing the developing theoretical structures back to the data.

Table 4

Proforma—Data Extraction: Country, Setting, Interventions Utilized/Proposed, Number of Participants, Defining Characteristics of Participants

Document	Country	Setting	Interventions Utilized/ Proposed	# of Participants	Defining Characteristics of Participants
Gilbert (1977)	USA	n/a	n/a	n/a	n/a
Munro & Mount (1978)	Canada	Hospital	Various	6 case examples	Palliative care in hospital—"advanced malignant disease"
Munro (1984)	Canada	Hospital	Various	n/a	n/a
Wylie & Blom (1986)	USA	Nursing home, patients' homes	Various	2	adult- 1 male, 1 female, hospice (cancer)
Bright (1989)	Australia	Palliative and hospice care	Various	n/a	n/a
Forinash & Gonzalez (1989)	USA	Inpatient hospice unit	Therapist-improvised music and songs	1	42 yo female-"terminally ill client" (met breast cancer)
Martin (1989)	USA	Inpatient hospice unit	Various	2 case examples	End stage cancer
Porchet-Munro (1989)	Switzerland	Hospital	Various	1 case example	55 yo male, advanced malignant melanoma
Forinash (1990)	USA	Patients' home, Inpatient hospice unit	Various	10	5 male, 5 female, age 47-82 yo, terminally ill, hospice program
Beggs (1991/2012)	USA	Hospital	Instrument playing, Musical life review	1	86 yo, male palliative care
Whitall (1991/2012)	USA	Palliative care unit	Song choice, Song legacy	1	42 yo female, terminal cancer
Martin (1991, 2012)	USA	Palliative care hospital	Song choice, Life review	1	Female, breast cancer with metastasis
West, T. (1994)	USA	Home	Various	1 case example	74 yo female-breast cancer with metastasis

Table 4

continued

Document	Country	Setting	Interventions Utilized/ Proposed	# of Participants	Defining Characteristics of Participants
Salmon (1994)	Canada	Inpatient palliative care unit	Various	1 case example	56 yo male, end-stage ALS
Aldridge (1995)	Germany	n/a	n/a	n/a	n/a
O'Callaghan (1996)	Australia	Hospital	Songwriting	39	Ages 26 to >80, with advanced neurological disease or cancer
O'Callaghan (1997)	Australia	n/a	Songwriting	n/a	n/a
Skaggs (1997)	USA	Private practice	GIM	3 Case examples	Male with AIDS; male with pancreatic cancer; woman with breast cancer
Aldridge (1999a)		n/a	n/a	n/a	n/a
Hogan (1999)	Australia	Hospital	Song choice; music listening; life review	1 case example	50 yo male, terminal brain cancer
Hartley (1999)	UK	Inpatient hospice unit	Various	7 case examples	6 males, I female, HIV/Aids
Magee (1999)	UK	Hospital	Various	2 case examples	1) 30 yo male, advanced MS; 2) 50 yo female, HD
Neugebauer (1999)	Germany		Improvisation	3 case examples	3 males, HIV positive
Weber (1999)	Germany	Inpatient hospice center	Various	2 case examples	1) 50 yo male, metastatic prostate cancer; 2) late 50's female, breast cancer
Krout (2001)	USA	Homes, nursing homes, local hospitals, inpatient hospice unit	Various	80	33 males, 47 females, age range from 38-97 yo, terminal illness

Table 4

continued

Document	Country	Setting	Interventions Utilized/ Proposed	# of Participants	Defining Characteristics of Participants
Krout (2003)	USA	Inpatient hospice center	Various	5 case examples	1) 37 yo female, ovarian cancer; 2) 78 yo female, end stage dementia; 3) 85 yo female, breast cancer; 4) 83 yo male, CHF, renal failure, Alzheimer's; 5) 77 yo male, pancreatic cancer
Clements-Cortés (2004)	Canada	Inpatient palliative care	Various	3 case examples	1) 71 yo female, lung cancer; 2) 72 yo female, breast cancer; 3) 76 yo female, ovarian cancer
O'Callaghan & McDermott (2004)	Australia	Cancer hospital	Live music, usually song choice; music and relaxation	258	128 patients with cancer who participated; 27 patients with cancer, who overheard or witnessed music therapy; 41 visitors, 61 staff; music therapist-researcher.
Hilliard (2005)	USA	Hospice-home	Various	2 case examples	1) 70 yo female, lung cancer; 2) 52 yo male, pancreatic cancer
Dileo & Parker (2005)	USA	Inpatient hospice unit	Various song methods	17 case examples	9 females, 8 males, terminal illness
Loewy & Stewart (2005)	USA	n/a	Lullabies	n/a	n/a
Lee, C. (2005)		n/a	Improvisation	4 case examples	1) 70's female, breast cancer; 2) 60's female, Parkinson's; 3) 30's female, external tumor; 4) 60's, Parkinson's

Table 4

continued

Document	Country	Setting	Interventions Utilized/ Proposed	# of Participants	Defining Characteristics of Participants
Abrams & Kasayka (2005)	USA		Music imaging	3 case examples	1) 32 yo male, AIDS; 2) 47 yo female, metastatic breast cancer; 3) 59 yo female, ovarian cancer;
Scheiby (2005)	USA	Treatment facility neurological conditions.	AMT/Musical Meditation	1 case example	59 yo male, Multiple Sclerosis
Nakkach (2005)	USA	n/a	Vocal techniques combined with yoga meditation	n/a	n/a
Sekeles (2007a/2012)	Israel	Hospice-home	Receptive methods	1	45 yo male, lung cancer
Horne-Thompson & Grocke (2008)	Australia	Inpatient hospice unit	Various, individualized to participant	25	14 males, 11 females, age 18-90, terminal illness
Marom (2008)	USA	Nursing home	Various	4 case examples	1) 83 yo, metastatic breast cancer; 2) 89 yo male, failure to thrive; 3) 80's male, chronic airway obstruction; 4) 72 yo female, COPD/CHF
Magill (2009a)	USA	Hospice-homes	Various	7	Caregivers of home hospice patients, present in music therapy sessions prior to the death of patient
Magill (2009b)	USA	Hospice-homes	Various	7	Caregivers of home hospice patients, present in music therapy sessions prior to the death of patient

Table 4

continued

Document	Country	Setting	Interventions Utilized/ Proposed	# of Participants	Defining Characteristics of Participants
Dimaio (2010)	USA	Hospice-home, nursing home	Music Therapy Entrainment (MTE)	4 case examples	1) 63 yo male, debility; 2) 88 yo female, Parkinson's; 3) 69 yo male, COPD; 4) 93 yo female, debility
Clements-Cortes (2011)	Canada	Inpatient palliative care center	Various	4	2 males, 2 females, age 63-91 yo, terminal illness
Sato (2011)	USA	Inpatient hospice unit, homes	Various	1 case example	58 yo male, prostate cancer
Hilliard & Justice (2011/2012)	USA	Hospice-home	Various	1	62 yo male, head and neck cancer
O'Callaghan et al. (2014)	Australia	Cancer hospital and hospice	n/a	52	22 males, 30 females, mean age 58, varied cancer diagnoses
Kidwell (2014)	USA	Hospice-home, nursing facilities	Various	3 case examples	1) 73 yo female, vascular dementia; 2) 63 yo female, breast cancer; 3) 74 yo male, prostate cancer
Wilkerson, Dimaio, & Sato (2015)	USA	n/a	n/a	n/a	n/a

Table 5

Proforma—Data Extraction: Study Design, Data Collection/Analysis Methods, Purpose/Aim of Research/Paper, Main Findings/Conclusions

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Gilbert (1977)	Theory paper	n/a	To examine the nature of death and dying in contemporary society and concomitant needs of the dying person and family…needs then discussed within the context of MT theory and practice to discover how MT can broaden the scope of services for dying	Music therapy, both theoretically and in practice, may prove to be a powerful, effective tool in assisting patients and their families in dealing with death. To establish music therapy as a viable service in death and dying, practicing music therapists must confirm the benefits of music therapy in terminal illness, by demonstrating its effectiveness. Music therapists should concentrate upon devising effective techniques for using music in the death and dying process.
Munro & Mount (1978)	Theory paper	n/a	To outline the rationale of using music therapy in palliative care and to offer preliminary observations on the impact of this underused therapeutic tool.	In the hands of a trained music therapist, music has proven to be a potent tool for improving the quality of life. The diversity of its potential is particularly suited to the diversity of the challenges—physical, psychosocial and spiritual—that these patients present
Munro (1984)	Theory paper (book)	n/a	To present music therapy work in each aspect of the palliative care program: inpatient unit, home care, consultation, outpatient clinic, and bereavement through case examples and theoretical concepts.	n/a
Wylie & Blom (1986)	Case study	n/a	To describe the music, relaxation process, guided imagery, and patient responses to imagery used with hospice patients.	Guided imagery with music was used by two hospice patients in various ways. It helped both patients relax and ease some physical discomfort. It provided both patients the opportunity to explore, be creative, control portions of their life, to reminisce, or to feel safe

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Bright (1989)	Theory paper	n/a	To present skills and competencies needed for music therapist working in end of life care	Which skills music therapists should use in their work depends upon working style, the way they approach people, the clientele and their special needs. Palliative care we must bring together music skills and therapy skills with a therapeutic personality, to enhance the therapeutic alliance.
Forinash & Gonzalez (1989)	Phenome-nology	Phenomeno-logical inquiry. Modified 7-step process based on Ferrera's procedures, a system developed for researching the aesthetic experience	To present a qualitative research method—phenomenology—that is directly applicable to music therapy experiences at end of life	The essences were in two areas: the auditory field and the visual field. In the auditory field, the relationship of the client's breathing to the music was an essential aspect of the unfolding of this session. The visual field contained not only what was physically present but also the images that were triggered by the visual presence. Again, there was a connection between the music and these images. The selected music reflected, on a feeling and sound level, what was presented in the visual and imaginal realms.
Martin (1989)	Theory paper	n/a	To present the work of music therapy in a comprehensive palliative care program	Music therapy plays a distinctive and valuable role in a comprehensive palliative care program. Music is something very beautiful and special; it is unmatched in its ability to touch, move and affect us. When this beautiful, powerful phenomenon which we call music is used in an intentional, compassionate manner by a trained professional it can be of great benefit to terminally-ill patients and their families.
Porchet-Munro (1989)	Theory paper	n/a	To present the scope of music in palliative care and the challenges for music therapists	The scope, not only of music but of the music therapy profession is vast and the challenges taxing but exciting.

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Forinash (1990)	Phenome-nology	Transcript of sessions, phenomenologic al analysis	To study the "lived world," or the complete experience, of music therapy with the terminally ill patient.	Three general groups of essences emerged—Relationship; Music, and Process. Final description: Music therapy with the terminally ill patient is the coming together of patient and therapist in a process oriented exploration. This exploration takes place in the present moment yet is also expansive in that it can include both the past and future. It takes place in the realm of direct human interaction through music and words but also accesses the unconscious and symbolic levels of understanding and relating.
Beggs (1991/2012)	Case study	n/a	To describe the use of life review with an amateur violinist in palliative care.	Through strong and open relationships between the patient , family, and music therapist, music therapy provided patient with an outlet for self-expression, while also motivating him to become more independent and to communicate with and relate to others; helped to maintain feelings of dignity, self-accomplishment and self-worth; facilitated reminiscence and evoked memories of significant events and people; provided positive memories of him for family during the last few months of his life.
Whitall (1991/2012)	Case study	n/a	To describe music therapy with a 42-year-old woman with terminal cancer	Through song choice, patient was able to gain insight into her own feelings during the dying process, and by listening to the songs, she worked through the pain of leaving her husband. A songbook and tape of these songs provided her husband with a last gift of her love.

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Martin (1991, 2012)	Case study	n/a	To describe music therapy with a woman dying of cancer and her family and phases in the therapy process. To illustrate the techniques of "Song Choice" and "Life Review" and present the personal thoughts and feelings of the therapist.	Music therapy allowed for patient to state her needs, ask for help, and accept help from others, indirectly, through the song material, enhancing communication and understanding, and enjoyment between patient and family. Diminished anxiety, improved coping and acceptance.
West, T. (1994)	Theory paper	n/a	To present issues frequently faced by the dying adult in hospice and propose a theoretical framework which supports assessment and treatment by tracking the patient's efforts to move through phases and tasks of dying; explore grief issues and spiritual aspects; suggest goals and roles for the music therapist and for the music with particular attention to the changing needs presented as the patient moves closer to death.	An understanding of the psychological processes unique to death and dying is essential for effective music therapy treatment in hospice; therapist can select supportive music and interventions by tracking the patient's movement through phases and tasks of dying, and they; spiritual issues often arise in response to music; both quality of life and ease of death may be supported.
Salmon (1994)	Theory paper	n/a	To present the author's schema of music and emotion in palliative care, and elaborate on 5 identified shared characteristics.	The experiences of the presented case and others with whom the author worked over the years suggest that music therapy contributes to the well-being of terminally ill patients.
Aldridge (1995)	Theory paper	n/a	Voicing spiritual needs of patients in creative arts therapies, elaborating on spirituality and linking the promotion of hope to working creatively with music, and to demonstrate that talking about spirituality can be brought into the discourse of patient care.	The music-therapeutic relationship is an important one for maintaining interpersonal contact, a contact that is morally nonjudgmental, where the ground of that contact is aesthetic. For the sick, maimed, disfigured and stigmatized, the opportunity to partake in a greater beauty is important. It is important to keep ideas of creativity broad and include caregivers in treatment initiatives and research.

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
O'Callaghan (1996)	Grounded Theory (modified)	Qualitative analysis of song lyrics, open and axial coding	To examine the use of song writing in palliative care and investigate the lyrical themes and categories (groups of concepts) in 64 songs written by 39 palliative care patients; present the song writing paradigm that facilitated the palliative care patients' song writing	Song writing is a worthwhile technique for some palliative care patients because the lyrical themes suggest that the process may aid in meeting their physical, psycho-social, and spiritual needs.
O'Callaghan (1997)	Theory paper	n/a	To describe the origins of song writing in music, its use in palliative care, and offer distinctions between song writing and poetry writing.	Although both writing poetry and writing songs can enable patients to communicate messages and express memories and inner states, there is a unique impact of music in palliative care, with ten therapeutic opportunities found to be associated with music when using song writing.
Skaggs (1997)	Theory paper	n/a	To present the integration of GIM in a psychotherapy practice with clients who have been diagnosed as terminally ill. Case examples are given which elucidate how specific music and responses to focused listening have assisted in a broad range of client needs.	The GIM therapist working with terminally ill clients in a private practice setting has the advantage of having time and the emotional and physical energy of the client not available to the therapist in a hospice or hospital setting. Understanding the many aspects of the client's needs and being able to assist in meeting them is essential for the therapist.
Aldridge (1999a)	Theory paper	n/a		
Hogan (1999)	Theory paper	n/a		
Hartley (1999)	Theory paper	n/a		From out of the isolation of an HIV positive diagnosis, the improvisation of music can assist in moving beyond denial and offer glimmers of hope, an installation of well-being, a fostering of courage in the face of adversity and a new and animated understanding of both life and death.

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Magee (1999)	Theory paper	n/a	To present music therapy work with individuals with chronic neurological conditions—Huntington's Disease and Multiple Sclerosis—and the implications for treatment of those conditions	
Neugebauer (1999)	Theory paper		To reflect how music therapy can help through case examples with immunologically challenged patients that are HIV positive.	Music therapy has a significant role to play in the treatment of HIV positive patients. Not only does music therapy offer an existential form of therapy that accepts the person as he or she is, and an opportunity to define him or herself as he or she wishes to be, it is primarily concerned with aesthetic issues of form and existential notions of potential rather than concepts of pathology.
Weber (1999)	Theory paper	n/a	To discuss what was found to be most helpful and meaningful uses for music in this particular hospice.	For our hospice patients, who have often suffered so much, music brings them something beautiful. So many sick and older people have been very alone and music can pull them out of their isolation and make it easier to share their concerns and joys. Music helps them calm down and face personal issues that are not always so pleasant. Music often fills a spiritual need or reconnects them to their own spirituality. Music plays a distinctive and valuable role in a palliative care program.
Krout (2001)	Pretest/ Posttest, within subjects	Behavioral observation and subject's self-reporting	To quantify and evaluate the effectiveness of single-session music therapy interventions with hospice patients in three patient problem areas: pain control; physical comfort; and relaxation.	Single-session music therapy interventions appear to be effective in increasing subjects' pain control, physical comfort, and relaxation during both data collection scenarios.

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Krout (2003)	Theory paper	n/a	To discuss music therapy as a way to ease communication and sharing between dying patients and their loved ones and describe the ways in which music therapy can facilitate a means of release for both patients and family members	In each of the case examples, music therapy played an important role by helping family members to be actively involved in the last hours of the lives of their loved ones. Within the context of the inter-disciplinary care team, music therapy can help to bring comfort to patient and family alike.
Clements-Cortés (2004)	Theory paper	n/a	To discuss the role of music therapy in palliative care and the function music plays in accessing emotion and describe techniques used in assisting clients to express their thoughts and feelings.	It is evident that music therapy holds the power to facilitate emotional expression and exploration of loss and grief issues in the terminally ill. The case examples demonstrate music's effectiveness in decreasing social isolation, increasing communication and self-expression, stimulating life review and reminiscence, and enhancing relaxation. A music therapist's techniques are unique and are customized to help clients achieve their individual goals.
O'Callaghan & McDermott (2004)	Grounded theory	Thematic and content analysis of answers to open-ended questionnaires	To investigate the relevance of music therapy in a cancer hospital that is, what did the music therapy do and did it help?	Many patients', visitors' and staff members' affective, contemplative, and imagined moments in music therapy affirmed their "aliveness," resonating with an expanded consciousness, in a context where life's vulnerability is constantly apparent.
Hilliard (2005)	Theory paper	n/a	To help illustrate how music therapy addressed quality of life issues for participants in a previously completed study by the author, examining the effects of music therapy vs. routine treatment on the quality of life and physical status of adult patients diagnosed with terminal cancer.	

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Dileo & Parker (2005)	Theory paper	n/a	To present case studies that portray how songs used to enhance relationship completion assisted dying patients to achieve a final stage of growth.	
Loewy & Stewart (2005)	Theory paper	n/a	To discuss the use of lullabies in the end of life transition, and present the method for using lullabies as a therapeutic intervention	The use of music to achieve a place of comfort and familiarity provides patients with feelings of safety, while at the same time offers space for transition to occur in a way that is directed by the patient. Lullabies used at the start of life may be helpful in assisting patients to move within a trusted holding place. A transitional space, where one can experience moving from wake to sleep during end of life care, can be achieved within a musical context.
Lee, C. (2005)	Theory paper	n/a	To provide a personal exploration of the author's experiences of music therapy, aesthetics and dying. To present case examples that explore what happens during defining moments - how they occurred, how they were explored and what they meant for the future direction of work.	
Abrams & Kasayka (2005)	Theory paper	n/a	To provide a general description of music imaging, material on its potential benefits, contraindications, and specific applications for persons at the end of life.	The unique properties of music imaging offer a wide range of benefits specifically for persons at the end of life. Clients at the end of life may well benefit from a process that transcends physical recovery (although relief from the immediacy of physical discomfort might be part of this), and that promotes wholeness through the integration of the client's most fundamental life values and meanings.

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Scheiby (2005)	Theory paper	n/a	To present the application of Analytical Music Therapy (AMT), combined with Musical Meditation, to music therapy practice at end of life, helpful in coping with issues around death	
Nakkach (2005)	Theory paper	n/a	To present a framework within which to consider the subtleties and modalities of implementing the voice, music and sound to accompany the death process. This approach is based on the premise that music therapy at the end of life can be enhanced by the insights of the philosophy and practice of yoga	The approach presented broadens the range of music therapy to a spiritual practice that provides benefits for the patients and their families, as well as the therapist, and becomes another form of yoga
Sekeles (2007a/2012)	Case study	n/a	To describe the use of music therapy with a 45 year old man with lung cancer	
Horne-Thompson & Grocke (2008)	RCT	Anxiety measurement using ESAS, heart rate. Nonparametric statistical analysis	To examine the effectiveness of a single music therapy session in reducing anxiety for terminally ill	Significant reduction in anxiety for experimental group on anxiety scores. Post hoc results also revealed significant reduction in pain, tiredness and drowsiness. No significant decrease in heart rate. Results of study support use of MT as effective intervention when working with anxious people in last stages of terminal illness.
Marom (2008)	Theory paper	Nursing home	To examine and analyze some of the difficulties that may arise, for patients and therapists alike, when working with people who are dying.	

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Magill (2009a)	Naturalistic Inquiry	Hospice-homes	The role of music in palliative care music therapy is examined and representatively summarized, followed by a review of strategies provided by this author to home hospice patients and their caregivers.	The caregivers described these aspects of music in sessions to have memorable and lasting effects: "music is a conduit," "music gets inside us," "live music makes a difference," and "music is love"
Magill (2009b)	Naturalistic Inquiry	Hospice-homes	To learn how music therapy sessions, held prior to the death of a loved one, impact spirituality in surviving caregivers of advanced cancer patients.	Caregivers reported autonomous joy (music therapy affected the caregiver directly) and empathic joy (caregivers' joy was based in remembering seeing the patient happy in music therapy). They also noted feelings of empowerment due to the ways they felt they had contributed in the care of the patients through music therapy. Spiritual themes: reflection on the present (connectedness), reflection on the past (remembrance), and reflection on the future (hope). Meaning through transcendence was found to be the overarching trend in this study.
Dimaio (2010)	Theory paper	Hospice-home, nursing home	To present four case studies that describe music therapy entrainment with hospice clients experiencing pain, demonstrating specific needs of dying clients and how music therapy entrainment can meet those needs. The author also explored insights discovered about herself and music therapy entrainment.	MTE introduced positive new skills to clients who were losing skills. They learned a new language and how to communicate the meaning of their pain and dying process with loved ones. This technique may be used as a one time intervention or become instrumental in the therapeutic process. Music therapy entrainment can influence more than a person's perception of pain; it can affect his or her dying processes and family's grief.
Clements-Cortes (2011)	Phenome-nology	Inpatient palliative care center	To describe a study that investigated the experience of 4 dying persons and their significant relationships, as they engaged in music therapy sessions designed with the goal of facilitating relationship completion.	6 global themes were identified including love, loss, gratitude, growth/transformation, courage/strength, and good-bye. Results indicate that life review, song dedications, and the creation of musical gifts were a core part of each participant's process.

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Sato (2011)	Theory paper	n/a	To describe a Musical Life Review Model (MLR Model), which examines the life review process, the role of music, and therapeutic outcomes.	The therapist needs to consider musical elements, questions to open discussion, and the condition of the patient when guiding MLR. The challenge lies in the therapist's ability to listen to patients and to understand the diversity of their backgrounds. The case study of illustrates how MLR can promote the last stage of growth in hospice patients while addressing their unique needs. The case study also shows that various aspects of MLR may change throughout the course of treatment, as the condition and the needs of the patient change.
Hilliard & Justice (2011/2012)	Case study	n/a	To provide a foundational framework for the utilization of music therapy in end of life care and present a case study demonstrating the benefits of music therapy for this population. A theoretical orientation of cognitive behavioral music therapy combined with a humanistic approach is presented, and the case study provides an example of assessment, treatment planning and the achievement of therapeutic goals.	Music therapy is highly beneficial in holistically treating the patient and his or her family, and is therefore a natural choice as a treatment option for enhancing quality of life throughout the dying process. Utilizing Cognitive Behavioral Music Therapy techniques, the music therapist can address behaviors, physical symptoms, thoughts, emotions and relationships within a relatively brief therapeutic time. Because hospice care, by nature of its end of life treatment, is often brief in nature, CBxMT can be regarded as a viable treatment for those facing multifaceted needs at the end of life..
O'Callaghan et al. (2014)	Grounded theory	Semi-structured interviews. Convenience snowball and theoretical sampling. Inductive, comparative analysis.	To understand how music is personally used and experienced by adult Australian cancer patients before and following cancer diagnosis.	Health professionals can support patients by inquiring about their music behaviors and recognizing that altered music usage may signify vulnerability. Although commonly recommended, hospital concerts and music broadcasts need sensitive delivery. Patients' preferred music should be available in diagnostic, treatment and palliative settings because it can promote endurance and life enrichment

Table 5

continued

Document	Study Design	Data Collection and Analysis Methods	Purpose/Aim of Research/Paper	Main Findings/Conclusions
Kidwell (2014)	Theory paper	n/a	To describe the range of spiritual experiences, from formal religious to transpersonal, that the author encountered in working with hospice patients in end-of-life care.	Issues related to spirituality are not always clearly defined in terms of what they are, what they mean to each patient, and how they should be addressed. Spirituality is multi-dimensional, and while many parts may be impacted or changed as each process unfolds, it is the music therapist's responsibility to know when the spiritual needs of a patient should be the focus of therapy, and when they go beyond their scope of practice.
Wilkerson, Dimaio, & Sato (2015)	Theory paper	n/a	To explore the experiences and influences of countertransference in the unique situations presented by end-of-life music therapy, thus increasing readers' awareness of the potential impact of countertransference upon their clinical practices.	There are unique challenges associated with end-of-life music therapy that demand recognition and examination. Countertransference is always operating, whether we are willing or able to consciously acknowledge it nor not. Addressing countertransference is important, however, because it can be a valuable source of information about our clients, ourselves, and the music we and our clients create, and this knowledge may allow for deep empathy. Our scope of practice requires us to recognize that countertransference influences our work.

In the first phase of data analysis, I utilized open coding as I read documents, considering each paper as potential for inclusion in the study. Once I reached a significant number of codes (639) over 30 documents, I begin to narrow and consolidate the data, and began the initial phase of synthesis. At this point, I sorted and exported all of the data to an Excel spreadsheet, printed and began to manually organize the data as I took notes about my developing thoughts and interpretations. Through these reflections, I began to identify patterns, themes and categories, as they emerged. I then returned to the literature and incorporated axial coding, using the themes and categories identified in the first phase of analysis, while also adding to these as new ones emerged. I continued to take notes and reflect on the process. This process continued iteratively, until I felt that theoretical saturation had been reached.

Conducting the Interpretive Synthesis

Dixon-Woods et al. (2006) originally intended to use meta-ethnography, devised by Noblit and Hare (1988) as their method of interpretive synthesis. Until that time, meta-ethnography had only been used to synthesize small samples of qualitative research. However, Dixon-Woods et al. (2006) found the tenets and some of the techniques of meta-ethnography to be applicable to their study of a large sample of diverse methodologies, with modification.

I employed two of the major strategies of meta-ethnography—*lines of argument synthesis* (LOA) and *refutational synthesis*—to create the foundation for the interpretive synthesis. In meta-ethnography, LOA "involves building a general interpretation grounded in the findings of the separate studies. The themes, or categories that are most powerful in representing the entire dataset are identified by constant comparison between

individual accounts" (Dixon-Woods et al., 2006, p. 39). In refutational synthesis "contradictions between the study reports are characterized, and an attempt [is] made to explain them" (p.39). CIS uses the techniques of LOA synthesis and refutational synthesis to build *synthetic constructs* and produce a *synthesizing argument*.

I engaged in this process of developing synthetic constructs throughout data extraction and analysis. Synthetic constructs arise from the data as a new conceptual form; they are transformations, rather than summaries, of the underlying evidence. "Synthetic constructs are grounded in the evidence, but result from an interpretation of the whole of that evidence, and allow the possibility of several disparate aspects of a phenomenon being unified in a more useful and explanatory way" (Dixon-Woods et al., 2006, p. 39).

Throughout the study, I aimed to develop the synthesizing argument, which "integrates evidence from across the studies in the review into a coherent theoretical framework comprising a network of constructs and the relationships between them. Its function is to provide more insightful, formalized, and generalizable ways of understanding a phenomenon" (Dixon-Woods et al., 2006, p. 39). The synthesizing argument may link synthetic constructs as a well as constructs directly reported in the literature. The synthesizing argument also incorporates a critical and reflexive approach to the literature, considering contradictions or flaws in the evidence or theories presented. In this sense, refutational synthesis is an integrated part of the interpretive synthesis, as the aim of a CIS is to approach the body of literature under study as inherently warranting critical scrutiny. "Authors are charged with making conscientious and thorough searches, with making fair and appropriate selections of materials, with seeking disconfirming

evidence and other challenges to the emergent theory, and with ensuring that the theory they generate is, while critically informed, plausible given the available evidence" (Dixon-Woods et al., 2006, p. 44).

Trustworthiness

I have provided my personal stance as the researcher. As a hospice and palliative care music therapist, I have many ideas grounded in my personal and professional experiences, and the presence of bias is inevitable. In an attempt to avoid any manipulation of the data and to insure its integrity, I integrated investigator triangulation during the process of synthesis. Triangulation is used in qualitative research to establish credibility and transferability, and to ensure that the findings accurately reflect and are grounded in the data. Once I felt secure in the identified major categories and themes, I employed a second and third reviewer (one music therapist and one person in a related field to provide a different perspective) to review a random selection of the data across codes; both reviewers produced an agreement rate of 85.6%. While this does not insure validity of my findings, it does increase the likelihood that my analysis is indeed grounded in the data. Prolonged engagement, another strategy for trustworthiness, helped to ensure that the resulting interpretations and constructs are accurately reflective of the literature. CIS is a prolonged, highly iterative and reflexive process, therefore requiring ongoing deliberation for the interpretive synthesis.

CHAPTER 4

RESULTS

In some ways, my initial approach to coding was descriptive and positivist. While unintentional, I now realize it is my default way of seeking knowledge. When I stopped coding and began to look at the data excerpts in print, as units, I recognized something was missing in my process. I knew I needed to shift my thinking and analysis to avoid an aggregative summary of music therapy at the end of life, which strayed from the purpose of my study. I refocused my efforts on seeking what about music therapy was unique and different from music therapy in other settings. My initial research question, "What is the essence of the music therapy experience at the end of life?" was indeed my interest, but I was unclear about how I was answering it. As part of my refocusing, I began to reorganize my codes, and removed data that did not reveal anything unique about music therapy at the end of life. I removed data that merely listed or described interventions, the qualities of music or the therapist, and goals, for instance, that could be used to describe music therapy in any setting. I kept data that described music therapy in a way that was distinctive to end of life practice, and began to organize the data into themes and categories.

After this initial data organization, I returned to the literature, seeking ideas that added to, confirmed or rejected the emergent themes and categories. Throughout the analysis, I examined all of the documents multiple times as I compared the data against the themes, categories and developing theoretical framework. My use of the qualitative software MAXQDA allowed for different visualizations of the frequency of themes and

categories across the literature. For instance, I was able to use the word frequency feature of the software to introduce another means of analysis. I searched key words I felt were significant, which revealed additional data meaningful to the analysis. These words (in order of frequency of occurrence) were: spiritual/spirituality, relationship, choice, relaxation, hope, intimate/intimacy, companion/accompany, imagery, project/projection, reminiscence, unconscious, flexible/flexibility, funeral, adapt/adaptive, song choice, anticipatory, divine, transcendence, catharsis, and individualized. Figure 2 provides a visual example of a code matrix browser, the MAXQDA visual output for the frequency of codes per category and document.

Of the 118 documents considered for the synthesis, 47 were included. Figure 3 demonstrates the categorization of the papers; they consisted of quantitative studies (n=2), qualitative studies (n=7), case studies (n=7), and theory papers (n=31).

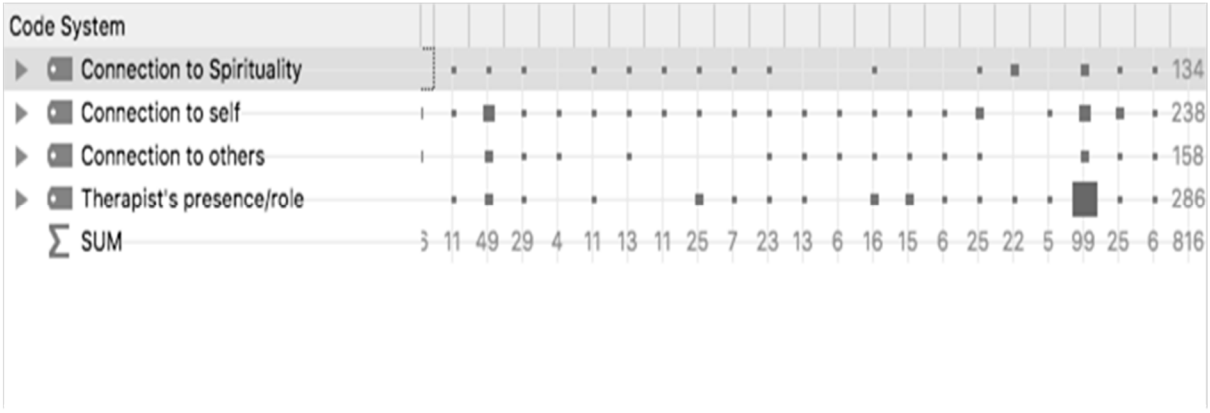

Figure 2. MAXQDA Code Matrix Browser—Code Frequency per Document and Category

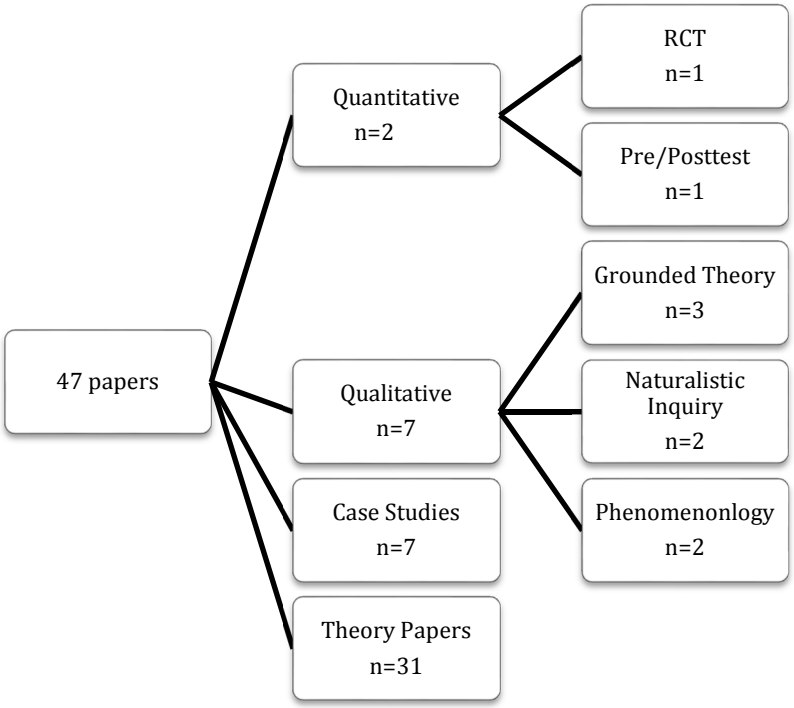

Figure 3. Categorization of included papers

The Synthesizing Argument—Connection

In CIS, the output of the synthesis is in the form of a synthesizing argument, a unifying theoretical framework, demonstrating the relationships between networks of constructs. The synthesizing argument and most significant theme unifying the included literature was *Connection*. This theme was conceptualized in four categories. Music therapy allows people at the end of life to establish, reestablish, or enhance their 1) *Connection to Self*, 2) *Connection to Others*, 3) and *Connection to Spirituality*. A fourth category encompasses the role of the therapist in this connection, as a *Companion* at the end of life, and includes discussion of therapeutic boundaries and countertransference. Figure 4 demonstrates the frequency of illustrated data excerpts per category and Table 6 lists frequencies of these data excerpts per included document.

Figure 5 presents a visual model for the theoretical framework of *Connection* and the network of constructs that contribute to this overarching theme.

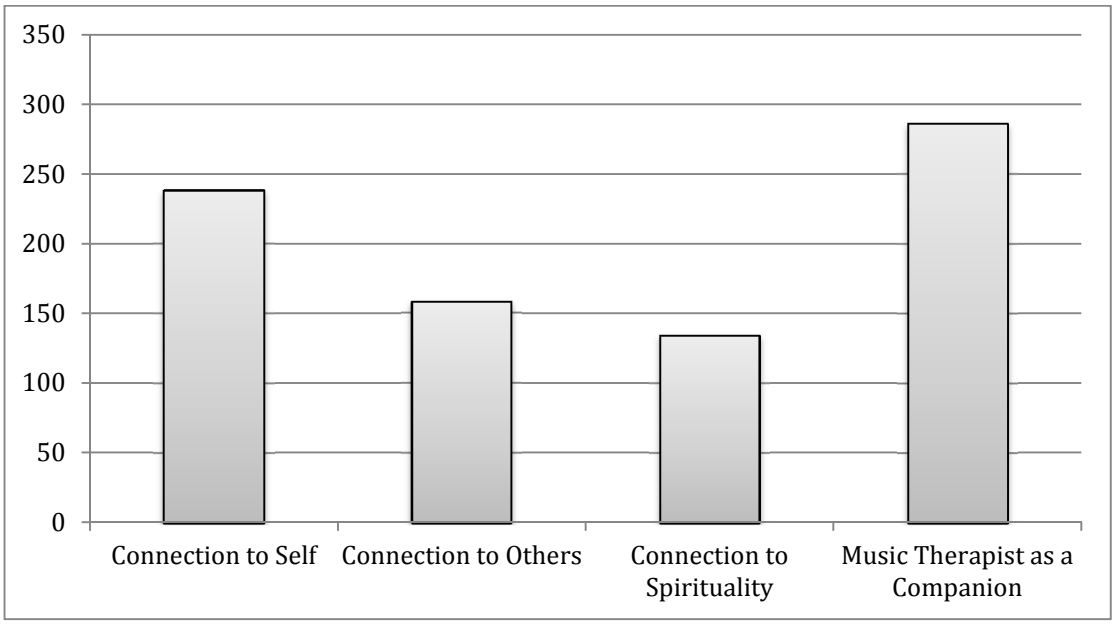

Figure 4. Frequency of Data Extracts per Category

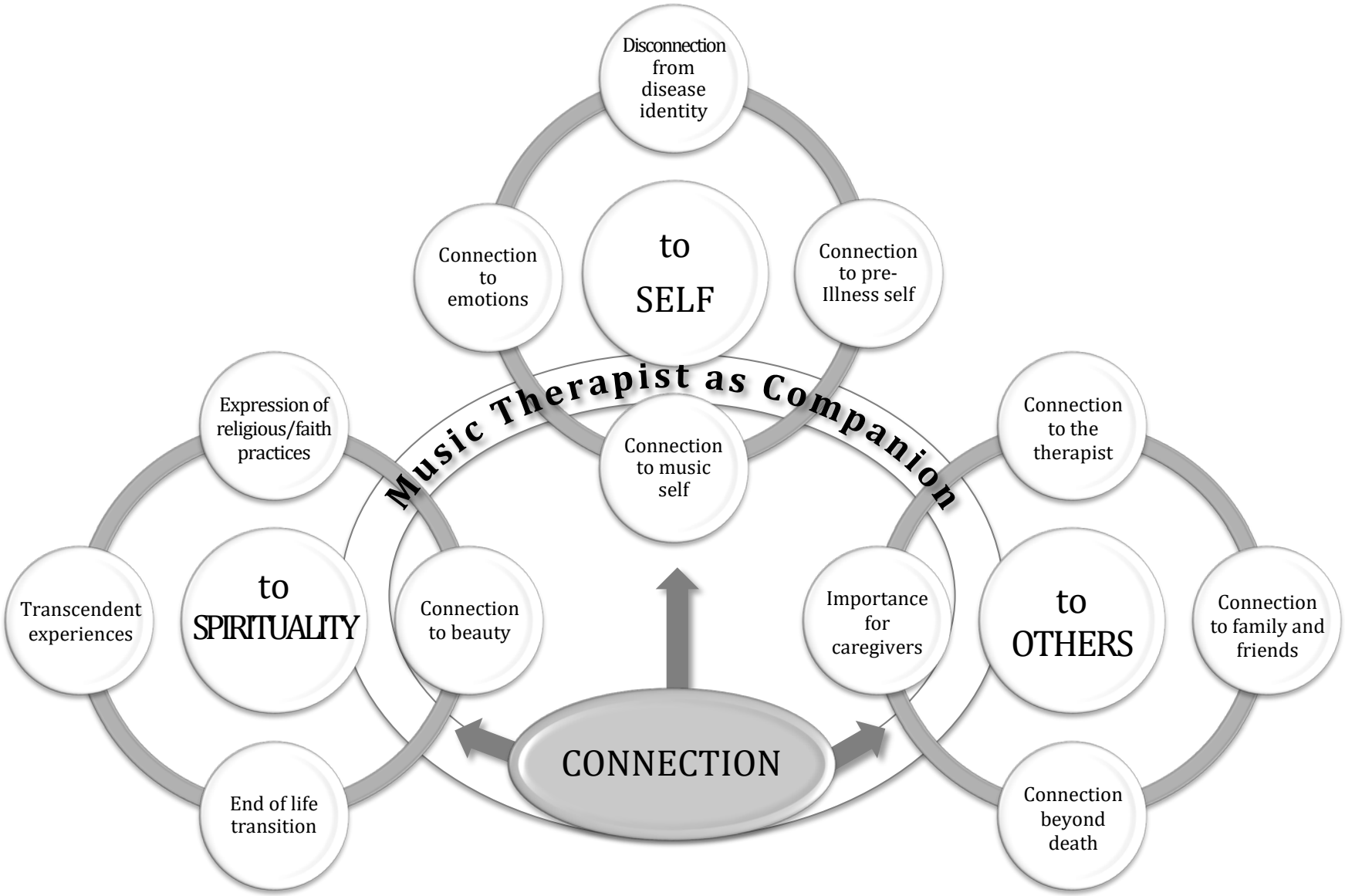

Figure 5. Visual Model--Theoretical Framework of Connection

Table 6

Frequency of Data Exceprts per Included Document

Document	Connection to Self	Connection to Others	Connection to Spirituality	The Music Therapist as a Companion	Totals
Abrams, B. & Kasayka, R. (2005)	0	2	2	1	5
Aldridge, D. (1995)	7	4	0	0	11
Aldridge, D. (1999a)	6	8	7	8	29
Beggs, C. (1991, 2012)	0	3	3	0	6
Bright, R. (1989)	0	1	1	13	15
Clements-Cortés, A. (2004)	3	12	8	2	25
Clements-Cortes, A. (2011)	1	6	2	1	10
Dileo, C. & Parker, C. (2005)	6	2	12	6	26
Dimaio, L. (2010)	0	1	4	6	11
Forinash, M. (1990)	3	2	1	10	16
Forinash, M. & Gonzalez, D. (1989)	13	0	0	9	22
Gilbert, J. (1977)	1	2	2	1	6
Hartley, N. (1999)	2	5	5	9	21
Hilliard, R. (2005)	4	3	3	2	12
Hilliard, R. & Justice, J. (2011/2012)	1	3	6	4	14
Hogan, B. (1999)	4	19	14	12	49
Horne-Thompson, A. & Grocke, D. (2008)	0	3	0	1	4
Kidwell, M. (2014)	11	14	4	13	42
Krout, R. E. (2001)	0	1	0	2	3
Krout, R. E. (2003)	4	1	8	4	17
Lee, C. (2005)	4	8	1	11	24
Loewy, J. & Stewart, A. (2005)	0	0	0	2	2
Magee, W. (1999)	2	6	0	3	11
Magill, L. (2009a)	1	4	5	2	12

Table 6

continued

Document	Connection to Self	Connection to Others	Connection to Spirituality	The Music Therapist as a Companion	Totals
Magill, L. (2009b)	5	4	6	1	16
Marom, M. (2008)	0	1	0	16	17
Martin, J. (1989)	3	13	6	3	25
Martin, J. (1991, 2012)	3	7	4	9	23
Munro, S. (1984)	13	21	10	55	99
Munro, S. & Mount, B. (1978)	4	13	3	5	25
Nakkach, S. (2005)	0	1	0	8	9
Neugebauer, L. (1999)	0	5	1	2	8
O'Callaghan, C. (1996)	1	8	4	0	13
O'Callaghan, C. (1997)	0	1	3	0	4
O'Callaghan, C. (2004)	0	4	0	2	6
O'Callaghan, C. et al. (2014)	3	2	0	3	8
Porchet-Munro, S. (1989)	0	1	1	4	6
Salmon, D. (1994)	4	8	2	1	15
Sato, Y. (2011)	1	11	10	8	30
Scheiby, C. (2005)	5	2	0	4	11
Sekeles, C. (2007a/2012)	1	1	0	5	7
Skaggs, R. (1997)	5	1	0	5	11
Weber, S. (1999)	7	12	14	3	36
West, T. (1994)	6	5	0	14	25
Whitall, J. (1991, 2012)	0	5	6	2	13
Wilkerson, Dimaio, & Sato (2015)	0	0	0	12	12
Wylie, M. & Blom, R. (1986)	0	2	0	3	5

Music Therapy Facilitates a Connection to Self

By the time patients are receiving end of life care, they have likely been through months, if not years of treatment. Lives filled with doctor appointments, treatment visits, hospital admissions, and surgeries have been the norm for quite some time. People with life-threatening illnesses have potentially experienced cumulative losses of physical and vocational abilities, a loss of independence, cognitive impairments, psychological trauma, and changes in roles and relationships.

> As the progressive nature of the illness takes its course, individuals have an ever-changing sense of self and identity which is gradual and long term. Such changes stem from gradually increasing dependence on others for even the smallest task, loss of skills or the opportunities to develop skills, reduce opportunities for achievement, and a very general sense of loss on many levels. (Data excerpt, Magee, 1999, p. 88).

As people experience these many losses, they often encounter crises of identity. Who am I now, with this disease, and with all of these changes? For people at the very end of life, who are approaching the unknowns of dying, death and the beyond, they may be further contemplating their metaphysical identities.

It is no wonder then, that connection to self, or identity, is a core theme when approaching music therapy with people at the end of life. Music therapy helps patients to disconnect from the identity of one with a disease, reconnect with their identities prior to illness, create new identities, feeling alive and continuing personal growth in the face of illness and impending death, connect to their music self, and connect to their emotions. Figure 6 presents the portion of the overall visual model related to connection to self.

Data excerpts will be used throughout this section to illustrate these results, and Table 7 provides examples of data excerpts that characterize each sub-category.

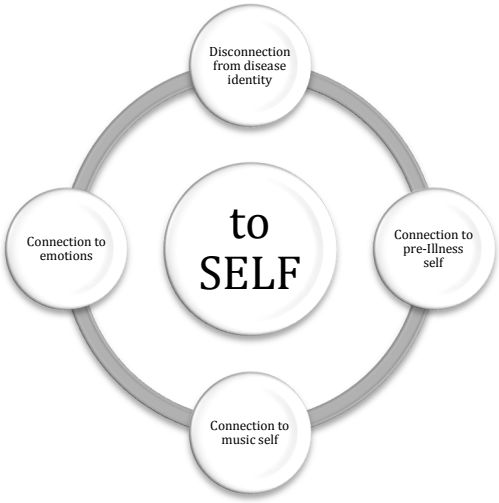

Figure 6. Visual Model—Connection to Self

Disconnection from Disease Identity

Music therapy facilitates ways of disconnecting from the disease identity and from symptoms. In one study, this disconnection was referred to as a "transcendence of the person/patient split" and one of the study participants articulated this phenomenon: "Any experience like this reminds me that I am much more than a 'cancer patient,' I am a person with all sorts of needs, like everyone around me, who happens to have cancer. Music is one way I am reminded of this duplicity" (Data excerpt, O'Callaghan & McDermott, 2004, p.175). Music therapy has a way of dismantling defenses that may have developed in patients over the course of their illness as patients exhibit traits of their personality during music therapy that may have not been lately accessible (see Table 7 for data excerpt, Magill, 2009b).

It is possible that it is the aesthetic and existential aspects of music therapy that help a person disconnect from their pathology:

> Not only does music therapy offer an existential form of therapy that accepts the person as he or she is, and an opportunity to define him or herself as he or she wishes to be, it is primarily concerned with aesthetic issues of form and existential notions of potential rather than concepts of pathology. (Data excerpt, Neugebauer, 1999, p. 133)

Music therapy, as an active experience, provides musical opportunities for change and as a result, patients become active participants in their healing process, rather than passive receivers of treatment. Pleasure is also important in music therapy experiences, and plays a role in helping patients to disconnect from a disease identity. The mere mention of music brings some patients out of preoccupations with illness and symptoms and provides temporary escape (see Table 7 for some examples of data illustrations, Munro, 1984; Martin, 1989; Martin, 1991/2012; Neugebauer, 1999; Wylie & Blom, 1986).

Table 7

Examples of Data Excerpts—Connection to Self

Code	Data Excerpt
Connection to Self/ Disconnection from Disease Identity	By using a variety of music or scenes that help the patient relax and temporarily escape the disease, music therapists can help the patient use music and their imagination to its fullest. They might help that person open up a world in his or her mind at a time when their conscious world is changing, closing, or becoming difficult to comprehend and accept. (Wylie, & Blom, 1986)
	Across interviews, caregivers commented on their observations of seeing loved ones display personal traits in music therapy sessions that had otherwise been absent during this stage of illness. (Magill, 2009b)
	Phil mentions an element about the approach that many other clients have commented on the fact that the musical meditation makes it possible to travel space and time and out of the body. When many clients reach the terminal stage of an illness, they tend to feel stuck in their body, their bed, their wheelchair, and in their pain. Music can help to distract them from the pain or otherwise transform the experience. (Scheiby, 2007)
	In addition, this experience opens up in him the possibility of bringing about active change, that is, of grasping and developing musical opportunities for change. As a result there is active participation in the healing process. The patient becomes active instead of merely being given treatment. (Neugebauer, 1999)
Connection to Self/ Disconnection from Disease Identity/ Regaining Control	I find that terminally ill patients usually prefer to choose songs with which they are familiar. In an environment increasingly inhibited by a progressive illness, the opportunity to recognise music as familiar and recall a song's lyrics provides patients with a sense of achievement and greater control over their environment. (Hogan, 1999)
	Persons with terminal illness often experience tremendous loss of control. Music therapy can offer choices which elicit an internal locus of control. The patient may select the music or songs, choose activities, or decide whether or not to have music or music therapy at any given time. It is important for the therapist to understand that a patient's resistance or reluctance to engage may be caused by defenses functioning to protect the self from emotional overwhelm. When the therapist senses a struggle for control, it is time to explore with the patient, if possible, the underlying issues. (West, 1994)
	Allowing imagery to emerge from within the individual, rather than from a programmed script, validates the uniqueness of each client. Moreover, at a time when so many decisions are made for them by medical personnel and families, clients experience something of their own when images arise from within—something within their control. This practice also lessens the feeling of being a victim of the disease. The client is actively assisting in the healing process. (Skaggs, 1997)

Table 7

continued

Code	Data Excerpt
Connection to Self/ Disconnection from Disease Identity/Relieving symptoms	Terminally ill patients often benefit from the opportunity just to listen to music. Music provides a structured stimulus in which patients may profoundly reflect upon and contemplate existential issues. It also offers them opportunities to experience a positive alteration to their physical, emotional and/ or spiritual state of well being. (Hogan, 1999)
	music…occasionally can provide enough distraction to re-focus the person's attention and thus help relax aggravated muscular wretching reflexes. Causes of insomnia are not always definable and have undercurrents of anxiety, fear or unexplainable restlessness. Here, music can be a presence, a lullaby, a diversion that helps to shorten long wakeful nights or bring unexpected sleep. (Munro, 1984)
	Music played a large role in reducing this patient's anxiety, which decreased from the start of each session to the end. She often appeared uncomfortable when I arrived for a session; she called for the nurses continually and fidgeted with items around her bedside. Although her anxiety resumed after sessions, music was successful in reducing her anxiety during sessions. (Clements-Cortes, 2004)
	As music therapists working with end of life patients, we rely on the soothing properties of the music we play and create, concentrating on relaxing the patient's body and mind, while accommodating feelings of loss, suffering, and forgiveness. (Nakkach, 2005)
	Once immediate distress has been relieved, the music therapy activity can reach out to meet the other dimensions of the patient's suffering. (Hogan, 1999)
Connection to Self/Re-Connection to Pre-Illness Self/ Connection to Wholeness and Aliveness	The patients were brought "back to life" and had a "renewal of self." The majority of caregivers found that the sessions tended to help revitalize and reawaken their loved ones, and conveyed the significance of these unequivocal responses. Coming back to life and having a renewal of self were striking themes that often signified their being able to partake in interactions and being able to see glimpses of their personalities, attributes, and strengths once again. (Magill, 2009b)
	At times it was an inner relationship; the relating of the patients as they are now to some aspect of themselves. This aspect was usually from their pre-illness life. It is my strong sense that this exploration and expression allowed these patients to identify with their strengths and abilities. This positive identification and strengthening of self esteem hopefully improved their ability to cope with facing a terminal illness. (Forinash, 1990)

Table 7

continued

Code	Data Excerpt
Connection to Self/Re-Connection to Pre-Illness Self/ Connection to Wholeness and Aliveness	MLR [Musical Life Review] provided David an opportunity to use his remaining time for personal and spiritual growth. It helped him to reach a state of integration by giving him the opportunity to work through unfinished business, reconnect with his heritage, and regain a sense of his identity. (Sato, 2011)
	The relevance of music therapy was evident through its capacity to enable, in many individuals, a renewed or heightened sense of personal historical significance and ongoing presence. (O'Callaghan, 2004)
	Mario experienced a strong feeling of being alive in music whilst journeying towards his own death…when a person is encouraged, enabled and celebrated as being whole, music can act as a very special agent. It is here, during musical improvisations in music therapy sessions, that life can be experienced in its rawest, truest sense. (Hartley, 1999)
Connection to Self/Re-Connection to Pre-Illness Self/Connection Through Memories and Life Review	Listening to familiar music naturally stimulates association with memorable moments. Patients tend to request to hear specific selections to go back in time and restore connection with transformative events in life. (Magill, 2009a)
	What was crucial was that Margaret could express, through the smallest of musical ideas, reflections on her life or perhaps just the immediate gentleness of her leaving. (Lee, 2005)
	The opportunity to discuss the relevance and importance of memories and associations elicited by the music, helps patients to clarify life values. This allows patients to experience a sense of self-worth whilst giving meaning and purpose to their suffering. (Hogan, 1999)
	The presence of music from their homeland has brought many immigrant patients a connection with traditions and associations from the past. Such patients often long particularly for their native country and family as they face death. Music may help them trace back to their roots, and to feel less isolated and alone in a foreign land. (Munro, 1984)
	The patient may be soothed by lullabies or familiar songs from childhood. In solo improvisations using alto flute, compositions based on a descending minor third motif have proven very effective in supporting a return to comforting associations and memories of nurturance from earlier in life. (West, 1994)

Table 7

continued

Code	Data Excerpt
Connection to Self/Connection to the Music Self	The music therapeutic process, with its various demands and changes is a joint effort. The function of the music therapist...is pointing the way for new modes of expression and in the context of the musical relationship, allowing a new identity to emerge. (Aldridge, 1999a)
	Creative music therapy opens up a unique possibility to take an initiative in coping with disease, or to find a level to cope with near death. Rather than the patient living in the realm of pathology alone, they are encouraged to find the realm of their own creative being. (Neugebauer, 1999)
	Music therapy is able to…facilitate development of a more able identity. Through the experience improvisation, individuals reported that they had heightened experiences of ability, independence, skill, ownership, achievement and success. Individuals reported feeling 'professional' and 'successful' in what they had achieved, and through developing the skills associated with music making, unmet hopes and dreams were stimulated leading to life review. (Magee, 1999)
	As the music encouraged her to use her voice again, she ultimately found peace and acceptance…In the face of illness and death, the music gave this patient the ability to "find" the most important part of herself. (Kidwell, 2014)
	In some ways, the chance to conduct for the last time allowed him to experience himself as whole again; this was what he needed. (Dileo, & Parker, 2005)
	When I suggested that we sang together, she declined saying that she could not sing. I played a note on the piano and asked if she could sing it, after a few moments she began to hum very quietly. I began to support her singing with sustained chords, gradually her sounds became more confident and words began to emerge…At the conclusion of our first meeting she appeared surprised by what had happened. She said: 'It's as though a part of me I never knew existed has come to life. (Hartley, 1999)
	Another patient who had enjoyed singing and playing the piano with the therapist until breathing difficulties and generalized weakness curtailed this activity, continued to live her music through the therapist's playing of previously shared melodies. She was able to compensate for her loss by taking pleasure in the music, even though she could no longer be the active musician. (Munro, 1984)

Table 7

continued

Code	Data Excerpt
Connection to Self/Connection to Emotions	The first song seemed to express his anger and frustration as well as a willfulness of spirit. The second song suggested that beneath his anger and bitterness lay great sadness. Finally, in this first session Jacques acknowledged that he would soon die and expressed the hope that he could do so with music present. Anger, willfulness, sadness, hope; these different emotions could be revealed through and contained by the music. (Salmon, 1994)
	An important aim of music therapy in palliative care is to facilitate the expression and exploration of feelings, thoughts, hopes, fears, etc., regarding hospitalization, illness, death and any other area of concern. It is often difficult for patients to acknowledge what they are feeling; music therapy offers patients the opportunities and avenues to express what they are experiencing. Often this is done through song choice…Some patients make such choices consciously, some more intuitively. Music runs the gamut of the human experience, and patients can choose music to accompany them wherever they are along the continuum, as well as to help them to move from one place to another. (Martin, 1989)
	Music therapists in palliative care are often faced with such eruptions [of anguish] during the therapeutic process. The client has a deep, embedded sense of longing and acceptance that cannot be spoken through words. Offering music allows the client to find a different path, one based on precision yet openness to creativity. Once identified, the ensuing eruption can seem granite-like and impenetrable. Susan, a woman in her late 60's, who was living through the final stages of Parkinson's, used music in precisely this manner. As she began to lose her speech, music became her voice. Music portrayed the pain of her illness and also her joy for living. (Lee, 2005)
	She sang along a little but mostly listened, and finally she began to cry. When the song was over, she told me about her son and her concern that he would be left behind when she died…The music she requested helped bring her feelings to the surface, and speaking about her son was very important. She revealed that she had not expressed these feelings before, and she was now open to telling her son about her concern for him. She always thought she needed to be strong, and that she should not show depressed or sad emotions to him…The music we shared had created a bond and connection between us, and she felt comfortable discussing her feelings with me. (Clements-Cortes, 2004)
	It was only upon reflection and discussion of the lyrics with me that she began to identify with the sense of loss and longing that is inherent in the song. She began to talk more about how things had changed since she became ill, and no longer assured me that everything was fine. She often cried while listening to this song, saying, "Isn't this ridiculous? It's only a song about someone else and here I am crying. Denis [her husband] tells me not to listen to these songs if they make me cry, but I want to." I let her know that I had noticed a trend in the songs she had requested and asked her if she had. With encouragement and guidance, she was able to articulate that the songs reflected her recent life path and unexpressed feelings of loss, and she was relieved to find that other people had had similar feelings. (Whitall, 1991/2012)

Regaining control. One component in disconnecting from the disease identity is in the process of regaining control. By the time patients reach the end of life stage, they have experienced a tremendous loss of control over their lives. Music therapy offers many different types of experiences in which patients can exert their control over the present. As shown in Table 7, song choice is most often the chosen intervention when addressing issues of control (Hogan, 1999; Martin, 1991/2012; Skaggs, 1997 West, 1994). Having control over the familiarity, emotional content, topics of their chosen music, or over their imagery in GIM and other types of music and imagery experiences, allows patients to engage as they wish, on their own terms.

Relieving symptoms. Music therapy helps to relieve physical symptoms such as anxiety/distress, pain/discomfort, and shortness of breath. It is even plausible that a music therapist *must* address physical symptoms first before being able to access other dimensions of suffering or work at a deeper level (see Table 7, Clements-Cortes, 2011; Hogan, 1999).

Pain and discomfort are among the most prevalent symptoms addressed by music therapists, and receptive methods help to relieve symptoms. Not just familiar music, but familiar music that has been used in previous sessions offers a sense of security and predictability for the patient in increasingly unpredictable conditions. Listening to therapist-improvised live music combined with relaxation and imagery experiences; listening to patient-requested songs played live by the therapist; listening to live calming or sedative music; listening to recorded preferred music during procedures or personal care, sometimes with directed breathing/relaxation exercises; and music therapy entrainment (see Table 7 for some examples of data excerpts, Bright, 1989; Dimaio,

2010; Hilliard, 2005; Krout, 2001; Munro, 1984; Munro & Mount, 1978; Sato, 2011; Weber, 1999) are among the most common receptive interventions used to address pain and discomfort.

For patients experiencing anxiety, distress and insomnia, music therapists use listening to recorded music, listening to live familiar music, music in combination with relaxation exercises, lullabies, and therapist-improvised songs to address to patients' needs (see Table 7 for some examples of data excerpts, Clements-Cortes, 2004; Hogan, 1999; Martin, 1989; Munro, 1984; Munro & Mount, 1978; Sato, 2011; West, 1994). The soothing and anxiolytic properties of music is an inherent value of music therapy, and relaxation, of body and mind, is a pertinent goal for patients at the end of life even without reference to particular symptoms being addressed in the moment or specific music therapy interventions being used (see Table 7 for some examples of data excerpts, Aldridge, 1995; Krout, 2001; Marom, 2008; Munro, 1984; Nakkach, 2005). When receptive methods are used to address physical symptoms, more process-oriented interventions can follow the alleviation of presenting physical symptoms for patients who are responsive, willing and able to participate in more depth-level work (see Table 7 for some examples of data excerpts, Clements-Cortes, 2011; Hogan, 1999).

Less prevalent are music therapists' use of more active forms of music therapy to relieve symptoms. The rationale for this practice appears to be a combination of therapist-preference or inclination to use certain methods in their practice, their perception of patients' abilities (related to physical decline), and patients' willingness to participate.

Re-connection to Pre-illness Self

As patients disconnect from their disease identity, as a person with an illness, a person who is dying, they are reconnecting to their former selves, not defined by the illness. "Music therapy for the dying should always include the identification and elicitation of coping strengths and resources. The patient often has become so identified with the dependency of the patient role that inner strengths have been forgotten" (Data excerpt, West, 1994, p. 120). Through various music therapy experiences, patients can connect to the self through identifying with wholeness and aliveness, and through memories and life review.

Connection to wholeness and aliveness. Music therapy experiences allow patients to experience themselves as whole, and connect to their life force once again. More than disconnecting from the disease identity, these moments reflect a restoration of spirit and wellness that may have been missing for quite some time, or slowly diminished over the course of illness. "When a person is encouraged, enabled and celebrated as being whole, music can act as a very special agent. It is here, during musical improvisations in music therapy sessions, that life can be experienced in its rawest, truest sense" (Data excerpt, Hartley, 1999, p.112). The addition of music into the patient's milieu can restore normal life: "it has accompanied us life-long, even if unconsciously. Our music is a reflection of our period of time, personal and global and is symbolic for our experiences, ideas, behaviours and philosophies of life" (Data excerpt, Weber, 1999, p. 97). Similarly, music experiences can reconnect patients to an inner relationship, between their present self and some aspect of their pre-illness self, which allows for greater access to strengths

and abilities, and improved coping with dying (see Table 7 for data excerpt, Forinash, 1990).

Through GIM and other forms of music and imagery, patients can access the health and vitality of their bodies and spirits through their imagination. Through various music experiences patients can awaken or renew parts of themselves they thought were gone, overcome losses resulting from suffering, recognize their strength of spirit through melody, lyrics, and singing, and experience increased emotional well-being through feelings of accomplishment and increased self-worth (see Table 7 for some examples of data excerpts, Abrams & Kasayka, 2005; Beggs, 1991/2012; Hartley, 1999; Kidwell, 2014; Magill, 2009b). "In connecting with healthy physiological processes and life memories, music can help maintain continuity of pre-illness identities, allow imagining in life beyond cancer and render life worth living" (Data excerpt, O'Callaghan, 2014, p. 1046).

It may seem counterintuitive and paradoxical for some, to focus on aliveness with people who are dying.

> Living in music in the face of dying contains a paradox that is at the heart of the human condition. Music is a life-giving force and in many ways is contrary to the process of dying. Yet this seeming imbalance miraculously finds a level that can potentially heal and find peace. As creativity blossoms, one's place within the panorama of music and relationship also changes and deepens. It is this sense of musical deepening that makes possible an opening between music and consciousness for the client. (Data excerpt, Lee, 2005, p. 150)

Lee (2005) is the only author who acknowledged this paradox. Most authors quite naturally made the connection between music therapy and its relationship to aliveness. It is a central component of the hospice philosophy, and thus important for music therapists working in this setting, to help patients have quality of life for the remainder of their lives and "actively live while dying" (Data excerpt, Hogan, 1999, p. 71). Caregiver participants in one study confirmed this sentiment when they expressed that engaging in music therapy allowed them to "again observe and access the 'living' essence of their loved ones" (Data excerpt, Magill, 2009b, p. 103). Another patient's experience also confirms this sentiment, as he had "a strong feeling of being alive in music whilst journeying toward his own death" (Data excerpt, Hartley, 1999) p. 112). Yet another study found that "song writing offered palliative care patients opportunities to creatively express themes significant to their life experiences, enabling them to live out their life, and avoid existing until death" (Data excerpt, O'Callaghan, 1996, p. 89). As a result of song writing experiences, participants in this study began to think of future living, and experienced personal growth. Participation in music therapy helps patients and their loved ones realize that dying does not equate with death and allows for personal and spiritual growth, while regaining a sense of identity.

Connection to self through memories and life review. Life review is widely accepted in hospice and palliative care practice as a need for patients at the end of life. All disciplines, especially those more focused on emotional support, such as social work, spiritual support/chaplaincy, and music therapy, offer opportunities for life review in their work with patients and families. Most of the authors in this synthesis find that music therapy is particularly suited to eliciting memories and life review (39 out of 46).

The words "life review" or "memory(s)" were found in 83% of the included documents, the third most frequently found words in the literature.

Life review, which is practiced in many different forms by the various disciplines, may involve recall and reminiscence, and contribute to transformation of self and relationships with others. In music therapy, life review and connecting through memories transpires both formally and spontaneously, and *song choice* most readily facilitates this process. Bright (1999) first defined song choice specifically in relation to end of life care: "Patients are provided with the opportunity to express thoughts and feelings through the medium of pre-composed songs. This may or may not include a verbal follow-up discussion of any material raised in the songs. Any lyric interpretation is initiated by the patient" (Data excerpt, Bright, 1999, p. 23). Patients choose songs to reflect emotions, communicate to loved ones, and to receive comfort from memories associated with their chosen songs.

Connection to the Music Self

For patients who are musicians as well as those who find themselves actively making music for the first time during music therapy sessions, this connection to the music self is a powerful one. Final moments with patients engaging in music making can be vital to their end of life experience.

For musicians, offering music making opportunities (singing, instrumental improvisation, piano playing, conducting) helps patients to "find the most important part" of the self again (Data excerpt, Kidwell, 2014, p. 131), to experience the self "as whole again" (Data excerpt, Dileo & Parker, 2005; p. 46), "to meet" the self in music (Data excerpt, Neugebauer, 1999, p. 132), or to find the "time in hospice all worthwhile" (Data

excerpt, Dileo & Parker, 2005, p. 50). Patients can experience remarkable transformations, as if reconnecting with the music self gives a renewed energy or purpose for living (see Table 7 for some examples of data excerpts, Beggs, 1991/2012; Hartley, 1999; Martin, 1989; Munro & Mount, 1978).

For patients who are not musicians, having opportunities to make music can be life changing. A patient of who initially said she could not sing, but when invited, eventually began humming, then singing with confidence and improvising lyrics, remarked afterward, "It's as though a part of me I never knew existed has come to life" (Data excerpt, Hartley, 1999, p. 114). This sentiment was echoed throughout the literature as patients were having entirely new experiences of their music selves, developing a "more able identity" (Data excerpt, Magee, 1999, p. 88), finding "the realm of their own creative being" (Data excerpt, Neugebauer, 1999, p. 134), forming a "new identity that is aesthetic even in the face of disfigurement" (Data excerpt, Aldridge, 1995, p. 107). Even as people are nearing the end of their lives, approaching death, in music therapy they are connecting to this music self, and as a result to a greater sense of self which extends beyond the confines of the physical body. Perhaps this is why such elation is experienced in these moments—patients are feeling a remarkable sense of freedom in the midst of severe restriction and limitation.

Connection to Emotions

We know that music therapy can easily access emotional content and that emotional expression is often a clinical goal. However, unique to end of life, music experiences facilitate connection to emotions specific to the dying process. Music both accesses and expresses the breadth and depth of patients' emotions regarding death. It

provides a channel for the expression of the deepest, most intense of emotions, becoming the 'voice' of so many patients for whom words cannot adequately express (see Table 7 for data excerpt, Lee, 2005). Fear, anger, sadness, anguish, turmoil, pain, frustration, concern, conflict, grief and loss are among the many words used to describe the emotions accessed by the music experiences. For some patients not needing, wanting, or able to engage in verbal discussion, the emotional connection can be strictly held within the music experience. For others, the music serves as a springboard for discussing this emotional connection in preparation for death and the remainder of their lives. In both cases, this access to intense emotions allows patients to experience some resolution and new energy for living, or gain insight into their needs at the end of life, especially in regards to closure.

Song choice is again a prominent intervention used in this context. Patients choose music to access and influence their emotions, exercising control over their lives. "Some patients make such [song] choices consciously, some more intuitively. Music runs the gamut of the human experience, and patients can choose music to accompany them wherever they are along the continuum, as well as to help them to move from one place to another" (Data excerpt, Martin, 1989, p. vi). Whether songs are chosen consciously because of particular memories or associations, or intuitively because of unconscious processes, patients are able to connect to their emotional self through their connection to the expressions within the music. This is particularly important for people at the end of life, for whom unresolved tensions, or unexpressed emotions can result in physiological manifestations of pain and discomfort unable to be controlled through pharmaceutical interventions.

Music Therapy Facilitates a Connection to Others

Patients at the end of life are in need of connection with others, whether initially realized or not. In both new and old relationships, it seems imperative for people at the end of their lives to connect with others, as close, intimate relationships with others are what make life meaningful. In a qualitative study of songs written by palliative care patients, participants reflected upon their meaning for significant others in their lives and other's meaning for them in 31% of all the songs analyzed (O'Callaghan, 1996). Data excerpts will be used throughout this section to illustrate these results, and Table 8 provides examples of data excerpts that characterize each sub-category. Figure 7 presents the portion of the overall visual model related to connection to others.

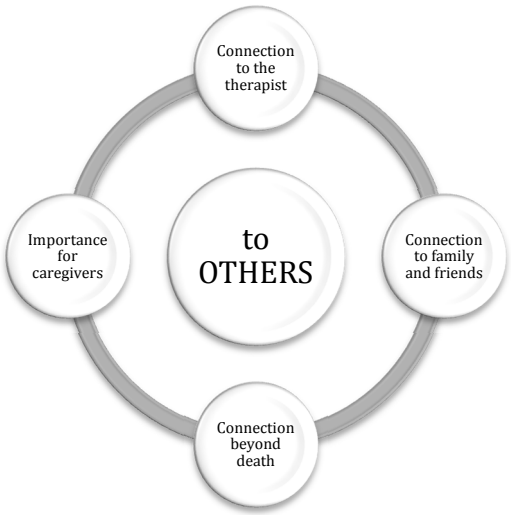

Figure 7. Visual Model—Connection to Others

It is the shared music experience that is key for this connection with others. Patients can connect emotionally, intimately, and in a concrete way, decreasing the sense of isolation often felt at this stage of life (see Table 8 for some examples of data excerpts, Aldridge, 1999a; Krout, 2003; Martin, 1989; Salmon, 1994; Weber, 1999).

> The creation of music can never be an isolated act, even when playing music alone we are relating to the world around us—it is the most social of the arts. Therefore the experience of making music should be paramount to human existence. It is from out of the contact we have with other people that we can begin to value who and what we are and glimpse the potential of who and what we can be. Music offers a direct and uncomplicated medium for being close together, a medium within which participants can be respected, revered and even celebrated. (Data excerpt, Hartley, 1999, p. 124)

The personal contact inherent in music therapy experiences creates intimacy and closeness with others, a core human need.

Table 8

Examples of Data Excerpts—Connection to Others

Code	Data Excerpt
Connection to Others	Music has the ability to connect people emotionally. In palliative care music may help alleviate the sense of aloneness which patients and their loved ones sometimes experience. Music therapy, then, becomes a valuable tool for addressing the complexities of human relationships. (Salmon, 1994)
	The music also appeared to connect all in the room—therapist, patient, and family—in a concrete way through the vibrations of the guitar and voice, and the eye contact between us. (Krout, 2003)
	Songs, and music in general, can help decrease feelings of isolation, so common among the terminally ill. There can be a real intimacy involved in a shared musical experience. The patient can feel a connection with the composer and the emotional expression or quality of the music, as well as with the performer, be it either the therapist performing live or a recording artist. The patient may encounter the commonality of the shared experience through the music. (Martin, 1989)
	With this song we spontaneously expressed the feelings of oneness through faith and the sense of community which we had just experienced. On subsequent days the incidents of this encounter through hymns and songs remained a very meaningful memory for the four patients. Even though they conversed only slightly more than before, there now was a sense of family between them. They took a new interest in each other's well-being and did not again withdraw into their previous isolation. (Munro, 1984)
Connection to Others/Connection to the Therapist	Tonya was able to reconnect through something that felt safe and familiar. However, it was the therapeutic relationship formed through the sharing of this music that seemed to have the greatest significance. Despite her cognitive limitations, Tonya and I could interact in the music and feel as one. Even when words did not come easily, the melody was something that always kept us on common ground. Tonya essentially had very little support and her desire to be validated and cared about played out in her anxiety and fear. Because the music used was so familiar and easily accessible, Tonya was able to immediately relate to me and I believe she finally felt a true connection to someone. Perhaps due to her cognitive limitations, she wasn't able to comprehend death, but she clearly understood loss and the desire to not feel alone. The relationship that grew through the music helped her feel validated and no longer alone. (Kidwell, 2014)
	I have repeatedly experienced patients quickly sharing their life stories through the music they were listening to or I was playing for them. It was as if the music had opened up a deep desire and a way to share these experiences. (Weber, 1999)
	The music therapy sessions seemed to allow Pat to be fully herself. Throughout the process note on this session I refer to Pat as someone who likes people, likes to be active and engaged in interacting with others. This active personality was coupled with a body that was severely debilitated from disease…The session provided Pat with interaction on an accessible level. It allowed her to be heard and for her to receive a response to her interaction. (Forinash, 1990)

Table 8

continued

Code	Data Excerpt
Connection to Others/Connection to the Therapist	If the progress of disease is an increasing personal isolation, then the music-therapeutic relationship is an important one for maintaining interpersonal contact. (Aldridge, 1999a)
Connection to Others/Connection to Friends and Family	One day she spoke about her husband, Tom, who was sick and unable to visit her at hospice. She said, "I want him to hear "Danny Boy," my favorite song. Can you play it now? I'm going to call him." She called Tom, told him to listen to the music, and held the phone close to me. As I played, Mary was tearing up. (Sato, 2011)
	Connectedness with others (their sense of connection with the patients and significant others and experiencing deeper communion with them in sessions) with others was a predominant theme in this study, as caregivers unanimously made references to their thoughts and feelings regarding revived interrelatedness. Most commonly these statements emerged in descriptions regarding connection and communication with the patients in, around, and following the music in sessions…Experiences in connectedness seemed to help them let go and prepare for death while leaving them with images of faces, eyes, and voices filled with smiles, laughter, and songs. (Magill, 2009b)
	We sang a few other songs, and the patient's daughter held her mother's hand and sang along to the ones she knew. Toward the end of the session, the patient talked about what a wonderful child her daughter had been. I suggested we sing a song for her, and together the patient and I sang "Shen Vi di L'Vone," which is a Yiddish song that means, "You are as beautiful as the moonlight. (Clements-Cortes, 2004)
	I began the hymn, with the family supporting each other and listening. As I sang the beginning of the chorus, Mrs. J. began to sing with me. She sang along with each verse and continued to hold her husband's hand. (Krout, 2003)
	Firstly he directed his gaze towards me and then, with an enormous amount of effort began to sing. He sang intermittently to begin with, mostly at the end of phrases. Gradually it became more sustained and I felt that he was motivated by the simplicity of the musical structure. Spontaneously, his partner began to sing with us, and for a time the three of us were together in music; it was an intensely emotional experience. Much later, after the funeral, I spoke to his partner. He believed that the singing had been an important experience for both of them, as he felt it was the last time they had truly made a connection with each other. (Hartley, 1999)
Connection to Others/Connection to Others Beyond Death	Further counseling led David to believe that this process would also allow him to rebuild any broken parts of his relationships, and to allow him to leave a "legacy" that was more powerful than any negativity he had displayed in his friendships up to that point. (Hilliard & Justice, 2011/2012)

Table 8

continued

Code	Data Excerpt
Connection to Others/Connection to Others Beyond Death	I believe MTE assisted Walter in accepting his death, as indicated by his ability to process the meaning behind his pain and dying. He was able to leave a transitional object/legacy for his family: the music he created. His wife reported listening to the CD many times throughout her grieving process. (Dimaio, 2010)
	During our fourth session, when the patient's daughter was not present, I suggested that we change the song's lyrics and make it a present to leave for her daughter. She agreed and shared ideas about her daughter to include in the song. This song-writing project allowed the patient to share her thoughts about her daughter, and it left her daughter with a wonderful gift. During the next few sessions, we worked on the song. We sang the song together for her daughter in one of our last sessions. (Clements-Cortes, 2004)
	The making of a tape of these songs helped Claudette to slowly process this newly acquired insight (because she listened to the tape very often) , and to provide her loved ones with a gift that would out live her. This was perhaps one of the most personal gifts she had ever given, as it shared the inner emotional turmoil of her last days of living, as well as providing her loved ones with a legacy of her life. In the bereavement process, this might serve as a transitional object for those who are grieving since it is a real presence of Claudette's personhood, yet it is also very soothing. (Whitall, 1991; 2012)
Connection to Others/The Importance of Music Therapy for Caregivers	Ms. Johnson's son thanked the therapist for singing, remarking that, in his mind, he could hear his mother's voice as the therapist sang her favorite songs. (Hilliard, 2005)
	Adam displayed no awareness that anyone was with him, staring straight ahead. After a short time, I began to sing non-verbally, my voice was soft, the tempo was slow, and I chose a simple four-phrase structure. Slowly Adam became involved. Firstly he directed his gaze towards me and then, with an enormous amount of effort began to sing. He sang intermittently to begin with, mostly at the end of phrases. Gradually it became more sustained and I felt that he was motivated by the simplicity of the musical structure. Spontaneously, his partner began to sing with us, and for a time the three of us were together in music; it was an intensely emotional experience. (Hartley, 1999)
	L often tells me how it has helped her through her bereavement, The music has put a time perspective on K's death. It has given it a framework. With each song I am able to vividly recall what happened during his death experience which I find very comforting. (Hogan, 1999)
	His daughter and son-in-law were at his bedside, and I told them briefly about our musical connection, and they were amazed that he had been so open and full of life, as this had not happened since his heart attack. I had brought a recording of Nessun Dorma with me, and we held hands as we sang along tearfully. He died shortly thereafter. (Dileo & Parker, 2005)

Within the context of new relationships, such as those between the patients and music therapists or other staff, or between patients and other patients (i.e., sharing a room, in a group on a unit), music experiences soften defenses, allowing for the meaningful and needed connection to transpire between the patient and whomever they identify as important. Patients once hostile or rejecting necessary palliative services became approachable, cooperative and open to services after engaging in a music therapy session: "We traveled together with the melodies, sounds, tensions and resolutions, and in his music he let me see and feel with him his vulnerability, gentleness, suffering and despair. Through music we moved from being strangers to friends" (Data excerpt, Munro, 1984, p. 25). Music experiences transformed bleak, one-word answers into long, elaborate conversations between a patient and therapist allowing for a meaningful connection and relationship completion to occur (Data excerpt, Dileo & Parker, 2005). Shared music experiences brought together a room of women in an inpatient hospice, all speaking different languages and resistant to interaction with one another, and created "a sense of family between them" (Data excerpt, Munro, 1984, p. 46), causing them to take interest in each other's well-being and become less isolated. These stories depict several individual experiences, but they are just a few of many and represent the nature of music therapy in this setting.

The literature reflects two foci: connection to the therapist and connection to family and friends. The distinct difference between the two kinds of other-connections is in the role of the music and the therapist in establishing, re-establishing or maintaining the interpersonal connection.

Connection to the Therapist

The most obvious interpersonal connection in music therapy is that connection between the patient and the therapist. While the majority of the literature at end of life focuses on connections between the patient and significant others, there is substantial dedication of writings to the importance of the connection between the patient and the therapist. Sadly, many people die alone, without family or friends to accompany them. Some patients are limited cognitively, preventing them from requesting or maintaining connections with significant others, and others may be estranged for various reasons. The music therapist plays a significant role in these circumstances, providing meaningful connections and intimate experiences.

In these circumstances, where the connection between the patient and the therapist is paramount, the music is the point of contact, the facilitator and the foundation for this relationship. "Margaret never spoke to me, and yet in the music, we knew each other deeply and intimately. She seemed to open her soul through the improvisation" (Data excerpt, Lee, 2005, p. 155). Therapists and patients come to know each other through the musical connection. For some, this connection is held strictly within the music experience, without verbal discussion. For others, the knowing that transpires in the music provides opportunities for verbal sharing following the music experience.

> I have repeatedly experienced patients quickly sharing their life stories through the music they were listening to or I was playing for them. It was as if the music had opened up a deep desire and a way to share these experiences. (Data excerpt, Weber, 1999, p. 98)

The use of verbal discussion following the music experiences to further connect with patients is dependent upon patients' abilities, preferences, and the types of music therapy interventions used. For instance, therapists using improvisational methods are more prone to manage the interpersonal connection within the context of the music, whereas therapists using songs include more verbal discourse.

Connection to Family and Friends

Music therapy's ability to facilitate connection between patients and their loved ones at the end of life is a cornerstone of this work. Over half of the included literature focused on this connection at some point. Patients usually express the need to be with their friends and family during the dying process and to experience these relationships as loving and caring. However, different from the focused connection between patient and therapist discussed in the previous section, the music therapist becomes that of a facilitator for the patient's connection with loved ones. It is almost as if the therapist and the music become symbiotic, joined together to enable the relationship between the patient and the loved one(s) present to develop, mend, or deepen.

Music therapists predominantly make use of familiar songs when facilitating this connection. Patients and/or loved ones choose songs that hold meaning for their relationship, whether because of the memories and associations connected to the song, or because of the sentiments present in the lyrics which convey some message or emotion they need to express. Music experiences function in a number of ways to enhance the connection between the patient and family or friends. They often restore or rejuvenate patients' energies, allowing for a more authentic connection with loved ones:

> After hearing the song, 'Bad Moon Rising,' the patient remarked, 'that takes me back to another time, man.' He then proceeded to reminisce about his life during the seventies and laughed while sharing his memories. His wife told the therapist after the session that she had not heard her husband laugh in months. (Data excerpt, Hilliard, 2005, p. 23).

Music experiences help people to reconnect strained relationships:

> Further counseling led David to believe that this process would also allow him to rebuild any broken parts of his relationships, and to allow him to leave a "legacy" that was more powerful than any negativity he had displayed in his friendships up to that point. (Data excerpt, Hilliard, 2011/2012, p. 5)

Music experiences allow patients and loved ones to just be together and deepen their present connection:

> The music also helped enhance the feeling of closeness between Sarah and Jane. They shared many memories evoked by the music, experiences of childhood and their lives together. They also shared other thoughts and feelings they had experienced as they listened to the various songs. (Data excerpt, Martin, 1991; 2012, p. 11)

Finally, music experiences can help patients and loved ones acknowledge difficult emotions, or acknowledge their understandings of death and dying, which can open up their ability to be together in a meaningful and honest way, especially when death is imminent:

> A family music therapy setting, for example, can assist in the process of working through the stages of acceptance of death by using music as a vehicle to verbalize

> emotions and ideas that may be threatening to express otherwise. Through such a process, the family can move together toward acceptance of each other and of death as reality. (Data excerpt, Gilbert, 1977, p. 170)

Connection to Others Beyond Death

While it is imperative for patients to feel a connection to others in the moment, it is also important for many to prepare for a connection beyond the physical limitations of death. This is one of the reasons life review is a common practice at the end of life, across disciplines. People need to know they will be remembered for their life contributions and this knowledge can be carried through significant relationships in their lives. Patients can also have great concern for the pain and suffering loved ones experience as a result of grief and loss. It is not uncommon for patients to use music to celebrate the relationship through reminiscing and story telling, as a way of commemorating the relationship. Or, they may use music to express wishes, hopes, and messages of comfort for loved ones. For both, the connection to others in the moment is about preparing for the impending loss and finding ways to redefine the relationship, within new physical parameters. Music therapists most often utilize song legacy projects as a way to provide this bridge.

Song legacy projects are approached in a number of ways. Some therapists use a formal process of life review through pre-recorded songs, with the intent of making a CD compilation. Others encourage patients to make a CD compilation of significant songs used in therapy. Some therapists use songwriting wherein patients write original songs or lyrics to share something about themselves or their experience of dying, to communicate thoughts and feelings to loved ones. Music therapists also have patients choose pre-

recorded songs or write songs to dedicate specifically to significant people in their lives. Each variation of the song legacy serves two purposes. They help the patient to reflect on their own process of dying or communicate important messages to loved ones, which in turn leads to increased acceptance and comfort.

> Walter not only used the CD to assist in his pain management, but it also became a part of his dying process. When he played the CD for his daughters, it became an opportunity to address their anticipatory grief, and the song allowed them to discuss his dying process. The daughters could hear what he had been experiencing and they could hear his relief and his healing of his pain. (Data excerpt, Dimaio, 2010, p. 114)

Song legacies are tangible gifts to loved ones, sometimes referred to as transitional objects (see Table 8 for data excerpts, Dimaio, 2010; Whitall, 1991/2012) for the bereaved, often played and even distributed at funeral or memorial services. For the patient, this process solidifies the connection to others so important at the end of life. Finally, song legacies present an opportunity for ongoing connection through the shared and documented experience of significant music. With these recordings, patients can imagine their loved ones listening long after their physical death.

> Jacques' songs were a legacy that he was pleased to leave to family and friends - a personal gift that was precious to all. Confined to bed with extremely limited movement or speech he nonetheless extended himself further. Wanting 'others to learn from my songs', and suggesting that 'Sick and Full of It' be played for doctors whenever the opportunity arose. Our therapeutic relationship with Jacques was built through a sharing of the nourishing and expressive capacities of music.

> It allowed us to be there for and with him during the last months and days of his life and to provide support to his wife. (Data excerpt, Salmon, 1994, p. 80)

The Importance of Music Therapy for Caregivers

While Magill (2009a, 2009b) was the only author of the included literature to focus specifically on caregivers, many discussed the importance of music therapy for caregivers. The results of her qualitative study demonstrated that the importance of music therapy for caregivers was in the re-established or deepened connection with the patient, relating through the music. The music experiences were experienced as love, as "meaningful moments of communication" (Data excerpt, Magill 2009b, p. 36), as a "reawakening" (Data excerpt, Magill 2009b, p.36) of the connection with the patient. Music therapy experiences had by caregivers prior to the death of the patient can positively affect the bereavement process.

In the previous section, *Connection to Others Beyond Death,* the focus was on the patient's need for connection to loved ones beyond death. Song legacy projects allow a patient to have meaningful experiences at the end of life, hopefully easing suffering and allowing for a more peaceful passing. While the patient is the primary focus for the music therapist, the caregivers are important parts of this equation, and their involvement in music therapy sessions serves both the patient's dying process and their own bereavement.

Munro (1984), the pioneer of music therapy in palliative care, felt that family should be included in music therapy sessions and in almost half of the included literature, authors mentioned the impact of music therapy for caregivers specifically in their writings. Music experiences provide opportunities for processing anticipatory grief,

facilitate goodbyes and a means of letting go of the patient, and allow for meaningful communication of emotions and important sentiments. This serves to bring a sense of calm to the family, allowing them to just be together, positively changing the memory of the death and dying experience, which aids in coping during bereavement (see Table 8 for some examples of data illustrations, Aldridge, 1999a; Beggs, 1991/2012; Clements-Cortes, 2004; Dileo & Parker, 2005; Dimaio, 2010; Hartley, 1999; Hilliard, 2005; Hogan, 1999; Krout, 2003; Magill, 2009b; Martin, 1989; Martin, 1991/2012; Munro, 1984; O'Callaghan, 1996; O'Callaghan, 1997; Sato, 2011; Weber, 1999; Whitall, 1991/2012).

The capacity for music therapy experiences to change the memory of the death and dying experience for caregivers is extremely significant. From my own experience in bereavement support, I know that the memories of the end of life of the patient are often traumatic for caregivers. With a terminal illness comes images, smells, sounds, pain and suffering that can be horrific for surviving loved ones to experience and are not easy to forget. Death memories can overshadow the life memories, and it can be a process for the bereaved to work through the trauma of what they witnessed and experienced during the decline and death of their loved one.

This is not to say that with the presence of music therapy, these negative images disappear. However, the presence of music therapy does superimpose beautiful, meaningful images and sounds, and appears to transform these memories for many. There were countless, beautifully poignant stories of patient and caregiver experiences scattered throughout the literature, experiences that clearly impacted the caregivers' memories of the end of a loved one's life. However, this passage left a lasting impression on me:

> We asked Alan if there was a special song that he had shared with Gloria, and he stated that there were many. We began with a song that he said best expressed his feelings of the moment: *Always*. Alan sang this song tearfully and directly to Gloria, with only musical support from the therapists. After this song, Alan moved closer to the keyboard at the foot of Gloria's bed, and sang another of their favorites: *The Anniversary Waltz*. What had begun as an attempt by the music therapists to provide some music to accompany the family in their letting go of their loved one, grew into a full concert performed by Alan for Gloria. (Data excerpt, Dileo & Parker, 2005, p. 49)

Music Therapy Facilitates a Connection to Spirituality

Perhaps one of the most unique aspects of music therapy at the end of life is its not uncommon use to support patients' spirituality. Just as the palliative care tradition to consider spiritual needs has been historically exceptional in health care, music therapists working in hospice and palliative care are more likely to encounter spiritual support needs in their work than in other areas of practice. There can be a surge in the urgency of spiritual needs when life is threatened and death is imminent. Citing the work of Muldoon & King (1995) and Puchalski (2002), Magill (2009b) explained:

> As spirituality is often described as a construct that goes beyond religion and is concerned with inspiration, hope, meaning, connectedness, and a transcendental way to live one's life at a deeper level, it can be understood that those immersed and participating in end-stage care will inevitably face spiritual dilemmas and engage in existential inquiry. (Data excerpt, p. 97)

When combined, the words "spiritual" and "spirituality" were the most frequently found significant key words I searched among the included documents, confirming Magill's (2009b) assertion of the inevitability of presenting spiritual needs in end of life care. I identified four themes encompassing how spiritual needs were approached or understood in the included literature: as an expression of religious or faith practice, as a connection to beauty, through transcendence, and in the context of the end of life transition. In Figure 8, the portion of the overall visual model related to connection to spirituality is provided. Data excerpts will be used throughout this section to illustrate these results, and Table 9 provides examples of data excerpts that characterize each sub-category.

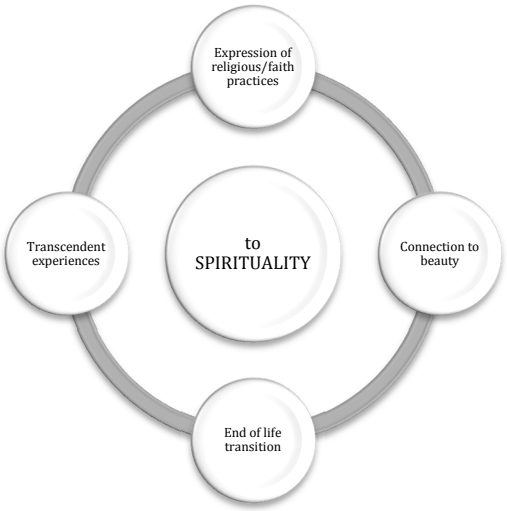

Figure 8. Visual Model—Connection to Spirituality

Expression of Religious/Faith Practices

While the focus of music therapists addressing spiritualty is not specific to any one religion or faith practice, patients instinctively use music experiences to express their individual faiths and seek comfort. Music found in religious traditions and customs and

used in therapy helps to re-connect or deepen patients' relationships to their God or personal sense of spirituality. In these circumstances, patients are choosing the spiritual songs, and it is the familiarity of the music as well as the content of the lyrics that initiates the spiritual connection and that patients incorporate into their spiritual process, or provide the impetus to further explore their relationship with God. "Music and lyrics can constitute a source of comfort and reassurance…the benefits of music therapy also include the ability of music to help individuals draw closer to God and derive a feeling of assurance through religious faith" (Data excerpt, Gilbert, 1977, p. 170).

More than in other contexts explored in this synthesis, patients sing spiritual songs together with the therapist. Congregational singing is an integral part of many religious traditions, so it is not surprising that patients would feel compelled to sing along with this music. Most patients at the end of life are too sick to attend religious services, and music therapy sessions are a place where they can engage in familiar spiritual rituals. One patient even remarked that, "the music therapist brought church to her through the music" (Data excerpt, Hilliard, 2005, p. 23).

Connection to Beauty and Transcendent Experiences

Aldridge (1995, 1999a) was the only author to truly discuss at length the relationship of aesthetics as a theoretical concept and end of life. Others referred to the aesthetic qualities of music or beauty as being accessed by music and essential to the patient's experience at the end of life. This connection to beauty is most appropriately categorized as a spiritual experience, when considering Magill's (2009b) discussion of spirituality as a construct that is concerned with inspiration, hope, meaning, connectedness, and a transcendental way to live one's life at a deeper level.

In a qualitative study of music's relevance for cancer patients, music helped some patients remember that beauty exists (O'Callaghan, McDermott, Michael, Daveson, Hudson and Zalcberg, 2014, p. 1043) This re-connection to beauty is especially important for patients at the end of life, who have suffered immensely and endured so much: "We humans have a need for the beautiful and the Divine. The aesthetic enjoyment of music satisfies these needs with the dying—perhaps in a way no other art form can" (Data excerpt, Weber, 1999, p. 97).

In her book, Munro (1984) shared a case study written by a physician colleague about one of their shared patients. He articulated the impact of the beauty of music on this patient: "Where all human and medical efforts at soothing the despair and agitation failed, the transcendental, universal and eternal beauty of music had reached into this man's heart· a man afraid and too deeply hidden, even to himself, unreachable either by the spoken word or by the human touch of nursing" (p. 51). Here, the music-beauty connection soothed despair and agitation. The connection to beauty within the music experience also helps patients find beauty in their own existence, make peace, gain a new understanding of life, and cope with the difficult challenges of this transition (see Table 9 for data illustrations, Hartley, 1999; Martin, 1991/2012; O'Callaghan et al., 2014; Sekeles, 2007a/2012). This connection to beauty as an outcome of the music therapy process is a foundation for other types of connections—to self, to others—and ultimately a quality of life that is more desirable.

Table 9

Examples of Data Excerpts—Connection to Spirituality

Code	Data Excerpt
Connection to Spirituality\ Expression of religious or faith practices	As the music therapist began singing the song with guitar accompaniment, the patient started singing softly. During the chorus, the patient looked at the therapist and sang boldly, "and He walks with me and He talks with me, and He tells me I am his own…" Ms. Johnson's affect was cheerful as she sang along, and she smiled brightly. When asked how she felt about singing the song, Ms. Johnson said "it reminds that God is with me even during my darkest hours." She clearly felt lifted by the music and the song appeared to provide her with spiritual comfort. (Hilliard, 2005)
	Wendell began singing an improvised spiritual call and response - a string of musical petitions to God; his wife melodically to each: "Hear me, Lord." I followed her lead, and we sang, clapped and danced around his bedside in gospel fashion. This continued for 15 minutes; Wendell's vocal stamina was remarkable considering the fragility of his physical condition; it seemed to have been fueled by his deep religious fervor. (Dileo & Parker, 2005)
	This moved us into the transformative phase of sessions where we sang and discussed familiar religious songs enabling Peter to speak about his questions concerning God and also facilitating discussions about his past mistakes. *Amazing Grace* was a song Peter had a strong connection to from his childhood. We sang it in many sessions…The lyrics of the song that day brought him to his own assessment that he had been ''blind,'' so to speak, for most of his life. Perhaps due to the memories associated with the song and the place it held in Peter's life, this song brought emotions and feelings to the surface that made them easier to speak about than trying to raise them independently. (Clements-Cortes, 2011)
	I was immediately aware, when Tonya started singing, that there had been a disconnect with her faith, but as soon as the music began, any hesitancy was gone and she was completely immersed in faith, most likely one of the only things in her life she could truly connect with, specifically through music and more through singing. Only after speaking to her for a few moments, and assessing her cognitive impairment, I knew that music would give her the immediate sense that her faith was recognized as important. Through singing songs she so confidently identified with, Tonya would be able to begin the process of freely expressing her faith and how it relates to loss, fear, and her own death. (Kidwell, 2014)
	As the music continued, it seemed to "ignite" something in Demond, and he began openly discussing his spiritual beliefs. After singing together, "Climb Every Mountain" (Rodgers & Hammerstein), Demond asked if I knew anything about Buddhism. I stated that I knew some things about this religion and Demond smiled and stated, "what do you know," almost challenging me. After I shared some of my admittedly limited knowledge (i.e., practice of giving), Demond reflected (again with great pause), "I have always been a good person…have never done bad to anyone my whole life." Through this statement, I immediately heard in Demond the "plea," why me? (Kidwell, 2014)

Table 9

continued

Code	Data Excerpt
Connection to Spirituality\ Connection to Beauty	Certainly, music is a sensual event: tonalities perceived by the ears; rhythm, vibration felt in the body-all processed through electrical/chemical activity in the brain. But there is a deeper musical experience which we are unable to talk about. Most of us have felt that inner light, that hidden beauty and, at times, that terror that music awakens and brings to our awareness, and for which we have no words. (Forinash & Gonzalez, 1989)
	We should consider that Nathaniel's physical alteration from an active man and a successful family supporter could have had some bearing on his psychological condition and trigger deterioration. Nonetheless, Nathaniel did not become bitter or demanding. Rather, he attempted to cling to life and in a way found beauty in his existence: his wife and children, music, poetry, his room, and friends. (Sekeles, 2007a/2012)
	For the sick, maimed, disfigured and stigmatized, the opportunity to partake in a greater beauty is important. (Aldridge, 1995)
	For our hospice patients, who have often suffered so much, music brings them something beautiful. (Weber, 1999)
	By means of the journey, with the music therapist as a constant support and companion, I became the creator, but also the sharer, of beauty. I am, then, no longer surprised by people relating their experiences of improvising music during music therapy sessions to an improved quality of life - I feel so much better, I don't know where the energy comes from are clients common reactions. Some HIV positive patients talk about how a new understanding of life has been gained from the experience of creating music during therapy sessions. (Hartley, 1999)
Connection to Spirituality\Transcendence	Jacques seemed to sense that by fully accepting his situation, including his death. he might somehow transcend his suffering and 'become more than just a man'. At the end of the session in which Jacques dictated the above words, he requested the Beatles' song 'Let It Be', which also speaks of the wisdom of acceptance. Jacques seemed to be accessing his own inner resources, his own depth and wisdom. (Salmon, 1994)
	Religious beliefs are seen through the patient's expression of suffering and questioning as he reflects on his life. Transcendence occurs when the patient is able to overcome the circumstance of his illness and attain a state of acceptance. Music acknowledges suffering and encourages an awakening of the spirit that brings about this acceptance. (Kidwell, 2014)
	Music therapy, with the potential for bringing form out of chaos, should offer hope in situations of seeming hopelessness, and therefore a means of transcendence. This idea of transcendence, the ability to extend the self beyond the immediate context to achieve new perspectives, is seen as important in the last phases of life where dying patients are encouraged to maintain a sense of well-being in the face of imminent biological and social loss. (Aldridge, 1999a)

Table 9

continued

Code	Data Excerpt
Connection to Spirituality\Transcendence	Another factor involved in music listening, as well as other strategies, is transcendence, the process of taking one beyond the self to an enlightened focus and ‘‘interest in others and the world through which [one is] led to a greater knowledge and capacity to love.’’ (Magill, 2009a)
	Music can act as a means to transcend the realities of illness and loss. Music that represents such dynamic life experiences must traverse the entire gamut of musical styles. (Lee, 2005)
Connection to Spirituality\ End of life Transition	Whether through song choice, listening to music or life reviews, music is capable of connecting with patients at a profound level. It shifts and balances the dimensions of their human compositions so as to creatively relieve discomfort and achieve a heightened awareness of self. The music gently guides terminally ill patients through their journey that searches for resolution, harmony and peace and prepares a path for existential transition and transformation; their rite of passage. (Hogan, 1999)
	At end-stage, the music supports surrender, focus of attention, and movement through the transition process of leaving the body. Long sustained tones, smooth melodic lines, tone qualities, and tonal centers may become the focus of improvised music played for the dying and also assist in setting a tranquil mood for others in the room. Themes and form should be simple; modes should support but not strongly elicit emotion. This is not a time to elicit responses, verbally or nonverbally. Live music may be used to connect rhythmically with the patient's breathing. Using the iso principle, the therapist matches the patient's breath rate then gradually slows the rate and supports more evenness and relaxation as periods of apnea naturally occur. The music therapist must use sensitivity, intuition, and astute observation to evaluate the effects of the music used at this point. (West, 1994)
	The improvised music used the rhythm of Jacques’ breathing as a guided tempo. Any sounds he made became tonal guides. This technique, which I call ‘matching’, demands a great deal of concentration and presence as the person’s breathing, his or her ebbing life force, is the point of contact and the basis of music-making. I have, at times, felt deeply connected to the dying person in these moments. It is not uncommon for the person s rate of breathing to change, usually becoming slower and more regular. On occasion, death has occurred during the live music. (Salmon, 1994)
	The music reflected this change. I improvised, basing the rhythm on Sara’s breathing. As her breaths became more shallow and slower, I changed to softer and slower music. This was not a conscious choice. I was simply aware that as she changed, I also changed. (Forinash, & Gonzalez, 1989)

Table 9

continued

Code	Data Excerpt
Connection to Spirituality\ End of life Transition	Loss is a part of living, and the use of music to reflect life and loss appears natural. As my work and theories have developed, my understanding of the link between music and dying has deepened. Although I may never fully comprehend the mystery of music in the face of illness and death, I do know that the music is created is often beyond conscious, rational thought. (Lee, 2005)

The word transcendence often conjures up images of light, weightlessness, limitlessness, or boundless energy. This philosophical idea holds greater significance for people at the end of life, given their approaching ultimate transcendence into the next dimension (however the individual defines that according to his or her particular spiritual beliefs). Transcendent images developed in GIM sessions can be a part of the preparation for dying, "for journeying to an unknown territory that is beyond life as we know it, and transcending the self as it has been known" (Data excerpt, Skaggs, 2007, p. 41). The transcendent capacity of music—whether through song lyric content, musical elements, or associations—to acknowledge suffering and encourage awakening can facilitate a state of acceptance (see Table 9 for some examples of data illustrations, Hogan, 1999; Kidwell, 2014; Salmon, 1994).

Aldridge (1995, 1999) dedicated a significant amount of writing to the idea of transcendence in music therapy for people at the end of life. He described music therapy's capacity for bringing form out of chaos, and discussed creativity and the creative act of making music as being the means through which one experiences transcendence:

> The main emphasis of spirituality has always been that it will help us to achieve this new consciousness by transcending the moment. So, too, with the concept of hope, there is the expectation of a leap forward. In music therapy this transcending, expectant leap is made through the creative act. Through creative play, we can distinguish the inner world of ourselves. In this sense, consciousness is realized by doing. (Data excerpt, Aldridge, 1995, p. 103)

Similar to this idea of a "new consciousness," music listening can take patients beyond the self to an enlightened focus or act as a catalyst, transcending "out of despair and into heightened moments of awareness and connectedness" (Data excerpt, Magill, 2009b, p. 105). The musical elements are fundamental to this process, wherein music, of all styles, can act as a means of transcending the moment (see Table 9, Lee, 2005). Transcendence is not a goal of music therapy at the end of life; rather, it can be a meaningful outcome of the process.

Accompanying the End of Life Transition

Just as music therapy can facilitate transcendence in the moment throughout the dying process, it can be an integral part of the end of life transition. In over half of the included literature, this actively dying stage is addressed. I have categorized this phase under the connection to spirituality, due to the ways in which authors describe this aspect of the work at end of life as being connected to the spiritual realm. And regardless of religious or spiritual beliefs, there is a transfer of spiritual energy that happens in the final moments of life that gives the work during this phase a spiritual component.

It is the responsibility of the music therapist to be prepared to accompany or assist patients through this transition, using therapeutic music interventions, which permit the

transition between life and death (see Table 8 for other examples of data illustrations, Munro, 1984; Skaggs, 1997). Music therapy is a meaningful and beneficial accompaniment to this phase. Music therapy continues to be "a way in" (Data excerpt, Magee, 1999, p. 88) for patients who are no longer conscious or visibly responsive, as the nonverbal communication of music reaches patients in different dimensions, transcending emotional, physical and spiritual barriers and helping them to find a "path of acceptance and existential resolution from which to leave their bodies, separating themselves from this world to the next" (Data excerpt, Hogan, 1999, p. 75). Music therapy may actually facilitate this transition, calming agitation and helping patients to let go of what may be holding them back from the release of death. Music therapy also brings families together during transition, allowing them to feel more deeply connected to the patient, whose essence is being transformed (see Table 9 for other examples of data illustrations, Hogan, 1999; Krout, 2003; Munro, 1984; Salmon, 1994). In the hospice community, the term *good death* is often used to describe circumstances where patients are comfortable, suffering minimized, living out their final wishes. For patients who desire it, music can contribute to the good death.

Why is music suitable for these final moments? It appears that music can intimately connect to the dying experience. Whether it is the ability of music to connect to life, "Surely it is because of the relationship between music and life that music therapy fits so readily in an environment where people face death, dying and all that this brings" (Data excerpt, Hartley, 1999, p. 112); or loss, "music and loss are inextricably linked. To begin a piece of music is to face the end. To begin a musical experience with a client is to know a lifecycle with an unwavering clarity" (Data excerpt, Lee, 2005, p. 158); or other

realms of consciousness, “In its sacred practice, music has been used to transport the listener to other realms of consciousness, and is used thusly in the final stages of dying” (Data excerpt, Aldridge, 1995, p. 107); or “all aspects of human life” (Data excerpt, Scheiby, 2005, p. 173), music is a well-suited accompaniment to the end of life transition.

> “Music, because of its capacity to give voice to the ineffable, its capacity to express beauty and pain simultaneously, and its ability to transport us to another time and place, provides the music therapist with a particularly well-suited tool with which to help dying patients and their families cope with the difficult challenges they face” (Data excerpt, Martin, 1991/2012).

The elements of the music used by therapists change as patients are nearing death. The music becomes gentler, slower, softer, and simpler, utilizing more silence. Music that was meaningful in previous therapy sessions is often used during this phase, yet may be played or sung with more simplicity, greater reverence, or adapted to match patients’ energy or breathing. More than in other phases of the dying process, therapists improvise their own music in these moments, often entraining to or matching the patient’s breath (see Table 9 for some examples of data illustrations, Clements-Cortes, 2004; Dileo & Parker, 2005; Forinash & Gonzalez, 1989; Hilliard, 2005; Kidwell, 2014; Krout, 2003; Martin, 1989; Munro, 1984; Munro & Mount, 1978; Salmon, 1994; West, 1994; Weber, 1999). The music during this actively dying phase is highly sensitive and intuitive, as there is very little feedback for therapists to use for assessment and evaluation. In a case example of a session with an actively dying patient, who actually died while therapists were improvising, a metaphysical connection was implied:

> As her breaths became more shallow and slower, I changed to softer and slower music. This was not a conscious choice. I was simply aware that as she changed, I also changed… I was looking but no longer really "seeing." I was aware of her breathing, my improvising, and our vocalizing, yet I did not feel connected to my body. (Data excerpt, Forinash & Gonzalez, 1989, p. 42)

Although other music therapists do not articulate their experience quite like this, there are elements of this spiritual dimension and deep connection when they describe the music experience during this end of life transition. It is a sacred, hallowed space when people are taking their final breaths, and music therapists are tenderly accompanying this transition in momentous ways.

The Music Therapist as a Companion

Working in end of life care is not for the faint of heart. The terms *compassion fatigue*, *caregiver burnout* and *cumulative grief* are often discussed in the hospice and palliative care literature as important to consider for the professional caregivers, due to the great impact this work has on their health and wellbeing. I remember telling my music therapy interns time and again, that the greatest gift I believed we gave our patients at the end of their life was our willingness to even be present with them at this exceptional time. Not everyone is willing to be in the presence of the illness and death on a daily basis. Sometimes, not even the patients' closest friends and family are capable of accompanying them in this space. For my interns, it was often a developmental process to reach a point of comfort with just *being* with patients and not always feeling like they must be *doing* something. Data excerpts will be used throughout this section to illustrate

these results, and Table 10 provides examples of data excerpts that characterize each sub-category.

To accompany is to be a companion, and the description of the therapist as a companion was articulated well by Forinash (1990), capturing the essence of the therapist's role in end of life care: "The therapist's role in these sessions takes many forms but always focuses on serving as a companion on the patient's journey. It is the patient's journey, and the therapist is simply sharing in this process during the session" (see Table 10 for full data excerpt, Forinash, 1990, p. 105). The conceptualization of the music therapist as an intimate companion is expressed in different ways. To accompany the dying person is to be present in the moment, with unconditional presence and musical energy (see Table 10, Aldridge, 1999a; Nakkach, 2005; Weber, 1999). Music therapists provide a comforting, holding environment; a sounding board or mirror; a witness and support, like a midwife assisting; and understand patients' needs at a deeper, unspoken level (see Table 10 for some examples of data illustrations, Bright, 1989; Dileo & Parker, 2005; Forinash, 1990; Lee, 2005; Marom, 2008; O'Callaghan & McDermott, 2004; Salmon, 1994; Sato, 2011; West, 1994).

Flexibility is a key component of the therapists' presence. Patients' physical, cognitive, and emotional status changes dramatically from session to session, therefore, therapists must constantly adapt and shift their approach: "The progression of the illness, the presence of physical symptoms as well as the psychological adjustment of the patient and his family continually fluctuate and demand flexibility in the chosen approaches" (Data excerpt, Munro, 1984, p. 11). This need for flexibility is present across many elements of the therapist's role. Sessions require movement between directive and non-

directive interventions, between use of music and verbal interventions, and musical flexibility between a large range of styles, genres, and generations, and adaptations of the musical elements of pre-recorded songs.

Therapeutic Boundaries and Countertransference

Therapeutic boundaries can become blurred in the hospice setting, so that therapists may need to be especially mindful of their interactions with patients and families (see Table 10 for some examples of data illustrations, Aldridge, 1999a; Hartley, 1999; Wilkerson, Dimaio, & Sato, 2015). Therapeutic boundaries may also need to be flexible and perhaps, redefined (see Table 10 for some examples of data illustrations, Dimaio, 2012; Hartley, 1999; Hilliard & Justice, 2011/2012; Martin, 1991/2012; Munro, 1984). The hastened intimacy that occurs between patients and therapists in end of life setting provides a rationale for both schools of thought—to be cautious or to be flexible—and there is not consensus among music therapists.

The exceptional intimacy of the therapeutic relationship at end of life is in part because of the home setting. Surrounded by the artifacts of their lives, in the privacy of their home, patients may be more inclined to share more intimate details of their lives, or treat the therapist as they would friends or family visiting their homes. Another factor impacting the intimacy of the relationship is the therapist's use of personal touch. Whether patients reach out with their need for physical contact or therapists feel compelled to use touch to further support the patient or family members (see Table 10 for some examples of data excerpts, Aldridge, 1999a; Gilbert, 1977; Kidwell, 2014; Lee, 2005; Munro, 1984; Nakkach, 2005; Weber, 1999), the intimacy of the relationship is altered by touch.

Table 10

Examples of Data Excerpts—The Music Therapist as a Companion

Code	Data Excerpt
Music Therapist as a Companion	The therapist's role in these sessions takes many forms but always focuses on serving as a companion on the patient's journey. It is the patient's journey, and the therapist is simply sharing in this process during the session. The therapist sometimes reflects, sometimes questions, sometimes directs and sometimes just listens as the patient travels on his or her journey. The therapist is the sounding board or mirror to the patient's experience. This places a great demand for flexibility on the part of the therapist. It is not necessary for the therapist be an expert on the patient's journey, but rather a caring, interested, and compassionate companion. This style of therapy draws upon the therapist as a person and calls upon him or her to bring him or herself to the session and to be present in the experience. (Forinash, 1990)
	The therapist is much less concerned about facilitating change in hospice than in other music therapy settings. Death is a natural process which will eventually take its course regardless of what we "do" about it. The therapist is a witness and support person to the dying and when skillful, may serve very much like a midwife assisting the birth of a new life. (West, 1994)
	Most dying patients do not have the luxury of unlimited treatment time, and they may lack the desire to delve into such work. My work with dying patients was performed primarily on a supportive level, with a goal of providing a comforting, holding environment for the patient unless a patient was clearly interested in delving into deeper levels of therapy. (Marom, 2008)
	While listening, playing, and singing, the therapist is encouraged to avoid reasoning or deliberately understanding and dissecting what is going on, but rather to go with the flow and to be highly flexible. This stance often helps clients to listen to themselves from a mindful place during their process of dying. (Scheiby, 2005)
	Finally, we learn to accompany the person by peacefully 'being there,' with an unconditional sense of presence, providing our musical energy as needed. (Nakkach, 2005)
	Harriet cried out when there were natural pauses in the music and so I disregarded these breaks/interludes and held onto notes longer to attempt to "hold" her and then she started to sing, aloud, all of the words to the refrain of the song. (Kidwell, 2014)

Table 10

continued

Code	Data Excerpt
Music Therapist as a Companion/Therapeutic Boundaries	End-of-life music therapists may be particularly susceptible to boundary issues. Sometimes the client (and the family) treats us as part of their family. We often conduct sessions in the private and intimate setting of clients' homes. The power of music to elicit emotions and memories adds to the intimacy of the client-therapist relationship. These unique aspects of end of-life work often present a challenge for us to set clear boundaries with our clients, families, and ourselves. (Wilkerson, Dimaio, & Sato, 2015)
	Within an environment such as Lighthouse, boundaries need to be flexible. If they are not, their rigidity can damage if not halt, the therapeutic process. (Hartley, 1999)
	Mr. Sanchez shivered slightly so I found him an extra blanket and helped him to reposition himself better in the bed. I made sure things on his bedside table were accessible to him and refilled the glass with fresh water. I wanted him to sense that I cared, regardless of his behavior. (Munro, 1984)
	To work with a patient in the intimacy of his / her home is a privilege Which allows the therapist to witness and share the difficulties, joys, tensions , worries, defeats and triumphs of the struggle with terminal illness more closely than in the hospital setting. (Munro, 1984)
	At the end of the visit, Tonya expressed her thanks and as I was about to leave the room, I noticed that she had reached her hand out. So, I took her hand and told her that I would see her soon. I was deeply moved by this simple act and did not rush to let go. For me, it was connecting with a remarkable woman who had such openness, who just wanted to be heard, and needed to be free. (Kidwell, 2014)
Music Therapist as a Companion/ Countertransference	The less active/participatory a patient is in the music therapy process, the more potential there is for the therapist's thoughts, feelings or beliefs to impact the therapist's interventions. (Marom, 2008)
	As therapists we are constantly challenged to define and separate our countertransferential responses in music and in words. This is never more acute than when working within the realm of death and dying. Musical expressions of loss can facilitate the most profound therapeutic encounters available within the spectrum of clinical practice. Therapists must be acutely aware of how music and verbal interpretations affect their place in the therapeutic partnership. Music therapists have to remain in a place that will allow them to be effective and at the same time protect their mental health. And yet loss surrounds and is deeply embedded in every facet of life. (Lee, 2005)

Table 10

continued

Code	Data Excerpt
Music Therapist as a Companion/ Countertransference	I am a music therapist, and I will someday die. Not every music therapist will experience a disability, not every music therapist will contract cancer, and not every music therapist will be diagnosed with a mental illness. However, every music therapist will die. As end-of-life music therapists, we find that our work is influenced by our personal and professional relationships with death and people who are dying. Our own thoughts, beliefs, and feelings associated with death and dying will influence our assessment, treatment, and evaluation of our clients at the end of life. (Wilkerson, Dimaio, & Sato, 2015)
	This was an extremely difficult session for me. For some reason Sarah's pain and anxiety affected me deeply. Perhaps it was because I felt so helpless. It is difficult to witness someone in such acute distress, and as a professional, I felt that I was supposed to be able to help. While music could and did help, I wanted it to do more, to take away Sarah's pain and breathing difficulties. I began feeling uncomfortable and anxious myself. I also knew that for the music to be most beneficial it had to be steady and grounded yet flexible, which was certainly not how I was feeling. I wanted to provide a calm presence. Being able to play the music helped. At first I focused on the music until I felt a little stronger, and then I was gradually able to focus more on Sarah and meet her in the music without losing my sense of groundedness. (Martin, 1991/2012)
	In essence, the issues summoned within us by this work must be used both to strengthen and deepen the effectiveness of our practice and also to engage in full lives in which self-care is a priority. (Dileo & Parker, 2005)

Munro (1984) shared many different experiences in which she provided caregiving interventions, such as helping a patient reposition in bed, covering a patient with a blanket, rearranging an oxygen mask, or wiping a patient's face, all of which impact the intimacy of the therapeutic relationship. Other authors did not share similar experiences in their writing, perhaps because they felt them insignificant or maybe because of the questionability of boundaries. However, it was my experience working in this field that these acts of caregiving were not uncommon among non-nursing professionals.

Whether advocating for the need for firm boundaries, or suggesting that boundaries need to be redefined, all authors advocated for the management of personal thoughts, feelings, and reactions. Rarely in other types of therapeutic encounters are therapists challenged to face their own mortality, or that of loved ones on a daily basis. Also unique to music therapy at the end of life is the manifestation of countertransference in both musical and verbal interactions. Music therapists have to be aware of countertransferential interpretations and responses in their intense encounters with patients (see Table 10, data excerpt, Lee, 2005, p. 149).

Music therapists may need to acknowledge their fears, anxieties and the desire to protect patients from pain and suffering (see Table 10 for some examples of data illustrations, Dimaio, 2010; Forinash & Gonzales, 1989; Kidwell, 2014; Magee, 1999; Martin, 1991/2012; Munro, 1984; Wilkerson, Dimaio, & Sato, 2015). It is extremely important to allow patients to approach death as they wish, and not according to the therapist's appraisal of an appropriate dying process (see Table 10 for some examples of data illustrations, Bright, 1989; Forinash, 1990; Forinash & Gonzales, 1989; Marom,

2008; Munro, 1984; Porchet-Munro, 1989; Scheiby, 2005; Whitall, 1991/2012). Managing countertransference reactions becomes even more important when the patient is not alert or unresponsive, when the therapist's intuition is solely guiding the music interventions.

Music therapists must acknowledge and come to terms with their personal beliefs and feelings about life, death, dying, and suffering. To not acknowledge personal beliefs is to compromise the integrity of the therapists' presence and empathy, further impacting the relationship and outcomes of therapy. To acknowledge personal beliefs is to deepen the therapists' presence and capacity for empathy, and allow them to bear witness to the depth and breadth of expression of patients' suffering. A worthy companion is stable enough to endure these difficult moments, as well as celebrate the joys of life.

This is not to suggest that therapists should never experience negative emotions or be triggered by patients' experiences. But, the therapist who has explored his or her own feelings related to death and dying is better equipped to acknowledge feelings and remain grounded in the moment in order to be fully present to the patient's experience. Lee (2005) was the only author who discussed a sense of detachment for maintaining a healthy boundary and protection for himself. He also talked about not acknowledging the enormity of his work, in the moment, with a woman while helping her to plan her funeral, alluding to the idea that some emotional distance from the intensity and finality of death is necessary at times. Interestingly, despite convictions about the intensity of this work at end of life and the need for close management of countertransference, making self-care a priority was only mentioned by a few (see Table 10 for some examples of data illustrations, Dileo & Parker, 2005; Marom, 2008; Munro, 1984; Scheiby, 2005;

Wilkerson, Dimaio, & Sato, 2015). "The therapist may learn one of the most precious skills of all and that is to be able to follow patients into the depths of the shadow and yet be able to emerge from the session and continue life without being overshadowed in the process" (Data excerpt, Marom, 2008, p. 21).

CHAPTER 5

DISCUSSION AND CONCLUSIONS

The purpose of this study was to provide a critical interpretive synthesis (CIS) of the music therapy literature in end of life care. This was not intended to be an exhaustive summary of the literature, but an effort to uncover a unifying framework, linking existing constructs present across the literature. As is instructed by Dixon-Woods et al. (2006), the developers of the CIS methodology, specific research questions should not be identified at the onset of the study, rather, broad question(s) without specific hypotheses should guide the research. Hence, the broad research question guiding this research was "What is the essence of the music therapy experience at the end of life, as it is explained across the literature?" In CIS, the output of the synthesis is in the form of a synthesizing argument. "This argument integrates evidence from across the studies in the review into a coherent theoretical framework comprising a network of constructs and the relationships between them" (Dixon-Woods et al., 2006, p. 39). As a result of my analysis, the synthesizing argument and theoretical framework unifying the literature was C*onnection*—to self, others, and spirituality—and this emerges through the music therapist as a companion to the dying person.

My research interest took shape and was validated after months of engaging with the literature. I was most interested in documents that attempted to capture the essence of music therapy at the end of life, the nuanced differences, intricacies, the uniqueness of this work. This was most prevalent in the theory papers with case vignettes, case examples, and case studies that beautifully captured this essence. These publications

would never be included in meta-analyses, quantitative or qualitative, because they are not research studies. Yet, they represent the core of the work of music therapists in end of life and deserve representation beyond their individual contributions. This revelation also supported my choice of methodology to encompass complex, methodologically diverse bodies of literature, and include literature outside the boundaries of quantitative or qualitative evidence.

Even though quantitative research represents a small percentage of the literature in this area of practice, I thought it necessary to address in this discussion its underrepresentation in this synthesis. I do find value in the quantitative research and consider it important to demonstrate music therapy's effectiveness. Funding and resources are often made available as a result of this type of evidence, encouraging hospices and palliative care programs to continue employing music therapists in this meaningful work. Especially in the medical field, outcome-based research has more power and influence over decision-making. There has clearly been an impetus to contribute more controlled, quality research to the evidence base, as this need was stated time and again in authors' research agendas.

Yet, there is real incongruence between the positivist paradigm and the end of life experience. Control groups are ethically questionable at the end of life, which is problematic for conducting controlled research. There are issues of attrition, as people who are dying decline unpredictably and ultimately die, posing another challenge for the quantitative researcher. Also, it may be difficult to demonstrate effectiveness with traditional outcome measures, where dying people are experiencing a negative change in most health domains. Researchers have studied both pain reduction and quality of life,

domains I believe most music therapists working in end of life care would attest to improve, , and the quantitative research has failed to demonstrate music therapy's effectiveness, without stipulation. McConnell, Scott & Porter's (2016) findings suggested that music therapy may be effective for helping to reduce pain, but they state that this conclusion is based on studies with a high risk of bias.

How does one attempt to quantify such a unique and subjective phenomenon? Lee (2005) speaks to this dilemma:

> Music therapy with people who are dying is one of the most rigorous yet imprecise areas of clinical practice. Why is this? What is the nature of music and loss that makes the connection so exact, yet at the same time ambiguous? It is because of this discrepancy, I believe, that writings on music therapy in palliative care often miss the point by describing the work in overtly clinical and emotionally distant tones. If we were to truly describe the depth, the ineffable and the mystery of music, then perhaps the reader might become disenchanted that this area of work is lacking in rigor. (p. 157)

It is possible that the pressure to contribute rigorous, outcome-based research to the evidence base has actually suspended potential progress in this research. McConnell, Scott & Porter (2016) identified only one study conducted in the last five years that could be included in their systematic review. The authors admit that RCT's may not be the only option for assessing the benefits of music therapy and suggest that methodologies that reveal the process and qualitative aspects of the work can make important contributions to the evidence base. However, in their conclusions they continue to urge for "methodologically rigorous trials of clearly defined music therapy interventions with

common outcome measures" (McConnell, Scott & Porter, 2016, p. 881). It seems as if there is an understanding that the positivist paradigm may not be a good fit for end of life research, but researchers are constrained by the supremacy of this paradigm in the research and healthcare community.

The recommendation for clearly defined music therapy interventions (McConnell, Scott & Porter, 2016, p. 881) highlights yet another issue with quantitative research protocols, commonly employing standardized interventions. Gutgsell et al. (2013) used a standard intervention protocol for all participants in the study. In their discussion, they identified the significance of this study using the same procedure for each patient producing significant positive results. The outcomes for the experimental group were significantly positive, however, the control group also experienced a significant decrease in pain. The question remains, then, would the results have been significantly more positive for the participants receiving music therapy had the treatment been individualized to each participant, as is customary in clinical practice? And is the research using standardized treatment protocols actually capturing the effects of music therapy, which is generally applied as individualized, process-oriented treatment? Munro (1984) would answer no to this question. She felt that seeking effectiveness and quantifying effective techniques would have compromised the depth of meaning experienced by patients in her practice. Forinash (1990) found in her phenomenological study that it was not possible to find a common thread or existing pattern that tied the sessions she studied together. While many years have passed and the research community has evolved since the writings of Munro (1984) and Forinash (1990) were

published, I do not think their convictions about the individuality of music therapy sessions at the end of life has been altered by clinical practice or research in the interim.

Some researchers have been successful in incorporating individualized music therapy as the experimental treatment. Included in this synthesis was the research of Horne-Thompson and Grocke (2008) and Krout (2001). Horne-Thompson and Grocke (2008) published a rigorous RCT (meeting Cochrane standards), wherein the music therapist was able to choose appropriate methods to use in consultation with the patient for each session. Krout (2001) provided music therapy interventions based upon the interdisciplinary care goals for each individual. No single or standard music therapy approach was used with all participants, rather, they were flexible in design and individualized, based on the needs of the subject and family as each session took place. It was this quality—the flexible and individualized treatment approach—that made these studies more fitting for the context of this synthesis.

Reflections on The Synthesis

During my first reading of the literature, while also coding and developing themes and categories, I was focused on the needs of patients being addressed in music therapy, the qualities of music, and interventions. As I read and re-read, and revisited the developing categories, this idea of connection kept presenting itself to me. After reading this passage from Weber (1999) "Our music is a reflection of our period of time, personal and global and is symbolic for our experiences, ideas, behaviors, and philosophies of life," (p. 97), I wondered if music is effective because it is connected with identity. Illness compromises identity, deforms the mind and body, and challenges the spirit. Because music is related to identity, perhaps it reconnects the person to these parts of

self, lost in the fight for life. I returned to the literature with this theme of connection in mind, remaining constantly vigilant that I was not manipulating the data, but allowing ideas to emerge through the analysis, and found that it was providing a link, or bridge between the literature, which had before felt isolated and distinct. After establishing this overarching theme of *Connection*, my interpretation of the essence of music therapy experiences at end of life as they are explained across the literature began to take shape.

Connection to Self

The patient's connection to self is intimately related to disconnecting from the disease identity, reconnecting with the pre-illness self, and continuing personal growth. The data reiterated the remarkable ability of music therapy to address the whole person, not just one aspect such as pain, but all aspects of the self. Even if just for a moment, it allows patients to feel whole and alive again, to create distance between the identity of one with an illness, of one who is dying. Even though music experiences also help patients connect with the intense and difficult emotions of grief and loss related to dying, these emotions were transformed by the music and empathic presence of the therapist. Accessing, expressing, and experiencing some release of this tension gives patients new energy for the work of dying and achieving closure of the life they have lived.

One aspect of this theme of connection to self that I find particularly poignant is the connection to the music self. It is remarkable to be creating music, or enveloped in the aesthetic experience of music when the physical body is declining and preparing for death. I often used this quote from Aldridge (1995) in my presentations about hospice music therapy, "The patient is encouraged to creatively form a new identity that is aesthetic even in the face of disfigurement" (p. 107). In my clinical practice, I remember

patients or family members questioning the purpose of music therapy, almost as if it would be a waste of the precious time that was left. Even I questioned my own purpose at times, when I began to feel like I was just performing music for people. However, once patients experienced music therapy, and I remembered how extraordinary it was for people to receive or participate in live music carefully offered with sincere empathy, its significance was undeniable.

The ways in which music therapists use music to access memories and engage in life review is also unique and appears to be a core practice. While many disciplines in end of life care engage patients in life review, music accesses another dimension of these memories; it becomes the sound representation of the reminiscence, the soundtrack of their lives. This process in music therapy is the only one presented in the literature in which therapists almost exclusively use one method—song choice—to facilitate life review.

Connection to Others

For many, the end of life, is about relationships—celebrating, mending, recalling their life experiences in relation to others, or remembering a life of connectedness to others. Aldridge (1999a) used the term "social matrix" in regards to personal expression within shared music experiences, and that healing occurs within the "ecology of relationships" (p. 24). Music is shared sound in space, an intermingling of many sounds, textures, harmonies and reflects the feelings, emotions, and memories of those relationships. It is this shared experience that affords the meaningful connection to others in music therapy.

The ‘others’ in this context includes: 1) the therapist and 2) any family or friends present or thought of by the patient. The data demonstrated that the role of the music and the therapist are significantly different within these two types of relationships. The interpersonal connection between the patient and therapist, at times, is a primary relationship, and the music is the means of this connection. When the focus is on the patient’s personal relationships with significant others, the therapist along with the music becomes the facilitator of the patient’s connection to loved ones. Of course the relationship between the therapist and the patient and/or family remains important; without established trust and rapport, significant moments rarely occur. However, there were times in my own practice, when I felt that if I spoke or even moved, I would interrupt the intimate connection transpiring between two people. In these moments, I became a conduit for the music, which established, maintained, and deepened the connection between the patient and significant others. My experience is substantiated in the literature.

Despite omitting texts which focused strictly on caregivers or bereavement, the importance of music therapy for caregivers is a significant theme in this synthesis. The music experience is open in such a way that caregivers or loved ones are able to take from the experience what they need for comfort and closure. Music therapy gives caregivers the opportunity to be active in the patient’s emotional healing, where they may have otherwise felt powerless. The experience of caregivers caring for the dying is a unique one; they are faced with the responsibilities of caring for the physical, and often emotional needs of the patient, while managing their own intense emotions, anticipating their impending grief and loss.

For the bereaved, the task may be to redefine the relationship outside the confines of the physical body; to come into a new relationship with the loved one who has died. It seems that music therapy experiences actually help to prepare caregivers for the extremely hard work of grief. The introduction of music into the environment while a person is dying forever changes that space, and subsequently the memory of the time leading up to the death. These memories of the end stages of illness can be traumatic for people to witness. Music therapy does not erase the harsh realities of dying, but transforms them. Once the consciousness of the patient has shifted, loved ones may struggle to feel connected to the patient when they can no longer speak or interact in the ways in which they have been accustomed. However, caregivers reported feeling deep connections to patients through the music, even once patients were no longer alert and responsive. This experience is a glimpse into the future potential for this redefined relationship and connection. The thoughts, feelings, and emotions present during this time continue to be accessible for caregivers during bereavement.

Connection to Spirituality

Throughout my analysis, I had a strong feeling that there is a connection between the innate qualities of music, i.e. movement, harmony, dissonance, transcendent or spiritual qualities, and a sense of why music is particularly useful for end of life, especially during the end of life transition. Hogan (1999), however, is one of only a few authors who talked about the rationale for using musical elements (pitch, tempo, rhythm, vocal or instrumental, melody and harmony) in ways that correspond with specific patient needs, process, or position in phases of dying. Gilbert (1977) stated that there is an integral relationship between music and religion, but did not elaborate. Nevertheless, the

literature demonstrates that music therapy is used, frequently, to address patients' spiritual needs.

It is not surprising that patients who identified with a religion that integrates music into traditional customs and rituals would use music to connect to their sense of spirituality. Patients who are homebound and reliant upon others for activities of daily living have likely not been able to attend religious services for quite some time, and for some, this is a significant loss. The ability of religious music to bridge this severed connection between the patient and religious practice is invaluable. The finding most interesting in this context is the patients' participation in singing together with the therapist, not that they might feel compelled to sing given the prevalence of congregational singing in religious customs, but that they unearth the energy and stamina needed to participate in the music in such an active way. I believe this speaks to music's access to spiritual energy not bound by physical limitations, when delivered in sensitive, intuitive, and empathic ways, as is done by the music therapist.

The other aspects of spiritual connection present in the literature are the connection to beauty, transcendent experiences, and the most distinctive to music therapy practice at end of life—the end of life transition. When a music therapist accompanies this end of life transition, it can be a culmination of the work done in therapy along the way or it can be the one and only time the therapist sees a patient. In either context, the care with which the music therapist is present to the transition between life and death and the sometimes exclusive use of intuition to guide interventions (as there may be little feedback from the patient), I believe, are defining features of this work. Most of the literature addresses this transitional phase, and there is consensus among authors on how

to approach the music—with more gentleness, softness, simplicity, and space, entrained or synchronized with the patient's breath, and in tune with the spiritual energy of the patient.

Music Therapist as a Companion

Having never read Forinash (1990) and her characterization of the music therapist as a companion, I remember using the word 'accompany' to describe what I felt was my central role as a music therapist at end of life. I was there to be with patients at difficult and exceptional times in their lives, to offer companionship and empathy through my presence and my music. I also felt that patients' song choices and expressions through the music told me what they might need from this encounter. Song choices and musical expressions revealed how I should position myself in relationship to them, without them having to explicitly ask, understanding that the patient may not even consciously know what they need from me, the music, or the relationship. I often felt in awe of patients' willingness to enter into a relationship with me at all during this finite time, yet many patients craved my presence and the music. There was often not enough time, or patients did not have the energy that traditional therapy relationships require in order for significant work to transpire. However, the music afforded an accelerated connection, a crucial element in this context of end of life.

On the other end of the spectrum, patients did decline services at times, and it was my experience that client rejection can be very hard to handle in this setting. I remember feeling extremely affected on several different occasions, where clients rejected music therapy or me, at what I felt were crucial times for music therapy to be advantageous, or when I thought the meaningful work that had transpired should continue or was left

undone. Other times patients were resistant to participating at all, or caregivers were 'gate-keepers' and not allowing music therapy, or at times, any services other than nursing in to support the patient. Marom (2008) addresses this issue in her article exploring the difficulties therapists may face in their work with hospice patients. She presents case vignettes that address issues such as apathy, depression, anger, and frustration experienced by the therapist, explores countertransference, and discusses self-care. A discussion of therapeutic boundaries and countertransference was present in about half of the included literature. Some authors directly address the topics, and others allude to countertransference with their inclusion of personal thoughts and feelings in their writings.

Strengths and Limitations of the Study

CIS offered an innovative methodology with which to uncover a wealth of information and begin to understand the essence of music therapy experiences at the end of life. The tenet of CIS to focus more on processes than outcomes revealed significant findings and allowed for a unifying framework to be developed. CIS also allowed for a synthesis of the literature, spanning almost forty years, that is actually representative of clinical practice in music therapy at the end of life, highlighting the important work in this area of practice, and making it useful and accessible for music therapy practitioners working in hospice and palliative care.

A critical interpretive synthesis is not intended to be reproducible or exhaustive, but one researcher's interpretation of the relationship between the constructs presented in the literature. When interpretation is indeed grounded in the data, it is credible in its own right. I appreciate that my voice, as a music therapist with extensive experience in end of

life care, could be present, and was actually encouraged, in the analyses and reporting of the data. I did not have to try to remove my personal beliefs or opinions about the topic in order to achieve objectivity and produce credible results. On the other hand, that characteristic could be seen as a limitation. The personal biases and idiosyncrasies of the researcher can more easily influence the quality and results of qualitative research. Incorporating self-checking and other-checking—having a second and third reviewer—helped to minimize the impact of my personal biases on the analysis.

Though CIS incorporates elements of traditional systematic review, it is predominately a qualitative inquiry. While I value constructivist paradigms in their contribution to the knowledge base, and often find those outcomes more applicable to clinical practice, I acknowledge that my default way of seeking knowledge tends to be positivistic. Thus, the iterative and recursive nature of the approach, which allowed for flexibility and creativity, was challenging, rather than freeing, for me. This is a potential limitation of this study, in that my skills as a researcher directly influenced the results, given the subjective nature of the output of the synthesis.

A general limitation of qualitative inquiry is that "rigor is more difficult to maintain, assess and demonstrate" (Anderson, 2010, p. 2). Rigor was difficult to demonstrate concretely in this study, as is valued in quantitative syntheses, given the reflexive component of the data analysis process. For this reason, and because of the dominance of quantitative research in the research community—especially in healthcare—the relevance of this study could be seen as limited to the research community.

The volume of data approached in this study was massive. I read and re-read 118 papers, coded over 800 data excerpts, organized and re-organized these codes into themes, categories, and sub-categories in multiple different ways. The process was time consuming and the data overwhelming at times. This presents difficulty in terms of time and energy for thorough and cohesive exemplification of the data, and could present a possible limitation of the methodology and this study. The immersion of the researcher in the data and analytic process in CIS can also affect the findings, as the mental and emotional state of the researcher is inextricably linked to the analysis.

The original CIS by Dixon-Woods et al. (2006) included multiple researchers on the project, as did the many of the other published syntheses. While I used additional reviewers to assure intercoder reliability, doing so did not introduce a new perspective into the account. I see after undertaking this project as a solo endeavor that there could have been great value in having multiple perspectives contributing to the synthesis, as I am sure that engaging in dialogue could have resulted in an even richer and deeper understanding of the literature. On the other hand, O'Callaghan and McDermott (2004) believe that a single researcher's analysis is not inferior to multiple researchers': "Different researchers and "research verifiers" have different life histories and can thus interpret data in different, but not necessarily inferior or superior ways" (p. 162).

Overall, I found CIS to be a useful methodology for synthesizing the literature in music therapy at the end of life. This study illuminated the subtleties and complexities of this unique practice at the end of life, rather than reducing it to outcomes. It provided understanding on a global level, uniting and enhancing the work of individuals. This study embraced and elevated the case studies, vignettes, and personal narratives of music

therapists, and what we can learn from them as a whole. This has not been done and this literature would not have been included with other synthesis methodologies. It is likely that this study will help music therapists working at the end of life think more critically about their work, and bring conscious awareness to this overarching theme of connection, to which they may only be peripherally aware.

Concluding Remarks

The essence of music therapy experiences at the end of life centers around the theoretical construct that I call *Connection*. Music therapy helps people who are living with terminal illness establish, re-establish, or enhance their connection to self, to others, and to their spirituality in meaningful ways. The music therapist functions as a companion to patients in this journey, offering a flexible, empathic presence, within a therapeutic relationship that is accelerated and enhanced by the music.

This synthesis provides a useful and meaningful resource for music therapists working in end of life care, or for those who aspire to do this work. Dixon-Woods et al. (2006) believed that this type of synthesis would be most beneficial if the theoretical account of the evidence and existing theory is "neither so abstract that it lacks empirical applicability nor so specific that its explanatory scope is limited" (p. 36). I propose that the synthesizing argument of *connection*—to self, others, and spirituality—is both a theoretical foundation that supports music therapy at the end of life, and a primary clinical goal. If music therapists can begin to view themselves as companions (though highly skilled) to patients on their personal journey of dying, they may find themselves better able to facilitate experiences that enhance connection for patients and families. I also hope that in this synthesis I was able to resurrect some of the important work of

music therapists, which may have been forgotten, or would otherwise not be included in synthesis research. To approach an entire body of literature to use as a resource for practice can be overwhelming. This synthesis served to provide a unifying theoretical framework that is accessible and useful for music therapy practice at end of life.

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