A CIRCLE OF LOVING AND CREATING: JOURNEYING TOWARDS WHOLENESS IN THE ARTS THERAPIES WITH CHILDREN WHO GRIEVE

by

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A Circle of Loving and Creating: Journeying Towards Wholeness in the Arts Therapies with Children Who Grieve

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Abstract

This thesis explores connections between the arts, human suffering, and healing through an in-depth examination of my personal journey as a music therapist in palliative care. In particular, it explores what I have learned about grief and healing through my clinical work with children who have lost a loved one to a terminal illness. This inquiry led me towards the articulation of a personal model of music therapy practice, rooted in a holistic view of healing, which has emerged from my clinical experiences in palliative care, and from a phenomenological analysis of those experiences.

The guiding premise behind this inquiry was not a search for ‘truths’ or causal links, but rather a search for a greater depth of understanding of the meaning of lived experiences of grief and healing in arts therapy from both the participants’ perspectives and from the therapist’s perspective. Meaning was explored in five thematic dimensions, each of which is examined in more detail in the five chapters that make up the body of the work: dissonance, wounding, healing, grieving, and love. In addition, dialogues with five bereaved children who participated in an arts therapy support group were conducted by the clinician-researcher in order to gain more insight into their experiences of grief and healing. It was discovered that the group provided a community of belonging for grieving children; a space where they felt safe, comforted, relaxed and understood.

Arts therapists have struggled in Canada for recognition of their work, and for ways to convey its meaning and depth through research to other health care professionals. In addition, there has been very little written in the academic literature about the use of music or arts therapy with grieving children. One of our greatest challenges is the translation of our experiences in music, movement, and visual imagery into words. The arts happen in the ‘inbetween spaces’--those spaces which are impossible to measure and
difficult to capture in discursive language. Meanings in this realm are conveyed intuitively rather than propositionally. In an attempt to shift from traditional positivistic paradigms of measurement, this thesis engages a phenomenological approach of inquiry, incorporating the arts as an integral part of the research process. Narratives, stories, images and poetic forms which illuminate connections between the arts and healing are used in order to invite the reader inside the world of lived experience, and to illustrate a particular way of understanding the arts in therapy and in education which promotes a holistic conception of healing.
DEDICATION

This thesis is dedicated to my love, and partner Basil Van Heerden

who has been my companion on this journey:

every step

each breath

and heartbeat

of the way.
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This thesis has been created through a process of dialogue and in the context of a loving, nurturing, and challenging community.

First of all I would like to thank my co-researchers: the children and parents who so willingly and openly shared their stories and their lives with me. I have been profoundly moved and enriched by your insights, your wisdom, and your hope. In addition, I would like to thank all of the patients and family members whose stories I have been privileged to share in this work.

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Prelude

Introduction

This thesis explores connections between the arts, human suffering, and healing through an in-depth examination of my personal journey as a music therapist in palliative care. In particular, it explores what I have learned about grief and healing through my clinical work with children who have lost a loved one to a terminal illness. This work has been a significant part of my own education, opening me up to the world within and around me, and providing me with a window into the mysteries and complexities of human suffering and healing. An integral part of the inquiry process has also been the explication of the tacit foundations of philosophy and theory which guide my practice. According to Clandinin and Connelly (2000), “the ... researcher’s experience is always a dual one, always the inquirer [observing] the experience, and also being part of the experience itself” (p.81). Therefore, in the final chapter of this thesis, I will articulate a model of practice, rooted in a holistic view of healing, which has emerged from my clinical experiences in palliative and bereavement care, and from a phenomenological analysis of those experiences.

In searching for the focus of this dissertation, I realized that I had not one burning question, but many overlapping and interrelated questions. These questions were inspired by my work in palliative care: questions about caregiving relationships, the therapeutic potential of the arts, finding hope and meaning in the face of death and grief, the power of love in healing, the grief process for children, children’s spirituality and their capacity for creativity, hope, and resiliency in the face of suffering. These interrelated themes will be explored and woven throughout the thesis. In its simplest essence, this thesis is an inquiry into healing. Healing, as it is understood in the broadest sense of the word, is a
holistic conception that encompasses physical, emotional, and spiritual dimensions: the movement of the human spirit to integrate challenging life experiences into the context of meaning that forms the embodied whole. In a palliative care setting, this kind of healing can emerge as a demonstration of our human capacity for finding hope and meaning in the face of death and grief. As caregivers to those who are dying and those who are grieving, we are called to create environments or spaces which nurture and support such holistic healing. As a music therapist in this setting, I have often witnessed how the arts can assist in creating these environments.

Although my education and professional identity is grounded in the field of music therapy, this dissertation will be framed in a larger context than my own specialized field. It is necessarily and intentionally an interdisciplinary work, blending literature, experience and knowledge from several fields: music therapy, art therapy, philosophy, aesthetics, psychology, education, palliative care, and contemplative spiritual traditions. As well, it is inevitably rooted in the uniqueness of my world view. The data which informs this dissertation comes from multiple sources and multiple perspectives: dialogues with bereaved children, discussions with the children’s parents, my own reflections as a participant-observer in the field of practice, an individual process of heuristic inquiry into my practice, a review of literature and research in the fields of music therapy, art therapy, palliative care and education, and a hermeneutic analysis of original and spontaneous songs and artwork created by grieving children. In a qualitative approach to research, multiple sources of data enhance the trustworthiness of the research findings (Merriam, 2002). Using a phenomenological lens, I will seek to illuminate the contextualized
essences and meanings of *my shared experiences in arts therapy*\(^1\) with grieving children. The role of the data in this inquiry is to illustrate the ideas and concepts articulated in the thesis; not to substantiate a particular claim or hypothesis about children, the arts therapies and grief. Phenomenological research, unlike traditional scientific research, does not seek to establish causal relationships, but communicates the personal meaning of a particular human experience by offering a holistic, rich and detailed description (Shapiro & Bentz, 1998). Building a repertoire of descriptive accounts of music therapy clinical work is particularly important in developing interdisciplin ary understanding in a field which is still struggling to establish and maintain itself within and among the mainstream disciplines of medicine, psychology, rehabilitation and education. While the phenomenological method (Spinelli, 1989) provides the overarching framework for the research approach taken in this inquiry, I will also draw on aspects of heuristic inquiry (Moustakas, 1990), mindful inquiry (Shapiro & Bentz, 1998), hermeneutics (Gallagher, 1992), narrative inquiry (Clandinin & Connelly, 2000), portraiture (Lawrence-Lightfoot & Davis, 1997), and arts-based research methods (Diamond & Mullen, 1999) to explore and illuminate the lived experience of the arts therapy process for grieving children. Narratives will be woven throughout the dissertation, reflecting the multiple voices and experiences which inform this study. Names and personal details have been altered to disguise the identity of the clients in all of the stories.

While many people seem to agree that the arts are important for our human expressions of grief—for the expressions of pain and suffering which words cannot capture—there has been very little written in the academic literature about the arts and

\(^1\) The term *arts therapy* refers to a process in which a therapist uses a variety of art forms in the context of a therapeutic relationship to address suffering and to promote well-being. Throughout the literature it is also sometimes referred to as *expressive arts therapies*, or *creative arts therapies*. Music therapy is one specialized discipline/field under this broader category of practice. Others include art therapy, dance therapy, and drama therapy.
grief. In addition, there is a need for a continued paradigm shift both in grief research and in music therapy research from quantitative to qualitative modes of inquiry (Klass, Silverman & Nickman, 1996; Langenberg, Aigen & Frommer, 1996). When we are trying to gain insight into a creative, therapeutic process such as music therapy, as well as a complex human process of suffering such as grief, a research approach which relies only on measurable, observable data is limiting (Kenny, 1989).

Although music and art therapists have gained increasing recognition in the palliative care field over the past ten years (Salmon & Rykov, 2001; Bertman, 1999), children's bereavement care is still a new area of practice for Canadian music therapists. In my literature review, I found only one Canadian-based case study of music therapy with a grieving child (Burke, 1991). At this time, I know of only two other Canadian music therapists who are doing clinical work in this area. As the field of music therapy expands, there is a need to document our development in such new areas of practice.

In the final chapter of the thesis, the implications of these findings for practice in arts therapy, health care, and education will also be considered. By sharing stories which illustrate links between the arts and a process of healing through grief, I hope to invite the reader inside the world of lived experience, and initiate the kind of dialogue that may assist not only music and other arts therapists, but also caregivers in many different disciplines—nurses, doctors, teachers, counsellors—who are fundamentally concerned with healing. I do not intend to 'prove' that the arts therapies are 'better' than other approaches to healing, but intend rather to offer an arts-centred therapeutic approach as one possibility in a multiplicity of paths to healing. Of fundamental importance in this exercise is, after all, the realization that it is not how we come to healing that matters so much, but that we make an attempt to point ourselves in that direction, and to find a path
that fits our own unique Being and purpose in the world. As Rumi, the Sufi poet said
"Let the Beauty we love be what we do. There are hundreds of ways to kneel and kiss the
ground."

In the Beginning: Seeds Planted in the Early Years

Every research inquiry emerges out of an underlying world view which shapes
how we perceive and experience the world around us. This unique and personal ‘lens’
influences our research endeavours from beginning to end (Lawrence-Lightfoot & Davis,
1997). Our place in history, our childhood years, our culture, our physical environment,
and our gender are just some of the factors that help to shape our view of the world.
However, unless we have taken the opportunity to articulate it, our world view generally
operates at a more tacit, embodied level. By thinking more carefully and clearly about our
tacit assumptions, we may gain more understanding about our responses to others, and
we may be inspired to make changes in our often taken-for-granted ways of being in the
world. Although theory and practice are always intertwined, these links can be revitalized
and made clearer through the research process. So, I will begin this thesis with a dive
inwards--an heuristic inquiry--in an attempt to explicate as much as possible the
assumptions of my world view; values and beliefs--the ‘bones’ of my own perspective--
both motivate and shape my questions and my perceptions of the answers (Moustakas,
1990). In a qualitative approach to research, the personal values and beliefs of the
researcher are not viewed as a limitation, but rather as an integral part of the context in
which the research takes place.

My childhood home was a small farming community in southeastern Ontario.
Tweed was a pretty, idyllic village with a population of 1 800 people. It was bounded by
a small lake on one end, and a river curved gently throughout the center of town. Softly rolling hills and farmland surrounded the village. It was the kind of place in which crime seemed non-existent; many people never locked the doors of their houses, and you would always meet a familiar face when you walked down the main street. Our home was a large, old stone house set on a wooded four acres about one mile out of town. I lived there with my mom and dad—who were both school teachers—my two sisters, and an ever-changing menagerie of dogs and cats. I assumed, in my middle-class, egocentric way, that most children (other than those who were clearly starving on the television in Africa) had the opportunities and lifestyle we did. The influence of these early years instilled in me a kind of innocence about the world, enabling me to see it as an interesting and rich realm which, most of the time, could be trusted. Coming from these kind of sheltered roots, I wonder what it is that now draws me towards human suffering, towards knowing more about pain and grief? Grief can be a difficult topic to immerse oneself in.

I travelled back in time to find an answer to my question:

Why do I study grief?

What is the inner space that draws me there?

Rilke called it an "intensified sky, hurled through with birds.... and deep with the winds of homecoming..."

Clover fields and corn field days,
back in time....

I wandered amongst the gentle hills; sweet with the smell of spring, and I drifted among the purple singing of the lilacs.

I wandered amongst the gentle hills; beauty of wind and sky: space, open, space to Be, space to fly.....

I curl up in a windowseat
warm, content
I am a child.

I wrote a story for the newspaper.
"The Motherless Pup".
A story about death, loss, grief, and healing.
.....my first publication.
I can't remember exactly when I wrote it... after Penny died?
Death shattered me on that 10-year old day.
Did Art help me then? Using the poetry of words to ask life's deepest questions?

Now, almost 22 years later.
I find myself embarked on an inquiry
re-search immersion in stories, in experiences... of death, loss, grief, and healing.

Why grief?

I learned to love....

and to accept that grief is a part of this human dance, of loving...
"Where-ever I go you are with me. Won't this always be true?"
We are connected.
And when the space in us is an invitation...
when we meet someone in the clear light of compassion...
opening our hearts to love like a child,

Then we also open our hearts to grief.

How shall we sing our love's song now?
In this strange land where all are born to die.
Each rock and leaf and star show how,
The universe is part of this one cry.
That every life is noted and is cherished,
And nothing loved is ever lost or perished.
(Madeleine L'Engle)

As a child I was intuitively drawn to the arts because they helped me to explore the realms of my imagination; they helped me to define my thoughts, my feelings, and my identity. From a young age, I saw things with the eye of an artist: I was drawn to the beauty of form, of colour, shape, and sound. I felt the world around me strongly; I sensed the unspoken feelings of my family members and others, and I needed ways to express
what I sensed and felt and imagined. I found these outlets in writing, in poetry, in creating my own dramatic productions and ‘art shows’, and in making music, especially in singing. I often invited my sisters and my friends to be part of my creations--I loved to share these artistic expressions. My imagination knew no boundaries; all things were possible. Creativity connected me to my gifts, to other people, and to my own spirit. In math class, however, I constantly struggled to keep up, and to understand. My comfort level and preference for artistic expression (in contrast to the logic and linearity of the standardized mathematics curriculum) started much earlier than my formal education.

Of course, the naiveté of my childhood years and ways of seeing has been tempered by time, maturity and some painful experiences, yet there is still something of this early essence of trust in me. As I speak of suffering throughout this thesis, I am always aware that I am speaking from a place of privilege and security, and that it is my privilege which gives me the luxury to reflect, and to write about my ideas. Someone living in a war-torn region--such as Afghanistan--experiencing daily losses, in addition to a lack of basic human necessities such as housing, clothing, food and medical attention, would clearly have a different perspective on grief and healing. However, to compare forms of suffering does not seem to me to be a productive task. I must write from what I know, and in my work, I have come to know that grief--even in the midst of a setting where food and shelter are abundant, and medical care is easily accessible--can bring emptiness, sorrow, pain and suffering into the lives of those it touches. I have also come to believe that how we respond to the presence of grief in other people’s lives (as well as in our own) can make a difference to the healing process.

The innocence of my childhood in the idyllic small farming community where I was raised only became really clear to me when I met my life partner, who was born and
raised in the turbulent and violent years of Apartheid in South Africa. Through sharing in his stories, I have learned much about a world completely different from my own. I do not pretend to understand his early years and experiences completely, but I do now have a better understanding of our different ways of being in the world—differences which are sometimes as sharply vivid as fresh blood drops on white snow. While he grew up knowing intimately the necessity of carrying firearms, the importance of bars on windows and locked gates around homes, I had never seen or known such things. Despite many years living in Canada and the radical lifestyle changes he has made since immigrating here, he circles the house at night instinctively to check that every door and entrance is locked before we go to sleep. He is acutely alert to movement, to light, and to sound. In a new environment, he ensures that he knows the location of exits. This is tacit knowing: the body searching out information based on the ingrained need to be alert and watchful for signs of trouble or unease. These responses, within the context of his cultural and life experiences, are perfectly natural, but I was initially surprised to discover what he was doing. His actions are rooted in a world view which does not implicitly trust the goodness and safety of the world, while I continue to be guided by a sense that home is a safe place, and most people can be trusted.

Throughout my life, I have always been drawn towards social interaction, towards building relationships and friendships with the people around me. Even as a young child I was immensely curious about people, and intuitive about their feelings. I always sensed there was a deeper world than appearances. I wondered about what lay beneath the surface of other people’s lives. Although I now consider my spiritual belief system to be more diverse, and no longer attend any church regularly, I was raised in the Christian Anglican tradition. As a child, I wondered about the existence of God, and felt drawn to a
sense of spiritual presence and connection with the outdoor world. Whether I have done so consciously or not, I think that I have always been seeking the kinds of connections that fulfill me on a level which is not simply materialistic, that goes beyond my own personal needs and desires, that reminds me of the bigger picture. This connection manifests in a sense of awe and wonder for the natural world, a feeling of vitality, a sense of compassion for other human beings, and an embrace with the Mystery and Beauty of the world around and within me. This developing sense of spirituality finds its nurturing in places beyond words and intellectual understanding: the quiet strength and wisdom I sense when I lean my back against the rough bark and gnarled branches of an old oak tree, the flash of colour on a bird's wings in the dimming summer light, the intimacy and sweetness of my partner's gentle touch, the solitude of quiet thought and reflective prayer, the luminous sweetness of cherry blossom scent in the quiet morning air, the effortless harmony of singing with an old friend whose voice blends with mine like honey, and of course, always, in relationships where I am held safe in the warmth of a trust and love that both holds me steady and gives me wings to fly.

A Call Towards The Deep: Working with Life, Death and Grief

This kind of spiritual search and journey undoubtedly led me to my current work and to my research interests in palliative care settings. My work in palliative care began when I was an undergraduate student in university. I took a part-time job as an in-home care worker for a six year old boy who had numerous physical and mental handicaps, as well as complex medical problems related to a severe seizure disorder. Jeffrey was non-verbal, blind, hard-of-hearing, and completely dependent on others for his physical care. When Jeffrey was born, his parents were told bluntly to “take him home to die.” He did
not die immediately, however, and so began a long journey of surgeries, consultations with specialists, hospitalizations and the unrelenting efforts of his parents to secure the funding and equipment needed from the Ontario government to keep their severely disabled and terminally ill son at home. Despite his many labels and limitations, Jeffrey was an engaging child, gentle and loving, and generally happy and content when surrounded by the comforts of his home and his routines. He impressed on me the power of non-verbal communication: despite his lack of verbal language, he was able to communicate very well through his body language, sounds and vocalizations which, over time, as I got to know him, became as easily discernible to me as a spoken language.

When I came to work again with children at Canuck Place Children's Hospice in Vancouver, many years after I had said goodbye to Jeffrey, I thought of him often. Perhaps it was the work with him which drew me back towards working closely with children living with chronic and terminal illnesses. My time with Jeffrey had instilled in me a sense of comfort and a knowledge of how to communicate with children who were mentally and physically limited and frequently unable to express themselves through verbal speech. Music was often a key to building a connection with these children. Indeed, at times, music seemed to be their only form of expressing their inner worlds of feeling. Music was a place of meeting, a language we could share without words. In the musical improvisations and songs we created together, it seemed that there was room for the spirit to soar beyond the limits of illness. In my work at the hospice, I also discovered the necessity of attending to my own spiritual journey. As I faced the losses of children I had come to know and love, and witnessed the grief of their family members, I realized that if I wanted to continue working in this field, I had to find ways of making sense of this suffering. I had to find ways to love and to let go.
Palliative care—whether it is delivered in a free-standing hospice such as Canuck Place, or in a special hospital palliative unit (where I now work), or in a patient’s own home—creates an environment where there is room for intimacy, room for connection, and room for the spirit to touch and to be touched. In this environment we tend to seek meaning rather than answers, and closeness rather than objective distance. It is, in a strange sense perhaps, a comfort zone for those who feel drawn towards Mystery, the concepts of Depth psychology, Depth of Being, existential and spiritual questions. In this world, we try to create spaces for the sacred to arise: in silence, in music, in the soothing rhythms of a bed bath or a foot massage, in the holding of a hand, in shared laughter, hopes and fears. In this place, we also come face to face with profound pain and the depths of human despair; we learn to honour and accept the complexity of life, human relationships, and the fact that suffering and joy, despair and hope, love and hate can exist paradoxically side by side. All of these things are part of the whole of life.

Recently, I gave a presentation on music therapy in palliative care at our hospital’s annual seminar for a group of doctors, nurses and volunteers who work in this field. While I touched on some basic statistical research in music therapy, I spent most of my time sharing stories of clients with whom I have worked—experiences which I felt exemplified the power of music, the arts, and therapeutic relationships in healing. Afterwards, many of the conference participants spoke to me on the edge of tears, and thanked me for sharing these stories, which they described as the human face of suffering and the heart of our work in palliative care. As I prepared myself for this talk, writing and re-writing the stories in many different forms, and talking with family members of these patients, I became more aware of how deeply they had impacted my life. I realized how they had become part of my way of Being, in a very tacit, embodied sense, and I began to
understand how deeply intimate moments connect us—even beyond death. For me, working in a palliative care setting is a daily opportunity to grow, to deepen my awareness of others and of myself. My world view and my way of being-in-the-world have been (and are being) intimately shaped by my experiences of working with those who are dying and those who are grieving, by the intimacy of the relationships I have developed in my work, and, of course, in my own life.

I would like to share a more personal story now—about how cancer first entered my world when I was a teenager, and pointed me in the direction of the work which is now very much a part of my life. This particular story begins when one of my dearest aunts was diagnosed with breast cancer.

Amazing Grace: Sharing a Cancer Journey

There are days now when I cannot remember a time when cancer was not part of my life in some way. But it has not always been so. Illness beyond the usual colds and bouts of flu, and the occasional broken bone, was not a part of my childhood experience. Both of my parents were healthy and encouraged healthy living for their three daughters; my mom baked her own granola, had a vegetable garden larger than the house I now live in, and insisted that we eat brown bread. My dad’s recipe for health was simply “get outside, and do something...” Exercise and outdoor activity were very much a daily part of our lives. Cancer, in those days, was a distant word, and it didn’t enter my life until I was in my late teens; my mother’s only sister—and my most beloved aunt—was diagnosed with breast cancer. Cancer has a way of altering one’s perception: what may seem like a benign, safe world can quickly become changed when someone who is close to us receives this diagnosis. “Illness is an upside-down world, a mirror image that reverses the assumptions of our normal daily lives. It can pull one into the proximity of the soul and illuminate the truth of what matters and who matters” (Bayly, 2000, p. vi).

Although my aunt Dinny lived many hours away from my childhood home in another city, she had been an intimate part of my growing up. Large parts of our summer vacations were spent at her island cottage in the beautiful rocky and pine-treed Muskoka region of Northern Ontario. During Spring Break, we would make the lengthy drive along the seemingly
endless Trans-Canada highway to visit Aunt Dinny and Uncle Don in their large gracious home in Oakville as a family. In my teenage years, I was allowed to make the three hour train journey alone; so that I could have a special visit with my aunt. She would take me out to the theatre, take me shopping (one of her favourite pastimes), and treat me to meals in fancy restaurants. While all of this was an interesting and exciting adventure, my favourite times with my Aunt Dinny were centred around our conversations in the evening. After a day of shopping in the city, we would curl up next to the fireplace, and talk for hours about our lives. Her four adult children were scattered around the world in a number of places, involved in their careers and new families. She would tell me about each of her children, and talk about my grandparents (who died before I was born), and my mom. But mostly, she would ask lots of questions about my life, my school, and my hopes for the future. Her undivided attention to my stories, and her interest in my life always gave me a feeling of "specialness" when I was in her company.

After her initial diagnosis of cancer, Aunt Dinny immediately began the traditional medical rounds of treatment: surgery, chemotherapy and radiation. I remember making her a tie-dyed scarf at summer camp to wear when she lost all her hair in treatment, and sending it to her in the mail. She held her own for several years, and we all breathed sighs of relief. However, while I was studying to be a music therapist in my fourth year at university, and ironically, also not long after I began my first student placement in the Kitchener-Waterloo hospital's palliative care unit, things took a sudden turn for the worse. My aunt's cancer had spread to her lymph nodes, and she had severe reactions to the radiation treatments, which incapacitated her greatly, and left her house-bound for months at a time. Although she had initially been trained and worked as a nurse, and was not unfamiliar with dealing with illness, she was understandably distressed and anxious about the changes in her condition.

Fortunately, she was able to get some emotional support through a nearby cancer centre where she learned to use visual imagery to assist in decreasing her anxiety and stress levels. I can still recall a conversation we had about this new technique that she was learning to help her cope with the stress of treatments, with the uncertainty, and not knowing of what was to come. She explained to me that, using her imagination, she was learning how to create peaceful places where she could go whenever she felt overwhelmed by fear or anxiety. She was thrilled with this new-found sense of peace and empowerment, and began to use meditation and relaxation techniques, in conjunction with further cancer treatments, on a regular basis.
At that time, I had no way of knowing that the methods she was describing to me would one day become an intimate part of my own work. As part of my current work at Lion's Gate Hospital in North Vancouver, I co-facilitate a relaxation support group for people living with cancer and their family members. Participants are introduced to the concepts of progressive relaxation, deep breathing and guided visualization. After a time of verbal sharing and support in our opening circle, group members lie down on mats while facilitators use words and music (incorporating the participants' suggested images) to create a visualization; a web of aesthetic beauty which supports a sense of relaxation and escape from the pressures of living with illness. A specially trained group of volunteers provide head and foot massage to those that wish it. The use of improvised live music and familiar songs which are both soothing and imagery-evoking is central to the relaxation experience.

One day, I was called back from my summer job at a camp in Northern Ontario to visit with my aunt, who was, by this time, on the palliative care unit of a hospital near her Oakville home. Aunt Dinny’s condition was getting worse, and she wanted to see me. She asked me to bring my guitar. Never uneasy about telling those around her what she needed, and what to do, her first request upon seeing me was to hear the song Amazing Grace. This was the song, she matter-of-factly informed me, that I was to sing at her funeral. She got up out of bed and arranged herself in her wheelchair; she had an IV running into her arm for hydration, and an N-G tube draining fluid from her nose. I valiantly managed to sing a few lines of the song before I collapsed in tears into the arms she held out for me; her words, murmured softly into my hair, I remember still so vividly: “Oh, you precious, precious child....”

Although she ultimately lost her battle with cancer shortly after this time, my Aunt Dinny continues to live on in me through the work I now do. Whenever I introduce the idea of relaxation through imagery to a new oncology patient who arrives, tentative and unsure at our group, I remember her joy and her sense of peace (even when it was fleeting and momentary) at discovering the powers of the imagination to soothe and ease the spirit and the body. So often, when I see the familiar soft turban worn over a newly bald head, and when I hear the tears and joys in the weekly stories of recurrence and remissions, a small part of me thinks of my aunt’s journey down this same unknown path, this journey into cancer, into the “upside-down world of illness”, and all that it brings.

And so the past leads us, pushes us into the present, and towards the future.
What is gone is not gone completely, but remains in different ways, transformed in us, and through us.

**A Story About Irene's Song: Live in Hope**

In this work,
Loss is a part of every day.
People coming and going into our lives with sudden urgency, with intensity, or with quiet grace.
We connect and then we say goodbye.
How do we make sense of these endless beginnings and endings?

Irene died on Tuesday morning.
She came, almost every week, to our relaxation cancer support group for one year.
Her weekly presence there became part of the fabric of my life.
She could so easily share all of herself: tears, anger, joy, faith, laughter, and hope....

I came home tired on Tuesday.
I felt sorrow draining my energy completely; pressing me down like a heavy weight.
This grief calls out for my attention.
It is so easy to bury our grief in "doing."
There is, after all, always another patient, another crisis, another need.

But I have learned that I need to listen to my losses.
To make space and time to honour the lives that touch mine.

Just weeks before her death; visiting with Irene in the palliative care unit,
I asked her if there was anything she would like me to say to the relaxation group.
She looked into my eyes, and said:
"Tell them to live in hope".

Then she smiled her beautiful smile.
We hugged in silence for a long time,
and finally we said goodbye.

On Tuesday night, as I took the time to sit with my sorrow.
To whisper words of thanks and goodbye into the silence,
These words, along with a simple melody, came to me.
It became a song for Irene...

   In the falling of the night...
   Softness opens up my heart.
   As I search to find the reasons,
   Why those we love must part.
Can you find a path to hope...  
In the face of all you know?  
Can you make a space for passion?  
Keep learning how to grow...

Well, I hope right now you know  
Just how much you gave this place  
And how the Beauty of your Spirit  
Touched us all with Grace.

But, you're only just a breath away  
And you know much more than I  
You taught me how to live in hope.  
You taught me how to fly....

Now, you're only just a breath away.  
And you see much much more than I  
And I really want to thank-you, Irene...  
Just for being part of my life.

For days, the words and melody ran through my mind. And as I sang it over and over—each time remembering Irene’s smile, her eyes, the intensity of her Being—I began to find some healing in her loss. Each time I sang, it was as if I was speaking directly to Irene. Speaking about her life, what she meant to me, and to others. I felt connected to her: in the bright sunlight on the day of her memorial service, in the blue of the wide open sky that she loved so much, and in the gift of the words that she left behind her: “Live in Hope.”

The music heals, if only we will hear.

Chapter Outlines

Chapter One will provide an introduction to the field of music therapy and the broader field of the expressive arts therapies. A brief overview of literature relevant to music therapy and grief will be described. Some of the current tensions and conflicts in the music therapy field will be highlighted, particularly the problems which are currently impacting music therapists practicing on the West Coast of Canada. A brief overview of research issues and methods will also be included in this chapter.

In Chapter Two, the questions and issues raised in Chapter One will be addressed
by looking at the broader social-cultural context in which Canadian music therapists' practice. Specifically, I will critique modernism—a world view which stems from a mechanistic and positivistic view of human beings and systems—and its pervasive influences on caring professions in North America. In tracing the influence of the modernist world view on our current Canadian education and health care systems, I will problematize the devaluing of our human interconnectedness and our understanding of healing in medical and educational settings as I point out how (as they are currently understood) these conceptions have the potential to distort and limit our understanding of human experience.

In Chapter Three, I will examine the connections between the arts and healing: working out the notions of wholeness in music therapy practice, and contextualizing clinical experiences within a holistic framework. I will suggest a more holistic perspective of healing and health than the traditional North American modernistic viewpoint normally allows, and describe the role of the arts in facilitating this holistic understanding of health.

In Chapter Four, I will discuss children’s experiences of grief and healing in a process of arts therapy, drawing from my clinical work, relevant literature, and conversations with bereaved children who participated in my grief support group as sources of insight. Content will be shared in the forms of dialogue, narratives, images, art, poetry, and music.

In the final chapter, I will articulate a holistic model of healing, rooted in a therapeutic view of the arts, which has emerged from my clinical experiences in palliative care. I will also summarize the emergent themes of the thesis, consider the implications of this work for caregivers in health care and education, and make suggestions for future research.
Chapter One: Dissonance
Introduction

In my ten years of working as a music therapist within the British Columbia public health care system—in psychiatric institutions, community centres, schools, long-term care facilities, hospitals, and hospices—I have often experienced a sense of incongruence between my views of health and healing, my personal experiences with and beliefs about patients, and the way in which the larger system seems to view and respond to these concerns. Our Canadian health care system suffers from problems too numerous and broad to tackle here. I will focus in the next two chapters on the tendency in medical settings to focus on ‘the disease’ which fosters an inability to ‘see’ the person with the disease. This tendency promotes both a general devaluing of holistic models of health and caregiving, and a lack of understanding about the role which music and the arts can play in health care. According to Bonny (1986), “Most modern medical practitioners ... do not see music fitting into scientific procedures which have hailed the left-brained mentality over right-brained intuitive faculties” (p.3). The profession to which I belong does not neatly fit into the borders and guidelines for patient care constructed by many institutions. In addition, as I have moved throughout the course of my formal education, I have felt this same sense of incongruence with approaches which are rooted in a positivistic, scientific world view, and which seem more frequently to emphasize the pathology of human beings rather than their complexity and their potential for change and growth. My vision and practice of music therapy, has, at times, been in conflict with other practitioners in my field, who approach their work in a more positivistic manner. In this chapter, I will provide an introduction to my specialized field of practice, music
therapy, and to the broader field of the arts therapies. I will also provide a short summary of the literature on music therapy and grief. Tensions and conflicts in the field of music therapy—in particular the problems currently impacting music therapists practicing on the West Coast of Canada—will be identified, and questions about the future of Canadian music therapy will be raised. In addition, I will provide a brief overview of research issues in music therapy, and a rationale for the methodological approach I have chosen for this dissertation.

**What Is Music Therapy?**

Music therapy is a process in which a therapist uses music in the context of a therapeutic relationship to address suffering, to promote well-being and quality of life. According to Amir (1995), “all human beings have inside themselves a musical self no matter where they live, what their handicaps are, or which culture they come from” (p.53). It is this creative aspect of the person, in addition to an understanding of what is blocking the flow of this creativity towards the person’s health, which therapists seek to connect with, and to draw out in music therapy practice. As a music therapist, I have developed skills which allow me to perceive people’s needs, as well as certain qualities in music which can connect with those needs. This linking of music directly with the patient or client’s need or health concern can assist in their recovery or in situations where recovery is impossible, and can assist in enhancing the patient’s quality of life. In addition to a specialized university degree—which includes course work in human development,

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2 When I use the word ‘art’, or phrase ‘the arts’ throughout this dissertation, I will be referring, in particular, to the fine arts—music, visual art, poetry, dance/movement, and drama. I view the arts as a form of play, expression, and communication, which emerge in an organic way out of the conditions of our human experience (Sartwell, 1995; Dewey, 1934). My own interest and curiosity about art has always been about the way it intersects with human suffering, the way in which it can be used to engage and support human beings in the process of change, transformation and healing, in the process of education which opens us up to the world.
psychology, counselling skills, music therapy theory, music therapy techniques and supervised clinical placements, it is this kind of conscious assessment and implementation which sets the professional music therapist apart from a volunteer musician who visits the hospital to give an evening concert to patients and staff. Music therapists obviously must be skilled and knowledgeable about music; and are required throughout their education to develop the ability to play a number of different musical instruments comfortably. Equally important, however, is a compassionate awareness of human suffering and an ability to listen and respond to that suffering, which is very different from the skills of a musician who is primarily oriented towards performing completed works to a large audience. The focus is not the music itself, but the client, and the ways in which music may assist them. The music therapist therefore combines counselling skills and knowledge of human behaviour and development with the ability to access his/her own creativity and musicality to encourage clients to access their own creative resources to support change and healing within the therapeutic relationship.

In a holistic approach to healing such as music therapy, "[h]ealth ... is subjective. It becomes a process of developing the emerging potential health through allowing or enabling the potential within a person to be realized through an active, creative process" (Allen, 1995, p.8). The music therapist provides an environment which supports the client’s creative expression of his/her inner life. The engagement of the client in the

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3 I use the terms ‘client’ and ‘patient’ throughout the thesis for practical purposes and for ease of reference. However, I do so with hesitancy and trepidation. I am much more comfortable with the idea of patients/clients as people with whom we form relationships and connections. I am aware of the tendency in health care to view patients as the receivers of care, while practitioners are deemed as the givers or providers of care. This view disregards what the patient gives to his/her caregivers, and implies the relationship is one-way, rather than a flow of care—not necessarily, but potentially, reciprocal in a variety of forms—between two human beings. As care flows between us, at different times in our encounters with one another, we are both the cared-for, and the care-giver; we are both nurtured and nurturer. Particularly in the care of the dying and the bereaved, we might ask ourselves the question; “[a]fter all, what, but time and vanity separates ‘us’ from ‘them’?” (Bertman, 1999, p.13).
creative process and the therapist's valuing and witnessing the client's creative expression, have been shown to have benefits which can assist the client on the path to health and healing (Bruscia, 1991; Kenny, 1995).

Helen Bonny, founder of the Bonny Method of Guided Imagery and Music and an innovative researcher in the field of music and consciousness, proposes that engagement in musical experience allows people to access varying states of consciousness. Experiences and insights gained through the music may then be brought forward into conscious awareness to assist in the healing process. According to Bonny (1994), “The music builds a field of sound which sustains focus on the inner experience and serves as both a catalyst for creative image formation, and as a container for the gestalt of feelings and images” (p.71). Bonny’s (1994) research emphasized the central role of the music in the healing process: the music acts, in essence, as a co-therapist. The therapist plays an equally significant role in the process, and this has been repeatedly noted throughout the music therapy literature (Ansdell, 1995; Bunt, 1994; Nicholson, 1999). Music has been described as a language of the emotions (Kenny, 1982). It has also been called a non-verbal language, a way to communicate which does not rely on words (Aasgaard, 2001). Music--this wordless place--can become a place of meeting and connection (Merrill, 1998). Regardless of how we describe it, the point is that music has the capacity to reach people on many levels; it is multi-dimensional in its effects (Bonny, 1986). Expression through music provides an opportunity for integration of many aspects of our life experience. Lochner (1988) described music as a connecting force which bridges the gap between experience and understanding: “With enormous affective energy, music brings together person and experience ... It says what we mean when we least know how to say it” (p.176).
While not exclusive to music therapy, the importance of expression in healing is a key theme found throughout the literature. Soelle (cited in Barnard, 1995) stated:

If people cannot speak of their affliction they will be destroyed by it, or swallowed up by apathy. ... People's lives actually depend on being able to put their situation into words, or rather learning to express themselves, which includes the nonverbal possibilities of expression. Without the capacity to communicate with others there can be no change. To become speechless, to be totally without any 'relationship', that is death. (p.22)

If we deny ourselves, or others, access to expression, we deny our own humanity (Kenny, 1982). While traditional psychotherapies have primarily relied on verbal, discursive language as a mode of expression, music and other arts therapists have made a strong case for the need to engage the whole person, including the senses, the body, mind, and soul in the expressive act. Even for the average person, who has no handicaps related to speech, what we can express in verbal language does not always touch the lived depths of our emotional experiences. Therefore, we need other modes (such as the arts) which more directly access our sensuous, embodied, and emotional experiences than verbal, rational language alone. Bai (2001) stated: "[l]anguage has gifted us a convenient means of communication, but it can rob us of the opportunities of communion, which is the sensuously grounded being-to-being connection" (p. 91). The creative encounter in the art form is one which expresses a wholeness, or a totality of our experience (May, 1975).

Wever-Rabehl (2001) pointed out that "poetry can, perhaps to some extent, precede deliberation, and thus capture the lived experience more directly" (p.126). The same could be said of music; particularly the music therapy technique of improvisation. Improvisation captures the immediacy of the moment, giving access to the lived experience before the conceptual mediation of language. The word "improvise" means to make something up as one goes along. It is the art of spontaneously creating and playing
The music therapist accepts the client's improvising regardless of artistic merit, whether it consists of musical or sound forms, and responds intuitively. Improvised, spontaneous music can function in a symbolic way: the particular choices of instruments, timbre, tone, rhythm, melody and volume act as a mirror of the client's feelings and lived experiences at a given moment in time. The method is not one-sided, however, but inherently dialogical. Unlike particular verbal approaches to therapy, in which the therapist sits at a distance from the client and says very little, or certain approaches to art therapy, in which the therapist witnesses the client making art but never joins her in the art-making process, the music therapist usually enters into the play, into the music, with the client. The musical improvisation is ultimately a co-creation, a dialogue that develops out of the interplay between therapist and client.

There are many groups of people (i.e. young children, elderly persons with dementia, adults with multiple disabilities, etc.) for whom language and speech are an inadequate, limited and sometimes impossible means of communication. Participation in music therapy does not require one to have particular cognitive, language or motor skills. Music therapists are able to adapt both music and verbal interaction to meet the particular needs and comprehension level of each client. But the range of clinical practice is extremely broad; while some music therapists work solely with severely impaired, non-verbal clients, others work with clients who have no identified physical or mental handicaps, but want to focus on exploring personal issues using a therapeutic method grounded in the creative process. In clinical practice with children, the uniqueness and suitability of music as a medium for communication comes to the forefront. Most children are not afraid of music, as many adults are. They have not yet learned to be critical of their singing voices (Campbell, 1997). They worry less about perfection, and are more
open to ‘playing’ with different sounds and instruments until they feel satisfied with what they have created. Children also often express their dilemmas and conflicts through symbolic means, rather than through direct verbal communication (Oaklander, 1988; Webb, 1993). Music therapy, like art therapy and play therapy, can thus be an important form of expression and communication for children. Nordoff and Robbins (1971) suggested that “[m]usic is a language, and for children it can be a stimulating language, and a consoling language. It can encourage, hearten, delight, and speak to the inmost part of the child” (p.238).

Although music has been used in conjunction with healing practices throughout history, the formal development of the profession of music therapy is still relatively new. Music therapists in training and in practice are trying to learn about a field of study which is still trying to find out about itself. We are a young field still in the process of becoming (Bruscia, 1989). In Canada, the first educational program for music therapists began at Capilano College in British Columbia only twenty-five years ago. It is now possible to obtain a Bachelor of Music Therapy degree at four Canadian universities. A new program has just been established at Acadia University in Nova Scotia (the first on the East Coast), and a Masters’ program is set to begin in September, 2002 at Wilfrid Laurier University in Waterloo, Ontario. It is only in recent years that one has been able to train at a graduate level as a music therapist in Canada. Prior to this, if one wished to obtain advanced training in music therapy, one had to move to study in Europe or the United States. The first Canadian music therapy students are only now beginning to graduate with doctoral degrees from Faculties of Education and Psychology.

The diversity of music as a therapeutic tool, along with the generalist training of those who obtain music therapy degrees, lends itself to adaptation and clinical work in a
wide range of settings. The successful use of music therapy has now been documented for the elderly (Bright, 1981; 1988), for persons with psychiatric illnesses (Priestley, 1994; Tyson, 1981), for mentally and physically challenged adults (Bruscia, 1991; Boxill, 1985), and for persons living with life-threatening and terminal illnesses (Aldridge, 1995; Munro, 1984; Salmon, 2001). The literature on the use of music therapy in palliative care reflects how music has been used effectively in pain management (Magill-Levrault, 1993; Magill, 2001; O’Callaghan, 1996), anxiety management (Gross & Swartz, 1982), and to enhance patient communication and self-expression (Aldridge, 1999; O’Callaghan, 1993; Salmon, 1993). Throughout the literature, one also finds references to the importance of music in spiritual care for those who are terminally ill (Aldridge, 1995, 1999; Salmon, 2001; West, 1994). The effective use of music therapy has also been documented with special needs children in a variety of educational and therapeutic settings (Herman & Smith, 1988; Nordoff & Robbins, 1971), and for children living with chronic, life-threatening and terminal illnesses (Aasgaard, 2001; Daveson & Kennelly, 20001; Robb, 1999).

The field of Canadian music therapy is broadening and developing as more music therapists gain clinical experience and complete advanced education. In addition, there is an increasing awareness for the need to define and root our clinical work in theoretical models which are arts-centred, rather than accommodating ourselves to the predominantly verbal language of traditional psychological therapeutic approaches, or the objectivism of the medical profession (Aigen, 1996; Kenny, 1989; Merrill, 1998). It is, however, necessary for music therapists to maintain a relationship to and an awareness of these disciplines (Ruud, 1980). Increasingly, Canadian music therapists in some areas of clinical practice are moving away from activity-based models--rooted in the tenets of
behaviourism and recreationally-oriented therapies— and embracing more process and aesthetic models of practice, which are more closely linked to an awareness of music as an ancient healing source, and to the conceptualizations of Depth, existential and transpersonal psychology. These approaches to psychology have not severed their connection from the original meaning of the word therapy, which is “care of the soul,” and lend support to the concept of the arts as one important way of attending to and caring for the soul (McNiff, 1981). In contrast to Freudian theoretical views (which have had far-reaching influence on the practice of psychology) of the arts as a flight from reality, or as a manifestation of pathological conditions, a healing view of the arts is grounded in a recognition of the arts as reflecting what is meaningful and sacred in human life and experience. The process and depth-oriented approaches to Canadian music therapy are particularly evident in the clinical areas of music therapy in dementia care (Merrill, 1998; Summers, 1999), palliative/oncology care (Nicholson, 1999, 2001; Salmon, 2001), and the combined use of imagery and music in the treatment of trauma, pain and abuse (McMaster, 1996; Moffitt, 1991; Nicholson, 2001; Purdon & Ostertag, 1999). However, in many respects, our practice is ahead of our research and literature. There is a need, not only to increase the quantity and quality of our writing and our research, but also to find a language and a research approach that can embrace and communicate to others the ambiguity and complexity of artistic, therapeutic processes (Aigen, 1993; Kenny, 1989; Langenberg, Aigen, & Frommer, 1996).

**The Arts Therapies**

Arts therapy is a process in which a therapist uses a variety of art forms in the context of a therapeutic relationship to address suffering and to promote well-being.
Clients are invited to explore their experiences with the therapist through the medium of an art form (Cattanach, 1999). Throughout the literature the terms “expressive arts therapies” or “creative arts therapies” are used interchangeably to refer to this broader category of practice. Music therapy is one specialized discipline under this broader category of practice. Others include art therapy, dance therapy, drama therapy and poetry therapy. Although these disciplines share common philosophical ground in the presupposition of art forms as intrinsically healing and therapeutic, each specialty generally maintains separate educational, professional, and accreditation programs and standards.⁴ There are a few exceptions to this—some American programs offer a Masters’ degree in Creative Arts Therapies (e.g. Hahnemann University in Philadelphia, Lesley University in Cambridge, MA). Currently, in Canada, it is possible to obtain a degree and receive professional accreditation status in only two of these disciplines: music and art therapy. Students interested in pursuing degrees in dance, poetry or drama therapy must travel to the United States or Europe for their education. Generally speaking, the professions of the creative arts therapies are more widely established and respected as treatment modalities in Europe and in the United States, than they currently are in Canada. This may be attributed to a longer history of practice and education in these countries.

I often use the term arts therapy (rather than music therapy) when describing my work, to emphasize the interdisciplinary nature of my own approach. In clinical work with grieving children, in particular, I frequently use as much visual art as I do music. As well, for younger children, combining music with movement in a session is usually a very

⁴ One of the differences in the training for music and art therapists is that music therapy education is more discipline-based than art therapy education. Art therapists do not necessarily have to be accomplished artists (although they often are), in order to obtain an art therapy degree or diploma. Music therapists, however, even prior to acceptance into a degree program, must be accomplished musicians, able to sing and/or play at least one musical instrument at a minimum of a Royal Conservatory Grade Eight standard.
natural connection. When we combine all of the arts, we offer clients increased opportunities for expression, insight, and for connection. I have sometimes been asked by other hospital staff members what I would do without my guitar in a session. If music is not required or appropriate on a given day with a particular patient, I may use other artistic media, or rely solely on verbal counselling skills, listening in order to respond to what is needed. In fact, with some patients, I find that music is not only inappropriate, but also not the artistic medium which has the most appeal for them. In addition, there are times when music may be contraindicated; for instance when a patient is feeling extremely fragile emotionally, they may find the presence of live music too overwhelming.

Nicholson (1999), a music therapist who specializes in oncology and palliative care, cautioned that music therapists need to be sensitive to and respectful of the emotional vulnerability of their clients. In her Masters' research—a study which explored the meaning of music therapy for cancer patients—Nicholson (1999) affirmed that “[p]articipants spoke of the importance of music in enabling emotional release, but that this needed to occur in an environment where people felt safe in expressing their emotions” (p.56). The potential of music to evoke such strong, emotional responses must always be acknowledged.

Eve was an elderly woman who was suffering with a combination of extreme arthritis pain, grief and depression over the recent loss of her husband, and her consequent move from their apartment to a nursing home. When I first met her, she was spending a lot of time alone in her room, struggling to deal with her losses and her pain. Although she was very open to talking with me, Eve did not want anything to do with music. She had recently had a very negative experience in which an enthusiastic care aide had, against her wishes, wheeled her into the facility common room to hear a live concert, and left her there. Due to the crippling arthritis in her hands, Eve was unable to wheel herself away. The live music (performed by a well-meaning group of volunteer musicians) triggered a devastating grief response for her. She was able to tell me about this, and in the ensuing months of the
sessions we spent together, I focused on supporting her grief, by listening and by talking with her. She also became willing to try some guided imagery with me, which became very useful for her in facilitating a sense of relaxation and temporary relief from her chronic arthritis pain. Eventually, Eve showed interest in joining a small support group I facilitated—where I used a combination of creative arts and dialogue to create a space where the elderly residents could share their experiences of aging, and talk about their multiple losses. As Eve became a dedicated and active member of this group, she began to connect with other women in the care home, and she no longer isolated herself in her room.

When someone says the word “art,” we generally imagine a painting, or a sculpture, a dance performance or a piece of music; we think of the finished product. In order to broaden our conception of what art is, we might try to understand it as a kind of behaviour fundamental to our human nature: a way in which human beings define what they care about, and a way of finding meaning in experience. By embellishing, shaping, transforming and exaggerating the natural elements in our world, we create something out of the ordinary which reflects something of importance to us. Dissanayake (1992) labeled the core, defining feature of a behaviour of art as “making special.” The act of creating art has frequently been described as therapeutic and healing, as “medicine for the soul” (McNiff, 1992, p.1). Art allows us to speak the unspeakable, and to make visible what is otherwise invisible (Greene, 1995). McNiff (1989) suggested that the transformative energy of healing and art are one and the same. In a process of art therapy, “the medicinal agent is art itself, which releases and contains psyche’s therapeutic forces” (McNiff, 1992, p.3). The arts have the potential for bringing form into chaos, and thus offer the potential for hope. “Even in the midst of suffering, it is possible to create something that is beautiful. This aesthetic expectation of self-in-relationship is positive; it is hope made manifest” (Aldridge, 1995, p.107). From a place of hope we may achieve a sense of transcending or transforming our immediate situation by extending ourselves to find new
perspectives (Aldridge, 1993). Jevne (1991) pointed out that hope is frequently found in symbolic realms, and that music can be a particularly powerful mode in the generation of images of hope.

The arts therapies have flourished in certain areas of medicine in recent years, particularly in the field of oncology (cancer care) and in palliative care (care for the terminally ill and their family members). There is a general recognition in these settings that the arts therapies can provide alternative forms of communication and expression in situations where words fail to capture the emotional depths of patients’ and families’ experiences (Bertman, 1999; Rykov & Salmon, 2001; Sheldon, 1997). Jevne (1991) stated that “[m]any cancer hospitals ... have begun music therapy programs. Research is now confirming the benefits” (p.167). Nicholson’s (1999) research on music therapy in cancer care concluded that it can be helpful for pain and symptom management, emotional and spiritual comfort, building and strengthening community, promoting health maintenance, and providing aesthetic sustenance. With a diagnosis of cancer, each person faces “a time of danger, and a time of potential transformation” (Jevne, 1991, p.69). Creating a personal work of art may allow persons living with cancer to communicate the experiences of their illness that are difficult to verbally express. Art may enable cancer patients to externalize both the intensity, and the ever-shifting landscape of their emotions, especially fear, anger, sorrow, and grief, which are normally experienced throughout the course of an illness and its treatment (Dreifuss-Kattan, 1990). In a phenomenological analysis of an art therapy process for women living with cancer, Bayly (2000) concluded that the women were able to use the art to reestablish a sense of wholeness, a functional unity. They created art which “not only reflected their suffering, but transformed it. ... Creativity proved to be integral to their journey towards integration and wholeness” (Bayly, 2000,
Robert Pope was an artist who suffered with Hodgkin's disease. While he was undergoing treatment, he created paintings which depicted the experience of cancer from the patient's perspective. Pope's compelling paintings have been described as large television screens which draw the viewer inward to the "inner landscape of cancer" (Bayly, 2000, p.26). His artwork has subsequently been used to help oncology and palliative care professionals to have a deeper understanding of illness from the point of view of the patient. Pope saw art as a powerful, preventative medicine. He paralleled the experience of looking at a piece of art to walking through a series of doors, each door leading us towards a deeper personal awareness. "This journey stimulates our minds, our emotions, our souls; it makes us more alive. Ultimately, the art experience heals us and makes us whole" (Murray, 1995, p.27).

Carl Jung was one of the forerunners of the development of the modern professional field of art therapy. Jung emphasized the importance of the development of each patient's latent creativity (Bertman, 1999). In addition to his acknowledgment of the important connection between the creative process and healing, Jung (1933) was also one of the first psychologists to use art images, as well as patient's dreams, to investigate their psychological, spiritual, and somatic states. He began to see that his patient's art contained symbols from the unconscious, which he believed could work as healing agents (Bayly, 2000). Bach was a Jungian analyst who spent many years collecting and analyzing the artwork of terminally ill children. She concluded that children not only communicated their unspoken wishes, fears and anxieties through their art, but that the art also expressed information about the child's somatic condition: their drawings, therefore, served as a kind of record documenting their current body-mind state (Bach, 1990). Allen
(1988), reflecting on the importance of art as a mode of communication for children, stated: “Though the spontaneous ... picture is an ‘uncommon’ means of communication, it is valid, and has meaning” (p.95). Kubler-Ross worked with terminally ill children, and children who had experienced the death of loved ones due to cancer. In thousands of cases, she discovered that “through creative work, either written or drawn, children are at some inner level attuned to events in their lives, and express this knowledge, often symbolically, to those who will hear them” (cited in Allen, 1988, p.94).

**Music Therapy and Grief**

This poetic reflection shares the compelling words of a love song written by a young child with whom I worked over a period of two months while her younger sister was terminally ill with cancer. With Rachel, music was always a place of meeting.

Sisters.
bonds of love.
This is Rachel's song:
"This is Sara’s love song, for her.
When she will be release-ed...
Because I love her."

Rachel is only five.
she sings her thoughts and feelings all the time
music that changes moods like the ocean waves
the nature of music is this change
it can not exist beyond the moment
music is in the air, and of the air
spirit-wind-rainbow-breeze-shining-connecting-thread
I meet Rachel inside the music.

Rachel tells me; "I will sing for her...."
"at the funeral place"
She asks me; "Will you be there too..."
"with your guitar?"
This is Rachel's song:
"Dear Mom and Dad.
I wish Sara wasn't dying...,
Because I love her."
Recently, the Canadian Journal of Palliative Care (2001) featured an edition entirely centred around the theme of music therapy practice in end-of-life care. However, although there is a significant amount of literature on music therapy in palliative care, there has still been very little written specifically about music therapy and grief, particularly in relation to children. West (1994) noted that since palliative care work includes the family within the unit of care, the music therapist must be prepared to address issues of family grief as an “integral part of the work which serves the patient” (p.119). She suggests that music therapists working in the palliative care field should be familiar with the grief process, and should be able to assess between normal and pathological or complicated grief responses (West, 1994). Another music therapist who has made links in her writing between grief and music therapy with adults is Ruth Bright, who was one of the early pioneers in the development of the music therapy field in Australia. Bright (1999b) began to notice in her work both with the elderly, and later with institutionalized adult psychiatric patients, the frequent presence of grief and “unmet needs linked to grief issues” (p.481). She discovered that patients’ grief was often revealed as she engaged with them in the music, and that “many people not only needed to cry, but also needed help in coming to terms with the losses of which the music reminded them” (Bright, 1999b, p.481). Webster (1994), a New Zealand music therapist, pointed out the numerous losses the frail elderly experience when they move from their own homes into an institution. She emphasizes the need for music therapists working in these settings to have familiarity with the grief process, to act as an empathic supporter to clients who are grieving, and to maintain a respectful awareness that they are sharing with the client in a profoundly human experience (Webster, 1994). She stated, “[L]oss and its associated feelings are more tolerable if able to be communicated. It is the music.
therapist’s task to encourage and facilitate this communication in sensitive and empathic ways” (Webster, 1994, p.16).

Music and a process of healing through grief seem to have a natural connection, which has been recognized and utilized throughout human rituals across time and culture. Funeral rituals and memorial services generally include some form of music which holds meaning for the person who died, and their family members. Roy (2001) suggested that we turn naturally towards music in grief because the depth of our mourning is simply too heavy to be carried by words alone. According to Morgan (2000), “expression is particularly important in crisis moments of life, and the arts often are the best and...sometimes the only way for...the grieving to find a means of expression” (p.92). Music therapy--with its combination of verbal and non-verbal modes--has the potential to allow bereaved clients a wider range of expression of feelings than verbal counselling alone (Bright, 1999a). Particularly for grieving children, who often have more difficulty verbally articulating their thoughts and feelings than adults, music therapy may be a very appropriate treatment approach. Music can promote an affirmation of life when one faces loss, assist a child to discover and affirm his/her uniqueness, offer a child a sense of control over a powerless situation, and assist in evoking and celebrating memories of a child’s loved one (McIntyre & Raymer, 1989). According to McIntyre and Raymer (1989), “the arts [are] primary tools in facilitating the expression and resolution of grief, especially in children and adolescents.” The advantages of using music in group work with children include its ability to evoke and identify emotions and the experiential form it provides for self-expression (Plach, 1980). The artistic process can be an empowering one which meliorates the sense of powerlessness often experienced by children in grief (McIntyre, 1990). When children are given the opportunity to change their self and self-
world perceptions through their engagement in the arts, they are empowered to begin a process of creative self development that can continue outside of the boundaries of the therapy session (Bratton & Ferebee, 1999).

When a choiceless event--the death of a loved one--has occurred, the arts offer bereaved children the possibility for sounding their own voices, giving at least a temporary sense of control and reducing the sense of powerlessness they may feel; providing them with opportunities to release pent-up emotional energy in their bodies through such actions as painting, scribbling, squeezing or pounding clay into forms, moving, dancing, beating drums, rattling shakers, or pounding on piano keys. Familiar songs and lullabies can provide a sense of comfort and security which can decrease anxiety and fear, and promote relaxation (Munro, 1984). Activities such as song-writing, improvisation, collage-making, drawing to music, and guided imagery allow an opportunity for conscious and unconscious feelings to be recognized and processed in a healthy, creative way (Munro, 1984). An article on the joint use of social work and music therapy in providing support for children of cancer patients highlights the role of music therapy in validating and expressing children’s feelings, and in assisting to improve family patterns of communication (Slivka & Magill, 1986).

A report by Daveson and Kennelly (2000) on music therapy in palliative care for hospitalized children and teens detailed the use of several specific music therapy techniques which they used to assist patients and family members struggling to cope with fear, pain, and grief before the death and during the bereavement period: songwriting, musical improvisation, lyric substitution, and guided imagery. A case example highlighting the use of these techniques with a twelve-year old girl, terminally ill with cystic fibrosis,
is described. The authors concluded that music therapy can assist in addressing the grief of both the pediatric palliative care patient, and their family members (Daveson & Kennelly, 2000). A phenomenological study on the use of psychodynamic group music therapy with bereaved teens was reported in the Australian Journal of Music Therapy (McFerran-Skewes, 2000). The clinical techniques utilized in this support group were musical group improvisation, group song sharing, and verbal discussion. Results from the analysis of research interviews revealed that the participants valued the opportunity to be with other teens who had experienced a loss, the chance to express their emotions nonverbally in the musical improvisations, and the opportunity to experiment with different forms of expression in a safe environment. The author of this study suggested that the “sharing of pop music served as a metaphoric bridge between participants conveying strong emotions and explicit pain without personal threat to the individual” (McFerran-Skewes, 2000, p. 14).

In the next section of this chapter, I will highlight issues relevant to research in music therapy, and briefly describe the qualitative research methods which I have used in this inquiry.

Research Issues in Music Therapy

Music and other arts therapists have struggled to find ways to convey the meaning and the significance of their work to other health care professionals through research. Grainger (1999) suggested that “[a]rts therapies are notoriously hard to evaluate.

5 The child, with the assistance of the music therapist, was able to complete an original song as a parting gift for her best friend. Her family worked with her in the last days of her life to help her complete the song lyrics, and she was able to sing the song for her friend the day before she died. This song later became an important memory, a concrete memento which reflected a time of shared intimacy, sorrow, and love for the patient’s best friend, and for her family.

6 Although I also reviewed research literature in the arts therapies and in palliative care (particularly in the bereavement aspect of palliative care), the scope of that review is too broad to include here.
Art, more than anything, happens between, in the place no one can measure directly or compare with any other...it communicates meanings intuitively, rather than propositionally; indirectly, rather than head-on” (p.21). A scientific paradigm of measurement is limiting when we are trying to understand those things which are difficult to measure. Jevne (1991) pointed out that “science has no categories for suffering and hope...[and] no language for meaning” (p.10). Life is larger than facts and numbers. According to Remen (2000), “[m]any very important things cannot be measured, but only observed, witnessed, and ultimately trusted” (p.253).

In its initial development as a profession in the United States in the 1940s, music therapy aligned itself closely with the behavioural sciences in order to gain validity, recognition and acceptance into the mainstream clinical and research practices of the day. A review of the music therapy literature reveals this historical reliance on quantitative research approaches (Kenny, 1989). Kenny’s music therapy text, The Mythic Artery, published in 1982, was dismissed and savagely critiqued by some current pioneers in the field at that time, precisely because it spoke in poetic and artistic language about subjectivity, culture, and the ancient connections between music and healing (personal communication, 1997). Kenny’s text presented a vision of music therapy practice which was in direct opposition to the perspective being promoted by many of the behaviourally-based training programs in the United States, which were trying to link themselves to the perceived scientific validity of the field of psychology. In doing so, these programs minimized the long-standing cultural link between music and healing, replaced the language of healing and the arts with the popular language of psychological systems, and emphasized the importance of observable, measurable results. According to

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7Early research in music therapy measured such things as the number of times eye contact was made over a session, or the number of times a client initiated a drum beat, in an attempt to quantify client responses and demonstrate the outcomes of the music therapy session.
Valle (1998), “[w]hether a particular psychological paradigm recognizes it or not, its basic understanding of human nature, its philosophical anthropology, influences the whole conglomerate of problems, facts and rules that govern its research” (p.4).

In addition to the philosophical problems with the assumption of objectivity in human interactions, music therapy research which emerged from the positivistic paradigm failed to capture the meaning and richness of music therapy experiences. How would such an approach to research, based on numerical and statistical data, ever be able to convey the meaning of a spiritual or aesthetic moment in a music therapy session, or capture the depth of connections developed in the therapeutic relationship? Some music therapists became dissatisfied with this focus on applying research methods designed for science to the human and social science fields. A dialogue thus began to emerge in the research literature which not only questioned this dominant approach, but which also began to offer alternatives rooted in the qualitative tradition. This shift of paradigms has involved a radical questioning of our basic presuppositions about what can and cannot be “proved” and “measured” in our work (Kuhn, 1962). The struggle and the search to find a language which conveys the depth of music therapy clinical experiences has therefore been taken up by a number of prominent music therapy educators, clinicians, and researchers (Aigen, 1993; Kenny, 1989; Langenberg et al, 1996; Wheeler, 1995). In addition, some American graduate programs in music therapy are now specializing in qualitative research methods, and a body of literature and research on qualitative studies in music therapy is beginning to develop. According to Bonny (1989), “Changes within music therapy practice have taken a healthy broadening turn from exclusive reliance on behavioural principles to a willingness to brave the cold waters of uncertainty in search of music therapy theoretical paradigms” (p.8). I do not mean to imply here that there is no place for quantitative
research in music therapy; in certain settings and in relation to certain research questions, it can clearly be justified (Wheeler, 1995). However, I do believe that we must resist the temptation to be seduced by the numerical at the expense of the artistic. Kenny (1989) urged music therapists to seek ways to balance the 'art and the science' of research, and to search for harmony between logic and intuition.

I have dialogued with many music therapists who express a sense of frustration and difficulty in being able to communicate to others what music therapy is and how it works. There are clear challenges to describing and naming our experiences of music therapy. Certainly, the most central of these is translating the language of sound and music into words. In my experience of trying to explain this work to people outside of the field, I have repeatedly found that turning to the stories and descriptions of the clinical work is a key to helping people gain more understanding of the power of the arts in healing, and therefore the clinical realm of music therapy. Building a repertoire of descriptive, phenomenological accounts of our work seems particularly important for a field which is still struggling to establish and maintain itself within and among the mainstream disciplines of medicine, psychology, rehabilitation and education.

McNiff (1989) pointed out that "behavioural science has not been an adequate forum for psychological inquiry into the arts" (p.6). Therefore, we need to explore research approaches which acknowledge the ambiguity of creative processes, and (in the case of the particular focus of this dissertation) the mysterious nature of processes such as grief and death. In fact, a similar call has been made by qualitative researchers in the bereavement field, a call for a new language in which to talk about loss. Traditional grief models have largely evolved out of a positivistic scientific methodology and world view that many have argued has not adequately considered the impact of culture on grief.
processes, has tended to pathologize the experience of grieving persons, and thus has failed to capture the complexity of human suffering and healing (Attig, 1996; Klass, Silverman & Nickman, 1996). Klass, Silverman and Nickman (1996) have stated that "we need to bring into our professional dialogue the reality of how people experience and live their lives rather than finding ways of verifying preconceived theories of how people should live" (p. xix). Their statement points us towards phenomenological approaches to research. To speak in the language of process is quite different from the language of outcome. In order to enter this territory, we need to delve into our subjective worlds. Phenomenology is a potential guide on this journey; it is an aesthetic approach which allows us to stay connected to the immediacy of our lived experience, sharing our stories in a way that maintains our artistic and imaginative sensibilities (Kenny, 1989).

Music therapy as a field has much to offer the health of the broader society. Aigen (1993) said that "The intrapersonal, interpersonal and transpersonal domains that music therapists explore through music on a daily basis contain experiences and forms of knowledge that suggest novel conceptions of what is possible for humans to learn about each other and their social universes" (p.37). Perhaps we have been seeking to find ourselves in places where we are not. And perhaps it is time for us to speak from within the uniqueness of our own vantage point, offering what we have learned from our clinical experiences to the larger society, rather than trying to accommodate and 'fit into' the language of psychological and medical systems.

Research Methodology

A review of the literature and dialogues around research in music and the arts therapies, as well as in palliative care, has highlighted certain themes and concerns which
have influenced and guided my choice of research methods for this dissertation. This review has led me to seek methods which are capable of attending to the quality of individual experiences and the complexity of human suffering, which can embrace the depth of existential and philosophical questions, which can engage multiple ways of knowing in the research process, and which can convey the nature of arts-based experiences (Klass, Silverman & Nickman, 1996; Langenberg, Aigen & Frommer, 1996; Lawrence-Lightfoot & Davis, 1997). While there are many ways in which my chosen qualitative methods overlap (stemming as they do from similar philosophical roots), they each have a slightly different focus, and thus contribute something unique to the research project. Each of these methods acknowledges the integral role that the researcher’s own subjectivity plays in the shaping of the final document. Personal biases are openly stated and acknowledged, and are mediated—to the extent that this can be done—through the practice of mindfulness and reflection on other literature in the field, maintaining a personal reflective research journal, and engagement with the research supervisory committee. We live in an intersubjective, interpreted world (Spinelli, 1989). This notion—rooted in the phenomenological philosophical tradition—shapes every word and nuance of this thesis.

Jardine (1998) described phenomenology as a “different way of understanding ourselves and our place in the world, one which problematizes our aspirations to clarity, progress, mastery, and dominance as images of our relation to the Earth and to each other” (p.19). It does not seek to establish causal relationships, predict or measure outcomes, but tries to communicate the meaning of a particular human experience by offering a rich, holistic and detailed description (Shapiro & Bentz, 1998). These descriptions are then used to illuminate the unique and essential features, the “meaning structure” of a
particular human experience. The phenomenological researcher searches to discover the essences—which are contextual and historical rather than universal—of the experience under study (Brooke, 2000). The philosophical foundation of this approach is rooted in the assumption that experience is non-repeatable, and thus each individual’s experience is considered to be a valid source of data (Stiles, 1994). The meaning structure of a particular experience, however, cannot be generalized; we can only describe what we see from our own viewpoint. The “lived experience” of the researcher is the ground out of which the work emerges. My direct experiences of being in relationships with grieving children, and my clinical work as a music therapist in palliative care, are viewed as a valid form and source of knowledge. This is a tenet which lies at the heart of the phenomenological research approach: “that experience is the ground of all knowing” (Valle, 1998, p. xiv).

My research began not with the formal process of my doctoral studies, but when I began to recognize, in my clinical work, the strengths—most notably the creativity and the resilience—which children bring to the process of grief. My initial questions evolved from my desire to understand these strengths more deeply, and also to bring that understanding to others who work with children. In the portraiture research method, the documentation of strengths, rather than pathology or problems is key. According to Lawrence-Lightfoot and Davis (1997), the researcher looks for “strength, resilience, and creativity in the people, cultures and institutions she is documenting. This is not an idealized portrayal; but a pursuit of complex truths, a documentation of what supports and distorts the expression of strength” (p.159).

The hermeneutic interpretive analysis—movement between the details, and the larger picture—is not so much a separate methodological step in the research process, but a particular way of viewing and reading data which is ongoing, constant, and ever-in-
process (Gallagher, 1992). The work is open-ended and expanding; a movement back and forth from the particulars of our texts to a view of the whole, trying to discern their interrelatedness, and the emerging configurations of meaning (Valle, 1998). In this research, ‘texts’ refers to all the multiple sources of data: previous research and literature in the related fields of practice, the lived experience of the researcher, the lived experience of grieving children as communicated to the researcher in interviews, session notes/observations from the researcher’s experience as a participant-observer in the field, transcripts of the children’s interviews, audiotapes, conversations with parents and other caregivers of grieving children, and songs and artwork created by grieving children. Mook (1999) suggested that “[s]ymbolic language speaks in an indirect and figurative way, and thus calls for hermeneutic interpretation” (p.176). She concluded that a combined phenomenological and hermeneutic approach is “eminently suitable in understanding and interpreting the meanings of children’s verbal and non-verbal expressions through imaginative play and other creative media” (Mook, 1999, p.176).

Artistic forms and narrative elements are intrinsic to both the process and the outcome of the research method. The arts are valued as an essential part of the inquiry process: the inclusion of artistic forms helps to keep the document emotionally alive (Diamond & Mullen, 1999). Stories capture the unfolding of experiences in time and in context (Clandinin & Connelly, 2000). Arts based inquiries also have the potential to convey the richness of children’s communication and may offer us different insights into their experiences than more linear, quantitative approaches. While clinicians often include the creative arts as methods for communicating with children in practice, researchers have been less likely to incorporate the arts into their inquiry processes. Dominated as many schools of psychology are by the scientific method, art is simply not viewed as a ‘valid’
According to Eisner (1981) artistic approaches to research are concerned primarily with the discovery of meaning rather than truth. While truth implies singularity—one way of seeing and knowing—meaning implies relativism, diversity, multiple perspectives (Kenny, 1989). Eisner (1981) stated, “Artistically oriented research acknowledges what already exists and instead of presenting a facade of objectivity, exploits the potential of selectivity and emphasis to say what needs saying as the investigator sees it” (p.5).

Linking the relevance of the research to the bigger picture—the reduction of suffering in the world—is an important tenet of mindful inquiry. By gaining insight into what helps children through a process of grief, this aim may be realized. The process of heuristic inquiry, “an inner search through which one discovers the nature and meaning of personal experience” (Moustakas, 1994, p.17), assists in the exploration and articulation of the researcher’s own therapeutic practice. Throughout the entire research process, the researcher keeps an open eye and ear for resonant metaphors, symbolic expressions, and repetitive refrains and themes. What keeps emerging from the many different sources and modes of data? Are there any deviant voices? These too should be acknowledged and noted. The purpose of identifying emergent themes is to make the complexity of the whole more comprehensible (Lawrence-Lightfoot & Davis, 1997). In the final product, the writer brings together the connecting themes and patterns into a coherent and aesthetic whole. In this creative process, there is a “blend of empirical choices and aesthetic sensibilities...insight and emotion...a narrative that both informs and inspires” (Lawrence-Lightfoot & Davis, 1997, p. 259).

By invoking experiences, stories, poetic, artistic and musical images throughout the text of this dissertation, it is hoped that both the form and the content will help to
connect the reader with those whose unique lives have inspired the research and the writing. Children’s voices, reflecting on their own experiences, have not been very prominent in the academic literature—most likely due to their (presumed) limited verbal abilities to describe these experiences. I think, however, that children are quite capable of describing their experiences if we give them the tools, the time and attention they need.

Indeed I discovered the children who participated in this research, were able to articulate their experiences with grief quite profoundly. Grieving children have something important to offer to the academic discussion: the meaning of their own experiences of loss and how they have learned to find their way to healing through these experiences. We may begin to “appreciate children’s capacity to cope, to be creative, and to prevail as we let them speak for themselves” (Klass, Silverman & Nickman, 1996, p.71).

In the final section of this chapter, I will describe some of the tensions I have personally experienced as a music therapist working in the public health care system, and highlight some of the current problems facing music therapists in British Columbia.

**Professional Challenges for Music Therapy: Understanding Conflicts in the Canadian Context**

**Misunderstanding, Fear, Ridicule, and Disbelief**

As I ride to work in the elevator with my guitar over my shoulder—I am granted an enthusiastic smile by a tall man in a white lab coat—he tells me how kind I am to volunteer my time to “entertain the sick old folks on the seventh floor.” I politely smile back as he gets off at the next floor—no time to explain that I am a staff member here, no time to explain that I am not paid to entertain patients. On another day, as I begin a new seminar course with other doctoral students at the university, I find myself confronted by outright cynicism as I talk about the field of music therapy. Because I have always previously studied in groups of ‘like-minded students’ (also becoming music therapists), I am shocked to encounter the reality that some people view the use of the arts in therapy as an absurdity: a
profound 'misuse' of the purity of the aesthetic form for practical and social purposes which will undermine any justification for the serious study of the arts in schools and academic institutions. The supposition that anyone--regardless of skill level, intellectual or physical ability--can participate in the healing aspects of music is foundational to music therapy education and practice. However, this democratic view is not always appreciated by other health care providers, educators, or even by artists themselves. Ruud (1995), a music therapy educator, commented on this: "within a serious institution for music education, which cultivated a classical, bourgeois education built on values like duty and exercise, music therapy distinguished itself through its anti-elite values. ... This democracy was regarded by the classically oriented musicians as a threatening vulgarity" (p.102).

A comment in a letter to the editor in the Canadian Medical Association Journal by a physician in response to a seminal article, written over twenty years ago, on the use of music therapy in palliative care, sadly gives an example of the hostility and lack of understanding some health care providers still feel towards our profession:

Surely we do not need some crackpot therapist with a half-baked degree in psychology to tell us what kind of music to listen to when we are sick? It is well known that "music hath charms". Therefore, is it necessary to publish such articles in the guise of learned scientific thought when they are merely common sense made muddy and obscure by jargon-ridden balderdash? (cited in Munro, 1984, p.110)

There have been numerous times in my work in medical settings when doctors and nurses have looked at me (as I sit next to a patient's bedside with my guitar) with a sense of disbelief clearly written on their faces. They question me with a kind of angry cynicism. The message conveyed is not simply "what are you doing here?" but "this is an inappropriate place for you to be". It is as if my presence, along with the presence of the music, is a kind of insult to their scientifically advanced technological environment. That the inclusion of something as soft as music, so incongruent with the hard-edges of their stainless steel machines and monitors, might somehow undermine the professional appearance and medical status of their hospital ward.

Current Problems in the Field of Music Therapy

Despite much evidence to the contrary, North American culture still tends to view the arts in general, and music specifically, as entertainment, something to be performed on
a stage by skilled experts, rather than something which can be an integral part of the health of individuals and communities. This view is supported by many school arts programs and by arts educators who focus only on developing the technical artistic skills and expertise of their students. This narrow view of the role of the arts in society and in education separates and removes the arts from everyday life and from everyday people. It also suggests that creativity and imagination are special talents, limited to “professionals in the arts”, rather than more universal aspects of human experience and character (Robbins, 1985).

In Canadian health care settings, music therapy is often on the edge, frequently misunderstood as in-house entertainment, and frequently undervalued in the funding hierarchy. Many music therapists feel a sense of alienation and isolation in their work sites which is due not only to our newness as a profession and the reality that most of us work as sole charge therapists, but also due to the fact that what we offer and value is not widely valued by the larger societal systems; particularly in a health care system which is dominated by the tenets of objectivism and the medical model. According to Bonny (1986), “Most modern medical practitioners...do not see music fitting into scientific procedures which have hailed the left-brained mentality over right-brained intuitive faculties” (p.3). Our North American cultural propensity for binary thinking makes it difficult for many in the medical profession to see the value in the co-existence of the creative with the technical, the abstract with the concrete, the artistic with the scientific, and the intuitive with the rational. It is rare to hear physicians speculate on the role of the arts in health, or the place of creativity and imagination in healing. Yet, in a holistic analysis, these things are very important to healing. Unless we attempt to counter rigidity, we cannot move forward in a process of healing. This countering of rigidity and
movement forward implies the activation of our own creative spirit; our capacity to imagine and ultimately create our lives (or our societal systems) to be different in some way.

There are many health care practitioners and administrators who are either completely unaware of the existence of the field of music therapy, or who are not convinced that it has anything of real value to add to the health care system. This has never been more clear to me than during the radical restructuring of the health care system by the current Liberal government which is occurring in British Columbia today. Many of my colleagues are losing positions in hospitals and long term care facilities which have taken years of lobbying and work to establish. In one of the largest hospitals in the city of Vancouver, the expressive arts therapy department will be deleted entirely. Senior administrators have decided it does not save the hospital money, and its services do not make significant contributions to patient care. They have reassured the public in a news release that patients in the palliative care unit will still have access to music through tapes and CDs. My own position--established more than fifteen years ago--was only saved from budget cuts at the last minute by the astute and creative efforts of a supportive manager--herself an artist--who not only understands the value of the arts therapies in palliative care settings, but believes they are worth fighting for. Other music therapy peers are being asked to develop statistical materials which demonstrate the cost-effectiveness of their work. Although this is not an impossible task, it is also a challenging one for a profession which considers quality of life to be a central concern. Measuring the quality of a service and its impact on patients’ lives is more complex than measuring what is physically observable. Music therapy does not fit neatly into an efficiency model and a positivistic paradigm of measurement.
A Canadian music therapy colleague, currently in the United States for the completion of her doctoral degree, writes words of encouragement for music therapists in British Columbia in relation to the current political climate here and its impact on our profession. Her words echo many of my own feelings and beliefs about the current situation of our field:

Dear colleagues: What we do is important beyond our own understanding of it. It is important to our clients, yes, but it is also important for our world. From a distance, I hear your stories of grief over lost jobs, and fears of further losses. I feel so strongly, that we must not look outside ourselves, certainly not to governments for validation. We have to deeply know our own value and be able to speak that value clearly. ... But not from fear! It is not the first time in history that music therapy as a profession has been compromised by political agendas. ... We do extraordinary good in an extraordinarily materialistic society. ... I believe that we can hold our candles high enough to weather this storm, but we must stick together, and be thoughtful, smart and fearless. We owe it to those who have gone before, ... all our founders, to work very hard to save our profession in British Columbia. (Merrill, 2002, personal communication).

Questions about Our Future

What is amiss in the field of Canadian music therapy today? Why is it still a challenge for us to name and label and describe and explain the heart of our work to other professions? Why do we still struggle for professional recognition and validation? How can we find a way to remain true to the nature of our work and our personal values in the face of systems which deny the benefits of our work and question the value and necessity of our very existence? How can we learn not to take the misunderstanding which exists in so many of our work settings, and in the most extreme instances the losses of our jobs, as personal affronts and failures?

In my ten years of experience as a music therapist in the British Columbia public
health care system, I have repeatedly witnessed the juxtaposition of the innovative clinical work that music therapists are doing with a frequent lack of support and awareness from health care administrators about the depth of that clinical work. Some music therapists are asked to adopt titles such as “activity worker” in order to maintain their employment, while others report a lack of control over their own practice within institutional settings (Merrill, 1998). It is common for music therapists’ job responsibilities (and thus the scope of their practice) to be decided by nurse-managers, facility administrators, or recreational therapists in managerial positions. Merrill (1998) pointed out that “[t]he message this sends to the therapist is that [s/he] is not valued, that the modality is not seen as the powerful agent for change and healing that it is. It would require a special kind of confidence, indeed, to continually uplift one’s work, and present it to their colleagues, in the face of seemingly unrelenting devaluation” (p.18).

In my first position as a music therapist in a long-term care facility on Vancouver’s downtown east side, a residence for men with substance abuse and mental health issues, I had a rude awakening to this working reality. As I enthusiastically began to design small group therapeutic programs, and individualized sessions for very isolated and impaired elderly residents in the facility’s locked special care unit, I ran up against the ‘wall’ of a manager who had an entirely different vision of music therapy than I did. In reality she had no vision of music therapy--but rather wanted me to ‘use’ my musical and therapeutic skills to manage and control the residents, and keep them entertained; perhaps making things easier for her care staff. She insisted that I make the best use of my contract time by keeping the residents busy and happy in large groups. She wanted me to develop a large rhythm band, and have daily singalongs. She had no appreciation of the importance of assessing people’s needs on an individual basis, and was impatient with my insistence on

Many music therapists do facilitate these kind of programs in long-term care facilities for the elderly. I do not mean to imply that such large-group programs can never be therapeutic. The power of choirs to build a sense of community for the elderly in care homes has been convincingly documented by Summers (1999) in her Master’s thesis *A Tapestry of Voices*. I am speaking here about the specific context in which I was being asked to facilitate these programs, where the intent was ‘management’ rather than ‘therapy’, and the direction of the program was being dictated by the nurse-manager, rather than by the music therapist.
working in small groups with the men, so that I could attend to them as individuals and work with them towards therapeutic goals. She perceived my difference of opinion as a direct threat to her authority as a manager, and began to follow me around throughout the work day; counting the numbers of clients in my groups, monitoring my activities by hovering near open doorways where I was conducting small groups, recording the amount of time I would spend in individual sessions, and sending memos to the executive director which recounted these details. It became a highly stressful working environment where my professional autonomy and judgment were questioned each day, and which got progressively worse over time; the stress ultimately taking its toll on me both emotionally and physically. It was a terrible experience. And, over the years in dialoguing with other music therapists in my community, I have realized, sadly, that my experience is not unique.

While it is true that many gains have been made in Canadian music therapy over the past twenty-five years, it is also evident that we have some distance to go. There are many areas in need of our attention and development. We must continue the ongoing process of educating others about our field, and we must continue to keep learning and growing ourselves. We must continue to advocate for the rights of those people who live with multiple handicaps or life-threatening illnesses--who are often ignored by politicians because they do not have the ability or the physical strength to speak out--to have quality of life services such as music therapy remain as an integral part of our health care system. In addition, we have to learn how to know our own worth as caregivers with something unique and valuable to offer to the current health care system.

Many people do not realize that music therapists are often successful in eliciting responses and building relationships with patients who have been largely abandoned or even ignored by other health care professionals: the confused, elderly patient who shouts and screams, strapped into his chair, all day long in the corner of the nursing home, the stroke patient who is completely despondent, the multiply handicapped child who cannot speak, or the aggressive young man with schizophrenia who is only cooperative
with staff if he is allowed out of his room on the locked ward for music therapy. Music has a way of cutting through all the restrictions of disability and illness; it has a way of reaching through limitations—sometimes only for a brief and shining moment—towards something whole that resides deeper inside. Sometimes, I think of music therapists as social justice workers, quietly doing their work with patients on the often harsh front lines of government institutional care settings. Nicholson states “there is immeasurable value in bringing aesthetic sustenance into our mechanistic, often ‘dehumanizing’ medical institutions. Music is this to me” (1999, p.2).

**Chapter Summary**

This chapter has provided an introduction to the field of music therapy and the arts therapies, and has identified relevant research studies and issues. The overlapping qualitative research methods I have chosen have also been described. In summary: phenomenology allows us to focus on the depth and uniqueness of lived experiences, and allows for an exploration of existential questions related to meaning; mindful inquiry helps us to keep the ‘bigger picture’ in view—linking the purpose of the inquiry to the reduction of suffering in the world; heuristic inquiry allows space for in-depth reflection on one’s personal experience in relation to the topic area; narrative inquiry keeps us connected to the unfolding of experience in time and space through story; portraiture reminds us to search for goodness and strength in our research concerns; hermeneutics highlights the role of interpretation in the reading of all the ‘texts’ (music, art, literature, dialogue, etc.) which form the basis of our data; and arts-based inquiry makes room for emotional content, and for children’s voices—validating artistic modes of thought and creative presentation of ideas and findings in the final research document.
In this chapter, the themes of dissonance, struggle, and misunderstanding have been highlighted in descriptions of my personal experiences working as a music therapist in the British Columbia public health care system, and in my analysis of current challenges facing Canadian music therapists. As hospitals and care facilities in British Columbia cut music therapy programs and services, we might be compelled to ask ourselves what these actions indicate in a broad assessment of our values. The implication is that while technology is indispensable, we can live without Beauty. However, Hillman reminds us that “the soul is born in beauty...and requires beauty for its life” (1981, p.25).

If caring for the whole person is to be a reality in any health care setting, we will need to start paying more attention to the aesthetics of our working environments. By bringing the beauty of music into these often stark environments, and advocating for the inclusion of music in the care of those who are severely impaired or disabled, or for those who are facing the pain and trauma of chronic illness and the medical invasiveness of treatments, the work of music therapy asks us to stop and question: to remember about the importance of Beauty and quality of life in a system which more often seems intent on warehousing and managing bodies then caring for and attending to human beings. Although music therapists are often devalued and undermined in many of the care settings where we work, we must learn to have confidence in ourselves, and stop looking to outside sources for validation or understanding. We must trust that our work will eventually speak for itself, and that positive changes--for ourselves and for the clients with whom we work--will come.

In the following chapter I will describe the norms and ideals of the modernist world view which I believe is exacerbating the struggle for identity and recognition which music therapists in Canada are currently facing.
Chapter Two: Wounding
Introduction

In Chapter One, I introduced the field of music therapy, and described some of the current tensions and conflicts in the Canadian music therapy field. In this chapter, I will examine these issues by looking at the broader social-cultural context in which Canadian music therapists practice. Reflecting on this broader picture may help us to understand why a profession like music therapy has had a difficult challenge in gaining acceptance in mainstream health and educational settings. Specifically, I will focus on critiquing the influences of modernism on caregiving professions by describing how our current health care and education systems are influenced negatively by the pervasive influence of the modernistic viewpoint. The threads of modernism wind their way through many aspects of our society: they influence our systems of care, our health services, our schools, our psychological understanding, our views of human nature, our responses to death and grief, indeed the entire process of our education. Throughout this chapter, I will link the problems experienced in the small, specialized field of music therapy to the current state of North American cultural values and norms, and emphasize the need for healing and change in the broader society. I will conclude this chapter with a narrative that reflects one woman’s process of shifting from a modernist, materialistic world view to a more holistic one, embodied in her actions and her experiences as she came to terms with a diagnosis of terminal breast cancer.

The Modernistic World view: Perpetuating a Culture of Disconnection

Numerous scholars have written about the contemporary problems of North American culture: skyrocketing rates of poverty and crime, increased incidences of violence and bullying among youth and children, ongoing violence against women, and the
destruction of the environment, to name just a few (Adair & Howell, 1993; Bowers, 1999; Cajete, 1999; hooks, 2000; Jardine, 1998; Kane, 1999; Taylor, 1991). What is the root of all these problems? Do they stem from a human propensity for excess, greed, cruelty and selfishness? Can they be traced and blamed on inadequate parenting, traumatic childhood experiences, and thus a turn towards a myriad of addictions to numb our pain? The causes of such problems are never simple to isolate, and I will not attempt to enter into that dialogue and debate at length here. However, in reflecting on the values of modern North American culture, it is possible to see, in a very general way, how a culture which highly favours the importance of individuality, progress, rationality and science, may be, at least partially responsible for the sense of disconnection and discontent many people experience in modern society. Further, it is possible to speculate that it is this sense of disconnection which may lie at the root of many of our present problems. Jean Vanier (1998) stated:

A society based on the Darwinian “survival of the fittest,” where we all fend for ourselves, has serious disadvantages. It promotes a strong, aggressive attitude and the need to win. It can paralyze the development of the heart, prevent healthy cooperation among people, and promote rivalry and enmity. ... In a society that encourages an ethics of economy, of winning, and of power, it is important to be admired. ... Individual success is all that matters. In such a society, an ethics of justice, solidarity and cooperation, an ethics of the common good, can quickly fade into the background. (p.52)

This sense of disconnection and loneliness, which as Vanier points out, can be linked to the values of an overly individualistic and self-absorbed society, may lead us to hurt not only ourselves, but also the environment, the world we live in, and other human and non-human beings we share that world with. Remen (2000) suggested that we might view this North American obsession with independence and self-sufficiency as a weakness that
makes many of us vulnerable to depression and isolation. She said, “In order to live well, we may need to know and trust one another again. To touch and be touched by those around us” (Remen, 2000, p.198). Our current cultural obsession with technology and the manipulation of externals has led to a devaluing and a dismissal of our inward, subjective worlds (Palmer, 1998). According to Palmer (1988), this is why “we train doctors to repair the body, but not to honour the spirit ... teachers to master techniques, but not to engage their students’ souls” (p.19). I do not mean to suggest that advances in science and technology have not benefited our society, but I believe their privileging has simultaneously created a lack of value for areas such as the arts, intuition, imagination, and the spiritual domain, and therefore has led to an imbalance in our current education and health systems. This imbalance is the wounding which has resulted from the dominance of the modernistic world view in our present-day North American society.

Sociologist Max Weber described the dominating feature of such a modernist perspective or world view as rationalization: “the expansion to more and more sectors of behaviour, thought, and social life of technically rational conduct--based on efficiency, calculation, predictability, procedures, and the adaptation of means to ends” (Shapiro & Bentz, 1998, p.21). The belief that human beings are rational, autonomous subjects who are capable of objective knowledge and control of their natural and social world is the outcome of the growth of such rationalistic belief systems (Shapiro & Bentz, 1998). The image of the rational, detached, autonomous individual is central to this ideology. The centrality of the human Self is repeatedly emphasized over the centrality of God or Nature in modern culture (Shapiro & Bentz, 1998). Modernism places significant value on the achievements of science and technology, and on the importance of rationalism, objectivity and progress (Usher & Edwards, 1994). These values stem from a mechanistic
and positivistic view of human beings and systems; this view continually separates and divides human beings and the world we inhabit into isolated parts. Each part is taken out of its context and studied as a detached object. This detachment is assumed to be foundational for maintaining an 'objective' attitude which will lead to the discovery of scientific 'truths' (Klass, Silverman & Nickman, 1996). Hillman (1981) said that “the heart that has no reactions to what it faces ... [is] the desert of modernity” (p.41). Bohm (1984) suggested that modern science has perpetuated a fragmented society because of this incessant need to isolate specific variables and divide wholes into parts; a need which Bohm linked to the desire to manipulate nature. In this positivist model of science, “the physical and social world is seen as an object to be mastered and thus controlled” (Klass, ed al., 1996, p.21). By attempting to divide things up which should not be divided (such as human beings!), we end up with a fragmented understanding of the world and human nature. This is the wounding of the modernistic view. In such a fragmented view of the world, an attitude of manipulation and mastery is the norm. Bohm (1984) said, “If the conception of wholeness was appreciated it would imply an attitude of humility towards the world rather than this ambition of manipulating...” (p.21).

Modernistic ideals have implications not only for our society, but for all the systems of care which exist within our society. They perpetuate our human experiences of fragmentation, alienation, separation and disconnection (Bohm, 1984; Taylor, 1991). Since it is impossible to do justice to this vast topic in one chapter, I will focus the remainder of this discussion specifically on the influence of modernism in education and in health care. According to the norms of modernism in these systems, cure becomes more important than care, outcomes become more important than processes, final grades on standardized tests become more important than a student’s understanding of a subject
area, rational, objective thinking becomes more important than intuitive, creative thinking, technology and science become more important than beauty and art, while clarity and precision become more important than ambiguity and mystery. Anything which falls outside of the key values of the modernistic view is devalued, seen as less important or simply irrelevant. Within the narrow confines of the modernist framework many important aspects of humanity are therefore diminished or forgotten. Such a perspective minimizes the importance of caring relationships, the interconnectedness of thought with feeling, and our essential interconnectedness as human beings.\(^9\) When these things are devalued in caring professions such as health care and education, the result is the depersonalization and objectification of knowledge, and distancing and disconnection in caregiving relationships (Palmer, 1998). These problems negatively impact not only those being served by an institution, but also those who hold the responsibility for providing services, for those in caregiving and leadership roles within the institutions. How will we respond to this problem? We need to work to articulate and implement an ethics of belonging, an ethics of compassion, rooted in love, caring and connection (hooks, 2000; Forsey, 1993). We might call this an “ethics of the heart.” According to Vanier (1998), “the heart is never successful. It does not want power, honours, privilege, or efficiency; it seeks a personal relationship with another, a communion of hearts, which is the ‘to-and-fro’ of love” (p.63).

**Education**

Education is the process by which we become the people that we are; it is how we open up to the world around and within us. From the moment we enter the world as infants, we begin this process of education. As we interact with the world, we shift and

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\(^9\) Along with Kane (1999) and Koepfer (2000), I categorize this as the spiritual dimension of humanity.
expand our awareness. We begin to see, to feel, and to experience possibilities in a region of ourselves that we previously may not have imagined. As we learn, we change and grow; we become. This leads us, ideally, into a process of transformation, described by Hart (2001) as “a movement toward increasing wholeness that simultaneously pushes toward diversity and uniqueness; becoming more uniquely who we are, and toward unity and communion, recognizing how much we have in common with the universe” (p.12). According to phenomenological thought, the world is not an objective reality, but is co-created; the intersection of the experiencing subject with the context in which s/he lives (Valle, 1998). Therefore, in a holistic, phenomenological conception of education, we understand the learning process as the interaction of our interior worlds of consciousness with the intersubjective interplay of the contextual world we live and breathe in. Long before we develop problems in living in this world, or come to need the services of health care providers due to ill health or crisis, we are engaged in a process of education. It is this formative, ongoing, and multi-faceted process that shapes us, forms us, inspires us, challenges us, and, in many cases, also wounds us. Therefore, we have to begin by asking what values are implicit in our education. What have we learned about the world and our selves that helps us in our growth, and what have we learned that hinders us in our growth? What keeps us trapped? What sets us free? This reflection will provide us with the space that we need to illuminate our assumptions and the societal and cultural influences which shape our systems of care. In this reflective space, we can perhaps come to see the whole more clearly. And one thing seems clear already. If our education embodies only modernist values, than we are in danger of becoming wounded people. Jardine (1998) highlighted the wounding process of a modernist viewpoint in education:

when the living character of education is rendered by a desire for clarity and distinctness, all that remains is what can be objectively documented without
difficulty and ambiguity. ... In all of this, we render children into strange and silent objects which require of us only management, manipulation, and objective information. ... Children are no longer our kin, our kind; teaching is no longer an act of 'kindness' and generosity bespeaking a deep connectedness with children. In the name of clarity, repeatability and accountability, such connections become severed in favour of pristine, objective surface articulations. (p.7)

**The Objectification of Knowledge**

Knowledge is a broad topic, one which could take up an entire thesis in itself. In this section, therefore, I will only touch briefly on the concept, and critique the modernistic tendency to objectify knowledge. When we objectify knowledge, treat it as a thing to be acquired, we act on the assumption that the truth about a particular subject area is always external, outside of ourselves, in books and journals and in the hands and voices of the experts and professionals in a field. The importance of the acquisition of objective information (which can be neatly measured and assessed by test scores) is implicitly valued as the goal in a modernistic approach to education. Little time is taken to encourage students to turn their attention inward, to contemplate the meaning of the curriculum or subject matter in relation to their own worlds and experiences. Great emphasis is placed on the importance of acquiring more information. One of the tools promoted as centrally important in connecting us to an unending source of information is modern technology, specifically the computer and the Internet. The values of technology, progress, and the mentality of efficiency are quickly translated into the domains of public education by politicians and others who herald the benefits of computers for every child, in every school. On the surface, this may appear to be a generous and progressive stance. However, Moore (1992) suggested that this kind of response to education comes from a place where we want to "make the child into the best adult possible, not in the ancient Greek sense of virtuous and wise, but in the sense of one who is an efficient part of the
machinery of society” (p.52). When we begin to look critically at some of the current norms in education and the directions and values supported by many governments with regard to public education, we may find ourselves growing concerned for the future of our children (Cajete, 1999; Kane, 1999). There is an increasingly popularized and dominant view of learning as information processing, and human beings as machines, a view which Kane (1999) characterized as “a model of human thinking that begins with the thinker as an object, rather than as a thinking subject” (p.2). When the human mind and spirit is equated with the metaphor of the machine, the modernist influence is evident. We must ask ourselves what kind of long term impact these mechanistic metaphors and values will have on children who are in many respects hostages in an educational system that they have had little part in creating.

Technology is undoubtedly beguiling and impressive. It has the potential to help us all in some ways. We often hear the enthusiastic accounts of those who believe the computer will connect us all, of those who see the advances in technology as a source of connection to the global world rather than as a source of disconnection (Bowers, 1999). What happens, though, when we dig a little deeper, and, as Cullingford suggested, ask ourselves “What is it that we are so busy communicating?” (1999, p.2). Exactly what is modern technology connecting us to? How might our communication become limited if we make the acquisition of technological skills the primary focus of our educational efforts? Can the computer teach us to wonder? To care for one another? To relate to one another and the world around us in respectful ways? We need to consider the quality of our dialogues and the directions they are leading us in. Perhaps the emphasis on technology in schools is actually closing us down rather than opening us up to the world around us.

When we conceive education to be primarily about acquiring skills and information, so
that each year we increase funding for computers and technology and cut back on arts programs, then we are in danger of missing out on the importance of including Beauty, the spiritual dimension, and the soul in education.

Palmer (1998) described objectivism as the dominant mode of knowing in modernistic education: a mode which "portrays truth as something we can achieve only by disconnecting ourselves physically and emotionally from the things we want to know" (p.51). Further, the higher the level of education, the more academic culture perpetuates the objectification of knowledge. Experts and professionals reveal to students the 'truth' about a subject area, which is always 'out there' and often bears little relation to what students know from within the context of their own lives. However, if we divorce knowledge from its connection with a life context, with our own emotions, we are disconnecting it from the source of its meaning, and in a drastic sense, we are dehumanizing it. Objectivism predominates—an outcome of the modernistic view—and therefore perpetuates disconnections between teachers, their students, and the subjects they are teaching and learning (Cajete, 1999; Parker, 1998). Tobin (2001) stated, "the opposite of objectivism is understanding, which involves connection, relatedness, intimacy, even oneness; but traditional education does not often permit this" (p.90). Traditional education has been primarily rooted in rationalistic, discursive modes of communication (Bai, 2001). Webster (1998), commenting on the British education system, stated that "what is most highly prized is propositional knowledge and the skill to which it is father, logico-deductive reasoning" (p.17). He suggested that this dominating value, along with the strong influence of a guiding positivist philosophy and utilitarian thinking, has seriously undermined and devalued the role which the arts, imagination and creativity can play in education (Egan, 1997; Webster, 1998). Because the arts do not fit
easily into the objectivist mode of knowing or learning, they are often at the bottom of the academic ladder (Greene, 1995; Parker, 1998).

Health Care

Education and health systems, though usually viewed as two completely different entities, actually represent a larger continuum of care. Care is a fundamental component of both learning and healing. In Canada, the government is responsible for providing access to education and health care services to all of its citizens, regardless of income level. We might liken our participation in education as a visit to our general practitioner’s office, where we attend to our development, health and well-being through regular check-ups, consultations, and preventative measures. We might liken our participation in the health care system, however, as a visit to the emergency room; we become involved in this system of care when some part of our bodies or minds are in severe or chronic physical or emotional distress. In health care, just as in education, the values of modernism have dominated, and resulted in wounding for many people—I would argue both for patients and caregivers alike. Objectivism in health care has alienated and devalued the human voice and the human spirit in patient care (Remen, 1996). Like an education system based on a modernist world view, a health care system which holds objectivity as its principal “mode of being” devalues the inherent intersubjectivity of the care giving relationship. When we fail to acknowledge our interconnectedness with one another, it is easier for us to detach (and therefore distance ourselves), and to objectify those who are different from ourselves, especially those who are perceived as weak, and those who are suffering. This detachment limits our capacity for compassion, and our ability to serve and respond to others in life-enhancing and healing ways.
The Objectification of Human Beings

Within many large health care facilities, there is often an implicit assumption or view of the person as an "object who must be managed." In a recent *Maclean's* article entitled "The Health of Nations," Dr. David Naylor, the University of Toronto's Dean of Medicine is quoted as saying, "We cannot manage what we do not measure" (Janigan, 2002, p.42). His comment reveals the intrinsic value and the unquestioned privilege given to the concept of management and the importance of measurement in the health care system. Within the norms of this model, patients quickly become bodies with diseases to be cured, identification numbers, or labels on a hospital chart. Jevne (1991) warned, "[i]t is difficult enough to be ill. It is even harder to be treated like a thing" (p.161). The reductionistic language commonly used in health care settings can be destructive to our individuality, to our uniqueness as human beings. By giving patients labels and maintaining a focus on this label (the medical or mental health condition) rather than on the person, medical staff reduce the complexity of the situation, perhaps making it easier to manage. Remen (2000) pointed out that in her experience as a physician-in-training in medical school, "the meaning of illness was seen as irrelevant" (p.29). Yet, meaning--how we perceive and make sense of what is happening to us--is actually central to our personal experiences of illness and of healing (Bakal, 1999; Lewis et al, 1994). In a modernist-influenced medical model of care, the contextual reality of the patient, including their emotional responses to their illness, is minimized. Symptoms, rather than being helpful signs which might give clues to the patient's larger context, are simply viewed as troublesome problems which must be cured. For instance, a symptom such as anxiety becomes a problem to be fixed, something to be quickly and easily treated with the anti-anxiety drug Adavan. This is a more efficient (though obviously at times necessary)
alternative for a nurse than taking the time to sit with a restless patient and speak with them about their fears and worries. Perhaps it is not just caregivers who perpetuate this problem, but patients as well, who have become accustomed to receiving such medical quick fixes, and therefore expect and possibly even demand them.

In the hospitals and care facilities where I have worked as a music therapist, I have been privileged to work with many incredibly caring nurses and other health care professionals. Yet, the structure of the health care system, and the norms of many institutions, do not generally allow the unrestricted expression of our compassion and caring. Time for in-depth human contact is often very limited and resources are frequently strained. In addition to the challenging nature of the work itself, the politics of the work environment often add a great burden to caregiver stress levels. Too often, fine, compassionate people are stifled in their work in the health care field and this leads to stress, disillusionment and burnout. We are all affected by the systems we work and live within. These are complex systems, and I do not propose that we will find a simple solution. It is not my intention to place blame on one party or another, but rather to propose the notion of a fundamental paradigm shift that may help to create a more balanced and humane system for all. Perhaps it is more accurate to describe this as an enlargement of the current dominant paradigms in health and education to include more holistic values. After all, I am not proposing that we exclude efficiency, rationalism, or scientific knowledge from these systems. Of course there are settings where efficiency must rightfully take top priority, the emergency room in a hospital, for instance. Yet, we have allowed these values to rise to the top of the hierarchy, to dominate and control us, like false gods. Our need to see things in black and white terms, our propensity for binary thinking and solutions must somehow be broadened to encompass paradoxical thinking--
thinking which is capable of embracing the ambiguity and the mystery of human life (Cullingford, 1999). According to Cullingford (1999), “[b]inary opposites continue to fascinate [us] because they are a simpler measure, a simpler tool of understanding than seeing the whole” (p.56).

For many who work in caregiving professions, a sense of depersonalization and disconnection in their work settings has led them in search of different environments and alternative approaches which honour a broader, more holistic perspective of human beings. This has led some health care workers towards the field of palliative care, and some teachers towards alternative schools. When a model of caregiving that is rooted solely in the values of objectivity and efficiency is prominent in health care and educational facilities, then we are in danger of losing touch with our most valuable resource for caregiving: our own compassion and humanity, the capacity we have to connect with one another, merely for the sake of connecting, without expectations of material or personal gains. In order to bring a sense of connection back into health care and education, we may have to step outside the paradigm of modernism and imagine something quite different.

The Interface of Music Therapy, Psychology and Modernism

Thomas Moore suggests that our uncritical acceptance of the values of the modern world have led towards a kind of “psychological modernism” (1992, p.206). We tend to associate problems in living with the emotions, or with family origins, rather than with a loss of meaning, a loss of soul, or a lack in our spiritual development. Psychology is separated from religion, and we are generally cut off from a deeper understanding of psychology’s ancient spiritual roots, where the Greek origin of the word actually meant
'the study of the soul' (Elkins, 1995). According to Shafranske and Gorsuch (1984), spirituality has been ushered out of psychology in part due to Freud's influence, a predominance of behavioural approaches, and an urgency within the field to gain recognition as an empirical science. The advent of psychology as the scientific study of human behaviour placed an inherent emphasis on things which are quantifiable and measurable. Modern psychology, in attempting to align itself with the physical sciences, has largely divorced itself from anything to do with mystery or spirit, beauty, aesthetics, or the arts, and has thus separated itself from its ancient roots (Hillman, 1979). Hillman asked the question, "How is it possible that beauty, which has played such a central...part in the history of the soul...is absent from modern psychology?" (1981, p. 26). In these ancient roots lay, not only a broader understanding of the whole person, but also a much deeper understanding of the importance of the arts in healing (Hillman, 1981; Kenny, 1982; McNiff, 1992). Perhaps this is part of the reason why many modern schools of psychology have not widely embraced or even recognized the value of the expressive arts therapies. McNiff (1992) suggested that, in order for psychology to understand art, it must learn to speak a new language and become part of a different culture: "We have to step outside the frame of positivistic science, and into the archetypal mainstream of poetic and visionary contemplation" (p.74). In recent years, there have been renewed calls (particularly from therapists influenced by Jungian, Depth and transpersonal approaches) for a re-visioning of modernist psychology. Moore (1992) stated, "Our very idea of what we are doing in our psychology has to be radically re-imagined (xv)...Psychology is an incomplete discipline until it includes spirituality and art in a fully integrative way" (p. xix).

10 There are entire books written on Depth and Jungian psychology which give more insight into these links. In this section, I have only been able to touch very briefly on an area which has a much broader scope.
The fragmentation of human experience and human nature which is so characteristic of modernistic ideals, can also be seen in the practice of psychology. As an example, I would point to the current attempt by the Ontario Psychological Association to change the regulated health professions act in order to make ‘emotional counselling’ a controlled act in that province. This means that no health care professional, other than registered psychologists and psychiatrists, would be legally permitted to engage clients in psychotherapy or counselling involving emotional matters. The assumption that a holistic activity such as counselling can be separated and divided into component parts (i.e., emotional, mental, social, physical) reveals a very fragmented view of human nature. I cannot see how certain forms of counselling could be labeled emotional, and others non-emotional. A palliative care nurse, for instance, should have the freedom to respond to the emotional needs of her patients, as much as to their physical needs. These needs are intimately intertwined. Although nurses are not therapists, many of them do develop and utilize counselling skills, particularly in settings such as palliative care. Secondly, if the Ontario government accepts this proposal, the implications for patients and health care providers would be dramatic and severe. A large number of people currently access counselling services which are not provided by psychologists. For many, psychologists' fees are prohibitive. For others, they simply prefer to work with counsellors who have expertise in a particular area; expertise which is often born out of years of working on the front lines of the health care system. Under the proposed guidelines, it will become unlawful for Masters' level counsellors/therapists, social workers, expressive arts therapists, addiction counsellors, chaplains and pastoral care counsellors, nurses, child and youth workers, community mental health workers, and victim services counsellors to provide any form of emotional counselling to their clients. In their attempts to have
control over such a broad area of practice, the Ontario psychologists who are bringing this proposal to the government are revealing the wounds of modernistic ideals: manipulation, isolation, control, all rooted in a very fragmented view of human nature.

As a field, music therapists have frequently turned to the more established discipline of psychology for assistance in understanding both the nature of therapy, and the nature of the clients we work with (Ruud, 1980). Indeed, numerous psychology courses are required for the completion of a music therapy degree. By linking our field to the perceived validity of an established caregiving profession such as psychology, music therapy educators perhaps hoped to gain greater acceptance in mainstream health and educational settings and to assist in the creation of employment for accredited music therapists. In a new field, it is important to work towards defining a professional identity, yet we must also be willing to draw on the knowledge and expertise of other disciplines. What I am critiquing here is not the use of other disciplines to help us in our education, but the unquestioned acceptance of the norms and values of other disciplines, in this case the norms of mainstream, modernist-influenced psychology which do not honour the healing and spiritual roots of our own discipline. Along with Epston and White (1990), I think that we need to become wary of situating our practices in “those ‘truth’ discourses of the professional disciplines, those discourses that propose and assert objective reality accounts of the human condition” (p.28). There can be a shadowy side to increased professionalization. In order to gain mainstream recognition and become part of the larger systems, perhaps one must buy in (at least, partially) to some of the prominent values in those systems. If these values are rooted in modernism and a positivistic paradigm of measurement, how then will music therapists--many of whom, by the very nature of their work, hold different values--be able to work comfortably in these systems? In our rush to
become accepted, we may find ourselves reticent about some of the more mysterious and less tangible aspects of our work in order to avoid being perceived as lacking in scientific accountability. We may avoid describing or reflecting on inner therapeutic processes, and find ourselves swept into the fray of proving outcomes to cost conscious administrators and co-workers—a predominant reality in the current British Columbia political and economic climate.

In Chapter One I described how the practice of music therapy in health care settings is commonly misunderstood, and even ridiculed by medical staff. Music therapists are often viewed as entertainers, rather than as health care professionals with extensive education and therapeutic training. In British Columbia, music therapists are facing numerous job losses due to government cutbacks and a lack of understanding about what their work can contribute to the health of communities and individuals. In a system where the modernistic world view dominates, the arts are simply less important than technology and science. Although they may be acknowledged to be life-enhancing, they are rarely acknowledged to be life-sustaining. The potential role of the arts in healing is rarely considered by those in the medical profession who think of healing only in terms of cure and progress. Music therapy, as I have noted earlier, is the kind of therapeutic approach which is not easily reduced to components that can be efficiently measured. It does not fit neatly into a positivistic paradigm of measurement, and therefore it is difficult to ‘prove’, for instance, that music therapy in a hospital could decrease the length of a patient’s stay. It would be easier to demonstrate, through qualitative analysis, how music therapy contributes to the quality of life for patients in a hospital ward. Questions of quality of life, however, are at the bottom of the list, in a health care system dominated by modernism, and obsessed with measurement. The current conflicts present in the field
of Canadian music therapy perhaps make more sense when we can view them not as personal affronts (although that is undoubtedly how we experience them), but as reflections of the values of a larger system. The paradox, of course, is that the disconnection and wounding created and perpetuated by a modernistic system is in dire need of modalities like music therapy which are capable of fostering life-sustaining and health-giving connections.

As we have seen, the threads of modernism wind their way through many aspects of our society: they influence our systems of care, our health services, our schools, our psychological understanding, our views of human nature, indeed the entire process of our education. This thesis, however, is not only about music therapy, but is also about the intersection of this arts-centred therapeutic approach with the suffering of grief. And the influences of modernism can also be found in our Western understandings of and responses to death and grief. This influence contributes to the breaking of our wholeness, to the fragmentation of our whole being. Vanier (1998) stated, “If we deny our weakness, and the reality of death, if we want to be powerful and strong always, we deny a part of our Being, we live an illusion” (p.40).

Modernism, Death and Grief

The subject of death has long been locked in silence and tension; in society, in families and in schools (Doka, 2000). Western society has been called a death-denying culture. The cumulative growth of a rational and scientific understanding of the world, and our propensity to manipulate and control nature, does not, however, guarantee us control over the events of our lives. Death is a certainty for all human beings. The deeply embedded norms of modernism (rationalism, efficiency, control, mastery, and progress)
have contributed to a lack of acceptance of the realities of death and existential suffering, and thus have wounded those who grieve and others whose experiences and illnesses cannot be ‘fixed’ or ‘cured’. According to Klass, Silverman and Nickman (1996), “When applied to grief, this view suggests that people need to recover from their state of intense emotionality and return to normal functioning and effectiveness as quickly and efficiently as possible. Modernist theories of grief and related therapeutic interventions encourage people who have experienced loss to respond in just this way” (p.32). In our modern Western society, people are expected to get over their grief and move on with their lives very quickly. The standard government leave granted to an employee who has experienced the death of a family member is only three days. According to traditional stage theories of grief, after mourners absorb the shock and experience the emotions of grief, they must then relinquish their attachment to the person who has died, in order to move on and invest energy in life. This model can be seen to reflect some of the values of modernity: a need to resolve problems decisively and efficiently. Much of the research related to bereavement (out of which these grief models have been developed) has been carried out within the context of a Western world view, in positivistic paradigms. However, more recently, qualitative researchers have been emphasizing that mourners (especially children) do maintain an ongoing sense of connection to the person who has died, and that this connection is in fact a healthy part of the grief process which may enable the survivors to cope. In addition, the modernist idea that grief can be ‘cured’ within a particular time frame, or indeed that it ever comes to a finite conclusion in a mourner’s life, is also being challenged (Attig, 1996; Klass, et al., 1996; Parkes et al., 1997;).

Often, people ask me how I can possibly work with dying and grieving children.
In our North American culture, accustomed as we are to a generally high standard of living and health, we assume that a long life should be our birthright, a given. However, I wonder how our view of death and dying might shift if we were to view life differently; not as a guaranteed time span, but rather as a mysterious opportunity given to us, in which the quantity of years is not the main issue, but rather the quality of our years. In a modernist age where science has made unprecedented and life-enhancing breakthroughs in the treatment of so many diseases, and where medicine has enticed many people to turn back time with the help of surgical and chemical treatments, we may unconsciously or consciously be denying the reality of death. The marvels of science and human progress may be strengthening our dreams of delaying, and eventually perhaps even outwitting death altogether. Yet, viewing death as a problem to be solved or a subject to be avoided completely is not the only way of seeing things. Is it possible that our avoidance of the subject of death might be altering and impoverishing our experience of living? Are we better off not thinking or talking about death at all? Or is it possible to “befriend our dying gradually and live open to it, trusting that we have nothing to fear?” (Nouwen, 1994, p. xii).

Prior to the 1980s, there was very little mention in the grief literature about the response of children to loss. Some psychologists believed that children could not mourn because they had limited ego capacities, lacked reality testing abilities, and a sense of object constancy (Wolfenstein, 1966; Freud, 1960). However, most professionals now agree that children do indeed experience grief. Still, as a consequence of North American society’s tendency to fear and deny death, and to minimize the impact of death and the length of the grieving process, children are often isolated or left alone to struggle with their intense feelings, bodily responses, and thoughts as they try to cope with the death of a
loved one. Denial of a child's life context, and a failure to hear their existential questions about life and death, can be likened to a wounding process. Children intuitively sense the discomfort of those around them--without any words being spoken--and thus, learn to disown and hide the personal experiences which seem to elicit this silence and discomfort (Oaklander, 1988). Vanier (1998) likened these moments to “a dagger in the heart ... [which brings] the child to a place of confusion and anguish ... she cannot understand what is happening, nor can she express her anger. She has to suppress it; she pushes it down into the secret recesses of her being” (p.42). And so it is that the wound, the shadow area, the inner darkness which influences our future attitudes, and shapes our becoming; our process of development and growth, becomes manifest. North American culture has become very sophisticated in its avoidance of pain; particularly existential "unfixable" pain (Nouwen, 1975; Levine, 1987). Attig (1990) suggested that this cultural tendency is manifested in an aversion to being with those who are grieving the death of a loved one. He elaborates:

Times of loss through death are times of distinctive vulnerability when persons are often suffering terribly, and where supportive, humane response is vital. Unfortunately, few are comfortable and willing to be with those who are grieving, and this adds to their suffering. All too often those who wish to be supportive pull away concluding, ‘I don’t know what to do or what to say’. (Attig, 1990, p.54)

Here is a story of one young girl’s experience with the death of her father, and the wounding she experienced as she tried to integrate his loss into her life, and found only silence, criticism, and a lack of compassion from her peers. Kerys’ father died of a brain tumor when she was eleven. She witnessed his death in the hospital intensive care unit--where he had gone into a coma after he contracted an infection following one of his surgeries. She describes this experience in her own words.
“My dad first got sick when I was only four years old. He had so many major
operations. I think at least forty-nine of them. In the last year before he died, he was in the
hospital more than he was at home. He had a whole bunch of infections in his brain and stuff.
Near the end--maybe the last four weeks or four months, I can't remember--he was in a
coma. That was really hard. Every day we had to drive about two hours in bad traffic to see
him. I wanted to see him, but it was just so much ... I'd get so tired. If he woke up he was
going to be brain damaged and have to be in a wheelchair and stuff. So we had to decide to
let him go if he wanted to go. He was breathing through a machine, which we took out to see
if he wanted to breathe on his own. But he didn't ... he just kind of went. I still remember the
day exactly, perfectly. I remember every single thing; taking off the gowns, putting on the
gowns, going back in ... we must have taken those gowns on and off about four times. Once
they took the machine out he only took one more breath. Basically we were at the door in the
racing position, and so we rushed in to see if he would breathe. I didn't get there in time and
my Mom didn't, and he was gone. It was hard, but everyone from my family was there--so
that helped a bit. We had lots of hugs. But, since then, its just been hard all around. No one
in my family has been the same since. Nothing has been going the way we needed it to this
year.”

After her father's death, Kerys began to experience the isolation that grief can
bring into one's life. She suddenly found herself to be the only child in her class at school
who didn't have a dad. Although Kerys' schoolteacher was supportive to her and that was
helpful, she was very disturbed by the responses of her classmates to her grief. She often
talked about this when she joined the children's grief group. The lack of empathy shown by
her peers was one of the main reasons her mother wanted her to be in a group where there
were other children with similar experiences who could validate Kerys' loss and the feelings
associated with that loss. This is how Kerys described her experience to me: “The kids in my
class were never supportive. At the beginning of the school year, when it was first really
hard, sometimes I'd have to go out of the classroom. My teacher was good. He let me do
that. Some kids in my class just thought that having your dad die was like the same as a
divorce. They didn't understand why I was so upset. But it's not the same at all. It's totally
different. If your parents are divorced you at least get to see your dad every once in a while.
You get to look forward to that day. But my dad is not coming back. He's never coming back,
and he won't be there for my Graduation. It seems the kids in my class don't care anymore.
They think "oh it's been a month, she should be over it by now." One girl I know told me that
I needed to get over it. She said I was using my dad's death just to get attention and sympathy from the other kids. Lots of people don't believe what it's like—they really don't have the feelings. So that's when I figured they'll never understand. And next year, I know some of them are going to totally forget. I'll get no support at school, so it's going to be hard again this September. There's so much that I miss about my dad. …"

Kerys’ story illustrates how a lack of empathy towards someone who is vulnerable can increase and amplify the suffering they already experience. Without compassionate responses to our suffering, we can become wounded people. One of the reasons, perhaps, why there is an uneasy silence in our culture around death and grief—particularly when they involve children—is because we find ourselves faced with a situation in which there are no easy solutions or quick fixes. We are confronted, on some level, not only with the reality of our own mortality, but also with our own powerlessness to change a difficult situation. It may be that “adults cannot quite bear the thought that their children are having to face the deepest questions” (Cullingford, 1999, p.13). If nurturing a child’s wholeness is identified as part of the essential purpose of caregiving practices (in therapeutic settings or in educational ones), we must be willing to hear stories of pain as well as stories of joy, for these things are intimately intertwined with a child’s development, and with their ability to learn any subject. In order to listen to stories which can be difficult to hear, we need to be capable of practicing a particular kind of attentiveness: the kind of listening which accepts pain and suffering as part of the whole of life, and allows it to be present, without rushing in to fix it or to take away the pain. If we want to be helpful, we must accept that we cannot carry another person’s suffering, and we cannot simply make it go away (Attig, 1990).

I would like to share another story from my work in palliative care—a story which I think illustrates the shift from a modernistic viewpoint to a more holistic view of life.
This is the paradigm shift that we need to make in our current North American systems of care, as I have argued here. It is the story of a woman who succeeded in achieving great financial, material, and professional success, but then found herself suddenly faced with a life-threatening illness. In the process of coming to terms with her illness and her imminent death, she drastically changed her view of life, reversing her assumptions and beliefs about what matters and who matters. In an interview I conducted with her only a few weeks before her death, Lian specifically spoke about how the kind of care she received in our palliative care unit helped her to accept her prognosis, and how the compassion she received there made a difference to the quality of the last months of her life. She said:

I think, for two months already I am in this Palliative Program. ... I think this helps accepting what is going to happen to me. I met very, very good people here. I have all the good treatment that gives me comfort. ... And I have attention from staff here, I mean not that official attention like nurse-patient. It goes beyond that, it goes beyond that. ... And that helps a lot. That helps a lot. I mean, sometimes you don’t need to be really capable of healing or treatment, but just have concern and care about. Being there is very much good enough. It makes a difference. Oh yes. I don’t feel alone here. I don’t feel lonely here. I have just regret. How come I didn’t know all these people, all these good people earlier?

In these past years of working as a music therapist in palliative care with adults and children, my life has been deepened and enriched by my encounters with many inspiring people. Lian has been one of those people. In her struggle to come to terms with her death too early in her life—and in her willingness to name and to share that struggle with me—Lian gave me hope and touched my soul very deeply. Jevne (1991) said, “In a world of disconcerting circumstances, the one remarkable display of hope is the profoundness and resilience of the human spirit. This ... in the presence of no apparent justice. There is no immunity. Just the courage of the silent hero, and the support of the
silent troops” (p.12). Here is the story of Lian’s courageous, despairing, and hopeful journey towards her own death.

Lian was a young single woman, born in Malaysia, who had lived and worked most of her adult life in Hong Kong. In Hong Kong she held a high executive position as a financial manager in an American company—where she was responsible for the development of business ventures and company expansion in China. Her job was extremely stressful and demanding. She travelled constantly, and regularly worked fourteen hour days, six days a week. She did not share her breast cancer diagnosis with her work colleagues; and she went back to work only days after her surgery. Even after she lost her hair during chemotherapy treatments, she returned to work immediately, wearing a wig, and did not inform her co-workers of her illness. Lian was fiercely independent, self-reliant and had worked her entire life to achieve the position and status that her job entailed.

These achievements were even more remarkable given that Lian was the youngest of seven children, born into a family where there was little money for education. So, she worked three jobs a day for seven years to save enough money to send herself to university in order to get a business degree. Though she told me she was always interested in philosophy, she considered this to be the kind of degree one would take as a luxury, and not when one had to further one’s position, and establish one’s financial footing in the world without the assistance of family money or government student loans or assistance. Lian’s drive to create a better life for herself than her family had, and her ambition to learn clearly motivated her to succeed.

When the cancer treatments in Hong Kong did not seem to be working, Lian came to Canada seeking further treatment for her cancer. She had vacationed in Vancouver, and had a friend who was a doctor there. She was so weak when she arrived that she had to be taken off the plane in a wheelchair, and was admitted directly to the hospital. It was determined that the cancer had spread even further, and the airlines would not allow her to fly back to Hong Kong. So, she was admitted to our palliative care unit; where she stayed the next three months until her death. Almost every person who walked into Lian’s room was struck by her beauty. She had a smile which reached out and drew you in; it truly lit up the room. She also had a sense of composure and clarity which was unique. She defined very clearly what she would and would not accept in terms of her care. This endeared her to some caregivers, and frustrated others.
In the beginning, I simply visited briefly. I introduced myself along with other members of the team. Initially she smiled and dismissed me. "No, thanks, she didn't need anything." Her care was very good, very satisfactory. Music she declined as she had her own tapes with her. She was always kind and polite, but didn't invite lengthy interaction. After a period of about one month, however, Lian began to reach outside of her independence ... to invite more people into her world. I was fortunate to be one of those people. One day, she invited me to sit beside her at the bed. She talked for a long time, that day. Mostly about the agony of "waiting to die"; wanting things to move along more quickly than they were. She had accepted that her disease was terminal; but why did it have to take so long? She always had many questions for me. Would she die today? Or did I predict it might be a few weeks? She was reluctant to take her morphine. She wanted to stay as alert as possible. Lian told me that waiting to die was like "having all your bags packed, waiting at the airport without knowing when the plane was going to depart, or what the final destination of your trip would be." Her acceptance of her death, and her openness to talking about it so directly was unique.

Lian had recently converted to Buddhism when she became ill. She practiced chanting, and was in contact with a convent in Malaysia for spiritual guidance. She was not afraid of death, but she wanted to know as much as possible about what to expect. For this, she drew on the knowledge of the doctors, nurses, staff, and volunteers who worked with the dying. She practiced holding an image of the Buddha in her meditation as a focus for the moment of her death. I invited Lian to try some guided imagery with me. Initially she declined. However, she was curious. She asked me lots of questions about it: what was it like, how did it work, did other patients enjoy it? One day she said she would like to "give it a try." She had a clear idea of an image she wanted to visualize. This was related to a life's dream she had not had the opportunity to accomplish: the dream of owning an orchard. After the first visualization, she was delighted with her journey. She smiled and laughed, and told me that she had been walking in the orchard wearing the pyjamas she had on that day! We continued to work with this same image throughout our time together. She always wanted to go to the same place. She often played her relaxation music; her room was usually filled with the peaceful sounds of birds singing. After hearing about the importance of Lian's image, our team volunteer coordinator, Maetel, brought her a small potted tree (intended to represent an apple tree) for her room. This tree gradually blossomed with tiny models of fruit and birds that various staff members donated, and someone added tiny white lights. Lian was moved and delighted with this gift. It represented all the kindness and concern of the
palliative care team for her. She mentioned it frequently. She explained to me that this kind of personal care and attention to detail would never have happened in a hospital in Hong Kong, where nurse-patient relationships are more official, and from her perspective, less giving and caring in such a personal way.

I spent a great deal of time with Lian as she approached her death; sometimes sitting and holding her hand in silence if she was feeling tired, other times talking, and also leading her through guided imagery sessions. She was immensely curious about the difference between our cultures, and she asked me endless questions about myself and my upbringing. We often laughed together at our assumptions, and at our very different ways of seeing the world. One day she turned to me and said "How long have I known you Heather? Only a few months? This is very deep. I care for you. If we had more time together, I would take you traveling to Asia with me and show you many things." And then she laughed and said "You know, my brother, I think he is still looking for a nice wife!" Another day, when she was feeling very weak and it was getting harder for her to talk, she said to me, "Heather. When I can no longer speak, will you please still talk to me? Because I will be listening to you." Her words moved me to tears. I reached for her hand and held it tightly as silent tears ran down my face. She offered me a Kleenex from the table beside her bed, and then we continued to sit in silence. Together, we cherished the stillness and the closeness of the moment.

Lian continued, slowly and comfortably to move towards her death. Her urgency to die and "get this over with" diminished, as she built relationships with the staff and volunteers. She was a good listener, and full of questions for everyone who came into her room. She radiated warmth and energy when you held her hand. One of the staff members said he had to stop holding her hand because he felt like "he was receiving too much from her, taking away her energy." Only a few weeks before her death I taped an interview with Lian. I wanted to capture some of her life story on tape, and also to try to understand what it was about being in the palliative care unit that was making death more bearable for her. She said that all her life she had analyzed things in a materialistic way. Her goal had been to earn money, and succeed in her career, so that she could be independent. She was a quiet, introverted woman, who had a few close friends, but kept mainly to herself and had no significant romantic relationships. At the end of her life, she said she became more spiritual; she started to listen to other people, and to allow herself to connect with other people. She also said it was the first time in her life that she was actually resting, not doing or achieving any tangible, material things. She discovered that "listening is much more
important than talking." At the edge of life Lian continued to learn new things, and in the process she transformed herself by giving of herself to others.

It has now been over two years since Lian slipped away like a candle gently extinguished in the night; over two years, since I woke--at home on Christmas vacation--early on the morning of her death to sense that she was gone. The night before I had unknowingly arranged the word magnets on my fridge with the phrase "sailing into eternity." Another wonderful and symbolic gift came in a Christmas package in the mail from my mom (who had no idea of the significance of her choice of gift) just a few days after Lian’s death. It was a tiny, blue glass bird; this was a symbol of Lian for me--as she always had tapes of birds playing in her room.

Lian touched my heart, and many other hearts, in the last months of her life. In the midst of dying, it was clear she was able to find a path to peace and to healing, not only for herself, but also for many of those around her. And some of the peace she found was within the imagery sessions we shared. When she walked through her apple orchard, and reached the top of the mountain overlooking the valley, she often smiled. Her face was calm and serene, her breathing deep and slow, as I watched her from my seat next to her hospital bed. She found her own way to walk the path of transition between life and death. It was when her illness brought her normal way of being-in-the world to a standstill that she discovered life can be lived in other ways.... She moved from a place of valuing money and a fast-paced, affluent lifestyle, to a place of valuing relationships, listening, and being. One day, laughing, she said to me "You know, I can’t take all this money I made with me...." In the face of death, Lian looked back on her life, and thought she might do it a bit differently the next time around...

The relationship I shared with Lian brought meaning and richness to my life. Saying goodbye to her was a difficult thing. Though I grieved very much for her loss, I do not remember her with sorrow, but with gratitude for the time we shared. She became, in such a short time, a precious friend. She still continues to bless me with her presence, which lives on in my heart and in my memory. I wonder aloud at times of what she might have thought of some action of mine, or how she is, or what she sees and knows, about the meaning of the relationship we shared, and how she touched so many of her caregivers
with such depth and truth and intimacy. Lian taught me about the continued importance of connection: until the final goodbye, the last breath, the last moment, and even beyond...

Thank you Lian. This is my prayer of gratitude.

Lotus flower blooming  
you unfold in my dreams  
angel-white  
a symbol of purity,  
a symbol of spirit  
joy--because you are in my life this day.

I remember your touch...  
hands clasped in shared agony  
reaching for some comfort  
as together,  
we watched your life slip away...  
and,  
together,  
we travelled the image-lands of imagination; mine and yours  
fruit trees  
ripe and bursting  
cherry blossoms spilling onto sun-lit paths  
that meander with delight  
through your life's dream

then, up the mountain  
climbing  
until rock turns into wide open sky  
and you find a place to sit  
breathing in  
breathing out  
You have found some peace here.

And on the day of your death  
you slipped away so gently  
in Grace and Silence  
And Blessed me  
with your presence...  
whispering goodbye, across the water...  
in my dream.
Chapter Summary

In this chapter I have critiqued the modernist world view as a negative influence on North American society and its systems of care, and have attempted to show how the influences of this world view surface in many different aspects of our lives. In my critique of modernism, I have not intended to propose that we need to do away with rationalism, science, individuality, and progress in our world, but rather that we need to balance these things with an equal respect for intuition, the arts, and an awareness of our connectedness to, rather than our separation from, one another.

The presence of music therapy in a very technologically oriented health care system compels us to move beyond binary, either/or thinking to embrace the paradoxes of a broader vision of health: a vision in which healing incorporates the latest advances in scientific medical research and technology with the art of compassionate, loving attention from caregivers. Where music and medicine, art and science, can co-exist, not in opposition, but in a mutually beneficial collaboration with a common goal of healing which ultimately and foremost benefits the patients we wish to serve. Moore (1992) stated that the time has come to replace “our modernist psychology with care of the soul and ... to begin rebuilding a culture that is sensitive to matters of the heart” (p.284). Music therapy could be an important part of this rebuilding and this re-visioning. Perhaps one of the reasons music therapy has encountered such resistance is because it consistently points towards the need to redefine and expand our view of health and healing. I think it is important to recognize that our struggle for identity and recognition in music therapy is not an isolated one, nor a purely personal one, but that it has something to do with the larger context--it is interrelated with the implicit norms and values of a modernist, materialistic society.

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While disconnection may be at the root of many of our societal problems and modern-day concerns, and while it may reflect a modernistic-materialistic period of human greed and over-consumption in history, I hope that those who take the time to read this work will be drawn in another direction, one which ponders the possibilities for healing suffering and alienation by drawing us into a healthy sense of belonging, to a sense of connection rooted not in fear and control, but in love, trust and freedom. In the next chapter, I will explore this view of healing, and articulate the connections between the arts and a holistic view of health and human nature.
Chapter Three: Healing
Introduction

In Chapter Two I linked the devaluing of the music therapy profession (as discussed in Chapter One) and the pervasive influence of the modernistic viewpoint on North American society. I also described the ways in which modernism influences and fragments our systems of care and built a case for a necessary paradigm shift in current caregiving practices in health care and educational settings. In this chapter, I will shift the focus from wounding to healing. Using a phenomenological lens, and drawing on my experiences as a music therapist in the field of palliative care, as well as literature from a variety of disciplines, I will examine in more depth the connections between the arts and healing. I will work out the notions of wholeness in music therapy practice, and contextualize clinical experiences within a holistic framework. I will also suggest a more holistic perspective of healing and health than the traditional North American modernistic viewpoint normally allows. The role of the arts and aesthetic experience in facilitating this holistic understanding of health will be described.

Healing and Wholeness

The educational and therapeutic approach I am articulating throughout this dissertation is inspired by a holistic view of healing--rooted in philosophical and spiritual traditions, and in my palliative care clinical experiences.

In 1926, when Jan Smuts introduced the word ‘holistic’ into the English language, he did it on the basis of his experience as a child on the South African veldt. Nobody introduced him to it, but he grew up with a concept of the veldt as a wholeness, a totally inter-related, interdependent organism made up of plants, animals, wind, seasons, sky--and he, as a child, was part of the whole universe of the veldt. (Allen, 1995, p.3)

The word healing is actually derived from the word “whole” (Exiner & Kelynack, 1994).
Thus the verb “to heal” may be used to describe a return to our essential wholeness; the movement of the human spirit towards integration of life experiences into the context of meaning that forms the embodied whole. Used in this way, the term healing is understood much more broadly than the common medical use of the word.

The Western medical model and system of care has traditionally used the word “healing” to refer to physical recovery from an illness or injury, brought about by the direct intervention of the physician or other medical professional on the patient’s body. Healing is understood as a physical phenomenon, unrelated to mind or spirit. Greenwood and Nunn (1994) suggested that the polarization of mind and body in Western medicine can be traced to the far-reaching influence of Descartes’ dualistic conception of human beings. However, this Cartesian view of the human body as a machine, separate from the human mind, is increasingly being challenged by pioneering researchers in the cognitive sciences and neurosciences who are affirming that inextricable connections between mind and body, psyche and the immune system, do indeed exist (Pert, 1997). Some health care settings are shifting towards a more integrated view of health, and an acknowledgment of the concept of the mind/body/spirit as a gestalt which cannot and should not be separated (Greenwood & Nunn, 1994).

Northrup (1998) suggested that the fundamental difference between healing and curing is that healing comes from within the individual, while curing usually consists of an external treatment, administered by a health care professional. Nabe (1987) stated, “It is not the task of the health care giver to give wholeness to the person who is diseased/suffering. ... But while we cannot give such wholeness to another, the process of achieving such integrity can be assisted (or hindered) depending on the environment in which the person finds herself” (p.284). From a holistic perspective, healing cannot
always be tangibly measured by the achievement of a cure or a solution. Healing goes beyond the physical dimension to encompass the mystery and paradox of the spiritual dimension. A patient may be healed, yet still go on to die of her illness (Northrup, 1998). In fact, in some cultural and religious belief systems, death itself is viewed as a healing, a merging of the individual self with the greater whole, bringing peace, fulfillment and wholeness (Levine, 1987; Singh, 1998). The ancient Druids greeted new births with mourning, believing that the infant would now have to face the suffering inherent in life on Earth, and greeted death with celebration, believing the person could now experience true peace and wholeness. This is clearly the opposite of our current Western norms, in which—generally speaking—birth is celebrated and death is mourned. Singh (1998), a transpersonal psychologist who works in hospice care, said, “Dying is safe. You are safe. Your loved one is safe” (p.1). Levine (1987) said, “Healing into death, the separate self dissolves into universal being” (p.278). Similar sentiments are expressed in the words of famous poets and religious leaders. Walt Whitman said, “Who need be afraid of the merge?” Gautama Buddha said, “It is in the nature of all things that take form to dissolve again.” In Ecclesiastes 12:7, we find the phrase “The spirit returns unto God who gave it.” Healing in this context becomes a reference point for describing a movement toward mind-body-spirit wholeness; a process which is perhaps beyond our capacity for imagining, something which has little to do with success or progress as it is defined in a materialistic, ‘results oriented’ world; a process of growth we cannot necessarily observe or measure through traditional, scientific means.11

Living with a life-threatening illness or with grief often results in an extreme sense

11The positivistic paradigm gives us little room to explore or inquire beyond the bounds of what is physically observable. The desire to ‘isolate conflicting variables’ and to find what can be measured, may blind us to the subtle, sometimes invisible, and irreducible elements of the whole. However, an inquiry which embraces artistic language and modes of communication, may help us to embrace the paradoxes of healing, and to respect the mystery of those things which are beyond words or logic, thus keeping the fundamental spirit of mindful inquiry alive.
of personal alienation, wounding and fragmentation. The death of a loved one shatters and fragments the world as one knows it, and forces one to assume a new way of being in the world. Medical treatments for cancer such as surgery, chemotherapy and radiation are highly invasive and are experienced by many patients as violating, destructive, and fragmenting to their sense of self. Health care providers need to help those who are suffering to overcome this sense of fragmentation, and support their “striving toward wholeness” (Nabe, 1987, p.282). According to Nabe (1987), the most basic purpose of all forms of care is to facilitate wholeness. Wholeness lies beyond perfection and goodness (Levine, 1987; Palmer, 1998; Remen, 1996). It relates to the process of finding a state of balance in which one is able to recognize and express many facets of one’s being and one’s experience with a level of acceptance and integration. Paradoxically, it is about embracing all that lies within us, our strengths and our weaknesses, our fear and our courage, our pain, our grief, and our joy. It is a process of coming to accept and embrace the parts of ourselves and the life experiences, which, for whatever reasons--most often in response to our own self-judgments, or those of other people--we have disowned or cut out of our awareness. If we are forced to deny, suppress, or hide parts of our human experience--and we know this frequently happens with children who experience loss, trauma and abuse--we create a wall which impedes the development of our health and our wholeness (Oaklander, 1988; Webb, 1993). By hiding our pain, we also hide, and therefore limit, our ability to heal (Levine, 1987).

A Holistic View: Finding Connections between Music Therapy and Wholeness

How does the view of healing and wholeness I have just described manifest in actual music therapy practice? For me, it begins with the way in which we ‘see’ those
with whom we work. Our actions are grounded in our ways of seeing, our ways of perceiving. The way in which we think about our clients and assess their capacities to interact and to understand, influences the way we respond to them (Ruud, 1980). Unlike psychologists or medical doctors, music therapists do not have to diagnose, label or prescribe medications or a particular course of therapy for their clients. However, we do have to make decisions (in joint consultation with our patients) about the directions of our therapeutic efforts. We must reflect on our purpose for working with a particular person at a given point in time. Purpose is the intent that influences our choices as therapists. I often ask patients, or parents/caregivers of children I am working with: “How would you like to ‘use’ the music therapy? What goals feel most important to you in your life right now? What do you think your child needs that music therapy can assist them with?” In my undergraduate music therapy education, I was taught that it was the therapist’s job to define and set goals, and to clarify measurable, achievable objectives for their clients. However, over my years of practice, I have come to believe it is more client-centred to discuss and set goals of therapy with the individual or (in the case of those who are non-verbal) with people who know and love them well, people who have their best interests at heart. A client-centred approach tries to reduce the power differential between therapist and client.

However, our attempts to be more human and vulnerable in our interactions with those who we are serving (in a departure from the typical detached ‘professional’ stance), should not imply that we are lackadaisical or unprofessional in our work. Like any health care worker, music therapists have ethical and professional obligations to their clients. We need to uphold the ethical values and principles of our field.\(^{12}\) There are certain required

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\(^{12}\) The CAMT (Canadian Association for Music Therapy) has developed an extensive code of ethics for music therapists. If one wishes to retain one’s music therapy accreditation status (MTA)—a certification necessary for most unionized music therapy positions—one must adhere to this code.
standards of documentation that we must adhere to in music therapy practice, and in
addition, each individual organization we work for will have certain government-regulated
standards that we must also abide by. The ethics I am most interested in, however, are
not the lengthy, wordy documents that are sitting in my filing cabinet. Like Vanier (1998),
I believe we need an “ethics of the heart,” rooted in love and compassion, to guide our
work as caregivers, regardless of whether our work is in music therapy, education, or
nursing. This kind of ethics becomes evident through our lived practice.

Holistic medicine acknowledges the importance of the whole person in healing.
Perhaps music therapists have found more ready acceptance in holistic medical settings
(i.e., palliative care), because “music has always concerned itself with a person’s total
beingness” (Bonny, 1986, p.6). In reading descriptions of music therapists’ clinical work,
or listening to colleagues speak about their work, I often sense this underlying holistic and
depth-oriented view of the client--whether it is explicitly stated or not. Salmon (2001)
stated, “Music therapists in palliative care regularly describe profound encounters with
patients. The work seems to facilitate quick movement beyond ordinary awareness,
where disease is prominent, into the realm of spirit and psyche” (p.142).

It is important to reflect on how we see those with whom we work, because much
is passed down to us that we do not question throughout the course of our education in a
particular discipline--including, of course, our understanding of human nature. Wever-
Rabehl (2001) stated that “[m]ost of our day-to-day actions are derived from habits of
perception and judgment that are deeply engrained and embodied. They are not deliberate,
but are rather tacitly built on unexamined assumptions” (p.74). If educational and

53 I want to caution the reader that my conceptions of wholeness and healing have emerged from a music
therapy practice which has been centred in oncology and palliative care, including the bereavement aspect of
palliative care; these are areas of practice which generally value a more holistic approach to client care.
Music therapists working in other settings may or may not share my views on music therapy and
wholeness.
therapeutic practices emerge out of our assumptions about the nature of clients or students, "[w]hat would practice look like if the child [or client] was seen as a spiritual being and an unfolding soul" (Hart, 2001, p.135)? Music therapists who ground their work in client-centred, humanistic-existential, and transpersonal theoretical traditions tend to emphasize strengths, rather than pathology or illness. We begin with the view of the patient as one who has the potential for healing, one who is both resilient and capable of change (Aldridge, 1995; Amir, 1992). Embracing a holistic view, and believing that clients are capable of change and growth however, is not the same as adopting a naively optimistic or idealistic view of the client. To acknowledge the whole is to accept others (and ourselves) as they are, with all their human limitations, and with all their strengths. Robbins (1985) said that "we can realize the blessing of wholeness only by conceding our defects. Through this realization, the chimera of perfection ... is exploded and a larger awareness, inclusive even of imperfection, emerges" (p.25). The holistic view takes into consideration that human beings have individual strengths and weaknesses, and exist within a broader familial, social and cultural context than medical history or psychological labeling usually reveals. In addition, we must acknowledge, that to know another ‘wholly’ is an impossibility—we can never completely know the whole of anyone or anything. It is therefore our conscious and intentional efforts, our ongoing striving towards a conception of the other in his or her wholeness, which implies our commitment to a holistic view (Bruscia, 1996).

Perhaps music therapists are frequently able to sustain a holistic view of their clients, because very often, in our clinical work, we are given the opportunity to see beyond the person’s illness, beyond their disability, through our shared experiences in the music. Perhaps many of us were drawn to the Beauty of the whole, that beauty that can
be hidden beneath the surface, and that music can often reveal, before we ever thought of becoming music therapists. While music helps to illuminate the whole, music therapy can make space for its expression, creating spaces where the unexpected can come into being.

I remember one client and his wife, with whom I shared just such a moment. Dan’s Alzheimer’s dementia was slowly impeding his ability to speak and walk. One day during our music therapy group, he turned to his wife Betty—who was visiting him on the special care unit where he lived—and gracefully invited her to dance with him. As they danced together (Dan in his wheelchair with his arms outstretched, and Betty swaying in time with him), I played a simple, favourite waltz. Dan sang each word clearly, looked into Betty’s eyes, and they both seemed transported to a time and place without disability. At the end of the dance, most of those who witnessed the moment were in tears, as were Dan and Betty; tearful but smiling, something whole shone through.

Merrill (1998) contended that it is through the process of ‘meeting in the music’ that we are able to see more fully the wholeness and the uniqueness of our clients. She described this place of meeting as one where we are “transparent to one another ... the masks of disability, of habitual behaviour ... dissolved (p.86) ... as a result of ‘meeting in the music’, the individual’s personhood emerges in the fullest possible sense: creative, whole, sentient, and relational” (Merrill, 1998, p.87). Merrill’s research and clinical work in improvisational group music therapy with severely impaired elderly clients demonstrates how they can become engaged in connection, relationship, memory, imagination, fantasy, and creativity. These are the people who are often treated as less than human in care homes; the ones who scream and shout in seemingly incoherent ways, the ones who stare vacantly off into space, strapped into wheelchairs; the ones who are assumed to be so ‘far gone’ that they have little to offer the world, or the nursing homes they live in. If they were taken seriously, Merrill’s research findings could have radical implications for caregivers in institutions for these elderly patients. In the conclusion of
her Masters’ thesis, Merrill (1998) asked this thought provoking question: “If hallucinations and fantasy were considered to be a face of an active and creative imagination, one which can be used to facilitate contact with the animate world, how might the lives of Persons with dementia change? How might the lives of caregivers and health care professionals change?” (p.141).

Music compels us to see, or at least to sense, the whole. When we meet another human being inside the music, we can sometimes experience something profoundly different from our habitual mode of being. There is always more to know, always more for us to learn and understand about the people with whom we work. Life is never as one-dimensional or simple as it can appear to be on the surface. There is always the possibility that a person with dementia, usually withdrawn and non-verbal, may raise her eyes to meet our own and grasp our hand to sway in time with the music, or that a dying patient in a seemingly non-responsive, comatose state can hear every word we speak and be comforted by the music we choose to play. People are full of surprises, but we may miss these moments, miss these possibilities for new ways of being to emerge when we are not open to them. We may miss them if we hold too tightly to the limits inherent in many health care settings: the common practices of labeling and measuring physical, observable results. We have to allow our thinking to move beyond the purely behavioural, physical level. There are many events going on around us which have the potential for meaning, but which pass us by when we are engaged in other tasks or not open to receive them. The most ordinary experiences can be surprising when we are aware and attentive. Yet we can participate in an oblivious way, unaware what the situation may contain, “like someone walking through rooms where wondrous music is playing, deaf to it all” (Nozick, 1989, p.59).
A holistic view honours the mystery which is at the heart of each individual. It resists reducing the mystery of spirit and uniqueness to psychological labels or medical diagnoses. Moore (1992) pointed out that:

Ancient psychology, rooted in a very different ground from modern therapeutic thinking, held that the fate and character of each of us is born in mystery, that our individuality is so profound and so hidden that it takes more than a lifetime for identity to emerge. Renaissance doctors said that the essence of each person originates as a star in the heavens. How different this is from the modern view that a person is what he makes himself to be. (p.19)

Herman, a music therapist, (1988) suggested that helping professionals have historically had a tendency to emphasize the deficit areas rather than the strengths of their clients, and have seldom considered the possibility that handicapped children might have an innate creativity that can be accessed for development. She said that “[o]ne of the advantages we have is in being able to make contact with the whole child. In a creative context the child is not treated as a student, client, or patient, but as an individual” (1988, p.19). Herman’s statement points to valuing the uniqueness of each client. This uniqueness is the essence of spirit which we might imagine has descended from the stars: shining, mysterious, and whole.

In relation to children’s development in particular, we need to question dominant psychological and educational norms. As a society, particularly in the disciplines of education and psychology, we have held on to, and worked from a basic understanding of childhood as being a time of innocence, ignorance and helplessness (Cullingford, 1999). Studies of human experience and developmental theories have traditionally been rooted in the assumption that people move from childlike innocence and limitation to the wisdom and sophistication of adulthood, in a series of regular patterns or stages. Piaget’s stage-based, developmental view of the child—which is frequently used as a basis for the
development of school curriculums and for planning psychological interventions—is essentially a deficit model, which focuses on children’s intellectual development in isolation from their emotional, social and spiritual development. Cullingford (1999) suggested that the experience children undergo in their early years is much more complex than any such stage-based theory can convey. He posed a compelling question to those who build their work on such assumptions: “Suppose we have got [it] wrong?” (1999, p.4). The traditional psychological and educational focus on empirically assessing the cognitive abilities of children in isolation from their affective, social and moral abilities, may have prevented us from realizing the depth and quality of their holistic understanding of the world. In addition, the conclusions widely drawn from Piaget’s research are that young children are concrete thinkers, incapable of abstract thinking until an older age (Egan, 1997). However, by examining children’s propensity for stories, and their capacity for relating to imaginary figures such as talking rabbits, flying ghosts and goblins, Egan (1997) concluded that children are abstract as well as concrete thinkers. Cullingford (1999) observed that “[l]ong before they have linguistic mastery over self-expression, children are able to analyze and understand what they see and hear ... they can often discriminate, make judgments, and analyze social situations ... by the time they are four” (p.5). I have long believed that children are much more perceptually aware and intuitive than we traditionally have given them credit for. The songs and artwork which I have seen grieving children create for family members who are dying have taught me about their capacity for compassion.

In the darkness of suffering and in the sorrow of saying goodbye, a child’s gift of music is often able to shine a light of hope for the family. Consider these words written by a young girl whose grandmother was dying of terminal cancer on the palliative care unit where I work. This was a song which she wrote spontaneously in one of our sessions, and I helped
her to find the music which fit the words. When it was complete, she wanted to perform it for her granny and the many family members who were gathered around her granny's bed. Sharing this experience with Katie and her family was one of those profoundly rich and emotionally alive moments which I think will always stand out in my memory. Katie named her song “To Granny with Love.”

To Granny with Love
For all that you've done for me,
I will remember you
And all the special things we've done.

We made the flowers grow.
We shared the beaches in Hawaii.
We've been through so much together.
All kinds of messes and weather.

To Granny with Love,
I will always remember you.
I will remember you
And all the special things we've done.
Oh, I will remember you,
And all the special things we've done.

In the midst of her own sadness, Katie was able to reach out in love towards her granny. Her song was a gift which created a sense of harmony for everyone who was present in the room that day. It revealed Katie's heart, her moral goodness, her compassion and love, and her ability to express that love for her granny in a beautiful way. Katie used her creativity to meet her own suffering; and the music she created not only reflected her suffering, but also transformed it. The song, which she and I later performed at her granny's memorial service, became an important part of Katie's healing through the grief process. Her creativity was central to her journey back towards integration and wholeness.

Healing in Palliative Care

"Do you Know How Much I Love You?" A Story

Dan was a gracious man whose progressive Alzheimer's dementia was slowly impeding his ability to speak and walk. Most of the time, Dan's words were now like a garbled tangle—you could see the frustration on his face as he tried valiantly to make himself understood, often giving up in anger and disappointment when he was unable to find the words he needed
to express himself. In the small music therapy group that I facilitated on the special care unit, however, Dan was still able to sing the words to many of his favourite old songs. He would use simple rhythm instruments (often choosing the drums) to improvise with me. In the improvisations he seemed to find a way to express some of the frustration and anger he experienced as a result of his progressive disease. His wife, Betty, often joined us in this music therapy group—she told me later, she loved to watch Dan participate there; in a setting where he felt at ease, and where he was able to find ways to express himself without being hindered by the limitations of his illness.

One day, I was sitting in the dining room with Dan and Betty—who had come to take him for a doctor’s appointment. Dan suddenly turned to Betty, picked up her hand, and said with a clarity that surprised us both; “Do you know how much I love you?” When they returned from their outing to the doctor later that day, I heard the sad news they had received. Dan had liver cancer which had metastasized throughout his body. The doctor felt that he had not long to live—perhaps only a few weeks. Our palliative care facility response team met together to discuss a plan for Dan’s care. His family wanted him to remain in the nursing home to receive comfort care, where he was familiar with the staff and the living environment.

Dan’s disease moved quickly—he lived only about one week past his diagnosis. In the last days of his life, he slipped into another level of consciousness—and although he was physically comfortable, it was clear that he had not much longer to live. Betty asked me to come into the room that day, and play some of Dan’s favourite songs. As I played and sang for them, she sang along with me, and talked about memories she had of times they had shared together during their long and happy marriage. Dan was included in these conversations, as Betty held his hand, and gently stroked his head, talking to him through her tears; comforting him with her voice and with her touch. “We’re all here and we love you, Dan. Heather is playing our favourite music for you. We all love you, and we just want you to be at peace.” Dan died peacefully at the end of that day in the room which had been his home for the past two years, surrounded by love, with Betty and members of his family at his side.

In this story of palliative care, we can see the juxtaposition of grief and love, Beauty and suffering. We might also sense how music entered into and embraced that paradox—illuminating the healing which can be present even at death. Palliative care is a field that has evolved in an attempt to change the “imbalance created by an increasingly
scientific and technological medical system” (Kearney, 1996, p.17). It strives to focus on the whole person, rather than the person’s disease. Palliative care is defined by the Canadian Palliative Care Association (1997) as “... the combination of active and compassionate therapies intended to comfort and support individuals and families who are living with, or dying from, a progressive life-threatening illness, or are bereaved.” Of central importance in this model of care is the goal of helping patients achieve the best quality of life possible, given their circumstances. The patient, along with their family members, are placed at the centre of a circle of care made up of a multidisciplinary team of professionals and volunteers. Bereavement support services for family members are an integral part of palliative care: grief support is usually offered for families before and after their loved one’s death.

To approach health from this broader perspective requires a paradigm shift, a “transition from a position of control, where one “does” something to solve a problem to a state of “being” in which one becomes vulnerable to witness and experience the mysteries of human suffering and death” (Kane & Primomo, 2001, p.166). To be in the presence of such mysteries is to learn to cultivate a certain comfort level with ambiguity, and the capacity to be a compassionate witness to another human being’s suffering. Remen (2000) said, “[m]ystery does not require action, [it] requires our attention. Mystery requires that we ... become willing to not understand. That we be open to witness” (p.338). If every being has within them a dimension of the unknown, of Mystery, then possibility and potential are ever-present. Healing—whether in a palliative care setting, or in daily life—is a mysterious process which can be very complex and yet very simple at the same time.

Palliative care integrates the psychological and spiritual aspects of care with the
control of physical symptoms, and embraces a holistic view of the individual, one which supposes that human nature contains physical and spiritual elements. Singh (1988) pointed out that "pain is not purely physical. We are whole beings, and suffering is at the level of the whole being" (p.103). If we think about this work in the context of caring for the whole person, we can view it as an approach to care that concerns itself not so much with fixing or problem solving, as with attending to and being present with. Paradoxically, much can be accomplished by stepping back, by not "doing for." This approach is very different from traditional views of therapy in which we "lay our problems at the feet of a professional who is supposedly trained to solve them for us" (Moore, 1992, p.4). Being present is a kind of action-through-non-action that calls on our flexibility, creativity, and capacity to withstand ambiguity and not-knowing (Nhat Hanh, 1987). In palliative care settings, patients and families are ideally empowered to set their own goals and to play a leading role in directing their own care. Although the health care team is there to offer support, they strive not to impose their values and ideas about 'the right way to die' or 'the right way to grieve' on the patient or family. Respect for different cultural traditions and belief systems, as well as for the uniqueness of individual responses is very important.

To bring palliative care values into our modern health care system, however, requires a willingness to be vulnerable. The kind of vulnerability required of the palliative care caregiver is in direct opposition to traditional Western medical teachings. Instead of detached objectivity, this work calls for the active and compassionate struggle of the caregivers along with the patients, a demonstration of love through the concrete acts of caring for and journeying with. In this holistic approach to care, the spirituality of caregivers is expressed in simple acts of compassion, tenderness, attentiveness, and love.
Nouwen (1975) stated, “In our solution oriented society [and health care system], it is more important than ever to realize that wanting to alleviate pain without sharing it is an impossible task” (p.43). In becoming vulnerable, we must participate. Singh (1998) stated, “Participation is a profound stance. It is not mere observation, looking from the outside in, imagining and interpreting. It is a “being-with,” a knowing, an empathic experiencing from the inside out. It is a dialogue. Because participation creates depth and connection, it fosters humility and acceptance and understanding” (p.7). Palliative care values may help us to expand our ideas about wholeness and healing in society, in health and in education.14

The Spiritual Dimension: Interconnectedness in Healing

Northrup (1998) pointed out that “[c]reating health requires making a paradigm shift ... to a new way of thinking and being in relationship with our bodies, our minds, our spirits, and our connection with the universe” (p.582). In contrast to the fragmentation perpetuated by modernism, Northrup (1988) suggests that our wholeness can be revitalized when we gain awareness of our interconnectedness. This brings spirituality into our discussion of healing. Since completing my Master’s thesis in 1998 (a phenomenological exploration of the connections between music therapists’ spirituality and their work in a caregiving profession), I have become increasingly aware of a tendency in both health care and educational settings to devalue and/or completely ignore the spiritual dimension of human experience and interaction. One of the key findings of my Master’s research was the sense of conflict and fear therapists feel in expressing and integrating their spirituality in their work environments. This fear is expressed in the

What I am extrapolating here are the general values repeatedly named in the palliative care literature. The palliative care team I work with strives towards these values. I do not mean to imply that all palliative care staff and palliative care programs accord with these values. As in any other health care or institutional setting, our actions do not always neatly match our written standards.
following quote by Howard Gardner (1999), a well known educational psychologist, about using the term spirituality in his own work:

I would be less than candid if I did not concede that I am also somewhat alarmed by the prospect of being assimilated to the many “crazies” and “frauds” who invoke spirituality as if it were a given or known truth, rather than a tremendously complex phenomenon that demands careful analysis. ... I think it best, therefore, to lay aside the term spiritual, with its manifest and sometimes problematic connotations, and to speak instead in terms of an intelligence that explores the nature of existence. (p.122)

In analyzing why the spiritual dimension of care is so frequently silenced within professional settings, and so fraught with controversy, conflict and fear in academic settings, it seems that at least some of the problem lies in the incompatibility of a spiritual perspective with the rational, mechanistic and modernist perspective which has served for many years as the implicit foundation for our modern North American way of life (Miller, 1999; Palmer, 1998). Singh (1998) suggested that our “spiritually impoverished culture has failed to provide an adequate context for both living and dying” (p.97). However, simply because we cannot measure something scientifically, or define it precisely or comfortably, does not mean it should be ignored. I am not satisfied with Gardner’s decision (cited above) to avoid using the term spiritual altogether because of its “problematic connotations,” and the difficulty we have in fitting this concept into an academic culture which relies heavily on linear thought and discursive language for the presentation of ideas.

In its broadest definition, spirituality is “a code word for the depth dimension of human existence” (Becker, 1994, p.257). The word spirit itself simply means breath. For the purposes of this dissertation, I will use the terms soul and spirit (I use them interchangeably) to refer to the spiritual part, “the vital animating essence” of human
beings (Allen, 1990, p.1173). The soul manifests itself in our uniqueness, yet keeps us connected to the whole. It reminds us that we all emerge from and return to the same ground of Being. Hillman (1979) suggested that soul is not a thing, but rather a symbol, “that unknown human factor which makes meaning possible, which turns events into experiences, and which is communicated in love” (p.42). Miller (1999) described soul as “an animating energy ... [a] loving energy” (p.212). Like music, the soul resists definition, and will always be elusive. Ingersoll (1994) pointed out that “spirituality must be understood as having observable and non-observable elements. The observable elements can point to, but never fully explicate, the non-observable elements” (p.7). Spirituality can be understood as a dynamic, ongoing process, connected to the human spirit, which involves finding meaning, hope, and purpose in life. It is an experience in which we attempt to connect our ‘small’ or individual selves, with the larger whole. Thus, it includes an awareness of something larger or more transcendent than our individual selves. It reflects a “faith which embraces the interconnectedness of all life, a conviction which may be subjectively observable, but not quantifiable or rationally explainable” (Koepfer, 2000, p.192).

The spiritual world view that lies at the heart of my clinical work is one that acknowledges and seeks out such interconnectedness. Connectedness to Love, to other human beings, and to the natural environment around me. L’Engle (1983) said that “we are most free when we acknowledge our interdependence” (p.55). Abram (1996) said that “every aspect of the earthly sensuous..draw[s] us into a relationship,” and that human beings are innately tuned for relationship; “the eyes, the skin, the tongue, ears, and nostrils—all are gates where our body receives the nourishment of otherness” (p. ix). Connection is the heart of my work as a music therapist. It can happen in the music, in
the art, the playing together, the words, or the spaces in between. It is what I strive for, not what I always achieve. It is what I hope for, not what I expect. I cannot force a connection to happen, but I can be open to its arrival. Recognizing the sacredness of such felt and lived connections brings me to a place of hope and meaning in my work. hooks (2000) said that “[t]his connectedness calls us to spiritual awakening--to love” (p.83).

In striving for the kind of connection which does not expect or demand material rewards or reciprocity, we enter the spiritual dimension, and “[w]hat we call “the spiritual” pertains to the connected aspects of reality” (Deikman, 2000, p.303). We shift from what Deikman (2000) referred to as the “instrumental mode of consciousness” in which our sense of the separate self is strongest, into a receptive mode, a place where we can “know our connection to one another” (p. 314). Our spirituality is therefore revealed in and through the caring we extend and receive in our personal and professional relationships (Davies et al., 2002). Koepfer (2000) said that “spiritual empathy [is] fundamental to establishing a working therapeutic relationship” (p.189). Since I do not believe that words can ever adequately capture the spiritual dimension of life, I encourage the reader to listen for echoes and ripples of this dimension of experience--as it may be revealed in the stories and relationships described throughout this thesis.

Caring and Love in Healing

Recently, I travelled to Tokyo, Japan, to teach at a conference for a group of music therapists, music therapy students, and hospice workers on the use of music therapy in palliative care settings. During that time I had the privilege to meet Dr. Hinohara, the honourary medical director of St. Luke’s International Hospital (where I had been invited to teach). He is a 92-year old physician whose innovative and holistic
ideas on patient care continue to contribute to both the physical expansion and highly respected reputation of the hospital, especially in the area of palliative/hospice care. In addition to the contributions of his vision and insight, he also continues his involvement with patient care. He conducts daily rounds in which he sits and talks at length with each patient on the hospital’s sixteen bed palliative care unit. Dr. Hinohara is internationally known and respected, and is the author of numerous books on cancer and healing, healthy aging, and music therapy. He is a much sought after teacher and lecturer, and he frequently volunteers his time to do so. He has been a supporter and advocate of music therapy for many years. During his opening address at the conference, he spoke about the importance of caring in medicine. The main point of his talk was that hospitals must become as concerned about the quality of care they are giving as they currently are about the scientific quality of their medical techniques and interventions. Dr. Hinohara said:

Medical care must be delivered with compassion, warmth, and love, or it cannot be considered care at all. ... [C]aregivers must not be afraid to reach out, to hold the patient’s hand. We must not be afraid to extend our love to our patients. For it is love and care which are of the most importance in healing. Without love, we have nothing. (personal communication, July 28, 2002)

In my two-day presentation to this group of caregivers, despite the language barrier that existed (I do not yet speak any Japanese!), I experienced something very different than my previous presentations of lectures on music therapy to medical professionals and academics in Canada. In Japan, I found there was an implicit and deep understanding of, and receptivity to, the holistic perspective and approach I was describing in my work. There was no resistance, no cynicism, no demands for “scientific proof.” I did not spend enough time there to know if this reflected an aspect of Japanese culture, or more specifically of the particular group of people I was teaching (clearly it
was a combination of both cultural and individual values). Nevertheless, it was a rewarding and renewing experience which affirmed, for me, the importance of compassion in health care. The year before I had travelled to New Zealand to lecture on music therapy, and had found there a similar depth of understanding and receptivity to the holistic approach from some of the Maori people I spoke with. One Maori nurse, who worked in a care home for elderly people, told me that when their elderly residents are confused and agitated, the nurses first attend to their distress by sitting quietly and singing with them. They also pray with them. Only after those two approaches prove to be unsuccessful in alleviating anxiety and distress do the nurses offer anti-anxiety or anti-psychotic medicines to their patients (personal communication, April 28, 2001). The Maori people have a fundamentally different vision of health than the view of health promoted and sustained by the Western medical model.

A Maori perspective sees health as a four-sided concept representing four basic tenets of life. There is a spiritual component, a psychic component, a bodily component, and a family component ... Together these ... blend to form an integrated and comprehensive model for health. But, the spiritual side is widely regarded by the Maori people as the first cornerstone of health ... the most basic and essential requirement for health. Without a spiritual awareness, the individual is considered to be lacking in well being and more prone to disability or misfortune. (Durie, 1983, p.2)

Hearing the story of the Maori nurse, and reflecting on what I learned while I was teaching in Japan, helped me to understand how much culture shapes our view of healing, and in a very concrete way, our responses to human suffering.

The intention of any caring practice—whether it is centred on physical illness or psychological distress—is to alleviate or soften suffering. In a cure-focused medical setting, however, the art of caring can become diminished and lost. Of course, there are times when we are consciously striving for a cure, and when it is most appropriate to do
so. However, there is a fine and subtle balance that needs to be maintained between caring and curing, which is often overlooked, particularly in acute medical settings. Moore (1992) said that the word “care” "implies a way of responding to expressions of the soul that is not heroic and muscular" (p. xi). In attending to the needs of those with terminal illnesses and their families in grief, we must recognize that we are not there to rescue, or to solve a clearly defined problem, but rather to acknowledge the paradoxes and complexities, the light and the darkness, the mystery of what is present. While cure implies a definitive end to a problem, care is characterized by a more ambiguous, open and ongoing sense of attentiveness. Bai (1999) suggested that such caring extends from our awareness of our interconnectedness with, rather than our separation from, other human beings. For it is “[i]n a moment of empathic perception where the presence of the other has affected [us, we] may realize ... how much the other has become part of the self in the literal sense” (Bai, 1999, p.9). It is by meeting pain and suffering with compassion that we can bring others new strength. Healing begins through our solidarity with our own pain, and the pain of those we wish to serve (Levine, 1987). We must be willing to embrace the tension between acknowledging the suffering and the losses of our clients, and continuing to meet the challenge of seeking love, intimacy and meaning in the face of this suffering.

In working with children who grieve, I, as a caregiver, must resist the temptation to believe that I am there to solve a problem, or to find a solution for the child. I cannot change what has happened. I cannot protect the child from feeling the pain of their loss. The death of a loved one remains fixed. I cannot provide the child with what they most long for, the physical presence of their loved one. I can only walk with them, beside them, listening and attending with care, as they find their own way through the all-pervading
experience of grief. Nhat Hanh (1996) said, “sometimes if we don’t do anything, we help more than if we do a lot. ... It is like the calm person on a small boat in a storm. That person does not have to do much, just to be himself and the situation can change. That is also an aspect of Dharmakaya: not talking, not teaching, just being” (p.25). Our well-intentioned heroism as caregivers can be both dangerous and disempowering. This is how my practice as a music therapist has shifted “away from a tendency to manage and control, towards a tendency to dwell and to be with” (Merrill, 1998, p.144). I step back a lot more. I am more willing to wait and to listen.

**Children, Spirituality and Healing**

When we are talking about grieving children and a process of healing, we must also find ways to consider the spiritual dimension. There is perhaps no event which throws us more suddenly and completely into a tailspin of questioning about the meaning of life and the possibility of life after death than the death of a loved one. These are spiritual questions. The work of psychiatrist Robert Coles (1986, 1990) affirmed that children have existential and spiritual questions and dilemmas, just as adults do. “How young we are when we start wondering about it all, the nature of the journey and of the final destination” (Coles, 1986, p.335). When a cherished loved one dies, life is forever changed. Children try to make sense of their situations, to put them into a broader context of meaning (Sourkes, 1995). They struggle to find meaning in their experiences of loss, just as adults do, although they may not express this struggle in the same kind of philosophical language which adults use.

There is a need to find ways to understand and to name children’s spiritual lives within the secular world, or our ability to see the “whole child” will be limited, and a
dynamic component of child development will remain uncovered. Children’s spirituality has been largely ignored in most existing child development theories. Myers (1997) connected this, at least partially, to the dominating influence of Piaget, whose child development theories suggest that “at a young age, I should have been unable to cogitate on things theological or process my own pain ... that I should have been unable to empathize with human suffering” (p.48). Myers (1997) framed her ideas about spiritual development in children around the concept of transcendence, a derivative of the Latin word *transcendere*, which means “to climb over.” She said, “[t]he word transcendence, therefore, can be used by us to name a process of going over, beyond, or through various limits or obstacles” (Myers, 1997, p.11). Part of healing for a child through a grief process can therefore be understood as a process of transcendence which is the fundamental movement of the spirit within human beings. Children are supported in this process of growth through their interactions with caring others who believe in their capacity to transcend the challenges in their lives.

Children’s spirituality is like a wellspring, a resource from which they can draw strength, resilience, and comfort (Sourkes, 1995). The arts are powerful modes for engaging children’s spirituality (Davies et al, 2002). Although we might assume that when children create art, they are are merely developing basic physical skills like motor coordination, another view is to imagine that they are sharing with us something of their own souls. Hillman (1979) said that “play may keep the soul alive” (p.63). Artistic forms have intrinsic qualities which can penetrate the depths of our heart; they help to remind us of our human connectedness (Kenny, 1982). They can help children to identify and express their spiritual concerns, questions, and felt meanings. The process of creating, of making art, is a whole body experience, one that engages us on sensory, intellectual,
emotional and spiritual levels. In the arts therapies, a child’s spirituality is expressed through their creations, in their engagement with the creative process, and in their sense of connection within the therapeutic relationship (Aldridge, 1995, Koepfer, 2000). Since they engage with the world around them—especially in their early years—so easily in a sensory, intuitive, and creative manner, the arts, for children, can become primary modes of learning and healing (Bertman, 1999; Egan, 1997). In my work with bereaved children, I have discovered that most of them have a seemingly natural affinity to access the power of the arts, as structures which hold their search for meaning in their loss experiences, as forms for the expression of their feelings, and as a central part of their transformation and healing process through grief.

So far in this chapter, I have explored and articulated a holistic view of healing, spirituality, and caring, drawn primarily from the palliative care literature, and from my experiences as a music therapist in this setting. I have also looked in more detail at children’s spirituality, particularly as it relates to a process of grief. In the remainder of this chapter, I will focus my attention more centrally on examining the connections between the arts and healing, highlighting the ways in which the arts can contribute to the holistic view of health I have just described.

The Arts and Healing

The concept of art as an integral part of the health of individuals and communities is a thread from the past which needs to be connected to our present-day system of care (Kenny, 1982). In every human society we know (prehistoric, ancient and modern) at least some form of art has been willingly practiced and displayed by the community. According to Dissanayake (1992), art has “played a critical role in human biological
adaptation” (p. xvii), and “we have a core human nature that has evolved to require aesthetic and spiritual satisfaction” (p.3). The vitality inherent in art-making, the level of energy invested, and the universal evidence of art forms across cultures and through time, suggests that art fills a fundamental human need. Music and other arts therapists work from a basic belief that art forms have intrinsic healing qualities which can assist any individual who wishes to utilize them in this way. It is perhaps important to note the obvious, that the arts can also be used in ways that facilitate disconnection from others, in ways that are destructive or are geared to support the goals of a materialistic society rather than the purpose of individual and collective healing. I do not mean that that the arts are unequivocally healing at every moment, but that they have the potential to be healing, depending on the ways in which we choose to utilize them. For instance, music can be perceived as background noise, extremely irritating and intrusive at specific times.\footnote{This is why in music therapy practice, it is imperative that the therapist learn to assess and listen for patient’s personal preferences and needs. We must not assume that a particular type of music is healing for others because we personally enjoy it, or that music is the best mode of engagement in every case. The music therapist must always be sensitive and vigilant to the timing of her interventions, constantly checking for feedback from patients and families as to the appropriateness of her presence.}

The arts can help us to make Beauty a part of our lives. They offer symbolic representations of what has meaning and significance in our lives and in our culture. Participating in the arts is not simply about making beautiful things which showcase our talents, but is “about the preservation and containment of soul” (Moore, 1992, p.303). The arts provide us with an opportunity to express a deeply felt part of our being, to participate in the creation of our worlds and the nurturing of our own souls. Through our engagement in these imaginative, creative, interactive processes we may find a way towards healing. L’Engle (1980) said that “we write, we make music, we draw pictures, because we are listening for meaning, feeling for healing” (p. 55). For some people episodes of healing may be sporadic and isolated--standing as brief, discrete experiences--
while for others, such episodes may gradually accumulate towards an increasing sense of wholeness (Mabbett, 1995). This sense of wholeness can be activated by our engagement in the creative process, by our journey into the aesthetic of the particular art form.

Creativity, Imagination, and Play in Healing

Kenny (1982) stated that a “primary objective of any therapist is to encourage ... people to accept change, to experiment with alternatives within an atmosphere of support” (p.9). In order to explore alternatives to a life situation in which we feel stuck or trapped, we must nurture our capacity to creatively engage with ideas, thoughts, and feelings, to find new ways of seeing a situation, or to experiment with new ways of being in the world. This may sound simplistic, but the work of personal change is rarely simple. Fundamentally, change requires an activation of our own creativity— that which counters rigidity, and allows us to break away from our usual way of doing things or perceiving the events in our lives (Kenny, 1982). When we can form a picture— whether in sound, words, movement, colour or shape— of what is troubling us, we may be able to soften and reduce our suffering. Winnicott (1971) stated, “Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy is about two people playing together” (p.44). This statement articulates a basic assumption I bring into each therapy session. I value the idea of play as an essential process for self-discovery, for expression and for healing. When the client or patient is not able to play, then the work of the therapist is to encourage them towards a place where they feel safe and free enough to do so. In the role of therapist, we must also strive to listen for the symbolic communications which are often revealed in play.

Creativity may be understood most simply as “the ability to generate something
new” (Merrill, 1998, p.130). I conceptualize creativity in my work in a very broad and open way; understanding it as a kind of life-force which exists in all human beings, and can manifest itself in a variety of ways and forms--including, but not limited to, the arts. While both science and art are modes of creative discovery, the arts seem to provide very easy access to our creativity. The creative impulse is an ever-present part of human existence, expressed as we reach out into the world, risking steps into unknown territory, risking change, creating, manifesting our vitality. Robbins (1985) said that “creativity comes from the most sacred part of ourselves” (p.18). According to Buber (1958), artistic activity includes both sacrifice and risk: “To produce is to draw forth, to invent is to find, to shape is to discover. In bodying forth, I disclose” (p.10). Johnston (1986) described the creative as a “description of the relationship between essence and the material: the mysterious, subjective, and undefinable is the reality of the source of the creative impulse; the world of objective materiality that of the most manifest stages of creation” (p. 11).

Although we do not often acknowledge it, creativity is an integral part of our daily lives, and is often evident as we do our daily work, build and foster our human relationships, and weave the culture and the meaning of our lives (Robbins, 1985).

Carl Rogers (1980), a pioneer in the development of client-centred and humanistic therapies, noted that part of the intent of the therapeutic process is to awaken a client’s “creative life force energy.” Rollo May (1975), also a psychologist who worked within the humanistic-existential tradition, critiqued the tendency in psychoanalytic schools of thought to explain creativity as regression in the service of the ego. He suggested that the creative process needs to be explored and understood, not as a product of sickness, but as an expression of health and well-being. According to Sarason (1990), the discipline of psychology--with a few notable exceptions--has almost completely ignored the role of
creativity and artistic activity in general human development. Psychological research has tended to continuously specialize the creative impulse by focusing on exceptionally creative people, or by examining the products of ‘successful’ artists, thereby reinforcing society’s notion that artistic abilities are unique to specially gifted individuals rather than a more universal dimension of human experience. Sarason (1990) suggested that psychology’s limited interest in creativity is “symptomatic of a world view in which the developmental significances of that activity are hardly recognized and seen as special rather than universal” (p.82). However, living creatively can be understood as an essential part of a healthy and meaningful life. Winnicott’s theoretical work in Playing and Reality affirms the value of creativity in health, and points the way towards our understanding of creativity as a universal process which is easily observed in children’s play.

Children sometimes lack the capacity to put their thoughts and feelings into words, and bereaved children often express their grief through their behaviour, their play, and other non-verbal modalities such as the arts (Oaklander, 1988). Their ability to verbalize their feelings and experiences can be limited (Webb, 1993). In play, children can dismantle, create, re-create and communicate their worlds (Axline, 1947; Sourkes, 1995). The practice of play therapy is based on the rationale that a child will project his/her worries and conflicts onto play materials. In this way, a child is able to identify and gain mastery over his complex feelings related to the death or trauma which he has experienced (Webb, 1993). Myers (1997) stated that “it is through play that young children become adept at imagining” (p.20). This affirms the importance of play, imagination and creativity to children’s learning and healing processes--valuable tools which enable their capacity to transcend and move forward in their development.

Children’s imaginations are an essential part of how they perceive the world, and
construct meaning out of their experiences (Egan, 1997). Madeleine L’Engle (1980) says that “all children are artists, and it is an indictment of our culture that so many of them lose their creativity, their unfettered imaginations, as they grow older” (p.51). There is a kind of openness and lack of self-consciousness with which most children (especially those who have not yet encountered the rules, expectations and competitiveness of many school arts education programs) engage in artistic experiences. Young children particularly will play with colours, with textures, with shapes and lines, with different sounds and musical instruments, with movement of their bodies, in a way which is often free of inhibiting self-criticism and judgment (Campbell, 1997). Rather than viewing the arts solely as school subjects in which students learn to play an instrument in music class, we could view them as basic educational tools which can be woven throughout the curriculum, as particular modes of knowing which can engage us experientially in exploring what is already present in our lives, and what might be possible in the future.

Children’s capacity for creativity and imaginative thinking draws them naturally to the arts as “a language” which allows them to express symbolically and metaphorically their inner worlds (Oaklander, 1988). They use their energetic imaginations as they attempt to understand the world around them all the time, not to “escape the world, but to join it” (Murdoch, 1970, p.90).

Connections between the Aesthetic Experience and Healing

If we examine more deeply what the different art forms have in common, and therefore what intrinsic structural qualities they may hold which might be linked to healing, we find a general agreement that the aesthetic experience is a central feature of art (Aigen, 1995; Kenny, 1989; Smith, 1997; Smith & Simpson, 1991). While art educators
and philosophers have not traditionally considered the possible role of the aesthetic experience in healing, I think it is a connection worth exploring. The Oxford Dictionary defines aesthetics as that which is “concerned with or sensitive to the beautiful; artistic, tasteful; the philosophy of the beautiful in art” (1990, p.12). The word “aesthetic” emerges from the Greek root *aesthetikos* which means pertaining to sense perception (Smith & Simpson, 1991). This is not an intellectual activity; the primary organ of sensation in Ancient Greece was the heart (Hillman, 1979). Hillman (1979) explained that the original Greek meaning of the word “aesthetic” also implied “taking in, breathing ... like a gasp” (p.31). The aesthetic experience is thus one which engages our thoughts, feelings, and bodily responses, in a complete and sudden way, in a moment which often feels set apart from ordinary time.

Dr. Kenneth Aigen is a music therapist and researcher who has called for a dialogue in the field of music therapy about aesthetics. Aigen (1995) noted that music therapists have traditionally been reluctant to discuss the role of aesthetic considerations in their work. He pointed out that “[t]he aesthetic is essential to our healthful embrace of life” (p.243), and therefore, “aesthetic considerations are central to clinical music therapy process” (p.235). Beardsley (1991) offered a framework of five criteria which define the aesthetic character of experience: “object directedness, felt freedom, detached affect, active discovery, and wholeness” (p.75). I accept the general outline of Beardsley’s definition of an aesthetic experience, but I would like to interpret it in light of its applicability to a therapeutic context.

The term “object directedness” signifies the engagement of the music therapy client in the aesthetic experience. They become engaged through the art-making process (i.e., creating a piece of music), and/or by the art-perceiving experience (i.e., listening to a
piece of live music). At some level, patients make a choice to surrender to the artistic process, to open themselves to engagement in the moment, and all that it has to offer, the qualities and relations of the perceptual field. Bai (1997) stated, “to view a thing aesthetically must mean to submerge the self within the thing in itself” (p.42). As one enters the aesthetic experience, one loses track of time, merging, or becoming one with the process. This invokes a “particular state of consciousness: a state of deep concentration and focused attention” (Kenny, 1989, p.89). Beardsley calls this “felt freedom.” This state of altered consciousness may be experienced in an arts therapy context by both the therapist and the client, as they share reciprocally in the aesthetic experience together. Beardsley (1991) defined the third quality of the aesthetic experience as “detached affect,” “a certain detachment of affect, so that even when we are confronted with dark and terrible things, and feel them sharply, they do not oppress but make us aware of our power to rise above them” (p.75). Therefore, in the aesthetic experience of arts therapy, one becomes aware of one’s feelings, is given the space to express them freely, but is not overwhelmed completely by them. The art form, along with the therapist’s presence, provides the safe container--the form and structure and space--which can hold the intensity of our emotions. The fourth quality, named by Beardsley as “active discovery,” is equivalent in a therapeutic context to clients’ attempts to find meaning in their experiences, to make connections, and to try to make sense of life’s challenges through the aesthetic experience. Beardsley defines the fifth quality of the aesthetic experience as “wholeness.” The client is able to experience a “sense of integration as a person, of being restored to wholeness from distracting and disruptive influence and a corresponding contentment, even through disturbing feelings, that involves self-acceptance and self-expansion” (Beardsley, 1991, p. 75).
Music (along with other art forms) offers an aesthetic experience; a web of sensuous imagery and sound which has the potential to radically change the space it enters. The aesthetic qualities and properties of music (melody, harmony, rhythm, tone) “have the ability to frame raw experience into whole experience ... Experience in this aesthetic realm is not peripheral to the therapy, but is the therapy” (Aigen, 1995, p.241). Thus, music, in its way, can help to create the kind of space which can provide a sense of wholeness that becomes healing. If we accept a definition of healing that relates fundamentally to wholeness, and we accept a definition of the aesthetic as “that quality of existence that provides unity, completion and wholeness to our experience” (Dewey, 1934, p.39)--then we can conclude that the two are indeed, linked.

Beauty and Healing

Hillman (1979) said that “Beauty is an epistemological necessity; it is the way in which the Gods touch our senses, reach the heart, and attract us into life” (p.29). I have often noticed, on the hospital ward where I work, that patients will surround themselves with different art forms, with objects that they perceive to be meaningful and beautiful (favourite music, photographs, poems, visual images, etc.). Perhaps, intuitively, we know that Beauty can comfort, support, inspire, and give us hope in stressful and anxious times; that Beauty can help us to find harmony with our world. Perhaps there is a part of us that knows that Beauty can heal.16 Bai states “the sense of beauty is born when the opposition between subject and object has been dissolved” (1997, p.42). Through this dissolution of the self-other dichotomy, we are moved beyond our sense of separateness, 16 I use the term Beauty here to signify a holistic experience of engagement in an artistic or aesthetic experience in which the relationship between qualities in the created form (i.e., organic unity, balance, vitality, novelty, poignancy, shapes, sounds, nuances, etc.) and qualities in the participants’ being (i.e., sense perception, listening, attentiveness, openness, awareness, energy, interest, etc.) interact to create a sense of completeness, a sense of wholeness, and a sense of pleasure in the participant.
into a sense of oneness and wholeness which is an experience of healing.

Beauty is not necessarily ‘prettiness’, or a simple pleasantness of form. According to Pavlicevic (1997), “[s]ometimes, in music therapy, the beauty is terrible—indeed for some people, to play dissonant, ugly music is the supreme therapeutic moment: it is the beautiful moment” (p.15). In a caregiving setting such as a music therapy session, Beauty can also be found in the dialogue between therapist and client, in the responsiveness of one to the other, in the interplay and the intimacy of their co-creations (Pavlicevic, 1997). We can say then, that Beauty is a particular kind of quality in an experience or an object, in nature, or in another person, that arrests and commands our attention, invites us into a place of absorption and contemplation, and awakens in us a sense of completeness and wholeness. When we are drawn into art (creating and/or perceiving), our selfish concerns may vanish in the act of directing our attention outwards; we move beyond our individual, limited consciousness, become absorbed in the art experience, and expanded by its Beauty (Murdoch, 1970).

Merton (1955) suggested that we can never heal if we live only for ourselves, that selfishness dooms us to frustration and despair, since we will never be able to make the world act according to our own will. Art can be a path out of such self-centred striving and seeking, because it opens us up to Beauty. Merton (1955) called the perception of Beauty a spiritual activity which liberates us; “Art enables us to find ourselves and lose ourselves at the same time” (p.29). Our encounters with Beauty are encounters which may help us to grow, to expand, to develop—in Murdoch’s language; to turn our eyes toward the Good. Kenny (1989) said that “[a]s one moves toward Beauty, one moves toward wholeness, or the fullest potential of what one can be in the world” (p.77). This expanding sense of our own wholeness brings with it “an increasing awareness of the
unity and interdependence of the moral world" (Murdoch, 1970, p.70). In art, the isolated I ceases to be, and we turn our attention to that which is larger and beyond ourselves. Murdoch (1970) suggested that art, far from being an entertaining diversion, is a place of insight, and the most educational of “all human activities[,] ... a place in which the nature of morality can be seen” (p.87). Viewed in this way, the arts could become an important part of moral education. This is a link which traditional art educators do not seem to have considered very seriously. Art gives us a place where we can contemplate what is Good; “an attempt to look right away from self towards a distant transcendent perfection, a source of uncontaminated energy, a source of new and quite undreamt-of virtue” (Murdoch, 1970, p.101). In that moment of contemplation, the presence of the world intensifies; it becomes more vivid, and we may see and experience life more deeply.

**Insights from Other Cultural Perspectives on the Arts and Healing**

The traditional Western view of the arts has not allowed educators to consider the possibility of the arts for healing. There is a sense in discipline-based arts education that the use of the arts for purposes beyond the aesthetic (e.g., for therapeutic purposes) somehow poses a danger to the pure form of the aesthetic experience. Indeed, a radical aestheticists’ position would assert that the only value of artworks is aesthetic, and that art has nothing to do with morality, religion, politics, or any other area of human activity (Battin, Fisher, Moore & Silvers, 1989). Smith (1997), a proponent of discipline-based arts education, suggests that other approaches will “ultimately dissolve art education as a distinct subject of schooling, and undercut any serious justification for its study” (p.15).

Sartwell (1995) said that “[t]he modern West has learned to treat art as merely interesting form ... this view about how art is to be experienced relies precisely on a
contrast of the aesthetic and the practical” (p.6). However, there is an emerging multicultural perspective of the arts in education which questions the dominant Western idea of art, and integrates, rather than separates, the aesthetic and the practical (Sartwell, 1995). The multicultural perspective therefore gives support to the theoretical underpinnings of the therapeutic view of the arts which informs the practice of music and other arts therapies. Smith (1997), in his critique of the multicultural approach, characterizes it as one which “erases the boundaries between art and non-art, devalues quality and excellence in favour of difference, and uses aesthetic learning to advance social and political objectives” (p.15).

Although Smith is not referring to the arts therapies, he could be. Through our work, arts therapists are broadening the boundaries of what North American culture (and educators) traditionally think of as art, and who can participate in the artistic process. In addition, we do place more value on inclusivity and honouring difference than on developing excellence and technical skill, and we often use the aesthetic experience to foster social connections (or, in Smith’s words, “to advance social objectives”). Ruud (1995) described a split between music educators and music therapy educators:

within a serious institution for music education...music therapy distinguished itself through its anti-elite values. It became central to our ideology of music therapy that everyone could take part in musical activities regardless of psychological, physical, or social presuppositions. In music therapy, total democracy with respect to musical interaction became a norm. This democracy was regarded by the classically oriented musicians as a threatening vulgarity. (p.102)

Arts therapists have been instrumental in bringing the arts into contexts which are often arts-impoverished, and where arts educators are usually non-existent: prisons, institutions for the mentally ill and the mentally handicapped, hospitals, cancer care centres, and nursing homes. A therapeutic view maintains that the aesthetic experience is central to
healing and to learning, and that the arts can “transcend handicapping conditions by their pervasive role in shaping [our] thoughts, feelings and behaviours” (Herman & Smith, 1988, p.11). Herman (1988) pleaded to educators to consider that “there need not be barriers to artistic expression or participation simply because a child is handicapped” (p.11).

The inherent values in the arts therapies for inclusivity, democracy, and accessibility seem to have something in common with educators who bring a broader cultural approach to arts education. In many African, Native American and subcontinental Indian cultures there is no distinction between the aesthetic and the practical (Sartwell, 1995). The idea that something is beautiful in and of itself does not negate the fact that it may also be used for a purpose beyond itself. For example, a traditional First Nations mask, created to be used by a dancer in a ceremony, “does have a visual existence which is a demonstration of spirituality, but its visual nature has no value in itself, and its being cannot be considered separately from its function” (Rogers & Irwin, 1997, p.21). In this example we see a merging of beauty and function, a blending of the aesthetic and the practical.

If we look beyond the North American and Western norms, we also find in other cultures a far more advanced understanding of the power of the arts for healing. The songs, masks, poems, dances, and art forms of a community are considered to be the essence of Aboriginal spiritual life (Kenny, 1998). Through performance and participation in the art forms and rituals of the community, members share their hopes and dreams, reveal and define their collective and individual identity, and search for paths towards healing. Kenny (1998) summarized this view of healing and art as follows: “Art was not a separate word in our language. It was the way we lived (p.77). We feel that this sense of
art is what holds us together ... [A]rt is the aesthetic and spiritual foundation of our experience as Aboriginal people. It grants us not only knowledge, but intuition, by which we can make healthy choices for a well-sustained life” (p.83).

In the Zen Buddhist view of art, the aesthetic experience is seen as a fundamental deconstruction of the subject-object dichotomy or the dualistic consciousness. The uniquely distinguishing feature of the aesthetic experience is therefore the immersion of the self within the creative or artistic process. In this immersion, or flow, the observer becomes one with the experience, and the distinction between self and object disappears. Bai (1997) explained, “To be one with is a common expression used over and over again in the practice of any Zen-inspired arts, and it must be understood as an expression of the central effort in Buddhism to discover our fundamental interconnectedness with, and embeddedness in, the phenomenal world” (p.45). The merging Bai described is an experience which is potentially available in all art forms, whether one is receiving an art form (i.e., listening to a piece of music), or creating an art form (i.e., painting a picture). In Buddhist terms, this dissolution of the self-other duality can lead towards the development of moral empathy, giving us a sense of the kind of merging which is experienced when we openly extend our compassion to others (Bai, 1997). Participating in the arts thus becomes a practice of “deep seeing,” a practice which can result in our own growth by teaching us to “enter into the things themselves” in an effort to extend and expand our awareness beyond our own small world. A Zen Buddhist perspective of art thus offers us the idea of a direct link between engagement in the arts and our own moral and personal development.

In summary, an examination of a broader cultural viewpoint of the arts leads us to understand that many Aboriginal, African and sub-continental Indian cultures have

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traditionally integrated art forms with the daily life of the community, rather than separated them—as is the North American custom—in formal institutions such as museums and art galleries, or reserved their use for the exceptionally talented few in a community. My South African-born husband tells me that music in Africa is simply a part of life. It is as close to life, as easily accessed, as one’s own breath; it is the rhythm of the hot sun beating on the ground, the monsoon rains, the sound of the wind blowing the long grass across the veldt... Music inhabits and reflects the lives of the African people—at times despairing, at times hopeful, at times grieving, at times celebrating, at times cruel, at times tender, but always alive, throbbing with rhythm, teeming with life’s melodies and possibilities, always passionate. In typical North American arts education, the focus, however, has not been this linking of music with the richness of life, but rather the creation of a kind of separate, detached, aesthetic (and often elitist) plane where the formal properties of music, art, dance, creative writing and drama can be “properly” cultured and nurtured. The traditional arts education focus has been on developing technical skills and “a disposition which prizes artistic excellence” (Smith, 1997, p.15). This narrow focus limits the possibilities for arts education which engages students in social and personal change. However, in other cultures, the aesthetic experience offered by the arts is understood to be central to spiritual, moral and personal development, and therefore, central to healing. These ideas give support to the therapeutic view of the arts which informs the practice of arts therapists, and which has been a strong impetus for the formal development of the arts therapy professions.

**Thoughts on Wholeness:** (I wrote this poem during my reflections on this chapter)

simple awareness
of the completeness
of each breath...
I never think I am ready to say goodbye
to this earth....

But, maybe
We are always ready.
And, maybe
we always have all that we need
For each moment.

Maybe we always have wholeness.
but we forget it.
Instead, we feel
fear anxiety insecurity hopelessness -bitterness
all-pervasively
beneath the surface
of routine lives.

So, what is wholeness?
the freshness
the aliveness
the sense of newness
the shift in seeing
that happens,
in an instant....

when I walk the wooded trails, alone
and let the silence of my thinking roam
like the great gusts of wind
speaking through the trees

this moment
of oneness
of unity
and flow........
A sense of the sacred.
in the smallest details of the earth.

I breathe the scent of earthen pebbles beneath my feet.
Extend my Being across the glass surface of
the dark blue inlet
and dance with the surprisingly
red-breasted bird who scratches in the low-brush along the wooded trail.

And then, I watch in awe at
the transformation
of spindly-dead brown branches to graceful white feathery plumes
as an unexpected snowstorm descends....
Snow comes
sudden softness unbidden
a breath of Wonder catching me....

Snow comes
like feather-winged Angels, falling...
quiet peace on my bare skin
into my breath
the snow falls
deep
and, I am
hushed
quiet beating of heart
soft thud
rhythm
lulling me
soothing me
snow-soft whiteness
quiet all around.

Snow falls
in a gentle Blessing.

and when the sun bursts through cloud
lighting up the newly-fallen snow
it is like watching iridescent diamonds--bubbles of water-multicoloured light
sparkle and shimmer on the old, dead trees.....

shining like Magic.

watching,
I feel a sense of Wonder
coursing with the blood through my veins.

gifts of silence and light,
wind and sky
new snow
transformations
when I feel alive-whole
everything is poised, vibrant, expectant yet complete.......

Wholeness.
what does it mean to you?

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Chapter Summary

In this chapter, I have articulated a holistic perspective of the arts in healing and in education which implies the need for a paradigm shift in many of our current caregiving practices in North American health and education systems. My particular approach to music therapy practice is influenced by this holistic perspective; an understanding of the arts—drawn from music therapy clinical practice and broader cultural models of arts education—as inherently healing, and a holistic view of healing, informed by the values of the palliative care field and a spiritual world view. In Chapter Four, I will move from this general discussion of the arts and healing to a more specific discussion of music and arts therapy practice with grieving children.
Chapter Four: Children and Grief
Introduction

In Chapter Three, I explored the concept of healing, and established a link between the arts and healing. In this chapter, I will now focus more specifically on one area which illustrates this link; my clinical practice of arts therapy with bereaved children. I will describe children’s experiences of grief, and explore how their participation in an arts-centred grief support group assisted them on their journey of healing. While music was integrated as a part of the group structure, children had access to a wide range of creative media within the group. In this sense, it is important to note that the group did not reflect a typical music therapy session--where music is the primary mode of engagement--but rather combined a variety of art forms and play opportunities for the children.

Coles (1986) suggested that the best way to initiate research with children is to “tell them what you want to learn, and then hope that they will become colleagues, instructors, guides” (1986, p.35). Attig (1996) suggested that we need to listen carefully to the individual stories of those who mourn to aid us in our understanding of grief. Stories connect us to the lived experience--to the phenomenology of grief and healing--which keep the participants in the centre of the inquiry, rather than at the periphery as “anecdotal evidence.” In order to gain more insight into the meaning of children’s experiences of grief and healing, I engaged in dialogues with five children who had been participants in the children’s grief support group that I facilitate in my current work. Approval was sought and received from the University Ethics committee before the research interviews were conducted. In addition, consent forms which described the potential risks and benefits of the project, were signed by both the parents and the children who participated. Children were invited to choose their own pseudonyms to conceal their identities, and these have been used throughout the text--with the exception
of several children, and one parent, who requested that I use their real first names. In our ensuing discussion around the issue of confidentiality, Andrew wondered why he should want to hide his identity; especially since part of the intent of such research is to bring discussions about death and grief and children out of silence. He said “What is there to hide? This is just our life ... it's what has happened in our family ... It is my hope that we can help others by sharing our story.” I honoured these requests from each of the families. Verbal permission was also sought and granted to include the children’s artwork and songs within the body of the thesis. In addition, consent forms from the palliative care program at Lion’s Gate Hospital which give permission for the photographic recording of children’s artwork, for audio taping, and for the release of photographs, were also included as part of the ethics procedure.

My “co-researchers” were all girls between the ages of nine and twelve who had experienced the death of a family member through cancer; one lost a grandfather, one lost a mother, and three lost a father. The length of time since the death had passed ranged from four years to one year. The concept of purposive sampling in qualitative research enables the researcher to select participants who are “most likely to serve as the best informants for [the] particular study” (Amir, 1996, p.112). Merriam (2002) called these “information-rich cases--those from which one can learn a great deal about issues of central importance to the research” (p.12). I chose these particular children, not only because they agreed to participate in my research and their parents gave them permission to do so, but because I felt they had some valuable insights which might help others to understand more about children and grief. It should be noted that this may also be linked to their gender, and the general tendency for girls to be more emotionally and verbally expressive than boys of the same age. Each of these girls generally participated fully in
the children’s group, shared their thoughts and feelings quite openly, and had found ways to integrate the death into a context of meaning in their lives. In the group process, they revealed both their strengths and their vulnerabilities: compassion, fragility, hope, fear, creativity, sorrow, resistance, openness and resilience. The relationship we developed in our previous work together provided the trust which was the basis for the dialogues described in this research. In these dialogues, I also gave the girls an opportunity to share their experiences through art and through music. Additional family information was gathered through interviews with surviving parents. I asked my co-researchers to help me to help others--adults who help kids, and other children who experience death--understand their experiences of:

1. losing a loved one to cancer, and what it has been like for them since the death;
2. being in the children’s grief support group which I facilitate;
3. what has helped them to get through their grief.

In the case of one child with whom I had worked prior to her mother’s death, I also asked her about her experience of meeting with me individually at the hospital.

It was during the implementation of a music therapy pilot project at Canuck Place Hospice for Children in Vancouver in 1996 that I first became interested in exploring the experiences of children who grieve. It was in this work with children who were facing such profound losses that I first began to notice the power which artistic media held for them. They seemed to very naturally move towards the arts as structures which could hold their search for meaning in their loss experiences, as forms for the expression of their feelings, and as a central part of their transformation and healing process through grief. The spontaneous songs, musical improvisations, and artwork they created inspired me. They seemed to find, through the music, and in the safety of the therapeutic environment,
an ease and clarity of expression which reflected depths beyond the surface. Given a choice of music and art materials, and a supportive atmosphere in which to explore these materials, the children often seemed to know what they needed to create to facilitate their own healing. They found their own sounds, movements and colours that reflected and expressed what was important in their world in the moment. The children were teaching me, not only about their unique perspective of what was happening within and around them in the midst of a painful experience, but also about the movement of something deeper; their capability to engage the creative process to transcend their conditions. One girl, who had lost both her mother and her younger sister to cancer at the age of fifteen, described this eloquently: “When we had a session where we danced and played music, I found that I could feel myself shining. Grief can take away your feeling of self and these activities helped me to see myself again.”

These children, and others I have worked with in the palliative care program at Lion’s Gate Hospital--where I facilitate our current children’s bereavement support services--have undoubtedly been my greatest teachers about grief and healing. Each has contributed to my understanding that there are no correct formulas or set answers to finding your way through loss and grief. Nouwen (1975) said that “Children are strangers whom we have to get to know. They have their own style, their own rhythm” (p.56). Each child is unique; each one has a different story, and their own stories are intimately intertwined with the stories of their family members. The complexity humbles me. Like Coles (1986), I believe that “prolonged encounters with children are the essence of the work I do” (p.27). Each meeting, each children’s group, each music therapy session, is an opportunity for me to learn; for the child to teach me something about their experience and something about their world. Nouwen (1975) said that “[c]hildren carry a promise
with them, a hidden treasure that has to be led into the open through education in a hospitable home” (p.56). These lessons are offered gradually, they unfold over time. They cannot be forced, pressured, or rushed. I must be patient and learn to wait. It takes time to listen to a child. As therapists, it is our job to “listen, of course, and to record, to look, and to try to make sense of what [we] have heard and seen” (Coles, 1986, p.27). I have gradually come to the understanding that my role as a music therapist in this clinical context is, more than anything, to be a supportive and compassionate witness to a child’s grief and healing process. Certainly there are times when I take a leading role in suggesting a direction for exploration, or when I ask questions which probe for more information or clarification; but generally, I find that grieving children need gentle support more than directive guidance.

Children, Death and Grief

Children’s grief is difficult, and perhaps impossible to fully describe. It is deep, ambiguous and complex; it is intertwined with a child’s Being and with their becoming; it shapes their emerging lives. As I understand it, their grief does not unfold in a progression of predictable stages, but rather is all-pervading and life-changing at once; paradoxically often present and yet visibly absent at the same time. Although experiences of loss and change are prominent features of human life, and something we must confront repeatedly in different ways throughout their lives, our capacity to come to terms with loss, our capacity to grieve, is key to our mental health (Attig, 1990). Rando (1984) defined grief as “the process of psychological, social and somatic reactions to the perception of loss” (p.17). To Rando’s definition, I would add the existential and spiritual dimensions of our responses to loss. Grief is a natural response to loss, and a process which unfolds over
time in unique ways for each individual mourner. Jevne (1991) said that grief is “a land of incomparables ... that challenges every dimension of our lives” (p.98). Grief has been conceptualized in different ways by different professionals in the bereavement field: as a disease (Engel, 1964), as a process of unfolding, sequential stages (Kubler-Ross, 1969), and as list of tasks that must be completed before mourners can heal (Worden, 1991). Worden (1991) suggested four central tasks of mourning which children need to resolve in order to adapt to their loss: accepting the reality of the loss, experiencing the pain/emotional aspects of the loss, adjusting to an environment in which the deceased is missing, and loosening one’s ties to the deceased. However, holding rigidly to either a stage or task-based view of grief may be limiting to our understanding of this human experience. The word “stage” implies the existence of a sequential and invariant process which emphasizes the uniformity and predictability of grief and fails to account for individuality within the process (Rando, 1984). Snowber (1995) suggested that our responses to loss become visible in a cyclical rather than a linear fashion such as that proposed by Kubler-Ross. The word task implies that the bereaved may take steps to complete concrete, modest problems and then move on with their lives. However, our coping with grief is not task-like, since the challenges are not small in scale, nor is it possible to fully complete (Attig, 1996). Attig (1996) affirmed that “we cope...with the major losses in our lives, as long as we live” (p.49).

The theoretical viewpoint which has been most influential and helpful in my work with grieving children offers a different conception of grief from these medical, stage, and task-based views. Congruent with phenomenological thought and a holistic understanding of human nature, Attig (1996) suggested that we might try to understand grief as a process of relearning the world. In this process, we are compelled to reshape every
aspect of ourselves and our worlds after the death of a loved one. Our losses force us to assume a new way of being and orienting ourselves in the world: spiritual perspectives are altered, habits and behaviours are transformed, relationships must be reworked, identity and sense of worth must be rediscovered, and our physical environment must be relearned (Attig, 1996). As we try to recover our bearings in this changed new world, we also seek understandings which will help us to find a purpose in ongoing life (Attig, 1990).

Grieving, therefore, is an active process that requires an immense effort on the part of the mourner. It is a process which also takes time. The process of healing through grief is the search for wholeness in a world which is fundamentally changed, described by Attig (1996) as “a struggle to transcend suffering and to reestablish wholeness in our selves” (p.191).

Love is not simply about bliss and pleasure. It is also about worry and grief, fullness and emptiness (hooks, 2000). Grieving is an integral aspect of the experience of loving. As we grieve, we have to come to terms with our loving, and discover its meaning and its worth in our lives. If our relationships have been conflicted, and we are caught up in ambivalence, resentments, regrets, conflicts and unhealthy dependencies, the grieving process may be even more complex. Attig (1987) said, “Death does not entail the cessation of loving but rather is compatible with its continuation and transformation” (p.139). We do not forget those we love. They live on with us and through us in different ways and forms. An important part of the work of grieving is a process of learning how to maintain a loving connection with the dead, to convert a relationship of physical presence to one of spiritual presence (Attig, 1987). According to Bertman (1999), the potential for healing in the midst of suffering exists because grieving “is about creating and transforming bonds of attachment/love, not severing them irrevocably” (p.15). While
mourners must be able to let go of the physical reality of their loved ones, they "may be helped to see that continued, albeit transformed, loving of the deceased is a healthy connection to sustain" (Attig, 1987, p.146). By honouring and remembering those we love who have died, we are participating in an essential part of healthy living.

For bereaved children, it seems particularly important for them to maintain some kind of internal attachment and connection to the person who has died. This connection can serve an important function in their development. Over time, this internal relationship will change as the intensity of their grief lessens and the child matures (Webb, 1993). Some research has shown that children who have lost a parent commonly experience a sense of being watched over by their dead parent, of feeling their parent’s presence, and have frequent dreams about them (Worden, 1996). In my dialogues with the girls in this study, and in my observations of bereaved children who have participated in the children’s group over the past several years, I notice that most of them do search for ways to maintain a connection to their loved ones. For some, this feeling of connection comes through keeping special objects, photographs, or mementos of their loved one close to them. Others write letters to them, or talk to them--telling them about normal, everyday things like what they’re doing in school, or just how they are feeling. Participating in memorial rituals, such as planting a tree in their loved one’s memory, or bringing flowers to the gravesite, is another way they stay connected. One girl told me that "I like being around my grandpa--my dad’s dad--because he reminds me a lot of my dad. I like seeing his brother and sister too, ‘cause they look like him, and they smile just like him too.” For others, a connection is sustained in an experience of hearing their loved one’s voice, imagining their loved one in heaven, or by sensing their presence as a guardian angel or spirit they carry in their hearts. These connections seem to be an important part
of children’s healing, of learning how to integrate and live with their losses.

In my work with grieving children, I also keep in mind the importance of Winnicott’s theoretical work on transitional objects and phenomena. These phenomena, referred to by Winnicott (1971) as an “intermediate area of experiencing” (p.2), occur initially as a result of the young child’s attempts to relate his or her inner, subjective reality with the objective, external reality of the world outside of them. In the case of a young child the transitional object is often a blanket, or a favourite stuffed animal. Interestingly, Winnicott (1971) also suggested that the transitional object might be a song, which “becomes vitally important to the child at the time of going to sleep, and is a defense against anxiety” (p.4). The object is external, yet not entirely, since it is viewed by the child as an extension of herself; it is invested with personal meaning and represents an interface between her internal and external worlds. The need for the transitional phenomena or object can reoccur in times of anxiety and stress such as the death of a loved one. I believe that the songs and artwork children create while they are grieving can become like transitional objects, assisting them to cope and live through stressful and uncertain times.

Death is usually a choiceless event. Our grief, however, is shaped by our choices; it is an active and not a passive process as stage theories imply (Attig, 1996). Children’s responses to grief are affected by a number of factors: individual personality characteristics, age, gender, family coping style, the functioning of the surviving parent, the nature and circumstance of the death, and their relationship to the deceased (Worden, 1996). What I have learned from the children I have worked with about their grief is that they experience a range of intense emotions including anger, loneliness, sadness, fear, worry, and anxiety about the fate of their surviving loved ones. For some these emotions
arise when they are at school, for some when they are alone at night in their rooms, and for others the feelings of grief are experienced most strongly on special days such as birthdays, mother’s day, father’s day, or the death anniversary. The girls I spoke with also told me that they experience isolation, a feeling of being different from their peers, who generally lack understanding about what they are going through. In addition, they are conscious of changes in their family since the death, and are aware of many of the emotions that their other family members experience. Slivka and Magill (1986) emphasized the need for families to speak openly with their children about an illness in the family; they noted that “children are better able to cope when they can assimilate facts and feelings, and when there are no secrets to separate them from the support of other family members” (p.33). Wolfelt (1996) and Worden (1996) also stressed that a child’s adjustment to a death is strongly influenced by and intertwined with the way in which his/her family responds. Parents may be overwhelmed by their own grief, and may lack the emotional energy to reach out to their children. Since children do not always express their feelings openly or directly, parents may mistakenly think that their child is coping “just fine,” or has been unaffected by the death.

Children feel and experience the world around them in much greater depth and acuity than many adults in their world might want to believe. It has been said that children are marvelous observers, but poor interpreters. They sense emotional undercurrents which are unspoken, and often internalize those feelings, or attribute them to some unknown thing which they have done. They have a tendency to blame themselves for what they sense but do not understand (Oaklander, 1988). In the past twenty years there has been a shift in our understanding of children’s perceptions around death and grief. It was once a mainstream assumption that children are oblivious to death,
cannot understand it conceptually, and therefore, are not affected by it. Along with this assumption went the desire to protect children from such grim realities as illness and death, as though that their innocence needed to be spared the pain of thinking or talking about such things. As an example, Davies (1999) told the story of how her doctoral research proposal—in which she proposed speaking to children whose siblings had died of cancer—was turned down by the university ethics committee. She was told “it was not ethical to subject children to the stress of such a discussion” (Davies, 1999, p.23).

Thankfully, this view is now evolving—particularly in and through the work of those in the palliative care field—and with it has come an increasing awareness that open communication around illness and death can greatly assist children in their process of healing and coping with loss (Doka, 2000; Trozzi, 1999; Wolfelt, 1996).

Children are not simply innocent and naive, passive observers; they are constantly trying to make sense of their worlds as they grow, constructing their own world view. They do not have to understand death in a conceptual sense in order to feel frightened or distressed by it (Doka, 2000). Children have vulnerabilities, to be sure, but they also have strengths such as creativity, resiliency, the capacity to live in the present, and the capacity for finding hope and ways to put their loved one’s death in a context of meaning. These strengths can assist them in growing and healing through a challenging process such as grief. What I have learned from the children I work with is that in the face of their grief, they do not simply sit down and refuse to go forward with their lives. They continue to go to school, play with friends, participate in their favourite sports activities, enjoy their favourite foods, celebrate birthdays and holidays, listen to their favourite music, draw pictures, and write in journals. They may often participate in these activities with a sharp awareness of the absence of their loved one. They may often experience sorrow and anger,
but they are not completely immobilized and disempowered by their losses.

When we are working with grieving children, our implicit assumptions about healing, as well as our own personal experiences with death and grief, will impact our way of interacting and relating with them. Our responses are filtered through our own experiences, which frequently include fears and anxieties (Doka, 2000). Contrary to the view of the adult who thinks, “She’s too young, she will never be able to cope with the pain of this loss,” I propose that we need to begin with a basic view of the whole child as one who brings both vulnerabilities and strengths to the process of grief. Jevne (1991), reflecting on her work with the bereaved, said, “Few knew the resolution toward which they were moving. Each somehow knew they would survive[.] ... The remarkableness was not in their pain, but in their willingness to go on with their lives. Therein lies the hope” (p.99). If we believe that children are capable of healing, of moving forward, despite the challenges life presents them with, then we begin our work with them in this place of trust and hope, and we communicate (verbally and non-verbally) this deep belief in their unique power and resiliency, through our loving presence and caring interactions with them. As caregivers to those who grieve, we must try to understand their paradoxical need to feel both that their grief is a normal, human experience, and that their particular loss is unprecedented and unique (Attig, 1990). While it is important to have a general conceptualization and understanding of the grief process, it is equally important that we are able to listen for and appreciate the uniqueness which exists in each story of human loss. Attending to the suffering of bereaved children provides us with an opportunity not only to help foster a child’s growth into wholeness, but also with an opportunity to foster our own wholeness through the development of our capacity for compassion.
Music Therapy and Grief

This fictional account of a music therapy session is intended to give the reader a sense of how I use an improvisational, arts-based therapeutic approach with a grieving child.

Singing and Dancing Our Sorrows: A Child's Grief

It is a quiet, still morning in the hospice. The sun filters through the stained glass windows, and sends rich rays of coloured light onto the pine floor. Someone has been up early baking. The smell of fresh banana bread fills the air, and draws me towards the kitchen. I breathe the comforting smell deep into my nose, my lungs, my belly. One of the nurses is sitting alone at the well-worn kitchen table. She has both hands wrapped around a steaming mug of tea; and she invites me to join her. She lets me know that Julie died last night, with her mother at her side. I have tensed my body in preparation for this news. This death was expected, not sudden. But still, I need to absorb it, and the mix of emotions it awakens in my body. I take a few moments to gather my thoughts and attend to my responses as I walk outside in the hospice garden. The flowers shimmer with colour and drops of dew in the early morning light. A child's life has ended. I breathe in beauty and breathe out sorrow. He only had three years of living. I have had 28 years. I breathe in the air that brushes soft on my skin and breathe out the question "why?". The sun is filling the day with promise. The flowers bloom. The flowers die. I continue to breathe, and to walk slowly along the garden path. I notice the soft crush of earth beneath my feet. I let the breath find the tender spaces in my body, and soften them. Death reminds me to live each breath, each precious moment. It reminds me how we move in cycles and spirals and connecting circles across this earth. I fill my lungs with life-giving sunlight--- and then I release everything back into the garden.

Annie is Julie's sister. I meet her for the first time at our support group for grieving children, several months after Julie's death. She is lively and energetic. It is hard for her to sit still in the opening circle of the group. She wriggles and wiggles like a slippery worm. She is anxious for everyone to stop talking, so that she can move! Her mother told me that Annie has been singing her own songs about Julie ever since she died. When I invite Annie to join me in the music room, she is immediately enthusiastic. We run together up the stairs to the third floor of the hospice. Here there is a big, open space to move around in. The floor is carpeted and soft. There is a scratched-up, old piano in one corner of the room. Annie remembers that she used to come up here sometimes when her sister was sick. I let her
know that we can make as much noise as we want to up here, and I invite her to move and sing and play in whatever way she would like to.

Annie immediately takes charge. She knows exactly what she needs to do. I sit quietly at the piano, and listen as she begins. I watch her body carefully. I follow her rhythms, her movements and her pace. At times, I echo her words and sounds with my own voice. I try to match the intensity of her expressions and reflect them back to her. The music seems to act as a catalyst for the release of Annie's grief; anger and sadness, mixed with questions and fears. She is completely absorbed in what she is doing. Her only direct acknowledgment of my presence is when she turns to me on several occasions and says emphatically "Don't stop the music." The whole session lasts for about 45 minutes. She curls up in a ball on the carpet, and begins to sing... After some time in this position, she gets up from the carpet and begins to move around the room in circles and spirals with her arms outstretched. She sings; "Julie is flying in heaven, and that's where she will always be." Annie spins and flies and floats. Suddenly, her movement changes. She starts to walk in big, heavy steps. She finds a chair, and climbs up on top of it. In a deep, loud voice she shouts "I say that you will not die." Then she climbs down off the chair, and marches round and round the room; quickly at first, then more slowly, until she lies back down again on the floor and is still. The room seems filled with sadness. The music is soft, and sad, too.

Now Annie moves from the carpet to the rocking chair and tells me that she is sick with cancer. The music rocks with Annie who is quiet and sick. After a while, Annie gets up from the rocking chair. She tells me that she is all better now. It is time to dance again. Time to dance and spin around, and sing. Time to sing all the music that’s inside, time to sing all the fears and all the feelings. It's a busy time for Annie. She moves quickly; changing and shifting. She orders the music to follow. "Don't stop the music. Don't stop the singing." Annie pounds hard on the floor with both of her fists. She squirms back and forth. She rolls her body like a log across the carpet. She rocks and spins. She opens up her arms like wings and floats endlessly around the room. "We are flying with the angels in heaven." And, finally, Annie draws her dance to a close. Her voice softens, her movements soften and become quieter. She is rocking herself gently on the floor next to the piano again, and we are singing quietly together. And, finally... all sound, all motion, stops. Annie's “dance of grief” is complete for this day. She smiles up at me, takes my hand, and we return to the rest of the group for the closing circle.

Later, in the quiet darkness of my home, I think about my time with Annie. Listening
is hard work—my body is exhausted from travelling into the liminal space of grief with her. My hands are still sore and red from pounding hard on the piano keys. I breathe in the candlelight, and release the tension in my muscles as I breathe out. A precious child has died. Another precious child cries out her grief, her loss, her sorrow, and her fears. Life doesn’t seem fair. I cannot stop the cycles of time. I have no answers. Yet, a white bird of hope still flutters in my heart. In Annie’s dance of grief, there are seeds of healing being planted, and promises of life to come. The sun will rise tomorrow, and the flowers will bloom again in the garden.

Childhood bereavement has been noted as a risk factor for the development of future mental health problems (Davies, 1999; Doka, 2000). Support may be crucial in helping children to adjust and make a significant difference to their future well-being by allowing them outlets for expression and opportunities to integrate their experiences over time, (Trofizzi, 1999; Webb, 1993; Wolfelt, 1996). How can music therapists offer support to grieving children? Although grief arrives, unbidden, in our lives, we may use the arts to “capture it back and reshape it. ... [T]he expressive arts therapies function beautifully as vehicles to help us reshape grief” (Bertman, 1999, p. 15). By engaging the child in the creative process, we can encourage them to externalize their inner worlds, and begin a process of integration. Kenny (1989) stated that “the creative process is informed by love, the intelligence of the heart, and thus the knowledge of the self-organizing system. It assumes that given creativity, a safe environment, and appropriate resources, after trauma, a person will naturally use the creative process to facilitate reorganization and reintegration. The process is the product” (p.89). The healing comes from within the child, but the environment which holds that healing is sustained by the caregiver’s presence and attention. However, we have to understand our roles with humility, and respect the child’s role in their own healing. Nabe (1987) stated, “We cannot make others
whole. ... But we can support them in their attempts to achieve it, and we can be an advocate for them with others so that the means necessary to achieve such wholeness can be brought within their reach” (p.286). In addition, we must have an awareness of the influence of important socio-cultural contextual factors such as the child’s home environment, the norms and values of the particular community they live in, their family’s response to the loss and to the child’s grief, and the family’s cultural and spiritual beliefs about death. The process of healing through grief may take years, and may never be fully realized. There are no methods or prescriptions for practice which can guarantee a positive outcome.

The work of grief involves a transformation of one’s identity, one’s environment, and one’s relationships—a complete relearning of one’s world. In music therapy with grieving children, we can consciously engage them in the creative process to support them on their journey towards relearning a world which is fundamentally changed; to assist them in overcoming the fragmentation wrought by grief. By offering them a safe environment where they can do their work of healing, we walk with them on their journey towards wholeness and Beauty. Such a safe environment is ideally grounded in the therapist’s compassionate presence and loving attention to the child’s needs. It is characterized by a continually developing sense of safety and trust within the relationship, by openness to what emerges within the session, and by a freedom of expression and communication between the therapist and the child. While the arts may help children find ways to articulate and express their suffering, the presence of a compassionate witness to their pain may help them to know they are not alone, that others do care, and will not abandon them on the long journey to healing. Children need to express themselves in order to grow, to develop, to learn, and to heal. Sourkes (1996) said
that “the therapist becomes an anchoring presence. ... The depth of the therapist’s
tenderness and commitment sustains the child in his or her confrontation with mortality”
(p.59). According to Barnard (1995) our capacity to respond to threatening situations
with creativity and courage depends on “our experience of being embedded within a
nurturing human community. ... Caregivers must embrace the sufferer, and continuously
reaffirm his or her capacity for relationship” (p.24). While individual support or therapy
can be very significant, a broader understanding of health compels us to acknowledge the
importance of helping grieving children and their families to build a community, or a
network of support. The grief support group model can become a central part of this
network.

Since I first began my work in music therapy with grieving children, I have
questioned how we can understand healing in the context of children’s grief. If one has a
conceptualization of grief as a natural process, which is our human response to loss, then
grief has no end. It is not a “problem” which we can precisely and definitively “solve.”
The work of grief is never complete. We are not “cured” of grief. Instead, we learn to live
with grief. We relearn our worlds, and find ways to integrate our loss into a context of
meaning. By embracing, rather than avoiding, suppressing, or denying the pain of grief, we
learn to live with it. Levine (1987) said “as in any healing, the first step is acceptance. We
cannot let go of anything we do not accept. ... It is at this stage of recognition ... that
tenderness is most necessary. It is a tenderness that simply allows us to feel what we
feel, the compassion with which we allow the process to unfold as it may” (p.110).

In the next part of this chapter, I will describe my role as a music therapist in the
palliative care program where I currently work, and summarize what my co-researchers--
the five girls whom I interviewed for this dissertation--have shared with me about their
Music Therapy in the North Shore Palliative Care Program

The North Shore Palliative Care Program is based in Lion's Gate Hospital, in North Vancouver, in the province of British Columbia, on the West Coast of Canada. The program runs a twelve bed in-patient care unit in the hospital to assist patients in need of acute symptom management, and also supports approximately one hundred terminally ill patients in the community who are living in their own homes. The services in palliative care are delivered by a multidisciplinary team of health care professionals (including nursing, medicine, social work, music therapy, chaplaincy, home care workers, bereavement counselling, pharmacy, physiotherapy and occupational therapy), and a large group of dedicated and specially trained volunteers. As a music therapist and a member of the psychosocial team, my primary role is to provide emotional-spiritual support for patients and their family members throughout the dying and grieving process. I work both in the hospital unit and in the community; visiting patients in their own homes. I work with patients of all ages who are facing death (including some pediatric cases in special circumstances), and family members.

The North Shore mountains provide a stunning visual backdrop to this region, and the cities of North Vancouver and West Vancouver rest between these mountains and the edge of the Pacific Ocean. The region attracts many outdoor enthusiasts and nature lovers with its easy access to old growth forests for hiking, downhill and cross-country skiing on the local mountains, mountain biking, kayaking, and a multitude of other outdoor activities. Real estate prices are high here, and there is a generally high standard of living. Culturally, the region has a fairly large number of people of Iranian descent and a large
First Nations population. The predominant cultural background of most patients we see at Lions Gate Hospital, however, is still best characterized as British and European.

In addition to my role as music therapist in the palliative care program, I am also responsible for facilitating bereavement support services for children and adolescents; in this capacity I provide individual grief counselling, and facilitate grief support groups specially oriented to meet the unique needs of children and teens. Music and other art forms are an integral part of my therapeutic approach. When I first developed the children’s grief group four years ago, I used my experiences in the bereavement support program at Canuck Place Hospice as a general model. Based on the idea that children need time to process their grief, the children’s group runs over the course of the school year, from September to June. A support group for parents of grieving children, facilitated by another staff member from our palliative care psychosocial team, is also offered at the same time. The average length of time that children come to the group is about one year. The group model is client-centred. Emphasis is not placed on the group facilitators as being the “experts” on grief, but rather on the children as being knowledgeable both about their own grief and what they need to heal.

The children have a self-directed free play time within our hour and a half sessions, during which they can choose what media they would like to play with. It is often during this free play time that I observe themes of illness or death being “played out” by the children in a variety of ways. The inclusion of trained volunteers within the group structure allows for adult supervision and individual interaction with the kids during this free play time. In fact, the presence of volunteers is key to the success of the group format. Not only do they add the diversity of their own life experiences and skills to the group, but without them, safety and supervision would become a concern during
the children's free play time; there are too many individual needs for one therapist to
effectively monitor when the children move out of the opening circle.

In the following story I will share a narrative, composite description of the
children's grief support group (based on my experiences in this group over the past four
years) which I hope will help to illuminate the process more clearly. Individual children's
names and personal details have been altered to protect confidentiality. According to
Merrill (1998), “the concept of interdependence illuminates the idea that in moments of
meeting, there are at least two unique experiences to be understood: the client’s and
therapist's. ... [W]hen we meet, my consciousness and yours create a kind of shared
territory” (p.37). It is this “shared territory” which will be explored in the following
narrative.

A Circle of Belonging

It is a grey Wednesday afternoon; the sky hangs heavy and low; pressing downwards
on after school traffic. The air feels muted and thick. I am inside the community preschool
which sits in the basement of the old United church on the corner. I am moving furniture,
 Pillows, stuffed animals, and chairs; making the space warmer, softer, inviting. One of my
dedicated volunteers has made a snack for the children who will soon come through the door;
she sets down interesting shapes with celery, peanut butter and raisins on a small table,
next to the door--ready for hungry eyes and tummies looking for an after school snack. I
tune my guitar and put my pick into my pocket. And I try--within the rush of physical
preparation for the children's grief group---to connect to my own heart centre. Breathe,
calm, become open, become receptive; this is a part of contemplative practice. Can I just be
present today? Can I be here to listen and to accept what each child brings to the circle?
Can I find a way to extend my caring for even the most withdrawn and the most outrageously
behaved child? Myers (1997) described a model of educational practice; "a spirituality of
caring", that has similarities to the way in which I approach my work in the children's group.
She named four conditions necessary for such a spirituality of caring that include: the
 provision of a safe space or environment, an attentiveness to the important unfolding events
and the contextual reality of children's lives, the presence of caring adults who are willing to listen and to respond to children's concerns and questions, and a trust in the capability of the child to transcend (Myers, 1997). Before I get overwhelmed with the complexity, I remind myself that at the core there is just one simple idea: this is a circle of loving and creating.

And, suddenly, THEY ARE HERE! Arms and limbs bursting through the door; favourite toys clutched tight to chest, introductions to animals I haven't met previously, complaints of heavy homework-books in backpacks, questions and hellos; all tossed into the air simultaneously in a melee of colour and energy. The children know the routine of this room, now--we have been meeting together for about six months. Food is part of the greeting ritual, but so is this hectic blend of greetings and news and sharing of treasures. These are the beginning rituals which set the boundaries for our shared field of experience. Raylene has a new braid to show me today. This one is capped with a tiny, purple bead. She smiles as I admire it--and says that she will "leave it in forever". Oh, and too, I must meet Mr. Beans. "That's the last special thing my mom ever gave me." I hold the precious treasure lightly in my hands, fleetingly ponder the meaning this grey little rabbit holds for her--a connection between her heart and another realm; a precious memory of her mom. Raylene is breathtakingly sweet--round and rosy-cheeked, blond and curly haired. She is often smiling, and she hides much of her sadness, from the world. "I hate to feel sad"--she painted in large broad strokes across her paper, one day.

I crouch low to look into little faces. I feel my tallness like a limitation; how can you talk to a tree which you can't see the top of? I extend my body and my intentions outwards; inviting the children into our shared space, encouraging them to be comfortable here. Katie always likes a hug; she is such a trusting child; her body relaxes completely in your arms. Chris doesn't like to be hugged, but he leans into me with his full body weight while I am talking in the circle. Each week he leans into me with a little more confidence and trust. Janie holds her head in her hands, and says she's tired. A volunteer sits quietly beside her, and offers to rub her back. We are all in the centre of the preschool now; sitting on the carpet with its circle of round pillows and stuffed animals waiting to be clutched and manipulated by small hands and bodies. The circle is our shared space, in a more intimate way than the preschool itself; which is more like the larger field. Because the circle is home, it is like the musical space, described by Kenny (1989) as "a contained space...a sacred space, a safe space, which becomes identified as "home base", a territory which is well known and
secure" (p.79). Although we share more than music here, we almost always begin with music. The song we sing together is our first structured engagement as a group; and everyone sings and claps the rhythm: "Who's in the Circle?". Everyone is named, and those who are away are also remembered. The final refrain shifts from naming individuals to a shared group chant: "We're all in the circle tonight."

In the opening circle, when we have completed our song, we pass a carved wooden First Nations talking stick around to each person who wishes to speak. The children tell newcomers to the group that they can use the stick to "speak about death and the people you love and stuff." The guideline is the rest of us try our best to listen quietly to the person who is holding the stick. If you don't want to talk, you can simply say "I pass." In our circle, a sense of communion builds over time. Vanier (1998) called this the "to and fro of love[...] ... the trust that comes from the intuitive knowledge that we are safe in the hands of another and that we can be open and vulnerable, one to another. ... Such a trust calls forth trust in yourself" (p.43). Trust develops as the safety of the circle is established and reinforced and participants share their stories, their experiences and their feelings: the ups and downs of their lives. This sharing is a part of our ritual; part of what contains and provides the basis for the experimentation of play. Later, at the close of the evening, we will return to this home base--where we will sit in the circle together again to say goodbye with another familiar song. These songs are always sung when we are together as a group in the circle. They represent familiarity and security for all the group participants.

"And, now is it time yet?" Anxious, wriggling, impatient bodies are bursting to play. The time for talking is short, but intense--and soon there is a real need to move, a real need to let the body lead in exploring the possibilities of play. Pillows to wrestle and throw. Baby dolls to cradle and soothe. High heels to totter in and glittering velvet capes to swirl. Sandboxes to bury and dig; where toy soldiers often die and are buried, and then come to life again. Rich, lush paints and creamy white paper, drums and wooden boxes to tap and crackle; all kinds of possibilities. The children have a self-directed, free play time in which they choose where in the preschool they would like to play. They choose their own materials, their play partners; and they have the freedom to create their world. This is their space of experimentation. However, I am always conscious of the importance of balancing freedom with structure. We have four, simple ground rules, centred around respect, which the children know that we will uphold. Before they can fully engage in creative experimentation, they must feel a sense of trust in knowing that the adults in the room will keep this space
safe for them.

There is deep concentration inside the play, and the world outside begins to fade away. Volunteers keep their focused attention on what the children are doing. They are listening, watching...available to respond; but letting the children lead them. I think about the note which I carry taped to the inside of my work binder: "It is not what we do that makes a difference, but what we allow to happen." I read it often, reminding myself to move away from doing, and towards being. The children, too are engaged fully in their play; absorbed in the kairos time of the present moment. Janine is lost inside the task of creating a clay sculpture of her grandmother. As she molds and shapes the smooth grey mass into form, her words tumble over themselves to share with me the hurdles she has had to endure today: "I have never felt such despair"—this articulate eight-year old tells me—"The girls at school were bugging me, and all my friends were fighting, and I just kept thinking of grandma and how much I miss her, and I just kept spinning down into this kind of dark feeling. Over and over again, I had flashes of seeing her in my mind. I was just crying and crying, and I couldn't stop." And, as she talks, her grandmother's figure emerges out of the clay; tall, strong, lifelike—she places a perfect round halo on her head. "Grandma is in a really nice place now, and she's looking down on all of us who love her. I know she still hears me when I talk to her...." I feel myself caught in deep concentration, a "particular state of consciousness" as I listen to Janine's story. I sense too, that she is experiencing her own "state of consciousness". This is described by Kenny (1989) as "a state of focused attention, yet deep relaxation. It allows a receptivity to new experience, new forms, new sound perceptions in the movement toward wholeness" (p.88).

There are moments when time seems to stop, or to stand still. Moments when something new, and previously unformed is spoken out loud. A child asks a searing question or makes a profound statement. As I watch Carly's face, I can see the fleeting shadows of struggle move across her skin. I move to sit close to her. I know she is wrestling with something important, searching to find the words. So often, her anger explodes like sharp barbs at others in the circle. "This is ugly. You're ugly. I hate this. What a stupid painting." Anger at her mom for dying too young, too soon. Anger at her mom for not being home more often. So much hurt, so much anger. I don't know if she will share it with me. She has already turned herself away from one of the volunteers who first moved to sit beside her. Body and face are contorted: curled into a tight ball—she turns her face away from the others in the circle. I move close to her and speak softly: "Carly. I can see you are thinking.
really hard about something. Your face is telling me that something important is going on right now for you. Do you think you can tell me about it?” There is a silence, a long pause, and then she decides to reach out in trust; to share her thoughts and feelings with me. The moment Carly speaks her body relaxes, her face relaxes, and she shifts into a new space. Together we talk about some things we might do to help her with this mix of confusing feelings. She decides she will write a letter to her mother telling her how she feels. We are learning something new, important information about the children in these moments. There is motion, there is movement; the possibilities inherent for change seem tangible. What a leap of faith a child takes, when she experiences the power within herself to move forward.

Kenny (1989) describes power as “the cumulative energy which draws one into new possibilities” (p.88). What courage it takes to speak all of your fears, your feelings and worries. So often we learn that what is acceptable to the world is only our “best face.” People do not want to see pain, nor do they want it to be sounded from the rooftops.

Children come to the circle to grieve, to do the work of healing. Some stay for a few months, and then are ready to go. Others stay for a year or more. Here, they learn that they are not alone in their experience. Janie says, “Sometimes I feel like I’m the only one in my class at school who doesn’t have a mom.” There are nods of agreement around the circle; solemn attention to and affirmation of Janie’s words: others here know the meaning of her reality. They too know this sense of aloneness, this sense of having an experience of life which their peers cannot understand, and often, cannot speak to. Adults, in their discomfort with “not knowing what to say” often pull away, too. The unspoken weighs heavy on children; for what is unspoken is as important as what is spoken. A sense of warmth and belonging builds in our little circle over time. I try to cultivate this sense; encouraging the children to answer questions which are initially directed towards the adults in the room. “What do you think you would do in that situation, Johnny? Do you have any suggestions for Chris?” The children can teach each other. They have something to give, to contribute to the dialogue; and in sharing what experience has taught them, they learn that they are not alone. In this way, we build a sense of belonging. Vanier (1998) described belonging as:

the place where we can find a certain emotional security,...the place where we grow to appreciate others, to live with them, to share and work [and play!] together; discovering each others’ gifts and weaknesses. We all have to discover that there are others like us who have gifts and needs. We are a small but important part in our universe. We all have a part to play. We need one another. (p.58-59)

And so, the children enter into this space, into this field of play. In this environment
they can experiment until they find authentic expressions which reflect and actualize growth and change. In a movement between form and freedom they begin to explore; through play, through the movement of their bodies and the sounding of their voices, through imagination, and through all the artistic media available to them. They engage in a creative process of healing. The process manifests itself from the outset, but it develops in complexity and depth over time. And so, the mysterious process of healing, informed by love, unfolds.

Each year, as I facilitate these groups, and watch the children move through the waves of grief in their life, I am reminded that transformation is an ever-present possibility; healing—sometimes subtle, sometimes dramatic, happens. Alan Wolfelt (1996), a leading clinician, author and educator in the area of children's bereavement care, critiqued the traditional medical model of understanding human behaviour. He points out that approaching grieving children as if they need to be fixed or cured puts the responsibility for healing in the hands of the doctor or caregiver who treats the patient. He advocates instead an approach to working with bereaved children which places trust in the child's own ability and inner capacity to grow and heal: “We do not cure the grieving child....instead we create conditions that allow the child to mourn” (Wolfelt, 1996, p.2). And part of the conditions for healing are provided by the group setting: a space where children can learn with and from each other. hooks (2000) said that "rarely, if ever, are we healed in isolation. Healing is an act of communion" (p. 215). The children's group provides a space of community where mutual healing can take place.

The room is becoming quiet now. Pillows are carried from the pillow play room back to make a circle on the floor. Bodies are tired and thirsty from play and living-in-the-moment. Each group member finds a comfortable place on a lap, a pillow, or wrapped around a soft teddy bear. One of the volunteers brings cold water—it is received enthusiastically by outstretched hands. There is a tiredness, a releasing of tension and energy which is evident now. Time for the last song. I put my guitar on my lap, and begin to strum: “It's time for us to say goodbye--the circle of friends is saying goodnight.” Every child sings it in his or her own way. Chris sits right in front of me and helps me to strum. He does this every week now; it is part of his contribution to the circle. Raylene flops onto a big pillow with Mr. Beans, tucks her thumb into her mouth and hums. Johnny knows every word, and he sings each line twice. Carly doesn't sing tonight. Janine rocks back and forth to the rhythm of the song; singing with her body and her voice. Katie sits on one of the volunteers laps. She sings and
closes her eyes at the same time. I feel such a warmth, such a sense of completeness in being part of this experience tonight. We shut our eyes and join our hands; sending a "love squeeze" gently around the circle. A sense of connection and comfort flows. These children give us their trust so fully and so completely.

Each child, each one unique.
Each one a field of beauty;
Whole and complete.
I struggle to name
the complexities
the intricate-mysterious web of play and sound
movement, spirit, feeling, voice...
which are being formed in this
space

sometimes time flows
and is gone before I am aware of its flowing
sometimes time is stopped.
suspended

by a phrase
a look
an expression
a moment of meeting.
a new way of being.
silence turns,
into the spoken word
words dissolve...
into tears

sadness hangs heavy,
like a cloak.

laughter flows, infectious,
into our bellies

around the circle
we imagine and create
dancing, singing, playing, spinning worlds...
loving and whole worlds.

I observe and participate simultaneously
Not only do I embody my knowing
I embody my unknowing.

The children bring their lives to the circle.
And so do I.
Children’s Reflections on the Grief Group

After completing my interviews with the five girls who participated in this component of my research, I studied the transcripts of our conversations, listened to the tapes of our dialogues and music-making, and studied the artwork the children had created. In addition, I engaged in my own creative process, writing poetry, and creating a visual mandala of each child’s interview while I listened to our taped dialogues (I have included these mandalas on the title pages of each chapter). The artwork reflects my sense of their grief and healing process, and is another way for me to integrate our shared experiences. This heuristic inquiry—described by Moustakas (1994) as “a process of internal search through which one discovers the nature and meaning of experience” (p.17)—eventually enabled me to construct an individual depiction of each child’s experience of grief and healing. I wrote these depictions primarily in the first person in an attempt to enter into the world of the child through tone and language; foregrounding their voices rather than my own. Out of these individual summaries, I created a composite depiction of the dialogues. This involves the hermeneutic process of interpreting the “data,” and identifying the qualities and themes which seem to consistently emerge. The composite depiction “includes all the core meanings of the phenomenon as experienced by the individual participants, and by the group as a whole” (Moustakas, 1990, p.52). It is important to note that I was not searching for causal connections, and the outcomes cannot be generalized in a numerical or statistical sense. In fact, the intent is not to generalize, but to learn from each individual story. Epston and White (1990) stated that “the narrative mode of thought ... is characterized by good stories that gain credence through their life likeness. ... The narrative mode leads, not to certainties [or truths], but to varying perspectives” (p.78). What we learn from individuals can, however, help us to
add to our general understanding of a phenomenon. Moustakas (1990) said that “with virtually every [story] that matters personally, there is also a social--and perhaps universal--significance” (p.15).

The children whom I interviewed described their experiences in the grief support group, generally in very positive terms. They offered me a few suggestions for things we could do to make the group better, which included spending more time outside, letting kids bring their pets to the group, having the group more often, and separating the children into different age groups, rather than having such a wide age range in one group (the current group is for kids aged five to eleven years). The main themes which emerged through an analysis of the children’s feedback about the group were: it was a place of belonging that was fun and helpful, safe and comforting, relaxing, supportive and accepting.

The theme of belonging was very prominent. My co-researchers linked this to meeting others like them who had also had a death in the family, and to the environment created in the group setting. Since they repeatedly described the lack of understanding they received from other children in their classes at school, and their sense of being different, isolated or alone in their grief experiences, finding this sense of belonging with their peers was very significant and, I believe, a central part of the healing power of the group format. Feedback from the children’s parents also strongly supported this theme. They repeatedly noted the benefits they felt their children received by getting to know other kids who were in similar situations. Vanier (1998) connected belonging to a process in which we break out of “the shell of individualism and self-centredness that both protects and isolates us” (p.35). I see this in the children’s group as they reach out to listen and to help one another. A sense of belonging grows over time as they find and share a certain kind of emotional security. Vanier (1998) also suggested that as human
beings we have "an innate need in our hearts to indentify with a group ... to discover and affirm our identity' (p.35). As children grieve, they are reconstructing a new identity--a new life without the presence of their loved one--and so, meeting others who are 'like them' in one particular way helps them to discover and affirm themselves as they relearn their worlds and their selves. Here is a composite summary of what the children said about belonging in the kids group:

The best part is being with other kids. They understood, they just understood. Its a bit exciting to meet other kids who have the same thing as you, and you're kind of nervous at the beginning of the group--before you get to know everyone's names. It's more fun being in a group with other kids than just talking to one therapist by yourself. Before I didn't know any other kids who had someone die. It's nice to know other kids have the same problem as you. I like talking and hearing other people who have had this ... kind of seeing I'm not the only one going through this. We are all in the same boat. It's easier sometimes to talk to other kids than to adults. Sometimes kids don't really like to talk to adults about their problems. I think it really helps to be with other kids who had a loss.
Another theme which surfaced in the children's descriptions was their perception of the group as fun and helpful. These words were also mentioned repeatedly in the evaluations I had previously completed with a larger number of children at the conclusion of our recent children's group in June. This theme was also affirmed by feedback from parents who described their kids as eagerly looking forward to each group session, becoming very upset if they had to miss a group, and talking with excitement about the group, and activities they did there after they went home. The girls I interviewed described many of the specific activities we did in the group as both fun and helpful. The arts activities and the talking circle (the time in the group where we pass the talking stick and each member has an opportunity to share) were mentioned by all of the girls as positive experiences that helped them with their grief. Here is a summary of their experiences in the group's activities:

I felt that I'd been able to learn some things, if I ever felt sad again to just go and maybe draw a picture ... or put on some music or something. I liked all the activities we did; the paintings, the power shields, painting our feelings to music, playing feelings on the instruments. There were a lot of fun projects to do there. I liked the art. Art helps you express yourself more. We could also go to the park and play, just get some fresh air. I liked it when we sat in the circle and passed around the little totem thing ... the talking stick. I find that talking is very helpful. I like to hear what the other kids have to say. I can tell about my day, or my feelings, or talk about my dad, or I might just be in the mood to not talk that day--and that's okay too. Talking helps to get things off your chest, though. We had a visit by the SFU soccer team--that was a really fun night. I liked playing soccer too, in the gym. The pillow room was fun sometimes, and that little dress-up place. I liked the choices we had about doing the activities. We could just watch, or join in if we felt like it.

Other key themes which emerged from the children's descriptions were that they found the group to be safe and comforting, relaxing, supportive and accepting. These themes seemed to be related not only to the activities we did, and the presence of their
peers and ‘friendly’ adult helpers, but also to the environment which I (along with my volunteers) tried to create for the children. Several of them mentioned that they liked the element of choice in the group; they appreciated the flexibility of the format, and the fact that they were never pressured to talk or to participate in a particular activity. This is part of what I believe contributed to their descriptions of the group as relaxing. Even though they did not always choose to talk about their loss in the circle, they perceived it as a place where difficult feelings could be shared if they wanted to share them, as a place which was supportive and accepting of sadness and grief. I think their sense of being able to relax there was also linked to feeling safe in the environment. I was pleasantly surprised to hear several of the girls describe the group as a place where they felt comforted, and a space where they felt comfortable. Of course, this is part of the space that we try to create, but I didn’t know that the children would articulate it so clearly that way. Here is how they described the group environment:

Something I really like about it ... it’s a place where you can relax and have the weight of feeling so sad be lifted off you for awhile. Its a place that understands. Its a place to relax and sort of forget about all the pressures of being upset. ... You know, its kind of refreshing--after a hard day it would be nice to go there to kind of get refreshed. It was a cheerful, friendly environment, all the stuff was right there at your fingertips, ... we had choices about what we wanted to do, and that was nice. I think it was nice because you weren’t pressured to do anything. There was lots of space, and there were places to be alone or away from the group too. It was a place where, if I felt a little bit upset, it could be helped right away. It’s comforting. If you cry, nobody worries about it. Its okay to be upset there. It was a really nice place to talk if I had anything, or if I didn’t have anything to say, and I just wanted to listen that day. There was no pressure to do anything. I like that freedom. There were very nice helper people ... and you know if you wanted to talk to them they would really listen to you. It’s a comforting kind of place. There are helping hands, listening and friendly ears. It makes me feel safe. Gosh, it was a really good group. We really

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had a lot of fun there too.

In evaluating the group, I also asked the children to draw a "before and after" self-portrait; the "before" depicting how they felt before they came to the group, and the "after" depicting how they felt at the end of the group. This technique was described in a pilot study by Graham and Sontag (2001), in which they used a number of different art activities to gain insight into children's perspectives of their experiences in a grief support group. All of the children in my group drew themselves as crying and sad before they came to the group, and smiling (although not without tears) at the conclusion of the group. These are the words they used to describe how they felt when the group ended:

I think that the counselling helped me to recover. I would tell other kids to come here, 'cause it helped me so much. I don't know why it helps, but it just does. It helped me a lot. Before I felt alone, confused, and lost. Now I feel happy, better, not alone. You should maybe do a show on television about it, or write a newsletter, so that more kids can know about it. Before I was sad all the time. Now I still have some tears, but I'm happier. There is sun and cloud both. Before I came to your group, I was just like a shell. Now I'm much happier. Before I felt kinda lonely because no one else I knew was dealing with the loss of a loved one. Now I feel more comforted, knowing there are a bunch of kids going through the same thing as me.
Since the children’s grief group is only one aspect of the children’s lives, I also asked them to help me understand in a more general way what kinds of things had been helpful to them as they learned to live with their grief. I view the work we do in the kids group as just one aspect in a broad continuum of what contributes to healing for grieving children. Researchers have noted that children’s responses to death are intimately intertwined with their family context, and I have certainly observed this to be true in my own work (Worden, 1996). Parents play a large role in either hindering or supporting their child’s healing. This is one of the reasons why, in our program, we offer a parents’ support group at the same time as the children’s group. Not only does it model the concept that grief affects everyone in the family, but it also provides parents with a place where they can attend to their own needs in grief, share their concerns about their children, and get feedback from other parents who are going through a similar experience. Children are usually very aware of the grief that other members of the family are experiencing. The girls I interviewed described changes and responses to the death in their family as follows:

I went to the group because everyone in my family was upset and everyone was blaming everyone for something they didn’t do. Everyone was crying. Everyone was sad. No one was themselves after my dad died, they still aren’t, it’s really weird. At the funeral service, everyone around me was crying and everything...there were lots of tissues being passed around. For awhile everyone was a bit upset. My Grandma especially...I’d always look over at her in church and I’d see her eyes water. I’d feel really upset because she was really, really missing him. No one in my family’s been the same this year. Not my mom, not my sister, not me. We have had very dark and very bright moments.

In addition, family support was identified by some of the children as being an important part of what they needed to get through their grief. One girl said, “I can talk to my Mom--she is one of my greatest supporters.” Another child explained about the importance of
family in detail:

Since my dad died, I have learned more about what it means to be a family, that family is kind of everything. So while you got all your family together, you gotta make the best of it. I was lucky to have a supportive family, we are pretty close knit, we know each other really well, so that helped. You know, giving each other space, or a helping hand if someone's had a bad day. Just respecting each other's feelings.

"Our family after my dad died."

"Our family all together."
Children stressed repeatedly that they need to be listened to in their grief, but that parents and other caregivers should not push them to talk, or question them all the time about their feelings. One co-researcher explains:

You have to listen good and observe so that you can maybe get a better idea of what’s happening. There are some people that kind of watch you, and make a pause like you’re supposed to fill it in. ... You can ignore it, but they try again, and you want to say back off, you don’t like talking. It’s important to really observe what kids are saying and thinking so that you know when to leave them alone, or if they really want to talk. Kids need someone to listen to them. But adults have to be patient. ... They shouldn’t force you to talk. Give them space if they need it.

Another point identified by some of the children was that having a school teacher who shows understanding for their grief makes a real difference. One eleven-year-old girl said, “At the beginning of the school year, when it was first really hard, sometimes I’d have to go out of the classroom. My teacher was so good. He let me do that. Also he gave me a break on my homework--let me hand it in a day late and stuff--without the other kids knowing. It kind of helps not to have as much pressure.” This is a summary of all the things which the children suggested have been helpful to them in their grief:

- being with other kids who have had a loss; helping one another
- talking with someone who listens, but not being pressured to talk
- counselling (defined as the support group, and/or 1:1 time with Heather or others)
- art
- music
- having supportive friends
- having support from your family
- having a school teacher who is understanding
- hugs and cuddles
- playing sports, or just playing ....
- being with your pets
- time to be alone
- time to be in Nature
- keeping a feeling of connection with your loved one; remembering them
- having spiritual/religious beliefs (ie. believing your loved one is safe in Heaven)
In the next section of this chapter, I will share in more detail two ‘portraits’ of individual children’s stories of grief and healing:

**Sammy**

I meet with Sammy on a sunny summer afternoon in her home in North Vancouver for our interview. As I drive up and stand at the front door waiting for someone to answer my knock, I notice that you can see the ocean, sparkling in the distance, from the front porch. There is a gentle breeze quietly rustling the leaves on the old cherry tree, and the day seems alive with light and the softness of summer. Sammy lives here with her mom and dad and younger brother. It has been some time since I have seen Sammy, and I wonder how she will have changed. She was ten when her grandfather died, and when she came to the children’s group. It is now almost two years later. When she opens the front door I can see that she has grown much taller, but she still exudes the kind of warmth and openness that I remembered from the time we spent together in the kids group. There is no defiance in her attitude; yet, I can sense she has grown in confidence since the last time I saw her. As soon as I arrive, Sammy introduces me to her pets--whom I have heard about but never met; her cat, her friendly big black dog, and her hamster. Sammy wants to be a vet when she grows up, and the walls of her bedroom are covered in photos of animals of all kinds. There is also a large collection of stuffed animals sitting on her bed--each one placed very carefully as if in its own special spot. They are obviously well cared for. I first met Sammy at the hospital where she came to see me not long after her grandpa’s death. She was really struggling at that time, and in addition to her grief, she had also just moved to a new school, which she was finding difficult. Sammy and her grandpa had a very close relationship. Although her grandpa was deaf from birth, she was able to communicate with him--he was able to lip-read, but they also developed a way of being together that did not rely just on words; sharing their mutual appreciation for nature and walking with their dogs. This is how Sammy described her story of grief and healing to me on that sunny July afternoon.

"My grandpa has been sick ever since I was alive. But it didn't really start to settle in until he started to go into the hospital. I started wondering, 'Will he be here for this? Will he be here for that? Will he be here for my birthday?' And it kind of scared me. So I was pretty scared and worried at that time. I only ever got really upset one time before he died. It was at school. I used to carry a teddy bear he gave me everywhere I went, and one of the kids started making fun of it. He grabbed it from me, and threw it on the ground. That hurt..."
me a lot because it felt like he was hurting my grandfather.

It was at the church, where we had a big service for my grandpa that it really clicked that he was dead. Everyone beside and around me was crying. And it clicked that he’s gone, and he’s never coming back. After that, I was really upset all the time. I was crying myself to sleep every night, and I sort of didn’t know that much how to handle it. I tried to help myself. I wrote this long letter to him, telling him about my pets, how school was, and everything... Then I burned it and went out with my mom and threw the ashes on to a field. I just sort of felt that the ashes would come together and go up to Heaven and he’d be able to read it. ‘Cause that’s where I believe he is. But I was having a really hard time. When I went to my grandma’s house, it felt so empty without him sitting there on the couch, or walking around. I felt really upset, too, for my grandma, because she was really, really missing him. I don’t think my friends at school were all that sure how to handle it. I sort of had the feeling they were thinking, ‘Is she all right, or is she just going to burst into tears at anytime.’ So we never talked about it. I just sometimes left them to go off and sit by myself. My teacher was so supportive. She said if I ever felt a certain kind of sadness, I could stop work and go out of the classroom: just go to be by myself for awhile.

It’s been almost two years now since he died. The grief is still there, but its not so much. After I got over feeling really upset that he wasn’t here, I could start thinking about all the nice memories, and the things we did together. He and I used to go for nice long walks together with his dog. Just the two of us, not saying much, just walking. His dog still comes over to our house to sleep over. So that’s nice, a really big memory of him. We had a special connection. Still, sometimes memories come back and make me sad. But mostly, I think he’s happy now, up in Heaven. It makes me feel happy that he’s up there. Its maybe cause of my religious beliefs and church. I feel connected to him when I look up at the stars, and I think maybe our eyes make contact for just a few seconds. He’s just up there in a luxury house, maybe playing golf, happily waiting for me and my grandma to come up there when it’s our time."

After meeting with me a few times at the hospital for some individual counselling, Sammy agreed to give the children’s support group a try. This is what she told me about her experience in that group, and the things that have helped her to heal since her grandfather’s death. "When I first came to the group I was a bit nervous, and excited too. I wanted to meet some other kids who had had this, and talk to them. It helped me a lot when you said I could bring my own teddy--I have a really special teddy. So I brought my Daisy. And I got
more relaxed there as I started to know everyone's names. I think that I was able to learn some things that I could do to help myself; like if I was ever sad I could just go draw a picture, or just put on some music. I really liked the music and the paintings we did there, also the dress-ups and the pillow room. There was a time when you let us do painting to music, and another time when we used the instruments to show our feelings. I liked those things too. Something I really liked about the group was it's a place where you can relax. The weight of feeling so sad can be lifted off you for awhile. It's a place that understands, and that's relaxing. I also felt that if I was feeling a bit upset that day, it could be helped right away. At school my friends were all worried about what to do with me, I think they were thinking I might just burst into tears suddenly, and they wouldn't know how to help. But in the group, that would be okay. It was okay to be sad there. You know, I really did enjoy it there. It was a really nice place to talk if I had anything to say, or if I didn't feel like talking that day, I could just listen. That was fine with everyone. I didn't feel pressured. And I really like that freedom. Maybe one thing you could do for the next group is to let kids bring in their own pets--because animals like being with kids a lot; it's joy, it's comforting. They don't judge you either.

When my grandpa died, at first I tried to help myself, but I didn't really know how to handle it that much, and I was having a hard time. When I came to talk with you at the hospital, I felt that I would be able to handle it a bit more afterwards. My teacher was really supportive at school. That helped too. The children's group helped me to learn some things to do that I could help myself. Like using music and art to help with your feelings. It's good to have a place where you can go and just talk, or if you don't feel like talking, you can just listen to the other kids. It helps to take the weight of the sadness off you for awhile. That group is a very relaxing place.

I found I started listening to a lot of music, calm music; my favourite composers are Beethoven, Mozart and Bach. I also find that being outside really really helps me. I like the nature, it's very peaceful and quiet and sort of soothing. I've got a cherry tree in my backyard where I go and sit. It's my quiet spot where I go to just be alone and have some peace; not really to think about anything, but just to sit there and listen. Sometimes kids just need to have their own space to think. It bothered me sometimes when my parents would ask me how I was feeling all the time. Sometimes you just have to let kids be alone, and unless they want to talk, not really talk to them. You might feel pressured to be upset if everyone keeps asking you over and over again "Are you all right?" Another thing that helps you get through this is
your pets. Pets understand, and they won't judge you or ask you a lot of questions. Lots of times my dog would come up to me when I was feeling upset, and we'd just hug, and I'd feel better. I think maybe the easiest way to handle a death is to think about a place where your loved one is. For me, maybe it's 'cause of my religious beliefs, but I feel happy that my grandpa is in heaven now. But for other kids, maybe they think their dad or grandpa is like a fairy now, or maybe he's come back as a bird or a chipmunk. So then, whenever you see that chipmunk you can say, "Hi, Dad." I think it's important to think of a place where they are, or think of something to have that's your special thing; maybe a certain piece of music you can listen to and think about him. Or have a picture of them close by you, or something that was special to them, and every time you see it you will have a good memory. Just different ways that you can feel connected to them."

Sammy and I spend the last part of our interview time together drawing and talking while we sit on the floor of her bedroom. She creates an elaborate sketch for me of her conception of heaven, and the house where she believes that her grandpa (and all the other dead people in her family) are now living. Although Sammy identifies with Christianity in her own meaning-making of her loss, I was struck by her capacity to consider that others may have different ways of understanding death. She is what some might call a child with "an old soul." Her green eyes, and her confident, articulate manner of speaking point to an awareness which seems well beyond her years. Her mom says that Sammy has always had this remarkable ability to express herself, and a kind of spiritual sensitivity—even as a very young child. As we say goodbye, and I walk with Sammy and her mom towards my car in the driveway—Sammy suddenly rushes back into the house. She returns, a few moments later, with a little yellow book for me. It is a guidebook for English travellers in Japan. I had mentioned to Sammy and her mom that I would be going there to teach the following week. Sammy wants to lend me her book to help me on my trip. I hug her, and thank her for her thoughtfulness and her kindness. Then I drive home—with my heart lifted at this unexpected gift; this spontaneous generosity from a child....
Chloe

It is early in the morning when I leave my home in the city to drive east, towards Abbotsford. The sky is a particularly clear blue today, and Mount Baker's creamy white surface looms large and vivid against this blue sky as I leave behind the busy city traffic. I am going to meet Chloe and her sister Eve—to talk with them about the time we shared in our children’s grief group. As I get closer to their house, I am amazed that they and their mom made this long drive each week to North Vancouver. The suburbs turn into farm fields, and I pass hand-written signs proclaiming fresh-picked corn and organic vegetables for sale. As I wind my way through the maze of country back roads, reading a detailed list of directions from my lap, I have a feeling of delight to be out of the city chaos. The country is where I grew up as a child, it is home to me, it feels familiar, somehow—and as I drive I fleetingly wonder if I will ever give myself the opportunity to live in the country again. I am looking forward to seeing both of the girls again. Although they had very different personalities and ways of being in the group, what they shared in common was a remarkable capacity for compassion. Their presence helped to foster the sense of belonging and caring which grew in our group this past year—it was this particular group, more than any other I have facilitated, where I have been most aware of the children’s capacity for caring and helping one another. All of these thoughts go through my mind as I pull up in the driveway of a neat, blue ranch-style house. Beautiful English gardens surround the house; flowers and trees are abundant—as is the quiet. I turn off the car, and before I know it, both girls are rushing out to greet me, and to ask me if I need any help carrying my things. They are both eager to show me around.
As I walk into the house, I see a large picture of their dad before he died—he is smiling, and his arms are wrapped around both of the girls. The reality of their loss becomes much more real to me as I see this photograph. Bob had lung cancer, which was only diagnosed in its late stages, and the family were given very little hope for his survival right from the time of diagnosis. Despite the beauty of their home and their surroundings, and the girls’ exuberant welcome to me, I sense the emptiness and sorrow that lives here too—the loss of their dad’s physical presence is palpable. Patti, their mom, is very gentle and easy-going with her daughters and she reminds them not to overwhelm me with requests to look at every one of their photographs and special objects. After I take some time with both girls to look at the photos they want to show me, and to go for a tour of their house and gardens, Chloe and I sit down in her bedroom for her interview. Chloe is full of energy and curiosity; she is very social, and very talkative. She tells me that she wants to use ‘all the things’ for our interview—she wants to talk, and paint some pictures, and she wants to play some music together too. This is how Chloe described her experience of losing her dad, her experience in the kids group, and how she found ways to cope with his loss:

“My dad was a healthy guy, a get up and go kind of a guy. He never wanted to sit down and relax. He was the best and most coolest dad a person could have. One day when we were out biking, his shoulder locked up—he just couldn’t move all of a sudden. And that kept happening. Then another day he said “Patti I can’t see, I can’t see”—so right away we sent him to the Emergency room at the hospital. That’s when they found out he had cancer. It was really shocking, ’cause you wouldn’t expect it. It was shocking and scary for everyone in our family. He went for lots of different treatments. There was one that made him lose his hair—that’s chemotherapy. Another one made him mad all the time—just kind of didn’t want anyone to go near him. We had so much medicine in our bathroom then; all kinds of pills, they took up the entire bottom cupboard. You know just the day before he passed away in Lions Gate Hospital, I had a weird thing happen to me. I was with my Aunty because my mom was staying the night at the hospital with my dad. Well, my mom called and told us she had decided to stay there—and I got to say goodnight to my dad on the phone—but after we hung up, I just couldn’t get to sleep. I was tossing and turning and rolling all around. Then I had this horrible nightmare that he died, and my mom was sitting alone in her bedroom, just crying. I got up and ran out into the hall, and my grandpa was there. I said, “What are you doing here, and where is my mom?” Then my mom came out and she said, I have to tell you guys something. She got Eve up, and then she told us. It was kind of shocking and strange.
'cause I had already visualized it happening. It's kind of weird but I usually do that before something major happens.

After my dad died, all the family came to our house. Everybody just sat around. My cousins were crying, and my uncle was so sad—he just sat outside looking into the bushes, and he didn't say a word. I tried to keep my chin up. I had a friend who I called right away. His dad died about four years ago. His mom was very helpful towards me, 'cause at that point I had no appetite, I wasn't hungry, I just stopped eating. I didn't eat for a couple of days, I think. But my friend's mom said I was in shock and I should eat something—so she made me some french fries, and that was helpful. At my dad's funeral everyone was crying, except for me. I was smiling and singing the song that was playing when we walked in. The song was "Here Comes the Sun"—and you know what, it was pretty cloudy that day as we were driving in the limo to the church. But then all of a sudden, when we walked into the church, the sun just burst through this stain glass window, lighting everything up. And it stayed that way until the song ended. The Reverend, she was nice. She didn't try to tell people, "oh, now is the time to become a Christian." She was just very helpful, and funny, and she let a few people get up to say a speech for my dad; some poems and stuff that his friends said. Then, on the way out they played the song "Hey Jude" which I know my dad would have liked. Then we had six Harley Davidson motorcycles all around the limo while we drove to the cemetery. That's the way we rode, and my dad would have really liked that, 'cause he had his own navy blue Harley. I think he sold it for a mortgage or something like that, and that was very nice of him—'cause mom didn't want him to, but he really wanted to make sure our family was taken care of. After that I wasn't very happy about myself. I just wanted to get away from the world. I wanted to go away and start a new life where nobody knew me. But that can never happen—what you are is what you are and you can never change that. My mom and sister like going to the grave, but I don't like it there. It doesn't make me feel very connected to my dad. You know, because nobody is there anymore. Nobody is home, that's just a shell. This has been a very stressful year for my family. Not only my dad has died, but my mom's uncle died too. And now my mom's aunt, who is my grandma's closest sister, is having a hard time with breast cancer. No one has been the same. We've had some very dark moments—some bright moments too. But you know how an artist has a dark period. Well, I've been having a dark period too.

Before I came to your group, I was kind of like a shell. A shell that walks and talks and eats. I felt alone and lost and confused. Now, I am much happier, feeling much better. I
don't feel so alone anymore. I made a good friend there; Carol--she was my first friend in the
group. Her dad died of cancer too. We talk on the phone, and we have each other's email.
Carol and I can talk for hours. Sometimes it was sad to be at the group, and hear from the
other kids how their parents died... but most of the time, I really felt comfortable there. It
was fun and helpful and kind of nice and refreshing. After a hard day it would be a good place
to go to kind of get refreshed. Talking really helped me to wash out the bad stuff. It kind of
helps to talk it out. I liked it when we talked in the circle with that little totem stick kind of
thing. And I talked when I was playing with the other kids too. Sometimes when we were
playing soccer together, or just playing over at the park. I liked talking to the other kids, and
hearing what they are going through. Sometimes I'd try to talk to Susan about her brother.
Her mom said she doesn't like to talk about him, but once she got close to me she kind of
talked way more about it. You know, if you send a kid to do an adult's job you might get
something more out of them. Kids don't always like to talk to adults about their problems,
but they still need to get it off their chest. Sometimes my mom and sister tell me that I
talk too much. They're alot quieter than me. But I want to be who I am, and I don't want to
be nobody else, and nobody can change that. Anyways, in the group, you see what other
people's lives are like, and you notice you're not the only one going through this. We are all in
the same boat. Ya, I really like talking with other people in my grief, and I wish the group
came more days.... It took us an hour to get there, 'cause we live out near Abbotsford. I
usually got a couple of units of math done in the car on the way there. But it was worth the
drive. I wonder if there is any way you could just move that group a little bit closer to us?

I think it really helps to talk things out with other kids. You gotta get it off your
chest. You gotta get rid of the bad stuff in your mind. What I try to do is to help other
people too. You know, because it's not just me that needs help, but other kids too. We're all in
this together. It helps to know that you're not the only kid in grief. If this happened to
another kid, I would tell them, "Don't let it get you down." You gotta keep on going. You gotta
stay straight, not make any silly mistakes, when your parent has died. You can't just stop--
you gotta keep on playing.... You got the rest of your life to live. Sometimes, when I'm doing
something wrong, and I know I'm doing it--like eating too many blueberries--I can kind of
hear my Dad talk to me and tell me not to. I listen to his voice. You gotta remember that
your parent is safe, and they're not gone forever, and you'll see them again someday. My mom
always said that down on earth is only part of your life, and heaven is the rest. I think my
dad is with his mom now--he's out of pain, he's got no more broken foot, and no more cancer.
He can play all the soccer and football he wants to. You gotta remember that if you lost a parent, they're not totally gone—they are still watching over you like a guardian. Maybe they are always beside you, watching you. So, you gotta keep on smiling, I guess. And, for adults who help kids—it's very important to know when and when not to talk to them; when is the okay time for talking. If kids walk away, don't try to talk to them some more, just let them be. 'Cause that's a sign they don't want to be bothered. If they keep on talking to you, then sure, go ahead, they probably want to get something off their chest. But, don't push them. Don't clobber them...."

When Chloe and I finish talking, we take a break for lunch, then we return to her room so that she can complete her painting, and improvise some music with me. Before I leave she asks me if I will watch a video with her—it is a video that that was specially made for her dad's memorial service; and it captures images of him from his own childhood, through his marriage and the birth of Chloe and Eve, and their family life together, right up until his death. We sit together on the floor in the living room, and watch the video—while Chloe tells me about each person that comes up on the screen. It is a moving tribute to her dad—as I watch I begin to get a better sense of his good-natured personality, and I have a better understanding of how the girls, even in their grief, still embody that part of him. At the end of the day, I drive home, profoundly grateful for their trust in me, their willingness to share their experiences to help others... and very moved by the depths of their sorrow, and the vastness of their courage.

Chloe's drawing of the many feelings of grief.
The Family Context: Parent’s Perspectives

In addition to dialoguing with children who participated in the kid’s group, I also talked with their surviving parents. I hoped, through this, to get a sense of the parents’ perspective on their child’s experience in the group and how the family was coping as a whole. I also hoped to clarify medical and historical details that some of the children were unable to articulate. I would characterize the parents who I interviewed as being generally very open and supportive with their kids, as having an awareness of the difference between their child’s grief and their own grief, and as acknowledging the limits of their own energy. Each of them initiated reaching out for bereavement support for their kids, and all of them participated in either the parent support group, or individual counselling, or a combination of both. These parents were, and continue to be, an integral part of their child’s healing. Parents described several things which helped them as a family to get through their grief. The main themes appeared to be love, support of friends and other family members, having an acceptance of death and grief as a part of life, and their own inner strength. The main themes also included seeking outside support and counselling, maintaining a sense of hope during their loved one’s illness so that the experience was not entirely negative; involving their children in aspects of their loved one’s care; maintaining open communication in the family during the illness and after the death; having an understanding of the need for kids to have their own special kind of support; and acknowledging the differences between what they needed in grief and what their children needed.

Reflecting more specifically on how their children benefited from the children’s group, the following themes predominated: much needed peer support for the children which fostered a sense of belonging and reduced their sense of isolation about being
different, and opportunities for verbal and non-verbal self-expression, which resulted in positive changes in their children's grief. In addition most of the parents mentioned the aspect of prevention—they believed that this experience would help to reduce long-term mental health problems for their children down the road. The next paragraphs contain some of their comments verbatim on these themes.

About peer support, parents said: “It's just kids being with kids, and I think that is probably the most healing thing.” “In a one-to-one counselling setting, it emphasizes the fact you're special or different, whereas in the group, you're a part of something. The group normalizes their experience, reduces their sense of ‘I'm the only one.’ I think it was comforting for her.” “Some of the kids in my daughter's school were so insensitive, and that bothered me so much—the lack of sympathy from those kids—so I felt that it was really important for her to be with kids who could empathize; who were feeling the same way, and could understand the way she was feeling.” “My girls had a real need to know exactly what everybody's suffering was all about. Just to know that they are not alone, because here in our little community, and I mean for their whole lives. ... It's all Mom and Dad and the kids, that kind of conventional family. Now all of a sudden they don't have that anymore ... and I really think they were feeling kind of gypped.”

About the opportunities which the children received for self-expression, the parents said: “They learned different ways to express themselves there. Since you use a combination of different things, you teach them to express themselves in many ways; the art, the music, and teaching them to talk about what they feel.” “My kids listen to music, they like all kinds of music, so I know that the music part of the group was beneficial for them.” “It was a place of her own, where she could talk, or just listen, if she didn’t want to talk. She didn’t have to worry there about what other people were thinking. It gave her
a forum to be totally open and honest.” “She used some of the tools, things she learned there, at home and in school ... just whenever she needed to. Things like the memory box, the journalling books ... that, she said, helped her, and I know she used it at school, too. She would bring these things home from the group, and then we'd talk about it together.”

About positive changes they saw in their children they said: “She became much more self-confident. ... She was in much better control of her feelings. She could also learn about helping others, and that was very valuable.” “I don’t think death is as scary for them now. I think it’s part of the group. ... They have come to accept what has happened.” “They won't ever get over it. But they have learned to heal and to move on. They have learned to accept that life keeps going.” “They always seemed more light-hearted, not so pensive, on Wednesdays, after the group. I know they have gotten a lot out of this. From the first day, right away, they really liked it...as we were driving home (and we have quite a long drive; about an hour) ... They were just a-buzz with talking about the group the whole way home.” “She has grown tremendously ... because of all that happened, and her efforts to work it through, that has helped her to grow.” “You know, they know you, Heather, and they like spending time with you. It’s a positive thing, even though you’re talking about something (death and grief) that’s not so positive ... but you do it in such a way that it’s not a negative experience, it’s done in a very positive way.” “I thank you. I thank you so much that I had this to take them to. You’ve done an awesome job.”

In relation to the theme of prevention, parents said: “You need a support system when the death happens. There are lasting effects that can happen if you don’t deal with things. So the group gave her that chance to make it better for down the road. It’s prevention.” “I feel that groups like this now can do a lot towards maybe preventing
things in the future. You know, maybe chronic depression setting in because you really never learned how to deal with the big issues. I’m glad my girls had this opportunity—’cause my husband lost his mom when he was fifteen, and it was a closed book. No one ever mentioned her name again. And I think he and his brother and sister would have benefited from a group like this. ... I’ve always seen a big sadness in their hearts ‘cause they never dealt with the loss of their mom.”

Each year, the children’s group (and the parent’s group) reunites in the summer with the staff and volunteer facilitators for a picnic. This event provides time to reconnect, time to play, and a time for the families to participate in a simple memorial ceremony for those who have died. At the end of the evening, families are invited to write messages to their loved ones on small cards, which we then attach to helium balloons—and, standing in a circle, release into the air. The moment when the balloons lift into the silent blue sky is often filled with sadness, tenderness, and gentle rays of hope and meaning.
Chapter Summary

In this chapter, I have described how an arts therapy process can assist bereaved children towards healing. Grieving involves a transformation of one’s identity, one’s environment, and one’s relationships, a complete relearning of one’s world (Attig, 1996). By engaging the child in the creative process within the context of a supportive environment, we can walk beside them as they relearn their worlds: offering our compassionate presence and attention, giving them opportunities to externalize and process their pain, and supporting them on the journey of integration and healing. The group setting has emerged through this analysis as a particularly powerful mode of support for children who grieve.

The children whom I interviewed described the support group as a place of belonging that was fun, helpful, safe, comforting, relaxing, supportive and accepting. Each of these qualities seemed to contribute towards the children feeling “better” by the end of the group. One child said, “You need some time to talk with other kids this has happened to. I know I felt that I was the only one, and no one else could understand. But in the kid’s group, that’s a place where they understand.” All of the children identified the arts as a part of what helped them with their grief. One girl put it this way, “I like art a lot. Art helps me. With art you can use all the different materials, and you can express yourself with it more.” These themes were supported by the children’s parents who observed that their children gained much needed peer support in the group, and had important opportunities for verbal and non-verbal self-expression. All of the parents felt that, although their children’s grief was not gone, the group had helped them to integrate their loss, and had given them support through a difficult time.

The girls who participated in this research described their experiences with grief as
a mix of intense emotions for everyone in their families, including anger, loneliness, sadness, fear, worry, and anxiety about the fate of their surviving loved ones. They also experienced isolation, a feeling of being different from their peers. In learning to live with their grief and to heal, the children spoke about the need to continue on living: going to school, playing with friends, participating in their favourite sports and arts activities, and still remembering to have fun. Other general suggestions for healing that they made were: talking with someone who listens (but not being pressured to talk by parents or others), having support from your family and friends, having a school teacher who is understanding, having lots of hugs, being with your pets, being in Nature, and having time to be alone. One girl said “It’s important to have supportive friends.. You have to tell your friends what you need--even if they’re mad at you for a couple of days--its worth it if they give you support in the end.” The children I interviewed also recognized the importance of being compassionate to others, and particularly appreciated opportunities to talk and to be with other children who were grieving. One girl put it this way: “I think I learned to be more compassionate to other people, ’cause if they are upset, you don’t really know what’s going on.”

Children who grieve seem to search for ways to sustain a connection to their loved ones, and this connection becomes a part of their healing. For some, this feeling of connection comes through participating in special memorial rituals, being around family members who resemble the deceased, visiting the grave, writing letters to them, or keeping special objects or photographs of their loved one close to them. For others, this connection is found in an experience of hearing their loved one’s voice, imagining their loved one in heaven, sensing their presence as a guardian angel, or a spirit they carry in their hearts. One girl described her connection to her grandfather this way: “There is a
way I feel connected to him ... when I look at the stars ... that makes me feel happy that he's up there. ... Sometimes I think our eyes make contact for about two seconds before we look away."

Daddy, I miss you, and I'm very sad.
But some days I'll still be happy, other days, mad.
Have fun up there, grow back your hair.
Get back your health...
I want to feel your smile,
and maybe, in school, you can sit with me awhile.
So, please watch us through
Those skys so blue,
And always remember:
I LOVE YOU.
"Let us meet at some point in space and time—which will be in relation to what we are, but also to our ability to let us be taken to where we are goin'..."

(Nicholas Mosley, Hopeful Monsters)
Forever Oneness,
Who sings to us in silence,
Who teaches us through each other
Guide my steps with strength and wisdom.
May I see the lessons as I walk,
Honour the purpose of all things.
Help me to touch with respect,
Always speak from behind my eyes.
Let me observe, not judge.
May I cause no harm,
And leave Music and Beauty after my visit.
When I return to Forever,
May the circle be closed,
And the Spiral be broader.
(Australian Aboriginal prayer, in "Message from Forever")

Introduction

In Chapter Four, I described children's experiences of grief, and explored how an arts-centred therapeutic approach could assist them on their journey of healing. Through this clinical work with grieving children and with others in palliative care, I have developed a particular model of therapeutic practice that is rooted in the holistic framework and spiritual world view I have been articulating throughout this thesis. This model also implies a particular way of understanding the arts in therapy and in education which promotes healing. In this final chapter, I will outline the key concepts in the model, summarize the themes which have been explored throughout the entire thesis, and consider implications of the thesis findings for health care providers and educators.

A Model of Music Therapy Practice: A Circle of Loving and Creating

The model of music therapy practice I have been articulating throughout this thesis is aesthetically-based, process-oriented, and spiritually rooted in the concepts of
love, compassion, healing, and service. In this particular way of understanding the arts in therapy and education which promotes healing, our engagement in the arts facilitates our connection with Beauty, reduces our sense of fragmentation and wounding, and brings us to a place of wholeness. As a working model it was not first preconceived and then applied, but has evolved out of my lived experiences as a music therapist in palliative care settings. It is not my intention to present the model as rigid or static, or as something which can be precisely replicated by other therapists. Loving is expressed uniquely and differently through each person’s presence, and thus defies the intent of replication anyway. (In addition, whether or not a model formed in palliative care is relevant for music therapists or caregivers working in different settings, I do not know.) My practice is constantly in process, shifting and expanding as I continue to read, learn, and gain experience in life and clinical practice. The purpose of articulating such a model of practice is not to reduce the complexity of the whole, but rather to increase the clarity and awareness of the assumptions and influences that guide one’s practice, and to make that complexity more comprehensible to others. In seeking to define my own work more clearly, I have drawn on the work of clinicians in music therapy, art therapy, psychology and education, as well as the theoretical work of writers in philosophical and contemplative spiritual traditions. I have called this model of practice “a circle of loving and creating.” Before I describe what I mean by loving and creating, I will begin with explaining the reasons for my choice of the image of a circle as the form which symbolizes the therapeutic process.

The Circle

“The circle goes round and round. Every ending brings a new start. The circle goes round and round. Say goodbye and hold me in your heart. Until next time, until we meet again.... May the sun shine softly on your face, may you walk in the company of
friends. The circle goes round and round. Every ending brings a new start. The circle goes round and round. Say goodbye and hold me in your heart." (A song I wrote for the closing ritual of our cancer relaxation support group in 1998. We still use it today.)

The circle image is very important to me for many reasons. From a personal perspective it highlights certain themes from my past which draw me towards circles in the present. It was in a circle around the campfire at summer camp, where I worked during my university undergraduate years as a camp counsellor for emotionally disturbed children, that I first learned to play the guitar. It was in these campfire circles, deep in the beautiful pine woods of Northern Ontario, that I first recognized the emotional and healing power of simple folk songs, and the power of music to connect us to one another.

One night, a group of fellow counsellors and I, returning back to camp from a night off in the nearest small town pub, lay together in a circle on the outskirts of the camp grounds. I remember it so clearly; our giggling intoxication heightened by the feeling of the velvet night around us; the shimmering bowl of stars and Northern Lights arching above in streaks of colour through the black-night sky. We lay on our backs in the circle, heads together, feet pointing outwards—breathing in the dangerous Beauty of our summer night. And we began to sing to the stars a song that represented so much about the friendships we had created together that year: that classic Indigo Girls folk song "Closer to Fine." We sang it a capella, without fear or hesitation. We had sung it many times before, and we knew every word. It was a moment of music, a moment of connection, unplanned and spontaneous, a moment of Beauty shared in the circle. Inside and outside merging into one. In that moment, we knew the indwelling essence of Spirit, that mysterious essence that unites us with all beings. In that moment, vulnerable to the Beauty of our surroundings, we invited the night into our hearts; we sang to each other and to the stars. And Grace, unbidden, arrived.

The circle image also represents the many circles I have participated in—both in the role of therapist and in the role of client—which have contributed to my own healing, and to the healing of others struggling with illness, grief, childhood sexual abuse, food and drug addictions. It symbolizes the healing I have found in loving relationships; the arms
which circle around me in warmth, giving me the strength and nurturance which sustains me in the often challenging and emotional work in palliative care settings. In every circle I participate in today, I bring this past with me. I embody what I have participated in. A deep part of me knows that the circle is safe. I trust the circle as a form which can hold and contain the deepest of emotions and thoughts, of human experiences, safely.

A circle is an image of the whole. It represents the unity of mind/body/spirit; it represents the Gestalt nature of our experiences. A circle has no end. It speaks to the cyclical nature of life and death, to the constant ever-changing motion of life. The circle also symbolizes ritual. In our children’s group, we gather in the form of a circle to sing the same opening and closing songs every week. The circle brings us together in a ritual, healing form. It defines and contains the space of healing. A circle can be vulnerable. One cannot hide, as in a church where people sit in rows of pews, separate from one another. In a circle, the power differential between therapist and client, caregiver and the one cared for, is reduced. In the children’s support group, adults and children alike sit in a circle on pillows on the floor. Anyone can hold a stuffed animal. We all face one another. Our feet, our hands, our bodies are visible to one another. In this sense, in a circle, we are exposed. But, if the circle is made safe, then this ‘exposure’ becomes a sharing that is healing.

Above all else the circle represents Love, a "ring of endless light," that all-encompassing mystery of Creation, the Grace which eludes our complete human understanding. This is the spiritual foundation on which my work is built, in which it is contained and sustained.

Creating

As I have outlined earlier in this thesis, my work emerges from a basic belief that
engagement in the creative process, particularly within the context of a therapeutic relationship, can provide conditions which cultivate healing. It is because of trust that a client will feel safe enough to play and to create (Winnicott, 1971). Once trust is established, we can explore new or different ways of seeing, of being, and of expressing what is within us by using our imaginations and engaging our creativity through the arts. Winnicott (1971) stated that “[t]he basis of what we do is the patient’s playing, a creative experience taking up space and time and intensely real for the patient. ...

Psychotherapy of a deep-going kind may be done without interpretive work” (p.50).

Although my style of practice does include questioning and searching for clarification, I rarely offer children my verbal interpretations of their work. Generally, I do not believe that adult interpretations are particularly helpful to children. Instead of approaching their creations in a mode of deconstruction, analysis and criticism, I try to give them my loving attention. In this way I can honour the uniqueness of their expressions, and try to understand the meaning it holds for them. Rilke, in Letters to a Young Poet, said that “[w]orks of art are of an infinite solitude, and no means of approach is so useless as criticism. Only love can touch and hold them. And be fair to them.” Hillman (1979) suggested that loving attention transforms images into presences; and “reveals the living being they naturally contain” (p.118). By entering into the arts experience in a loving way with our clients, we encourage the birth of their unique vision and expression. Hillman (1979), speaking about dream work in psychotherapy, said, “I let it speak, and I speak to it--rather than analyze or interpret it. By speaking to the dream, one addresses its mood and images, and encourages the dream to go on telling its tale” (p. 65). This resonates with my approach to children’s (as well as adult’s) artistic creations. Kenny (1989) pointed out that “one of the possible limitations of the cognitive and verbal psychologies is the
abstraction created by the separation from the world of concrete experience through solely intellectual and verbal abstraction” (p.56). A fundamental aspect of the arts therapies is their experiential engagement with sensation. To truly join with children (and others) in their moments of playing, of engagement with the creative process, we must know how to play ourselves. This approach is inherently dialogical. We cannot participate from a distance. Winnicott (1971) said that “if the therapist can not play, then [s/he] is not suitable for the work” (p.54). We must surrender willingly to what the moment brings. We must be always listening, and always trying to maintain a sense of the whole, the larger context of the encounter.

An improvisational process-oriented approach to arts therapy, such as I am describing, requires that the therapist has the following capacities:

1) to trust in her own tacit knowing and intuition to guide decision-making in the moment;
2) to be willing to accompany rather than direct the client through the session;
3) to be familiar with the universality of the client’s narrative (i.e., in bereavement care to be familiar with the grief process), and at the same time, to be open to hearing the uniqueness of the client’s particular story and experience;
4) to surrender control; to take risks, to leap in, to “let us be taken to where we are going”;
5) to trust in the healing potential of the artistic forms;
6) to trust in the healing potential of play;
7) and to enter into “the field of play” with the client.17

It seems to me, that if we work from an understanding of the music or arts therapy session as a circle of loving and creating, we cannot rely strictly on the guidelines

17 Often one of the greatest hurdles to overcome, particularly in working with adults, is to empower them to set aside their own self-judgements about creating, to enable them to feel free enough to play within the creative process, without concern for the quality of the finished product. In this sense, I have always believed that a purely discipline-based arts education is responsible for creating wounds in many children who learn in music class, for example, that if they are not ‘talented or gifted enough’ then they should mouth the words instead of singing out loud. The impact of this kind of arts education often ensures that some children move into adulthood never feeling safe enough to engage in arts experiences (as a participant rather than as an observer).

18 This is one of the key elements outlined by music therapist Carolyn Kenny (1989) in her model of music therapy practice. She describes the field of play as “a space for experimentation which contains the qualities of surprise, playfulness, fluidity and confidence” (p.71).
of any particular methodology to lead us. We come together into a shared space, and we
do not know what will occur there. Levine (1987) said that “[i]n the moment where
response is called upon, there are no answers that can be carried from one moment to the
next. Clear-eyed and open-hearted, we sense from moment to moment what we must do.
There are no easy answers” (p.21). Loving attention cannot be preplanned like a school
lesson. It requires that we have the capacity to draw on our own creativity, to respond to
the needs of the moment. At times, confrontation and boundary-setting may be required.
At other times, silence and stillness are needed. Peck (1978) stated that “love is not
simply giving; it is judicious giving and judicious withholding as well ... it requires
thoughtful and often painful decisionmaking” (p.111). No prescription or technique can
give us the answer as to how to act. Sessions, whether group or individual, are always
characterized, on my part, by an initial sense of uncertainty, by a sense of not knowing.
In the role of therapist, I must be able to withstand this ambiguity, this sense of things
unfolding, since it is an essential part of the creative process. Though I do think ahead of
time about some possible directions for the session to take, and some possible ways we
might explore different themes together, I must always remain open to the process. I am
always willing to let my plans change to respond to the immediacy of the moment.

Although there can be no clear predictions before a session about what will occur,
this does not mean that the session is without structure or boundaries. Structure and
freedom must be carefully balanced for a space to be safe. Without structure, freedom
becomes chaos. Without freedom, structure becomes a form of control and rigidity.
Structure is reinforced by shared rules or guidelines (particularly in a group setting), by a
particular time frame, by the musical or arts experience itself, and by ritual forms which
are repeated over the course of a session. Kenny (1989) defined ritual in a music therapy
context as “an arena of repeatable forms and gestures, the constants, which provide a
ground base for innovation” (p.86). The ritual aspect of my practice is often contained in
familiar songs (usually these are songs I write specifically for a particular group or client)
which are used to open and close our time together. Every moment in the music therapy
session after the ritual opening draws on my ability to embrace the unknown, to leap in,
to take a risk, and to find ways to connect with those in the therapeutic circle. Human
beings are enormously complex, as are their relationships. We have complex decisions to
make about the timing and the nature of our therapeutic interventions: when to sing, when
to be silent, when to ask a question, when to reflect on a feeling we tacitly sense in the
music, and so on.

As an undergraduate student I was educated in an eclectic approach to music
therapy, but the dominance and influence of the positivistic paradigm and the behavioural
model of practice was always apparent. A large part of this influence also came from the
numerous psychology courses which were required for completion of the music therapy
degree. The importance of learning how to write clearly defined (measurable and
observable) goals and objectives for each music therapy session was emphasized. In this
model, music therapy is viewed as a way to modify and change a client’s behaviour, as “a
method of behavioural manipulation” (Ruud, 1980, p.30). Another important emphasis in
my undergraduate education was building a repertoire of ‘population-specific’ music
therapy activities. As a young music therapy student, I wanted to learn as many music
therapy activities as I could. Although there are specific work settings where an activity-
based approach may be appropriate, and having such activities can be a helpful resource
for one’s initial practice as a music therapist, there is also a danger that they may help to
create a false sense of security, the illusion that if one has enough of the ‘right activities
for the right population’ then one will always know what to do in every situation. Perhaps this is also true in the education and practice of student teachers. Somehow, we might feel that if we come prepared with enough material to occupy the allotted time, we will appear to know what we are doing, and there will be no empty spaces or awkward moments in our interactions with students or clients. However, I have learned that when we are overly focused on the doing, when we have each moment in a session preplanned, we presume that we know what the client/student needs even before we meet them face-to-face, and we potentially miss what is needed, because we are too focused on filling the space with our own agenda.

I have now moved far away from a style of practice which is behaviourally based, a model in which the therapist is expected to predict outcomes by pre-defining the objectives, and having a comprehensive session plan. Over time, I have learned to soften and surrender my need to control or plan every moment before I arrive. I have become more comfortable with allowing what is present to unfold. Merrill (1998) also described her music therapy practice as moving “away from the tendency to manage, toward a tendency to be with and to dwell. This model stimulates a kind of readiness, an alertness which is poised to respond as opposed to a style which is planning the next step” (p.144). Amir (1992) described this style of practice in her doctoral dissertation. In this research, she used a grounded theory approach to illuminate how meaningful moments were experienced by both therapists and clients in music therapy practice. She concluded that “the music therapist did not plan these moments, but prepared the environment and was open to trust him/herself and to receive whatever happened” (Amir, 1996, p.120). Naomi Remen (2000) called this kind of therapeutic approach “befriending life” (p.247). Instead of exerting our will over another—no matter how well-intentioned our will may be-
-we join with the other, and listen for the potential within them, trying to create conditions that enable this potential to be expressed (Remen, 2000).

A model of music therapy practice which abandons the preplanning so important in behavioural models in favour of a more process-driven, improvisational approach, should not be understood as an easier way, however; a lackadaisical, undisciplined approach to therapy. We need to prepare ourselves to be present for people, especially those who are living in very vulnerable places of deep suffering. There are times in my work at the hospital when I feel myself contracting away from patients, pulling myself away from their pain. I may be tired, distracted, overwhelmed, or feeling vulnerable about something in my own life. I try to recognize when I am feeling this way because then I know that I am not prepared to effectively be with a patient. These are times when I try to attend to other “indirect patient care” duties required in my job such as charting and other documentation, or staff meetings and consultations. Preparation is different from planning. It involves nurturing our capacity to be present, to be receptive to all the conditions that exist in the field—those that are named, and those that are not named, the subtleties and nuances of body language. This kind of preparation begins long before we enter the therapeutic space. It implies an ongoing discipline in the therapist’s own life, a commitment to contemplative practices such as meditation which assist us in creating the inner emptiness and stillness that are so important to listening and receiving the stories of others. When we have experienced the quiet, clear spaces of the heart in our own lives, we are better able to bring these qualities into our therapeutic work.

To be open and receptive is not the same as to be passive. Presence requires attending with all of the senses. It is an opening of the heart and mind to the whole of the client’s being, and requires attention to maintaining the delicate balance between
suspensiong judgment and making decisions about what directions to explore, based on cues from the client. It is a focused and intense state of readiness for possibilities.

Johnston (1986) described the importance of receptivity this way:

To receive is always a vulnerable thing. As with expression, receiving is always in the end a leap into the unknown. ... [H]ow fully alive we are is precisely a function of how deeply we can trust, and engage, that risk. (p.235)

Any time we risk really hearing someone; letting who they truly are dance against the intimate core of our being, what we give that person is the gift of themselves. When the space in us is an invitation; we find things around us answering by coming alive. (p.232)

Paradoxically, preparation--an action word--is also about non-action; it is also about Being. Moustakas (1997) said that “what is most essential is the being of the ... therapist” (p.18). Our being streams forth from our inwardness, our spiritual state. We bring this being--who we are, as well as the conditions of our lives--into each therapy session. Palmer (1998) made a similar point about educators: “As I teach, I project the condition of my soul onto my students, my subject, and our way of being together” (p.2). It is difficult to describe this in words, since our being is communicated through our presence, through body language and non-verbal, subtle cues. Our therapeutic presence does not come from particular techniques, but rather from our inwardness, our spiritual state, our identity, and our integrity (Palmer, 1998).

Nicholson (1999) offered the concept of music therapy in oncology care as “a strong and magical container: at once, a cradle for comforting, and also a vehicle for achieving the balance and harmony of body-mind-spirit” (p.72). Her image of music therapy as a magical container could be visually depicted as the circle of loving and creating I am describing here. Salmon’s (2001) theoretical framework for music therapy practice in palliative care proposed the concept of music therapy as a sacred space in
which the boundaries of ordinary awareness may be expanded, and ventures into the realm of psycho-spiritual awareness may safely occur. She suggests that “the three elements of patient, therapist and music combine to create [this] containing or sacred space in which the return voyage into depth and back again may safely occur” (Salmon, 2001, p.144). Salmon’s concept of sacred space in music therapy is also relevant for the model I am describing. The idea of the music therapy session as a field of loving and creating “which has as its goal the creation of beauty” was developed by Kenny (1989, p.7) in her theoretical work on music therapy practice, *The Field of Play*. Kenny’s multidimensional and interdisciplinary model draws on ancient healing traditions, including the power of myth and ritual, aspects of existential psychology and philosophy, and systems and field theory to describe the process of music therapy. The creative process, understood to be central to healing in Kenny’s model, is described as the “interplay of forms, gestures, and relationships which as a whole constitute the context for a movement toward wholeness” (1989, p.89). Kenny (1989) linked wholeness to beauty, suggesting that as we move towards Beauty, we move towards our fullest potential, reclaiming our own wholeness.

The concept of Beauty as the primary goal of therapeutic practice is also supported by Moore’s work in *Care of the Soul* (1992). In Chapter Two I critiqued the tendency of modernist psychology and modern medicine to relate to patients through the lens of a diagnosis, or a label, rather than responding to them as a whole person in whom body, mind and spirit (or soul) are intimately intertwined. Earlier I defined the soul as the animating essence, the spiritual part of human beings. The soul mediates body and mind; it manifests itself in our uniqueness, yet keeps us connected to the whole. Levine (1987) describes soul as “the indefinable essence of being that hums at the very center of life, the
...the stillness in which all activity floats, the formlessness that defines form” (p.160). Moore (1992) suggested, “If our idea of psychology is rooted in a medical view of human behaviour and emotional life, then the primary value will be [cure]. But if our idea of psychology is based on the soul, then the goals of our therapeutic efforts will be Beauty” (p.278). Moore’s ideas offer support to music therapists who ground their work in a holistic view of human nature. Like Kenny, he also asserts the importance of loving in our therapeutic encounters. Moore (1992) said, “The ultimate cure, as many ancient and modern psychologies of depth have asserted, comes from love and not from logic” (p.14). What I would like to take from these ideas and build on in particular is the concept of loving in music therapy. Although Kenny makes references to love in her Field of Play model, she neither clearly defines what she means by love in the context of a therapeutic relationship, or elaborates her own conception of loving. I consider love, quite simply, to be the foundation of all my work in music therapy. So, I will try to clarify further what I mean by this.

**Loving**

Abby radiates light. Her blue eyes have a depth of knowing that is beyond her four years of living. Her brain tumor is inoperable. They are trying to treat it right now with experimental chemotherapy. Abby and her mom, Cher, spend a lot of time going back and forth to the hospital. You might think that a child who has only ever received needles and medicine at the hospital would become fearful of that place; that she would not want to go near the staff who have to stick needles in her arm. But Abby has a way of reaching out. This is her life. She is not bitter. Angry and sad and afraid sometimes, yes, but not bitter. She reaches out her arms to hug the nurses and doctors who give her treatments. I visit Abby in her home at her mom’s request. We met in the clinic at the hospital, where Abby and Cher came to get blood tests. Cher feels that Abby needs to talk with someone about her illness. I have previously worked with Abby’s eight-year-old sister, and Cher feels that an
arts therapy approach has been very helpful for Emily; that it has helped her to deal with
the stress that often comes with having a sibling with a serious illness. So, she asks me to
work with Abby too. Abby is very isolated from other children, and doesn't socialize much,
when she does have the opportunity in the playroom at the hospital. She often clings to her
mom, and doesn't like to go far from the safety of her special blanket on the couch, her
favourite spot to sit at her house.

Over time, Abby begins to trust me. Each week she will spend a little longer playing
with me, a little longer away from her mom. Abby begins to sing our special song sometimes
when she sees me now at the front door. Mostly, we play together on the couch. We take
train journeys, and we go to the market. I make up songs to go with our playing--and I bring
the egg-shakers for Abby to play. She likes the egg-shakers a lot. Abby also loves Fluffy--my
big, soft lion puppet--and he is a part of almost every game. One day she uses Fluffy to tell
me about her chemotherapy, about the needles she gets when she visits the hospital. After
that day, here and there, she tells me a little more about her treatments, a little bit more
about her feelings. But I have no lesson plan. I simply trust in the playing to lead us, and
trust in the loving to hold us. I let the creative process unfold. And I listen hard. Listen for
the spoken and the unspoken, the symbolic communications of a young child facing a very
serious illness. The tumor has impacted her vision dramatically--she usually sits physically
very close--in order to see me. She often reaches out to examine my earrings or to run her
fingers through my hair. One day she traces her hands gently over my face and giggling, asks
me just how many freckles I have. Too many to count, I say! Another day she stops in the
middle of our playing. She comes close to me, and reaches out her arms towards me for a
hug. As she hugs me, she says, "I love you" and smiles at me. I am speechless. Abby--defying
the life-threatening tumor that grows inside of her--radiates love and light into the world.
She may have cancer, but cancer sure doesn't have her.

Priestley (1994) said that in order to understand our clinical work in music
therapy, we must come to grips with "the immeasurable waywardness of love" (p.125).
This is perhaps not a simple task, since "love ... has a wealth of meanings" (D'Arcy,
1956, p.27). Like all Mysteries, it resists our attempts at definition within the framework
of language. Levine (1987) called love "the sense of the inherent connection between the
two that goes beyond duality to the oneness of Being...When we speak of love, we are not speaking simply of a state of mind, but rather of a state of our underlying suchness” (p.67). Through my work I have come to believe that love is the essence of the therapeutic relationship, although the word “love” is viewed as unprofessional in some caregiving circles, and is often avoided in the literature in favour of words such as “empathy,” “warmth,” “respect,” and “concern” (Barnard, 1995). In certain theoretical viewpoints--which are embodied in many health care and educational settings--there is suspicion of deep personal connections in the professional caregiving relationship. We might link this, at least partially, to the modernistic ideals I outlined in chapter two.

However, love is an essential ingredient in meaningful psychotherapy; it is what nurtures the growth of the client and therapist (Peck, 1978; Priestley, 1994). Love is both the ground of our shared connection with another human being, and our active striving to further know the depths of that connection. And even though our striving to love others may be, and perhaps always is, imperfect and incomplete, it seems, to me, better to risk imperfection then never having tried to love at all.

Bayly (2000), an art therapist, called the therapeutic relationship “a circle of love,” which has the potential to become a parallel journey of healing for both therapist and client. In offering our love to others freely, we do not, however, seek specific returns or rewards for our giving. Love increases in proportion as it is shared; love is its own reward. Loving someone is not about possessing or controlling them--although in many relationships, people experience loving as equivalent to having or owning. Attig (1987) said, “the only way to ‘have’ the other in love is to let go, to allow the other to be other” (p.140). The paradox is that love can only be kept when we give it away (Merton, 1955). When we give love freely, we also receive it. Love is a mode of being with others that is
both receptive and active. It "allows ... for the free movement of the other and spontaneous reply" (Attig, 1987, p.140).

In a therapeutic setting, love can be understood as the therapist's willingness to go out on a limb, to struggle and to truly involve oneself at an emotional level in the therapist-client relationship. It is the way in which we nurture our own or another person's spiritual growth (Peck, 1978). In our caring for others, we are caring also for ourselves, honouring the Being we all share (Levine, 1987). In order to engage on this level, we extend ourselves into unfamiliar territory, and take the risk of walking on unfamiliar ground which compels us to change some part of our own self. This can be unsettling, and even frightening. Loving requires courage, effort, and a willingness to be vulnerable, an openness to personal change. In a model of practice which is centred on loving and creating, we must be prepared fundamentally to take the risk of personal involvement. We risk sharing "the intimacy of space and time, of consciousness. In so doing, we risk our own undoing. It is, after all, safer to be at a distance" (Merrill, 1998, p.111). The growth of our spirit through loving, therefore, involves not only courage, but also risk (Peck, 1978).

Love also relates to connection. When we strive to be loving in our interactions with others, we are moving against the fear which is so much a part of isolation and alienation; we are deliberately choosing connection over separation (hooks, 2000). It is my sense of being deeply loved and cherished, of being connected to loving relationships in my own life which gives me a sense of place and the confidence to reach out to connect with others. I am blessed to have an intimate partner in my life who nurtures me constantly with his love, and who shares my desire to serve the world through love. I have read somewhere that being loved gives one strength, but that loving someone takes
courage. It is therefore the love in my own life, combined with my desire for fostering intimate and loving connections with others, which grounds my capacity to be present in any therapeutic relationship. Nhat Hanh (1996) said that “when you love, you naturally act in a way that can relieve the suffering of people” (p.15).

The essence of love is found in action. It is an act, rather than a concept. Wever-Rabehl (2001) said, “Love directed towards the beloved is embodied in the act of love itself, and is therefore inseparable and self-evidencing ... beyond definition, only demonstrable” (p.107). Love is revealed in our actions and through our presence; in patient silence as we wait for a client’s response, in our reaching out towards the client through the melody of our music, in the depth of our listening and attentiveness to what the client is communicating. Peck (1978) stated that “love is as love does ... [it is] an act of will, namely, both an intention and an action” (p.83). This loving is not conceptualized or planned, rather, it is expressed tacitly “in our bodies ... in the comfort and touch of bodies, in pre-reflective, felt union” (Wever-Rabehl, 2001, p.106).

In the model of practice I am articulating, love is central to healing. hooks (2000) said that “the practice of loving is [a] healing force...that transforms” (p.220). According to Murdoch (1970), “love ... is the energy and passion of the soul in its search for Good, the force that joins us to Good, and joins us to the world through Good. Its existence is the unmistakable sign that we are spiritual creatures, attracted by excellence and made for the Good” (p.103). Love is therefore not simply a feeling, but the work of the Spirit, the Divine, the Good, the Holy, in us. By “living life in touch with divine spirit [we can] see the light of love in all living beings” (hooks, 2000, p.71). Love is bigger than our small, individual selves; it is a connection to the greater whole. In essence, as we love, we honour our interconnectedness with all of life. In helping others, we surrender our personal will
for the benefit of the larger whole. Merton (1955) described this process of letting go in
this way: “My will must be the instrument of God’s will in helping them create their
destiny. ... My love must be for them the minister, not of my own spirit, but of the Holy
Spirit. ... I can only discern and follow that mysterious life by the actions of the same
Holy Spirit living and acting in the depths of my own heart” (p.5).

This model of practice does not outline specific music therapy methods or
techniques which can be implemented, but instead calls for recognition of the importance
of the therapist’s own Being in the therapeutic relationship. Practice therefore becomes
primarily a way of being, rather than a way of doing. In educational terms, we might call it
a pedagogy of love. It is our willingness to surrender ourselves to the encounter with the
other, in addition to who we are, which defines the quality of our moments of meeting.
When we can love in a selfless way--not viewing the other as an object to be manipulated
or possessed, but as an autonomous and free being--we desire only the happiness and
healing, the well-being of the other; “to love another is to will what is really good for him”
(Merton, 1955, p.3). D’Arcy (1956) stated that “God is the archetype of love who
always wishes well to [Her] beloved” (p.80). It is only when “we do not desire the things
of this world for [our] own sake, [that] we become able to see them as they are” (Merton,
1955, p.11). Selfishness, however, blinds us to seeing. L’Engle (1978) expressed this
theme in poetic language:

If thou couldst empty self of selfishness. And then with love reach out in
wide embrace. Then might God come this purer self to bless; So might thou
feel the wisdom of His Grace. And see, thereby, the radiance of His face.
But selfishness turns inward, miry black. Refuses stars, sees only clouded
night. Too full, too dark, cannot confess a lack. Turns from God’s face,
blessed, holy, bright. Is blinded by the presence of the Light. (p.20)
From these conceptualizations of loving, we can connect to the ideas of hospitality and of service.

**Hospitality and Service**

Service moves us out of our ego-driven propensity for selfishness and separateness. It brings us into the lived experiences of loving, connection and belonging. hooks (2000) said that “service is [a] dimension of communal love” (p.141). We can all benefit when we serve others. This is part of the reason that support groups can be so powerful in the healing process. Expression (sharing one’s own experience) and receptivity (listening to others’ experiences) work together to aid the healing process.

Chloe, the young girl whose story I shared in Chapter Four, expressed this eloquently: “What I try to do is to help other people too. You know, because it’s not just me that needs help, but other kids too. We’re all in this together. It helps to know that you’re not the only kid in grief. We’re all in the same boat.” In the children’s grief group, all participants have the opportunity to listen to and serve one another. Some children seem able to do this very easily and naturally, while for others it evolves over time, or is simply less evident. In the group setting, healing then becomes a collective rather than an individual or dual effort.

By listening to others; making space for their needs to be met and their stories to be heard, we participate in creating a circle of love. Hillman (1979) said that love “embraces ... nourishes and encourages us to believe. This ground welcomes us home to ourselves just as we are” (p. 126). This is a space of hospitality. Nouwen (1975) offered this ancient Christian concept of hospitality as a key to all healing. He described hospitality as an attitude which allows us to create spaces of freedom where we can
attend to the needs of others. Freedom is implied in the attitude of the host towards the guest. There are no illusions of control or ownership. The host (parallel to the therapist or caregiver) does not bring guests into her space in order to change them. Instead, she strives to create a space, rooted in love, and free of fear, where change can take place. A sense of community and communion can be found in this kind of hospitable space, which Nouwen (1975) further described as “a friendly emptiness where strangers can enter and discover themselves as created free; free to sing their own songs, speak their own languages, dance their own dances; free also to leave and to follow their own vocations” (p.51). In a space of freedom such as this, we can learn to trust. When we can trust that we are safe and loved in the hands of another, that trust is also called forth in ourselves (Vanier, 1998).

How is such a space of hospitality created? According to Nouwen (1975), “the first and most important aspect of all healing is an interested effort to know the patients fully, in all their joys and pains, pleasures and sorrows ... which have given shape and form to their life” (p.67). This statement implies that hospitality is fundamentally about listening—listening to and for stories. Hillman (1979) said that “[w]e receive the other as if he were music, listening to the rhythm and cadence of his tale, its thematic repetitions, and the disharmonies” (p.22). In the circle which is the music therapy session, stories are always shared, sometimes in words, sometimes in sounds, in music, in movement, or in images. The stories of joy, pain, laughter, fear, sorrow, grief and hope are each unique and meaningful. White and Epston (1990), family therapists who work in the narrative tradition, state, “every telling or retelling of a story ... is a new telling that encapsulates and expands upon the previous telling ... [By] interacting with others in the performance of [their] stories, [clients] are active in the shaping of their lives and relationships” (p.13).
Hospitality in a circle of loving and creating therefore begins with our attentiveness, and willingness to extend our listening to those who enter this space. Listening, deep listening, in which we enter into another's world, and forget our own, is always a manifestation of love (Peck, 1978). This kind of attentiveness requires us to set aside temporarily our own desires and biases, indeed it requires that we step right out of our selves in order to see, feel and experience the world of the other (as much as possible) from the inside. Peck (1978) said, "[This unification of speaker and listener is actually an extension and enlargement of our self, and new knowledge is always gained from this]" (p.128). This kind of listening requires tremendous effort on the part of the therapist; it is not a technique or a method which we can apply, but rather a striving of our whole being towards the other, an opening of an inner space which can receive the story of the other (Nouwen, 1975). In Buddhist terms it might be conceived as the dissolution of the self-other dichotomy; the lived experience of non duality. Learning how to listen in this way is a process which I am always trying to improve. Sometimes, especially if I am tired, or overwhelmed by the demands of my own life, I cannot seem to do it all; while at other times, when I am centred and grounded, I am able to listen more fully. To open this inner space, we become receptive.

However, receptivity does not imply that "anything goes." Boundaries are as necessary as receptivity to making the space safe. In the children’s grief group, for instance, we have four, simple ground rules (boundaries), centred around respect and safety, which the children know that I will uphold. Before they can fully engage in creative experimentation, they must trust that the adults in the room will maintain the boundaries of the space. In any therapeutic circle, the participants need to know the space is safe before they can trust—and usually this trust, this sense of communion,
builds over time. Merton (1955) said, “[a] love that is selfless, that honestly seeks the truth, does not make unlimited concessions to the beloved” (p. 7). Space can only be welcoming when clear boundaries and limits are defined. These limits define our own personal position. We are not ‘neutral’ in the space, but active, and we reveal our own values and beliefs through our actions and responses to others. Even if they are not stated verbally, they “constitute conditions in the field” (Kenny, 1989, p. 101). Nouwen (1975) suggested that we need a combination of receptivity and confrontation to offer true hospitality. He explained, “Receptivity and confrontation ... have to remain in careful balance. ... [R]eceptivity without confrontation leads to a bland neutrality that serves nobody. Confrontation without receptivity leads to an oppressive aggression which hurts everybody” (Nouwen, 1975, p. 70).

Through our efforts to extend our hospitality to strangers—strangers who we meet in our clinical work—we are engaging in service; the work of extending our love to others. Naomi Remen (2000) told of a 16th century Jewish story by Kabbalistic Rabbi Isaac Luria which offers a beautiful cosmology of the world, and one meaningful way for us to understand our human existence and purpose on earth. This purpose relates to service:

Before the world began, there was only pure Being; this holy light—an emanation of light from the Infinite, Absolute Source of the world—was held in a holy vessel. Accidentally, this vessel fell down and was shattered. The Holy Light of God was thus scattered around the entire universe, into an infinite number of holy sparks, which are now hidden deep in every person, place, and object on Earth. According to Rabbi Luria’s tale of Creation, the purpose of human life is to uncover these sparks of light, this hidden holiness, and restore the world to its original wholeness. (Remen, 2000, p. 326)

We can restore the holiness of the world through service, through simple acts which embody attentiveness, listening, compassion, caring, kindness, and love. Healing is not
just a task for professionals or specialists. Everyone participates in healing the world through service. It is a collective task. According to Remen (2000); “Every act of service bears witness to the possibility of freedom for us all. And every time anyone becomes more transparent to the light in them, they will restore the light in the world” (p.328). We are all capable of helping others, and we are all in need of help ourselves (Vanier, 1998).

A central part of healing in my own life has become this process of outward movement or action, transcending my personal concerns by giving of myself to others, serving others. At the root of my spiritual belief system lies an awareness of the interconnectedness of all life, and a desire to foster and experience connection. The way that I am able to manifest this value, or in Murdoch’s (1970) words “to inhabit my philosophy” (p.47), is through service. Merton (1955) said that we have to make our faith “really part of [our] own live[s], not by rationalizing it, but by living it” (p. xiv). Service is the living embodiment of our faith, our spirituality. Deikman (2000) cautioned that we need not view service simply as an outcome of obligation and duty, of doing good because we feel we should or ought, or of being spiritual in an instrumental way. He suggests that we should understand it “as a matter of epistemology[,] ... a way of knowing. ... Service is a way of knowing our connection--at a deeper level--with a reality much larger than our object selves” (Deikman, 2000, p.303). As a health care professional, I am in a privileged position to assist others on their journeys through suffering; whether that suffering is the result of life-threatening illness, physical pain, or the grief of a loved one’s death. Each day that I walk through the door of the hospital, I have the opportunity to reach outside myself and my own concerns, and to reach out towards someone in need. There are times when I am able to be helpful, and other times when I am not. However, grounding my practice in a philosophy of service helps me to expand my ego-driven
(small) self to encompass a broader perspective, in which I am simply a part of the greater whole; it helps me to grow, and reminds me that there is always more to learn. We all have gifts through which we can serve the world. "[T]he more we give, the more truly we shall be" (Merton, 1955, p.145).

In service, we reach out to others as fellow human beings, sharing aspects of the same human condition. This is the gift which flows from the uniqueness within us to the world around us. To serve another does not require that we have a university degree, societal status, power, wealth, or even the ability to speak. Abby, the young child with the brain tumor whom I described in an earlier narrative, serves me through her spontaneous and open expressions of love, and through the beauty of her Being. When I leave her home, something deep within me often feels lifted, feels more whole. Although I believe that this sense of well-being comes partially from what I have tried to give her, the exchange is not one-way; it is also true that Abby has given to me, that she has served me with her Being.

Service comes from the heart; it goes beyond expertise, and when we serve, it is with our whole selves, drawing from the experiences of our lives, using everything we know, but perhaps, more importantly, everything we are. Remen (2000) said that "[t]rue service is not a relationship between an expert and a problem; it is far more genuine than that. It is a relationship between people who bring the full resources of their combined humanity to the table and share them generously" (p. 232). Buber (1958) said that "[t]he relation to the Thou is direct. No system of ideas, no foreknowledge and no fancy intervene between I and Thou. The memory itself is transformed, as it plunges out of its isolation into the unity of the whole" (p.11). In "a circle of loving and creating", we must try to leave our psychological theories behind at the door of the therapy session, and
reach out as human beings in love and compassion. This compassion creates a place of meeting between two human beings, rather than a place of critical, negative judgment (Remen, 2000). It is in the presence of compassionate attention from another human being that we may feel safe enough to reveal our wounds. Compassion is based on our awareness of the interdependence of all living beings (Fox, 1990). In Buddhist terms it might be called the nurturing of ‘interbeing’; the work of extending our compassion towards the reduction of suffering in the world (Nhat Hanh, 1996).

An important question we need to consider in this kind of model of practice is how we sustain ourselves in the work of service. Merton (1955) suggested that this work is sustainable because it is not motivated by a desire for control, reward or purely personal gain. He describes service as a love that loves without hunger; “Charity is not hungry...It is the *juge convivium*, the perpetual banquet where there is no satiety, a feast in which we are nourished by serving others rather than by feeding ourselves” (Merton, 1955, p.10). The busy pace of the North American urban lifestyle, along with the emotional energy required to face the suffering that exists in palliative care settings, sometimes leaves me feeling depleted, fragmented, divided, rushed from one thing to the next, without absorbing the whole of an experience. Wholeness is a balance I am constantly striving towards. At the same time, paradoxically, I recognize that there is never a finite end or a completion to the spiritual journey of healing. Part of healing, for me, has also become a process of inward movement; taking time to check in, to slow down, and to “listen to my life.” In palliative care practice, it is, I think, imperative for the caregiver to recognize the importance of self-care: to balance sorrow with laughter, pain with joy, and sound with silence. Although our being naturally demands to be expressed in action, we need to alternate periods of activity with periods of rest. The
capacity to listen and communicate with others is born, first of all, in our capacity to listen to our own souls, and this requires taking time alone, time out from the world in reflection, contemplation, meditation. Merton (1955) said that "[s]elf-knowledge is impossible when thoughtless and automatic activity keeps our souls in confusion" (p.111). He uses the metaphor of music to highlight the importance for caregivers to balance the busy pace of their lives with solitude and with silence:

Happiness is not a matter of intensity, but of balance; order and rhythm and harmony. Music is pleasing not only because of the sound, but because of the silence that is in it. Without the alternation of sound and silence, there would be no rhythm. ... If we have no silence, God is not heard in our music. If we have no rest, God does not bless our work. (Merton, 1955, p.112)

Contemplative and meditative practices help me to nurture self-reflection, awareness, and inner strength. With this contemplative reflection comes a deepening awareness of my own gifts, coupled with a willingness to serve others freely through those gifts, described by Nouwen (1975) as "a movement from loneliness to solitude...which creates the inner space where a compassionate solidarity with our fellow human beings becomes possible" (p.43).

Summary

In this model of practice, we have an image of the music or arts therapy session as a circle of loving and creating. This can be a circle which includes only the therapist and client, a circle which includes family members within a session, or a larger circle of many people with similar needs coming together to share such as in the children’s grief group or the cancer support relaxation group I described earlier in this thesis. The model is general enough to encompass practice in a wide range of settings.
In creating, the therapist comes prepared to play, to improvise, to surrender control and planning in an effort to follow the needs of the moment. Participants in the circle are also invited to create with the therapist, in whatever way they are comfortable. Some may simply choose to listen quietly or to receive the music which the therapist creates. Others may choose to be more active or more engaged in their own creative process. Comfort level varies dramatically from client to client, and from session to session. Loving attention may help to increase the participants’ comfort level and willingness to engage. The therapist trusts in the healing power of the play and the aesthetic experience offered by the music (and other artistic forms)—which awakens our imagination and our creativity—to lead the way. Her ability to draw on her intuition and tacit knowing, as well as her capacity for risking emotional engagement in the relationship are key. Loving is conveyed through the therapist’s Being, her presence, and by a movement out of self-absorption towards the needs of the other, a movement from the ego-self to the spiritual self where the therapist can know and manifest her connectedness to the other. In the circle, she strives to create a space of hospitality where participants can share their stories in safety and freedom, where she can serve the other through her receptivity, her attentiveness and clarity about her own limits. The caregiver tries to take off her professional ‘mask’—the tendency to want to analyze, diagnose, and label—and simply be present in love, as a fellow human being, sharing aspects of the same human condition, striving towards wholeness and Beauty, in dialogue and in relationship, with her clients.

Before moving to the final conclusions of this thesis, I would like to share one more story of a child’s experience of grief and healing in arts therapy. The story evolved over many hours of meeting and creating with one particular little girl who I came to know
when her mother was a patient on our palliative care unit, four years ago.

A Story of Loving and Creating with Jacynata

When I approached Andrew and Jacynata about participating in this research, they were both enthusiastic. Jacynata wanted to come and do some painting and music at the hospital with me. From Andrew's perspective, he felt that if they could share their story and possibly help others in the process, then it was a worthwhile cause. At the time Jacynata and I met to reflect back on our work together during her mom's illness and after her death, almost four years had passed, and Jacynata was now nine years old. She was growing up so quickly! Jacynata wasn't really interested in talking and answering questions, but she thought that making up a storybook together about what she went through with her mom's illness and death would be a good idea. We met together to create this story over the course of four, lengthy (we usually met for about two hours) sessions--three at the hospital, and one at their home--because Jacynata thought there would be more things at her home that would remind us of her mom. She talked sometimes while she was painting, but she often painted in silence, concentrating intently on what she was doing. She made her colour choices very carefully, after much deliberation and conversation with me about what the right colour would be. It had to be 'just right,' and she was often very self-critical during the process--telling me that she had made a mistake, or that she was not painting 'as good as she should be' today. She also frequently looked to me for guidance--asking my opinion about the colours she should use, or the size of the figures she should draw--but I tried to encourage her to stay with her own process, letting the story come from her perspective, rather than mine, letting her know that it was okay to be messy, that we could always go back and change things she didn't like. I reassured her that there was no 'wrong way' to tell the story. The music we made to accompany the story came from the songs Jacynata had written with me earlier. When it was finally finished, I think we both felt a sense of closure and completeness. The only sad part, Jacynata told me, was that now we would have to say goodbye. The aesthetic experience had taken us on a journey, and there was satisfaction in creating and naming this very significant time in her life. She knew that I was going to take the story to 'show my teacher' and 'put it in a book', but she asked me if I could make a copy of it for her. And, although the story will be too big to fit in her memory box, I suspect it will become one of those special things that keeps her feeling connected to her mom.
Jacynta’s father approached me one day on the palliative care unit to ask if I could help him help his daughter face her mother’s imminent death. Andrew immediately struck me as a very gentle and loving soul, a kind-hearted father struggling to balance the needs of his wife, and his two children--Aidan, who was almost three, and Jacynta who was five at that time. He told me that the children were as aware as they could be of the seriousness of their mom’s illness, and he was trying to prepare them for the fact that Abby would not be coming home from the hospital. Abby had a very aggressive form of breast cancer, which, at the time that I met her, had already metastasized to her brain. It caused severe headaches, seizures, blindness and impaired speech. She had been given only weeks to live. Not long before her admission to the palliative care unit, Abby and Andrew had taken the children on vacation to Disneyland. On the day that they were scheduled to fly back to Vancouver, Abby suggested that they change their tickets, and fly to Las Vegas to renew their wedding vows, with the children participating in the ceremony. Andrew, although he felt anxious about the possibility of Abby having a seizure or a sudden dramatic turn for the worse, threw caution to the wind, and agreed to give her what they both knew would probably be their last opportunity to travel together as a family. He told me later that this was part of how Abby chose to deal with her diagnosis: “She just said I’m going to live life to the fullest, have quality time with you and the kids... enjoy every moment. But Abby was like that anyway, she lived life, she took hold of it....” So, they shared the renewal of their wedding vows with the children, and returned, safely, to Vancouver. It was only weeks later that Abby was admitted to our palliative care unit.
"What it's like for a kid who lost a parent."

"Me and my family meeting with Heather at the hospital."

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When I first met Jacyntha, she was quite shy and self-contained. However, it didn't take long before she became more open and expressive. Our relationship grew through our playing in the music together. I had a collection of simple rhythm instruments, a piano, and my guitar—and together, we would play different feelings on the instruments, sing, and make up songs. Jacyntha was very matter-of-fact about her mother's illness, and would talk to me very openly about it. I think this really reflected the approach that both her parents had taken in trying to prepare her for what was to come.

One day I asked Jacyntha if she would like to write a song for her mom. She was enthusiastic about this idea: especially because it was the day of her parents' wedding anniversary, and she liked the thought of making up a gift for them. When she decided on the words she wanted in her song, I set them to a simple, familiar tune, to the music of "Twinkle, Twinkle, Little Star." Jacyntha and I sang it for her mom and dad who received it with loving, open arms—and she was very proud to give them this gift. Not too long after that day, Abby died.
Andrew called me shortly after that time, and said that Jacynta would like to see me. He asked me if I could come to their house, and help Jacynta to prepare for the funeral. I still remember that day very clearly—Jacynta asked me a lot of questions about coffins, and wanted to know how her mom, who was so tall, would fit into a box. She did not want to go to the wake, but she wanted to draw some pictures with me for her dad to put near the coffin. One of the pictures she drew was a large, green monster, which—in my interpretation—represented death, which had taken her mom away. After the monster was finished, she drew a picture of her mom as an angel in heaven. She told me very simply that her mom was now an angel, with white wings, who was looking out for her and Aidan and her dad. When she was finished with her drawings, she asked if we could play some songs with the guitar. She made up some words for a new song for her mom, and told me she might like to sing it at the funeral service, if I would be there to help her. A few days later, when I arrived at the church with my guitar, Jacynta came running up to me to tell me that she had seen her mom’s ‘box’ (the coffin) that was sitting at the front of the church. There were lots of pretty flowers on it, she told me. She also told me that there were too many people there, and she didn’t think that she would like to sing her mom’s song in front of so many people. That was absolutely fine, I told her. I was only there to help her if she wanted to sing it, but we didn’t have to sing it at all. There would be other music in the service. Nobody was relying on us to perform. Jacynta seemed relieved at this, and ran off to play with her cousin before the procession into the church.

"My mom in Heaven."

"Mom, I love you. And I wish you didn’t die..."

"The Funeral Song"
Jacynta and I met again when she came a few months later to our children's grief group. Andrew attended the parents group at the same time. His openness about his own grief continued to be a helpful role model for Jacynta, and she shared and participated very easily in all aspects of the group. Whenever she painted an image of her mom, she was always connected to her, by a heart, or by a line between the earth and the sky, where her mom was depicted as an angel. When she left, I really felt that she had, in a healthy way, integrated her mom's death into her life. She decided to return to the group the following year because she liked it, but also because her little brother was now old enough to attend, and he was too shy to come without her. Jacynta attended the group that year as a "helper." This is how Jacynta described the children's group, and the time she spent together with me at the hospital:

I don't know why. Counseling just helped me. It helped me to recover. It helped me a lot. I liked going there to that church place. We had the talking stick there, and there were other kids there too who lost someone special. In school I felt different from the other kids, not 'cause of my looks or anything. But, nobody else lost their parent. No one in my school. We made memory boxes. I still have mine at home. It has a picture of my mom, and some of her special things, and letters I wrote to her in it. And I liked coming to the hospital to visit with Heather. We made up some music together. When my mom was sick, we made a song for her. We sang it in her room. My dad still remembers it. After my mom died, Heather came to my house. We drew some pictures together; a monster picture and a picture of my mom in heaven. And we made a song for her funeral. But I didn't sing it that day, 'cause I was too shy--there were so many people in that church. Standing room only. Heather and I do lots of art together. I like art. It's fun to paint. I draw good in school, and I am one of the best art people in my class. If another kid had this happen to them, I'd tell them, "Don't worry, because your mom (or dad or grandpa or grandma) is always with you, no matter what happens. They are somewhere in your heart."
Thesis Summary

This thesis has been a parallel journey from the beginning—at once both a dive inwards into my own Being, into my own practice and what I have learned as a palliative care music therapist, and also a search outwards for a better understanding of what constitutes healing through a process of grief for children. In a qualitative, phenomenological spirit of inquiry, I have drawn deeply from the lived experiences of my work, and the many stories that have been shared with me, in an attempt to understand their meaning. The search for meaning has been sought in a multitude of forms and places: in the words, the artwork, and the music of bereaved children, in my own creative process, in the stories of other patients I have met in my work in palliative care, as well as in the voices from many disciplines who have helped to inform my own understandings of the arts therapies, wounding, healing, grief, and the importance of serving others through love. Throughout this process, I have searched for the qualities and themes which characterize my shared experiences with bereaved children (and others in palliative care settings) in a process of arts therapy.

This inquiry began with a focus on the themes of dissonance and wounding. Dissonance was described in relation to my own personal experiences as a music therapist working in the public health care system in British Columbia, and in relation to current struggles in the music therapy field. Threads of dissonance were also revealed in the stories of palliative care patients and of grieving children—in their struggles to gain understanding from others, and in their struggles to move through grief and come to terms with their imminent or realized losses. Dissonance was also found in the fragmented view of human nature perpetuated by modernist psychology, Western medicine, and traditional approaches to education underpinned by modernist and objectivist notions. Wounding is
a related theme, linked to the larger, societal context of modernism which emphasizes objectivity, self-sufficiency, and rationality at the expense of interconnectedness. When our essential interconnectedness is devalued in caring professions such as health care and education, the result is wounding on many different societal and individual levels. I concluded that modernism contributes to wounding because it perpetuates our human experiences of fragmentation, alienation, separation and disconnection (Bohm, 1984; Taylor, 1991; Vanier, 1998), and that we are in need of a shift in our current caregiving paradigms. In order to move towards healing, it is important that we acknowledge these aspects of dissonance, wounding and suffering which are present in our lived experiences and implied in many of our North American societal norms. To accept the whole is to accept the struggles and downfalls that are a part of that whole. Experiences of dissonance and wounding (whether they be struggles for recognition in our workplace, the struggle of learning to live with an illness like cancer, or the struggle of learning to live with the loss of a loved one), are often the catalysts that motivate us to search in new or different directions for healing and for change.

As an alternative to the problem of disconnection perpetuated by the influences of this modernist world view in health care and education, I explored the theme of healing: articulating a holistic view which incorporates a spiritual dimension, and foregrounding the role the arts can play in such healing. Healing was described as a movement toward mind-body-spirit wholeness; a process which has little to do with success or progress as it is defined in a materialistic world. I suggested that music and other art forms lead us into aesthetic experiences that dissolve the self-other dichotomy, bringing us to experiences of Beauty that activate a sense of wholeness that becomes healing. By helping us to foster and build connections and relationships, and assisting us in the search for
meaning in life's challenges, the arts (in both health care and educational settings) can be a part of a creative process which invites us to transform our suffering and reclaim our wholeness. Traditional North American arts education has primarily focused on the development of technical skills, and has not very seriously considered the place of the arts in engaging students in social, moral and personal change/development. However, an exploration of the use of the arts in other cultures helps us to recover healing as a core element of the aesthetic and creative experience. In other cultures, the aesthetic experience offered by the arts is understood to be central to spiritual, moral and personal development, and therefore central to healing. These ideas give support to the therapeutic view of the arts which informs the practice of arts therapists, and which has been a strong impetus for the formal development of the arts therapy professions.

In Chapter Four, I focused on exploring children's experiences of grief and healing in a general sense, and in relation to their participation in an arts-centred children's grief support group. In this exploration I discovered that my five 'co-researchers' experienced the group as a place of belonging that was fun, helpful, safe, comforting, relaxing, supportive and accepting. The healing that seems to unfold in the group is revealed in the children's perceptions of the group as a place where they feel safe and supported, as something that they look forward to attending each week, as a place where they can share their personal experiences with loss with other children who know their reality, and as a place where they can "help others too." Although it was difficult for some of the children to articulate exactly how or why the group helped them, the repeated theme was that it did help them with their grief. This theme was mirrored in their self-portraits (before and after drawings), and supported by their parents observations. Children described their experiences with grief as a mix of intense emotions for everyone in their families including
anger, loneliness, isolation, sadness, fear, worry, and anxiety about the fate of their surviving loved ones. In learning to live with their grief and to heal, children spoke about the need to continue living, to spend time with their family, pets and people who will give hugs, support and comfort. They also stressed the importance of talking to and being with others who can understand. Bereaved children also searched for ways to maintain a connection to their loved ones, and this connection--whether it was found through visiting the grave, or sensing their loved one’s presence as a guardian angel--became a part of their healing.

In the final chapter of this inquiry, I articulated the model of therapeutic practice that has emerged from my clinical experiences as a music therapist in palliative care settings; a model I have named a circle of loving and creating. In creating, we play and improvise, surrendering to the beauty of the moment, without knowing what the end results will be. The circle represents the space of hospitality that occurs when we can create a “free and fearless” place for our clients to share the stories of their lives. Loving is conveyed through our Being, our listening, and through our presence. In some respects, the model brings together all the previous explorations and themes into a final simple realization that the essence of all healing is simply, love. Love which is given freely from one to another, which is given in a spirit of service towards the other’s needs without expectation of a reward, love which moves us from our self-protected, small worlds towards the needs of the other; a movement from the ego-self to the spiritual self where we can know and manifest our connectedness to the larger whole. This connection is the heart of my work as a music therapist. Fostering these sacred connections is a risk which, most days, I am prepared to take.
Implications for Arts Therapists, Educators and Health Care Providers

Although the purpose of this inquiry was not to establish causal connections between a process of arts therapy and healing, the possibility of arts therapy influencing the healing process has been illustrated by the different stories described in this document. By sharing words, stories and artistic images which give voice to the experiences of grieving children, I have hoped to build a better understanding of their suffering and of what they need to heal. I have also hoped to show how much children have to contribute to the professional dialogue on children and bereavement; how much we can learn by listening to their voices. These reflections can assist caregivers in any discipline to have a better understanding of how to help. By raising awareness of children’s needs in grief, and by sharing examples of how a process of arts therapy can help them, I hope that educators and health care providers might be inspired to recognize the potential that exists in arts-based approaches to healing. The therapeutic use of the arts are offered here as potential forms for meaning-making and self-expression, as forms for creating aesthetic spaces which can hold suffering in a gentle embrace, and as pathways which can build connection, intimacy and relationship with those who are suffering. In recent years, in the field of palliative care, there has been a heightened level of understanding that children have unique needs in grief. Many palliative care programs which used to offer bereavement support only to adults now offer programs to support children. This only makes sense, as the palliative model of care is repeatedly described as family-centred throughout the literature. We have come to the realization that illness affects every member of the family, and palliative care programs which do not currently offer services for children need to work towards that goal in order to bring their practice in line with their philosophy of care.
Throughout this thesis, I have also suggested that if educators can expand their view of the arts (from a narrow, discipline or technique-based focus) to a broader understanding of the therapeutic power of these mediums, then the arts can play a larger role in school curricula and in learning and human development in general. Part of the work of educators, from a holistic perspective, is the work of healing, and in order to participate in such healing, educators might have to become willing to embrace a broader view of the children or students who enter their classrooms, to become willing to imagine as well as to reason, to reveal themselves as vulnerable as well as knowledgeable, and to value personal development along with specific skill development. By focusing arts education primarily on developing the technical skill and creative genius of the artistically-gifted child, and underestimating the therapeutic and social value of the arts, both teachers and students are deprived of a tool that has the capability to assist learning and growth on many different levels, particularly in times of suffering and trauma. I have also pointed out that teachers can make a difference in a child’s process of healing through grief if they are not afraid, and do not avoid this subject—even the simplest acts of kindness towards a child who has lost a loved one can make their daily lives in the classroom more bearable.

This thesis also has implications for music and other arts therapists. I believe that arts therapists need to become more knowledgeable about grief, as it is a process which affects so many of the clients with whom we are called to work: elders, persons with disabilities and other chronic illnesses, people living with cancer and their family members, including, of course, children. Grief is a process which can hide in the shadows unless we are willing to name and to witness its presence. The arts are important modes of helping us to express and to find meaning within our human struggles with grief. The model of practice I have described in Chapter Five offers a conception of arts therapy.
practice which may resonate for others who work from a holistic understanding of human
nature, or who work in health care settings where holistic models of care are
acknowledged and embraced. This model builds on the established theoretical work of
Kenny (1989), further developing her conception of loving in music therapy, and
exploring its application in a group context. This model also draws on the work of
Canadian music therapists Nicholson (1999) and Salmon (2001), who have extensive
front-line experience in oncology and palliative care. The power of the arts to connect us
to the spiritual realm, as well as our own personal spiritual values, need not remain hidden
behind the masks of professionalism, or couched carefully in the diagnostic language of
psychology. In certain areas of health care and education there are windows of openness
that will listen to what arts therapists have to say about the spiritual nature of our work.
Of course, we will never fully be able to describe or capture this mystery. Of course, we
will always find resistance and cynicism from those who fear or feel threatened by the
spiritual, the subjective and the personal. If we can brave the waters of vulnerability, and
begin to share these aspects of our work, to offer our different perspectives, our clinical
stories, and our personal experiences, then perhaps we can all benefit, caregivers and
clients alike.

Thesis Contributions and Directions for Future Research

Merrill has suggested that “there is a need for music therapy research which
illuminates direct experience and explores the impact of the work on music therapists”
(1998, p.143). I believe that this research has made a contribution to our field in this
regard. It has also articulated an area of Canadian music therapy practice which has, thus
far, been largely absent from the professional literature. In addition, the work described in
this thesis contributes to an articulation of the depth and process-oriented approaches to music therapy which are beginning to emerge in our field. As Canadian music therapists complete graduate studies and bring a new depth and breadth of knowledge to their work, we must share our developments with one another, and with other health care providers in order to counter the easy dismissal of music therapy as frivolous entertainment which can be simply replicated by volunteer musicians.

In some ways, every thesis is only a beginning—a bridge to ideas that are in a process of change and becoming, a bridge to the future. It is my hope that I will continue to develop this work on the arts therapies with bereaved children. Given more time and resources, I would like to dialogue with a larger number of children about their experiences with grief and healing. Although it was not my original intention to select one gender over the other for the interviews, the process evolved in this way. Talking with a group of boys might provide some different insights than those realized in this inquiry; where all the co-researchers were girls. It would also be fascinating to see, for instance, how the children (in this study) will develop in the future; how they will reflect back on their experiences in the children’s group as they grow into adolescence and adulthood. In addition, I am interested in how a “circle of loving and creating” (the model of practice defined here) might benefit children who experience loss or trauma in other geographic and socio-economic settings, in regions of the world where there is limited access to health care and other psychological services.

I made the decision to take an interdisciplinary approach in this dissertation, and in my attempts to have breadth, I have perhaps lost some of the depth that might have been possible if I had focused more intensely on one single area of music therapy practice. However, this inquiry has only strengthened my conviction for arts therapists to remain
open to interdisciplinary dialogue. We need to be open to what we can learn from other fields, and in addition, to recognize that we have valuable knowledge to contribute to other disciplines. Because I chose to do my graduate studies in the field of education, I found I was able to take a different perspective, perhaps a broader perspective, than if I had been immersed in music therapy curricula, where other students shared similar assumptions. Much of my learning has come through challenge, and a call for better articulation from peers and teachers, those who do not know about music therapy, but are interested in learning more about it. We can easily become isolated within our work and within the bounds of our small field, yet we are called to work with other disciplines, and our interdisciplinary dialogues can only assist us in the ongoing process of developing our identity and our purpose. Interdisciplinary cooperation and understanding is also an essential part of holistic care. Therefore, I would encourage other music therapists to articulate their work, and to explore educational and collaborative opportunities in such interdisciplinary contexts. Finally, I would encourage Canadian music therapists--many of whom are doing clinical work of great depth and meaning--to write about it, so that, collectively, we can begin the process of establishing a broader literature and research base for our young field.

Closing

Remen (2000) said, “We do not return from the journey into pain and illness to the same house that we left. We have become more and the house we will live in will be more as well, for however long we may inhabit it” (p.321). While these words refer specifically to the experience of the person living with a life-threatening illness, I think they apply also to the experience of caregivers. As caregivers to those who are ill, to
those who are dying and to those who are grieving, we do not remain untouched by our shared experiences. We are invited into an incredible opportunity to learn about others and about ourselves. To be with another human being during such an intimate time as the time of dying, to travel alongside children as they find their way through grief, to be of service to other human beings during times of such vulnerability, is, in my experience, simply an honour which has the potential to deepen and enrich our relationship to life. When we commit to sharing the journey with another, to being a compassionate witness to human pain and suffering, we too are changed, and do not “return to the same house that we left.” I now know that I have been shaped, perhaps in depths and ways I will never really understand, by the people whom I have been privileged to walk with on their journeys through life as they face illness, and through the hills and valleys and spirals of grief. Whether these people have been family, friends, or strangers who entered into my life with the intimacy that mirrors the closeness of blood ties, the impact is unmistakable. When we walk closely at the edge of life with others, we begin to see the rest of the world differently. We are stripped of our assumptions, our rationalizations, and often our convictions and certainties. We may discover there, in the “depths of the most unimaginable vulnerability[,]... that we live not by choice, but by grace ... and that life itself [is] holy” (Remen, 2000, p.325). My work has brought me to this place of gratitude, and to the knowledge that life is a gift, a challenge, and a deep blessing--not to be hidden in the shadows or held onto tightly, but to be lived fully in the light of love which must be given away as fully as it is received, a love which is meant to be shared generously and compassionately with ourselves and with others. It is by loving and serving others that we can all participate in the healing of our world.
References


Merrill, T. (personal communication, August 1, 2002).


Webster, J. (1994). Moving into an institution: Music therapy to support the elderly in their loss and grief. *Journal of the New Zealand Society for Music Therapy*, pp. 7-34.


APPENDIX A: ETHICS APPROVAL

1. SFU Ethics Committee Approval Letter p. 248
2. SFU Parental Consent Form p. 249
3. SFU Participant Consent Form p. 251
4. LGH Consent for Photographs p. 253
5. LGH Consent for Use of Art and Sound Recordings p. 254
6. LGH Interview Consent Form p. 255
June 27, 2001

Ms. Heather Mohan
Graduate Student
Faculty of Education
Simon Fraser University

Dear Ms. Mohan:

Re: A Phenomenological Inquiry into Children's Experiences of Grief
And Healing in Arts-Centred Therapy

I am pleased to inform you that the above referenced Request for Ethical Approval of Research has been approved on behalf of the University Research Ethics Review Committee. This approval is in effect for twenty-four months from the above date. Any changes in the procedures affecting interaction with human subjects should be reported to the University Research Ethics Review Committee. Significant changes will require the submission of a revised Request for Ethical Approval of Research. This approval is in effect only while you are a registered SFU student.

Best wishes for success in this research.

Sincerely,

Dr. James R.P. Ogloff, Chair
University Research Ethics Review Committee

c: C. Kenny, Supervisor

/bjr
SIMON FRASER UNIVERSITY

Parental Consent to Participate in a Research Project

When a research project is undertaken at Simon Fraser University, the researcher must obtain informed consent from all participants. If the participants are minors, consent must also be obtained from a parent or guardian. This page describes a research project in which your child has been invited to participate.

I cannot use your child’s answers to the questionnaires for the research project unless this page is completed and returned along with a signed consent form from your child.

Your signature on this form will signify that you have received a document which describes the procedures, possible risks, and benefits of this research project, that you have received an adequate opportunity to consider the information in the document, and that you voluntarily agree for your child to participate in the project.

This research project is intended to explore--from a child’s perspective--their experiences of the death of a family member and their subsequent participation in expressive arts therapy (either individually and/or in the children’s grief group setting) intended to support them as they move through the grief process. Your child will be invited to meet with me to discuss and explore through words, music and art their reflections on losing a loved one, participating in expressive arts therapy, and how they “moved through” their grief. These sessions will be designed with the utmost respect for the child’s comfort level, and for the pace at which the child would like to work through the questions. Several sessions may be held to accommodate the child’s preferences in this regard. The child may refrain from answering any question they don’t wish to answer. All sessions will be audio-taped.

Potential risks of this project to the child may be some emotional exertion in relation to discussing and remembering the death of a loved one. Potential benefits would be the opportunity to re-live positive memories, to share their personal experience with someone who is willing to listen, and to help educate others about what children experience and need to support their process of healing through grief.

Your child’s answers are confidential. When the results of the study are reported, your child’s identity will be protected by changing identifying details and by using a pseudonym rather than their real name. Segments of the interview transcripts (including the art and music created during the interview) may be shared when reporting the results of the study.
You may withdraw your child's participation at any time. You may register a complaint, or address any questions about the project to the chief researcher (named below) or with Dr. Robin Barrow, Dean, Faculty of Education, Simon Fraser University. (604-291-3148).

If, after reading the above description, you wish to consent to your child's participation in this project, please read and complete the section below. A copy of the results of the study, upon its completion, may be obtained by contacting Heather Mohan at (604-984-5951, x. 8007).

As (parent/guardian) ______________ of (name of child) ________________________, I consent to the above named engaging in the procedures specified in this document.

I certify that I understand the procedures to be used and have fully explained them to: (name of child)___________________________.

In particular, the subject knows the risks involved in taking part. The subject also knows that she has the right to withdraw from the project at any time.

Child's Name:__________________________
Your Name:____________________________
Address:______________________________

Telephone Number:_______________________
Signature:______________________________
Witness:_______________________________
Date:_______________________________

Chief Researcher: Heather Mohan, MMT, MTA; Doctoral Candidate; Faculty of Education, Simon Fraser University (604-984-5951, x. 8007)
Supervisor: Dr. Heesoon Bai, PHD; Faculty of Education, Simon Fraser University (604-291-5443)
Informed Consent by Participants in a Research Project

The University and those conducting this project subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort and safety of participants. This form and the information it contains are given to you for your own protection and full understanding of the procedures of the research project. Your signature on this form will signify that:

a) you have received a document which describes the procedures, possible risks and benefits of this research project
b) you have had enough time to consider the information in the document
c) you voluntarily agree to participate in the project.

The purpose of this research project is to gain a better understanding of your experience of having someone in your family die, and what it was like for you to participate in individual counselling and/or the children's grief support group while you were grieving the loss of your loved one.

If you agree to take part in this research study, you will be asked to participate in an interview with Heather Mohan and to answer questions about what it was like for you to lose someone you loved, to participate in either individual arts therapy and/or the children’s grief support group, and about what kinds of things you think helped you to get through this experience. During the interview you will have the choice to answer the questions through words, music and art. You will not have to answer any questions you don’t want to answer. You can also choose to stop the interview, and/or to withdraw your participation in this study at any time.

The interviews will be audio-taped, but all of the information you share will be kept confidential by changing your name to a “pseudo-name”, so that your real name will not appear on any written material associated with this project.

Potential risks of this project may be some emotional exertion in relation to discussing and remembering the death of your family member. Potential benefits would be the opportunity to re-live positive memories, to share your personal experience, and to help educate others about what children experience and need to support their process of healing through grief.

Any concern or complaint you may have about the study can be registered with the researcher; Heather Mohan (604-984-5951, x.8007), or with Robin Barrow; Dean of the Faculty of Education at Simon Fraser University (604-291-3148).
I have read the procedures outlined in this document.

I understand the procedures to be used in this study, and the personal risks to me in taking part.

I understand that I may withdraw my participation from the study at any time.

I agree to participate by being interviewed by the Principal Investigator; Heather Mohan. I understand that the interview questions will focus on what it was like for me to lose someone I loved, what it was like to participate in expressive arts therapy (individually and/or in the children's group), and about what kinds of things I think helped me to get through this experience. I am aware that the interview will be audio-taped, and will take place at________________________ on________________________.

Name (please print):________________________
Address:________________________________
Telephone:______________________________
Signature:______________________________
Witness:________________________________
Date:________________________________

Chief Researcher:  Heather Mohan, MMT, MTA; Doctoral Candidate; Faculty of Education, Simon Fraser University (604-984-5951, x. 8007)
Supervisor: Dr. Heesoon Bai, PHD; Faculty of Education, Simon Fraser University (604-291-5443)
CONSENT TO PHOTOGRAPH / VIDEO-TAPE FOR PUBLIC INFORMATION

I, the undersigned, hereby give my consent to the North Shore Health Region to take photographs / video-tape of myself, without liability, to be used for public information (including newspapers, magazines, pamphlets, brochures, reports, displays, educational materials, television) or to be used in any other way for the purposes of public information.

Name of person consenting

Signature of person consenting

Address

Phone#

Relationship of person granting permission if not principal subject

Date Signed
Consent for Use of Art and Sound Recordings for Public Information

I, the undersigned, hereby give my consent to ________________________, of Lion’s Gate Hospital, to record my artwork photographically, and to make audio/sound recordings which may be used, without liability, for the purposes of public information and education. I understand that my real name will not be used when this data is shared. I also understand that I am free to withdraw consent, in whole or in part, at any time, and that this consent will be valid until such time as I withdraw it.

Name of person consenting

_____________________________________________________

Signature of person consenting

_____________________________________________________

Signature of parent/guardian for minor subjects

_____________________________________________________

Signature of Witness

_____________________________________________________

Date Signed
Interview Consent Form

I, the undersigned, hereby give my consent to ______________________, of Lion’s Gate Hospital, to conduct an interview in which I will be asked to share my experiences of being a patient/family member receiving the services of the palliative care program.

I understand that the intent of the interview is to gather information which will help staff and members of the public to better understand what elements of the palliative care program contribute to a patient’s level of comfort and quality of life, and what elements need to be improved to better meet patient/family needs. I understand that the interview will be conducted at my convenience, and that I may withdraw my participation at any time.

I also understand that my name and other specific demographic information which might identify me, will not be used in the reporting of the results of the interviews, and that I am free to withdraw this consent, in whole or in part, at any time.

______________________________
Name of person consenting

______________________________
Signature of person consenting

______________________________
Signature of parent/guardian for minor subjects

______________________________
Signature of Witness

______________________________
Date Signed