

Introduction

This paper discusses a music therapy support group for cancer patients in a community setting. The group is described in terms of goals, content and process. Participant evaluation themes and the therapist's observations and reflections are provided. The "music mode" of music therapy treatment in cancer care is described as a palliative care orientation. Music therapy can function in "music mode" to preserve continuity of cancer patients' sense of self throughout the course of their disease.

Description

Background

Music therapy groups are a recent addition to a variety of group programs offered in a community cancer support setting. The music therapy group is a closed group that runs for 8 weeks, and is 1.5 hours in length. The goal of the music therapy group is to provide music and related nonverbal media as a means by which participants may express and explore their cancer experiences.

Content and Process

Music therapy groups include combinations of singing, song-writing, vocal toning and improvisation, guided imagery and music, improvisation, music sharing, psychodrama and/or theatre games, movement, and pastel drawing.

The group process typically unfolds, as follows:

Week 1. Introductions; singing; much talking

Week 2. Introductions, continued; singing; introduction to instrumental improvisation (Murrant et al, 2000)

Week 3. Introduction to improvisation, continued; singing/toning/movement

Week 4. Improvisation as self-expression; psychodrama/singing/movement

Week 5. Guided Imagery and Music (adapted Bonny method); drawing

Week 6. GIM; improvisation; closure discussed

Week 7. Improvisation (vocal and/or instrumental); develop closure

Week 8. Evaluations and closure exercise

The content at any given week is a function of the issues brought forth by the group. By week 4, participants are comfortable enough with the instruments and each other to bring these issues into the music. Often during the life of an 8-week group, one or more participants experience changes in health, for better and worse. These changes are expressed and processed musically, nonverbally (art, movement, psychodrama) and verbally. With permission, sessions are audiotaped and participants receive copies of the audiotape at the last session.

Evaluation

Participant Evaluation

Participants evaluate programs by means of written questionnaires at the conclusion of each 8-week group. Responses to "ways in which you found the program helpful" yielded the following themes:

Uplifting: E.g., "leaving feeling uplifted and good about myself"

Calming: E.g., "created a sense of inner peace"
"relieved anger, rage, stress"

Social: E.g., "The rapport with various individuals, combined with the sounds from the music definitely contributed to a feeling of well-being when the group is over." "Sharing experiences"

Empowering: E.g., "Respectful of our ability to cope with deep issues."
"It allows for better coping with my pain."

Fun, enjoyment: E.g., "Making noise and having fun."
"It brought a smile on many faces."
"It gave me a lot of pleasure."

Music experiences: E.g.,

"Finding the meaning of beauty in music"

"Reintroduced me to music and its healing qualities."

"Restored and motivated me to return to my music."

"Opened my mind to practice more listening of music."

"Explore a new type of music."

"I could express myself freely using musical instruments."

"Using music and sound in a free form way was extremely liberating"

"Encouraged us to let go into the music."

"Music lifts my spirits."

Therapist's Observations and Reflections

Music, as is its nature, functions to open people to themselves and each other. Discussions can be deep and fraught with the existential crises inherent in coping with potentially life-threatening illnesses and their treatments. Joy and sorrow are profoundly expressed through the music, song and discussion. The group dynamic is supportive and intensely caring.

Each group has its distinct characteristics. One group was attended by a majority contingent of participants who sought recreation and escape and had previously attended other programs together. These participants were relatively well, had good prognoses, were at the end of their treatments, or were in remission. They certainly were enjoying themselves, but were not playing (Bruner, 2000) in the full sense of the word. One participant whose health was much poorer was unable to get the support she had experienced during another music therapy group she had attended; her health declined further and she was unable to continue.

The remaining participants continued to seek diversion and I became aware of my boredom. I wondered how this might be experienced by the group. I remembered Lawrence LeShan's (1994) advice that therapists be "aware of their own special orientation, compensate for it, and be as sensitive to patients as possible (p. 166)," I realized my palliative care orientation and spiritual philosophy influenced the manner and tone of my leadership. This awareness served to diminish my boredom and enabled me to "lighten up" to meet the needs of these participants.

Discussion: Music Mode and the Cancer Treatment Continuum

The profile of cancer treatment (Expert Working Group, 1988, p. 80) is conceptualized in Figure 1.

(Insert Figure 1 here.)

Callahan (1993) contends that death should be seen as the necessary and inevitable end point of medical care and not as what happens when medicine fails. This is clearly depicted in Figure 1 where active treatment stops and palliative treatment begins. In Callahan's terms, oncology treatment should extend to the very end-stage of disease, i.e., death. He also recommends that books dealing with potentially fatal diseases should include a chapter dealing with the care of people dying of that disease.

The boundary between active and palliative treatment in the minds of cancer patients is clearly delineated. For example, one music therapy group discussion concluded that they certainly want good symptom control when this becomes necessary; but call "it" (i.e., palliative care) something else, they challenged. The stigma of palliative care is hardy.

In contrast, Figure 2 depicts the profile of AIDS treatment (Expert Working Group, 1988, pg. 81).

(Insert Figure 2 here.)

This figure depicts the concurrence of active and palliative treatment intent over time. Here, palliative caring begins concurrently with active treatment, and increases over time. Similarly, active treatment continues, and diminishes over time as the disease progresses towards death. This model has developed into the current proposed norm of practice for Hospice Palliative Care (Ferris et al, 2001), an adaptation of which is shown in Figure 3.

(Insert Figure 3 here.)

This model suggests permeability between active and palliative caring. It is this palliative model of treatment that I advocate for cancer care. Here, whether in sick mode or dying mode (as per LeShan, 1994), music therapy service delivery has the flexibility to treat cancer patients in "music mode," according to their energy reserves and preferences in any given moment. This music mode of service delivery is not altered by a change in medical prognosis and disease progression. Furthermore, music mode has the capacity to preserve identity and integrity, contain fear and express hope throughout the continuum of cancer treatment.

Summary and Concluding Challenge

A music therapy group in a community cancer support centre was described. Participants' evaluation of what they found helpful focused primarily on the positive experience of music-making. Therapist's observations and reflections convey the need for self-awareness and awareness of personal orientation and philosophy. The palliative care model of cancer care treatment, extrapolated from Callahan (1993) and LeShan (1994), was discussed as "music mode" in terms of its manifestation in music therapy service delivery.

Music therapy can function in profound ways throughout the continuum of cancer treatment but the challenge of how to do so remains. Currently, boundaries and funding of music therapy in active cancer treatment and palliative care are firmly distinct. Continuation of active treatment until death and the assumption of palliative care at diagnosis—as per the proposed standard for hospice/palliative care—might serve to redefine these boundaries. Perhaps then the challenge posed by cancer patients to call palliative care "something else" would not be necessary.

References

Bruner, Katherina S. (2000). Group play therapy with adults. *Arts in Psychotherapy*, 27(5), 333-338.

Callahan, Daniel. (1993). *The troubled dream of life: in search of a peaceful death*. New York: Simon & Shuster.

Expert Working Group on Integrated Palliative Care for Persons with AIDS. (1988). Caring together: summary of a report to Health and Welfare Canada (December 1987). *Journal of Palliative Care*, 4(4), 76-86.

Ferris, F. D., Balfour, H. M., Farley, J., Hardwick, M., Lamontagne, C., Lundy, M. & West, P. (2001). Proposed norms of practice for hospice palliative care. Ottawa, ON: Canadian Palliative Care Association. www.cPCA.net

LeShan, Lawrence. (1994). *Cancer as a turning point, revised edition*. New York: Penguin Books.

Murrant, G. M., Rykov, M., Amonite, D. & Loynd, M. (2000). Creativity and self-care for caregivers. *Journal of Palliative Care*, 16(2), 44-49.

Pavlicevic, M. (1995). Growing into sound and sounding into growth: improvisation groups with adults. *Arts in Psychotherapy*, 22(4), 359-367.

Figure 1: Cancer Care

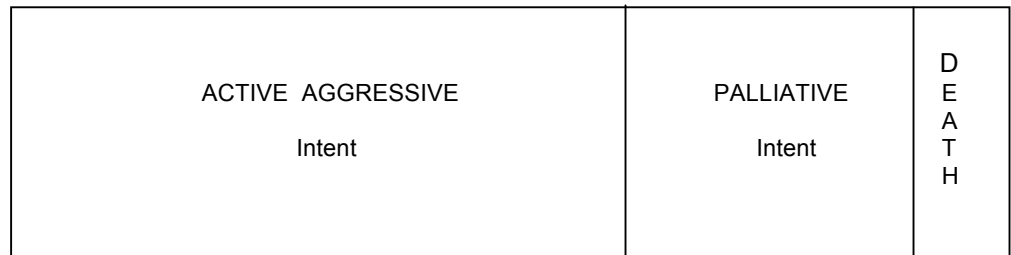


Figure 2: AIDS Care

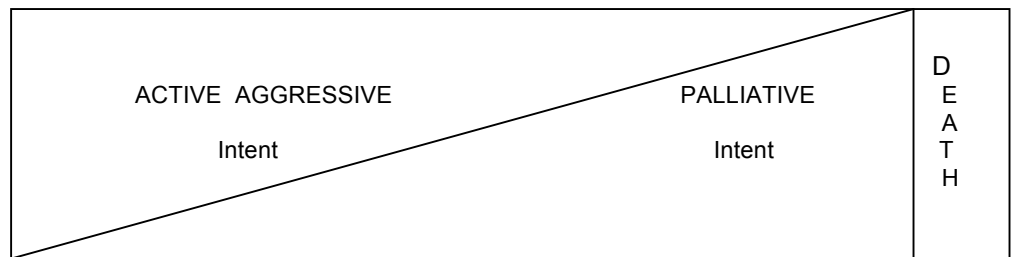


Figure 3:
 Proposed Norms of Practice for Hospice Palliative Care (adapted)

