

**How Culture Informs Hospice Music Therapy:  
A Critical Interpretive Synthesis**

By

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In Partial Fulfillment of the Requirements for the Degree of

**MASTER OF SCIENCE**

In

**The Department of Music Therapy**

State University of New York

New Paltz, New York 12561

May 2017

HOW CULTURE INFORMS HOSPICE MUSIC THERAPY:  
A CRITICAL INTERPRETIVE SYNTHESIS

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Approved on May 19<sup>th</sup>, 2017

Submitted in partial fulfillment of the requirements  
for the Master of Science degree in  
Music Therapy at the  
State University of New York at New Paltz

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Author Note

The author expresses sincere appreciation for the Music Department of the State University of New York at New Paltz. Special thanks to Dr. Michael Viega, Vincent Martucci, Dr. Laurie Bonjo, and Dr. Noah Potvin of the University of Dayton, Ohio.

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### Abstract

This systematic review investigates hospice music therapy and the role culture plays in informing clinical practice. Due to the emphasis on cultural, contextual understanding in this review, the exploration of end-of-life care through qualitative inquiry, and the transformative nature of the implications yielded by the study, a critical interpretive synthesis was chosen as the best suited form of review. Studies in interdisciplinary fields of end-of-life care were also considered. The SUNY New Paltz library database Proquest was utilized in order to search articles from the following databases: CINAHL, PsycINFO, MEDLINE, VOICES, The Australian Journal of Music Therapy, and The New Zealand Journal of Music Therapy. The American Music Therapy Association (AMTA) research database was also utilized in order to collect research articles from the Journal of Music Therapy and Music Therapy Perspectives. Exactly 10 studies met inclusion criteria. Results of this study indicated eight themes relevant to culturally-sensitive practice in hospice music therapy: *perception of death and dying*, *appropriate level of sensitivity*, *spirituality/religiosity*, *expression of grief*, *family dynamics*, *legacy/life review*, *perceived role of music therapist*, and *perceived role of music*. The themes presented in this study bolster the argument that culturally informed practice is crucial to effective implementation of music therapy. Implications for future music therapy research, education and training, and direction for treatment are discussed.

## **CHAPTER 1: LITERATURE REVIEW**

### **Introduction**

End-of-life care is a culturally sensitive and personalized experience for the individuals and families involved (Bowers & Wetsel, 2014; Forrest, 2014; Masko, 2013; Potvin & Argue, 2014). Every culture responds to death and dying differently, which includes the role of music during end-of-life care and rituals related to the preparing for burial and bereavement. It is therefore important for a music therapist working in hospice care to be attuned to the client's worldview to better meet his or her needs (Forrest, 2014; Bowers & Wetsel, 2014; Potvin & Argue, 2014; Topozada, 1995). Drawing on previous research in music therapy, palliative/hospice/end-of-life care, and the awareness of cultural diversity in therapy, I intend to investigate how cultural beliefs on death, dying, and bereavement inform the practice of hospice music therapy (HMT). It is my intention that this study will highlight the significance of diversity and cultural competencies in HMT, which will inform both contemporary practice and future research.

### **Literature Review**

#### **End-of-life Care**

End-of-life care, including palliative and hospice care, is a sensitive practice for the patient, patient's family, and healthcare professionals involved (Bowers & Wetsel, 2014; Doka, 2009; Gawande, 2014; Infeld, Gordon, & Harper, 1995; Kubler-Ross, 1969; Marom, 2016). Palliative care is the stage of healthcare at which medical intervention is no longer used to cure or reverse the terminal illness/condition, but rather to relieve the pain, suffering, and stress through symptom management, the development of coping skills, and patient-centered care (Bowers & Wetsel, 2014). Hospice care is the stage at which medical intervention is delivered with the

intention to support a patient and their family in preparation for the patient's ultimate passing. Hospice care focuses on improving quality of life, diminishing stress, managing pain and distressing symptoms, and supporting the patients at the end of their life with dignity. Clinicians working in both palliative and hospice settings must also attend to the individual's emotional and spiritual needs, as well as address the family in time for the patient's inevitable passing. This complex realm of healthcare involves goals and desired outcomes concerning an individual's emotional wellbeing, stress levels, and mental wellness.

For palliative care and hospice patients, responses may be fear, dyspnea, anxiety, or pain. Improved outcomes are composed of quality of life, control of symptoms, time and energy to cope with end-of-life issues, time to say 'I love you' or 'I forgive you,' and a peaceful death with well-managed symptoms (p. 232).

Some of the fundamental challenges faced by healthcare professionals in this field of work are coping with the patient's despair, grief, frustration, depression, dread, and resistance (Marom, 2016). Furthermore, Marom (2016) highlights that one of the most stressful and difficult aspects of attending to a patient in hospice is, "the painful gap between their [hospice therapists] expectations prior to starting their work in hospice and the reality of that work," and "the uncertainty regarding how long the relationship will last" (p. 21). Due to the inevitability yet temporal uncertainty of the patient's death, hospice work has been known to lead to burn out and cynical, bored, or depressed feelings in the professionals attending to the patient and patient's family.

### **Music Therapy**

The American Music Therapy Association (AMTA) defines the practice of music therapy as: “The clinical and evidenced-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program” (About Music Therapy & AMTA, 2016). Since its inception, the practice of music therapy has expanded and specialized its scope to work with a myriad of different populations, settings, and presenting problems (Wheeler, 2015). Music therapy involves the use of music interventions geared towards treatment of the client’s presenting problems, throughout physiological, mental, emotional, and spiritual domains of health and well-being (Davis, Gfeller & Thaut, 2008).

“Musicking” is a term coined by music therapists to accentuate not only the process of engaging an individual in a meaningful musical experience but also the importance of the therapeutic relationship that develops through the treatment process. “To musick is to create a relational meaning making experience that is at once intrapersonal and interpersonal” (Potvin & Argue, 2014, p. 119). Musical experiences, whether active, receptive, compositional or improvisational, combined with the professional clinical training of the therapist themselves, serve as dynamic forces of change in the targeting of deficits, establishing objectives, and realizing goals (Davis, Gfeller, & Thaut, 2008). The act of engaging a client in music is a central aspect of many different music interventions and is relevant to the realm of HMT practice. While there are many perspectives and approaches in the field of music therapy I have chosen to position myself with this term due to its increased usage in the literature and familiarity from personal experiences in clinical work.

### **Hospice Music Therapy**



Of the many diverse populations that music therapists serve and settings in which music therapists operate, hospice is one of the more established clinical sites in the field (Potvin & Argue, 2014; Wheeler, 2015; Włodarczk, 2007). The use of music as an agent for therapy is relevant in the end-of-life clinical setting due to the connections between music and spirituality, and music and cultural practice.

Throughout all cultures, music has a long history of use as a therapy for symptoms such as anxiety, depression, and pain. Advocates for the use of music therapy understand the unique abilities of music to diminish these symptoms through activation of the limbic system, as well its ability to promote feelings of peace, forgiveness, and resolution for patients at end of life (Bowers & Wetsel, 2014, p. 238).

Hospice music therapy (HMT) utilizes music interventions geared at meeting the goals typically seen in end-of-life care such as alleviation of anxiety, depression, and pain. The scope of treatment also extends to providing opportunities for emotional expression for both the client and the client's family, improving quality of life, emotional validation, legacy work, and life review (Forrest, 2001; Hartwig, 2010; Hillard, 2005; Lipe, 2002; Włodarczk, 2007).

### **Cultural Competencies**

Cultural competencies have been described as: “a body of knowledge, skills, attitudes, and behavior in which physicians ought to be trained if they are to deliver ‘sensitive’ and ‘humanistic’ care” (Chan, MacDonald, & Cohen, 2009, p. 119). Cultural competency is an important ethical responsibility for music therapists, as well as other social science and healthcare professionals (Hadley & Norris, 2016; Kim & Whitehead-Pleaux, 2014; Stige, 2002; Swamy, 2014; Topozada, 1995). The ability to not only relate to but also to empathize with

clients' perceptions through their cultural lens is vital to understanding their condition and delivering the highest quality of care possible.

**Culture.** Although a complex concept to fully explicate, an operational definition of culture will be put forth using language from the literature. Culture is not just an individual's racial or ethnic background, or the content of their religious beliefs; culture is a blend of multiple factors that contribute to how individuals perceive themselves, their environments, and their interactions with others. Dileo's (2000) definition of culture will be adopted for this study:

Broadly speaking, culture refers to those beliefs, actions and behaviors associated with: sex, age, location of residence, educational, status, socioeconomic status, history, formal and informal affiliations, nationality, ethnic group, language, race, religion, disability, illness, developmental handicaps, lifestyle, and sexual orientation (p. 149).

**Cultural competencies in end-of-life care.** Death is a poignant and universal experience for all people on this planet (Gawande, 2014). Not only have human beings struggled to grasp and understand the finality and meaning of death through various religions, belief systems, and philosophies, but so has the variety of meanings constructed permeated each and every family unit; creating millions of separate constructed views of this quintessential phenomenon that all living things must undergo (Gawande, 2014; Johnson & McGee, 1998; Kubler-Ross, 1969; Parkes, Laungani, & Young, 2015). Cultural competency is an ethical responsibility for all interdisciplinary healthcare fields and social sciences (Hadley & Norris, 2016; Swamy, 2014; Topozada, 1995).

The therapeutic relationship is central to the therapeutic process. Understanding a client's cultural views aids the therapeutic relationship by allowing the therapist to better empathize

clients' situations (Doka & Tucci, 2009; Infeld, Gordon, & Harper, 1995; Kim & Whitehead-Pleaux, 2014). Chan et al. (2009) expand upon this by stating: "Just as cultural competence literature has expanded to more sophisticated models and approaches, so too can end-of-life care research and practice benefit from an expanded view of culture" (p 122).

Cultural competencies can also include exploration of the therapist/clinician's own cultural biases and notions, and how they might affect a therapeutic relationship (Hadley & Norris, 2016). "Therapists who are attuned to their own cultural identity and biases are more effective in working cross-culturally, and a multicultural counseling/therapy (MCT) framework is useful particularly when working with clients who are of a different culture" (Sue & Sue, 2008). Becoming culturally competent in the realm of healthcare is not only a requirement for the profession, but also a learning process towards authentic self-awareness. Bringing awareness to the variety of cultural variables brought out in a therapeutic relationship may include everything from expectations, the influence of culture on past experiences, to personal impressions, and the inherently cross-cultural nature of human interactions.

**Cultural competencies in music therapy.** In order for music therapists to better understand, assess, and treat their clients, the profession itself must evolve and adapt to their clients. The cultural diversity of the populations that music therapists treat, not only in America but internationally as well, have presented unique contextual situations with both exciting opportunities and sensitive limitations for therapeutic work (Forrest, 2014). Topozada (1995) asserts that "music therapists are able to understand the issues involved in working with clients from different ethnic and cultural backgrounds" (p. 72).

Forrest (2014, p. 15) asserts "Given the ever-increasing cultural diversity of the communities with whom music therapists work, and also of clinicians themselves, the need for

cultural awareness, sensitivity, and responsiveness is paramount.” To develop the appropriate skillset, intelligence, sensitivity, and self-awareness to better the quality of care provided for individuals in treatment is a professional obligation. The AMTA code of ethics considers it a general standard to “...respect the social and moral expectations of the community in which he/she works,” and,

...refuse to participate in activities that are illegal or inhuman, that violate the civil rights of others, or that discriminate against individuals based upon race, ethnicity, language, religion, marital status, gender, gender identity or expression, sexual orientation, age, ability, socioeconomic status, or political affiliation.

The music therapist will also actively “work to eliminate the effect of biases based on these factors on his or her work” (AMTA Code of Ethics, n.d.). In order to be present with a client and ascertain his or her needs, a therapist must examine their own cultural identity as well as the client’s. “It is important to understand that the client’s unique blend of cultural issues influences all aspects of music therapy treatment. How the client (and family) conceptualizes his or her problem as well as treatment is an essential consideration in the therapy process” (Dileo, 2000, p. 149). The professional competence and responsibilities of a music therapist, as stated in the AMTA code of ethics, declares:

The Music therapist is aware of personal limitations, problems, and values that might interfere with his/her professional work and, at an early stage, will take whatever action is necessary (i.e., seeking professional help, limiting or discontinuing work with clients, etc.) to ensure that services to clients are not affected by these limitations and problems.

In *Ethical Thinking in Music Therapy*, Dileo (2000) affirms that it is a music therapist's ethical responsibility to put an effort into bettering his/her self-awareness. This may be accomplished through personal therapy, supervision, directed self-study, journaling, and self-care. This systematic review details an investigation into the literature on cultured-informed music therapy practice in end-of-life care in order to better understand how the practice must evolve.

The richness of cultural interplay that exist between an individual's behaviors, beliefs, and personality can be understood in the context of a music therapy session. "All clients bring to music therapy a blend of cultural factors and can be considered multicultural" (Dileo, 2000). Thus, all music therapy work is multicultural. Multicultural issues become more apparent and significant when an individual must adapt to an environment in which his or her cultural beliefs, behaviors, or values are unknown or misunderstood by others. From a professional, ethical, and human viewpoint, it is important that music therapists are aware of their own cultural values and behaviors as well as their clients'.

**Defining culture-informed hospice music therapy.** Several terms have appeared across the literature concerning this particular aspect of music therapy work, as well as interdisciplinary fields such as general psychology, nursing, chaplain ministry, mental-health counseling, and grief counseling, including: cultural competencies in therapy, cultural diversity and therapy, cultural awareness in therapy, multicultural music therapy, culture-centered music therapy, and culture-informed music therapy (Coolen, 2012; Doka & Tucci, 2009; Forrest, 2001; Forrest, 2011; Forrest, 2014; Hartwig, 2010; Infeld, Gordon, & Harper, 1995; Kim & Whitehead-Pleaux, 2014; Stige, 2002; Sue & Sue, 2008; Sue & Torino, 2005; Topozada, 1995).

Stige (2002) developed culture-centered music therapy (CCMT) as a theoretical perspective of music therapy: "The perspective may work as a basis for community work and

ecological interventions, but is not restricted to that. It is also relevant for individual music therapy in more traditional formats and contexts” (p. 5). CCMT is about tolerance for diversity in the broadest meaning of the word (considering a myriad of biological, personal, social, and spiritual variables), rather a new model or form of MT practice.

Stige (2002) asserts that his primary ambition is not to develop techniques and procedures to be labeled as culturally-centered, but rather to provide the necessary information to support the integration of cultural perspectives into all music therapists’ thinking. Individuals are products of their culture, and their identities are often negotiated in social and cultural contexts, creating a plethora of unique individual cultures that exist and influence each individual’s motivations and behaviors in life. “Culture develops as ways of life shared by groups (small or large), and is thus in constant change and exchange. Culture is interactive and historical, and cultural elements and artifacts – such as music – are (partly subconsciously) internalized, identified with, or rejected by the individual” (p. 4). Culture-informed music therapy (CIMT) is defined as a “music therapy approach designed for clients who have experience with two or more cultures and addresses clients’ cultural well-being through music” (Kim & Whitehead-Pleaux, 2014, p. 55). CIMT involves taking into account the client’s culture in assessment as well as selecting and implementing effective culturally based methods for treatment. CIHMT will be defined as an approach to music therapy that addresses the client’s culture in assessment and treatment implementation in the hospice setting. This term has emerged as an amalgam of previously coined music therapy terms out of necessity of effectively communicating the topic of interest, to narrow the scope of applicable research for this systematic review, and to answer the research questions proposed.

### **Purpose of the Study**

For the purposes of this study, the definition of CIHMT (culture-informed hospice music therapy) has been created as a synthesis of two pre-existing terms in music therapy; CIMT (culture-informed music therapy) and hospice music therapy (HMT). This has been operationally defined in order to improve transparency of interpretation and provide a standardized term for the topic under investigation. The purpose of this study is to corroborate evidence between the compiled studies to answer three essential research questions:

- (1) How does music therapy research report on culture in relation to hospice care?
- (2) Does culture inform music therapy methods investigated in research?
- (3) How does the impact of culture mediate the therapeutic relationship?

## **CHAPTER 2: METHODS**

### **Critical Interpretive Synthesis Definition and Rationale**

The critical interpretive synthesis (CIS) is a specific form of research method that would fall under the larger umbrella of systematic review. A systematic review is a rigorous research method used to evaluate the existing literature pertaining to a designated clinical problem through a five-step process (Hanson-Abromeit, 2014). Systematic reviews are essential to better understanding the information used by practicing clinicians and their clients. The steps of this methodological process are as follows: (1) Identify the research plan and operationalize research question(s); (2) identify and organize the existing literature relevant to these question(s); (3) detail coding of data extracted from the compiled literature; (4) explain the synthesis of coded findings and analysis in order to answer the research question(s); and, (5) examines the weight of the evidence, evaluation, and results in order to procure the best possible practice recommendations. The systematic review process offers an advantageous step in the

development of any clinical practice by offering recommendations based not only on the past studies and experiences of other therapists, but also establishing evidence-based outcomes and research decisions. Multiple publications were instrumental in providing further guidance in conducting a CIS, including: Hanson Abromeit & Sena Moore (2014), Yinger & Gooding (2015), Medcalf & McFerran (2016), McFerran, Hense, Medcalf, Murphy, & Fairchild (2016), and Dixon-Woods et al. (2006).

A CIS also differs from a traditional systematic review by incorporating both quantitative and qualitative research articles in the review process. Examining numerical as well as descriptive data across a spectrum of research viewpoints allows the reviewer a greater level of perspective on the research topic at hand. The research questions themselves may even be sculpted or generated as a result of the literature review. Ultimately, this leads to the generation of themes that best answer the research questions proposed at the beginning of the review. Subject matter that appears most frequently across the literature, and that answers the research questions aptly, may then be used in the results and discussion sections to offer implications for future practice and for future research.

Due to the nature of this research investigation, which involves understanding culturally and socially-relevant subject material through multiple viewpoints, a CIS allows for the data to be interpreted and conveyed congruent with the core components of the research questions. The intent of utilizing the CIS methodology, grounded in a socially transformative stance, was to articulate the implications of culture in end-of-life care. It was my intention that knowledge gained from this review will augment a music therapist's ability to not only advocate, but also empower the clients they work with. Considering the social relevance of the topic of CIHMT and



the inclusion of both quantitative and qualitative studies in the systematic review process, a CIS has been chosen as the most rigorous and appropriate design.

### **Researcher Stance**

The researcher's stance should be elaborated on in order to understand the rationale behind this CIS. See Figure 2 for the knowledge framework. In terms of my research epistemology, I am coming from a transformative stance (Wheeler, 2005). It was my intention to better understand how culture informs HMT, why this is important, and how it can be integrated into practice going forward in order to better the lives of individuals in end-of-life care. The power to evoke social change by addressing the importance and inclusion of culture in HMT practice reflects a transformative worldview (Creswell, 2014, p. 9). It was my hope as the investigator, that insight gained from researching culturally sensitive practice will strengthen the therapeutic process and relationship, as well as reduce risks of misunderstanding, unfair biases, and incidents of racial prejudice or stereotyping.

I chose to include the music therapy term "musicking" because the act of engaging a client in music is important to utilize and understand in HMT, it is commonplace in MT textbooks and literature, and it was an important aspect of the HMT work I got to experience firsthand during my own fieldwork placement in a hospice setting. Due to hospice care's primary focus on quality of life and emotional expression, progress and goal attainment may be best understood during musicking, such as when a client glows when they talk about their memories of a beloved song, squeezes their loved one's hand while singing a hymn, or simply smiles and laughs while playing along with the MT.

**Procedures.** This review examined studies that addressed the influence of cultural perspectives on music therapy practice in end-of-life care. Step-by-step overview of the procedures used in the CIS are displayed in Figure 3. Hospice and palliative populations were considered with no exclusion based on age, pediatric, adults, and older adults receiving end-of-life care were all considered. In order to be included, studies had to meet the following inclusion criteria:

1. Studies were primarily research, published in English, in peer-reviewed journals published between 2002 and 2016.
2. Studies were qualitative, quantitative, or mixed-methods with no restrictions on age or gender within the population.
3. Studies included music therapy practice in end-of-life-care (including hospice and palliative care).
4. Studies included discussion of cultural diversity, cultural competencies, or cultural awareness in relation to clinical practice.

Studies were excluded if they were not published in a peer-reviewed journal; published in languages other than English; published before 2002; did not involve music therapy in end-of-life care, specifically; did not explore cultural diversity/awareness/competencies. The inclusion and exclusion process of the review is displayed in Figure 1.

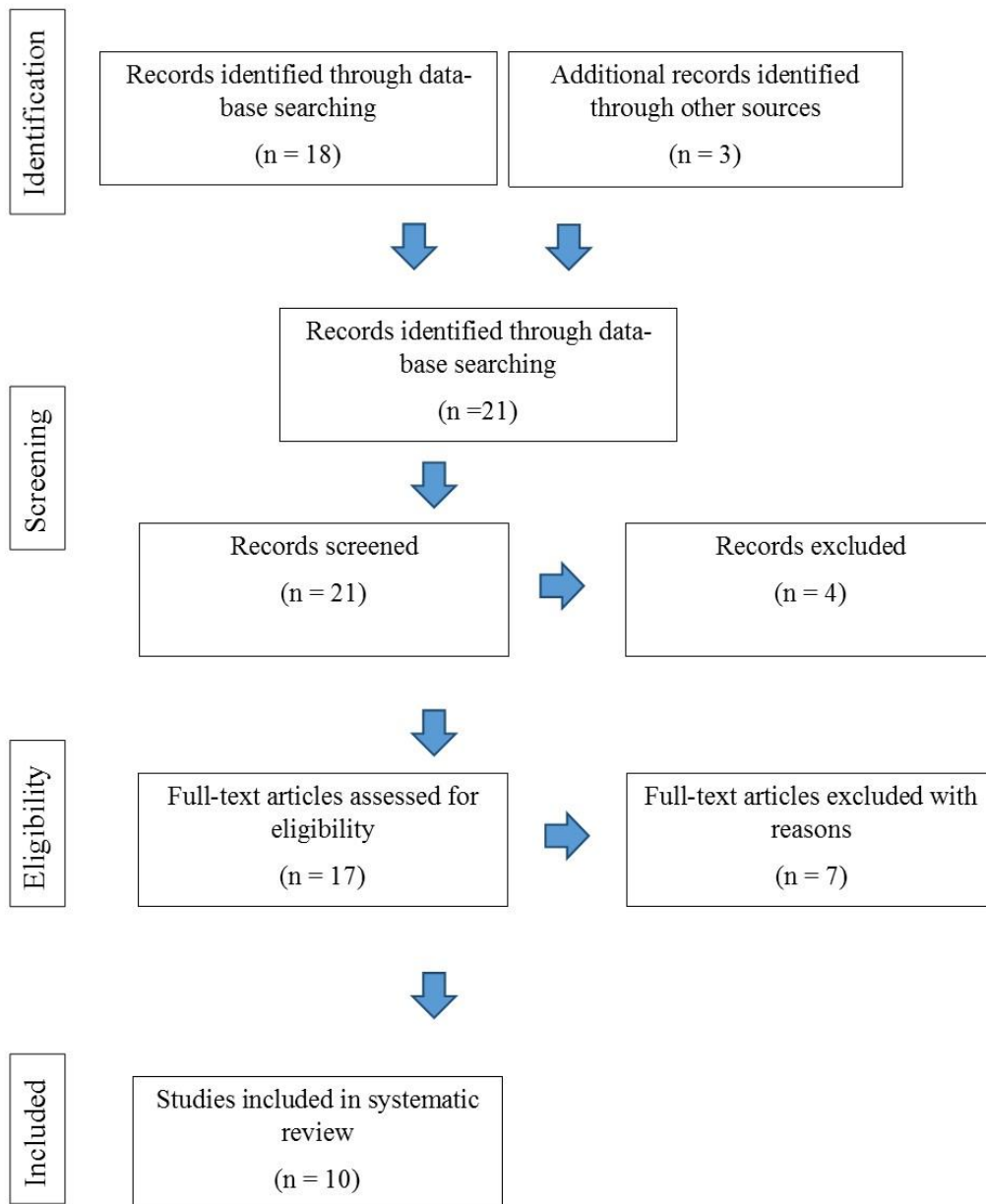
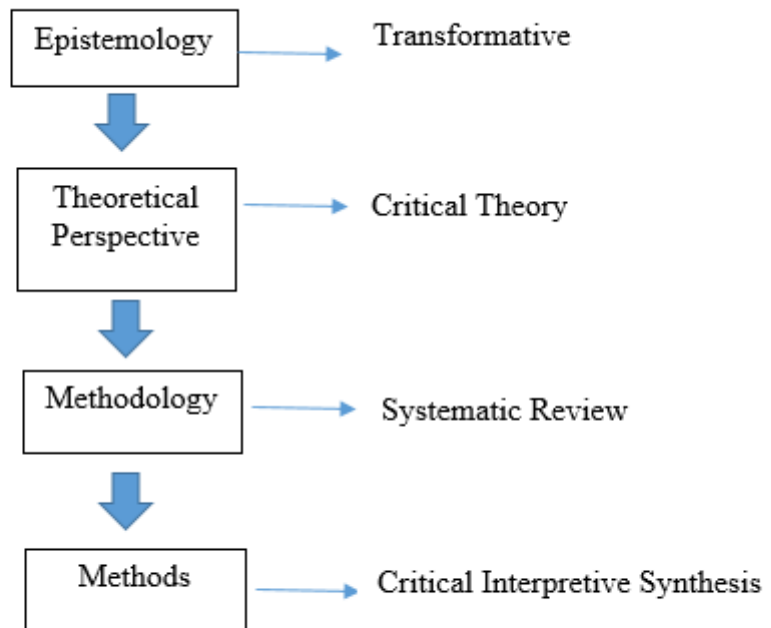


Figure 1. Flowchart of article inclusion process.



*Figure 2.* Knowledge framework

**Search Strategies** Potential studies for analysis were identified by searching the following databases: Proquest, PsycINFO, PsycARTICLES, Psychology and Behavioral Sciences Collection, CINAHL, MEDLINE, Academic Search Complete, Humanities Source, ERIC, Health Source: Nursing/Academic Edition, and ethnoMED between February and August, 2016. A hand search was conducted for The Journal of Music Therapy, Music Therapy Perspectives, and Voices: A World Forum for Music Therapists. Database searches identified some articles published in the New Zealand Journal of Music Therapy and Australian Journal of Music Therapy as well. Articles in journals of interdisciplinary fields, such as healthcare and psychology, were also examined in order to gather more potentially relevant studies.

Search terms included: *cultur\*(culture/cultural)*, *multicult\*(multiculturalism/multicultural)*, *diversity*, *spirit\*(spiritual/spirituality)*, *religio\*(religion/religiosity/religious)*, *hospice*, *palliative*, *end of life*, *terminal*, *music*, and *music therapy*. The reference lists of these articles were also examined in order to identify other possibly applicable studies.

### **Data Extraction**

This study was approved as exempt by the Human Rights Ethics Board and permitted by the International Research Board at the State University of New York (SUNY) at New Paltz. Exactly 21 articles met the inclusion criteria set forth for the study. Out of those 21 articles, 4 were excluded due to inability to access full-text and relevance to study, leaving 17 articles assessed for eligibility. Another seven articles were excluded due to published date and lack of relevance to investigation at hand. A total of 10 articles were used for the synthesis.

Initial coding involved organizing the articles by identifying information and design characteristics. Publication date, study design, setting, measures, and outcomes were all

examined for each individual article. See Table 1 for full list of included articles' characteristics and identifying information. Content was compared between articles, and sections related to the research questions were highlighted. By identifying information related to how culture informs HMT, the first research question was addressed: the degree to which MT research reports on culture and HMT.

### **Data Generation**

The excerpts of text with relevant information were marked by numbers corresponding to the research questions that the information related to. This content that spoke to the intersection between end-of-life care, cultural competency, and MT, became the raw data for the CIS. This data was then reread and scanned for further supporting information. Common themes and concepts became apparent throughout the readings and a list of initial key themes were written up. Some of the initial themes generated were: *cultural perception of death, death rituals, religious values, bereavement, cultural identity, and cultural perception of music*. These themes most directly addressed HMT and cultural factors. The articles were reread and the key themes list was shortened to include only the subject material most prevalent to the research questions. Some themes, such as: *bereavement* and *cultural identity* were dropped due to a significant degree of overlap in explaining two or more themes. Some themes seemed to be encompassed in a larger theme (such as *death rituals* and *religious values* into *religiosity/spirituality*). Other themes were dropped due to their lack of emphasis throughout all of the literature (*bereavement* turned out to be less prevalent than first anticipated).

Narrowing the scope to a smaller list of pertinent subjects was necessary for more rigorous dissecting. Information was synthesized across all 10 articles in order to put forth a thorough report on CIHMT prevalence, methods, and utilization. This synthesis involved

combining the data (content related to research questions) across the articles in relation to each other (eight themes). The final list of eight themes were thus defined out of rigorous screening, analysis, and logical necessity. The narratives synthesized as a result of fleshing out these themes created the results section. Elaboration on the eight themes in terms of implications for future research, education, training, and practice manifested into the discussion section.

Table 1

*Articles Included in Critical Interpretive Synthesis*

	<b>Title of Study</b>	<b>Publication Date</b>	<b>Author(s)</b>	<b>Journal</b>	<b>Research Methodology</b>
1	Utilization of music therapy in palliative and hospice care: An integrative review	2014	Bowers & <u>Wetsel</u>	Journal of Hospice and Palliative Nursing	Quantitative – Integrative Review
2	Addressing issues of ethnicity and identity in palliative care through music therapy practice	2001	Forrest	Voices	Qualitative – Case Study/Vignette
3	Supportive cancer care at the end of life: Mapping the cultural landscape in palliative care and music therapy	2011	Forrest	Music and Medicine	Qualitative – Systematic Review
4	Your song, my song, our song: Developing music therapy programs for a culturally diverse community in home-based paediatric palliative care	2014	Forrest	Australian Journal of Music Therapy	Qualitative – Case Study/Vignette
5	Music therapy in the context of palliative care in Tanzania	2010	<u>Hartwig</u>	International Journal of Palliative Nursing	Qualitative – Questionnaire
6	Beyond therapy: Music, spirituality, and health in human experience: A review of literature	2002	<u>Lipe</u>	Journal of Music Therapy	Qualitative – Systematic Review
7	Music therapy and spiritual care in end-of-life: Ethical and training issues identified by chaplains and music therapists	2013	<u>Masko</u>	Dissertation	Mixed Methods – Sequential Exploratory
8	Theoretical considerations of spirit and spirituality in music therapy	2014	Potvin & Argue	Music Therapy Perspectives	Theoretical Article
9	Music therapy in the global age: Three keys to successful culturally centered practice	2014	<u>Swamy</u>	New Zealand Journal of Music Therapy	Qualitative – Ethnography
10	The effect of music therapy on the spirituality of persons in an inpatient hospice unit as measured by self-report	2007	<u>Włodarczk</u>	Journal of Music Therapy	Quantitative – Survey



### CHAPTER 3: RESULTS

Eight themes were systematically identified across the 10 articles that most appropriately supply the data necessary to answer the three initial research questions. These themes are (1) perception of death & dying, (2) appropriate level of sensitivity, (3) spirituality/religiosity, (4) expression of grief, (5) family dynamics, (6) legacy/life review, (7) perceived role of music therapist, and (8) perceived role of music. The identification of these themes across the literature is displayed in Table 2. These themes were consistently addressed throughout the reviewed literature, and helped illuminate implications for future practice development, clinical training, research opportunities, and academic curricula. The influence of the client's culture, the client's family's culture, and the music therapist's culture permeates everything in sessions from communication to interaction and perception. The reported outcomes were organized as follows: each theme was broken down into three subsections (summary, methods, and therapeutic relationship) in order to answer the three research questions. The final list of key themes for the CIS is displayed in Table 3.

Table 2

*Key Theme Identification Chart*

	1 <u>Bowers &amp; Wetsel</u> (2014)	2 <u>Forrest</u> (2001)	3 <u>Forrest</u> (2011)	4 <u>Forrest</u> (2014)	5 <u>Hartwig</u> (2010)	6 <u>Lipe</u> (2002)	7 <u>Masko</u> (2013)	8 <u>Potvin &amp; Argue</u> (2014)	9 <u>Swamy</u> (2014)	10 <u>Włodarczk</u> (2007)
1.) Perception of Death & Dying			pp. 10, 11	p. 1		p. 220		p. 122		
2.) Appropriate Level of Sensitivity	p. 231	p. 1	p. 11		p. 503, 504	p. 223	p. 3	p. 126		p. 113
3.) Spirituality/Religiosity	p. 231		p. 10	pp. 1, 3	pp. 500-503	pp. 210, 219, 223	p. 3	p. 118, 123, 127	p. 403	p. 114
4.) Expression of Grief		pp. 1, 2	pp. 10, 11	pp. 1, 3	p. 501	p. 218, 219	p. 3	p. 123		p. 115
5.) Family Dynamics		pp. 6, 11, 12	p. 12	pp. 1-3	p. 500	p. 220	p. 3	p. 122	p. 403	p. 117
6.) Legacy/Life Review		p. 11			p. 500	p. 220				p. 115
7.) Perceived Role of Music Therapist	p. 232	p. 3	pp. 10, 11	pp. 1-3	p. 502	pp. 219, 223	p. 2, 3	p. 118, 120, 126	p. 404	pp. 113, 115
8.) Perceived Role of Music	p. 232	p. 3		p. 3	pp. 499, 502	pp. 217, 222		p. 120, 122, 124	p. 404	

Table 3

*Key Themes Chart*

	<b>Author(s)</b>	<b>Key Themes Addressed</b>
1	Bowers & <u>Wetsel</u>	Appropriate Level of Sensitivity, Spirituality/Religiosity, Perceived Role of Music Therapist
2	Forrest	Appropriate Level of Sensitivity, Expression of Grief, Family Dynamics, Legacy/Life Review, Perceived Role of Music Therapist
3	Forrest	Perception of Death & Dying, Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Perceived Role of Music Therapist, Perceived Role of Music
4	Forrest	Perception of Death & Dying, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Perceived Role of Music Therapist, Perceived Role of Music
5	<u>Hartwig</u>	Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Legacy/Life Review, Perceived Role of Music Therapist, Perceived Role of Music
6	<u>Lipe</u>	Perception of Death & Dying, Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Legacy/Life Review, Perceived Role of Music Therapist, Perceived Role of Music
7	<u>Masko</u>	Appropriate Level of Sensitivity, Spirituality/Religiosity, Family Dynamics, Perceived Role of Music Therapist
8	Potvin & Argue	Perception of Death & Dying, Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Perceived Role of Music Therapist, Perceived Role of Music
9	<u>Swamy</u>	Appropriate Level of Sensitivity, Spirituality/Religiosity, Family Dynamics, Perceived Role of Music Therapist, Perceived Role of Music
10	<u>Wlodarczk</u>	Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Legacy/Life Review, Perceived Role of Music Therapist

## **Perception of Death & Dying**

**Summary.** The perception of death and dying has been one of the most ubiquitous mentions of culture throughout the compiled end-of-life care literature. Although death is a universal experience, this inescapable and ultimate phenomenon in our world is perceived differently depending on the cultural lens it is examined through (Forrest, 2001; Forrest, 2014; Lipe, 2002; Potvin & Argue, 2014). While it is true that the scientific community may have a standardized definition of what it means to be dead, there are thousands of belief systems, and even more variations if the individualistic cherry-picking of beliefs of families is taken into account. The impact of individuals' and their families' perception of death on end-of-life care is undeniably one of the essential aspects of coming to understand methods and the therapeutic relationship involved in CIHMT. Forrest (2014) revealed in a vignette of a young adolescent client of Northern Asian descent that "within her culture, the death of a child is a source of great shame, something that is not talked about and which usually results in families having to leave the community" (p. 15). In this specific example, the family would not allow the client's sister to come visit her in the hospital because of their beliefs that she might also fall ill and even die. In this situation, the music therapist had to work with the client's sister at home and compromise had to be made with the family in order for such multifaceted therapy to take place

**Methods.** A client's perception of death influences the method of choice in HMT (Forrest, 2011; Forrest, 2014; Lipe, 2002; Potvin & Argue, 2014). This cultural factor plays in to an individual's ability to respond and come to terms with their circumstances. Thus, clinical decisions, communication, boundaries, and style of intervention can all be affected. "Understanding the ways in which people enact care of the sick and dying, knowing what is important to them in doing this and being open to negotiating potentially changing role of the

professional health care team within different cultural contexts are essential skills for the clinician” (Forrest, 2011, p. 10). A music therapist working in hospice may develop more effective interventions by gaining some insight into a client’s perception of what is happening to them.

**Therapeutic relationship.** The therapeutic relationship is informed by the client’s perception of death and dying. Communication, as well as musical and physical interactions, may all be influenced by the client’s contextual understanding of what is happening to them. Depending on their values and beliefs regarding death and dying, the family members of a client may feel open and accepting, or pressured and threatened, by clinicians, such as a music therapist, coming into their home and interacting with their dying relative. “The culture of the family also includes their beliefs, family and community supports, and the ways in which they understand and conceptualize health, illness, death and dying” (Forrest, 2014, p. 15).

Consider in Forrest (2011), a vignette of a young Vietnamese girl who had developed a brain tumor, the mother of the client expressed to the music therapist that her daughter’s illness was a punishment for her own faults as a “bad wife and mother” (p. 11). The mother of the client felt so much shame connected to the situation that she asked all staff visiting her home to come in unmarked cars and remove any identification badges or articles, for fear of the stigma to the Vietnamese community. In this case, the client’s family’s perception of dying was formed through cultural values and demanded increased sensitivity and discretion in order for end-of-life care to take place.

### **Appropriate Level of Sensitivity**

**Summary.** The professional opinion that the use of music in end-of-life-care requires sensitivity, not only in delivery, but also in situational context was consistently brought up throughout the literature (Bowers & Wetsel, 2014; Forrest, 2001; Hartwig, 2010; Masko, 2013; Potvin & Argue, 2014; Swamy, 2014; Włodarczk, 2007). Individuals in hospice care, as well as family members and caregivers, can be one of the most vulnerable populations to provide care for. Cultural rituals, music, and practices associated with death and dying are intimate subjects to approach. In order to better understand boundaries, expectations, and values, the music therapist must approach therapy with an appropriate level of sensitivity.

**Methods.** Being sensitive and receptive to understanding a client's cultural beliefs is essential to CIHMT. "Sensitivities include the roots of music in a particular society, its traditional function, and factors that have shaped music for use today" (Hartwig, 2010, p. 504). Music interventions geared towards quality of life in HMT become designed with the client's cultural understanding of the music in mind. Bowers & Wetsel (2014) echo this view and discuss a call for a more patient-centered and culturally competent treatment approach in end-of-life care. Hartwig (2010) contained the example of a Tanzanian patient in a predominantly Muslim community who was afraid to request church hymns in the presence of their Muslim neighbors for fear of an adverse reaction or hindrance of the therapeutic environment (p. 503). This sentiment reverberates in the realm of hospice care when cure is no longer possible, and the therapist's treatment approach is concerned with every dynamic of wellness; physical, emotional, mental, and spiritual.

**Therapeutic relationship.** Under the AMTA code of ethics, music therapists are sworn to respect and preserve the dignity of the clients they work with. Being sensitive to boundaries, already an important component of the therapeutic relationship, becomes even more explicit in

HMT when the multicultural views of both the therapist and client are taken into account. Forrest (2011) draws attention to the sensitivity to the mere mention of the words “death” and “dying” to clients and their family members during a session:

For some families, it is preferable neither to tell the patient his/her diagnosis, nor to have discussions about death and dying with either the patient or family as it is believed this is not supportive care, and removes hope. Where it may not be appropriate to use words such as ‘death’ and ‘dying’ and phrases such as ‘terminal care’ and ‘end-of-life-care,’ sensitive topics may be broached using alternate words and phrases (p. 11).

The level of sensitivity required to discuss cultural beliefs, values, and perceptions with the client in end-of-life care is critical to not only better understanding the client’s condition, but also to implementing effective treatment (Swamy, 2014). The process of rapport building and establishing a productive therapeutic relationship is informed by cultural values and, therefore, must be approached with an appropriate level of sensitivity.

### **Spirituality/Religiosity**

**Summary.** The role of spirituality and/or religiosity, and the multifaceted influence of these beliefs was a topic that dominated discussion in the available research. Religion, spiritual wellness, prayer, and ritual have captured the attention of many clinicians and healthcare professionals both within the music therapy field and beyond (Bowers & Wetsel, 2014; Forrest, 2014; Hartwig, 2010; Lipe, 2002; Masko, 2013; Potvin & Argue, 2014; Swamy, 2014; Włodarczk, 2007). While closely linked in conception, spirituality and religiosity can be difficult to define and measure. Using the words of author Włodarczk in *The Effect of Music Therapy on the Spirituality of Persons in an In-Patient Hospice Unit as Measured by Self-Report:*

“Spirituality refers to a connection outside of the self and defined by the individual; religion refers to a specific denomination of tradition” (2007, p. 114). Spirituality and religiosity will be operationally defined by these statements for conciseness and practicality of this statement in the article.

**Methods.** The cultural influence of a client’s, and/or client’s family, spirituality/religiosity on clinical methods and interventions in HMT is pervasive. Though there can be significant differences between spiritual and religious perceptions, it is evident throughout the compiled literature that an individual’s spiritual or religious beliefs may serve the same purpose; with past evidence showing correlations between the realm of spirituality/religiosity and coping skills, support, well-being and good health, hope, increased quality of life, and positive psychosocial status.

In Masko (2013), a survey of music therapists and chaplains on providing spiritual care revealed strong feelings towards addressing spiritual goals in hospice care. Not only did music therapists feel that the selection of appropriate music and interventions based on their clients’ cultural and spiritual backgrounds was important, but also that “assisting with spiritual practices, meditative practices, guided imagery experiences, and experiencing God or a higher power” are within the spiritual care scope of practice for music therapists (p. 3). It is also apparent from the literature that “hospice patients frequently make associations between music and spirituality” (Włodarczk, 2007, p. 114). The confluence of music, expression, and spiritual/religious rituals critically informs the style of intervention used in HMT. Families from different cultural backgrounds use songs and music to celebrate and commemorate religious celebrations and events (Forrest, 2014). “Many families undertake rituals at the start or end of each music therapy



visit, for example the lighting of candles or saying of prayers to bless the child, family and music therapist; and the singing of sacred or significant songs” (p. 15).

Music and spirituality share a strong connection in many cultures and religions (Forrest, 2011). The use of a culturally-informed musical experience in a therapy session should be understood with the same gravity as prayer or meditation. “Music can help to create an environment conducive to prayer and spiritual reflection, and can be a stimulus to contemplate existential issues” (Hartwig, 2010, p. 500). Potvin & Argue (2014) delve deep into the experience and relationship of music and spirituality. This study draws specific attention to the musical qualities of prayers and rituals, the concept of music as prayer, and the interdisciplinary mingling of music therapy and ministry in end-of-life care situations. While responding to a client’s requests for particular musical qualities in a prayer or hymn may seem culturally competent and spiritually sensitive, the study also discusses how important it is for music therapists to perceive music and prayer exclusively so as not to offend or denigrate a sacred act.

**Therapeutic relationship.** Accessing a client’s spiritual or religious understanding of their circumstance may not only inform methods used in a music therapy session, but also shine light on a different dimension to the therapeutic relationship. For example, Information about the client’s illness and condition may be communicated to the music therapist through the family members in context of their religious beliefs. “People understand and conceptualize illness in varying ways. For some groups, such as Indigenous Australians, a diagnosis of cancer is inherently connected to the spiritual world and may be seen as a curse of punishment for a past misdeed” (Forrest, 2011, p. 11). A lack of awareness of the client’s religious beliefs can hinder rapport building, create boundaries between the client and therapist, and possibly lead to offensive interactions or misunderstandings. The literature also suggests that families with strong

religious beliefs may gain strength and support through their faith (Forrest, 2014). The confidence, strength, and peace of mind offered by a person's faith or spiritual beliefs are important resources to draw upon in the dialogue between therapist and client. Connecting through a mutual respect or acknowledgement of spiritual significance may help embolden the therapeutic relationship and create a deeper alliance for the therapeutic process to unfold.

### **Expression of Grief**

**Summary.** Another prominent topic throughout the 10 studies was the concept of grief; how it presents itself, is regarded, and expressed by different families across cultures (Forrest, 2001; Forrest, 2011; Forrest, 2014; Hartwig, 2010; Lipe, 2002; Masko, 2013; Potvin & Argue, 2014; Włodarczk, 2007). The role of culture in expression of grief is mentioned throughout HMT literature. At such a fragile and difficult time in an individual's life, grief may lead to further exploration of one's cultural identity; where they stand on certain traditions, beliefs, and practices, and the extent to which their life experiences have been shaped by them.

**Methods.** It is important for a music therapist to understand the client's cultural beliefs and practices regarding loss and acceptance, as these beliefs may provide insight into effective methods of channeling healthy expression of grief and provide avenues for the therapeutic process (Forrest, 2001; Forrest, 2014; Potvin & Argue). The physical breaking down of an individual's body, the mental shift of grasping their situation, and the extent to which an individual may identify with cultural beliefs surrounding death all flesh out the transitional nature of terminal illness and end-of-life care. Forrest (2001) explains the shift or loss of identity often associated with grief in hospice:

In preparing for their death, patients with terminal illnesses may express a need to explore and confirm their identity in terms of their familial, social, cultural and ethnic heritage. The identity of patients with terminal illnesses may in many ways be challenged and controlled, defined and at times consumed by illness, and the loss and grief associated with this illness (p.1).

Individuals with terminal illness may meditate on the choices they've made and the paths they've taken through life, which may trigger significant feelings of success and fulfillment or sorrow and regret. Music interventions and musicking may provide a valuable outlet for expression of difficult feelings as well as provide a dynamic force of change from the mental state of despair to acceptance (Potvin & Argue; Wlodarczk, 2007). This dimension of cultural influence is crucial to informing effective and appropriate music interventions in HMT.

**Therapeutic relationship.** Grief is a strong area of focus in end-of-life care treatment (Forrest, 2001; Forrest, 2011; Forrest, 2014; Hartwig, 2010; Lipe, 2002; Masko, 2013; Potvin & Argue, 2014; Wlodarczk, 2007). The manner in which a person expresses grief is a result of cultural influence, identity, and personal values. A client's ability to grieve, to come terms with their situation, and even explore their own mortality is a major aspect of an effective therapeutic relationship in HMT. The literature highlights that it is important for the music therapist to bring awareness to the variation in expression of grief that exists not only across different cultures but also different family members, different situations, and settings. The grief of the client's family and cultural community is also mentioned throughout the literature. "In some situations, families have few or no supports around them, and are grieving not only the illness of their child, but also separation from their homeland, extended family and cultural community" (Forrest, 2014, p. 15). The cultural beliefs, rituals, attitudes, and practices that can potentially shape a client's

expression of grief should be approached with respect and sensitivity for the development of a healthy therapeutic relationship.

### **Family Dynamics**

**Summary.** Across the literature, researchers have examined the inner workings of a family unit, and emphasized the necessity of family integration in HMT clinical work. Home-based work can open the door to greater intimacy between the dying patient, family, and music therapist, but in order to accomplish this level of care and minimize disruption to family life, the music therapist must understand the family's dynamics (Forrest, 2011; Forrest, 2014; Hartwig, 2010; Lipe, 2002; Masko, 2013; Swamy, 2014; Włodarczk, 2007). When a music therapist is working in the home of a client, they not only step directly into that individual's private world, but their family's private world (Forrest, 2014). Music therapists working on home visits become immersed in the family's culture; they witness the daily behaviors and rituals of the family, their way of doing and being, relating and communicating, and the roles of the individual family members. It is an undeniable aspect of how culture informs HMT.

**Methods.** The literature draws attention to the ways in which culture informs methods in HMT through the interactions, values, and beliefs of the client's family. The music therapy process may help facilitate an exploration of cultural values within the family. "Towards the end of their lifetime, patients who have a terminal illness may express a need to return to, explore, re-establish and confirm their identity as a member of their family, social circle and wider cultural and ethnic heritage" (Forrest, 2001, p. 2). Music therapy sessions may open clients and their families into a conversation regarding the maintenance and conservation, as well as integration, of ethnic heritage and identity. Sometimes the clinician needs to ascertain what constitutes music for a family, and what is permissible within the cultural and religious beliefs of the family. For

example, Forrest (2014) stated that she had encountered some Muslim families in HMT who did not participate in listening to or playing music due to their cultural beliefs. In this case, the methods of treatment are heavily informed by the culture of the client's family. The literature also speaks heavily to the importance of providing support to the family, and the intricacies of multiple therapeutic relationships. "Pain, fear, anxiety, hopelessness and depression are commonly encountered in working with the terminally ill. The patient's family also suffers, as they may review regrets of the past, face the demands of the present, and entertain fears of the future" (Hartwig, 2010, p. 500). Gaining knowledge of a family's cultural values may inform the music therapist's treatment planning; targeting the source of anxiety and fear, developing coping skills, support systems, and emotional processing. The ubiquity of family dynamics and family cultural practices in the available HMT literature brings awareness to the need for culture-informed methods in end-of-life care.

**Therapeutic relationship.** Communication, expectations, and relationships are all the products of the family's cultural perspective, and the components of a family's dynamic. A music therapist may harness the knowledge of their client's family dynamics in order to more effectively establish a therapeutic relationship. Cultural traditions may have a significant impact on the family's views of the music therapist, the quality of hospice offered, and the manner in which their family member's death is addressed. For example, in Forrest (2011), a vignette of music therapy work with a Lebanese family revealed specificities of family roles; "...instead of working with the mother and child, or with the infant and his siblings, as would most commonly occur in family-based music therapy, the author instead worked with all the female members and children of the large extended family and local Lebanese Community" (p. 10). Up to 20 family members could be present in one music therapy session. The male family members did not

actively participate in the music therapy sessions, but served as the advocates and source of communication between the family and therapist during follow-up visits and discussion of how the family was coping.

The literature is rife with examples of the spectrum of relationships and expectations that exist within different families. “Clinicians should also be mindful of potential differences in beliefs and practices within a family: this can be particularly apparent at an intergenerational level” (Forrest, 2011, p. 13). The extent to which cultural traditions are held in reverence to different family members may put the music therapist in a complex position whereby he/she must now maintain neutrality within family relationships while also working as a productive advocate and care provider. In HMT, it is just as important for the music therapist to effectively maintain and navigate relationships with the client’s family as it is with the client.

### **Legacy/Life Review**

**Summary.** A powerful process, intervention, and goal in end-of-life care comes in the form of legacy or life review (Forrest, 2001; Hartwig, 2010; Lipe, 2002; Masko, 2013; Wlodarczk, 2007). Legacy work involves looking back through the events of the client’s life, usually through verbal processing that may or may not have been triggered by a musical experience; exploring past significant events, conflicts and accomplishments, in order to come to terms with their life experience as a whole. Ultimately, clients may come to terms with the breadth of their life experiences through the nostalgia and reflection that musical experiences may incite. A client’s legacy is heavily influenced by their cultural perception and values. The use of legacy work is a common intervention in HMT and mentioned throughout the literature.

**Methods.** The use of life review in HMT is an implicit influence of culture on music therapy methods. The value of music used in sessions may be determined by the cultural attachment a client has to it. “Music that is culturally significant or meaningful to the patient may trigger memories of other times, people and places, potentially allowing patients to explore and resolve past conflicts, and to reconfirm their identity as a member of their family, social circle, and wider cultural and ethnic heritage in preparation for death” (Forrest, 2001, p. 6). In the case study of Gretel and her family, music therapy allowed the client, Gretel, to “explore her present situation in relation to her memories experiences and important life events” as well as,

Allow the expression of feelings of pain, loss and grief and the sharing of memories.

Through the exploration of these memories and the resolution of issues or conflicts associated with them, Gretel was able to begin re-establishing and affirming her personal identity in the context of her family, society, ethnic community and wider cultural heritage (Forrest, 2001, p. 11).

The cultural belief system of a client may provide context and purpose for past life experiences and endeavors; revealing existential meaning to both the music therapist and client. The whole spectrum of life experiences may provide fuel for the therapeutic process as well as imbue the client with a greater awareness of their own accomplishments and journey. The use of music as an agent for coming to terms with mortality and the client’s present state, as well as past life experiences is apparent throughout the literature.

**Therapeutic relationship.** Legacy work is a culture-informed method that may be utilized within a therapeutic relationship in HMT. The power of music to trigger past memories and put life events in focus is not only a product of the client’s cultural values, but also a means to better understand them. Life review creates an exchange between client and therapist in which

the story of the client's life may be told in the colors and textures of the client's words, beliefs, and understanding. This is an invaluable intervention for engaging a client not only in music, but also in emotional processing, grief, and acceptance. Utilizing legacy work in a therapeutic relationship allows for a window into the client's cultural and personal values, imbues the client with greater agency, and sets the music therapist up for an accompanying role in the unfolding therapeutic process.

### **Perceived Role of Music Therapist**

**Summary.** The literature draws attention to the role of the music therapist in end-of-life care, as perceived and shaped by the client's cultural views. "Cultural beliefs and practices can impact the role and function of music in family and social life, the family's understanding of the music therapist's role (as healer, teacher, performer), and the interventions and instruments that are employed in music therapy" (Forrest, 2014, p. 15). The degree to which the client, and client's family, believe the music therapist can actually make a difference will indirectly affect everything from the quality of music therapy sessions, the closeness of the therapeutic relationship, and the nature of the interventions. The greater the level of understanding of what a music therapist's job is, the greater the ability for the therapist to reach the client and for the client to receive therapeutic intervention (Bowers & Wetsel, 2014; Forrest, 2001; Forrest, 2011; Forrest, 2014; Hartwig, 2010; Lipe, 2002; Masko, 2013; Potvin & Argue, 2014; Swamy, 2014; Włodarczk, 2007).

**Methods.** Understanding the role of the music therapist, as perceived by the client, may be vital to the music therapist's own ability to effectively reach their client in a genuine way. A client's initial perception of a music therapist may be influenced by their cultural associations with music and purveyors of music from their religious, ethnic heritage, or personal background,



whether it be to provide entertainment, spiritual, or celebratory (Forrest, 2011). This knowledge can work as a double-edged sword, giving the music therapist insight into music interventions that may be adapted from the client's cultural musical experiences while also providing an avenue for growth and understanding of the therapeutic process as a whole. Of the data culled, research consistently highlights the concept that the loss of identity associated with terminal illness may be bettered through music therapy and other creative arts therapy modalities. "The music that patients choose to hear, the songs they write, the instruments they play, and the modes, rhythms, tempi and dynamics they use in their playing are all expressive of their identity, whether proclaiming or whispering to the world 'this is me and this is my reality'" (Forrest, 2001, p. 6). The style of music used, the context of the musical experiences offered, and the role of the music therapist in musical engagement are all indirectly influenced by the client's perception of the music therapist's presence in their home. Bringing awareness to the music therapist's professional role as an ally, clinician, and member of the hospice care team is critical for effective therapeutic intervention.

**Therapeutic relationship.** The manner in which the client views the music therapist is a vital aspect to the therapeutic relationship that is mentioned in every article in this review. Communication, boundaries, and treatment are all affected by the extent and depth of the relationship formed between therapist and client. The cultural beliefs and values of a client may shape their understanding of the music therapist, however, and indirectly affect the therapist's ability to establish trust and build a working alliance. The boundaries of the music therapist and how these limitations fit with the family's expectations are also essential to the perceived role of the music therapist (Forrest, 2011). Masko (2013) emphasized that personal boundaries should be preserved and maintained while providing spiritual care in order to prevent, whether

consciously or unconsciously, the therapist's personal beliefs from affecting the client or client's family. Clients and their families may choose to sing songs in their own language; literally bridging the cultural and musical gap that may exist between the family and therapist. This is an invitation to the music therapist to share in the family's personal culture. Conversely, families may refuse to share their musical culture with the music therapist because of their perception of the therapist as an outsider to their cultural group. There may also be situations in which it is not appropriate for the therapist to sing certain songs or play certain instruments (Forrest, 2014). The music therapist must understand the client's perception of their role, being sensitive to their cultural lens and what expectations that might entail, while also maintaining personal awareness of their professional role in making clinical decisions.

### **Perceived Role of Music**

**Summary.** The concept of the role of music not only in a cultural context, but also in relation to death, and in relation to healing, was emphasized consistent throughout the 10 articles investigated in this CIS. The healing context of music can be seen across a traditional cultures when the role of music is inseparable from social events, celebrations, and rituals. The literature has shed light on a consistent and pervasive association between spirituality and the role of music in end-of-life care, and the potential of music to help an individual come to terms with meaning in life, transcend suffering, relieve pain and anxiety, and draw closer to God or some form of higher power (Lipe, 2002).

**Methods.** The client's perceived role of music may be defined through their past experiences of music's utility within a cultural context. Efficacious methods in HMT may, therefore, be determined not only by the client's needs but by their understanding of the purpose of music (Bowers & Wetsel, 2014; Forrest, 2001; Forrest, 2014; Hartwig, 2010; Lipe, 2002;

Potvin & Argue, 2014; Swamy, 2014). Forrest (2011) draws attention to the patient and family's use of music in day-to-day life, in healing, and therapeutic contexts. Through a better understanding of the patient and family's perception of music, the music therapist may incorporate music more effectively into sessions, and adapt material more naturally based on the context s/he is walking into. How an individual perceives healing, music, therapy, learning, and relationships all stem from identity—cultural identity, which is influenced by each individual's "relationship to ethnicity and culture, how much [they] accept or reject the values, communication style or worldview of [their] ethnic heritage" (Swamy, 2014). It is important in hospice, specifically, to differentiate between the role music is playing in the context of music therapy; music may be a catalyst for emotional processing and searching for meaning, or for a support for suffering, expression of grief, and shift away from the gravity of the situation. The healing power of music may be attributed to its "capacity to embody meaning and to provide a mirror of our inner world" or its capacity to "serve as a container or support for the expression of feelings rather than a stimulant for working through psychological issues" (Lipe, 2002, p. 217). Finding a balance between the clinical, therapeutic role of music and the personal, cultural connection of music to the client can manifest as two sides of the same coin in HMT methods.

While European music traditions have viewed the meaning of music in terms of technical elements such as harmony, pitch, and rhythm, the role and meaning of music is still under constant inspection by theorists and researchers (Swamy, 2014). The meaning and role of music is also referential, referring to non-musical phenomenon, memories, cultural attributes, and the listener's interpretation, perception, and experience. Some of music therapy's professional approaches, including Nordoff-Robbins, which places therapeutic emphasis on intervals, and the Bonny Method of guided imagery, which employs classical music in listening programs, both

rely on the absolute perspective of European music traditions. It is important, however, that the role of music, as perceived by a client, may not rely on European music traditions at all.

Hartwig (2010) found that music choices vary between situations, and cultural perception may be a powerful influence on these situations. The type of music utilized may be contextualized through the client's cultural viewpoint for an individual in pain as opposed to an individual experiencing depression, fear or anxiety, or more complex spiritual concerns. Bowers & Wetsel (2014) discuss how hospice providers can utilize music to alleviate suffering or shift energy and attention away from pain, while Lipe (2002) discusses how music can be used to facilitate meaningful interaction between client and family members, as well as instilling and maintaining hope. "Every culture uses music—to bring energy to daily chore; to comfort babies; to woo a lover; to meditate; to tell stories; to celebrate, mourn, praise; or dance to" (Hartwig, 2010, p. 499). There is a myriad of different musical uses mentioned throughout the literature that are informed through circumstantial and cultural perception.

**Therapeutic relationship.** Just as culture influences personal identity, music from a client's culture may expose hidden elements of a client's personal identity that may have been buried from the therapist as well as themselves (Swamy, 2014). In one client vignette examining music therapy with a client of African descent, the therapist draws on the ritualistic use of music from the client's culture to inform the music interventions used in therapy:

Most African music was rooted in recounting stories celebrating life events, or sending a message. An example is that of the 'talking drums': through the rhythm of the drum, one could announce a visitor, give a warning, celebrate a birth, announce a death, tell a story, or celebrate a victory. Similarly, singing was used in teaching moral values, remembering history or ancestry, or even to give a warning to someone (Swamy, 2014, p. 500).

Relating back to family dynamics, sometimes the music therapist must find what constitutes music in the eyes of a certain family. It is important to understand that musical preferences will vary between clients and families, even if they share the same heritage, ethnic, or religious backgrounds (Forrest, 2014). While one family espoused to the Muslim faith may prohibit the listening of recorded music and decline a music therapist's offer to record songs from sessions onto a CD, another family of the Muslim faith may embrace the opportunity to play a variety of musical instruments and love the idea of recording songs and music from the music therapy visits. In Swamy (2014), the author concludes the article with a very powerful statement about the dynamic between cultural perception of music for both the client and music therapist; "We should consider how our sociocultural backgrounds and biases affect our interpretation and understanding of music, and consider both absolute and referential perspectives of musical meaning. Understanding how our students and clients make meaning of music is critical to building a therapeutic, educational and musical relationship" (p. 49). This is significant for future theory building; implications not only for music therapy practice but also training, education, and research.

## **Discussion**

### **Implications for Future Research**

**Overall.** This CIS has illuminated the need for research that focuses on CIHMT. While rigorous research revealed 10 articles relevant to CIHMT, the authors themselves even comment on the dearth of literature and need for more investigation into the impact of CIMT.

Music therapy is increasingly being found to be an effective intervention in addressing the principles of palliative care, and there is a growing body of literature exploring the

use of music therapy to address the diverse and evolving needs of patients who have a terminal illness...the literature exploring issues of ethnicity and identity in palliative care and/or music therapy practice is, in contrast, quite limited (Forrest, 2001, p. 6).

The results indicate that music therapists can no longer deny the importance of cultural awareness and sensitivity in the context of therapy. Therefore, researchers must become more tenacious about addressing the impact of cultural factors on HMT studies.

**Methods.** In terms of research opportunities for an ameliorated understanding of CIHMT, future research could focus on the manner in which culture informs methods in HMT. Music therapists can learn a great deal about context from the fields of anthropology and ethnomusicology, especially in terms of cultural context (Swamy, 2014). Cultural context plays a significant role in intervention choice and methodology in HMT, as demonstrated by the key themes generated from this CIS. Furthermore, music therapists can learn more about culture through research—research into the anthropological, historical, political social, psychological, and even geographic context of various cultural groups. Forrest (2001) highlights this saying, “There is a need for further research examine the different mechanisms that underlie the concepts of ethnicity and identity, including the effects of migration on identity formation, and generational and cultural differences of experience (p. 12).” Music therapists must integrate their role of musician and ethnographer, researcher and clinician, by investigating important questions and seeing the behavior of their clients within a greater cultural context (Forrest, 2014).

**Therapeutic relationship.** The CIS explicates on the degree to which culture-informed methods are utilized within the therapeutic relationship. Rapport building is essential to the development of an effective therapeutic relationship. The cultural values and beliefs of a client and music therapist will affect the physical, verbal, musical, and emotional exchange that

transpires during sessions. The researchers also bracket themselves on the possible influence of their own cultural upbringing and their Western perspective on music, on hopes, expectations, and communication within a therapeutic relationship (Swamy, 2014). Future research directed at culture-informed methods and communication, interaction, and synergy of a therapeutic relationship would be transformative for the field of HMT.

### **Implications for Future Education & Training**

**Overall.** The manner in which culture informs HMT literature is pertinent to the future standards of education and training for all music therapists. The current state of cultural competencies for practicing music therapists as outlined in the ethics code of the AMTA are as follows:

- (a) To demonstrate awareness of one's cultural identity and socio-economic background/status and how these influence the perception of the therapeutic process; (b) to select and implement effective culturally based methods for assessing the client's assets and problems through various arts media; (c) to demonstrate knowledge of and respect for diverse cultural backgrounds; and (d) to demonstrate skill in working with culturally diverse populations ("AMTA code of ethics," n.d.).

It is clear from these statements that cultural competencies have become a prerequisite in terms of taking on the music therapy career, but the literature compiled in this CIS have put forth more insight into CIHMT specifically.

The results of this CIS has illuminated the various ways in which culture informs HMT. Though many of the issues brought up in the results are addressed by some part of the AMTA Code of Ethics, they could be further elaborated on for the betterment of future training and

education in the field. Music therapists learn from their clients, from their experiences, from feedback from contemporaries, and from research materials (Bowers & Wetsel, 2014; Forrest, 2001; Masko, 2013). Dileo (2000) asserts that, “An important ethical application, thus, is the therapist’s self-awareness of these issues when working with all types of clients” (149).

Clinicians have a responsibility to try and work in a culturally responsive way with their clients...when they understand what it is that gives meaning to their lives—whether this be the religious beliefs they hold, the music they use for different celebrations or remembrances, or the way in which they relate to members of their family and community—they can be more open to do what is important and meaningful for the client (Forrest, 2011, p. 13).

Sensitivity is important not only for music therapists but for all caregivers working across faiths (Hartwig, 2010). It is important to consider that “traditional cancer care and palliative care services have been grounded predominantly in Western philosophy and theory” (Forrest, 2011, p. 10). To become more aware of one’s own cultural beliefs and values not only helps to eliminate biases that may cloud judgement, but also to grasp a greater range of another person’s understanding of life. Lack of understanding may increase the risk of perceived discrimination against the client, racist comments or actions being made, or accidental cultural stereotyping that may damage the therapeutic relationship and process. Cultural immersion, even for a brief period of time, can provide powerful insight into new contexts for music therapists (Swamy, 2014). By immersing themselves in a different cultural context through an exchange program, volunteering abroad, going on vacation, or even attending a local, intensive, cultural event, music therapists may be able to directly experience new ways of thinking, challenging and expanding their own worldview. Culturally immersive experiences that involve learning inclusive language,



behaviors, beliefs, and rituals may help a music therapist to better interpret and relate to their clients. While this sentiment speaks to the principles in the AMTA code of ethics, this CIS reinforces cultural immersion as an appropriate addition to the code.

Bowers & Wetsel (2014) reported that: “Education about MT, as part of a holistic, culturally appropriate complementary intervention and treatment modality, should be included in basic nursing and APN (Advanced Practice Nurses) education programs...Music therapy should also be the focus of continuing education programs” (p. 237-238). Music therapists were also more likely to attend conference presentations, continuing education courses, and on-the-job learning seminars for spiritual care in hospice than chaplains (Masko, 2013). It is important to consider, however, that the extent of spiritual care provision may be limited depending on the client and family’s perception of the role of the music therapist. Similarly, while culturally competent practice may involve studying and focusing on certain tasks, rituals and death rites specific to the client’s culture, an attentive and eclectic therapist must bring their awareness to the client’s individual experience.

**Methods.** The combined literature of this CIS reinforces the need for addressing spirituality in hospice and palliative care, examining relationships between spirituality and music therapy within this population, and establishing guidelines for assessing spirituality (Bowers & Wetsel, 2014; Forrest, 2011; Forrest, 2014; Hartwig, 2010; Lipe, 2002; Masko, 2013; Potvin & Argue, 2014; Swamy 2014; Włodarczk, 2007). Hartwig (2010) asks: “How can we use music to teach, to express feelings, to mourn, to remember a loved one, to comfort, or to provide hope and security with this vulnerable group?” (p. 504). This sentiment is at the crux of theory building that this CIS hopefully taps into. Through proper education and training, music therapists and caregivers in end-of-life-care can have “more courage in using music as a tool in their ministry

as they further their sensitivities and refine its use to best benefit the people they serve” (Hartwig, 2010, p. 504).

Participation of the client, and/or client’s family, is a key aspect of the therapeutic process that is also inherently present in music (Hartwig, 2010). In collectivist cultures, or cultures where strong community participation is emphasized, musical collaboration within the therapeutic relationship may build stronger rapport and treatment outcomes. Different approaches, such as community music therapy, may be more appropriate to treat clients from a collectivist culture because of their understanding of interpersonal relationships and support are already so enforced by the communal mindset. Ultimately, the literature supports CIHMT and suggests that the existence of such a spectrum of cultural beliefs and practices across clients should inform the spectrum of methods and interventions devised by the music therapist for treatment.

**Therapeutic relationship.** CIHMT is exemplified by a therapeutic relationship informed by therapist self-awareness, reflexivity, and open dialogue of culture (Forrest, 2001; Forrest 2011; Forrest, 2014; Hartwig, 2010; Potvin & Argue, 2014; Swamy, 2014). In Forrest (2011), a discussion of cultural issues in palliative care is broken down into four key aspects; the culture of the patient and family, the culture of the clinician, the culture of palliative and hospice care, and the intersection between each of these. “Developing awareness of the cultural background of both self and the family and understanding the ways in which beliefs, practices and traditions can potentially impact engagement with palliative care and music therapy can assist the clinician in working in a culturally sensitive and responsive manner” (Forrest, 2014, p. 15). Finding the balance between these interlocking relationships and beliefs forms the interpersonal dynamic of CIHMT. The information synthesized from the literature draws attention to how complex the

interplay of culture on the therapeutic relationship is and how important it is for a music therapist to utilize culture-informed methods within the relationship.

More so, music therapists can learn through practice, by “patiently observing, interacting, documenting, studying, analyzing, and asking clients” (Forrest, 2014, p. 42). It is critical that music therapists are trained not to form clients’ identities based on their judgments, but rather, to allow the clients to self-identify (Swamy, 2014). “The role that music may play in addressing issues of ethnicity and identity in fields such as palliative and aged care should also be further explored” (Forrest, 2001, p. 12). The therapeutic alliance combined with musical accompaniment, or shared presence, can place music therapists in an even more meaningful role than merely a “helper-helped” relationship (Potvin & Argue, 2014). Also, music therapists must be cognizant of the cultural weight of language and appropriate communication in HMT.

Language barriers and differences in cognizant conceptual frameworks can also significantly impair meaningful discussion between clinicians, patients, and families.

Within some language, there is not a word to describe cancer and concepts such as ‘palliative care,’ ‘pain,’ and ‘relaxation’ can be difficult to translate from one context and language to another” (Forrest, 2011, p. 11).

The author uses the example of a Chilean client who used the phrase “music is the lullaby for my heart to rest” in order to best describe music for relaxation, a concept she struggled to translate into English for the music therapist (p. 11). Better understanding of a client’s culture, everything from their level of religiosity/spirituality to perception of death and manner of coping with grief, is necessary to further rapport building, communication, and development of empathy for a strong therapeutic relationship. Recommendations for future treatment, therefore, encourage the music therapist to participate in culturally immersion, to educate themselves on a variety of

cultural beliefs surrounding death and dying, educate themselves on the client's language and communication, and to practice self-awareness when examining the expectations and boundaries of a therapeutic relationship. These sentiments reinforce the AMTA code of ethics and provide incentives for growth in a productive, compassionate, and socially-conscious manner.

### **Implications for Future Directions for Treatment**

**Overall.** While the results of this CIS have spoken to the future development of research and training, it is important to use these themes to flesh out the future directions for treatment within CIHMT. Contextualizing music therapy is like "looking through a wide-angle lens" according to Swamy (2014). By acknowledging different cultural perceptions and contexts, music therapists are faced with more complex questions; what is the role of cultural background and privilege in a therapeutic relationship? What is the power dynamic? What is the "hierarchy between the ethnic and cultural background of clients, student and therapists or instructors?" and "How do our values, worldviews, and communication styles affect therapy and the healing process?" (p. 40). Music therapists, as well as other clinicians and healthcare professionals, working in end-of-life care will undoubtedly be confronted with their own sense of morality and personal identity, and how it is impacted and shaped by their ethnic and cultural background, present circumstances, and experiences of working with people who are terminally ill (Forrest, 2001). A self-aware music therapist must take stock not only into the extent to which their own cultural beliefs and sense of personal identity inform their approach to treatment with clients in end-of-life care, but also with clients whose ethnic and cultural backgrounds are different than their own. This sentiment echoes back to the AMTA code of ethics and the professional obligation of the music therapist to be aware of their own role in the delivery of music therapy services. The information on HMT treatment synthesized across all 10 articles shine some light

on the importance of CIHMT, culturally-informed methods, and the manner these methods are utilized within a therapeutic relationship.

**Methods.** This CIS has drawn forth compelling evidence to motivate music therapists working in end-of-life care to carefully examine how culture may inform their approach to HMT. Focus areas, from expression of grief to spirituality/religiosity and legacy/life review, directly speak to the necessity of culture-informed methods in end-of-life care. The associations made between spirituality and death, and the similarities between spirituality and music are undeniable in the literature. In Włodarczk (2007), the results of the spiritual well-being questionnaire revealed that, although a client requesting spiritual music does not necessarily indicate a specific level of religious or spiritual belief, spiritual music was requested overwhelmingly on days where hospice patients were offered music (music days), and these same participants were less likely to engage in discussion of a spiritual nature with the music therapist on days where music was not an offered (non-music days); leading the researcher to believe that the utility of spiritual music during sessions does stimulate discussion, a valuable tool for the therapeutic process. In Hartwig (2010), it was reported that all music therapists surveyed claimed: "...they were sensitive to the needs of the patient, wary of situations in which music might be harmful, and conscious that the music must be of an appropriate type... music must be adapted according to the patient's cultural heritage, age, and religious background" (p. 504). The knowledge of a client's culture will inspire current and future music therapists working in hospice to create/utilize more motivating, meaningful, and efficacious music therapy methods. The results of this CIS provide suggestions for future treatment in CIHMT using the eight themes as fuel for effective and appropriate practice.

**Therapeutic relationship.** Treatment in hospice care may be unique to other forms of therapy, especially in the case of sessions that take place in the home, because the therapist's relationship extends not only to the individual client in end-of-life care, but also to their role in the family dynamic (Forrest, 2014). Each family has its own culture, and this culture is directly affected and formed by their values, traditions, and beliefs. Again, these key themes of perception of death, appropriate level of sensitivity, spirituality and religiosity, expression of grief, family dynamics, legacy/life review, perceived role of music and music therapist are all important resources for furthering the ways in which the therapeutic relationship is understood in CIHMT.

During sessions, music therapists must be sensitive to the interaction of cultural variables that takes place in each discussion, physical, and musical interaction. Consider Forrest's (2011) guidelines for treatment:

Importantly, following the lead of the patient/family when engaging them in sensitive discussions will help to ensure that inappropriate topics are avoided. Questions such as 'Can you tell me how you are feeling today—are you tired, are you eating and sleeping well, does anything hurt?' and focusing on what can be done to alleviate issues that arise can allow exploration of patient symptoms and changes that the patient/family are experiencing without alluding to diagnosis or prognosis (p. 11).

Each of the eight themes discussed in the results of this CIS contribute to a resource pool for music therapists to pull from while currently practicing in the end-of-life care clinical setting. Music therapists should work to create a safe, open atmosphere, while paying attention to how their client perceives his/her place in the culture or community they are a part of now. The "minority stress" of an individual for feeling judged by appearance, their willingness to learn a

new language and discontinue their native tongue, or being “perceived as separatist for not socializing their own cultural group” will all play a part on their work in therapy and the therapeutic relationship that develops (p. 41). Clients’ cultural identities are multifaceted, and while some clients may identify as being bicultural, an equal hybrid of two cultures or an uneven amalgam of several different cultures, others may describe themselves as being recreated or reconstructed. The politics, laws, wars, and conflict from the client’s country of origin/inhabitation must also be considered. It is important for music therapists to be aware of any history of past injustices, wars, political conflicts, or colonization in the countries their client has lived in or shares ancestry with, as these complicated sociological events may impact that client’s personal culture and sensitivity around certain topics (Swamy, 2014).

### **Limitations of the Review**

Although this CIS successfully determined key themes throughout the culled literature, it is important to make note of the limitations of the study and areas of improvement for future work. One of the most prominent limitations of this study was the availability and accessibility of resources. Following the inclusion and exclusion criteria, only 10 of the original 27 articles research were used in this study. While 10 articles meeting inclusion criteria from a span of 14 years of music therapy literature may not be considered significant from a quantitative research perspective, it is adequate in context of a CIS/systematic review. Unfortunately, there were many sources, such as books, theses, and online articles that directly related to the investigation at hand, but could not be considered due to the exclusion criteria. Also, it was determined much later into the review that one of the articles was actually a theoretical article and, therefore, did not meet the initial inclusion criteria at all. The conclusions drawn from such a small set of sources must be considered in perspective to the total amount of literature in HMT. Perhaps

future research should attempt to incorporate theoretical articles, as well as case studies, in the review process. Although this article could not be justifiably labeled research, it provided valuable insight to the results of the CIS.

Examination of the literature made it very clear that historical context is another major factor in cultural identity formation, family life, and cultural idiosyncrasies that should be looked into more closely in follow up studies. Similarly, Potvin & Argue (2014) made the keen observation that the author's own level of spirituality and quality of beliefs may influence the study. This CIS was performed by someone with a Western viewpoint and a modern-American understanding of music, music therapy, and healthcare. This holds its own form of bias on the information being presented. For example, as the author and researcher, I am aware of my own bias in language, terminology, and approach looking back at the use of the term *musicking* during the initial stages of the review. I may be seeking out content in the literature that relates to this term because it is familiar to me and my perception of effective musical experiences. Also, I must take into account my own cultural perception through the lens of an American, middle class, heterosexual, Caucasian male with a traditional, Roman-Catholic, Italian-American upbringing. Realistically, there is a degree of privilege and even a power position because of my inclusion in this demographic in America. I may have done a disservice to the literature by overlooking important aspects of the studies simply because they did not conform to my expectations, views, and level of understanding.

Another limitation to consider is that the findings of this CIS cannot be generalized. As a systematic review, this study relies on contextual information and a rigorous search of the available literature. While the results hold significance in the way of future music therapy research, education, and practice, they do not carry the same weight from a research standpoint



as a quantitative style survey or experiment. As a young researcher who attempted a CIS style study for the first time, it is clear that I made oversights in terms of the level of organization and the rigor of tools/strategies involved in an effective systematic review. Tools for data extraction and analysis, such as a coding checklist or a quality assessment checklist should have been used. These could have been acquired by example through other CIS style studies and I would have had to take the steps to acquire and utilize them in my review. Standard coding was used as outlined by other CIS studies, but as a researcher I still have much to learn about the process.

The paper changed in both direction and content many times from the writing of the initial research questions to the actual procedures of defining criteria, extracting data, and synthesizing cogent narratives. For example, looking back at the entirety of the review now, the information presented in the literature corroborates that all music therapy work is truly multicultural. This indicates that operationally defining CIHMT as a singular approach in the beginning of this paper was really unnecessary after all. Similarly, a greater effort should have been made to draw distinctions in the narrative data from information regarding why culturally competency is significant to music therapy and how it is significant. Instead of searching for examples of CIMT or CIHMT, a follow up study should seek to specifically create outlines for cultural competencies to add to the AMTA code of ethics. This would be true to my initial research epistemology of a transformative worldview. Swamy (2014) stated: "The question is no longer whether music therapists should be culturally inclusive, but how music therapists become culturally centered" (p. 36). It is also important to consider that an operationalized definition for *culture*, taken from a music therapy ethics handbook, was used out of practicality for the study. Further studies should seek to create a more standard, universal definition for this complex concept. Ultimately, the study's strongest aspect may be its suggestions for future theory

building to transform music therapy practice. A combination of the key themes could be used to outline ethical guidelines in the AMTA standards, provide cultural competencies for training on family dynamics, levels of sensitivity, and appropriate level of spiritual care in hospice.

### **Conclusion**

This review into the current state of music therapy literature was conducted in order to better understand how culture informs HMT. In hopes of ameliorating ethical concerns, addressing multicultural viewpoints, and bettering the future of music therapy research, training, and practice, a CIS was chosen as the most effective form of review for the study. Working from a transformative stance, literature was culled, assessed, and synthesized in order to expand on practical augmentations for the field as well as address social injustices and cultural competencies in the end-of-life realm of healthcare. Three primary research questions concerning how music therapy research reports on culture in relation to hospice care, how culture informs music therapy methods in research, and how the therapeutic relationship is mediated by the impact of culture triggered a rigorous investigation and the generation of insightful key themes. Of the 27 articles originally researched, 10 met the inclusion criteria for exceptional pertinence to the research questions at hand. Eight themes ranging from cultural perception of death and dying to perceive role of the music therapist were synthesized from these 10 articles not only to see where the field stands on this topic today, but also to provide evidence supported information for future practice.

A synthesis of the most relevant and poignant aspects shared among the articles opened up meaningful discussion into theory-building, treatment approach, and the scope of practice for music therapists in end-of-life care. While the CIS may have exposed a relatively small amount of literature covering the topic at hand, it is heartening to see that the field is growing towards a

more multicultural approach, and grasping the significance of cultural implications not only within hospice and palliative populations but among all individuals. Ultimately, it is clear from this investigation that religious, spiritual, and general cultural perceptions affect everything from music selection to professional boundaries to the navigation of complex family relationships. A greater focus on cultural identity and context appears to be a necessary professional competency for music therapists working not only with individuals in end-of-life care but across all populations.

## References

- Bowers, T., & Wetsel, M. (2014). Utilization of music therapy in palliative and hospice care: An integrative review. *Journal of Hospice and Palliative Nursing, 16*(4), 231-239.  
doi:10.1097/NJH
- Chan, L., MacDonald, M. E., & Cohen, S. R. (2009). Moving culture beyond ethnicity: Examining dying in hospital through a cultural lens. *Journal of Palliative Care, 25*(2), 117-124.
- Choi, Y. K. (2010). The effect of music and progressive muscle relaxation on anxiety, fatigue, and quality of life in family caregivers of hospice patients. *Journal of Music Therapy, 47*(1), 53-69.
- Coolen, P. R. (2012). Cultural relevance in end-of-life care. *EthnoMED*. Retrieved from <https://ethnomed.org/clinical/end-of-life/cultural-relevance-in-end-of-life-care>
- Cresswell, J. W. (2014). *Research design: Qualitative, quantitative, and mixed methods approaches* (4<sup>th</sup> ed.). Thousand Oaks, California: SAGE Publications.
- Davis, W. B., Gfeller, K. E., & Thaut, M. H. (2008). *An introduction to music therapy theory and practice* (3<sup>rd</sup> ed.). Silver Spring, MD: American Music Therapy Association, Inc.
- Dileo, C. (2000). *Ethical thinking in music therapy*. Cherry Hill, NJ: Jeffrey Books.
- Dixon-Woods, M., Cavers, D., Agarwal, S., Annandale, E., Arthur, A., Harvey, J., Hsu, R., Katbamna, S., Olsen, R., Smith, L., Riley, R., & Sutton, A. J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology, 6*(35), 1-13. doi:10.1186/1471-2288-6-35

Doka, K. J. & Tucci, A. S. (Eds.). (2009). *Diversity and end-of-life care*. Washington, DC: Hospice Foundation of America.

Forrest, L. (2001). Addressing issues of ethnicity and identity in palliative care through music therapy practice. *Voices*, 1(2). doi:<http://dx.doi.org/10.15845/voices.v1i2.60>

Forrest, L. (2011). Supportive cancer care at the end of life: Mapping the cultural landscape in palliative care and music therapy. *Music and Medicine*, 3(1), 9-14.  
doi:10.1177/1943862110390820

Forrest, L. (2014). Your song, my song, our song: Developing music therapy programs for a culturally diverse community in home based paediatric palliative care. *Australian Journal of Music Therapy*, 25, 15.

Gawande, A. (2014). *Being mortal*. London, UK: Profile Books.

Hadley, S., & Norris, M., S. (2016). Musical multicultural competency in Music Therapy: The First Step. *Music Therapy Perspectives*, 34(2). doi:10.1093/mtp/miw016

Hall, C. (2014). Bereavement theory: recent developments in our understanding of grief and bereavement, *Bereavement Care*, 33(1), 7-12. doi:10.1080/02682621.2014.902610

Hanson-Abromeit, D., & Moore, K. S. (2014). The systematic review as a research process in music therapy. *Journal of Music Therapy*, 51(1), 4-38. doi:10.1093/jmt/thu002

Hartwig, R. (2010). Music therapy in the context of palliative care in Tanzania. *International Journal of Palliative Nursing*, 16(10), 499-504.

- Hilliard, R. E. (2005). Music therapy in hospice and palliative care: A review of the empirical data. *Evidence Based Complement Alternative Medicine*, 2(2), 173-178.  
doi:10.1093/ecam/neh076
- Horne-Thompson, A., Daveson, B., & Hogan, B. (2007). A project investigating music therapy referral trends within palliative care: An Australian perspective. *Journal of Music Therapy*, 44(2), 139-155.
- Infeld, D. L., Gordon, A. K., & Harper, B. C. (Eds.). (1995). *Hospice care and cultural diversity*. Binghamton, NY: The Haworth Press, Inc.
- Johnson, C. J., & McGee, M. G. (Eds.). (1998). *How different religions view death and afterlife*. Philadelphia, PA: The Charles Press, Publishers, Inc.
- Kim, S., & Whitehead-Pleaux, A. (2014). Music therapy and cultural diversity. In B. Wheeler (Eds.), *Music therapy handbook*, (51-63). New York, NY: The Guilford Press.
- Kubler-Ross, E. (1969). *On death and dying*. New York, NY: Touchstone.
- Lipe, A. W. (2002). Beyond therapy: Music, spirituality, and health in human experience: A review of literature. *Journal of Music Therapy*, 39(3), 209-240.
- Marom, M. K. (2008). "Patient declined": Contemplating the psychodynamics of hospice music therapy. *Music Therapy Perspectives*, 26(1), 13-22. Doi: 10.1093/mtp/26.1.13
- Masko, K. M. (2013). *Music therapy and spiritual care in end-of-life: ethical and training issues identified by chaplains and music therapists*. (Doctoral dissertation, University of Iowa). Retrieved from <http://ir.uiowa.edu/etd/5021/>

- Nakayama, H., Kikuta, F., & Takeda, H. (2009). A pilot study on effectiveness of music therapy in hospice in Japan. *Journal of Music Therapy*, 46(2), 160-172.
- Parkes, C. M., Laungani, P., & Young, B. (2015). *Death and bereavement across cultures*. New York, NY: Routledge Taylor & Francis Group.
- Potvin, N., & Argue, J. (2014). Theoretical considerations of spirit and spirituality in music therapy. *Music Therapy Perspectives*, 32(2), 118-128. doi: 10.1093/mtp/miu022
- Stige, B. (2002). *Culture-centered music therapy*. Gilsum, NH: Barcelona Publishers.
- Sue, D. W. & Sue, D. (2008). *Counseling the culturally diverse: Theory and practice, fifth edition*. Hoboken, NJ: John Wiley and Sons.
- Sue, D. W. & Torino, G. A. (2005). "Racial-Cultural Competence: Awareness, Knowledge, and Skills." In R. T. Carter (ed.) *Handbook of racial-cultural psychology and counseling: Training and practice, volume 2*. Hoboken, NJ: John Wiley and Sons.
- Swamy, S. (2014). Music therapy in the global age: Three keys to successful culturally centered practice. *New Zealand Journal of Music Therapy*, 12, 34-57.
- Topozada, M. (1995). Multicultural training for music therapists: An examination of current issues based on a national survey of professional music therapists. *Journal of Music Therapy*, 32(2), 65-90.
- Van Hyfte, G. J., Kozak, L. E., & Lepore, M. (2013). A survey of the use of complementary and alternative medicine in Illinois hospice and palliative care organizations. *American Journal of Hospice & Palliative Medicine*, 31(5), 553-561.  
doi:10.1177/1049909113500378

Werner, P. D., Swope, A. J., & Heide, F. J. (2009). Ethnicity, music experience, and depression. *Journal of Music Therapy, 46*(4), 339-358.

Wheeler, B. L. (Ed.). (2005). *Music therapy research*. Gilsum, NH: Barcelona Publishers.

Wlodarczk, N. (2007). The effect of music therapy on the spirituality of persons in an in-patient hospice unit as measured by self report. *Journal of Music Therapy, 44*(2), 113-122.  
doi:10.1093/jmt/44.2.113

Yinger, O. S., & Gooding, L. F. (2015). A systematic review of music-based interventions for procedural support. *Journal of Music Therapy, 52*(1), 1-77. doi:10.1093/jmt/thv004

American Music Therapy Association. (n.d.). Retrieved May 15, 2017, from  
<https://www.musictherapy.org/about/musictherapy/>

American Music Therapy Association Code of Ethics. (n.d.). Retrieved May 15, 2017, from  
[www.musictherapy.org/about/ethics/](http://www.musictherapy.org/about/ethics/)



## Appendix A

Table 1

*Articles Included in Critical Interpretive Synthesis*

	<b>Title of Study</b>	<b>Publication Date</b>	<b>Author(s)</b>	<b>Journal</b>	<b>Research Methodology</b>
1	Utilization of music therapy in palliative and hospice care: An integrative review	2014	Bowers & Wetsel	Journal of Hospice and Palliative Nursing	Quantitative – Integrative Review
2	Addressing issues of ethnicity and identity in palliative care through music therapy practice	2001	Forrest	Voices	Qualitative – Case Study/Vignette
3	Supportive cancer care at the end of life: Mapping the cultural landscape in palliative care and music therapy	2011	Forrest	Music and Medicine	Qualitative – Systematic Review
4	Your song, my song, our song: Developing music therapy programs for a culturally diverse community in home-based paediatric palliative care	2014	Forrest	Australian Journal of Music Therapy	Qualitative – Case Study/Vignette
5	Music therapy in the context of palliative care in Tanzania	2010	Hartwig	International Journal of Palliative Nursing	Qualitative – Questionnaire
6	Beyond therapy: Music, spirituality, and health in human experience: A review of literature	2002	Lipe	Journal of Music Therapy	Qualitative – Systematic Review
7	Music therapy and spiritual care in end-of-life: Ethical and training issues identified by chaplains and music therapists	2013	Masko	Dissertation	Mixed Methods – Sequential Exploratory
8	Theoretical considerations of spirit and spirituality in music therapy	2014	Potvin & Argue	Music Therapy Perspectives	Theoretical Article
9	Music therapy in the global age: Three keys to successful culturally centered practice	2014	Swamy	New Zealand Journal of Music Therapy	Qualitative – Ethnography
10	The effect of music therapy on the spirituality of persons in an inpatient hospice unit as measured by self-report	2007	Włodarczk	Journal of Music Therapy	Quantitative – Survey

Table 2

*Key Theme Identification Chart*

	1 Bowers & Wetsel (2014)	2 Forrest (2001)	3 Forrest (2011)	4 Forrest (2014)	5 Hartwig (2010)	6 Lipe (2002)	7 Masko (2013)	8 Potvin & Argue (2014)	9 Swamy (2014)	10 Włodarczk (2007)
1.) Perception of Death & Dying			pp. 10, 11	p. 1		p. 220		p. 122		
2.) Appropriate Level of Sensitivity	p. 231	p. 1	p. 11		p. 503, 504	p. 223	p. 3	p. 126		p. 113
3.) Spirituality/Religiosity	p. 231		p. 10	pp. 1, 3	pp. 500-503	pp. 210, 219, 223	p. 3	p. 118, 123, 127	p. 403	p. 114
4.) Expression of Grief		pp. 1, 2	pp. 10, 11	pp. 1, 3	p. 501	p. 218, 219	p. 3	p. 123		p. 115
5.) Family Dynamics		pp. 6, 11, 12	p. 12	pp. 1-3	p. 500	p. 220	p. 3	p. 122	p. 403	p. 117
6.) Legacy/Life Review		p. 11			p. 500	p. 220				p. 115
7.) Perceived Role of Music Therapist	p. 232	p. 3	pp. 10, 11	pp. 1-3	p. 502	pp. 219, 223	p. 2, 3	p. 118, 120, 126	p. 404	pp. 113, 115
8.) Perceived Role of Music	p. 232	p. 3		p. 3	pp. 499, 502	pp. 217, 222		p. 120, 122, 124	p. 404	

Table 3

*Key Themes Chart*

	<b>Author(s)</b>	<b>Key Themes Addressed</b>
1	Bowers & Wetsel	Appropriate Level of Sensitivity, Spirituality/Religiosity, Perceived Role of Music Therapist
2	Forrest	Appropriate Level of Sensitivity, Expression of Grief, Family Dynamics, Legacy/Life Review, Perceived Role of Music Therapist
3	Forrest	Perception of Death & Dying, Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Perceived Role of Music Therapist, Perceived Role of Music
4	Forrest	Perception of Death & Dying, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Perceived Role of Music Therapist, Perceived Role of Music
5	Hartwig	Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Legacy/Life Review, Perceived Role of Music Therapist, Perceived Role of Music
6	Lipe	Perception of Death & Dying, Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Legacy/Life Review, Perceived Role of Music Therapist, Perceived Role of Music
7	Masko	Appropriate Level of Sensitivity, Spirituality/Religiosity, Family Dynamics, Perceived Role of Music Therapist
8	Potvin & Argue	Perception of Death & Dying, Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Family Dynamics, Perceived Role of Music Therapist, Perceived Role of Music
9	Swamy	Appropriate Level of Sensitivity, Spirituality/Religiosity, Family Dynamics, Perceived Role of Music Therapist, Perceived Role of Music
10	Wlodarczk	Appropriate Level of Sensitivity, Spirituality/Religiosity, Expression of Grief, Legacy/Life Review, Perceived Role of Music Therapist

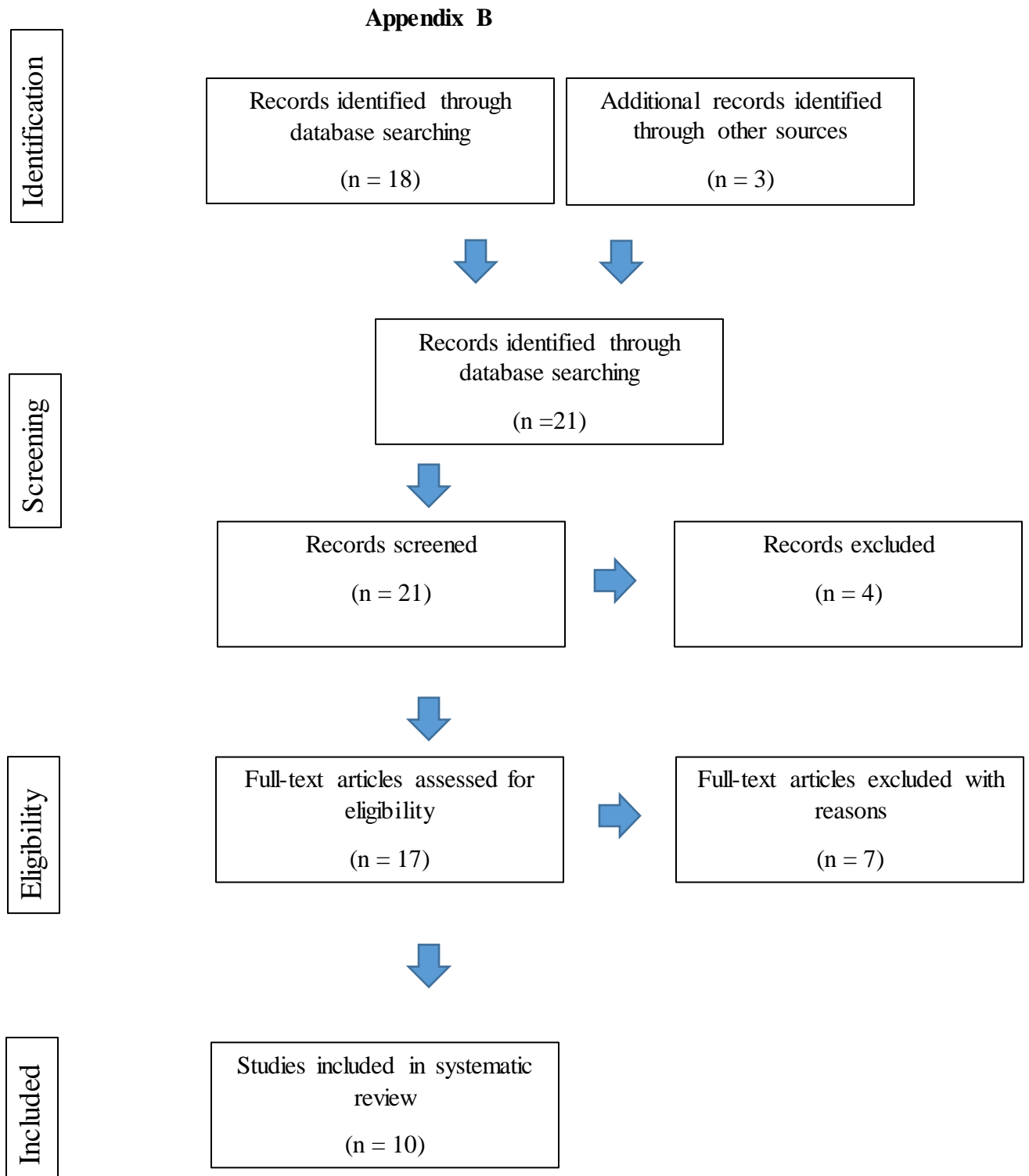
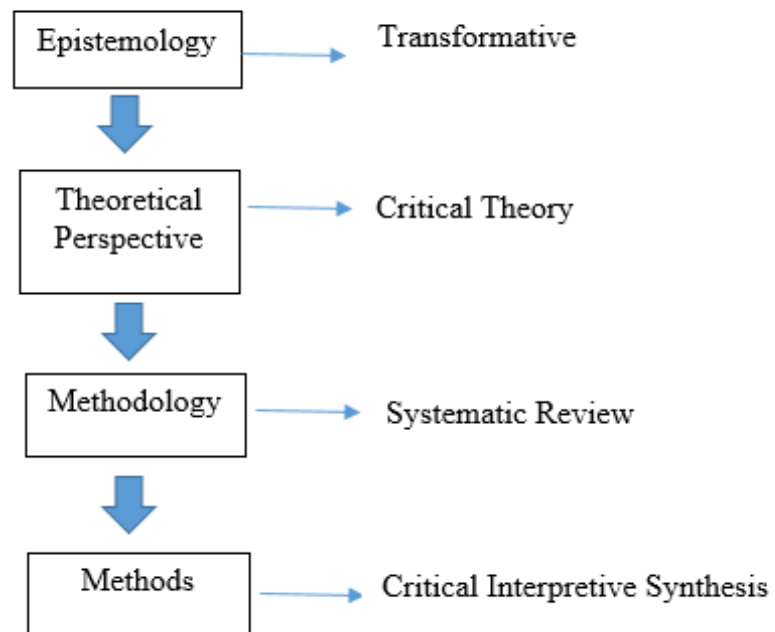


Figure 1. Flowchart of article inclusion process.



*Figure 2. Knowledge framework*

Foundation	Knowledge Framework	(see Figure 2)
Define Scope of Review	Identify Questions	<ol style="list-style-type: none"> <li>1. How does MT research report on culture in relation to hospice care?</li> <li>2. Does culture inform MT methods investigated in research?</li> <li>3. How does the impact of culture mediate the therapeutic relationship?</li> </ol>
	Clarify Purpose	Reform HMT in order to change lives of individuals in end-of-life care; incorporate greater level of cultural understanding to prevent racism, misunderstanding, and asymmetric power relationships
	Articulate Program Theory	Cultural competencies Social action and reform agenda
Search for and Appraise Evidence	Keywords	See Methods p. 19
	Databases	See Methods p. 19
	Inclusion/Exclusion	(see Figure 1)
Extraction, Analysis, & Synthesis	Data Extraction	Review of individual articles: publication date, study design, setting, sample characteristics, measures, outcomes
	Components of Analysis	Standard coding Screening for answers to research questions Generation of themes
	Synthesis	Integration of gathered information into themes Form narratives based on each research question
Developing Narrative	Results	Outcomes reported: all eight themes presented in context of three research questions
	Discussion	Implications for future research, training, and practice Limitations of review and encouragement of future studies

Figure 3. Methods procedural steps