

# Facing the Music: Speculations on the Dark Side of Our Moon

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**Abstract** / Work with people who are dying is painful and no palliative caregiver is exempt from this. The emotional pain associated with being a palliative care music therapist is related to professional training, the experience of being a professional minority and newcomer in the workplace, and the intensity and intimacy of the musical workspace. Questions are posed to facilitate music therapist self-reflection. Therapist self-acceptance includes tolerance for imperfection, which, in turn, affects the music's capacity for containment.

**Résumé** / Travailler auprès des mourants est éprouvant et aucune personne oeuvrant dans le domaine des soins palliatifs n'y échappe. La douleur émotive associée au travail du musicothérapeute en soins palliatifs est liée à sa formation, au fait d'être une minorité professionnelle nouvellement arrivée dans le domaine, et à l'intensité et l'intimité générées par ce type de thérapie. Divers points sont soulevés afin d'amener le musicothérapeute à réfléchir sur son travail. L'acceptation de soi du thérapeute passe par la tolérance face à l'imperfection ce qui, en retour, influence la capacité de la musique à contenir toutes les émotions.

*The arts persuade, but music invades us.*

— Eduard Hanslick (1825-1904) (1)

Music therapy in palliative care has its dark side: suffering is part of this work. Much has been written about evidence-based, measurable stress associated with work in hospice and palliative care (e.g., 2,3). What follows here is speculation about factors that influence suffering for palliative care music therapists. Speculation is not evidence-based, or grounded in measurable or established fact. Nor is this writing. It is guilty of contemplation and conjecture.

Like free-form improvisation, this exploration is informed by skill and experience, but is not necessarily bound by formal rules. Perhaps it even colours outside the lines. It follows the impulse of its first toned intention and, guided by instinct, follows its thread through until the impulse is resolved, satiated, spent.

I experienced the impulse for this speculation while listening to palliative care music therapy presentations, questions, and conversations at the Third International Music Therapy Sympo-

sium and at the 13th International Congress on Care of the Terminally Ill, September 2000. It became clear, particularly during informal dialogue, that palliative care music therapists are suffering. To a greater or lesser degree, many of us who bring beauty and solace to those who are preparing to die are not immune to compassion fatigue.

More troubling was a comment by Dr. Edwin H. Cassem (4) that palliative care music therapists suffer most because music speaks directly to the limbic system, the emotional "plexus" of the brain. Whereas other palliative caregivers communicate using language, music therapists communicate using music, sometimes with and sometimes without language.

Music and language are communication systems that appear similar in many respects, but are functionally distinct in how and what they communicate. Verbal meaning is semantically distinct from musical meaning, in that language is characteristically denotative, corporeal, and precise, whereas music is characteristically connotative, visceral, and indeterminate. Speech functions primarily to communicate ideas, and does so in a manner and with a precision that music cannot. Music is nonverbal communication that conveys emotional information (5-7) in a way that cannot be reduced to logical language (8-10). Furthermore, music can communicate what is pre-verbal and unconscious, as well as that which is speechless and beyond words (11).

## SUFFERING OF PALLIATIVE CAREGIVERS

No palliative caregiver is exempt from the profound and personal impact of death. Wisdom from the psychology of work informs us that people tend to be drawn to vocations that are harmonious with their psychological needs (12). Those who work with the dying may be motivated, in part, by a need to obtain control over their own death anxiety (13). Or, as Ernest Becker said, "Through the death of the other, one buys oneself free from the penalty of dying" (14).

Death is a boundary situation that shifts one away from trivial preoccupations and provides

life with depth and poignancy and an entirely different perspective (13). This death-boundary phenomenon is alluded to when the "Grim Reaper" is humorously referred to as the "Closure Fairy." Stanley Keleman says that all turning points are boundaries that lead to a new existence" (15). Arthur Frank states that death "is no enemy of life; it restores our sense of the value of living" (16). Audre Lorde described her understanding of the death-boundary situation thus:

Living a self-conscious life, under the pressure of time, I work with the consciousness of death at my shoulder, not constantly, but often enough to leave a mark upon all of my life's decisions and actions. . . . It helps shape the words I speak, the ways I love, my politic of action, the strength of my vision and purpose, the depth of my appreciation of living (17).

Work in palliative care may also be a life-enriching exercise in death acceptance, rather than a defense against death anxiety. Nuland eloquently described this acceptance:

Nature has a job to do. It does its job by the method that seems most suited to each individual whom its powers created. It has made this one susceptible to heart disease and that one to stroke and yet another to cancer, some after a long time on this earth and some after a time much too brief, at least by our own reckoning. The animal economy has formed the circumstances by which each generation is to be succeeded by the next (18).

All palliative caregivers encounter inspiring individuals who triumph in the face of fulfilling their inevitable and ultimate destinies. Yet those who work with dying patients and their families suffer because they are confronted with loss and their own death boundary issues. It is easier to encounter death than it is to encounter *my* death. For one thing, distressed patients project painful experiences onto the staff who work with them (19). Furthermore, palliative caregivers are at risk of over-identifying with patients and their families. Speck explains:

[T]here will always be patients who resemble us or someone who is significant to us in ways which stir up anxiety. We are repeatedly put in touch with past losses and reminded of the certainty of future ones. Each time, we are confronted with the reality that our work does not confer any special protection against death (20).

## SUFFERING OF MUSIC THERAPISTS

The anxiety provoked by the work stirs in music therapists the same defenses as in other palliative care colleagues. These are identified by Speck as avoidance, task-centredness and

chronic niceness (20). Whether music therapists do, in fact, suffer "most" need not be contemplated. Rather, I contend palliative care music therapists suffer differently from other palliative caregivers—we suffer in ways unique to our work. This suffering is related to our training, to our experience as a professional minority, and to the intensity and intimacy of the musical space within which we work.

### Training

The music therapy profession takes root early in the development of the personal biography. The training of a music therapist begins with the onset of music instruction, on average, at six years of age. Such early developmental roots and accumulated training hours (spent at scales and arpeggios, alone) has the potential to create "excess baggage."

We may have experienced conditional acceptance based on musical ability to play the right notes and to play them well. Conditional acceptance, competition, and performance anxiety put us at risk of hiding behind polished performances and pretty sounds, which may be seen as the music therapy manifestation of Speck's "chronic niceness" (20,21). We may not dare to let the wrong notes sound, yet these very notes are a crucial part of our authentic whole.

### Professional Minority

Each of us is usually the only music therapist in the workplace. This contributes to isolation and misunderstanding. Isolation and misunderstanding may be further compounded by competition for shrinking health care dollars. Music and the arts are traditionally relegated to frill status, and we, the music therapists, may share this devalued attribution.

Not only are music therapists a minority in the workplace, they may also be the newest addition to the clinical team. Some palliative care music therapists are contracted to provide services. They are not considered staff and may not be part of the clinical team. These music therapists must deliver services without the fundamental support of an interdisciplinary palliative care team.

### Intensity and Intimacy of the Musical Space

Music therapy differs from music performance because it is interactive. It entails musical responsiveness in the moment, often improvised, and sometimes directly at the bedside. To improvise music for patients and families we must participate fully and authentically, feeling the raw emotion—the raw material—that shapes

our sound. We interact and directly participate in the raw, emotional material of the music.

Because we play music interactively, we too must feel those feelings. We cannot be blank, reflecting walls. This interactive music is rich, murky, and serves as a container for feelings, sensations, imagery, symbol, soul, and archetype. To dwell successfully in this realm, we must develop a flexible tolerance for ambiguity and ambivalence.

What happens in the music therapy encounter can be intimate and intense. The pre-music silence speaks:

As I am who I am in my music and  
You are who you are in your music,  
So let us be who we are together in this sound.

The music becomes us and we become the music. There is no boundary between performer and audience, you and I, therapist and patient. Rather, it is an encounter of two musical souls, each affecting the other equally and profoundly, and contained by the musical space (22). Herein lies the capacity for depth of healing in our work, as well as the challenge. The usual intensity and intimacy inherent in interactions between therapist and patient (13) become amplified by the music. This amplified intensity and intimacy challenge us with the risk of being overwhelmed by feeling.

### MANAGING THE SUFFERING

Emotional pain is inevitable in the practice of palliative care music therapy. The reality is that our work hurts. We may be deeply affected by our patients' pain, loss, and hurt, and experience the echo of our own pain, loss, and hurt. Feel we must. The alternative—not to feel—is worse. This would result in internal deadness, depression, and our own living death, or physical symptoms and disease processes.

In order to survive and thrive as palliative caregivers, and to continuously improve in our work, it is crucial to begin with self-awareness as a competency (23). Caregiver self-awareness is the central competency from which stem all other competencies necessary for quality care provision. We cannot do soul work with others if we are not mining the depths of our own souls on an ongoing basis. Such self-awareness is the foundation of self-care. Mulder and Gregory discussed the importance of self-awareness for palliative care physicians (24). We music therapists must also work from a position of conscious awareness. Certainly, what we are unaware of can and will control us.

We must look over our own shoulders with fresh eyes and question what appears to be ob-

vious (25). This must begin with awareness of career choices and paths. Why are we doing this work? Roberts states:

It is...of the greatest importance for helping professionals to have some insight into their reasons for choosing the particular kind of work or setting in which they find themselves, and awareness of their specific blind spots...(26).

The kinds of questions we ask are crucial. The questions are, perhaps, even more important than the answers. Audre Lorde believed that there are no answers, only better questions (17). Marion Woodman believes that, once the question is in consciousness, the answer is formed in the unconscious. The answer "often lies in the unconscious waiting for the question to be consciously heard" (27). To this end, I pose the following questions to fuel our self-awareness and self-reflection:

- Why am I doing this work?
- Am I pleasing myself first by doing this work or am I first pleasing others?
- Why am I still doing this work and/or is it time for me to move on?
- How do I nourish myself and is it wholesome?
- Am I doing my own inner work: acknowledging, confronting, and working through my fears, integrating my losses?
- Do I recognize the difference between my human reactions to dying patients and grieving loved ones, and my own unresolved issues that this work triggers?

Emotional pain may be part of the palliative care territory, suffering, however, is optional. We suffer when pain overwhelms us. We are overwhelmed when we resist and/or fear pain, or otherwise find our countertransference ruling us. We must meet and work through this pain.

- How do I experience and process my emotional pain? How do I defend and harden against it? How do I soften and open towards it?
- How am I asking for help? Do I call on the physical, intellectual, social, spiritual, and musical supports available to me?
- How do I use music to evoke and contain my own experience?

### Working Through and Beyond

We risk the death of our creative impulse when we close our eyes to situations we do not want to consider and emotions we do not want to feel, because it is too painful to keep them open (28). Rather, we must turn and face our pursuing monsters. "When we confront the monster, it

becomes a 'giver of gifts' by exposing what we have repressed" (28).

Indeed, power comes from moving into whatever is feared most that cannot be avoided (17). To keep our music and ourselves vital and alive, we must cultivate self-awareness and consciously work through the inevitable emotional pain we experience as palliative caregivers.

We must keep our eyes open in the face of the pain and fear—of our patients and of ourselves. It is through our capacity to manage pain and the fear of pain that we develop the power of compassion, both for ourselves and for others. As we develop our capacity and tolerance for pain, our souls can grow to take on bigger burdens (4). Similarly, as we develop our tolerance for "wrong" notes, our music can grow in its capacity for containment.

Speck points out that one can be a "good enough" caregiver for the dying without being perfect (20). We, too, must realize we can be good enough palliative care music therapists without being perfect. This entails acceptance of all our "notes".

Wrong notes are an aural metaphor for imperfection. We can increase our self-acceptance by increasing our capacity to tolerate wrong, discordant sounds. Experiment during your own improvisations. Choose to rest in the dissonant places, the places of unresolved tension prior to harmonic resolution. Linger there a while. Repeat the "wrong" notes with courage. Play them *rubato* and with curiosity. Explore the echoed shadow of this tension, call it "jazz" and see where it takes you.

Stockhausen (29) talked about music as being a holy service, or diversion and entertainment, depending on the musical choices made. Music may function as diversion and entertainment in palliative care. The music of palliative care music therapy, however, must also have the capacity for holy service. Only then can the flexibility required for authentic being with dying patients in the need of the musical moment be achieved. Surely music that functions as holy service tolerates all sounds.

## SUMMARY AND CONCLUSIONS

All palliative caregivers suffer in the course of service provision. Palliative care music therapists, who provide music as support and containment for clients, families, caregivers, and programs, suffer. We suffer in ways that are similar to all palliative caregivers. And we suffer in ways that are unique to our training, professional isolation, and the nature of the musical workspace.

The impetus for examining the dark side of this work took root in informal professional dialogue that has, heretofore, been unpublished and unexplored. The impulse for this writing concludes that music, our working tool in palliative care, is deep, powerful and complex. It is, indeed, holy service. We must acknowledge that this music does invade us and we must allow it to do so in conscious awareness. Hopefully, further dialogue and improvisation on this theme will ensue.

### (CD-Rom Segment 8: Kristen)

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