The Music Therapy Intern Working in End-of-Life Care: A Study of Personal Experience

Mary DeLacy Kidwell
ABSTRACT

There is very little literature available on the personal experience of the music therapy intern, and not any specifically on the experience of the music therapy intern working in End-of-Life Care. Music therapy interns working with dying patients develop quite differently, as compared to those working with other populations. To provide music at the bedside of a dying patient is an extraordinary experience, one that seems to go beyond any level of preparedness. A survey examining the experiences of music therapy interns at the End-Of-Life Care was used to help participants share their experience about areas including: self-awareness, supervision, counseling skills, musical skills, and work with the dying. This survey was sent to both undergraduate and graduate music therapy interns training at specific clinical sites for either 6-months or 9-months.

Quantitative as well as qualitative data was gathered and analyzed for common themes and relationships. With regards to End-of-Life Care, some differences between those completing a 6-month internship and those completing a 9-month internship were found. Many participants acknowledged their immense growth from the time they began their internship to completion. Furthermore, personal perspectives about death and how this affects the individual music therapist are presented. The personal experience of the music therapy intern working in End-of-Life Care is a phenomenon that is worthy of much research. Because it is one of the most challenging and crucial times in the career of the music therapist, the music therapy internship, as a whole, needs to be studied more.
The Music Therapy Intern Working in End-of-Life Care:
A Study of Personal Experience
by
Mary DeLacy Kidwell
A Master’s Thesis Submitted to the Faculty of
Montclair State University
In Partial Fulfillment of the Requirements
For the Degree of
Master of Arts
May 2006

School of the Arts
Department of Music

Thesis Committee:
Dr. Joke Bradt
Thesis Sponsor
Professor Karen Goodman
Committee Member
Lucanne Magill
Committee Member
Dr. Robert Albridge
Department Chair
THE MUSIC THERAPY INTERN WORKING IN END-OF-LIFE CARE:
A STUDY OF PERSONAL EXPERIENCE

A THESIS

Submitted in partial fulfillment of the requirements for the degree of Master of Arts

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MARY DELACY KIDWELL

Montclair State University

Montclair, NJ

2006
ACKNOWLEDGEMENTS

I would first like to thank my thesis sponsor, Dr. Joke Bradt. To begin, without your guidance and support throughout the past 4 years, this journey would not have been possible. And thank you for showing me that statistics can be fun!

I would next like to thank my thesis committee. Professor Goodman, thank you for your encouragement and faith. You have opened new doors and opportunities for me. And Lucanne, I cannot tell you enough what you have meant to me over these last few years. I consider it an honor to have had you as an internship supervisor. You taught me how to “listen with my heart.”

I would also like to thank the participants who took the time to share, with me, their personal experiences. Without you, this research means nothing. It is my hope that your stories will inspire all music therapists.

And finally, I would like to thank my parents, Anne and Eugene Kidwell. I cannot say all that I think and feel, but I want you to know that you made my dream come true.
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REVIEW OF THE LITERATURE

Introduction

The music therapy internship can be a life-changing experience. It is the point in the music therapist’s training where they begin the final journey to professional and become independent of teachers, supervisors, and peers. Bruscia (1987) defines one aspect of the internship as “the time when the intern progresses from student to professional, moving from one developmental stage in life to another, while also developing a new identity and style in the process” (p. 100). At the beginning of the internship, choices about future career goals and plans are being formulated. It is here where the music therapist explores his or her own capabilities with and understanding of a specific population. And while every internship experience is fundamental, each is unique and worthy of examination for a deeper understanding of this life event. It is the search for a deeper understanding of the music therapy internship which inspired the current research.

So much in the training of music therapists focuses on the acquisition of certain competencies, namely musical, verbal, and therapeutic skills. Students of music therapy prepare for the internship by completing practica with a variety of populations. During this time, a preference for, or interest in, a particular population can be recognized. After choosing and being accepted to an internship, the student spends a determined amount of time developing the skills necessary to become a professional. And while many of these skills appear general in the development of the music therapist, the internship experience, itself, can be quite different.
For those students who choose a music therapy internship in End-of-Life Care, the experience requires not only acquisition of certain skills, but also exploration of personal attitudes and beliefs about death and dying (Bright, 1989). Because much of the pre-internship training emphasizes technical knowledge with brief clinical experience, the student may be overwhelmed by what is required of him or her as an intern. “The added intensity of being continually confronted with deterioration, death and grief, and the knowledge that there may be little or no time to correct mistakes may further increase anxiety” (Salmon, 2005, p. 252). Madsen and Kaiser (1999) found that music therapy interns rated “general preparation/being prepared” (p. 18) as the main source of pre-internship anxiety. The experience of music therapy with a dying patient reaches beyond any level of preparedness.

The following is a passage from the personal reaction log of the author written during the third month of her music therapy internship at a Cancer Center. It has been provided to deepen the understanding of the reader of what the music therapy intern working in End-of-Life Care experiences:

*This week I experienced something that I have never seen before. I watched as a patient took his last few breaths of life and then died. To witness someone dying is really quite extraordinary, and I don’t know now that I can still put into words what I am feeling about it. As a new life is welcomed into the world, just as quickly, one is taken out...just like that...one last breath and your whole life is over. Everything you were, everything you did, everyone you loved, and it's over that fast.*
When I left the hospital Friday, I was spooked more than anything else. I couldn’t help but see the bruised, blue face in the hospital room, with its mouth open. It was at this time, that for the first time, I saw the illness, instead of the person. I could see what cancer had done to this man’s body and the hell he went through just to breathe. But it is interesting, as I write now, I can no longer see that illness, I almost cannot remember what he looked like afterwards, but I have a completely clear picture of the man I met who yodeled the day before he died. I thought it a little strange to remain in the hospital room with the patient and pack up around him. It was as if he really wasn’t there anymore and just his body remained. Even his presence was gone, to the point where after initially feeling awkward remaining in the room, I no longer felt so. I believe that the patient was already on his way to somewhere beautiful.

So...I do not pretend to believe that what I saw on Friday was the first and last time I will ever see someone die. But again, I am having trouble putting into words exactly what happens at the moment you see someone draw their last breath. I have to say that I could feel my own breath as I stared at the patient before he died. The music made me very aware of his breath and my own. I could feel my supervisor matching the rhythm of the patient’s breath to her guitar strumming. And even when his breathing changed, so did her rhythm, as if to say, even in the very end, you are still not alone. This day will remain with me forever.

Much has been written on music therapy and End-of-Life Care, however, there is little in the literature that recognizes how life changing this experience can be for the
music therapy intern. One study, carried out by Grant and McCarty (1990), examined the patterns of and influences on emotional stages during the 6-month music therapy internship relative to personal and professional development. Results of this qualitative study indicated a higher intensity in feeling states during the last two months of the internship, suggesting significant growth both personally and professionally. And while this study provided some qualitative data and a general overview of the internship experience with regards to length of time at the clinical site, populations served, and personal/professional growth, it did not specifically address the personal experience of the music therapy intern working in End-of-Life Care.

As in other helping professions, the training of music therapists is ever evolving. The length of time spent training at an internship can last anywhere from 6-months to 1-year. Music therapy students are entering training programs at both the undergraduate and graduate level. Furthermore, Salmon (2005) recognizes some specific qualities that should be considered when selecting a music therapy intern for a clinical placement in End-of-Life Care: emotional stability, maturity, intelligence, spirituality, musicianship, and indications of support systems and self-care.

Sawatzky, Jevne, and Clark (1994) describe the experience of counselor training involving “personal and professional risk with attendant emotional turmoil and excitement” (p. 181). For the music therapy intern working in End-of-Life Care, the length of the internship, level of life experience, and self-awareness are all factors which must be taken into consideration personally and professionally. In order to fully understand the uniqueness of working with the dying, we must first examine those specific skills needed to work effectively with this population.
Skill Development of the Music Therapist in End-of-Life Care

In a symposium for music therapists working in palliative care, Bright (1989) presented on the particular skills and competencies needed to work in End-of-Life. Foremost, the music therapist must recognize and always be aware of what the needs are of the dying patient. After these needs have been identified, then the therapist can begin developing those skills needed to effectively treat the patient. Bright suggests two key areas of skill development: “(1) the areas of counseling and therapy skills and personality; and (2) the area of musical skills” (p. 14). Bright’s model is one of the few models for developing skills and competencies for the beginning music therapist in End-of-Life Care that has been published in the music therapy literature. In addition to Bright’s model, Dileo and Loewy (2005) also identify the following “advanced music therapy competencies” (p. 262) for the music therapist working in End-of-Life Care: assessment and evaluation, theoretical knowledge, research skills, interdisciplinary team skills, multicultural knowledge and skills, professional ethics, personal competence, and caring for the caregiver.

For the music therapy intern working in End-of-Life Care, it is, of course, of crucial importance that he or she meets the music therapy competencies and domains as outlined by the authors mentioned. These skills were created and developed from years of working “with people who have seen themselves as being in the final phases of living” (p. 14). These guidelines are a valuable source for the development of the music therapy intern. “You do not learn the really important things about interacting with dying people from secondhand information...Nevertheless, the information that others cull from their experiences with dying people is valuable” (Epstein, 1975, p. 5). To better understand
what some of these experiences may actually be like, we shall examine the care of the
dying as a helping profession. In addition, aspects of Bright’s model are offered below to
illustrate the potential impact of the development of population-specific skills on the
personal experience of the music therapy intern.

Personal Beliefs and Empathy

Before working with a terminally ill patient, a therapist must confront their own beliefs
about death and dying. One must consider and explore their personal feelings about
suffering and mortality. One of the first steps to prepare for working in End-of-Life Care
is seeking awareness about one’s own mortality and feelings about working with the
dying (Epstein, 1975). Epstein states that “if the inevitability of our own deaths is not so
easy to deal with, neither is the possibility that we may one day have the illness we
happen to be treating. And each dying patient becomes a reminder that we, too, one day
will be dying” (p. 181). Until personal beliefs have been acknowledged, the therapist
will not be able to truly empathize with the patient and may find conflict when faced with
a patient who’s beliefs differ greatly from their own. Empathy is an integral part of
understanding and being able to meet the patient’s needs through the music. Only after
this exploration of self can the therapist truly be empathic.

Salmon (2005) states “attention to one’s own cultural/religious beliefs and values,
particularly around death, dying and family, and an open-minded respect for those of
others are essential” (p. 252). Epstein goes on to suggest that the beginning therapist may
travel through the recreation of one who is dying in order to really grasp what this person
may be going through. Equally important is to examine one’s personal stereotypes about
the path of the dying. Again, the intern and young professional must examine their own
values and beliefs related to death. If unaware of one's own assumptions, one runs the risk of imposing these values onto the patient and their family.

Kubler-Ross (1969) suggests that the most important skill which the caregiver possesses is communicating to the patient that someone is there for them, ready to listen and share in their dying process. This is only possible if the caregiver has explored and worked through their own reactions and feelings. If one is too preoccupied or overwhelmed with their own emotional reactions, one cannot truly be available to the client. Kubler-Ross writes:

The door-opening interview is a meeting of two people who can communicate without fear and anxiety. The therapist will attempt to let the patient know in his own words or actions that he is not going to run away if the word cancer or dying is mentioned (p. 269).

This first step in the therapeutic relationship allows the patient the freedom and choice to decide when talking is most comfortable for them. After the relationship between therapist and patient has developed, Kubler-Ross suggests some views about the silence that inevitably comes with dying. She says that this silence is often hard for some to sit through, but for those who do, watching a quiet death can be reassuring for the caregiver.

*Meaning of Illness*

The therapist must also be aware of what the experience of the illness means to the patient and those around them. The experience of illness often includes physical, spiritual, social, and financial pain. Again, with this enhanced understanding comes more effective therapy. What a diagnosis of terminal illness may mean to one patient may
differ greatly from what it means to another. Emphasized here is the therapist’s ability to comprehend “what the patient is implying by the way he expresses things” (Bright, 1989, p. 14).

Counseling Skills and Medical Knowledge

In addition to the preceding areas of skill development, the music therapist working in End-of-Life Care must also be able to integrate counseling skills with knowledge about the medical aspects of the illness in order to fully treat the patient. Counseling skills include: effective listening, intuition, understanding, and acknowledgement of patient, family, staff, and our own feelings “when a pain-filled life comes to an end” (Bright, 1989, p. 16). Counseling the dying at different ages also implies that the therapist become aware of their own attitudes. “If we view life realistically, we know that our time on earth is limited and the older we get the sooner we will die” (Epstein, 1975, p. 101). This may distort one’s judgment about the experience of dying for an older person. It is important that the therapist recognize that an older person will also experience feelings of loss. Equally important to recognize are a young person or child’s needs.

The following is an excerpt written by the author during the fifth month of her internship. It illustrates how lack of awareness about the needs of a pediatric patient impacted the beginning of the therapeutic relationship. The beginning goals that were determined were not realistic and did not really address the needs of this dying child:

Because the patient will be in the hospital for a while, a future goal will be to continue supporting the communication between the family that is present, especially the mother. Another goal will be to introduce other instruments to the
patient and help him to build the strength to hold and play the instrument on his own. I would like the patient to become more verbally involved with the music, so a future goal would be to bring songs in that encourage more participation from him. And because he will be in the hospital for a while, continuing to use songs for developmental growth is also a goal.

Clearly, the above goals are better suited to the needs of a healthy child, rather than a child who would die a few weeks later. This particular patient brought many challenges that encouraged an assessment of self-awareness. Through supervision and exploration of feelings towards this patient and his family, the discovery was made that initial goals were formulated based on assumptions about the needs of the dying child. An understanding of the medical aspects (e.g. symptoms, stage) of a specific disease is also needed to effectively plan treatment and implement music therapy sessions.

**Personal Reflection**

Bright stresses that the therapist working in End-of-Life Care must be aware of their thoughts, feelings, and reactions to their own, personal experiences at the clinical site. These reactions encompass situations from a patient’s sudden death to suicide to reactions about difficult family dynamics. Furthermore, the therapist must examine their own sense of self in relation to the work they are doing. One must approach this kind of work with “a fairly robust self-esteem” (p. 18) or the therapist will come to rely on patient’s feelings and expressions to provide meaning in their own life.

As professionals caring for the dying, it is the responsibility of the therapist to seek help with personal reactions and feelings that may arise during sessions. Caring for the dying may cause intense stress personally and professionally: “Feelings of depression,
grief, and guilt constituted the single greatest manifestation of stress across all professional groups...and were usually experienced in response to a loss situation that involved bereavement" (Vachon, 1987, p. 154). A beginning therapist is very susceptible to this stress, especially considering the fact that he or she is simultaneously faced with acquiring new skills, getting acquainted with the mechanics of a new surrounding, and balancing a heavy work load. In addition, beginning therapists often have problems with establishing sound boundaries and may find themselves becoming too involved with the patient (Vachon, 1987). According to Vachon, these feelings can lead to anxiety, difficulty with decision-making, burnout, and other psychological symptoms. Through self-reflection and processing these specific feelings, one can more easily move beyond the loss, growing accustomed to facing these conditions daily and reaching a level of acceptance. Only then will the therapist be able to work effectively (Kindlen, 1999).

Musical Skills

Specific musical skills must also be learned in End-of-Life Care. When considering the needs of the patient, the therapist must make decisions about the type and presentation of the music. Bright identifies five areas of musical skill, specific to working in End-of-Life Care: (a) pain relief, (b) relaxation, (c) recreational work, (d) counseling through music, and (e) choice of instrument.

In the previous section, we have looked at some general aspects of caring for the dying patient. In addition to these specific competencies, the training of the music therapist in End-of-Life Care can also be examined through the literature in relation to counselor development.
Supervision

The development of the intern has been addressed manifold in the counselor literature. More specifically, the importance of supervision in pre-professional development has been an important point of discussion. As a result, several developmental supervision models have been developed over the past years. One such model is the IDM Supervision Model by Stoltenberg.

According to the Integrated Developmental Model (IDM), developed by Stoltenberg, McNeill, and Delworth (1998), as one trains to be a therapist, the development of awareness, motivation, and autonomy are recognized, not only by the trainee, but also by the supervisor. These “overriding structures” (p. 16) allow the supervisor to measure the growth of the supervisee. Furthermore, there are eight specific domains which assist the supervisor in more accurate measures of growth: intervention skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment plans and goals, and professional ethics.

Thomas (2001) describes the supervisory relationship during the music therapy internship through her own perception of student experiences. She presents the relationship in stages so that the reader can see the development of the intern. Often, at the beginning of the internship, through observations, students become overwhelmed by the work that they will eventually have to do. Wanting to perform adequately, the intern becomes anxious about learning new material and taking over existing groups. The supervisor must be aware of this anxiety and provide “structure, guidance, and support” (p. 136).
During the next stage, Thomas suggests that students will often have an impractical sense of what music therapy means with certain populations. This will lead to questioning their choice of profession. Here, the supervisor can present different approaches to therapy and orientation. Next, modeling becomes a supervision approach to help students merge into a co-leadership role. Thomas states that during this stage of supervision, the content focused on helping a student to develop his repertoire in differing musical styles by modeling applications in therapy sessions. After some confidence has been developed, it is time for the intern to begin leading parts of the session. Thomas describes one intern who became very anxious about leading the opening song despite her apparent readiness. By using supervision time to practice, the student gained the confidence to play in the session.

In the next stage, it is normal for the music therapy intern to become “stuck” in terms of finding their own identity. Until now, they have relied on their supervisor and may be “feeling intimidated by their supervisor’s ability as a music therapist” (p. 143). In one example, the intern found it hard to apply his session plans. When asked about this, he stated that he way trying to imitate his supervisor, but felt stuck at not being able to do this successfully. Through supervision, he was able to realize that he had acquired the skills needed to be an effective therapist and that he didn’t need to imitate the work of someone else.

And finally, music therapy interns will reach the stage where they begin to identify themselves as a beginning professional. Issues in clinical work also mature. Thomas provides the example of one intern who felt that her music therapy sessions were not going anywhere. After determining that her feelings were more about herself than her
work with the patients, the supervisor brought this to the intern’s attention. She began to realize that her sessions felt “slow” to her because she was not focusing on the needs of her patients, but, rather, her own needs. Through supervision, a deeper level of awareness was developing. In the termination stage, interns “come to clearly understand the impact of their work as music therapists with the clients” (p. 147). Furthermore, they begin to understand how their work affects them professionally and personally.

Despite the progress through these different domains, Sawatzky et al. (1994) states, “the growth of counselors-in-training is generally seen through the perspective of the supervisor, or in the context of supervisor-supervisee relationships. What is missing, for the most part, is the counselor’s views of their own development” (p. 178). It is indeed striking to see the development of the intern almost exclusively presented through the lens of the supervisor. What about the supervisee’s own personal experience?

Having completed an internship in End-of-Life Care, the author became intrigued by the personal experience and development of other music therapy interns working with this extraordinary population.

**Personal Perspectives**

Several publications are available describing the personal experiences of interns. Lipovsky (1988), for example, compares her own internship experience as a clinical psychologist with that of the development of an adolescent. She begins by acknowledging the burden of learning the practical work expected of her, on the logistics and policies of her particular unit, the new environment, and adopting to the schedule that was imposed on her. This can be compared to “acute identity confusion” (p. 606) in adolescence. Lipovsky goes on to say that despite wanting to present herself as capable,
she experienced a lot of self-doubt, especially when faced with tasks that were not familiar. During supervision, she adds that, at times, she found herself questioning her own responses and capability to make the right choices. She compares this with learning how to drive. She states, “a large part of the internship involves developing a trust in myself as a clinician and professional and feeling that my supervisors trust me to be autonomous in performing clinical responsibilities” (p. 607). And finally, she came to view her supervisors as more of a guide instead of “being directors of my behavior” (p. 607).

Furr and Carroll (2003) examined counselor development through critical incidents of practicum and internship students. They suggest that critical incidents should be considered in counselor development because of their impact both personally and professionally. One of the findings of the study indicates that while students value “cognitive learning” (p. 487), the critical incident which had the greatest impact on development was experiential learning activities. In addition, some students experienced critical incidents in their personal lives which led to counselor development. “In some cases, participants reported that they left relationships and friendships that were no longer viewed as healthy” (p. 487). And finally, some students reported that “life-threatening events or the death of a significant person” (p.487) also caused them to explore their own principles. Some even sought out their own counseling which caused a positive change. Sawatzky et al. (1994) also reported that psychology trainees gained more self-assurance after helping a patient in a crisis situation.

Freeman and Hayes (2002) reported on how those in helping professions are affected and changed by the patients they encounter. They state that “it seems that
training programs, theories, and research (external learning) are secondary to the impact clients have on counselor development” (p. 13). By being a part of the therapeutic process, the patient is not the only one who will experience a change. The counselor will internalize the change as well. The first author states, that personally, his own beliefs have changed out of admiration for the changes his patients have confronted. “Close personal encounters with clients who have unusual perspectives and personal circumstances may permit counselors to enter deeply into the client’s world in order to see reality through the client’s eyes” (p. 20).

The following is a passage taken from the personal reaction log of the author written during the second month of her internship:

*I also have to say that spending time with these patients and their families has made me appreciate my own family a little more. It has also made me look at how I view relationships and ultimately, how I view death. I am doing some further reading on what happens when we die. I am in search of answers that will allow me to continue this work in good faith without becoming consumed by the “slipping” away of so many. Most of the time, I have to force myself to discontinue thoughts about my own death because I cannot comprehend eternity. It brings about brief moments of anxiety and fear and I stop thinking about it so that I will not have to face the unknown. I am strong in my faith...but not strong in my ideas about death.*

*I find myself praying for them constantly...but I needed to find some more answers. The books I purchased have helped me to see what I always knew deep down inside. It was only through these readings that I have begun to tap what it*
I cannot say that I now completely know what my thoughts are on death and dying but I hope that the more time I spend in examining my reactions to what happens at the hospital my ideas and faith will strengthen. I also really look to this self-exploration to make me the best therapist I can be and the best helper for these patients.

I am finding many of my reactions to these patients are similar as I travel from room to room. It is strange to observe the commonalities between a 55 year old dying of lung cancer and a 2 and ½ year old suffering from a rare bone disease. Lying helpless in a hospital bed, unable to really communicate, in pain...but...loving family members forever at their side. People that may have to be left behind. An unfairness that she is so young and she is too young to die. How is it then, that I have been given the chance to share in this life evolving experience? I don't know how I know, but I was meant to do this work.

I really feel as though I have found my calling. I have such a long journey ahead. For the first time in my life, I want to be completely involved in what I am seeing. I want to be the most sensitive musician I can be. I just see an enormous amount of potential growth as a helping professional...but professional makes this sound like a "job"...and it is so much more...

Few descriptions of personal experiences of trainees are available in the music therapy literature. Wheeler (2002) provides excerpts from interviews with music therapy students on their experience of pre-internship clinical work. By providing students the opportunity to voice their concerns and experiences, the abovementioned study has many implications for professionals as well as students. For professionals supervising students,
it is a true look into what the students feel about entering a new placement, meeting new people, getting comfortable with patients, learning new methods, and experiences of supervision. For students, it is a comforting exploration that offers similar fears, thoughts, and experiences. Wheeler also indicates a difference between the experiences of graduate and undergraduate students, a crucial point when understanding the experience of a student.

And finally, to further relate the experience of what a music therapy intern may encounter when working in End-of-Life Care, offered below are some personal experiences of music therapists working with the terminally ill.

**Music Therapy and End-of-Life Care**

Several music therapists working with the terminally ill have written about their experiences in End-of-Life Care. Nigel Hartley (1999) reflects back on his work as a music therapist with the dying:

> Although I have been part of many peoples journey, I find that I must not lose sense of my own. My own journey as a music therapist working in this area is full of vivid memories and moments of deep experience, all of which help me towards a clearer understanding of the work (p. 109).

For the music therapist working with the dying, the work is full of continuous meaning making. So much so, that, personally, for the author, after completing a 9-month internship with cancer patients, it was hard to capture that deep meaning outside of the music therapy experience again. Hartley goes on to say that the journey towards dying
brought more fear than death itself. But "out of the experience of being fully alive in music must come a new comprehension of death and the dying process" (p. 111).

Another music therapist, Colin Lee (1996) describes his experience with losing a patient to AIDS:

Francis had at last been released, yet I could not fully believe our time together was over. Randomly selecting a recording of one of his improvisations I sat in the corner of my lounge and listened. The extraordinary thing was I do not think I heard the music at all. This was a final letting go, over which there was no control. It was the beginning of my bereavement. (p. 145)

Because dying becomes such a normal part of End-of-Life Care, the music therapist must process the loss of each death. In music therapy, listening to songs composed during sessions is one way to process the grief. During the author's internship, after learning about the death of a pediatric patient, she faced her own grief by secluding herself in a quiet space and listening to a recording of the songs they wrote together.

**Summary and Rationale**

So far, the following have been identified as having an impact on the personal experience of the music therapy intern working in End-of-Life Care: (a) specific music therapy skills and competencies, (b) the experience of working with the dying, (c) supervision, and (d) the music therapist's experience in End-of-Life Care. The literature reviewed presents many different aspects of the development, expectations, personal reactions, and influences of the internship on training helping professionals. However, there is a clear lack of literature capturing and exploring the personal
experience of music therapy interns, specifically the music therapy intern working in End-of-Life Care.

The Grant and McCarty (1990) study, while providing qualitative data about the personal experience of the music therapy intern, included in its sample only those students interning for 6-months. In addition, only 5% of those interns worked in a hospital setting. The following proposed study will focus on those music therapy interns working in End-of-Life Care, including a number of different medical settings and for 6, 7, and 9-month internships.

To date, there has been no research which captures the personal experience of the music therapy intern working in End-of-Life Care. Having experienced many life-changing events in the course of a 9-month music therapy internship at a Cancer Center, the author often searched for sources to support the different things she experienced. Sometimes comfort was found in talking to fellow interns and sharing experiences, but this did not occur very often, especially since many of them worked with different patient populations. The author also experienced some feelings of jealousy at those music therapy interns who were only required to spend 6-months at their clinical site and who did not appear to have to do as much work on self-awareness and such in-depth exploration of values and beliefs. While the author would not change anything about her music therapy internship experience, it would have been extremely valuable to have access to other students' personal reactions to working with the dying.

In order to more fully understand this experience, the author proposed a descriptive study which examined the music therapy intern's experience in End-of-Life Care through areas of counseling, musical skills, personal reactions to death and dying,
supervision, and personal life away from the clinical site. Therefore, this study focused on the following guiding questions:

1. What was your experience like working in End-of-Life Care?
2. How did your views on dying change (or not change) during your internship?
3. How would you have felt if the internship lasted 9 months (or 6 months)?
4. What was your experience like bringing music to the bedside of a dying patient?
5. How did you process the continuous loss of patients?
6. Do you feel as though you gained the skills necessary to work effectively with dying patients? Will you seek a professional position in End-of-Life Care?
7. How did supervision help (or not help) to guide you through working with dying patients?
8. Looking back, how well prepared were you for working with End-of-Life patients?
9. How did your internship affect your life outside of the clinical site?
METHOD

Design

This descriptive study used a survey (Appendix A) to gather both quantitative and qualitative data. The researcher sought to find relationships and themes through both essay-type questions as well as rating scales. The questions examined how participants currently viewed their internship experience and their own effectiveness as a music therapist working in End-of-Life Care. For the purpose of this study, End-of-Life Care was defined as work with any patient who has a terminal illness, is actively dying, or has already passed away.

Participants

Participants in this study were 15 music therapy interns who had completed the required internship, working in End-of-Life Care, between the months of June 2005 and February 2006. Participants were located and contacted through internship supervisors in End-of-Life settings found on the American Music Therapy Association (AMTA) national roster. Participants were to have completed all academic and clinical training prerequisites before entering the internship.

Procedure

Approval was granted for research after submitting an application to the Montclair State University Institutional Review Board for the Protection of Human Research Participants. Thirty-six training directors from the national roster were contacted, in writing (Appendix B), and asked to provide the names, mailing, and web addresses of students who were currently completing or had already completed their internship between the months of June 2005 through February 2006. Twenty-five
training directors responded. Any director who did not feel comfortable sharing the personal information of their intern was asked to forward information about the study to the intern personally. As the contact information was received by the researcher, eligible participants were notified, via email, concerning the purpose of the study, content of the survey, and instructions for participation (Appendix C). Any intern desiring to participate was instructed to simply send a reply back to the researcher. Any intern who had not responded within 2 weeks, was sent a follow-up email. In addition, the email and letter emphasized that absolutely no information gathered for the study would be shared with clinical directors and that absolutely no personal information would be seen by anyone other than the surveyor. Participants who expressed interest in the study were sent a cover letter (Appendix D), oral consent form (Appendix E) and survey. Thirty surveys were sent out and 15 were returned. Participants were asked to return all surveys by Wednesday, March 15, 2006 in the pre-stamped and pre-addressed envelopes provided.

**Instrument**

Provided in the Appendix A is the survey, as the participants viewed it, which included specific items from each scale identified below. The question format of this survey was based on a model developed by Heidel (1998) for a study focusing on therapist development. Questions were taken from following models: “The Counselor Development Questionnaire” (Reising (1982) as cited in Heidel, 1998), “The Counseling Self-Estimate Inventory” (Larson, Suzuki, Gillespie, Potenza, Bechtel, and Toulouse’s Model (1992) as cited in Heidel, 1998), and the “Integrated Developmental Model” (Stoltenberg, McNeill, and Delworth, 1998). In addition, questions were taken from
research by Bright (1989) and Epstein (1975). The questions addressed the following 6 categories: Self-Reflection, Knowledge of Aspects in Medical Setting, Music Therapy at the End-of-Life, Supervision, The Personal Side, and Death and Dying.

**Analysis**

Quantitative data was entered into SPSS and descriptive statistical analyses were applied to determine frequencies, means, and correlations. These conclusions can be found in the results section. Content analysis was used to search the qualitative data for meaning in the personal experience of the music therapy intern working in End-of-Life Care. The researcher made an inventory of all responses to the open-ended questions found in Part II of the survey. All responses to a particular question were put together in their raw form. Some of these responses can be found in the results section. “Significant statements” were recorded based on both similar and unique responses from the surveys. For each question, all responses were reviewed in an attempt to discover reoccurring themes and certain patterns. As patterns emerged, themes were formulated. Themes and implications can be found in the discussion section. To assure quality of the analysis, some of the data is presented in its original form in the results section. In addition, results are presented, guided by the following questions:

1. What was your experience working in End-of-Life Care?
2. How did your views on dying change (or not change) during your internship?
3. How would you have felt if the internship lasted 9 months (or 6 months)?
4. What was your experience like bringing music to the bedside of a dying patient?
5. How did you process the continuous loss of patients?
6. Do you feel as though you gained the skills necessary to work effectively with dying patients? Will you seek a professional position in End-of-Life Care?

7. How did supervision help (or not help) to guide you through working with dying patients?

8. Looking back, how well prepared were you for working with End-of-Life patients?

9. How did your internship affect your life outside of the clinical site?
RESULTS

The purpose of this study was to examine the personal experiences of the music therapy intern working in End-of-Life Care. The results of this study are discussed in two parts. Part I will present descriptive statistics related to subject demographics and closed-ended questions located in the last section of the survey. Part II will present the analysis of qualitative data gathered from the survey’s open-ended questions.

Subject Demographics

Thirty surveys were sent to music therapy interns who had completed the required internship, working in End-of-Life Care, between the months of June 2005 and February 2006. Fifteen students returned completed surveys to the researcher. Nine (60%) participants were undergraduate, 5 (34%) were graduate, and 1 (7%) was post-baccalaureate. Of the 15 participants, 8 (54%) completed a 6-month internship, 2 (14%) completed a 7-month internship, and 5 (34%) completed a 9-month internship. The mean age was 27.80 years (SD=8.28) with an age range of 22-50. One (7%) participant was male and 14 (94%) were female. In addition, participants were asked to provide the week that they began leading sessions on their own. On average, participants started leading sessions during the 4th week of their internship.

Quantitative Data

The last section of the survey presented the interns with statements related to their perception of death and dying, supervision, music therapy skills and competencies, and the overall internship experience. For each statement, the student was presented with a 6-point Likert scale. Because only 15 students returned the survey, the results for each scale were pooled into two categories (agree/disagree) for analysis purposes.
At the beginning of the study, the researcher had stipulated that length of internship and educational status is influential in the internship experience and plays a significant role in the professional preparedness of the intern at the end of the internship. It was the intent of the researcher to analyze the data for such differences. However, because of the small sample size (especially the low percentage of graduate students and students completing the 9-month internship), such analysis turned out to become impossible or statistically meaningless. Therefore, most results will be presented merely showing frequencies. If, however, for a particular question, there was a significant finding related to length of internship or educational status, this will be reported. Table 1 presents the statistical data related to each statement that was given to the participants.

**TABLE 1**

*Agree/Disagree Statements of the Music Therapy Intern Working in End-of-Life Care*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree %</th>
<th>Disagree %</th>
</tr>
</thead>
<tbody>
<tr>
<td>I can’t imagine anyone ever being free of the fear of dying.</td>
<td>27%</td>
<td>74%</td>
</tr>
<tr>
<td>I don’t think a person should be told he’s dying. There’s no point in adding to his suffering.</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Being around a dying person keeps reminding me that I will also die.</td>
<td>67%</td>
<td>34%</td>
</tr>
<tr>
<td>Being around someone who is sick or dying makes me feel proud of my good physical condition.</td>
<td>27%</td>
<td>74%</td>
</tr>
<tr>
<td>I feel that I have enough fundamental knowledge of assessment and treatment planning to do effective music therapy.</td>
<td>94%</td>
<td>7%</td>
</tr>
<tr>
<td>My assessment of patient problems may not be as accurate as I would like them to be.</td>
<td>67%</td>
<td>34%</td>
</tr>
<tr>
<td>I am uncomfortable about dealing with patients who appear unmotivated to work towards mutually determined goals.</td>
<td>20%</td>
<td>80%</td>
</tr>
<tr>
<td>I have personal doubts about my ability to be an effective music therapist.</td>
<td>27%</td>
<td>74%</td>
</tr>
</tbody>
</table>
Most of the time I feel quite anxious about becoming a music therapist and working in End-of-Life Care.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>22%</td>
<td>I feel anxious</td>
</tr>
<tr>
<td>74%</td>
<td>I alternate between feeling confident and doubtful about my therapy skills.</td>
</tr>
<tr>
<td>67%</td>
<td>Most of the time I feel I need encouragement, not negative feedback from my supervisor.</td>
</tr>
<tr>
<td>80%</td>
<td>I often feel it's a struggle just to get through supervision sessions.</td>
</tr>
<tr>
<td>27%</td>
<td>I often feel anxious before a supervision session.</td>
</tr>
<tr>
<td>87%</td>
<td>I feel competent and function easily using the piano, guitar, voice, and other instruments in this type of setting.</td>
</tr>
<tr>
<td>14%</td>
<td>I still wish, that, at times, my supervisor could be in the music therapy session to lend a hand.</td>
</tr>
<tr>
<td>7%</td>
<td>Sometimes my supervisor is too structured and too directive with me.</td>
</tr>
<tr>
<td>100%</td>
<td>It is important that my supervisor allow me to make my own mistakes.</td>
</tr>
<tr>
<td>94%</td>
<td>Given my current state of professional development, I believe I know when I need consultation from my supervisor and when I don't.</td>
</tr>
<tr>
<td>87%</td>
<td>Regarding counseling/therapy, I view my supervisor as a teacher/mentor.</td>
</tr>
<tr>
<td>80%</td>
<td>Regarding counseling/therapy, I view my supervisor as a peer/colleague.</td>
</tr>
<tr>
<td>74%</td>
<td>I will seek employment doing music therapy at the End-of-Life.</td>
</tr>
<tr>
<td>87%</td>
<td>This internship has been the biggest life changing experience for me.</td>
</tr>
<tr>
<td>14%</td>
<td></td>
</tr>
</tbody>
</table>

The following statements were found to have significant differences according to length of internship:

* I do not feel as though I possess a large enough repertoire of techniques to deal with the different needs a patient may present. * Fifty-four percent of participants agreed with this statement and of that percentage, 6 (75%) had completed a 6-month internship,
1 (20%) had completed a 9-month internship, and 1 (50%) had completed a 7-month internship. This seems to suggest that those who completed the 9-month internship felt as though they possessed a greater knowledge of specific music therapy techniques.

I have difficulty dealing with patients who do not verbalize their thoughts during the music therapy session. Forty percent of participants agreed with this statement and of that percentage, 4 (50%) had completed a 6-month internship, 1 (20%) had completed a 9-month internship, and 1 (50%) had completed a 7-month internship. Again, this suggests that those who completed the 9-month internship felt as though they possessed more competencies regarding counseling skills.

I am ready to be confronted and challenged on my therapy skills. Fifty-eight percent of participants agreed with this statement and of that percentage, 2 (25%) had completed a 6-month internship, 5 (100%) had completed a 9-month internship, and 1 (50%) had completed a 7-month internship. It appears that students who had completed a 9-month internship felt more secure about their skills and, therefore, these statements seem to indicate that length of internship does have some impact on the training of the music therapy intern working in End-of-Life Care.

I feel most comfortable when my supervisor takes control of what we do in supervision. Forty percent of participants agreed with this statement and of that percentage, 3 (38%) completed a 6-month internship, 2 (40%) completed a 9-month internship, and 1 (50%) completed a 7-month internship. This seems to suggest that those completing the 6-month internship did not experience as much of a sense of independence from their supervisor as did those completing the 9-month internship.
Qualitative Data

The following section presents results from the second part of the survey. This section required participants to answer open-ended questions based on their internship experience. For specific questions, the researcher chose only to share the personal statements as written by each participant, so as not to make any assumptions or conclusions about the experience and growth of the individuals who have agreed to share their personal stories.

Self-Reflection

How well did your pre-internship practicum and coursework prepare you for working in End-of-Life Care?

Participants were asked to provide information regarding length of pre-internship practicums and pre-internship experience with palliative care. The total amount of pre-internship hours averaged at 130.27 hours (SD=110.85). This was surprising as, according to AMTA guidelines, a student needs to spend a minimum of 180 hours in pre-internship training. The average amount of semesters of supervised practicum was 4.47 semesters (SD=1.64). Of the participants, only 20% had (non-music therapy) hospice/palliative care experience and 40% had (music therapy) hospice/palliative care experience.

Overall, 74% of participants reported that they felt prepared at the beginning of the internship. Twenty-seven percent stated that they felt unprepared. Fourteen percent stated that while they had no practicum experience in End-of-Life Care, coursework prepared them. Sixty percent of participants stated that the practicum experience
prepared them more for the internship than coursework. The next statement was the experience of an undergraduate intern:

Fairly well. A good overview of music therapy services; what they are; who they are for. Also, specifically how to plan and implement sessions and how to remain flexible to meet the demands of the client and current atmosphere.

The following are reasons, given by the remaining 60% of participants, for feeling unprepared. Many stated that their practicum consisted of only general populations, such as, geriatrics, adult psychiatry, and school-based children. In addition, coursework focused primarily on these populations and participants felt that End-of-Life issues were never appropriately addressed. Some mentioned that in order to enhance their own knowledge of music therapy at the End-of-Life, they frequently chose to write papers on this topic or self-taught by reading. The following experience, by a graduate intern completing a 6-month internship, seemed to summarize best what was described by many:

I did not consider myself well-prepared for my hospice internship. My 3 semesters of practica included working with elderly, pre-k, and psychiatric populations. Coursework appeared to focus primarily on these populations. However, we did consider issues facing individuals with a terminal illness in one music therapy course. If I encountered a hospice client, who may have had psychiatric or other secondary diagnoses related to their illness, I did feel more confident working with them.

Other areas where participants felt unprepared included education on grief and bereavement, counseling skills, and writing progress notes. However, it is not clear
whether the concern about lack of skills for writing progress notes was specific to this population or whether this was an overall unpreparedness.

**What are some of your strengths/weaknesses as a therapist working in End-of-Life Care?**

Participants were asked to share what they considered to be their strengths and weaknesses, at the end of their internship, as a therapist working in End-of-Life care. Empathy and compassion were two of the most common strengths reported, while lack of repertoire, boundary issues with patients/families, and burnout/self-care were the most common weaknesses reported by the participants. All strengths/weaknesses can be found in Table 2.

Because End-of-Life care exposes one to deeply emotional situations on a daily basis, the following two statements have been included to illustrate the honest reflections of the participants.

*I have difficulty with boundaries between my emotions and how I deal with them as a resident is dying. To some aspect[sic] it is important to be aware if you are too emotional in terms of crying or hanging on to memories, but it is also important to be yourself and that the client knows you are true. It is difficult to stay in that middle area between two extremes* (undergraduate student in 6-month internship).

*I am very sensitive, emotionally[sic]and have often had a hard time working through my own grief over losing patients. Although I go through this outside of*
sessions (not with patients) I know it is something I need to work on to avoid burnout. I have also sometimes had trouble with boundaries—particularly over identifying with people my age and in a similar life situation (i.e., young married couples) (graduate student in 9-month internship).

As this question was analyzed for common themes and relationships, no significant differences were found when comparing strengths between those participants completing a 6-month internship and those completing a 9-month internship.

**TABLE 2**

*Strengths/Weaknesses of the Music Therapy Intern Working in End-of-Life Care*

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Setting good boundaries</td>
<td>Difficulty eliciting emotions from patients</td>
</tr>
<tr>
<td>Compassion/Empathy/Understanding</td>
<td>Repertoire</td>
</tr>
<tr>
<td>Stable Emotions</td>
<td>(sight reading, singing in different languages,</td>
</tr>
<tr>
<td>Ability to separate work and home</td>
<td>confidence with singing)</td>
</tr>
<tr>
<td>Quickly establishing therapeutic rapport</td>
<td>Boundaries</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>(becoming too attached to patients)</td>
</tr>
<tr>
<td>Initiating Closure</td>
<td>Providing meaningful music therapy when pt is non-responsive</td>
</tr>
<tr>
<td>Involving Family/Family Systems</td>
<td>Time Management</td>
</tr>
<tr>
<td>Personable</td>
<td>Closure</td>
</tr>
<tr>
<td>Genuine</td>
<td>Insecurity about one’s abilities</td>
</tr>
<tr>
<td>Intuitive</td>
<td>Piano Skills/Finger picking the guitar</td>
</tr>
<tr>
<td>Musicianship (ability to meet pt/family needs)</td>
<td>Counseling skills</td>
</tr>
<tr>
<td>Flexibility</td>
<td>Knowledge of different faith backgrounds</td>
</tr>
<tr>
<td>Ability to work as a team</td>
<td>Knowledge of bereavement/spiritual issues</td>
</tr>
<tr>
<td>Listening</td>
<td>Burnout</td>
</tr>
<tr>
<td></td>
<td>Countertransference</td>
</tr>
</tbody>
</table>

Some therapists depend too much upon their work in order to maintain a sense of self-esteem. Please describe your own confidence level in regards to this statement.

Participants appeared to be able to relate more to this statement at the beginning of their internship, where they felt personally sensitive to feedback, criticism, statements made by patients, and their own self-evaluation. However, it appears that most
participants came to better understand their work in relationship to their sense of self. It was not surprising to find that many participants felt a greater sense of self-esteem when a session went particularly well or questioned their abilities and felt failure if a session did not go smoothly. No specific case examples to illustrate this were shared. Some reported that hearing positive remarks and compliments from colleagues increased their motivation to be a good therapist. Others felt as though the work contributed to who they were, but did not rely on their work to maintain a sense of self-esteem. The following were written by two undergraduates completing a 6-month internship:

*I think I may be guilty of being this type of therapist. I have been working on my confidence level as an intern. I have a tendency to feel like I have “failed” if a session does not work as planned. For me it is not that I depend on the work for self-esteem. Its more like the work depends on me and I am trying to work on this fear of failure so it does not run other areas in life.*

*Throughout my undergraduate studies and internship, I have asked myself to look into those feelings, and feel confident in saying that although I value my work and am proud of the therapist I have become, I do not rely on this alone for feelings of self-worth.*

Again, most participants revealed that their work did impact their sense of self at the beginning of the internship, but over time, they came to appreciate the balance between finding their self-esteem in work and in other areas of life.
Knowledge of Aspects in Medical Setting

What is your understanding of the physical, spiritual, social, and financial pain that an illness can mean to a patient and their family?

Overall, participants appeared to have developed a good understanding of what the physical, social, and financial pain of an illness can mean to a patient and their family. Surprisingly, while many participants mentioned that they have a deeper understanding of spiritual pain, after reviewing the statements, only one participant actually pointed out what spiritual pain may be like:

*It means everything to the patient and the family. In hospice care most patients are monitored for pain so that it can minimized to its lowest level. This is probably the most important facet of pain-physical. End-of-life care also puts strains on social care within the family. Certain family members have more difficulty than others dealing with a loved one dying or disagree with decisions that have been made about the patient’s case. Financial pain causes guilt for both the patient and family. The patient feels he/she is a burden financially whereas the family feels badly if they can’t afford upscale care versus “bad” nursing home. I didn’t have any patients with spiritual pain but it is my understanding that they would tell the family or the therapist and many questions of “why” or “where am I going?” can be appropriately explored.*

Between all levels of educational status and time spent at the clinical site, participants really seemed to grasp how devastating each of these pains can be for a patient and family at the end of life. Their understanding of these issues clearly impacted on their perception of how they can contribute to the well-being of the patient and family. To
begin, some found it extremely difficult to work with patients whose families did not communicate well. Others stated that some patients cut off communication with family because they could not face the imminent death of their loved one:

*In my opinion, the level of support that an individual receives from their family members or significant other has governed the distress experienced by a patient and their family. I can recall one situation in which a hospice client suffered from a long, interminable illness. Due to the client’s religious faith, and unshakable love of her family, the family weathered the client’s numerous crises and death with incredible grace. One patient, who suffered from inoperable breast cancer and dementia, rarely received visitors. Later, I came to understand that the client’s son, who also oversaw her legal affairs, could not accept his mother’s illness, and would not visit her in the nursing home.*

Second, issues concerning care as voiced by the family members were prevalent in the answers to this question. Participants mentioned the difficulty some family members had with the type of care being given, by other staff, to the patient. Words like helplessness and guilt were often mentioned. Family members felt helpless because of being unable to afford the best care and patients felt guilty for being a burden. Some mentioned that because they, themselves, had personally experienced the loss of a loved one, they had a deeper appreciation for what the families were experiencing. The following was written by a post-baccalaureate completing a 9-month internship:

*Pain manifests itself in so many forms. It appears in the physical pain associated with the illness the patient has. It comes in the spiritual pain that both the patient and family have from not understanding why their higher power would cause a*
life-limiting illness to affect them. Pain shows itself in the distress a patient feels from the fear of being a burden to their loved ones, so they isolate themselves from the ones they love. It appears in the family who’s in denial of a patient’s diagnosis and prognosis...the family who distances themselves from the patient who doesn’t know how to deal with or care for their family member who is dying. And, for the financial pain, it appears in insurance payments and qualifications...trying to make decisions about care for a patient based on what’s affordable.

Participants clearly understood the importance of faith and familial support. Participants would provide time for families away from the patient to help them cope. Some would work closely with members of the social work team or attend interdisciplinary meetings in order to better understand particular family dynamics. Others concluded with the understanding that this aspect of End-of-Life care was also very much a part of the care they provided.

How has your understanding of the social structures of the family and the ways in which different families operate helped you treat patients at the End-of-Life?

Many of the responses to this question included statements about the ability of the participants to appreciate the differences that each family brings to the end of life and to appreciate that each situation is unique and must be treated as such. Some participants mentioned their growing understanding that while music therapy can help facilitate reconciliation, not all past grievances between family members can be resolved. Furthermore, their role consisted mostly of supporting the family as they experienced role
changes, frustration, and their fears about dying. One participant even stated a deeper acceptance of families who, despite becoming nasty or impatient, only wanted the best care for the patient. Another participant mentioned that, in one case, as the family dynamics became clearer, this helped the therapist get closer to and gain more “access” to the patient. The following was written by an undergraduate completing a 6-month internship:

*I was unaware of how important it would be for me to understand family structures until I was put in specific situations that challenged me. Fortunately, I was able to sit in on some educational meetings with my music therapy supervisor and several different social workers that enhanced my knowledge of family structure and dynamics. After I received that informal training, I felt much more confident in handling challenging families. Understanding family structures helped me better assess situations and know my role as the music therapist before saying something I shouldn’t have said. It helped me keep control of the session.*

The next excerpt was written by a post-baccalaureate completing a 9-month internship:

*I’ve learned to adapt from families who don’t use the “D” word (death), to families who are completely open, to families who yell as their form of communication. I treat my patients [sic] always with respect while keeping in mind the structure and communication I see as being common in their lives.

Having an understanding of the social structures of the family appeared to be greatly appreciated and thought-out by each of the participants. Some were very honest in revealing that when they felt overwhelmed by particular family dynamics, they sought the help of their clinical supervisor as well as the site’s social worker. Furthermore,
many participants recognized the value that music has in supporting the different social structures, especially at the end of life:

*It is important to consider the roles each family member holds and the dynamics that exist within the family unit in order to effectively support them. I have also found that family members in different stages of the grief process can cause friction and discomfort which can be resolved through music therapy. Recognizing these different stages and facilitating reconciliation is important for treating patients in end-of-life care.*

**How has your knowledge about the medical aspects of terminal conditions, including probable course and individual diagnosis, changed since first beginning your internship?**

Most participants reported that, in the beginning, they felt overwhelmed by the medical terms, etiology, stages, and diagnoses that were continuously used at their sites. But, with growing experience and exposure, they grew comfortable and even found themselves using this vocabulary more frequently and with greater confidence. Furthermore, some reported that having this knowledge helped to know the physical and emotional capability of patients with a specific diagnosis. However, while understanding the course and stage of a terminal illness is important, one participant stated that despite disease similarities, every patient dies differently.

The first excerpt was written by a graduate completing a 6-month internship, the second, written by an undergraduate completing a 6-month internship:
The field of medicine has always fascinated me. Having received a graduate degree in biochemistry, I have attempted to keep a breast of medical advancements. Participating in a hospice environment has greatly increased my knowledge of the etiology and processes of specific diseases.

I have come so far in terms of medical knowledge since the beginning of my internship, but I'm the first to admit that I have so much more to learn. I remember feeling so lost and confused during the first month or so because I didn't understand medical terms and abbreviations. Eventually, I found myself using those very same abbreviations in my daily vocabulary. Most important, I wasn't afraid to ask questions.

How competent do you feel regarding your abilities to deal with crisis situations that may arise during music therapy sessions, i.e., suicidal ideation, a client stops breathing, etc.?

At the beginning of my internship, I felt very incompetent in dealing with crisis situations. However, by the last 2 months of my internship, I discovered I could relax and trust my professional judgment.

The preceding excerpt was written by a graduate completing a 6-month internship. Interestingly enough, this sentiment was not found to be true for most participants. And what was most interesting, was, while many participants stated that they were confident in their abilities when a patient was actively dying, that is, taking their last few breaths of life, some participants did not feel as competent in their abilities
regarding crisis situations, such as, suicidal ideation. Furthermore, they were unsure about what to do in the situation of a patient who may have suicidal ideation. Most participants reported that they would rely on their relationship with other staff members in order to deal with a crisis situation. Others felt an increased level of confidence based on those relationships with other team members. One post-baccalaureate completing a 9-month internship found her competence from previous experience:

*I feel quite competent in dealing with crisis situations. Something that has helped me is that I volunteered at a crisis hotline for a year before and during my internship. I had to learn how to actively listen and talk people down from suicidal ideation as well as deal with crisis in their lives. I believe that training helped me be able to effectively handle almost any situation that may turn into a crisis.*

Based on the researcher’s personal experience, it is not surprising that participants did not feel competent dealing with crisis situations. To expect the death of a patient and any surrounding family’s reaction is something that can be anticipated. As music therapists working in End-of-Life Care, it is expected that one is able to maintain professionalism and know what to do as a patient takes their last breath. But outside of this experience, it does not appear that crisis situations, that can actually be quite common at the end of life, are addressed enough during the internship.
**Music Therapy at the End of Life**

**Explain your confidence in using specific music therapy interventions for symptom management (e.g. guided imagery for pain relief, improvisation for relaxation).**

The confidence level in using specific music therapy interventions for symptom management ranged from very confident to not at all. The following three excerpts are used to illustrate the wide range of confidence between participants. The first excerpt was written by an undergraduate completing a 6-month internship. The researcher found this statement shocking, especially since the above mentioned music therapy interventions are so specific to End-of-Life Care:

*I am not at all confident using specific interventions because I have not had experience with them. I have observed them being used/facilitated, but that doesn't make me feel like I would do it well myself. There was not much training/teaching of those techniques in college and I did not have experience with that in my internship either. I would have to do some reading and self-teaching if a patient requested guided imagery or improv."

The next excerpt was written by an undergraduate completing a 7-month internship:

*More confident, yet not experienced enough to feel strong confidence. Through experimentation, class work, supervision, and actual field work, I have gained general confidence with these areas, but specific types and forms and which type of imagery to use for pain relief, etc., is still limited.*

And the final excerpt was written by a graduate completing a 9-month internship:

*Again, I think I feel much more confident using certain interventions due to my internship. For example, I often used the ISO principle to reduce anxiety or to*
help with regulating breathing. I also had many opportunities to practice
improvisation for relaxation and music and imagery.

There appeared to be a wide range of confidence with different music therapy
techniques and no significance between educational status/time spent at the internship
and confidence level. This aspect of End-of-Life Care appears to be greatly influenced
by the clinical site and personal technique of the supervisor. Other specific music
therapy interventions used with confidence were: Lyric Analysis, Drumming,
Psychotherapy-Led Music Making, Songwriting, Orff, and MAR (Music Assisted
Relaxation). Participants did not report on those music therapy techniques they did not
feel confident using.

A music therapist needs a vast repertoire of music to effectively meet the needs of
patients. How do you feel about your own repertoire at this point?

Naturally, if this question was posed to any level of music therapist, be it student,
intern, or professional, the answer would, most likely, be the same. And that is, that there
is always new music to learn, and repertoire should always be expanding. For the music
therapy intern, there appears to be a great eagerness to continue expanding repertoire.

Statements about repertoire can be found in Table 3.

<p>| TABLE 3 |</p>
<table>
<thead>
<tr>
<th>Statements About Repertoire by Music Therapy Interns Working in End-of Life Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am content with what I had to offer patients and eager to learn lots more songs.</td>
</tr>
<tr>
<td>I feel as though it is ever increasing. I always feel like I could learn more. I think I have enough music to get through the day, but that doesn't satisfy me. I always want to know more.</td>
</tr>
<tr>
<td>Having enjoyed all types of music during my life, I felt well-equipped to perform most musical genres. I sight-read very well, and that gift has helped me tremendously. I also gained a greater insight into culturally diverse music and singing in foreign languages.</td>
</tr>
</tbody>
</table>
The ability to have a certain skill level enables me to play certain music and be open to styles. At my internship, gospel and bluegrass music is very important. I have familiarized myself with much of the hymns and gospel music.

That was one of my main focuses during my internship, especially living in a city and working with such a diverse population, so I am proud of my repertoire but adding to it almost daily.

There is no way that I could say I feel confident about my current repertoire because I'm a fresh graduate and if I don't know every song-I still have work to do. However, I have made a real effort to be on the constant look out for reasonably priced music and I push myself to keep learning new songs. I also have found that musical tastes vary by geographic location, so the genres I used in my practicums were not at all the same genres I needed for my internship. This has caused my repertoire to broaden. I know I need more music in foreign languages-especially Spanish.

Need more repertoire in newer music for younger patients (1950’s, 60’s, 70’s). Need more skills in jazz music.

I feel fairly good about my repertoire. I had a lot of obscure song requests in my internship that I was able to learn fairly quickly. Right now, the largest population I'm working with are Jewish, which provides me with a new challenge for continuing to build my religious song repertoire.

I know that my repertoire is lacking and I definitely have learned so much through my practicum and especially my internship, but I still need to keep adding, most definitely!

What is your understanding about the use of the piano, guitar, voice, and other instruments and how they must be adapted to playing at the bedside of a dying patient?

Learning and understanding how to adapt music at the bedside of the dying patient, really seems to be where the skill becomes specific to the population. All of the participants appeared to have a good understanding about how to adapt the use of instruments at the bedside of a dying patient. Words such as soothing, softly, and fluidly, appeared repeatedly. Assessment and intuition play a large role in deciding how to use an instrument at the bedside of the dying. For example, music needs to be adapted to the mood, emotion, and physical functioning of the patient. Many participants mentioned that songs were played or sung in a lower register, in a more soothing, less intrusive way.

One participant, a graduate completing a 6-month internship had this to say:
Some facets of music are very critical for playing at the bedside of a dying patient. Most of my clients responded positively to music played in a lower register and dynamic and at a slower tempo. Occasionally, I played clarinet for clients and they relaxed when they heard the mellow tones. My supervisor reminded me to sing in a lower key, as I have a high soprano voice. When I observed clients flinch during my singing, I either transposed the song to a lower key or hummed softly.

Some participants acknowledged that the way in which they played or sang always needs to be adapted to the needs of the patient. Two participants even mentioned abandoning their instruments at one point and singing acapella at the bedside. The following was written by an undergraduate completing a 6-month internship:

Once again, I don’t think I understand the value of adapting until I was put in a specific challenging situation. I learned that it’s okay to abandon my instrument and do something acapella at the bedside. Playing an instrument inhibits me from using touch which is sometimes effective and even necessary, so I now try to be aware of those unique opportunities. I have also gotten a lot better at using a capo to change the key for patient’s vocal range.

In addition to the piano, voice, and guitar, the lap harp and ocean drum were also used. One participant mentioned “song-chaining” and memorization to ensure the fluidity of the session. Others found that having a guitar capo was necessary to transpose on the spot. Some of the goals mentioned by the participants in adapting their instruments were to decrease restlessness and agitation, and facilitate comfort and relaxation.
Supervision

There is a lot to learn about working with the dying. How did you use your supervisor as an educational resource?

The supervisory relationship is paramount in shaping the way one views their internship. It is a phenomenon in itself and has led to extensive literature and scrutiny on the topic. To best inform current clinical music therapy supervisors about the experience of the intern working in End-of-Life Care, Table 4 presents the statements in their original form, as shared by each participant. The researcher hopes that the candid reflections will enhance and become a learning tool for future supervisory relationships.

Most participants reported that they felt as though their supervisor was readily available and supportive throughout their internship. Meeting times varied and included meeting once a week to meeting every two weeks. Supervisors were often asked to share their own or similar experiences as learning tools for the intern. This shared experience may have helped to strengthen the supervisory relationship as it enabled the intern to better relate to the supervisor. Participants also reported that having a supervisor who shared cases, articles, and research was very helpful.

TABLE 4
Using Your Supervisor as an Educational Resource

<table>
<thead>
<tr>
<th>We met weekly and talked about my caseload. I had questions, asked how to get around tricky family issues, difficulty in music sessions as well as respect issues with fellow team members i.e., massage, chaplain, and nurses.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initially I used my supervisor as an educational resource. By the second month of my internship I consulted with other team members, such as social workers, pastoral counselors, and case managers.</td>
</tr>
<tr>
<td>My supervisor was very helpful and always available for support. My supervisor also provided me with literature about work with end-of-life.</td>
</tr>
<tr>
<td>Every 2 weeks my supervisor had me write a summary on how I perceived to be progressing or digressing as a MTI (Music Therapy Intern). This helped my awareness of the state of my internship and allowed my supervisor to help me in areas as needed.</td>
</tr>
</tbody>
</table>
We have 4 hours of observation and 1 hr. of supervision a week. I write down questions that I come up with during the week and talk to my supervisor about them during supervision. I find it’s very helpful.

My supervisors were amazing models for a wide variety of interventions, were always receptive to questions, gave good criticisms and feedback when observing me, recommended books and articles, and particularly focused on helping improve counseling skills.

We had weekly supervisor meetings, but my questions couldn’t always wait for that meeting. Luckily, my supervisor was readily available and very willing to listen to me and answer my plethora of questions. There was also a 2nd music therapist employed at the hospice and that person was available to answer questions as well. My supervisor also had journals and random articles to share with me.

Feedback, observation, formal and informal discussions related to it. Knowing my supervisor had a master’s degree and a concentration in music therapy in hospice work, but knowing there is so much to learn and even though my supervisor learned much, there are varying opinions and more we will always be learning.

Sharing and processing personal experiences as examples of various situations and how, maybe, to handle situations I may come across.

I questioned my supervisor and kept on asking and clarifying, asking for materials, experiences, advice, etc. I definitely clung to my supervisor and her experience during the beginning of the internship so that I could properly begin my own experience.

To what extent did you rely on advice/feedback from your supervisor?

As with other skills, the music therapy intern gradually grows more comfortable and is able to make more decisions on their own. Questions where they would have had to ask their supervisor are now being answered using the tools they have learned and acquired. The researcher presumed that those interns on the graduate level would have relied less on supervisor feedback than those on the undergraduate level. However, both groups appeared to rely heavily on advice/feedback from their supervisor at the beginning of the internship. As could be expected, at the end of the internship, greater independence was reported by most participants:

*I absolutely rely on it. There is a “high positive” philosophy at my internship, so the positive aspects come out of supervision, followed by constructive criticism.*
The environment is never negative, so feedback is always helpful, encouraging and inspiring.

Some participants relied on positive feedback and felt discouraged when receiving criticism from their supervisor. Those participants, however, acknowledged this, later, as a learning tool. One participant stated that they felt as if they did not have enough feedback:

_The first 4 ½ months of my internship, I had no supervision at all. I felt like I was flying blind and hoping I was doing the right thing. The last 4 ½ months, I had supervision every other week on Tuesday. My supervisor was always constructive with feedback and advice and most of the time, her comments would echo my internal feelings._

Other participants stated that they began to rely more on their own first-hand experiences:

_I relied more heavily on her advice and feedback in the beginning of my internship when I felt unsure of myself. As the internship progressed I found that I was developing my own style and tended to ask for feedback only with more difficult cases._

**The Personal Side**

Are you able to set aside your own beliefs in order to meet the needs of those with whom you work? If so, what helps you to prevent imposing your own beliefs (e.g. beliefs about death) on the patient during the session?

The following excerpt was written by a graduate completing a 6-month internship:
When I accepted the internship at hospice, I fully realized that I could not impose my beliefs on my clients. As a devout Christian, I respected my client’s personal feelings about spiritual practices. If questions about faith arose during a music therapy session, the client and I explored the issues therapeutically or I directed the client to contact a pastoral counselor or staff. Depending upon the situation, a pastoral counselor and I facilitated a joint session with a client struggling with their beliefs.

All participants answered “yes” to this question. Again, despite educational status or time spent at the clinical training site, it appears that each participant understands the complexity and delicacy of this question. To impose one’s beliefs on another, especially at the end of life, is both unethical and unprofessional. And while it would be counter-therapeutic, it is not an easy task to accomplish, especially for the intern working in End-of-Life Care. So, how does one learn to separate his or her own beliefs? One participant states:

*I think being a good listener helps to prevent me from imposing my beliefs on the patient. Empathetic listening and reflecting makes the experience completely about the patient, rather than my own beliefs. In some cases I have shared my beliefs, but only if the patient specifically asked and I deemed it appropriate to self-disclosure.*

Some participants agreed that, at times, during a music therapy session, it was not easy to put aside or forget their own beliefs, especially when a patient’s beliefs were so different from their own. However, while participants acknowledged that their own beliefs were still present, they did not verbally share those with the patient or allow them to interfere
with the music therapy session. Furthermore, many acknowledged that while not all beliefs are the same, their job was to be an effective music therapist, supporting the patient and not instilling any of their own beliefs.

Please describe some personal conflicts that may have interfered with your ability to administer music therapy sessions. How did you resolve these conflicts so that they would not interfere with your abilities to work with patients?

Because this research seeks to share the personal experience of the music therapy intern working in End-of-Life Care, the answers to the preceding statement and question have been presented in their original form in Table 5. Again, it is the desire of the researcher to explore those issues that have the biggest impact on the training of the music therapy intern. And so, the researcher chooses only to share the reactions of this section, so as not to make any assumptions or conclusions about the personal sacrifice and growth of the individuals who have agreed to share their personal stories.

**TABLE 5**

*Personal Conflicts and Resolutions of the Music Therapy Intern Working in End-of-Life Care*

<table>
<thead>
<tr>
<th>Personal Conflicts</th>
<th>Resolutions</th>
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<tbody>
<tr>
<td>Some patient’s caregivers were very controlling. I was prevented from effective service delivery because of their biases. I probably should have asked to be transferred from those cases, because I suspected the families had issues with my ethnicity and gender.</td>
<td>I never resolved them. I simply did my job as best I could and tried to work within the structure until my internship was finished.</td>
</tr>
<tr>
<td>Two major conflicts arose during my internship. Unfortunately, my supervisor and I differed greatly in personal and professional styles. Eventually, our personalities clashed. On many occasions, I resented my supervisor’s presence during my music therapy sessions. Secondly, issues related to prior personal trauma surfaced after I had worked with some of my clients. The majority of my clients had experienced some type of emotional or physical</td>
<td>My supervisor and I acknowledged our conflicts and we discussed possible solutions. We were both determined to remain professional throughout our professional collaboration. I respect my supervisor for their candor and courage in confronting me. Essentially, I accepted the fact that my personal issues existed, and I decided not to let them affect my skills as a therapist.</td>
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</table>
trauma during their childhood.

At times, becoming defensive when being questioned about my abilities due to my little experience. Occasionally when patients verbally attack my actions or viewpoints that I feel strongly about (of course would not have known my viewpoints) an internal feeling.

I was dealing with a lot of personal stress during my internship, working on the days I was not interning and taking a full course load-I was often very tired physically. Because of this I often felt depressed and low of energy.

My grandmother passed away a month before I started my internship, which caused a lot of emotional turmoil for me working with end-of-life cancer patients. I would say the conflicts/issues in my personal life would always be experienced for me in countertransference, and I would have difficulty keeping the session flow.

Reflect and working through them with reflection and introspection. Also, talking and reflecting with my supervisor, peers, etc. Silence, prayer, relaxation. Also, continuing to distance my personal feelings from what the pts are going through.

It was difficult to resolve my scheduling conflicts because they were unavoidable-I had to work in order to afford living expenses. I often sacrificed hours at my paying job if I needed rest in order to stay healthy physically and mentally. However, this in turn caused more financial stress! I did my best to leave these stressful thoughts outside when I entered the hospital each day.

I was able to get to a place where I was really taking time for myself, really nurturing and letting myself grieve outside of the internship, and just keeping a separate place for my feelings to come out, rather in the session. Of course, I still felt emotions and reactions, but I was able to provide music therapy for the patient without focusing on what I needed.

Did your internship ever cause conflict in your personal life? If yes, please explain.

Regarding this question, there were many different responses, including 67% of participants stating that the internship had not caused any conflict in their personal life and 34% stating that it had. Some of the conflicts mentioned were: financial strain, being far away from family and relationships, making it difficult to find time for self, bringing up hurtful past experiences, and losing friends.
Death and Dying

Have you ever been with a patient who died while you were in the room? If so, please explain your personal reactions to this.

This may be one of the most profound experiences of the music therapy intern working in End-of-Life Care. To witness the death of a patient is an extraordinary experience. It is one that sets the music therapy internship in hospice/palliative care apart from all other music therapy internships/populations. Fifty-four percent of participants had been with a patient who died while they were in the room and 47% had not. Because the researcher appreciates the individuality of this circumstance, the statements made by those interns who answered “yes” to this question are presented in their original form with no interpretation:

Hard to put into words. I felt relaxed, scared, awed, grateful, sad. I was able to appreciate the peaceful death and provide comfort to the family. I was glad I could be there to provide a peaceful transition for the patient and family.

It was the most amazing experience. I had been working with this patient for 5 months. He was alone on our in-patient unit. I sang 2 songs and he died. I feel as though he chose to die with me in the room. It was beautiful and peaceful. I was able to relay the information to his family.

In fact, for about 3 weeks, patients either died while I was in the room or minutes after I left. The first time it happened, the family was present in the room and unbeknownst to me, the patient was imminent. The nurse came in to check on
them and the patient died during the last verse of the last song I played. The family wanted their privacy, so I left to go process what just happened. The more I thought about what happened, the more beautiful it seemed-being surrounded by family and music as you leave this world.

The first time this happened was towards the beginning of my internship. I had never seen anyone die before and the impact on me was profound. I was very nervous and had to struggle not to cry. Luckily my supervisor was leading the session, so I could take a backseat when I needed to. I remember that as the patient’s heart rate slowed, my heart began pounding faster and louder-I almost felt like my own body was grasping at life while the patient was dying. I cried for a long time after the session, feeling the weight of the loss of life. At the same time, I felt honored that the family had involved us to share in such an intimate time.

After considering and exploring, in depth, your own attitudes about life and death, how has this changed or not changed your work with the dying?

Again, with this question, a common theme of growth was found throughout statements made by participants. Many stated that their own attitudes about life and death have changed to appreciating every day a little more:

I feel that it’s through working with the dying that motivates me to live more-I take more chances in my life. Life is short and the last thing I want to be saying at the end of my own life is, “I wish I would have...”
For some, the exploration meant a professional growth as they began to appreciate more
their role as a music therapist in the final moments of a patient’s life:

*I think confronting my feelings about life and death has helped me to become
more loving and caring in my work. In the end, there is not much I can do for a
dying patient other than offer them the gift of music and to love them when they
are suffering.*

One participant reported that fears of death have decreased, while another states that their
views haven’t really changed, only they have grown more compassionate for the patient
and family facing death.

**Does the awesome responsibility of providing music therapy to a dying person ever
scare you? If yes, please explain.**

Forty percent of participants answered “yes” to this question and 60% answered
“no.” There was a common theme of being scared about the fragility of the situation
among those who answered yes. None of the participants reported being scared about
seeing a patient die, but rather, scared about their role and the effect the music may have
on the family and the patient. One participant states:

*Music can be very intimate and a person never knows the effect music can have.

It may relax the patient or agitate the patient.*

Other fears that participants reported were the fear of a guitar string breaking, the voice
cracking while singing, choosing the wrong song, becoming overwhelmed by the grief of
the family, and playing music that is beneficial, not harmful, to the patient’s needs. One
participant found a way to use the fear in order to provide more effective music therapy:
Yes! But I think it's scary in a good way because I'm constantly reminded of the impact we have on people's life (and death). I am at times scared by how quickly patients and families latch on to me (and other staff) for support. You are an important person at a unique and vulnerable time in their life, but at the same time, it's just my job (or internship). What consumes their whole day-thoughts, priorities, etc. is still only my job, which sometimes instills a bit of fear in me.

Do you ever feel like you don't know what to say to a patient who knows (s)he is dying? If yes, please explain.

Seventy-four percent of participants answered “yes” to this question and 27% answered “no.” Of the participants who answered “yes” to this question, many stated that, at times, they could just not find the right words to say to someone who knows they are dying. In these cases, many reported that they were grateful to have the music to support communication at these moments in the relationship. The following excerpt was written by an undergraduate completing a 6-month internship:

Yes, of course with my minimal experience in hospice, there's no way I know what to say in every situation. I feel especially unsure when talking with patients who have a faith background that I am unfamiliar with because I do not know what they find as a comfort. It is in these very situations that I am so thankful to be able to use music as a tool and medium for connecting with patients. When there aren't words to be said, music can fill the silence and create a safe space.

Another concern was not having enough experience with this type of verbal interaction:
Yes. I really didn’t have many experiences like that. Many of my patients who died were non-verbal so I would probably have been at a loss for words with a patient who talked openly about their impending death.

It appears that the more participants experienced this difficult circumstance, the more they learned about how to become a better listener and how to use the music when there are no words. The following is an excerpt written by a post-baccalaureate completing a 9-month internship:

In my experience, people who know they’re dying are either coming to terms with it and accepting it or they’re angry. In both of these, I’ve found that active listening is very helpful. Using statements such as, “it sounds like you feel ______ because you want/don’t want ______.” A lot of times, it helps to just validate how a person is feeling about their situation.

Have you ever gotten too fond of a dying patient and had difficulty controlling your feelings? If yes, please explain.

Fifty-four percent of participants answered “yes” to this question and 47% answered “no.” There are many different circumstances with which the participants reported their difficulty controlling their feelings. Some stated that they found it hard to control their feelings when the family of the patient was present and grieving. Others found it difficult when the patient reminded the participant of themselves or someone close to them. One participant states:

I have. The first patient I had who died. It was fairly difficult and I had to talk to my supervisor often. Going to the facility for the first few times afterwards to see
others was hard. I felt sad, knowing she had breathing difficulties, and it was harder to make it smooth for her.

And while participants revealed their circumstances, at the same time, also shared that they felt it was okay to reveal their emotions to the patient and the family:

Yes in that when the family was around. I saw their grief and felt their sadness at losing such a fun family member. Sometimes, I think tears help a family. If a therapist is completely stoic it could be viewed as cold, especially if you have a relationship with the family as well. Of course sobbing uncontrollably would be harmful to the goal of the therapy session as well as inappropriate!

Other participants stated that they would wait until they were alone to cry or grieve for the loss of the patient:

Yes, once I got attached to a young woman, just a few years older than me. She shared so much with me-her thoughts, fears, hopes, and dreams. I found myself holding onto an unrealistic hope that she would get better. When she died, it came as a shock and my grief was profound. It took a lot of time and self reflection to deal with it. That being said, I was always composed in front of the patient and her family. It was when I was on my own that I became a puddle.

Have you ever had a feeling of disgust at the thought of being around a person who is dying? If yes, please explain.

Seven percent of participants answered “yes” to the question and 94% answered “no.” However, feelings of disgust did not stem from the actual death or dying of the patient, rather from the conditions that participants were, at times, exposed to. Those
who answered “yes” to this question shared that smells and appearances made their stomachs turn, and therefore they felt disgusted. The following excerpt was written by an undergraduate completing a 7-month internship:

Yes and I felt bad for those feelings. There was one or two people who were not taken well care of, and usually not kept clean. Breathing in the room was difficult because of odors, and I felt disgusted to get close to them.

What are some techniques (journaling, songwriting, etc.) you use to process the experiences of your internship?

Self-care is an important aspect of the music therapy internship, that, at times, must be learned. Table 6 illustrates all of the techniques, reported by the participants, used to process the experiences of working in End-of-Life Care.

TABLE 6
How the Music Therapy Intern Working in End-of-Life Care Processes Experiences

<table>
<thead>
<tr>
<th>Physical Exercise</th>
<th>Self-Reflection</th>
<th>Social/Spiritual Support</th>
<th>Creative Arts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spending time outdoors</td>
<td>Journaling</td>
<td>Church</td>
<td>Mandala</td>
</tr>
<tr>
<td>Physical Exercise</td>
<td>Self progress/Evaluation</td>
<td>Meditation</td>
<td>Artwork</td>
</tr>
<tr>
<td>Skydiving</td>
<td>Off-site Counseling</td>
<td>Death Ritual</td>
<td>Poetry</td>
</tr>
<tr>
<td>Bungee Jumping</td>
<td>Mentorship</td>
<td>Praying</td>
<td>Songwriting</td>
</tr>
<tr>
<td>Getting a tattoo</td>
<td></td>
<td>Talking with friends and family</td>
<td>Playing Guitar</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Talking with co-workers/supervisors</td>
<td>Improvisation</td>
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</tbody>
</table>
Had your internship only required a 6-month commitment, would you have felt as prepared to begin working as a professional? If you answered “no,” please explain in what areas you felt unprepared.

One of the focuses of this research was to compare the experience of those interns who completed the internship within a 6-month time frame with those who completed the internship within a 9-month time frame. This question received surprising answers, to the researcher, from those who completed the 9-month internship. Of the five participants who completed the 9-month internship, 3 were graduate status, 1 was post-baccalaureate status, and 1 was undergraduate status. Below are their responses:

No. Emotionally and repertoire (however, repertoire is ever expanding).
Hospice is very emotionally demanding and it is very important to have people you trust/work with to support you.

No. No one area—I was part-time so I needed the full 9 months.

No. I had different supervisors. However, I feel that if I’d had the second supervisor for my whole internship, with supervision and feedback, I would’ve been prepared in 6 months as opposed to 9.

Yes. If it was full-time, 40 hours a week.

No. It just seemed for me that I was feeling like I was growing into myself as a therapist and able to take my supervisor off the pedestal I had kept her on, and I
was finally able to be my own complete self, with my own interventions, without second-guessing how I did something that may not have been the way my supervisor would have advised.

While there was a significant finding with regards to those who answered “no” to this question, it was the assumption of the researcher, based on personal experience, that there would have been more of a significant difference between 6 and 9-month music therapy interns working in End-of-Life Care. And while some of the statements above reflect the need for more time in order to grow, others felt that had their internship been full time or had they received the proper supervision, they would have felt as prepared completing a 6-month internship. The researcher can only base her assumptions on that in the last three months of the internship, she did the most growing as a new professional. But perhaps, because of the seriousness with which one must approach this kind of work, self-exploration and skill develop more quickly.
DISCUSSION

Summary and Implications

In the previous section, data was presented in its original form, with little interpretation, so as to ensure the integrity of the research and to provide the reader with a candid view of the personal experience of the music therapy intern working in End-of-Life Care. However, in addition to giving a personal “voice” to participants, the aim of this study was to also gather information about the experience of this unique time during the music therapist’s training. And because the literature is lacking in terms of the development of the music therapist and personal reflections by those completing their internship, the following section is meant to provide the reader with a more complete understanding of the intern’s experience. In addition, implications for the training, supervision, and self-care of the music therapist are addressed.

Satisfaction and Preparedness

With 87% of participants stating that their internship was a life changing experience, it can be assumed that the music therapy internship impacts greatly on the individual both professionally and personally. Overall, participants seemed satisfied with their experience during their internship. It was clearly a challenging endeavor, to many, but with 75% of participants stating that they will seek music therapy employment in End-of-Life Care, the music therapy internship must have provided the support and guidance needed to make future professional decisions.

The levels of preparedness for working in End-of-Life Care varied greatly. Some participants had experience in both music therapy and non-music therapy related hospice work. Other participants touched upon the subject in school, while others had no
experience working with the dying. Overall, while many participants felt as though they possessed preliminary music and counseling skills, mostly learned from practicum and education, there was a strong theme of desiring more experience and knowledge of music therapy at the End-of-Life before the internship. Whereas most music therapy students are receiving comprehensive instruction on how to work with children, psychiatric patients and geriatric patients, only few undergraduate programs dedicate specific coursework to medical patients. Given that music therapy in End-of-Life Care has become a fast growing field, should undergraduate music therapy training programs begin to include instruction on this topic to reflect this growing job market? Should the undergraduate student be trained for work in End-of-Life care or should this be considered advanced level practice and, therefore, require graduate level training?

There is much to be implied by the current research study for students, professionals, and educators. To begin, more education and training in End-of-Life Care must be addressed in school curriculums. Working with dying patients is so unique, as are the skills needed to offer effective music therapy. In addition, many issues such as ethnicity and culture become very sensitive at the end-of-life. As seen in one of the statements made by a participant, it is important for all music therapy interns, despite population or clinical site, to be aware of and address cultural issues and biases that may negatively affect their work with patients or clients. Multicultural awareness should be an important part of the academic and clinical training of music therapists. In addition, many multicultural issues can be effectively addressed in supervision.

It seems that most of the skills and competencies, needed to work in End-of-Life Care, are learned at the clinical site. However, to help better prepare students, this
subject must be acknowledged in coursework alongside of the general populations usually focused on. Furthermore, students desiring to work with this population felt as though they were not emotionally prepared for what they experienced. More needs to be addressed, in coursework, with regards to coping skills and how to process experiences of the music therapist.

*Death and Dying*

For the most part, participants shared that they experienced some change in their views on dying. Common themes found in this area were: a deeper appreciation for each and every day, not waiting around anymore and taking chances, appreciating friends and family more, relying on faith and spirituality, finding the beauty in the passing of a patient or loved one, and not being so afraid of dying. Furthermore, it seemed as though, with this change in attitude about death, participants gained a deeper sense of compassion and understanding for family members of the patients they treated. Many stated that it became easier to empathize with a family after gaining a more complete understanding of how death impacts everyone. Only 14% of participants reported that they experienced no change in their views about dying and no further explanations were given.

For those who witnessed the death of a patient, responses were very similar with regards to being unable to really describe what they saw or how they felt. As those who work with the dying know, witnessing this passing of life every day, is not something you get used to, just something you get more used to. However, the data definitely revealed a universal theme; appreciating the beauty and sadness, while also, at the same time, feeling scared and excited, was a common theme found in statements made by those who witnessed this extraordinary part of the end of life.
Preparedness at End of Internship

Because of the reasons mentioned in the literature review, some of the questions were analyzed comparing those who completed the 6 and 7-month internship with those completing the 9-month internship. Despite the finding, regarding level of preparedness, that 27% of participants completing the 9-month internship (34%) answered “no” they did not feel prepared, it was to the researcher’s surprise that reasons for this reached beyond preparedness. Some of the 9-month interns felt that if they had been full-time instead of part-time they would have only needed 6 months to feel equally prepared. Another stated that if the proper supervision had been given, 6 months would have been an appropriate amount of time. This is rather interesting because it seems that the level of skill and knowledge one must acquire when working with this population would require more training and experience. All music therapy interns must complete the same amount of required hours so that they have equal opportunity for training and experience. However, given the opportunity to spend a longer amount of time at the clinical site, especially in End-of-Life Care, may provide the intern with more opportunity to grow and explore as their own therapist in a supervised environment. Furthermore, the level of self-exploration and intensity required for this type of work indicates a higher level of maturity, perhaps found at the graduate level. Yet, only 3 of the participants who indicated a 9-month internship were graduate students. In addition, it was clear to this researcher that many of the statements made by those completing the 9-month internship were, in some cases, more profound and deeper than those of the other participants. This leads the researcher to assume that a deeper experience is not a function of level of study. However, the researcher concludes that each music therapy intern learns and develops in
their own way, in their own time. Based on the findings of this survey, it is clear that length of internship is not the most important contributing factor to the intern’s perception of preparedness. It is clear that other factors played an important role in the growth process and perception of effectiveness of the music therapy intern. Because the response rate from those completing a 9-month internship was much lower than those completing the 6 and 7-month internship, to draw any definite conclusions would be misleading.

Seventy-five percent of the participants stated that they did not have any doubts, at the end of their internship, about their ability to be an effective therapist. Furthermore, 74% stated that most of the time they did not feel anxious about becoming a music therapist and working in End-of-Life Care. Several factors, potentially contributing to this feeling of effectiveness, could be distilled from the responses: a supportive supervisory relationship, efficient time management, positive experience with other staff outside of the music therapy department, multiple family interactions, learning a vast amount of repertoire, familiarity with stages and etiology of diagnoses, time spent developing music skills, and learning effective coping mechanisms.

Musical skills

Despite the overall feeling by participants that there was always more music to be learned, it appears that most felt like they had learned a sufficient amount and variety of music and gained a deeper understanding of how to adapt particular instruments at the bedside of the dying patient, mainly the piano, voice, and guitar. The issue of repertoire was mentioned in many answers of the participants. And while participants acknowledged that it was ever-growing, this could be an area that clinical supervisors and
educators may be of great help. During the researcher’s music therapy internship, a hospital songbook, containing over 50 songs, was given to her at the beginning of her clinical work. The book was not used in every session, but was a valuable source to have for groups, to use with patients who couldn’t think of music they wanted to listen to and for family members who wished to participate in music therapy sessions. In addition, some participants mentioned that they were encouraged to use a range of instruments and styles during the internship, and found this expanded their musical capabilities.

*Coping Skills*

While some participants struggled with the continuous loss of patients, there appeared to be an overall sense of healthy coping skills and processes for dealing with these losses. It is not surprising that many relied on their own skills as a musician to help process their experiences. All too often, music therapists forget to use their own craft to help deal with difficult cases. The participants in this study clearly appreciated that music could also be *their* therapy. As could be expected, participants reported that they sought counseling and supervision outside of the clinical site. In addition, it is only with absolute gratitude to her supervisor that the researcher considers the amount of hours she spent writing about her own personal experiences. Journaling happened to be the most cited process, by participants, for dealing with experiences from the internship.

*Supervision*

Most participants seemed to rely on supervision more towards the beginning of their internship. And, as they began completing more tasks independently, they came to rely more on their supervisor for only feedback and suggestions regarding difficult cases. Feiner (2001) states “part of the individuation process is having issues come up. Expect
them to emerge as a result of the intern’s past experiences and as a push for separation in the present” (p. 111). Fifty-four percent of participants agreed that they did not wish, at times, that their supervisor could be in the music therapy session to lend a hand.

As the supervisory relationship was analyzed, the following themes reoccurred throughout statements made by the participants about their supervisory needs: having a flexible supervisor, being available to answer questions, being able to observe the supervisor leading a music therapy session, giving supportive critiques, and sharing their (the supervisor’s) personal experience. Because the End-of-Life population is not generally a focus in music therapy education, participants agreed that they found articles and papers, given to them by their supervisors, very helpful.

For some participants, the supervisor was a model for which they could learn from and then decipher their own style and presentation of music therapy. Furthermore, at the end of the internship, 81% of participants viewed their supervisor as a peer/colleague. Referring to the end of the internship, Feiner states “there is a greater feeling of mutuality and reciprocity between supervisor and supervisee” (p. 112).

Again, many participants relied on their supervisors for support, feedback, and resources. Being available seemed to be the most important aspect of the supervisory relationship. In addition, most participants felt a natural change in the relationship with their supervisor as they became more independent. This aspect of the supervisory relationship is obviously unique to every individual. Some participants felt confident going out on their own, while others needed more support from their supervisor.

It is important to understand the intern’s phases of individuation in the supervisor-intern relationship and how they relate to the ways independence is asserted...it is
also important to be aware of when the intern shows signs that there is difficulty with the individuation process” (Feiner, 2001, p. 113).

The implication here, seems to be, that the clinical supervisor must be very attuned to the growth level and comfort of the supervisee in order to allow them to grow professionally and personally. In addition, supervisors must know, according to the individual, when to encourage independence and when to help interns acknowledge that they still need guidance.

Meeting times for supervision varied greatly, but most participants felt that they needed to be in contact with their supervisor at least once a week for both discussion and observation. Of great importance for the supervisor, in addition to the preceding, is the awareness of the emotional stability of the intern. Stress, personal loss, confused emotions, and conflict with the supervisory relationship were all mentioned as having an impact on the clinical work of the intern. The supervisor must continually “check-in” with the supervisee, both professionally and personally.

And finally, 34% of participants shared that the internship did have an impact on their life outside of the clinical site. It appears that relationships were one of the most affected aspects by the internship. Some participants stated that it was hard to maintain friendships because of the lack of understanding for what they were going through. Other participants mentioned that the internship caused great financial strain and some had to work other full-time jobs just to make ends meet. Of course, this is not unique to interns in end-of-life care settings. Distance between clinical site and participants’ homes was also mentioned as causing conflict.
For future interns and professionals as well, this study revealed the important need of taking care of oneself. This includes physically, spiritually, emotionally, and professionally. Many participants stated that what they felt helped them the most, at difficult times, was being given the opportunity to take a few days off, here and there, from the clinical site. In addition, YOU NEED TO WRITE! Talking about experiences with a supervisor or counselor is, of course, necessary and effective. However, to have experiences written down somewhere, where they can be accessed later on, is essential for really appreciating growth. Furthermore, using music to help process experiences brings us closer to why we are doing this work in the first place.

Limitations

One limitation of this study was the small sample size. Of the 30 surveys sent out, only 15 were returned. The researcher had desired more equality concerning educational status and length of time spent at the clinical site. However, the survey was to be filled out by those who were close to completing or already completed their internship and potential participants may have found it difficult to fill out the survey and return it at such a hectic time.

Another limitation of this study was the response from clinical training directors. Thirty-six clinical sites were sent information regarding the research; 25 directors responded either “yes” or “no.” In addition, some training sites, identified on the AMTA website, were, in fact, inactive or had misinformation regarding contact information and addresses.

And, finally, some of the questions on the survey were not presented in such a way as to gather the most meaningful or relevant information. The researcher found, as
data was being collected, that more questions regarding the length of internship and educational status should have been included for more comparative purposes.

**Conclusion**

The personal experience of the music therapy intern working in End-of-Life Care is a phenomenon that is worthy of much research. Furthermore, the music therapy internship as a whole needs to be studied more. It is probably one of the most challenging and crucial times in the career of the music therapist. For the researcher, having the opportunity to read about and reflect on the personal experiences of the participants brought about a feeling of oneness and understanding. It would have been wonderful to have had this kind of information available at the time of her own internship. The music therapy internship is an event in the music therapist’s life that appears to have an impact on the individual both professionally and personally. However, it is important that we acknowledge that every music therapy student approaches, experiences, and completes the internship differently. It is that acknowledgement of individual experiences that allows growth and change in both the intern and the internship.
REFERENCES


APPENDIX A

The Survey

This survey is designed to gather information about the experience of the music therapy intern working in End-of-Life Care. To better understand this part of a music therapist’s clinical training, specifically those who work with the dying, such areas as counseling skills, acknowledgment of personal experience, value of supervision, and acquisition of competencies are included. Some questions require you to circle the correct answer; others ask for short essay answers. Although not required, please feel free to use excerpts from logs and session reports to answer any of the following. Your total honesty will be greatly appreciated. As explained in the cover letter, all information obtained will remain anonymous.

I. Part One

Age: ________ Sex: Male  Female

Current educational status: Undergraduate  Graduate  Equivalency/Post Baccalaureate

Highest degree earned:__________

Prior to your internship, approximately how many hours of music therapy practicum have you completed: ________

Prior to your internship, how many semesters of supervision have you had:_______

Prior to your internship, did you have any experience (non-music therapy) working in hospice/palliative care:  Yes  No

If yes, to what extent:

Prior to your internship, had you had any music therapy experience working in hospice/palliative care:  Yes  No

If yes, to what extent:

What is the total amount of time (months) you must spend at your internship:

_______ Months   _______ Total Hours
In what week (i.e., “the third week”) did you begin individual (leading without a supervisor) sessions ______

Please describe some of your future career plans:

II. Part Two

Please answer the following questions in a way that best reflects your experience. Your answers may be short answer and paragraph form. If a question does not seem to apply to you, please acknowledge that it doesn’t. Please feel free to write on the back of the survey, making sure to number your answers.

1. How well did your pre-internship practicum and coursework prepare you for working in End-of-Life Care?

2. What are some of your strengths as a therapist working in End-of-Life Care?

3. What are some of your weaknesses as a therapist working in End-of-Life Care?
4. Some therapists depend too much upon their work in order to maintain a sense of self-esteem. Please describe your own confidence level in regards to this statement.

5. What is your understanding of the physical, spiritual, social, and financial pain that an illness can mean to a patient and their family?

6. How has your understanding of the social structures of the family and the ways in which different families operate helped you treat patients at the End-of-Life?
7. How has your knowledge about the medical aspects of terminal conditions, including, probable course and individual diagnosis changed since first beginning your internship?

8. How competent do you feel regarding your abilities to deal with crisis situations that may arise during music therapy sessions, i.e., suicidal ideation, a client stops breathing, etc.?

9. Explain your confidence in using specific music therapy interventions for symptom management (e.g. guided imagery for pain relief, improvisation for relaxation).

10. A music therapist needs a vast repertoire of music to effectively meet the needs of patients. How do you feel about your own repertoire at this point?
11. What is your understanding about the use of the piano, guitar, voice, and other instruments and how they must be adapted to playing at the bedside of a dying patient?

12. There is a lot to learn about working with the dying. How did you use your supervisor as an educational resource?

13. To what extent did you rely on advice/feedback from your supervisor?

14. Are you able to set aside your own beliefs in order to meet the needs of those with whom you work? If so, what helps you to prevent imposing your own beliefs (e.g. beliefs about death) on the patient during the session?
15. Please describe some personal conflicts that may have interfered with your ability to administer music therapy sessions.

16. How did you resolve these conflicts so that they would not interfere with your abilities to work with patients?

17. Did your internship ever cause conflict in your personal life? If yes, please explain.

18. Have you ever been with a patient who died while you were in the room? If so, please explain your personal reactions to this.
19. After considering and exploring, in depth, your own attitudes about life and death, how has this changed or not changed your work with the dying?

20. Does the awesome responsibility of providing music therapy to a dying person ever scare you? If yes, please explain.

21. Do you ever feel like you don’t know what to say to a patient who knows (s)he is dying? If yes, please explain.

22. Have you ever gotten too fond of a dying patient and had difficulty controlling your feelings? If yes, please explain.
23. Have you ever had a feeling of disgust at the thought of being around a person who is dying? If yes, please explain.

24. What are some techniques (journaling, songwriting, etc.) you use to process the experiences of your internship?

25. The following question should be answered only by those interns who completed a 9-month internship:
Had your internship only required a 6-month commitment, would you have felt as prepared to begin working as a professional? Yes No

26. If you answered “no” to question #25, please explain in what areas you felt unprepared.
III. Part Three

Please indicate your amount of agreement or disagreement with each item as it is true for you currently. Please use the flowing key:

1=Strongly Disagree  4=Slightly Agree
2=Moderately Disagree  5=Moderately Agree
3=Slightly Disagree  6=Strongly Agree

_____ I can’t imagine anyone ever being free of the fear of dying.
_____ I don’t think a person should be told he’s dying. There’s no point in adding to his suffering.
_____ Being around a dying person keeps reminding me that I will also die.
_____ Being around someone who is sick or dying makes me feel proud of my good physical condition.
_____ I feel that I have enough fundamental knowledge of assessment and treatment planning to do effective music therapy.
_____ My assessment of patient problems may not be as accurate as I would like them to be.
_____ I do not feel as though I possess a large enough repertoire of techniques to deal with the different needs a patient may present.
_____ I am uncomfortable about dealing with patients who appear unmotivated to work towards mutually determined goals.
_____ I have difficulty dealing with patients who do not verbalize their thoughts during the music therapy session.
_____ I have personal doubts about my ability to be an effective music therapist.
_____ Most of the time I feel quite anxious about becoming a music therapist and working in End-of-Life Care.
_____ I alternate between feeling confident and feeling doubtful about my therapy skills.
_____ I am ready to be confronted and challenged on my therapy skills.
_____ Most of the time I feel I need encouragement, not negative feedback from my supervisor.
____ I often feel it’s a struggle just to get through supervision sessions.

____ I often feel anxious before a supervision session.

____ I feel competent and function easily using the piano, guitar, voice, and other instruments in this type of setting.

____ I feel most comfortable when my supervisor takes control of what we do in supervision.

____ I still wish, that, at times, my supervisor could be in the music therapy session to lend a hand.

____ Sometimes my supervisor is too structured and too directive with me.

____ It is important that my supervisor allow me to make my own mistakes.

____ Given my current state of professional development, I believe I know when I need consultation from my supervisor and when I don’t.

____ Regarding counseling/therapy, I view my supervisor as a teacher/mentor.

____ Regarding counseling/therapy, I view my supervisor as a peer/colleague.

____ I will seek employment doing music therapy at the End-of-Life.

____ This internship has been the biggest life changing experience for me.
Personal Experience

APPENDIX B

Initial Letter to Supervisors

Dear ____________________,

I am a master's candidate IN THE MUSIC THERAPY PROGRAM AT Montclair State University. I am doing my thesis on the experience of music therapy interns working in End-of-Life Care. There is very little literature available on the personal experience of the music therapy intern, and not any specifically on the experience of the music therapy intern working in End-of-Life Care. After completing my own internship with patients diagnosed with cancer, I realized what a life changing experience this had been for me, both personally and professionally. I believe that music therapy interns working with dying patients develop quite differently, as compared to those working with other populations. To provide music at the bedside of a dying patient is an extraordinary experience, one that seems to go beyond any level of preparedness. Because of my own personal experience, it is my desire to acknowledge and learn from those interns currently working in End-of-Life Care.

For my thesis, I developed a survey examining the experiences of music therapy interns at the End-Of-Life Care. This survey will give them an opportunity to share their experience about areas including: self-awareness, supervision, counseling skills, musical skills, and work with the dying. This survey will be sent to both undergraduate and graduate music therapy interns training at specific clinical sites for either 6-months or 9-months. Data will be analyzed using both quantitative and qualitative measures. Furthermore, no references will be made to any clinical sites at which the internships were conducted.

What I would ask of you, as the clinical training director, is to help me reach those interns who are currently completing or have already completed their internship between the months of June 2005 through February 2006. After you have gained consent from the students to share their contact information with me, I would ask that the names, mailing and web addresses, and phone numbers of these interns be sent to me in the prepaid envelope included with this correspondence. After I have received the contact information of each student, an email will be sent to them, personally, explaining the
study in further detail and outlining what will be required of them. If, for some reason, an intern is interested in the study but does not wish to have their personal information given out, I will be more than willing to send all correspondence to the clinical site through you. I must depend on you to explain the necessity of this research and inform them about the study. Please, as you inform your interns about the possibility of participating in this study, reassure them that no information will be given to or shared with their clinical training director or site. FURTHERMORE, All information collected will remain confidential. Research reports or publications will only report data in aggregate form. Finally, results of the study will be sent to them personally.

I realize and appreciate that your time is valuable and after this initial phase of the study, your assistance will no longer be required. Thank you for your time and consideration regarding my research. If you should have any questions, please feel free to contact me at 410-733-2300 or kidwellm1@mail.montclair.edu. Again, thank you for your cooperation and dedication to training.

Sincerely,

Lacy Kidwell

Cc: Dr. Joke Bradt, Thesis sponsor

Assistant Professor and Coordinator, Music Therapy
APPENDIX C

Initial Email to Participants

Dear ______________,

Thank you for taking the time to consider becoming a participant in the following study. Let me tell you a bit about myself and the research project. I am a master’s candidate at Montclair State University, in the Music Therapy program, and am doing my thesis on the experience of music therapy interns working in End-of-Life Care. There is very little literature available on the personal experience of the music therapy intern, and not any specifically on the experience of the music therapy intern working in End-of-Life Care. After completing my own internship with patients diagnosed with cancer, I realized what a life changing experience this had been for me, both personally and professionally. I believe that music therapy interns working with dying patients develop quite differently, as compared to those working with other populations. To provide music at the bedside of a dying patient is an extraordinary experience, one that seems to go beyond any level of preparedness. Because of my own personal experience, it is my desire to acknowledge and learn from those interns currently working in End-of-Life Care.

I would like to inform you about the study and what would be required of you should you consent to participate. Through four different areas related to the development of the music therapy intern working in End-of-Life Care, I have created a survey which will give you a personal voice to share your experience about areas including: self-awareness, supervision, counseling skills, musical skills, and work with the dying. This survey will be sent to both undergraduate and graduate music therapy interns training at specific clinical sites for either 6 or 9-months. Data will be analyzed using both quantitative and qualitative measures.

Before describing your participation, I want to stress that absolutely no information gathered for the study will be shared with clinical directors and that absolutely no personal information will be seen by anyone other than the surveyor. In addition, while some qualitative data will be presented in its original form in the results of the study, no identifying information will be included in the results. Furthermore, no
references will be made to any sites at which the internships were conducted. After the research is over, you may receive a personal copy of the complete findings of the research.

Once you reply back stating your interest, a cover letter and survey will be mailed to you. You will have until Wednesday, March 15, 2006 to complete the survey and send it back to me in the pre-stamped and pre-addressed envelopes. I do realize that the survey will be occurring during a hectic time for you, but I am hoping that the data collected will help those future music therapy interns with this life changing process. The data will also be helpful to you in assessing your time at the internship site, assessing how you have grown, and giving you a voice to share your concerns, needs, and reactions.

If you wish to participate, please reply back to this email stating your desire to participate. If you should have any questions, please feel free to contact me at 410-733-2300 or kidwellml@mail.montclair.edu. Thank you so much for considering this valuable research and the very necessary and special care you are providing to patients and family at the End-of-Life.

Sincerely,

Lacy Kidwell
APPENDIX D

Cover Letter to Participants

Dear ____________,

Thank you for taking the time to be a participant in the following study, THE MUSIC THERAPY INTERN WORKING IN END-OF-LIFE CARE: A STUDY OF PERSONAL EXPERIENCE. Through four different areas related to the development of the music therapy intern working in End-of-Life Care, I have created a survey which will give you a personal voice to share your experience about areas including: self-awareness, supervision, counseling skills, musical skills, and work with the dying. This survey will be sent to both undergraduate and graduate music therapy interns training at specific clinical sites for either 6 or 9-months. Data will be analyzed using both quantitative and qualitative measures.

In addition to this letter, you will find an oral consent form which provides you information about your rights as a participant. Please read this carefully before completing the survey. No signatures are required. After the research is over, you may request a personal copy of the complete findings of the research by emailing the researcher at the address provided below.

You will have until Wednesday, March 15, 2006 to complete the survey and send it back to me in the pre-stamped and pre-addressed envelope. I do realize that the survey is occurring during a hectic time for you, but I am hoping that the data collected will help those future music therapy interns with this life changing process. The data will also be helpful to you in assessing your time at the internship site, assessing how you have grown, and giving you a voice to share your concerns, needs, and reactions. In addition, you may withdraw from the study at any time. If you should have any questions, please feel free to contact me at 410-733-2300 or kidwellml@mail.montclair.edu. Thank you so much for participating in this valuable research and the very necessary and special care you are providing to patients and family at the End-of-Life.

Sincerely,

Lacy Kidwell
APPENDIX E

Oral Consent Form

The Music Therapy Intern Working in End-of-Life Care: A Study of Personal Experience

Investigator: Lacy Kidwell

You are invited to participate, as a volunteer, in a study which examines the personal reactions of the music therapy intern working in End-of-Life Care. I hope to learn how the different aspects of the music therapy internship, including specific music therapy skills and competencies, supervision, the experience of working with the dying, and the music therapist’s experience impact the individual personally and professionally. Twenty four participants will be used in this study. Benefits of participation in the study include gaining a sense of development as a music therapist both personally and professionally. Also, information gained in this study will be beneficial to the field of music therapy.

Should you decide to participate, you will be asked to complete the enclosed survey and return it within the time period identified by the researcher. After completing the survey, you may experience some feelings related to the transition from intern to professional. In addition, some of the questions on the survey may bring up some feelings of inadequacy or emotional distress. Should you experience any of these feelings, it is suggested that you seek supervision from a professional other than your internship supervisor. Furthermore, peer supervision may also help you to process these feelings. In order to minimize these risks, I, again, want to stress that absolutely no information gathered for the study will be shared with clinical directors and that absolutely no personal information will be seen by anyone other than the surveyor.

By completing the survey and sending it back to the researcher, you have given your consent to participate. In order to maintain confidentiality, your signature on a separate form will not be required.

YOU ARE FREE TO WITHDRAW FROM THE STUDY AT ANY TIME, WITHOUT CONSEQUENCE. The survey will require approximately two hours of your time. If you should have any questions regarding the study now or at any time, please contact the researcher at: 9 Dodd Street, B5, Bloomfield, NJ 07003 or 410-733-2300. If
you have any questions about your rights as a research participant, you may contact the IRB chair, Debra Zellner (zellnerd@mail.montclair.edu, 973-655-4327) or the IRB Administrator, Fitzgerald Edwards (edwardsf@mail.montclair.edu, 973-655-7781).