Music therapy – a supportive distraction

An empirical, interpretivist study exploring music therapy interventions with paediatric oncology patients in the ambulatory chemotherapy unit in a public hospital in Lima, Peru

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English abstract

The aim of this Master's thesis is to explore how to integrate music therapy in the treatment of paediatric oncology patients. This is an empirical interpretivist study, using a phenomenological and hermeneutic approach, based on my 9th semester practical experience at the ambulatory chemotherapy unit at a public hospital in Peru. Through a thematic analysis of questionnaire-based interviews with caregivers, volunteers and staff members, the interviewees' experiences of the impact of music therapy in this unit are studied. Followed by a heuristic analysis examining the connection between culture and music therapy.

The outcome of the thematic analysis presents three emergent themes describing music therapy having an impact on *attention*, *enjoyment* and *relaxation*. Between and during medical procedures, music therapy can provide a supportive distraction from the challenging environment. With active and receptive music therapy intervention, relaxation or musical activities can be created helping the child to better cope with the situation.

Through the heuristic analysis, the importance of self-reflection, cultural sensitivity and the therapist's responsibility to respect, support and keep an openness to the personal-cultural-musical background of the patient, are presented. Multicultural music therapy is evolving due to international collaborations and more multicultural societies. Music and culture are both personal and phenomenon shared with others, therefore awareness of the therapist's and the patient's cultural background are needed. Nevertheless, it is essential to strive for a balance between cultural considerations and the spontaneous connectivity in the music, in music therapy.

Danish abstract

Formålet med dette speciale er at undersøge, hvordan man integrerer musikterapi i behandlingen af pædiatriske onkologiske patienter. Dette er et empirisk, kvalitativt (eng. *interpretivist*) studie, der bruger en fænomenologisk og hermeneutisk tilgang, og som tager udgangspunkt i min 9. semester praktik i ambulatoriet for kemoterapi på et offentligt sygehus i Peru. Gennem en tematisk analyse af spørgeskemabaserede interviews med omsorgspersoner, frivillige og medicinsk personale undersøger jeg, hvordan folk oplevede virkningen af musikterapi i denne enhed. Desuden, undersøger jeg, gennem en heuristisk analyse, sammenhængen mellem kultur og musikterapi.

Resultatet af den tematiske analyse præsenterer tre fremtrædende temaer, der beskriver, at musikterapi har en positiv indflydelse på opmærksomhed, glæde og afslapning. Mellem og under medicinske procedurer kan musikterapi give en støttende distraktion, fra det udfordrende miljø. Ved brug af aktive og receptive musikterapimetoder kan skabes afslapning eller musikalske aktiviteter, der hjælper barnet til at kunne klare situationen på en bedre måde.

Gennem den heuristiske analyse, præsenteres vigtigheden af selvrefleksion, kulturel følsomhed (eng. *cultural sensitivity*) og terapeutens ansvar for at respektere, støtte og være åben over for patientens personlige-kulturelle baggrund. Multikulturel musikterapi udvikler sig gennem internationale samarbejder og mere multikulturelle samfund. Musik og kultur er både personlige og fænomener der deles med andre, derfor er der behov for bevidsthed om terapeutens og patientens kulturelle baggrund. Ikke desto mindre er det vigtigt at stræbe efter en balance mellem kulturelle overvejelser og den spontane kontakt, der er i musikken, i musikterapi.

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THANK YOU to the whole *Aprendo Contigo* family, for welcoming me, trusting in my project and for sharing this journey with me, a piece of my heart will always be with you

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CHAPTER ONE – Introduction

This Master's thesis at the music therapy programme at Aalborg University, Denmark, is an empirical study exploring music therapy in the ambulatory chemotherapy unit for paediatric oncology patients. It has its starting point in my 9th semester practical experience at the hospital *INEN – Instituto Nacional de Enfermedades Neoplasicas*[1] (eng. National Institute of Neoplastic Diseases) in Lima, Peru, during the fall of 2017.

1.1 Motivation & wonderment

Interactions with people have always fascinated me. There is something really beautiful about meeting people, sharing a moment together and learning about that other person. Through meeting others, I find that I learn more about myself as well. Interacting in music are particularly an amazing experience. Here exist other ways of communicating – of expressing oneself, listening to and sharing with each other – and other rules and traditions, creating a possibility for an interaction where limits or barriers in other situations might not be present. In music therapy, interactions in various ways can develop. As music is often described as a universal language, I wanted to explore if the therapeutic perspective on music is universal as well or culturally connected. Therefore, I searched for an internship in a country, with a culture and language different from mine.

I was happy to get in contact with the NGO *Aprendo Contigo*[2] ("I learn with you), which is working with providing pedagogical activities for paediatric patients in somatic hospitals in Lima, Peru. In collaboration with the organisation, I provided music therapy at the hospitals during the fall of 2017. This thesis is focusing on the work I did at the public hospital INEN, which is the biggest hospital in Peru for treating patients affected by neoplastic diseases. During my internship in the ambulatory chemotherapy unit at INEN, I experienced music therapy to be a means of interaction and helping patients to better cope with the situation and the environment. I found the ambulatory environment to be very challenging, with many things going on at the same time, many various needs and a lot of crying, stress and noise.

[1] *Link to the web page of INEN http://portal.inen.sld.pe/*
[2] *Link to the web page of the NGO Aprendo Contigo http://www.aprendocontigo.org/en/*

In the ambulatory chemotherapy unit, there was no certainty or possibility of knowing how much time I would have with the patient in that moment or if we will see each other again. A medical procedure could interrupt the music therapy intervention or some other change could occur in this intensive environment. This clinical setting requires a multiple attention from the music therapist, an ability to keep up with the shifting environment and a *here-and-now* focus for the music therapy. This is a rather different way of working in therapy, as opposed to having a longer therapy course with the same patient on a regular basis. Even with only moments together with a patient, I experienced the music therapy to be meaningful and helpful for the child. Although, the question arose on how to build an interaction with the patient, when at the same time focusing on ending the interaction at any time. What is ethically correct to work with in a here-and-now music therapy session, and what kind of expectations can be set for the music therapy?

1.2 Field of study

This clinical setting is a complex and challenging environment, but I experienced music therapy to be helpful and needed in this context. My experiences at INEN made me interested in study in depth how to create meaningful music therapy moments, within a here-and-now focused therapy, and to help these young patients in this clinical setting. I find the holistic approach to be essential in treating a patient, as it is not "only" the medical procedure but the whole aspect of being diagnosed and having to go through a difficult period of treatments that needs to be taken into consideration. Therefore, I attempt to explore how music therapy can contribute to the patient's treatment from a holistic perspective, through a theoretical and self-hermeneutic approach in addition to descriptions of the intervention from the people experiencing music therapy at INEN.

In the end of my internship, I conducted questionnaire-based interviews with caregivers, volunteers of *Aprendo Contigo* and members of the medical team at INEN. Through analysing the interviewees' personal descriptions of their experiences of music therapy, I am interested to study if they can see a purpose for music therapy interventions in this setting. Do they perceive the intervention having a positive impact on their own experience as well as being helpful for the patients? What did they found music therapy to provide in this unit? Additionally, I want to explore the role of culture in music therapy from a personal and theoretical perspective. As music therapy evolving into multicultural settings, with the society

becoming more and more multicultural and with international collaborative music therapy projects, I find cultural considerations to be relevant in music therapy. Therefore, I am interested in exploring what is important for the music therapist to take into consideration and be aware of when working across borders of countries, culture and languages?

Based on these questions and wonderments my research questions are as follows:

1.3 Problem formulation

1. **Based on a thematic analysis of questionnaire-based interviews, how can music therapy create meaningful moments and contribute to the patient's treatment in the ambulatory chemotherapy unit for paediatric oncology patients?**

2. **Based on a heuristic analysis, how is culture playing a role in music therapy practice – and which considerations are needed in multicultural clinical practice?**

1.4 Disposition

This thesis has five chapters in order to explore and answer the research questions:

1. **Introduction** – presenting the background and starting point for the thesis, including personal motivation, problem formulation and purpose of study.

2. **Theory** – from a theoretical perspective describing the clinical setting, the pathology of neoplastic diseases, music therapy methods and how to work with the needs of paediatric oncology patients in music therapy. Additionally, describing the connection between music and culture, considerations in multicultural music therapy practice, the music therapy traditions in Europe and in South America, and a perspective on the Peruvian culture and health care system.

3. **Methodology & Method** – explaining the methodical stance chosen and how it is carried out in this thesis. Describing the procedure of collecting data, through questionnaire-based interviews with caregivers, volunteers of *Aprendo Contigo* and members of the medical team at INEN. Followed by a description of the step-by-step

process of analysing the data in the following chapter through thematic analysis and heuristic analysis.

4. **Empiricism** – firstly, analysing questionnaire-based interviews conducted at INEN through a thematic analysis exploring the participants' descriptions of music therapy in the ambulatory chemotherapy unit. Secondly, through a heuristic analysis examining cultural considerations needed in music therapy practice, from a personal and theoretical perspective.

5. **Evaluation** – discussing findings from the analysis, discussing methodical choices used and ending with the conclusion for this thesis.

1.5 The purpose of this thesis

The outcome of this study aim to provide a perspective on using music therapy in the hospital settings within an interdisciplinary collaboration for contributing to a holistic approach in the treatment of paediatric oncology patients. Furthermore, to give inspiration and initial basis for multicultural considerations in music therapy practice and in international collaborative music therapy projects. I have aspired to explain music therapy terminology to make this study more available to people interested in this topic, not only including music therapists working in this clinical setting.

1.6 Ethics

In the questionnaire-based interviews, I have chosen to presented the participants as a group, rather than as individuals. The data are organized by date and number, without any names presented. In the transcriptions of the caregiver's responses, I have presented the participants as "mother" or "father" and used pseudonyms for the patients being described.

CHAPTER TWO – Theory

This chapter concerns conceptual clarifications and describes the terms that set the focus for this thesis and the construction of the research questions. According to the research questions, literature describing *music therapy intervention* as integrated in the treatment of *paediatric oncology patients in the ambulatory chemotherapy unit* are relevant to include. A description of the group of clients, the clinical setting and music therapy in this setting will be presented in the first part of this chapter. The significance of *cultural considerations* is also discussed in the research questions and therefore the connection between music therapy and culture are explained in the second part of this chapter.

The included literature has been selected by evaluating literature that I have come across during my studies. Especially through the synopsis written in my 7th semester of music therapy with paediatric oncology patients, and the literature review in my 8th semester of the topic of music therapy interventions for pain management in paediatric hospitals, I have found inspiration for literature that I have used for *chain search* (Abbott, 2016). I have not come across literature presenting music therapy intervention specifically for this client group in this specific clinical setting. Literature on the connection between music therapy and cultural considerations are also quite rare but have been increasingly available in publications of recent years. The focus for this thesis is complex, with a challenge of choosing specific, relevant literature that can describe the phenomenon being studied.

Therefore, when searching using the database of Aalborg University, *Primo*, I have looked for literature that can explain different parts of the phenomenon in order to gain a broader understanding and to see the phenomenon from different perspectives. I have not used a systematic search or review structure, but rather the unsystematic narrative approach by presenting and comparing relevant sources (Abbott, 2016). Narrative literature reviews involve a discussion on the chosen research topic from a theoretical perspective to present key issues on the topic (ibid.). The only criteria for the included literature is being peer reviewed articles or book chapters.

2.1 Paediatric oncology patients

Paediatrics is the field of medicine working with children and their diseases (Sundhedsstyrelsen, 2018). A child's pattern of health differs from those of an adult, and therefore, a child's symptoms, treatment, prognoses and recovery process are also different (Sanfi & Bonde, 2014; Sundhedsstyrelsen, 2018). The field of paediatrics involve a wide range of ages as well as a variety of diseases including both psychological and physiological health problems (ibid.). The typically long-lasting treatments for oncology patients cause both the patients and the family to struggle with a great deal of uncertainty and stress (Aasgaard, 2002; Sanfi & Bonde, 2014). Beside hospitalization, isolation and side effects, there are many psychological, social and existential consequences associated with the disease (ibid.). Though the child may become the centre of attention in the family, the illness will easily be the element dominating their lives (Aasgaard, 2002).

The child needs to receive support and help to cope with diagnosis, treatment and hospitalization, as well as side effects (Dun, 2013). There is a need for moments where the child's focus is shifted from the disease to a feeling of a normal life of a child. The family also needs help to cope with the situation and strategies to support their child in the process (ibid.). A patient's experiences and expectations of painful and unpleasant medical procedures are critical factors and important to take into consideration (Aasgaard, 2002). In his Ph.D. thesis, the Norwegian music therapist Trygve Aasgaard (2002) explores song writing in music therapy with paediatric oncology patients. According to Aasgaard (2002), there is a cognitive impact on the patient, with challenges in handling a difficult period in his/her life and the thoughts about an uncertain future (Aasgaard, 2002). With significant time spent at the hospital, there is also a social impact on the child, due to isolation and distance from the elements of a normal every-day life of the child (ibid.). During treatment and long periods of waiting, fear, anxiety or boredom can occur, causing an emotional impact on the child (ibid.). These young patients are dealing with two potential traumas, the diagnosis of a life-threatening disease and the treatment that follows (ibid.).

The RCT-study conducted by Longhi, Pickett and Hargreaves (2015) also emphasizes the importance of taking into consideration the patient's whole experience of the time spent at the hospital as this has an impact on the child's physical and mental health. Being at the hospital can be a highly stressful experience which can increase the perception of pain (Longhi et al.,

2015). It is therefore important to provide a positive and supportive environment for the patient in order to manage painful procedures (ibid.). Stress is connected to increased production of the stress hormone cortisol, which is shown to suppress immune responses (Avers, Mathur & Kamat, 2007). It may be caused by changes in the autonomic nervous system due to emotional, psychological or physical states (ibid.). Studies (e.g., Whitehead-Pleaux, Zebrowski, Baryza & Sheridan, 2007) have presented a positive impact of music therapy on the autonomic nervous system and on reducing stress and increasing immune responses.

2.1.1 Pathology of neoplastic diseases

The patients at INEN deal with different kinds of cancer, i.e., malignant neoplastic diseases. Cancer is the description for more than 200 diseases, where abnormal cells divide in an uncontrolled way (Cancer Research UK, 2018; Clausen, 2001). Cancer starts with changes (mutations) in one cell or in a small group of cells. All cells have a control centre made up of thousands of genes that produce signals to control the growth of cells and division happen in a natural way. If any of these signals are missing or incorrect, cells may start to grow and multiply in an uncontrolled way and form a lump, called a tumour (ibid.). A mutation can happen by chance when a cell is dividing or due to external (e.g., chemicals) or internal (e.g., inherited faults in particular genes) causal factors (Cancer Research UK, 2018).

Cells do have the ability to repair damaged cells, but over time the impairments may build up. There must be about half a dozen different mutations before a normal cell turns into a cancer cell (ibid.). It may take many years for a tumour to grow into a size that gives symptoms and can be noticeable with scanning (Cancer Research UK, 2018; Clausen, 2001). From the place where a cancer starts, i.e., primary cancer, it can spread to other parts of the body and form secondary cancers known as metastases (Cancer Research UK, 2018). The first important step in treating the patient is staging, that is describing what type of cancer it is and which treatment is needed. The International Classification of Diseases, ICD-10 (WHO, 1992) are used to determine the location of the tumour (topography) and its form and structure (morphology). There are two main types of staging systems for cancer – *the TNM system* and *the number system* (Cancer Research UK, 2018). These systems are used in order for the medical team to have a common language to describe the size and spread of cancers and to have standard treatment guidelines across different hospitals (ibid.). If the tumour is found in only one place, a local treatment such as surgery or radiotherapy may be chosen to treat that

specific are of the body (Cancer Research UK, 2018). If the cancer has spread, then a treatment that circulates throughout the whole body is needed. These systemic treatments include chemotherapy, hormone therapy and targeted cancer drugs (ibid.).

2.1.2 Chemotherapy

Chemotherapy is a medical treatment using cytostatic drugs to destroy cancer cells. (Cancer Research UK, 2018). The treatment is received through intravenous therapy or tablets and circulates throughout the body in the bloodstream. Some drugs kill dividing cells while other drugs interrupt the chemical process of cell division in order to try and stop the multiplication of the malignant cells in forming a tumour (ibid.). These drugs can affect healthy body tissues where normal cells are growing, e.g., hair, bone marrow, skin and the digestive system. Normal cells usually replace and repair the cells that are damaged by chemotherapy. Therefore side effects will not usually last once the treatment is over (ibid.). While receiving chemotherapy, the patient might experience sickness and diarrhoea. The treatment can also damage nerves, causing a feeling of numbness or tingling (ibid.). Chemotherapy causes the level of red blood cells to fall, and as the cells receive less oxygen, the patient may become breathless and pale. Tiredness and weakness are also quite common side effects and can increase throughout the period of the treatment, as well as cause low blood level. Those levels can also change during treatment, creating the feeling of an emotional and physical roller coaster for the patient (ibid.).

2.2 Music therapy in the chemotherapy ambulatory unit

The American Music Therapy Association (AMTA, 2018) describes music therapy as an established healthcare option that uses music to address physical, emotional, cognitive and social needs of individuals of all ages. Music therapy can provide a valuable addition to standard pharmacological treatment modalities (Avers et al., 2007). The main purpose of integrating music therapy is to effect changes in the patient, e.g., pain management, emotional state, motor skills, cognitive processing, socialization, interaction, activities, verbal or non-verbal communication and coping skills (ibid.).

2.2.1 Here-and-now focused therapy

Working as a music therapist in a paediatric hospital setting differs from other fields of music therapy, as this field involves a broad range of ages and levels of development, addressing a

wide diversity of diseases and needs of the patients (Sanfi & Bonde, 2014). This success of many short sessions requires a flexibility on the part of the music therapist and an ability to create a safe and trusting relationship with the patient in a very short time (ibid.). There can be both sessions with hospitalized patients and ambulatory patients i.e., patients visiting the hospital for receiving treatment. The overall structure is that the duration of the child's time at the hospital is uncertain, therefore the focus in the sessions are usually on the moment right now rather than on creating a long-term music therapy course (ibid.).

The American psychotherapist Irvin Yalom is one among many therapists who has written about working with a here-and-now focus in therapy. According to Yalom (2005), a shorter intervention is required in a hospital setting, with the focus on helping the patient dealing with problematic behaviours both during the time at the hospital and outside. In this setting, what is needed is to focus on the dynamics that occur in the session rather than going into the child's past history (ibid.). This approach is presented by Chris Wildman (2010) when describing his experiences working as a music therapist in the Children's Hospital in Cape Town. In a hospital setting, a flexible music therapy intervention is needed that can work in conditions that are multilingual, short-term or one/off (Wildman, 2010). The focus for this short-term form of therapy is on supporting the child in expressing him/herself, rather than exploring the traumatic experiences (ibid.).

When providing music therapy in this clinical setting, a first step is to engage the child's own willingness to take part in the music therapy (Wildman, 2010). Familiar with painful procedures, the child might be anxious or frightened that the intervention provided by the music therapist might involve pain. Musical instruments can also trigger a fear or stress response connected with performance expectations (ibid.). The music therapist needs to approach the child in a gentle, supportive way and not assume that the child wants or should engage in music-making. If there are parents present, they might pressure their child to take part in the intervention and perform. The child should be asked if he/she wants to play, perhaps by presenting an instrument to acknowledge that the child has the control to make a choice if he/she wants to participate (Wildman, 2010).

2.2.2 Impacts of music therapy on the patient

Music therapy in individual and group sessions can work against social isolation, help the child to discover personal resources, being creative, playful, as well as including family

members and strengthening social interactions (Aasgaard, 2002; Sanfi & Bonde, 2014). Music therapy can help children cope with being in an unfamiliar environment and through the musical activities, provide the children with a choice and control in their music making. This can be a welcomed and uncommon experience for the patient (Avers et al., 2007). The musical activity can be an outlet for emotional expression, both non-verbal and verbal (ibid.). On a pragmatic level, the musical interaction can be helpful as the child, through music therapy, receives a break from their surroundings and focuses on something else. An opportunity is provided to step out of the role of patient to the role of a playful child (Bonde, 2011; Sanfi & Bonde, 2014). On a semantic level, musical stories and imaginations during music listening can create meaningful moments and experiences during a time that can be perceived as chaotic, insecure, confusing and scary (ibid.).

On a physiological level, the music can affect the brain in its managing of pain signals (ibid.). Music activates multiple areas in the brain both when listening to music or singing and playing music (Christensen, 2014). Music is directly having an impact on the body and the nervous system and also activates the corpus callosum, i.e., the bridge between the right and the left hemisphere, strengthening the connection between the two sides (ibid.). Music sends information through the auditory system and activates attention, memory, expectation, emotions and movement. Music can work as a distraction strategy that can help to shift the child's focus and at the same time maintaining a concentration (ibid.).

The music therapy can also work as a stimulation and relaxation, therefore helping to stabilize the child's breathing. Musical activities in music therapy can help the child to become more active (Sanfi & Bonde, 2014). Music regulates attention and arousal in the brain (Thaut, 2008). Arousal is physical and mentally alertness, involving processes in the nervous system shown in increased physiological activity in e.g., autonomic nervous system (e.g., heart rate, blood pressure), neuroendocrine system (e.g., hormones), or central nervous system (e.g., muscle activation, attention, movement) and emotional state (ibid.). Music elicits dopamine i.e., a neurotransmitter that is released in response to pleasure. Dopamine is regulating attention, recollection, motivation, emotional response and movement (Christensen, 2014).

In 2016, a Cochrane review was published by Bradt, Dileo, Magill and Teague (2016) to assess and compare the effects of music therapy and music medicine[3] for psychological and physical outcomes in oncology patients. Through a systematic review 52 studies were included, with 23 studies described as music therapy and 29 as music medicine. The review suggests that music therapy and music medicine have a strong beneficial effect on reducing pain and anxiety (Bradt et al., 2016). Furthermore, a small to moderate effect on fatigue, reduction in respiratory rate, heart rate and blood pressure has been observed (ibid.). Music therapy showed a large effect on improving patients' quality of life, while music medicine did not show any effect on this matter. The results of single studies suggest music listening reducing the need for anaesthetics and analgesics, as well as decreasing duration of hospitalization and time of recovery (ibid.).

2.2.3 Interactions in music therapy

Music has an immediate appeal that catches the child's attention and by using her voice, body language and mimic, the music therapist can engage the child in an interaction (Aasgaard, 2002). It is through this active interaction that music therapy can change the child's experience of being at the hospital (ibid.). Music therapy can give the child a possibility to be heard, as the unfamiliar hospital atmosphere might not be helpful in this way (Wildman, 2010). Members of the medical team usually do not have much time and might not interact or consult with the patient during the often painful procedure (ibid.). In music therapy, the child can receive an interaction with the music therapist who only desires to engage in a creative play where the child has the option for control and interaction. Through an emotionally compelling experience of making music together, the patient can have a meaningful and enjoyable moment in the hospital (ibid.). The interaction, engagement and enjoyment of music help the patient to better cope with the time spent in the hospital (Longhi et al., 2015). Parents being present can also be engaged in the joyful musical activity with their child. Having a shared moment with their child, can provide a rare positive experience that can help them to lighten up from feelings of guilt and solemnity (Wildman, 2010). Music therapy can help the family to cope with their new and different every-day life and create a supportive environment that promotes normalisation and provides emotional support for the family (Dun, 2013).

[3] *Music medicine, i.e., patient listens to pre-recoded music that is offered by a medical profession, while music therapy requires a trained music therapist providing the music (Bradt et al., 2016). See section "2.3 Music therapy methods"*

In the study conducted by Longhi et al. (2015), parents highlighted the positive effects of music therapy on interacting with their child during a difficult time and painful procedure. Studies have shown that it is not only the paediatric patients who need support to cope with the stressful experiences in the hospital. A parent's fear and stress can affect the child and his/her perception of the situation, making a more negative and painful experience for the child (Longhi et al., 2015; Sundar et al., 2016). Therefore, it is important to include the parents when focusing on the holistic experience of the child (ibid.). In the study conducted by (Whitehead-Pleaux et al., 2007), being a parent causes to you suffer when your child suffers and, therefore, when the parents see their children relaxed they can relax as well.

2.2.4 Music therapy during medical procedures

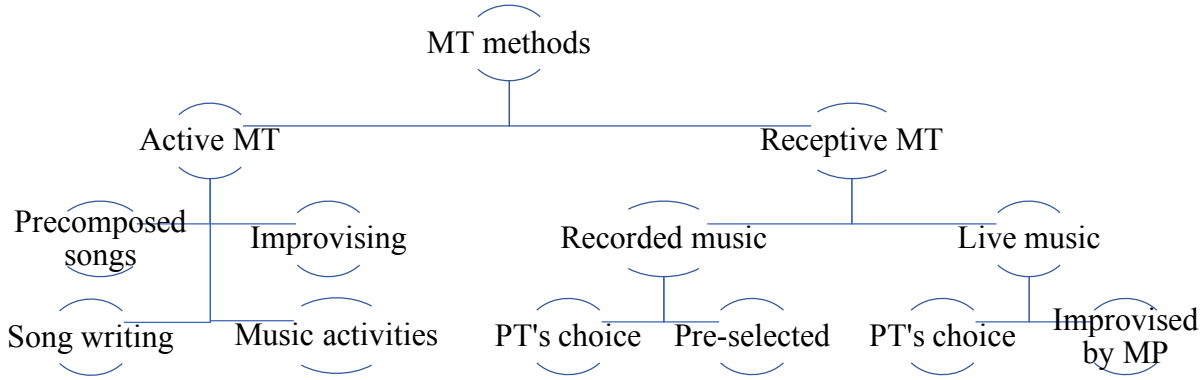
With a holistic approach to the child's treatment, music therapy can facilitate the patient before, during and after medical procedures (Avers et al., 2007). The goal with music therapy is to support the child in managing medical procedures, decreasing the child's experience of anxiety and pain, and working against negative experiences of repeatedly painful procedures that can become traumatic. Another benefit is facilitating the child's collaboration during the treatment (Sanfi & Bonde, 2014; Whitehead-Pleaux et al., 2007). Live music has the advantage of creating an additional activity, offering a distraction during medical procedure or during waiting time (Longhi et al., 2015). Studies show that live music performed by a music therapist not only helps the patient, but parents and medical staff to relax as well (Sundar et al., 2016; Whitehead-Pleaux et al., 2007). When the patient and surroundings around the medial procedure are calmer, the staff is facilitated in performing the procedures. This provides efficiency of care as well as job satisfaction by the staff (ibid.). During medical procedures, the music therapy intervention serves as an interdisciplinary collaboration aligning with the work of the medical team and the medical procedures. It is an individually focused session, following and listening to the patient's needs and responses during the procedures (Sanfi & Bonde, 2014).

2.3 Music therapy methods

Music therapy interventions involve active and receptive methods. Active music therapy includes singing and playing pre-composed songs with the patient, improvising, song writing or other musical activities (Sanfi & Bonde, 2014). Receptive music therapy includes music listening, e.g., relaxing to music with or without guidance from a music therapist (ibid.). In

addition to these interventions, music medicine is also used in paediatric hospitals (Sanfi & Bonde, 2014). Music medicine is recorded and specially selected music to improve the physiological and the psychological health of a patient (Bonde, 2014a). The music experience does not involve an interaction with a trained music therapist and which defines the difference between music medicine and music therapy. The music in the music medicine intervention might be selected by a music therapist and then provided to the patient by a member of the medical team (ibid.). *Figure 1* presents an overview of music therapy methods that can be used in this clinical setting. In this figure, *MT* stands for music therapy, *MP* meaning the music therapist and *PT* the patient.

Figure 1. *Overview of methods used in music therapy*



With the music therapist performing live music, the songs can vary from lively to quieter depending on the patient's state of mind (Longhi et al., 2015). The possibility of choosing and changing into the most suitable repertoire for the patient and the situation are the advantages of live music compared to recordings (ibid.). A music therapist is trained to be sensitive to follow small signs given by the patient and possible signs in the surroundings. These cues help the therapist to sense how to perform by adjusting, e.g., the tempo or volume of the song (ibid.). According to the study conducted by Whitehead-Pleaux et al. (2007), the music therapist should aim to involve the patient, whenever possible in selecting of the music. This gives the patient an unusual experience of control of the unpleasant situation. In this study, the children were asked if they felt a difference when engaging in the activity by singing along with the music therapist. Five out of nine patients perceived it to be an even more helpful experience when singing together, as opposed to only listening to the songs. The interaction made them happier, more relaxed and less afraid of the procedure going on at the same time (Whitehead-Pleaux et al., 2007).

In perspective to the focus for this study, improvisation was the most widely used music therapy method at INEN, both with the patients and as a method to improve the environment of the ambulatory chemotherapy unit, therefore these methods are described further.

2.3.1 Improvisational music therapy

In the study conducted by Whitehead-Pleaux et al. (2007), the participants were also asked about their experiences of familiar songs (chosen by the child) and unfamiliar songs (improvised songs by the music therapist) being used in music therapy. The majority of the participants (8/9) said familiar songs were more helpful. Although when the researcher asked *if* the music therapist had performed unfamiliar songs, only three said yes. The music therapist had in fact used improvised songs with everyone, but improvised songs were not perceived as unfamiliar since they were based on the songs chosen by the patient (Whitehead-Pleaux et al., 2007).

Improvisational music therapy (IMT) has the strength of adjusting to the situation (Jacobsen & Bonde, 2014). Improvisation methods in music therapy have developed in various ways and within different music therapy movements. A condition shared within IMT, is the focus on the here-and-now interaction with the patient, where the patient's individual needs, characteristics, background and values are significant (ibid.). Music therapist Tony Wigram defines clinical improvisation as *"the use of musical improvisation in an environment of trust and support established to meet the needs of clients"* (Wigram, 2004, p.37).

In IMT, the music therapist can use techniques such as *mirroring*, *imitation, matching* or *copying* to provide a supporting space for the patient (Jacobsen & Bonde, 2014). The music can be a dialogue between the music therapist and the patient, or the therapist can choose to take a step back while supporting the patient musically to explore a more independent musical expression (ibid.). Integrating IMT can be a process of several tasks, which Wigram describes by using the five letters of the word music (Wigram, 2004, p. 42-43):

> ***M****otivation* – start by looking for a motivation, and perhaps a framework is needed, for making music together or individually.
>
> ***U****nderstanding* – the therapist has a responsibility to listen to and understand the implications of the music and interpret the patient's verbal and non-verbal expression,

musical and non-musical behaviours, as well as taking into consideration the patient's needs, challenges and backgrounds.

***S**ensitivity* – when listening to and playing with a patient, a sensitivity to the intentionality of the sounds by the patient, both the patient style and approach to music making is important and should be based on knowledge and intuition by the music therapist.

***I**ntegration* – the improvised music and the therapeutic process develop, through connecting the music, engaging and recognizing separate musical identities and integrate within a shared musical experience. The music therapist is becoming aware of the patient's characteristics, challenges and personality in his/her music making and the influences on the experience of mutual engagement through music.

***C**ontainment* – IMT provides a container that allows the patient a space to work with a wide range of feelings and needs. The music therapist has to allow herself to be open to all the transferred and projected feelings of a patient and to accept and contain those feeling (Wigram, 2004, p. 42-43).

2.3.2 Environmental music therapy

The environment of the hospital not only affects patients and family members but also the staff (Aasgaard, 2002). Environmental music therapy (EMT) can take place in the corridor, waiting rooms, wards or rooms for medical treatment and provide a beneficial musical environment (Aasgaard, 2002). The individual patient should not be overlooked, but the main focus in EMT is on strengthening fellowship and facilitating interaction and communication between people. EMT is different from music therapy sessions where the music therapist works individually with patients and/or with selected groups (Aasgaard, 2002).

When music enters the hospital environment, the music can disturb people or other activities in the environment, it can be a positive distraction from the hospital setting but, nevertheless, the diversion is important to keep in mind (Aasgaard, 2002). The music therapist has to "tune in" and improvise not only musically, but also accordingly to the environment. In the paediatric oncology unit of the hospital, there is a diverse population with various needs at the same time (ibid.). Sounds in the environment may have both calming and stimulating impact

on the listeners, but Aasgaard (2002) emphasises that there is not one type of music or one type of instrument that is universally preferred. The social environment is also an important factor for a person's wellbeing, but this can be challenging in a hospital setting. In music therapy, social interactions can be created which facilitate a stimulating and secure environment (ibid.). EMT can develop into active music therapy interventions with people in the room start playing together with the music therapist, while others listen. Some children enjoy playing together and making the musical activity into a performance for the rest in the room (Wildman, 2010).

2.4 Music therapy and culture

This second part of this chapter has the purpose of looking into the connection between culture and music therapy from a theoretical perspective, following the second research question. Our society becomes more and more multicultural, as a result of immigrants, multiracial and minority groups, and the increasing age gap between generations (Kim & Elefant, 2016). The term *multicultural* indicates contrasting identities relating or interacting with each other (ibid.). Contrasting elements can include a person's gender, ethnicity, sexual orientation, language, religion, education or socioeconomic status. In the field of music therapy, global collaborative research and clinical practice in multicultural setting are evolving and therefore the need for integrating a multicultural perspective in music therapy is important (ibid.).

2.4.1 Music & culture

Music is a complex phenomenon shaped by culture and, at the same time, one that influences culture (Baines, 2016). Music is an important element in social context and its role is contextualized, where the experience of music is connected to the perceiver's attention and personal cultural context (ibid.). Music can have a fundamental and essential role in a person's life and identity, with the potential to remind him/her of joyful memories, to provide sensation of safety and to help strengthening a sense of identity (ibid.). Of music's many purposes in a person's life, some are determined by his/her culture (Yehuda, 2002). Culture is a complex phenomenon as well, as our ideas, values, feelings and actions are all formed by our culture – not only in an emotional, psychological and spiritual way but is also connected to our nerve system (ibid.). There are explicit aspects of culture, i.e., observable customs and traditions, as well as implicit aspects of hidden norms and expectations (Kim & Elefant,

2016). Culture can also be conceptualized as internal or external culture, with the perspective on personal aspects (e.g., one's values or knowledge) or political and organizational aspects in a social context (e.g., economic status) (ibid.).

As communication is based on learning a system of signs, customs and tendencies unique to every culture and understood by us after repeatedly experiences, musical understanding is similarly developed (Yehuda, 2002). Music is a culturally derived phenomenon – a structure of sounds to stimulate an experience – and its reception is based on understanding this structure (Baines, 2016). Sounds, i.e., vibrations, may be universally felt but understanding music means knowing these vibration structures in a culture, which means also knowing that culture (ibid.). When we understand the structures and terms of the music based within a cultural framework, the music becomes more communicative and opens for emotional attachment (Yehuda, 2002).

Music has an ability to cross barriers of cultures and create connections to people regardless of their background (Morris, 2010). Music can help cultural exchange and cultural education (Baines, 2016) and can be seen as a universal language, but music is also linked to culture (Morris, 2010). A person's cultural-musical background is a phenomenon of both personal and inter-personal aspects (Yehuda, 2002). A shared cultural background might facilitate understanding and communication, also in musical interactions (Morris, 2010). However, there is a risk if perceiving music as a universal language, recognised and accessible to all, as it may give the false notion that multicultural considerations are not necessarily an issue in music therapy (Brown, 2002). Music is a complex phenomenon in this way and the challenge is finding a balance between cultural considerations and the spontaneous connectivity of music in music therapy (Morris, 2010).

2.4.2 The music therapy tradition in Europe & Denmark

To use music as a therapeutic means to help people with physical and emotional challenges is a tradition as old as mankind (Nöcker-Ribaupierre, 2015). During the 20th century, music therapy developed with Juliette Alvin, Mary Priestley, Alfred Schomölz and Paul Nordoff together with Clive Robbins creating the roots for a development of music therapy as a profession in Europe (ibid.). In the 1950's in Europe, new theories about the therapeutic benefits of music evolved through research and developments in scientific knowledge. In After the 5th International Conference "Music Therapy and Music Education for the

Handicapped" in 1989, there was a fast development in creating training courses, organisations and practices in Europe (Nöcker-Ribaupierre, 2015). In the same year, *The European Music Therapy Association*, EMTA, was founded to work for a development of music therapy as a profession. In 1998, this association developed into *The European Music Therapy Confederation,* EMTC, with a more structured form and its main task of organising European conferences and supporting networking between music therapists in Europe (ibid.).

The tradition of music therapy in Denmark started in the 1960's with the use of music in special education (Bonde, 2014b). From these experiences, the first *Danish Association for Music Therapy* (Dansk Forbund for Musikterapi, DFMT) was founded in 1969 (ibid.). As the music therapy practice began in the field of special education, it evolved from a pedagogical perspective from which it has developed by influences from the USA with the Nordoff-Robbins approach and the psychoanalytic and psycho-dynamic perspectives from Germany and England (ibid.). Today, the Danish tradition of music therapy is based on the psychodynamic approach with the main focus on creating and providing a frame and a relationship that can meet and support the process of the patient (Pedersen, 2014). In 1982, the first music therapy programme in Denmark started at Aalborg University (Bonde, 2014b). During the years, the programme has developed and created a cooperation with Aalborg University Hospital, where the *Music Therapy Clinic* was established in 1994 (ibid.). Furthermore, the international research programme started in 1993 and the Center for Documentation and Research (CEDOMUS) in 2012, creating an important development for music therapy, from a scientific and professional perspective (ibid.).

2.4.3 The music therapy tradition in South America & Peru

Music is one of the most important forms of cultural expression in South America (Barcellos, 2001). This continent comprises a countless number of cultures with diverse roots. There are distinct sounds, styles, rhythms and instruments describing the identity of that specific region or country. From this musical environment, the music therapy tradition developed in the 1950's in Argentina and Brazil (ibid.), as a group of music educator started applying music in special programs for children with disabilities (ASAM, 2018). These two countries created the starting point for music therapy as a discipline and clinical practice in South America (Barcellos, 2001). In 1968, the first Latin American Music Therapy Conference was held in Buenos Aires (ASAM, 2018). Today, there is a continuous scientific and professional movement for music therapy, despite the challenge of little financial support for further music

therapy research. Yet, these countries have an important role in the development of music therapy in South America (ibid.).

In Peru, clinical music therapy was established in the psychiatric field in the 1970's, following the ideas of the Argentinian psychoanalyst Dr. Benenzon (Barcellos, 2001; Zagal, 2004). In 1971, the first paper on music therapy in Peru was written by the psychologist David Jáuregui about the first experiences of music therapy in a psychiatric hospital in Peru (Zagal, 2004). In 1974, *the Peruvian Music Therapy Society* (La Sociedad Peruana de Musicoterapia) was founded by professionals in medicine, psychiatry, psychology and music education (Barcellos, 2001; Zagal, 2004). A movement began with the purpose of integrating music therapy in institutions, but there has been challenges in lack of support from these institutions (Zagal, 2004).

In 1998, *the Music Therapy Society of Peru* (La Sociedad Musicoterapeutica del Perú) was formed (Barcellos, 2001) and since then, there has been an increasing movement in the country with *the Music Therapy Society of Peru, the Peruvian Association for Music Therapy* (La Asociación Peruana de Musicoterapia) and *the Center for Art Therapies' Development* (El Centro para el desarrollo de las Terapias de Arte) working on developing the music therapy clinical practice and creating music therapy training programs in Peru (ibid.). Members of *the Music Therapy Society of Peru* have been working in developing different projects, e.g., in special education, for homeless children and victims of terrorism (ibid.).

There is still no formal music therapy programs or specializations in Peru, but some institutions organized courses, workshops and conferences about music therapy (Zagal, 2004). The members of the three associations comprise a group of professionals from different specialities, working together to spread new music therapy ideas in different disciplines, especially within the discipline of health care, and to develop collaborations of music therapy with the other countries in Latin America (ibid.). The theoretical framework was based on the ideas of Dr. Benenzon and has developed with influences from various approaches, such as psychoanalytical, behavioural and cognitive (ibid.). Music therapy as a practice is still quite unknown and uncommon in Peru (ibid.).

2.4.4 Music therapy – a multicultural engagement

Adapting to a culture, i.e., acculturation[4], is a process of learning the language, the social norms, lifestyles and "hidden rules". Stige (2002) describes culture as customs connecting to and regulating a group of people and traditions transferred from generation to generation. Culture is also a personal matter, with the therapist and the patient bringing their own culture into music therapy (Stige, 2002). According to Stige (2002), music therapy is a *cultural engagement*, meaning each person has a cultural identity and when participating in cultural experiences it promotes socialisation that can increase the person's quality of life. Stige (2002) presents two ways for the connection between music therapy and culture, with *culture centered music therapy* and *culture specific music therapy.* The first one is defined as an awareness about music therapy *as* culture. Music is a social resource, a way to work with and strengthen communities as well as individuals (Stige, 2002). *Culture specific music therapy* is defined as where the cultural identities of the patient and the therapist meet (ibid.).

Cross-cultural treatment involves the meeting of people of different cultural groups and ethnicities, that can also occur within the same country (Gadberry, 2014). As music therapists move across borders, taking music therapy into cross-cultural[5] practices, cultural differences may impact the therapy session and the relationship, and therefore, cultural awareness is important (ibid.). Pavlicevic (1997) describes, therapy to be a mutual meeting where the therapist and the patient together create their own musical culture. This connects to Stige's (2002) statement that it is not always possible to adjust completely to the patient's culture, but the interest and respect communicated by the therapist are more important than the degree of success of adjusting to those specific cultural codes. Aigen (2001) underlines that cultural references may facilitate the therapeutic process, but there should not be the assumption that a musical idiom will suit a patient only because the therapist believes he/she has a knowledge of the patient's musical identity, or is able to play in the patient's cultural style, or that having a similar cultural background will automatically make therapy easier.

2.4.5 Cultural sensitivity in music therapy

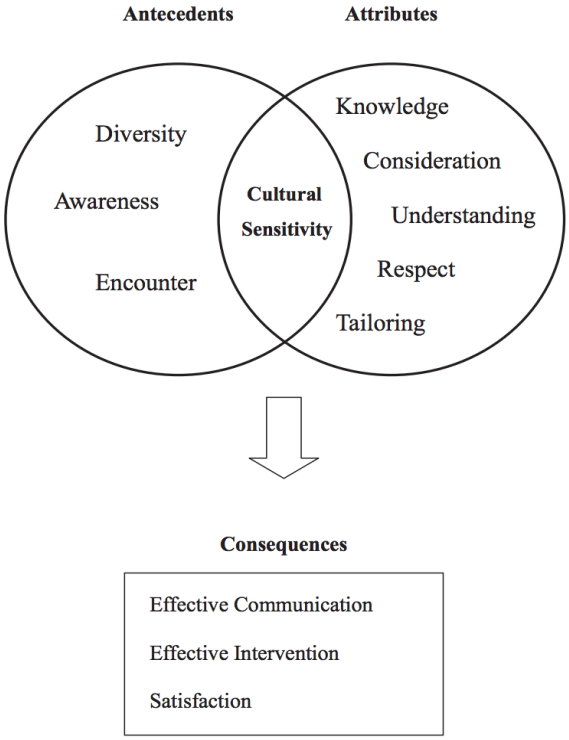
In music therapy, it is important for the therapist to respect, support and keep an openness to the personal-cultural-musical background of the patient, together with an awareness of

[4] *"Acculturation", http://www.dictionary.com/browse/acculturation?s=t*

[5] *Cross-cultural and multicultural are used interchangeable in publications, but the term multicultural is the preferred one in this thesis*

cultural sensitivity (Baines, 2016). A musical cultural understanding is important and assumptions should be put aside and not imposed on the patient (Morris, 2010). Cultural considerations are needed in meeting with a patient as there can be cultural difficulties for mutual understanding (ibid.). *Cultural sensitivity* is a term used in many contexts when discussing the topic of culture, but with various descriptions of its meaning. Through a concept analysis, presented here in *Figure 2*, Foronda (2008) describes the components of the term *cultural sensitivity.*

Figure 2. *Concept analysis of cultural sensitivity* (Foronda, 2008)



The three antecedents facilitate the possibility of employing cultural sensitivity (Foronda, 2008). *Diversity* refers to the differences of individuals (e.g., culture, language, belief systems, values, norms, traditions). *Awareness* refers to one's own culture and of different cultural perspectives and *encounter,* refers to experiencing cultural differences (ibid.). Together with antecedents, five attributes of cultural sensitivity are presented: *knowledge* of cultural differences and values, *consideration* of cultural beliefs, values and traditions; *understanding* the effects and importance of another's experiences and values; *respect,* meaning willingness to show appreciation of another's cultural expectations and regard for the person's needs, and *tailoring* i.e., adaptation (ibid.).

Based on this concept analysis, *cultural sensitivity* is defined by Foronda (2008) as *"employing one's knowledge, consideration, understanding, respect, and tailoring after realizing awareness of self and others and encountering a diverse group or individual"* (Foronda, 2008, p.210). Through cultural sensitivity an effective communication and intervention, as well as satisfaction, can take place (ibid.).

2.4.6 Essential components of cultural considerations

As music therapists, an openness to see and explore one's own cultural identity, as well as that of the patient is important (Baines, 2016; Morris, 2010). Additionally, to explore personal thoughts on cultural differences, as the therapist's own culture as well as the therapist's opinion of the patient's cultural background may affect the therapeutic process (Yehuda, 2002). Both perspectives of cultural consideration – the therapist's self-exploration and the understanding of the patient's culture – are essential and differences and similarities that exist between the therapist and the patient need to be taken into consideration (Brown, 2002). As cultural assumptions, cultural values, misinterpreting, and culturally unsuitable reactions can occur in the therapeutic process, an awareness of the patient's cultural world is critical (Bilu & Witztum, 1994). Music is a process based on elusive cultural symbols withholding meanings, beyond verbal definitions and a fundamental element of the cultural experience (ibid.).

In the dynamic therapeutic process, the therapist is not an external observer of process. Both the patient and the therapist bring their worldview into the therapy (Yehuda, 2002). Yehuda (2002) underlines to look for similarities in music from different cultures, by examining all musical elements. For example, lullabies from different cultures might have different musical parameters (e.g., tempo) but they are similar in the purpose of sending love and tenderness through the voice of the caregiver. This was also found in the study conducted by Laurel J. Trainor (1996) where she examined mothers singing to their children. The study shows that when singing lullabies for babies, the mothers modify their singing and the babies preferred the songs depending on the quality of the voice and the emotions that were communicated, not the musical parameters that distinguish a typical musical style (Trainor, 1996). This study indicates that in multicultural meetings, focusing on musical parameters is not the answer alone. It is also needed to look for subtle elements of common features in the experience, i.e., thoughts, feelings, sensations, and these elements' connection to the music (ibid.).

In the study conducted by Gadberry (2014), the researcher interviewed an American music therapist about her experiences of treating patients in a different culture (Ecuador) and what issues occurred in the cross-cultural music therapy treatment. The four greatest influences on the therapeutic experiences were 1) allowing the music to facilitate, 2) the noticeable role of drums, 3) the impact of different views on therapy and 4) the music therapist's anxiousness about language barrier (Gadberry, 2014). Music facilitated engagement and was the means of

communication. The role of music increased as it became the way to provide reinforcement when the music therapist was unable to communicate by speech (Gadberry, 2014). The music was a guide for the session and provided a structure, keeping the child's attention, building anticipation and creating playful interactions (ibid.). The music therapist used improvised music as the base to which cultural influences could be attached by the individuals (ibid.).

Cultural differences such as time management and scheduling can also be presented and become an issue in therapy (ibid.). The music therapist interviewed by Gadberry (2014), described cultural differences connected to therapeutic norms. She experienced cultural differences in respect of the therapeutic environment with timely arrivals and few interruptions (Gadberry, 2014). The understanding of therapy is also connected to cultural background as well as expectations from the therapy. The music therapist was American who did not know Spanish, the native language of the patients, and the language barrier created difficulties in communicating with the families (ibid.). She felt a disconnection from the client but learned to rely more on the music and the non-verbal communications. As the children's expressions and non-verbal communications helped her understanding them, she as well situated using more body language and facial expression to communicate than if she would have had the ability to speak with the children in their native language (ibid.).

2.5 A perspective on the Peruvian culture and health care system

Peru is a multifaceted country with a varied geography, with the coast to the Pacific Ocean to the west, the highlands (the Andes mountains) going parallel to the Pacific Ocean, and the Amazon jungle in the east (Thorne, 2005). Peru is the fourth most populous country in South America with over 32 million inhabitants (WPR, 2018). The capital Lima is located by the coast, in the middle of the country and with almost 10 million inhabitants making it the largest city in Peru (WPR, 2018). Spanish is the official language in Peru, spoken by more than 80% of the population but there are also around 150 indigenous languages of which Quechua and Aymara having official status as well (ibid.). There are significant differences in education, literacy, health care and nutrition depending on economic status, geographic

region, as well as rural and urban population (Thorne, 2005). According to statistics[6] of the socioeconomic situation in Peru, around 40% of the population belongs to the medium socioeconomic level, while more than 50% live in poverty and of these 20% in extreme poverty (INEI, 2007).

There are around 72 ethnic groups in Peru, with roots primary from Amerindian and Spanish traditions, as well as various Asian, African and other European countries (Nureña, 2009). There are social, political and economic inequalities between cultural groups creating tensions and challenges in their interactions (ibid.). In recent years, a positive development has come about increasing awareness of the diversity of cultures and improving social and cultural rights has begun, but there remains an inequality evident in the health care (ibid.). The possibility to receive health care can be a challenge in some areas of the country due to geographical barriers. Also, cultural differences create a complex challenge in comprehension of traditional health knowledge and practices, in receiving medical help in indigenous languages and in cultural disagreements, discriminations and tensions in interactions (ibid.). Strengthening the ongoing health-sector reform toward universal health coverage is needed, as well as adapting health services to cultural diversity and improve health-information system (ibid.). In the last decade, there has been a significant improvement in the access to health services and in the health of the population of Peru (Alcalde-Rabanal, Lazo González & Nigenda, 2011), especially in child health and nutrition (Huicho et al., 2016).

The health care system in Peru has two sectors, the public and the private one. The treatment in the public sector is for free, as opposite to the private one and there are noticeable differences between the two sectors (ibid.). Life expectancy is increasing, infant mortality is decreasing, resulting in the growth of the population (ibid.). According to the census in 2007, 40% of the population was under 18 years old and the median age in Peru being 27,7 years (INEI, 2007).

2.6 A summary of the chapter

Active and receptive music therapy interventions can help the patient to better cope with the medical procedures, waiting time and side effects. Music therapy can provide a distraction

[6] *The last census in Peru was held in November 2017, but the data has not yet been published. The statistics presented here are from the previous census, held in 2007 and presented on the national institute of statistic of Peru https://www.inei.gob.pe/*

from the stressful hospital environment and in a supportive interaction with the therapist, the child can discover personal resources, express feelings, relax or take part in a musical activity where family members can also be involved. Music therapy can in this way strengthen social interactions and create enjoyable moments. With a holistic perspective on the child's treatment, music therapy can work between and during medical procedures, decreasing the child's experience of anxiety and pain and facilitate the child's collaboration during the treatment. The focus for the music therapy intervention in this clinical setting is on the *here-and-now.* A flexibility is needed by the therapist and an ability to follow and adjust to the many changes and various needs of the patients in this environment.

Music and culture are both personal and phenomenon shared with others. In the dynamic therapeutic interaction, the therapist is not an observer but just as the patient, bringing his/her own culture into music therapy. The therapy becomes a mutual meeting where the therapist and the patient together create their own musical culture based on that moment and their backgrounds. Therefore, cultural sensitivity and cultural considerations are needed by the therapist, together with an openness to explore his/her own cultural background, as well as the one of the patient.

CHAPTER THREE – Methodology & Method

This chapter will present the research design chosen for this thesis. In the first part, I will describe the methodical stance and thereafter how it is carried out in this thesis, including data collection and process of analysing the data.

According to the research questions for this thesis, I am exploring how music therapy can be integrated in the ambulatory chemotherapy unit for paediatric oncology patients and contribute to a holistic treatment of the child. This thesis is an interpretivist study, using a phenomenological and hermeneutic approach. Through a thematic analysis of questionnaire-based interviews, I will explore how people in this clinical setting are experiencing the environment and the impact of music therapy on the environment. Do they find music therapy to be relevant, helpful and contributing to the patient's treatment? Furthermore, I will explore the role of culture in music therapy and which considerations are needed by the music therapist in multicultural clinical practice, through a heuristic analysis.

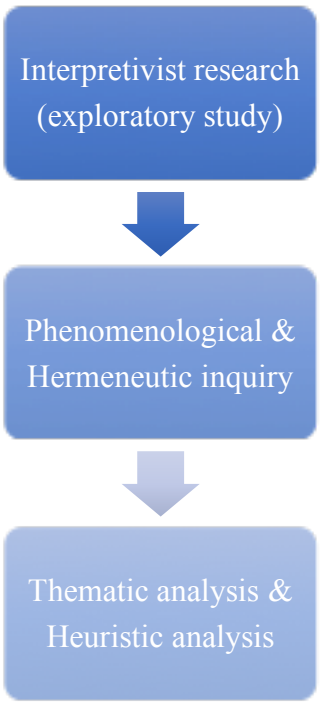


Figure 3. *Overview of chosen research design*

3.1 Methodology

3.1.1 A framework for the research design

In the book *Real World Research* (Robson, 2011b), the author presents a framework for research design, the process of turning research questions into projects. The purpose of a study, i.e., what the researcher is seeking to understand and the conceptual framework helps to specify the research questions to enable the decisions about methods and sampling strategies (ibid.). The author presents three basic elements for research – to explore, to describe and/or to explain (Robson, 2011a). These three basic elements in research can also be used to define the general research approach in a study (ibid.).

A commonly used description for the chosen research approach is qualitative or quantitative research, as presented in the latest edition of the book *Music Therapy Research,* as interpretivist and objectivist research (Wheeler & Bruscia, 2016). By using the three basic elements of research, the chosen research method can be described even further (Ridder & Bonde, 2014).

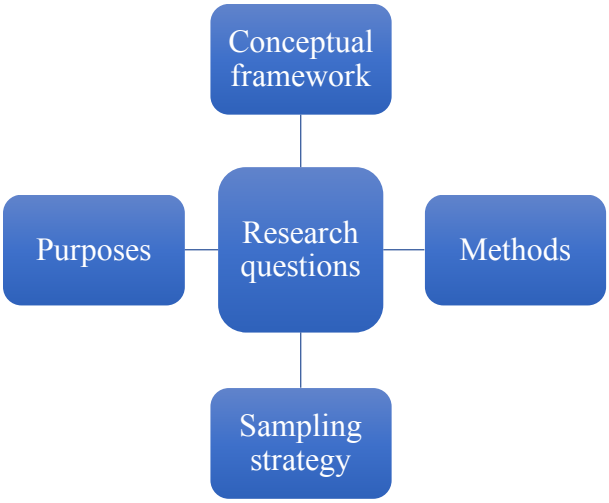


Figure 4. *Framework for research design*

Based on sampling strategy, methods as well as the researcher's epistemology and the purpose of the study, this thesis is exploratory in its design as phenomenology and hermeneutics are used in an interpretivist inquiry to gain deeper understanding of the subjective world of human beings (Ridder & Bonde, 2014). As an explorative method few sources of data, which holds a large number and complexity, are used.

This study starts with the collected data using an inductive approach and then adds theories so that the data can be explored from different perspectives (ibid.). The detailed framework of the design emerges during the process (Ridder & Bonde, 2014; Robson, 2011b). The interpretivist approach has a flexible design and it is important to stay open, enable changes and adjust the research, as it is a part of the dynamic design (Wheeler, 2016).

3.1.2 Methodical strategies

Interpretivist research involves a variety of strategies and designs behind the choice and use of methods for the desired outcomes (Wheeler, 2016). The data collection is taking place in a natural setting, meaning in the same setting that the researcher wishes to study (ibid.). For this study, questionnaire-based interviews were conducted in the ambulatory chemotherapy unit at the hospital INEN to meet the interviewees and capture their experiences in the same room as they had seen or participated in music therapy. Traditionally, interviews have been the primary source of data in phenomenological inquiries (Jackson, 2016). With interviews, direct quotations and descriptions from the participants can be captured, directly after the intervention in the same setting (Wheeler, 2016).

The research and findings are grounded in unique experiences based upon interpretations of personal experiences of the participants and the researcher (Wheeler & Bruscia, 2016). It is important to remember the epistemology underlying the interpretation of data (Wheeler, 2016). The design of a study is based upon the researcher's ontological and epistemological beliefs – what is being studied, who does the interpreting and how does the process proceed? Therefore, the researcher needs to continuously be aware of how she is influencing the research, in all steps and aspects of the process (ibid.). Through *epoché*, or self-hermeneutic, the researcher presents her connection to the research, including motivation, ideas and thoughts that might affect her perspectives on the research. By allowing the researcher's assumptions to be a conscious part of the process, those factors might be prevented from improperly influencing the research (ibid.). *Bracketing*, i.e., putting aside identified assumptions, is also needed to be more open to different aspects of the phenomenon (Jackson, 2016).

During the process of analysing the data it is important to continuously keep in mind *epoché* and to go back to the original data to examine if the interviewees' responses are being represented accurately (Jackson, 2016). When analysing data in interpretivist research, each case is focused on individually before comparisons are being made (Wheeler, 2016). A holistic perspective is important in interpretivist research. Looking at pieces individually is a step in the analysis, but the emphasis is on the whole phenomenon being studied, and to understand the phenomenon as a complex system more than a combination of its parts (ibid.).

3.1.3 Phenomenology & Hermeneutics within the Interpretivist paradigm

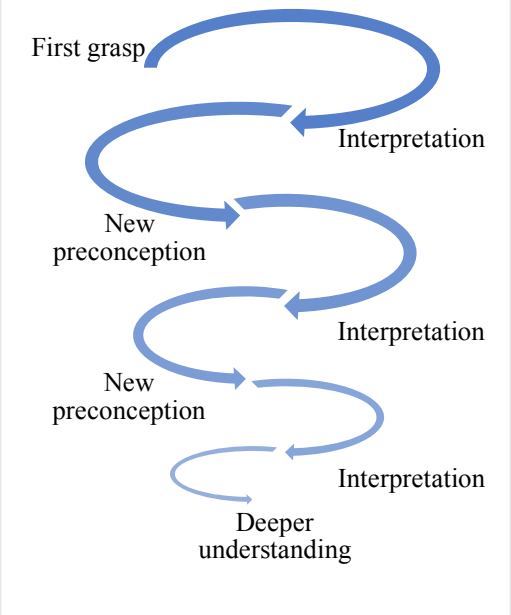
As mentioned in the introduction for this chapter, this thesis is within the interpretivist approach, with interpretation being a primary element of this paradigm (Wheeler, 2016). It is a human inquiry to better understand how a person thinks, perceives and derives meaning from an experience (ibid.). With questionnaire-based interviews, I will explore the participants' personal descriptions of their experiences of music therapy in this setting. I want to explore the contexts in which the music therapist work, exploring the professional perspective and how the music therapist is working in this clinical setting, exploring the disciplinary perspective, to better understand how music therapy can be integrated as a contribution to the patient's treatment (Wheeler & Bruscia, 2016).

Within the interpretivist paradigm, I am using phenomenology. This approach focuses on exploring and understanding a phenomenon, with the purpose of expanding and diversifying our understanding of reality and truth, i.e., our ontological and epistemological beliefs (Wheeler, 2016). To understand a phenomenon, phenomenology looks into peoples' perceptions and interpretations of their experiences (Jackson, 2016). Phenomenology gives a possibility to study non-quantifiable experiences in order to bring deeper understanding of self and others (ibid.).

This approach holds the belief that a person can only know or understand something through the person's own perception of the phenomenon (ibid.). The descriptions and interpretation are subjective and therefore represent a unique understanding of the person's own personal experience. Then through defining of the essence of the phenomenon, the basic structure which many can recognize as the same, a consensus can be reached and new understanding of the phenomenon can unfold (ibid.). Context sensitivity is important to keep in mind, as one of the principles of interpretivist research is that each situation is unique and therefore generalization is not possible (Wheeler, 2016).

In addition to phenomenology, I am using a hermeneutic approach in this study. Hermeneutics is the methodology of interpretation (Loewy & Paulander, 2016). It is a back-and-forth process of looking at details to a whole, in order to gain deeper understanding of a phenomenon. This process is referred to as *the hermeneutic circle*, that involves a continuous movement between preconceptions or understanding and interpretation, with new knowledge to emerge as a result of the process of interpretation (ibid.) The hermeneutic inquiry can be described as a dialog, at first conducted between the researcher and the participants, and then between the researcher and the data (ibid.).

Figure 5. *The hermeneutic circle*



Through the interpretative process of finding essential aspects of the phenomenon, it is important to remember that the researcher is actively involved in constructing the meaning of

the phenomenon (Loewy & Paulander, 2016). The researcher's own social and cultural understanding, preconceptions and beliefs are relevant in the hermeneutic process as they are affecting the interpretations and the finding of a description of the phenomenon (ibid.). In perspective to this thesis, I will use the hermeneutic approach together with the phenomenological approach to interpret and gain a deeper understanding of the interviewees' descriptions of their experiences of music therapy in the ambulatory chemotherapy unit.

3.2 Method

From the methodical stance presented in the first part of this chapter, I will now describe the procedure of collecting data for this thesis and how the data will be analysed in the next chapter. I conducted the data collection together with my colleague and supervisor Erik Baumann. He is a music therapist from Peru, working with his own music therapy practice in Lima and not at the hospital INEN.

3.2.1 Conducting questionnaire-based interviews

With the first research, I am interested in exploring the peoples' own personal experiences of music therapy in the ambulatory unit. I chose questionnaire-based interviews to collect personal descriptions of the participants' experiences. A questionnaire-based interview is a structured sampling strategy, with a fixed set of questions and pre-specified response options or scales, along with some open-ended questions (Robson, 2011c). Using this sampling strategy, the same structure is being used for each time data is collected (ibid.).

3.2.2 Designing the interview guide

Based on my experiences, personal reflections and discussions with my supervisors about working in the ambulatory chemotherapy units for almost four months, I started brainstorming for questions about music therapy in this clinical setting. From this step, I found three aspects of the phenomenon, which I wanted to focus on when designing the interview guide: the impact of music therapy intervention on the patients, the environment and the others in the room (caregivers, volunteers and members of the medical team). I wanted to hear how the participants perceived music therapy, with the perspective on what they observed as well as personally experienced. I designed the questionnaires in English, thereafter translated them into Spanish, one structure for the volunteers and another for the medical team. Additionally, I designed an English questionnaire for me, as the music therapist

to describe my experiences of the sessions and the impact of the intervention on the same three aspects as the other questionnaires. The different structures were chosen to work with the time frame of the data collection. Different lengths of the questionnaires were used because I was able to get more time for conducting the interviews with the volunteers than with the members of the medical team. Also, the two groups work and interaction with the patients in different ways – the medical team work with the child during medical procedures, while the volunteers work during waiting time, between procedures. During designing the questionnaires, I discussed both the structure and the translation with Erik.

3.2.3 Description of the setting

The data collection took place inside the ambulatory chemotherapy unit at INEN during the morning of the 2nd, 9th and 23rd of November 2017. The ambulatory chemotherapy unit is a shifting environment, with both patients and staff coming and going. The music therapy intervention, and interacting with the music therapist, was a new experience for some, while others had experienced several interventions during the four months the music therapist worked at the hospital. The volunteers of *Aprendo Contigo* varied in which room they were working, since some of the volunteers had worked with the music therapist several times, while for others it was a new experience altogether. The same was true with the members of the medical team. Inside the ambulatory room is a "station" for blood tests, a desk for the medical secretary and twelve beds placed next to each other with a chair between for a caregiver. Outside the room is a waiting area where some patients can also receive treatment.

3.2.4 Selecting interviewees

Choosing interviewees was a process of many steps, as I was working under *Aprendo Contigo*, with permission from the hospital administration. Agreements between several people were therefore needed to receive approval to conduct the data collection. On the other hand, once this was settled, there was an enthusiasm by those who were asked to participate. There were two or three volunteers working in the ambulatory unit each time and all of these volunteers were asked if they wanted to participate and all agreed, seven in total. One of them was for the first time working with *Aprendo Contigo*, while the other had more experience. They were all Peruvian women, in ages between 20 and 60. The approval to ask members of the medical team was not yet gained, when the first day of data collection took place. Consequently, on the 2nd of November, only questionnaire-based interviews were conducted

with the volunteers. On the second day, the 9th of November, approval was given to include members of the medical team in the data collection. Also, a nurse and a secretary working inside the ambulatory agreed to participate. On the 23rd of November, two paediatric nurses participated in the interviews. All four members of the medical team were Peruvian women. After asking the volunteers and the medical team about their experiences, Erik asked some of the caregivers if they wanted to describe their experiences of the music therapy intervention – how they found the music therapy to affect the patient, themselves and the environment? Because of the flexible structure of the medical treatment in the ambulatory unit and many uncertainties – especially due to challenges with gaining approval for collecting data – I did not design a questionnaire-based interview for the caregivers. On the first day of data collection, one mother who agreed to give a response and on the third day, two parents described their experiences for Erik who wrote down their responses.

3.2.5 Interviewing

When choosing questionnaire-based interviews, it is important to be aware that the person interviewing is influencing the situation (Robson, 2011c). As the questions focused on the interventions that I, as a music therapist, carried out, I found it important not to be the interviewer as well. Erik was willing to help out and being the interviewer. The differences between Erik and myself – Erik being a Peruvian, Spanish as his mother tongue, and the fact that he is male, were neither advantageous or disadvantageous, but factors that could influence the situation and the answers from the interviewee. During a questionnaire-based interview as the data collection strategy, the interviewer can clarify questions, ask the person to elaborate his/her responses, as well as encourage participation and involvement (ibid.). On the other hand, answers can be affected by characteristics of the interviewer (e.g., their personality, motivation, experiences and skills) and interviewer bias can occur, unintentionally influencing the responses verbally or non-verbally (ibid.). The interaction between the interviewer and respondent can affect the responses as well and the respondent can be less open and forthcoming when not answering the questions in a more anonymous way (ibid.).

The data collection took place in the end of my internship period at the hospital INEN where I worked every Thursday from August until December in 2017. During three Thursdays in November the questionnaire-based interviews were conducted. My work began at 10 in the morning and by 11.30 I finished and went to the office of *Aprendo Contigo* to answer the

questionnaire for the music therapist. My colleague Erik came to the hospital around 11 and when I had finished the music therapy intervention, he conducted the interviews inside the ambulatory unit with the volunteers. I was not present in the room, while the interviews took place. Erik asked the questions and filled out the responses of the interviewees. The questionnaire-based interviews were conducted one by one, not as a group. After the volunteers had answered, Erik continued interviewing members of the medical team and the caregivers. All interviews were anonymous, with only dates and numbers to organize the responses.

3.2.6 Translating

After the data was collected, Erik translated the responses into English and sent both the original in Spanish and the translated responses to me. As we discussed the translations, we attempted to keep them close to the original in Spanish, therefore translating word for word, if possible instead of replacing the Spanish expressions with English ones. This step was done a few months after the data was collected and after I had finished my internship and returned to Europe. This provided greater possibility for objectivity by giving distance from the day of collecting the data when I would have known who had been working in the ambulatory unit. Not knowing which responses belonged to which interview reduced the influence of my personal experiences and connections with the participants. Only the caregivers' responses could be combined with my descriptions in my own questionnaires. With giving some time between the collecting of the data and analysing it, I wanted to get some perspectives, distance and time to switch from the role of being the music therapist providing the intervention to being the researcher analysing the data.

3.2.7 Transcribing

To structure the responses, I used tables as a means of organizing. There are separate transcriptions for each group of participants, i.e., the volunteers, the medical team, the caregivers and the music therapist. The transcriptions are structured by horizontally, divided by the three days of collecting the data, and vertically showing the questions and answers, in English and in Spanish. The entire transcriptions can be read in Appendix 1–4 and the sections relevant for the thematic analysis are presented in the analysis. In the appendices, the participants' descriptions of the environment of the room *before* music therapy can be found, as these descriptions might be helpful in comparing and understanding the interviewees'

descriptions of the impact of music therapy. The music therapist's reflections on the impact of being in the intervention herself is in Appendix 4, but not relevant or included in the thematic analysis. The next step was to take the transcription into the process of analysing the data.

3.2.8 Thematic analysis

When analysing the data from the interviews, I will use thematic analysis, which is an exploratory approach looking for patterns, by structuring the data using codes and themes and comparing these units (Hoskyns, 2016). In the chapter on *Thematic Analysis* (Hoskyns, 2016), in the book *Music Therapy Research*, this method is described as "a way of seeing" and presents three main steps of this approach: 1) *seeing*: recognizing an important moment in the data; 2) seeing it *as somethings*: creating a code for the moment; and 3) *interpreting* it: creating or sharing the meaning (ibid.).

In the book *Microanalysis in Music Therapy* (McFerran & Grocke, 2007), the authors present this approach as a phenomenological microanalysis of text, e.g., used with interviews, as it is a valuable method for exploring in depth a peoples' perceptions of their experiences of music therapy. Thematic analysis is a flexible method that can be used with many different types of data and it provides a way of summarizing key features of large amounts of qualitative data (Robson, 2011d). However, the flexibility can also be overwhelming as the potential range of descriptions about the data can be quite wide. It is a constant comparison analysis as the process involves comparing each new unit of data with the previous codes (ibid.). Here follows a guide in the analysis process, presented in the book *Real World Research* (Robson, 2011d) and the book *Microanalysis in Music Therapy* (McFerran & Grocke, 2007). I will use these five steps in the next chapter when analysing the data:

1) **Familiarize yourself with the data**

   It is important to get to know the data and to transcribe all of it into text, word for word (McFerran & Grocke, 2007; Robson, 2011d). The entire questionnaire-based interviews with the volunteers and medical staff, as well as the caregivers' descriptions are transcribed in Spanish (the original language) and translated into English, in the Appendix 1–3. Additionally, are the music therapist's description of the sessions presented in Appendix 4.

2) Create initial codes

With this step, the data is organized into groups, also called units. Coding is about defining your data through identifying units and linking the similar ones together with a title (Robson, 2011d). By systematically identifying essential parts of the data, only the relevant material for the study should be included (McFerran & Grocke, 2007). McFerran and Grocke (McFerran & Grocke, 2007) emphasizing that this step should only focus on physical and explicit meaning of the person's experiences. The codes relevant to this thesis are the interviewees' descriptions of the impact of music therapy on the patients, the environment and the others in the room, as well as themselves. I will use colour coding to organize the units in the four tables of transcriptions.

3) Identify themes

After coding, the units are structured into smaller groups of themes. Some initial codes may turn out to be themes, along with several codes that may not belong under any theme (McFerran & Grocke, 2007; Robson, 2011d). To differentiate this step from the previous, the researcher now looks at the data from a different perspective – a further level of interpretation and subjectivity – by categorising the material that discusses the same underlying experience (McFerran & Grocke, 2007). Some techniques for identifying themes is to look for repetitions, indigenous expressions or metaphors used by the interviewees (Robson, 2011d). Within each unit, I will search for themes that describe the impact of music therapy and using numbers to organize these themes.

4) Compare themes and create thematic network

The next step focuses on how the themes can be put together, by looking for similarities, patterns, relationships, as well as contrasts between and within themes and units. It is important to not only looking for similarities but also seeking connections (McFerran & Grocke, 2007; Robson, 2011d). The data will be organized in a table where vertically presenting the groups of interviewees and horizontally the units, to facilitate the process of comparing and looking for connections between and within the themes and units. Then these themes, describing the impact of music therapy, will be examined in connection to the needs of the patient.

5) **Integrate and interpret**

The last step has the purpose of going from the unique individual descriptions to a broader understanding of the phenomenon by presenting a final essence capturing the fundamental elements of the phenomenon (McFerran & Grocke, 2007; Robson, 2011d). Explore within and across the themes and present emergent themes to understand the phenomenon. Displaying the data in a clear and accessible way can make it easier to understand and compare the data, e.g., using columns. A good structure is helpful both during the process of interpretation and for the presentation of the data (Robson, 2011d).

3.2.9 Heuristic analysis

For the second research question, I will use a heuristic analysis to explore the role of culture in music therapy and how cultural considerations are needed in music therapy practice (McGraw, 2016). This approach gives personal descriptions of subjective experiences with the phenomenon being studied (ibid.). With this analysis, I will look into my personal experiences of working as a music therapist across borders of language, culture and countries. The aim of this process is to comprehend the first-person experience with the phenomenon (ibid.). Heuristic research was developed by the American psychologist Clark E. Moustaka and has proven to be an inquiry particularly applicable when exploring personal, internal and subjective experiences (ibid.). There are six steps in the heuristic approach:

1) **Initial engagement**

Identifying the focus of the inquiry (McGraw, 2016).

2) **Immersion**

Exploring personal and professional experiences related to the research topic, as well as reading about related topics (McGraw, 2016).

3) **Incubation**

Taking a step back from going deeper into the topic, in order to allow experiences and knowledge to integrate, clarify and develop into new broader understanding of the topic (McGraw, 2016).

4) **Illumination**

Experiencing a gaining of new awareness, insight or epiphanies, as the understanding of the core nature of the topic unfolds (McGraw, 2016).

5) **Explication**

Developing a broader understanding of the topic by comparing and contrasting aspects of the topic that have appeared during the process. New views and alternative explanations are identified as a comprehensive picture of the topic falling into place (McGraw, 2016).

6) **Creative synthesis**

Integrating experiences, insights and understandings to form a coherent description of the meaning of the topic (McGraw, 2016).

3.3 A summary of the chapter

With this chapter, the methodical strategies and procedures in this thesis are described. This interpretivist study aim to explore how the participants are experiencing music therapy in the ambulatory chemotherapy unit at INEN. The phenomenological and hermeneutic approach is used to interpret and gain a deeper understanding of the interviewees' descriptions of their experiences of music therapy in this clinical setting. Through a thematic analysis of the questionnaire-based interviews conducted at INEN, the first research question will be analysed in the next chapter. Thereafter, the second research question will be explored through a heuristic analysis examining the role of culture in music therapy and which considerations are needed by the music therapist in multicultural music therapy practice.

CHAPTER FOUR – Empiricism

In this chapter, I will go into the procedure of analysing the data. This chapter is divided into two main parts with the first examining the participants' description of music therapy in the ambulatory chemotherapy unit through thematic analysis, in order to gain a broader understanding of how music therapy can be integrated in this clinical setting. The second part of this chapter will include a heuristic analysis focusing on cultural considerations needed in music therapy practice, from the experiences of working as a music therapist in an unfamiliar cultural setting.

4.1 Thematic analysis

This analysis focuses on the first research question for this thesis – how can music therapy intervention create meaningful moments and contribute to the patient's treatment in the ambulatory chemotherapy unit for paediatric oncology patients? As I am the music therapist in the clinical setting being analysed, I have chosen to use the term music therapist (MP) in order to step out of the role as the clinician and into the role of the researcher and analyst. As presented in the previous chapter, the process of using thematic analysis is done through five steps. I will now describe the analysis process step by step.

4.1.1 Familiarizing with the data

Through the process of transcribing and structuring the data into tables I become more familiar with the responses. From the transcriptions presented in Appendix 1–4, only the English questions and answers are presented in this chapter. Questions where the participants were asked to answer according to a scale, are presented with charts (in *4.1.3. – Identifying themes*), while the other questions are presented in tables. The tables are structured horizontally divided by the three days of collecting the data and vertically divided by the questions. As each day in the chemotherapy ambulatory unit were rather different, I found it to be relevant and clearer to structure the data by date in the beginning of this analysis, before structuring the data by themes.

4.1.2 Creating initial codes

Next, the data is organized into units by connecting similar sections together that are relevant for this analysis. These units are presented by colour codes. The four units divide the

responses from the participants by their descriptions of the impact of music therapy intervention on 1) the patients, 2) the environment, 3) the caregivers, and 4) themselves:

1) Which impact does music therapy intervention have on the patients?
2) Which impact does music therapy intervention have on the environment?
3) Which impact does music therapy intervention have on the caregivers?
4) Which impact does music therapy intervention have on the staff/themselves?

Here follow the tables with colour coding, divided into four tables by the group of participants and structured based on the interview questions. The 3rd step (*Identifying themes*) continues on page 49.

Table 1. *Colour coding of descriptions from volunteers of Aprendo Contigo*

Questions	Nov. 2nd	Nov. 2nd	Nov. 9th	Nov. 9th	Nov. 9th	Nov. 23rd	Nov. 23rd
1. How would you describe the environment of the room during the music therapy intervention?	Good, [PT] participated a lot, everyone was very participative, motivated to listen to her [MP], it relaxed them. Only the children were actively engaged.	Relaxed, [MP] focused on three kids. They didn't fight over the instruments, they were happy playing the guitar, it was very personalized. It's relaxing.	Calmed, there were children that were crying and she [MP] made them stop crying.	I saw two cases, the little blind girl got much more calmed and was entertained, and also a baby, who were the ones that were more stressed and it [MT] calmed them.	Calmed, [PT] paying attention, they like it [MT] a lot.	Most of the patients or caregivers look for this music with their eyes, and they have a more relaxed/passive attitude. It does help a lot, the way she [MP] plays.	You could notice a more relaxed environment in the people that worked with music therapy.

2. How would you describe the environment of the room after the music therapy intervention ended?	Calmed, the kids which whom she [MP] worked with are relaxed, it changed a lot the children which whom she worked with.	Relaxing.	Calmed.	They [PT] are calmed, all of them have been entertained and they are more relaxed.	More active.	More awake, they [PT] don't suffer pain. It takes them out of that sorrow/preoccupation.	I feel it is more calmed, but as the day advances I also feel the children more tired at this time (12:00), less energy.
3. Did you find that the music therapy intervention changed the environment of the room? If yes, in what way?	Yes. Undoubtedly! Music makes you forget other sounds, like the machines or the crying, it makes "the hospitalary" [the hospital feeling] go away. They [PT and caregivers] participate in something different and they identify musical	Yes. It distracted and relaxed the youngest kids.	Yes. More calmed, there were kids that were being calmed.	Yes. It calmed the environment.	Yes. [PT] paying attention, more calmed. It [MT] catches their attention.	Yes. The caregivers, when they listen to the music, they pay attention to it and the patients, the ones that listen to it, you can see their faces more relaxed, they smile, and look for the music with their eyes.	Yes. Specifically, with the ones she [MP] worked with. I felt that with them, that they were more distracted and happy.

	skills that otherwise wouldn't always survive [would go unnoticed].						
4. What were the responses from the patients after the music therapy intervention?	Two children that were identified as kids who like music a lot, another girl that fell asleep, who was very restless before and the parents that accompany them and they get distracted from the hospital setting.	They wanted to play the guitar, participate and collaborate. It was joyful.	They were thankful, more calmed.	They relaxed, the two that I saw, they stopped crying.	Good, they wanted to stay with her [MP], they wanted to clap.	More communicative with the volunteers, and happier and smiling more.	I noticed it [MT] help throughout interventions, it relaxed [PT].
5. What were the responses from the parents after the	To say: 'My kid loves music', parents rescued that with pride.	Joy.	More calmed.	Very happy, they were relieved.	They like music. They are stressed and music helps	They remain a little bit surprised, they don't ask many questions, they smile. The parent remains	Yes, they liked a lot their kids' reactions towards what was happening. They

music therapy intervention?					them to disconnect.	calmed and thankful. Also, when it isn't an urgent case.	took pictures, video, you could notice they were happy.
6. Do you find the music therapy intervention beneficial for the patient? If yes, in what way?	Yes. Relaxation, they participate, it motivates musical skills, it isn't common, there are more interpersonal relationships.	Yes. It distracts them, makes them participate, it makes the environment more joyful.	Yes. It helped them get their mind off their treatment.	Yes. It calms them, it relaxes them.	Yes. They are focused, but music helps them clear their minds.	Yes. And for the caregiver! It relaxes them, makes them think of something else. To listen to that sweet melody relaxes.	Yes. In my opinion it's been the way for them [PT] to stop feeling what was happening, "transporting" them, relaxing them.
7. Did you find the music therapy intervention affecting your work experience today? If yes, in what way?	Yes. I find that it can be applied to many fields. E.g. by age groups. [PT] more willing to participate, more willing to talk, uninhibited. It [MT] opened a door.	Yes. It's a time when we can accompany [PT] or come closer to do something fun.	Yes. It facilitated the other patients to become more relaxed, it did that the others enjoy the music. It helped me to care	Yes. Because there was no way to work. She [PT] was calmed and let me work with the other kids. She remained calmed and she was crying before.	Yes. They [PT] are more calmed, they can receive more things and the interactions are better.	Yes. When there's I.V.s or any difficulties, we go to her [MP]. Her attitude [PT], it's different once there's music therapy interventions. They are more receptive and more calmed. Most of the kids don't listen to that sweet melody, but when they do, they remain admiring it with their senses.	Yes. More relaxed.

			for them better, because when they cry you can't work with them.				
8. Would you prefer music therapy interventions in the room in the future?	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.	Yes.
9. Do you have any additional comments to the experience of the music therapy intervention in the room today?	That they train us to do it, how to improvise songs.	I would bring a songbook so that the mothers can participate. Kids love to see their mother happy as they spend most of the time worried.	No.	It seems to me like a very good way to relax. I thought that [MT] wouldn't be greatly accepted in Peru, some don't, but it does work.	That they always come, that it isn't routine, something different, is good.	That finally music therapy has arrived to the hospital! I hope maybe someone can be trained because it is not that easy. That it is someone properly trained.	This is my first time, so I have no point of comparison.

Table 2. *Colour coding of descriptions from medical team*

Questions	Nov. 9th Nurse	Nov. 9th Secretary	Nov. 23rd Nurse	Nov. 23rd Nurse
1. Did you find that the music therapy intervention changed the environment of the room? If yes, in what way?	No. I wasn't able to hear her. Maybe when she's right next to the patients yes, but I couldn't hear her over here.	Yes. The kids looked more calmed, they focused on the guitar and wanted to play.	Yes. Some patients relax and they like it [MT].	Yes. It allows children to be calmed and not crying.
2. Did you find the music therapy intervention affecting your work?	2 = Yes, it facilitated my work a little bit	3 = No, it did not affect my work	2 = Yes, it facilitated my work a little bit	1 = Yes, it facilitated my work very much
3. Did you find that the music therapy intervention helped the patient during medical procedures?	2 = Yes, I found it helpful for some patients	1 = Yes, I found it helpful for most patients	2 = Yes, I found it helpful for some patients	1 = Yes, I found it helpful for most patients
4. Did you find that the music therapy intervention helped the patients' collaboration during medical procedures?	2 = Yes, I found it helping some patients' collaboration	2 = Yes, I found it helping some patients' collaboration	2 = Yes, I found it helping some patients' collaboration	1 = Yes, I found it helping most patients' collaboration
5. Would you prefer music therapy interventions in the room in the future?	Yes.	Yes.	Yes.	Yes.
6. Do you have any additional comments to the experience of the music therapy	That they should bring other instruments that have more sound, and that	It [MT] helps a lot, now that I'm pregnant it helps me to relax.	No.	I think the intervention is very positive, and also that the kids can collaborate

intervention in the room today?	they should get the parents involved, giving them lyrics, because parents don't always know how to participate.	There were fewer nurses on the floor that day [more stressful day].		with the procedures.

Table 3. *Colour coding of descriptions from caregivers*

Questions	**Nov. 2nd** Mother of "Linda"	**Nov. 23rd** Mother of "Dylan"	**Nov. 23rd** Father of "Celina"
How did the music therapy interventions affect the patient? How did the music therapy interventions affect you (the caregiver)? How did the music therapy interventions affect the environment?	She's [MP] is engaging children and parents as well [in an activity]. She [PT] liked it, it was calming for her. I would like for her [MP] to continue teaching so that they [PT] feel more calmed.	It catches Dylan's [PT] attention, he gets distracted. It makes me feel calmed, it clears your mind from whatever you were worrying about. It is pleasant, the lady [MP] is very kind and trustworthy. We don't know what chemotherapy is, now I feel more calmed. I would have liked to listen to some children's songs or music from the Andes.	It was nice, she [MP] is very talented and loving. She [PT] was very restless, from radiotherapy. She [PT] was very happy and started playing the guitar until they placed the IV on her. I felt very good, calmed and relaxed. The environment was good, it [the music] was to calm the environment down, so that they [PT] don't feel restless. This time I see her [PT] doing as normal [as she usually is] and also, I think little by little she is getting used to it [the medical treatment].

Table 4. *Colour coding of descriptions from the music therapist*

Questions	Nov. 2nd	Nov. 9th	Nov. 23rd
1. How would you describe the environment of the room during the music therapy intervention?	There were much more sounds than earlier today, as well as before. The kids that were playing wanted a lot of volume and power to the music today. It created a fun atmosphere and activity which also inspired and captured the attention of other kids. More kids wanted to play together and wanted an activity. Music was a fun diversion. After some time, some kids got tired and I continued to play for them until they fall asleep. I felt that the music changed the environment of the room, it is distracting in a good way – from the stressful and boring silence.	The sounds from the machines disappeared. The room got a distraction so it is not less sounds, but less stressful sounds.	There were a lot of activity today. There are big changes all the time, the tempo is intense. There is a lot of sounds and things going on today. At some moments, there are many kids seeking and needing attention and support from me and I need to make a choice who to stay with/work with, at some moments there are all doing something else and not anyone I find the direct need to work with.
2. How would you describe the environment of the room after the music therapy intervention ended?	The room feels empty once the music stops. There are also many kids waiting and wanting me to come and play with them. I feel that the room is calmer. But the lack of other sounds than the machines and mostly the sound of silence, makes the room not so nice.	It was more relaxed, still a lot of sounds but a more relaxed environment.	The room was still filled with sounds, not silent. But I did feel that the music had made a difference, a positive impact on the environment of the room – a distraction. Helping the kids I worked with and their parents, as well as the kids around.
3. What were the responses from the patients after the music therapy intervention?	Many kids started to talk more, got more energy (waking up) and laughed. Lots of eye contact. Kids enjoyed it and the	The baby had a calmer body language, she did not move as much around a before. She kept eye contact and though she did cry	Most of the kids wanted to play today, both during and between treatments. I also played for some kids, but mostly active

	parents were proud and enjoyed the activity. Some got tired, relaxed and fell asleep. Or I continued to someone else. Many expressed joy, that the music activity was fun and enjoyable both for the kids playing and for the ones listening to it, even if they don't have the energy or if I was not able to work directly with them, they could be a part of the activity as well.	now and then, she laughed as well, and the crying was not hysterical and aggressive or lasted for as long time as when I first started working with her. The boy interacted with me during the treatment, while the mother talked with the nurses. He kept eye contact during the whole treatment and his breathing and body language became more relaxed. The girl started interacting more, she laughed and communicated both through laughter and by playing music. We found an interaction, the girl laughed and interacted with me. Before she was kicking a lot and throwing things, but when she realized that she can have some control with me/in the music, she became freer.	music therapy today. Positive development in eye contact, relaxed body language, laughing, interacting (both with me, their parents or the kid in the next bed).
4. What were the responses from the parents after the music therapy intervention?	"Thank you!" PT is more relaxed, falling asleep, needs to sleep, is tired. Non-verbal responses of proud parents, the joy of seeing the kid playing and the parents smiling, laughing and looking more relaxed.	The baby's mother started to cry while I was playing and singing. She said to me and to the mother, by the bed beside her, and to a volunteer, that the music was nice and helpful. That she and her baby liked it. The mother's body language became more relaxed, less stressful when her kid was not constantly crying. She	Parents were proud and positive (and surprised) about the activity and the positive impact on the kid. The music helped the kid to relax, as well as the parents. Some parents wanted to talk a lot with me, making it challenging to keep the interaction and communication with the kid, but I tried to involve all of them

		started also playing with her kid and in the end holding her child in her arms and singing to her (at first with me, then I stopped and she continued). The mother of the boy commented with a laugh, to the nurse that it was a new experience having guitar music during the treatment. After she thanked me for being there.	in the activity and/or the communication. Many parents wanted to be a part in some way, in the activity.
5. Additional comments to the music therapy intervention?	Many things on my mind, about audio recordings and conducting questionnaires… but I felt that I was present, following and listening to the kids and the needs of the kids. I feel safe in my role and in my responsibilities. I do get a bit nervous once my colleague Erik showed up, I want to show how I work, as I have only worked with him once before.	This was the first time that I got this strong connection to a parent and working with one of the parents. Through the kid, I also interacted with the mother. Not only with the focus on the kid but also connecting with the needs of the mother. It was a strong and powerful experience. It was an amazing experience for me, that the mother got empowerment and found a way to interact with her kid and both started playing with her daughter and then singing for her. With the three patients, the signs of their body language were an important guidance for me.	Some of the nurses, as well as the volunteers, have started to ask me to come along when they are going to a patient. To be a part of the team during the patient's treatment. It is an amazing feeling of collaboration and making the best we can for the patient!

4.1.3 Identifying themes

All data with the same colour code in the previous tables, are now organized into four tables divided by each of the colour codes. In each table, the units are structured horizontally by date and vertically by the groups of participants. With this structure, I am looking for *similarities* and *differences* in the interviewees' descriptions, as well as *unique expressions* or *descriptions* of their experiences of music therapy. Within the tables, there responses are categorized by numbers describing the 12 themes the interviewees found music therapy to have an impact on:

1. Participation
2. Motivation
3. Attention
4. Relaxation
5. Enjoyment
6. Discovering resources
7. Support
8. Pain management
9. Collaboration during treatment
10. More energy
11. Environmental impact
12. Facilitating the work experience

Here follow the tables presented in the order of the four initial colour codes, with the data categorized by the twelve themes. Each colour code is individually presented with a table followed by a description. In the following tables, I am using abbreviations for music therapy (MT) and for the volunteers of *Aprendo Contigo* (AC). The 4th step (*Comparing themes*) continues on page 59.

Table 5. *Which impact does music therapy intervention have on the patients?*

Group	02/11/2017	09/11/2017	23/11/2017
Volunteers	1. more participative, more willing to talk, uninhibited, creating	1. more receivable 3. catching their attention, paying attention to the MT, clearing their mind,	1. more receptive, more communicative (with AC) 3. distracted, looking for the music, thinking of something else, stopping the feeling on

	interpersonal relationships 2. motivated, wanted to play 3. distracted 4. relaxed (some fell asleep) 5. joyful, happy, enjoying, not fighting over instruments, kids love to see their mothers happy 6. identifying musical skills 9. collaborative	getting mind off the treatment 4. less stressed, calmed, relaxed 5. enjoying, entertained 7. not crying	what was happening, transporting them, taking them out of sorrow/preoccupation 4. relaxed/passive attitude, calmed 5. happier, smiling, enjoying 8. suffer less pain 9. helpful during treatment 10. more awake
Medical team	-	2. wanted to play 3. focused on the guitar 4. more calmed 9. helpful for the patient during medical procedures and for the patient's collaboration	4. relaxed, calmed 5. enjoying 7. not crying 9. helpful for the patient during medical procedures and for the patient's collaboration
Parents	2. engaging 4. calming 5. enjoying	3. distracted, caught their attention	2. starting to play 3. being as "normal" 4. not restless 5. happier
Music therapist	1. more talkative, more eye contact 2. wanted to be a part of the activity 3. fun diversion, capture their attention	1. more eye contact, more interaction, more communication 4. calmer body language, freer 5. laughing 6. more in control	1. more eye contact, more interaction 2. interested in playing 3. helping both the patient and the people around 4. more relaxed

	4. relaxed (some fell asleep) 5. laughing, enjoying 10. got more energy	7. less hysterical/aggressive crying/screaming	

The first ten themes are all presented in the interviewee's descriptions of the impact of music therapy on the patients. When asking the volunteers if they found music therapy to be beneficial for the patients, there was a unanimous response that the intervention had a positive impact. The medical team and the volunteers found the intervention to help the patients to relax and calm down (4) and that the children enjoyed the positive activity (5). The volunteers noticed that the music caught the patient's attention, distracted the child from the hospital setting and got his/her mind off the medical treatment (3). The volunteers noticed a change in the patient involved in the music therapy. One volunteer said that the music therapy took the patients out of their sorrow (3), out of feeling pain (8) and being restless (4). Through music therapy, the children became happier, they were smiling and laughing more (5) and their body language became more relaxed (4).

The music therapist also found the music therapy intervention to capture the children's attention (3). The activity was a fun diversion (3) and many kids started to talk more (1), got more energy (10), became happier and were smiling and laughing (5). The children wanted to play with the instruments and wanted to play together (1, 2). The volunteers shared this observation that with music therapy, the children could participate in a fun activity (1, 5) that at the same time cleared their minds and distracted them from the unpleasant procedures and stressful environment (3). The children enjoyed playing with the instruments (5) and through the music they became motivated (2), creative and discovered musical skills (6). Furthermore, the intervention engaged the patients (2) and they became more participative (1) as the intervention provided interpersonal relationships, which are not common in this environment, as the volunteers described. The patients became more communicative and interacted more with their parents, with the other children and the volunteers (1). The music therapist experienced more eye contact with the patients (1) and the patients' body language became more relaxed (4) through the music interaction. The music therapist described the flexibility of music therapy interventions as there can be a change from an interactive activity (1), for

the child to get more energy and become more active (10) to a more relaxed intervention, where the child can calm down, and in some cases, fall asleep (4).

Both the volunteers and the music therapist noticed that the intervention also facilitated the others in the room, not only the patient the music therapist was working with, but the enjoyment of music (5) spread to others in the room as well. In that way, as the music therapist described, many could be a part of the activity, by listening to, focusing on (3) and enjoying the music from a distance (5). The music therapist and the volunteers experienced much shared joy (5) through the intervention as it gave a possibility for the patient to play together with his/her parent or with the kid in the next bed. One volunteers noticed that the intervention affected the parents as well and the children enjoyed (5) seeing their parents happier (5) and more relaxed (4). The parents found music therapy engaging (1) and calming (4) the children, and the music caught the children's attention and distracted them (3). They described that both the children and themselves enjoyed (5) music therapy and became more calmed (4) after the intervention. The volunteers found it easier to work with the kids, as they became more relaxed (4), stopped crying (7) and became more motivated (2), participative and uninhibited (1) after the intervention. The volunteers noticed that some kids fell asleep (4) to the music or the music helped them through a medical procedure (9). The medical team also found that the intervention helped the patients and helped the patients' collaboration during the medical treatment (9).

Table 6. *Which impact does music therapy intervention have on the environment?*

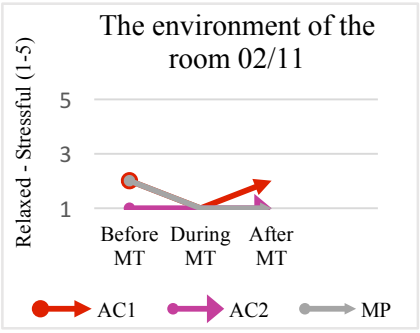
Group	02/11/2017	09/11/2017	23/11/2017
Volunteers	3. "music makes you forget other sounds and the hospital feeling" 4. relaxing, calming 5. more joyful 11. positive, changing the environment	4. calming 10. more active 11. changing the environment	4. relaxing, calming 11. changing the environment
Medical team	-	11. changing the environment	11. changing the environment
Parents	-	-	4. calming 11. positive change on the environment

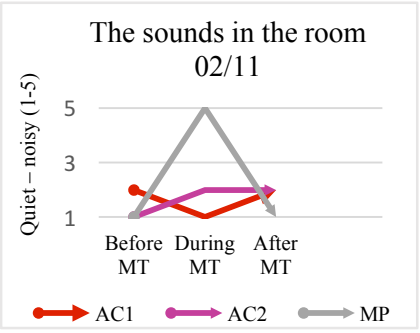
Music therapist	3. distraction 4. calming 5. fun atmosphere 10. more sounds/volume 11. positive change	3. distraction 4. more relaxed 10. more sounds but less stressful sounds	3. distraction 10. lots of sounds and activity 11. positive change

When asking the interviewees about their experiences of the impact of music therapy intervention on the environment, there was a unanimous response that the intervention changed the environment of the room in a positive way (11). Beside the environmental impact, music therapy was described to have an impact on attention (3), relaxation (4), enjoyment (5) and providing more energy (10).

The volunteers all responded that the room changed from a stressful to a more relaxed environment during the intervention (4). On the day when the first questionnaire-based interviews were conducted, the 2nd of November, one volunteer (AC2) responded that the room stayed the same – as relaxed before, during and after the music therapy intervention – while the other volunteer (AC1) described the environment changing from 2 before the intervention, to 1 during the intervention and back to 2 after the intervention.

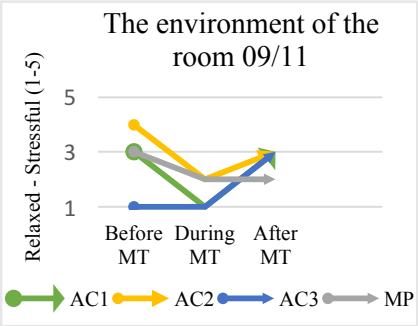
They experienced a calmness in most of the kids when entering the room and no kids were crying. During the intervention, there was a bit more sounds in the room, but the room was calm and relaxing during and also after the intervention (4). The volunteers described the impact of music therapy in changing the room into a more joyful environment (5) and expressed that *"the music makes you forget other sounds, like machines or the crying, it makes the hospital feeling go away"* (3). The music therapist described the environment from the start as quiet and calm, but with an underlying feeling of stress and pain. With the intervention, there were more sounds in the room, as the kids wanted a lot of volume and power in the music.

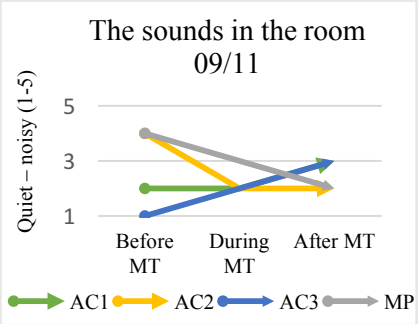




The environment changed to a fun atmosphere (5), with music being a good distraction for the patients (3). After the intervention, the room was calm but felt empty, with a lack of sounds other than the machines, according to the music therapist.

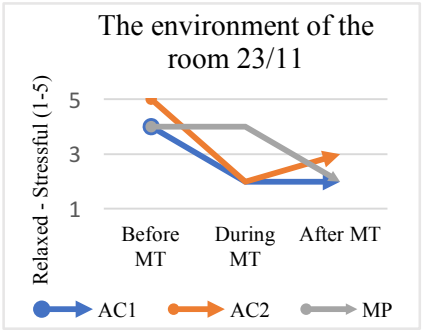
The second day of data collection, two out of three volunteers (AC 1, AC 2) described the room to be 3 and 4 on the scale describing the environment, while the third volunteer (AC3) describe it as 1. There was a difference in the volunteers' descriptions of the sounds in the room when entering, with two (AC 1, AC3) who described the environment to be calm and quieter, the third (AC 2) described the room as "loaded", tense and noisy. During the music therapy intervention, the volunteers experienced the intervention to calm the environment down (4), but in the description of the room during the intervention, there are some differences in the perception of sounds. One volunteer described the room to become much quiet (AC 2), another felt the room stayed as quiet as before (AC 1), while the third felt there were more sounds in the room (AC3). The third volunteer (AC3) also experienced the environment to become more active (10), but also more stressful after the intervention was stopped. All of the volunteers described the environment to be 3 on the scale, this meaning their experience of a stressful environment increases for one (AC3), decreases for another (AC 2) and for the third (AC 1) goes back to the same as before the intervention.

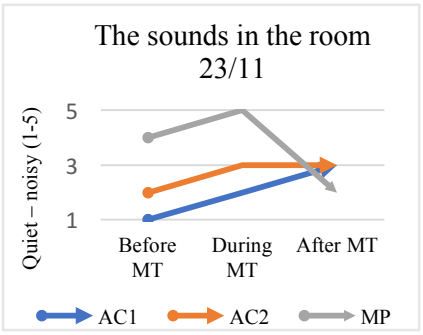




The music therapist found the room to be noisy when entering. There were a lot of sounds coming from the machines, but the music therapy intervention creates a distraction (3) from these sounds. Therefore, there were not less sounds, but less stressful sounds in the room during music therapy. After the intervention, there were still a lot of sounds but a more relaxed environment, according to the music therapist. On this day, the first questionnaire-based interviews with members of the hospital staff were conducted. The secretary working inside the ambulatory, meaning in the same room as the music therapy intervention took place, also described the music therapy to change the environment (11). She described the room to have more sounds during the intervention, but that the intervention also helped to create a more calmed environment (4), in a room that she described as 3 on the same scale as

the volunteers responded to. The nurse did not find music therapy to change the environment, with the room becoming more stressful during the intervention, from 2 to 4 on the scale, but with a bit less sounds, 4 to 3. She added that she could not hear the music therapist, therefore the music therapist could have changed the environment a bit when the music therapist was nearer a patient.





On the third day, both the volunteers and the music therapist found the room stressful, being as 4 and 5 on the scale and the room to be very busy and tense. Still the volunteers found the room to be rather quiet, compared to the music therapist who found it quite noisy. The music therapist described the room with many changes going on, an intense tempo and a lot of activity. During the intervention, the room was still rather intense but as the volunteers and the hospital staff also described, the music therapy intervention changed the room (11) into a more relaxed environment (4). The sounds increased, from an already high level, but one of the parents described that the music changed the room in its calming of the environment (4). After the intervention, the room was still filled with sounds, but according to the music therapist, the intervention made a positive impact on the environment (11). And the others working in the room found the environment to stay more relaxed (4) after the intervention, than before even though the sounds had increased.

Table 7. *Which impact does music therapy intervention have on the caregivers?*

Group	02/11/2017	09/11/2017	23/11/2017
Volunteers	3. distraction from the hospital setting, providing something different 5. enjoying, expressing pride 6. identifying musical skills	3. disconnecting 4. more calmed, relieved, helping with stress 5. enjoying, happier	3. catching their attention/paying attention, distraction, something else to think about 4. more relaxed/passive attitude, calmed 5. smiling, enjoying their kids' reactions, happier

			6. surprised about their kid's abilities
Medical team	-	-	-
Parents	1. engaging the parents	3. clearing their minds from worrying 4. calmed 5. pleasant	4. calmed, relaxed 5. nice, positive
Music therapist	4. more relaxed 5. enjoying the activity, smiling, laughing, expressing pride and joy when seeing their kid playing	1. playing along 4. more relaxed body language, less stressed 5. enjoying 6. empowering/inspiring to interacting/holding their kid 7. cried/emotional 9.helpful during treatment	1.wanted to interact, wanted to share the activity 3. helpful distraction 4.more relaxed 5.expressing pride 1/4.surprised about the positive impact of the activity on their kid

Within this unit, the interviewees found music therapy to have an impact on participation (1), attention (3), relaxation (4), enjoyment (5), discovering resources (6), providing support (7) and being helpful during treatment (9) for the caregivers. When asking the caregivers how they would describe their experiences of music therapy intervention, they all said it was both a help for themselves and their child. When their child was distracted, happy or calmed, then the parents could feel calmed (4) as well. The mother of Dylan said that the intervention helped her clear her mind from worrying (3) and she felt more calmed (4). The medical treatment was a new and uncertain experience for them, but music therapy helped her through it. The mother of Linda described the impact of music therapy as a way for both the children and parents to engage in an activity (1), which helped them feel calmed (4). The father of Celina expressed joy (5) of seeing his daughter being happy and seeing her as she usually is. The music helped him and his child to calm down, relax (4) and gave them a nice and enjoyable (5) moment.

The volunteers agreed that the music caught the attention of the caregivers (3) as well as the patients, and their facial expressions became more relaxed (4) while listening to the music (3). The volunteers found the parents to be happier, smiling (5) and expressing gratitude for the joyful activity. The intervention created an activity where patients and caregivers could participate in something different (1), that distracted them from the hospital setting (3). For a moment, they could disconnect (3) and relax (4), listen to music and enjoy the moment (5) with their child. The volunteers and the music therapist noticed caregivers expressing joy and pride (5) when watching their kid playing music. The parents took pictures and videos of their kid and enjoyed (5) watching their child's responses to the intervention. Many parents were also surprised by the activity and by the "hidden" musical skills in their children (6). The music therapist also noted the joy (5) from parents when seeing their children interacting in an activity, being creative, happy, distracted and laughing. Some parents wanted as well to play along (1) with their child, which created a way for the family members to interact and share a enjoyable moment in the hospital, without focusing on the medical treatment and the hospital setting.

The music helped the child relax and therefore also gave the parent a possibility to relax (4). On November 9th, the music therapist described her experiences of the impact of music therapy on the caregivers in a specific case description. She was working with a baby girl and the infant's mother. Through the intervention, the mother found a new way to interact with her child. As the child was very restless and constantly crying before and in the beginning of the intervention, the mother had both a stressed and helpless body expression. With music therapy, the child became less stressed and had less tense body language. She did cry from time to time, but not in a continuously hysteric way as initially. The mother became more relaxed (4) as her child became more relaxed. The mother was sitting next to her child, calming down (4) and also started to slowly cry (7) – as the music therapist described as an expression of feeling the possibility to relax. Through the intervention, the mother started participating in the musical interaction and ended up singing and interacting with her child through music (1, 6).

Table 8. *Which impact does music therapy intervention have on the staff/themselves?*

Group	02/11/2017	09/11/2017	23/11/2017
Volunteers	1. able to accompany the PT	1. better interactions	1.PT more communicative (with AC)

	5. helping to come closer to do something fun 12. would prefer MT in the future, affecting my work, "opened a door", helpful	12. would prefer MT in the future, affecting my work, "helped me to better care for the PT, because when they cry you can't work with them", "it lets me work with the other kids"	4. more relaxed 9. helpful during treatments 12. would prefer MT in the future, affecting my work
Medical team	-	4. MT helps a lot, helps me relax 9. it facilitated my work 12. I would prefer MT in the future	5. the intervention is very positive 9. it facilitated my work 12. I would prefer MT in the future
Music therapist			9. provide better treatment for the patient 12. facilitates collaboration

The medical team and volunteers found an impact of music therapy on themselves by providing relaxation (4), enjoyment (5) and helping with patient's collaboration during treatment (9). When asking the volunteers if they found music therapy to affect their work experience, they all answered affirmatively. They found the intervention to open a door, it facilitated their interaction with the patients (1) and helped them to better care for the patients (12). When the patients were more relaxed, the volunteers found it easier to interact, accompany and work with the patients (1). The intervention also gave the volunteers a fun activity (5) with the children. When there were difficulties or painful procedures (9), they found it helpful to ask the music therapist to come along. The music therapist also described a development during the time she worked at the hospital, with the volunteers and the medical team starting to ask her to come and help during medical procedures (12), which provided a better treatment for the patient (9) in her opinion.

The volunteers all responded that they would prefer music therapy in the future. The intervention helped both the children they were working with, and helped them to continue working with other kids in the room (12). When asking the medical team, the secretary did

not find the intervention affecting her work. Her work is not directly interacting with the patients but in the same room as the patients receiving their treatments. The three nurses who interact and work directly with the patients found music therapy to facilitate their work. They described the intervention to be helpful, relaxing (4), positive (5) and all of them, including the secretary, would prefer music therapy in the room in the future (12).

4.1.4 Comparing themes & creating thematic network

With the previous step focusing on looking inside each unit for themes, this step focuses on comparing these themes between the units, by looking for *similarities* and *differences*, as well as *unique descriptions*. The 5th step (*Integrating & interpreting*) continues on page 62.

When looking at the responses across the units, the volunteers described the music therapy intervention to provide enjoyment (5) and relaxation (4) for all the units – patients, environment (11), caregivers and staff. They found music therapy to create a more relaxed environment and as one volunteers expressed a change in the patients and their parents: *"you can see their faces* [are] *more relaxed, they smile and look for the music with their eyes"* and the patients are *"happier and smiling more"*. Many described an impact by music therapy helping the patients to calm down, that *"it changed a lot the children which whom she* [MP] *worked with"*, with one volunteers mentioned *"the little blind girl got much more calmed and was entertained, also a baby, who were the ones that were more stressed and it* [MT] *calmed them"*.

Enjoyment and relaxation were also the themes the medical team described as the impact on the patients and themselves, but did not mention an impact on the caregivers or the environment, although they did notice a positive change on the environment (11). The caregivers described the intervention providing relaxation (4) for the patients, the environment (11) and themselves. They noticed an enjoyment (5) of music therapy in patients and themselves. The music therapist also described music therapy to provide a relaxation (4) and an enjoyment (5) for patients, the environment (11) and caregivers, but did not mention the impact of these three themes on the staff. The music therapist mentioned that *"many expressed joy, that the music activity was fun and enjoyable both for the kids playing and for the ones listening to it"* and that the music had made a positive change on the environment and *"*[MT] *created a fun atmosphere and activity"*.

Additionally, the music therapist mentioned the intervention providing a distraction (3) as *"music is a fun diversion, it is distracting in a good way – from the stressful and boring silence"*. The volunteers found the intervention to have the same impact on patients, environment and caregivers, describing music therapy as catching the patients' attention, getting their mind off the treatment and focusing on something else (3) and that *"it takes them out of that sorrow, preoccupation"*. One volunteer said that *"music makes you forget other sounds, like the machines or the crying, it makes "the hospitalary"* [the hospital feeling] *go away"*. The medical team also described this impact on the patients (3) and the caregivers, saying that it helped both their child and themselves. As one mother said, *"it catches Dylan's* [PT] *attention, he gets distracted, it makes me feel calmed, it clears your mind from whatever you were worrying about"* (3) (4). Neither the medical nor the caregivers mentioned this theme in the impact on the environment or the staff, although the caregivers were not asked about the impact on the staff.

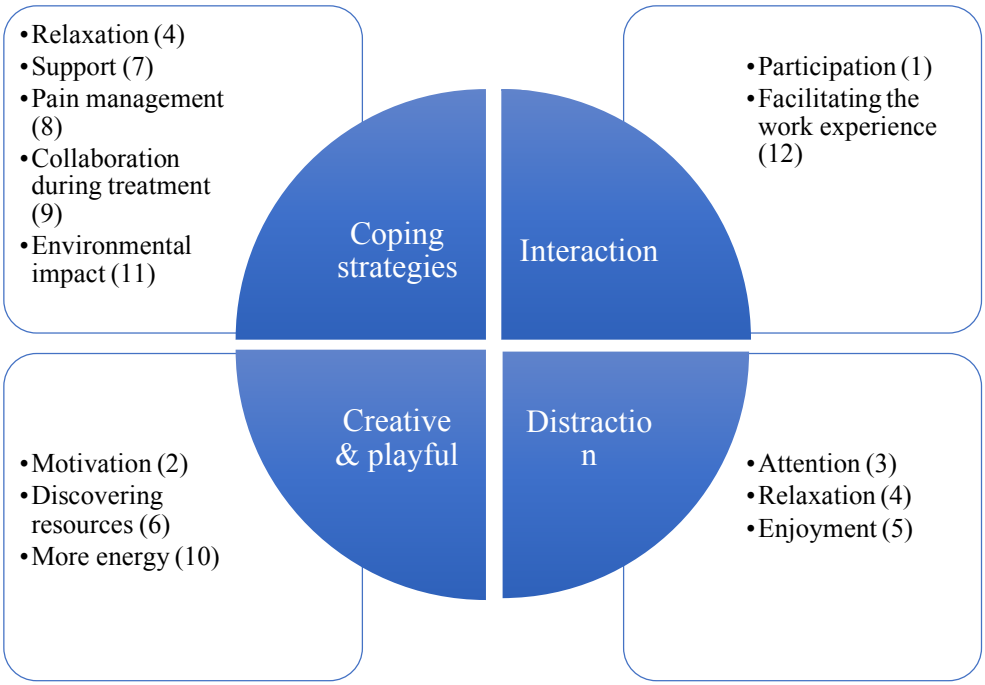
The impact of music therapy intervention on helping the patient during medical procedures, and with the patient's collaboration (9) were described by the volunteers, the medical team and the music therapist. The music therapist described responses from the caregivers and their appreciation of music therapy helping during treatments (9). The volunteers found music therapy helpful to the patients and therefore also to the staff as the patient calmed down, stopped crying or became more interactive which made it is easier for the volunteers to work with the kids (12). As one volunteers said, music therapy *"opened a door"* and another that the intervention *"helped me to care for them* [PT] *better, because when they cry you can't work with them"*. The medical team also said it facilitated their work as the intervention was helpful for the patient and for the patient's collaboration during medical treatment (12). The three caregivers who participated in the data collection did not mention this directly, although the father of Celine said that his daughter was restless from the treatment and during the music therapy intervention she became happy and played with music instruments until the treatment started. He did not mention her reaction during the treatment when the music therapist was working with his daughter.

The volunteers also responded that not only was there an impact on the patient's collaboration during medical procedures, but also an improvement in the interaction between patients and volunteers (1). As volunteers mostly worked with the patients between, and not during, medical procedures, they found the patients to be more participative (1), motivated (2) and

had better interactions with the volunteers during and after the music therapy intervention. One volunteers said that the intervention gave the patients and caregivers something to *"participate in something different and they identify musical skills that otherwise wouldn't always survive* [would go unnoticed]*"* (6). Another volunteer described responses from the patients saying *"they wanted to play the guitar, participate and collaborate"* and that music therapy created more interpersonal relationships, which was not that common in this setting, according to this volunteer. With music therapy, the patients became *"more willing to participate, more willing to talk, uninhibited"*. The caregivers also described the intervention to engage (1) both the patient and themselves. One of the fathers said that in the musical activity, where his daughter was playing the guitar, he saw her *"doing as normal"*, being as she usually is. Several of the volunteers mentioned positive responses from the parents after the intervention saying that many parents expressed joy and pride, and that *"they liked a lot their kids' reactions towards what was happening, they took pictures, videos, you could notice they were happy"*. The music therapist also described a development in patients and caregivers wanting to interact and communicate both verbally and through music (1). She said that through the intervention *"many kids started to talk more, got more energy (waking up) and laughed"* (10) and that *"more kids wanted to play together and wanted an activity"*.

From studying how the interviewees experienced music therapy and describing the impact of music therapy, a connection between these themes, as well as a connection to the needs of the patients, can be drawn. *Figure 6* presents all the themes described by the interviewees and are connected to common needs for this group of patients that can be integrated in the music therapy intervention in this clinical setting. As presented in chapter two, paediatric oncology patients may struggle with isolation and therefore providing possibilities to encourage social engagement and interaction are important. The patients need help to cope with the treatment, side effects, being at the hospital and to get a distraction from this focus is essential. It is also important for both the patient and the family to experience positive moments, to share joyful moments where the child can also experience a feeling of a normal life of a child being playful, creative and discovering resources.

Figure 6. *Connection between music therapy and the needs of the patient*



4.1.5 Integrating & interpreting

This last step of the thematic analysis has the purpose of going from the interviewees' individual descriptions of their experiences with music therapy to a broader understanding of this phenomenon. This step goes back to the first research question of this thesis which this analysis has the purpose of exploring: how can music therapy intervention create meaningful moments and contribute to the patient's treatment in the ambulatory chemotherapy unit for paediatric oncology patients? By asking the interviewees about their experiences of music therapy, I wanted to explore if they saw a reason for integrating music therapy in this clinical setting, and if so, what impacts did they find the intervention to have?

Then, through looking at these questions from four perspectives, i.e., the four units, twelve different ways in which the intervention can have a positive impact were identified. Of these twelve themes, four themes were described by all groups of participants as music therapy having an impact on helping with motivation, shifting attention, relaxation and providing joy to the patient. When looking at the impact of the intervention from all four perspectives, attention, relaxation and enjoyment are the three emergent themes described by all groups of participants. Based on these responses, music therapy can have a positive impact in the treatment of these patients by providing a distraction that helps the patient, as well as the people around, in shifting their focus, to relax and experience an enjoyable moment in the hospital. When looking at the responses from the people working in this setting, music

therapy was described as having a positive impact on them all, facilitating their work experiences in treating the patients. Therefore, they demonstrated a preference for music therapy in the ambulatory unit in the future. An improvement in the environment from the music therapy intervention was described by all participants and this also made a positive impact on themselves. The intervention provided something different in the ambulatory, an enjoyable activity with the possibility to interact and play together, or a moment to relax that can support and help the patients to cope with their time at the hospital.

The emergent themes identified through the thematic analysis are presented in *Figure 7*. When looking at the connection between the twelve themes, they can be connected into ways to work with the needs in this clinical setting. The patients need a distraction, where they can have fun, be creative, playful in an activity that can be a moment for themselves or include inter-personal interactions. A distraction can also be needed to get a moment to relax. The music therapy can in many ways help the patient in coping with the time at the hospital, with e.g., side effects, treatments and waiting time. According to the experiences of the interviewees, music therapy interventions not only have an impact on the patient – with whom the music therapist is working with – but also on the people around and on the atmosphere of the environment. The intervention can be helpful also for those who do not directly interact with the music therapist. People working in the ambulatory unit described the intervention as facilitating them as well and in the treatment of their patients.

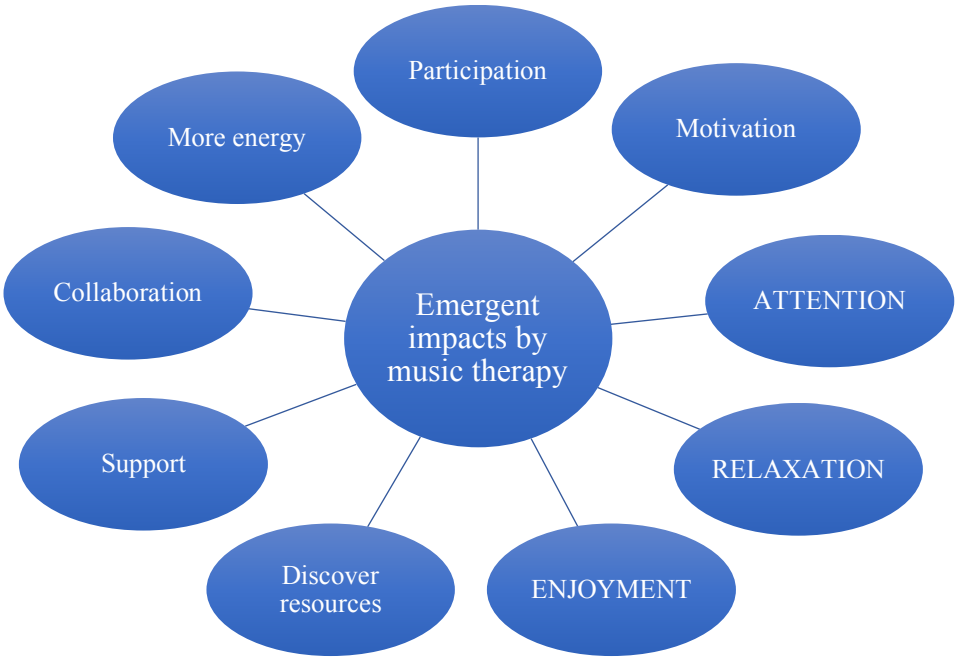


Figure 7. *Emergent themes described as the impacts of music therapy*

According to this analysis, there is a reason for integrating music therapy in this clinical setting. The intervention provides many positive impacts. It is especially interesting to find the strength of this intervention in being very flexible, as this ability is essential in this clinical setting, with many changes and many various needs present. Music therapy can provide a moment to relax or to gain more energy. The intervention can help to shift the attention to an interaction with others or into a moment for one's self. Finally, it is important to highlight that the intervention has an impact on more than that patient the music therapist is interacting with. This is a strength in the intervention, but therefore also important for the music therapist to be aware of what is going on around in the room and observant of impacts of the intervention on the whole environment.

4.2 Heuristic analysis

In this second part of this chapter, I will explore the second research question – how is culture playing a role in music therapy practice – and which considerations are needed in multicultural clinical practice? I am using a heuristic analysis, as described in the previous chapter (*Heuristic analysis 3.3.9*). As this analysis is about subjective description of an experience, I find it relevant to describe my personal experiences in first-person, not as the *music therapist* as I did in the thematic analysis. There are six steps in the heuristic approach as followed:

4.2.1 Initial engagement

I started this process by reflection on my personal experiences of the connection between culture and music therapy. Before going to Peru, I reflected on how to prepare myself for a meeting with a new culture. I wondered about language barriers, as I did not know how to speak Spanish from before. Would it be possible to communicate with someone in English? How would they react to me coming to the hospital as a white, European woman, not being able to speaking Spanish? Would they be open to music therapy? How would I be able to explain or present myself and my purpose at the hospital? Would I be respected, welcomed or the opposite? The whole experience involved so many new things for me, I had no idea what to expect, so I felt that the way to prepare myself was to try to stay open to what would come my way.

During my time in Peru, I wrote with regularity notes, personal description of my experiences, thoughts from discussions with my supervisors in Peru and over Skype with my University in Denmark. After my time in Peru, when starting the process of writing this thesis, I reflected on finding a way to include a perspective on the connection between culture and music therapy. Through drawing a mind-map (see *Figure 8*) on my experiences of cultural influences in my work in Peru, I found the focus for this heuristic analysis to develop into exploring cultural influences that leads to a need for cultural considerations in music therapy. I find this focus to be a relevant and meaningful supplement to the thematic analysis covering how to integrate music therapy in this clinical setting. By looking at my experiences of cultural influences and literature on this topic, I hope to find a broader understanding on cultural considerations needed in the music therapy practice, when working across borders of languages, countries and cultures.

Figure 8. *Mind-map of personal experiences of cultural influences in music therapy*

4.2.2 Immersion

Through the mind-map (*Figure 8*) I started exploring my personal and professional experiences related to the topic based on notes I have written before, during and after my time in Peru.

Finding my role

Exploring the experience from a professional perspective, I first reflected on coming into a new culture, meeting new people and their culture, as well as presenting myself and my cultural background. I wanted to come into the work of *Aprendo Contigo* in a respectful way, seeing how they work, and from that starting point, finding out how I could integrate my work as a music therapist in this setting. Based on my cultural background, taking an approach of slowly finding my place within their frame was a respectful way of coming into a new situation. Due to language barrier, I was not able to verbally communicate that much in the beginning, which meant being more quiet and observant. But it was not until further along into my stay, that I discovered that this was not perceived in as positive way as I had hoped. In Peru I was perceived as being too shy which made my co-workers insecure about me, my role and purpose at the hospital. I found out that I needed to "step it up" when it comes to small-talk and socialisation as these being important factors in this culture, as well as expressed in a different way.

Various expectations

I experienced an important lesson of being professional, presenting a distinct role with integrity and confidence especially as my role at the hospital was unfamiliar to the other staff members. Once it became clearer to my co-workers about me being the music therapist at the hospital, the communication and teamwork became easier. There was still a challenge with experiencing a lot of various expectations about my job from both the staff and myself. This was not only because of language barriers and me not being able to explain music therapy, but also due to the whole new experience for me working as a music therapist in this clinical setting. I needed time to find out *what* and *how* to describe my work. In the beginning, as I was unable to verbally communicate as much as I would have liked I felt a need to be able to show what I could do and why I was there. I quickly realized that I needed to put these expectations aside and "just" focus on the interaction with the patient – which was the purpose of me being there. I soon noticed that once I chose this focus, both myself and others could see my role and purpose of being in this setting.

Music – the primary language

Even as I found my role at the hospital, I recognized that being able to verbally presenting myself and my work was not really an option. Beside language barriers, it was difficult presenting myself in this continuously changing environment of people coming and going. There would be a constant challenge to explain my role as a music therapist. In time, I realized that the music itself presented me, which made the role of music in my work increase. In my meetings with patients, their families and hospital staff, the music was our first language and way of communicating. Though I started learning Spanish when I arrived in Peru, I was surprised to find that English was not an option at the hospital, not even in the use of one English word in a Spanish sentence. Therefore, I had to rely on the music and through this I got to experience the broader possibilities with music as a means for communication than if I would have, had I been able to speak Spanish fluently. Trying to explain what music therapy is was not important. In the uncertain time period, I had with the people in this setting, it was important to create an interaction and focus based on the needs of the patients in that moment. It did not matter if they thought I was a hospital clown, volunteer, "the music lady" or something else, the important thing was that the moment we shared could be meaningful and helpful based on what the patient needed.

Expressions & reactions

When working in a field that requires a connection to one's intuition and inner personal perspective, expressing oneself in a different language is difficult for many reasons. Even if the words might be familiar to me and I might have "a good therapeutic response", my responses might feel inauthentic. Though something may mean the same as I would say in my native language, Swedish, I do not have the same emotional connections to those words in another language. I found that there is an emotional connection to words and expressions and a personal cultural connection to how we react and respond.

This language barrier can also be helpful sometimes, as it creates a distance and helps me to focus on what the patient is sharing without me emotionally reacting to how those words might otherwise affect me. Instead of becoming to personally attached or involved in the therapeutic situation, I am enabled to maintain some added professional stance. On the other hand, not working in one's native language requires a translation process to be happening before responding. Even if this process is not always perceived as a conscious step, it is there and makes a delay in your response to the patient. This delay has been an important

experience for me. Because of language barriers, I have been forced to give myself more time to understand what the patient is expressing and how to react. This "extra" time given to the situation has many times shown to be meaningful and, had the conversation been in my native language, I might have responded "too fast", with less depth of understanding. Under the circumstances I experienced, both me and the patient had an extra measure of time, which was often truly important.

Time

In the Nordic part of Europe and, perhaps, especially among Finns, time is perceived as being quite fixed and non-negotiable. Being a person preferring a more flexible view on time than the "Nordic style", I looked forward to experience the "South American style" as I had expectations of time probably being perceived differently in Peru. Even with those expectations, the experience was different for me. In Peru, when talking about *when* or *at what time* something was to occur, it was a strange combination of a relaxed and stressful attitude, which many times was quite confusing to me. I could not expect things to happen as when discussed and planned something in the Nordic countries. The word for now (*ahora* or *ahorita*) was used for describing when e.g., a medical procedure would take place, when a meeting would be held or end. In Peru *now* could mean "at some time it will happen".

This flexible attitude towards time in relation to the intensive tempo at the hospital, the only solution I could find to keep to time was focusing on right now. In this here-and-now focus with an uncertainty about time, I also needed to give time to the interaction. This meant giving time to the patient to figure out if and what he/she wanted to do in the music activity I provided, as well as giving myself time to find a connection to myself during all the changes happening around me. I noticed that, in some ways, I was acclimating myself to the culture of Peru in the way they communicated, in expressing oneself and with the flexible attitude towards time. Also, I remained connected to my Nordic culture by bringing a calmer, less talkative and more patient side into my role as a music therapist. Admittedly, it was sometimes a challenge to find a balance between those two cultures but also an opportunity to really try different ways of communicating.

Interactions

When looking at the perspective on music, I was interested in finding out how cultural differences would be noticed in music therapy. Would it be a big problem, challenge or

barrier in my interaction with a patient if I was not familiar with a Latin repertoire, not able to sing in Spanish or play instruments in a Latin musical style. Even though these questions kept coming up now and then during my time in Peru, I noticed that in my meeting with a patient, it was more about creating an interaction than demonstrating my musical background or the child presenting his/hers. It was more about a meeting between two people and an interaction of those two peoples' personal cultures creating a shared one in that moment. My most important task was to listen to the patient and being there in that moment together with the child. In that moment, we created *our* music together that became *our* way of communicating, *our* language and *our* culture.

There were cultural influences in the musical expressions, but even though I learned and practiced Latin rhythms to use in music therapy, I also retained my own music style. I found it important to be authentic in my meeting with the patient. This meant for me, in my connection to the patient also having a connection to myself and my own culture. The music I expressed was created from the music of the child with my personal interpretation and influences. Especially when I was using receptive music therapy methods with a patient, I found the music I provided being similar to the improvised music I had used in music therapy sessions in Denmark. Creating music to express emotions and support to was the main focus, rather than creating music within a Latin music style.

Music & emotions

Music is deeply connected to emotions and a way to get in touch with, express and share emotions. That was the beautiful experience of using music in another culture, where barriers of fully knowing another person's language, background, culture or religion mattered less. Music created a connection, a way to interact and share not only that moment but the emotions that arose in that moment. As I had experienced in interactions with people from my cultural background and language, there can be a special connection when being together in music. This connection was wonderful to experience also with in Peru.

Although there were not many common elements in our diverse backgrounds, we could find a connection in music. Since the experience of being at the hospital could be quite difficult for the patient, the connection became a source of strength. With an intensive tempo, various opposed needs and emotions, many changes and noises surfacing at the same time, using words alone to deal with the situation was inadequate. But music could help us with this.

When approaching patients, I presented the instruments I had with me and then let them explore the instrument and how to use it. I then tried to listen and follow the signs and motions of the patient expressing non-verbally, verbally and musically. I knew little of the patient's background, what was going on inside of him/her and what emotions he/she got in touch with during the music moment we shared. But in our interaction, the patient could share expressions, feelings and thoughts. Even without putting words on the things being shared, the interaction could be supportive and helpful for the patient.

To connect

Once I began to discover my role in this work, I sometimes "forgot" that I was from another cultural background or that I might be perceived as exotic. This was especially noticeable in new meetings, as a tall, blond girl with a guitar was a surprising and exotic experience for many. This had both advantages and challenges for the interaction. Some people wanted to interact with me, opened up easily and asked me things about my background, while others became shy or did not know how to interact with me. Children have often a beautiful openness and interest to explore. I experienced that walking around with the guitar helped to create an immediate connection to the kids, both the music and the sight of the guitar caught their attention. They were curious about the instruments that I, or they, were playing.

When I was singing, the child often looked at me. The eye contact strengthened the interaction, though keeping eye contact was not common in this culture or in my own. In Peru, there is easier and more immediate communication and interactions. People talked much more and the tempo can also be higher and more hectic. During medical treatments, however, when the medical team was with the patient, I noticed that interactions between the team and the patient was infrequent. When a patient was alone, without any family member by his/her side, no-one would interact with the kid. When there was a family member present, they would often become involved in the medical treatment and interact with the staff. It was especially in these instances that I tried to stay by the patient's side playing music and/or singing to support the patient. The child would keep eye contact with me for most of the time and sometimes I would also hold the child's hand if possible or caress his/her head. Without me knowing precisely what was going on inside of the child, but through music, eye contact and if possible also a physical contact, music therapy carried the patient through the treatment.

Sharing experiences

Exploring the topic from a personal point of view, I came to think about the need to share experiences at the end of the day. Since I was living in a Spanish environment in Lima, it was a challenge in not being able to share my experiences in my native language, Swedish. My music therapy studies have been in Danish, therefore my supervision on Skype with my Danish supervisor and classmates were in Danish. I am used to describing music therapy in Danish and my only previous experience of working as a music therapist had been working in Danish as well. My identity as a music therapist is in a way connected to Danish, but even so, I missed the possibility of expressing freely my experiences without translating them first unconsciously in my head. Even while expressing myself in English (with some friends in Lima) or Danish, both of which I feel comfortable with, there is nevertheless a translation process happening in my mind. In Spanish, that process was even greater as I only learned and knew few expressions and words.

After reflecting on my experiences, I started looking for literature discussing this topic.

4.2.3 Incubation

During the process of writing this thesis, my reflections have brought me back to this topic frequently, with writing down thoughts that came to my mind and then going back to the other parts of the thesis. This topic has, in this way, been a part of the whole process. After writing down my reflections on my experience, i.e., step 4.2.1 and 4.2.2, I took a break from this analysis in order to allow my reflections to integrate and develop into new broader understanding of the issue.

4.2.4 Illumination

After some time, I returned to my reflections on this topic. I re-read those reflections in step *4.2.2* and wrote down a title for each section to describe the different themes I had come across in my descriptions of my experiences. This step gave me a deeper understanding and highlighted emergent themes describing my experiences with culture and music therapy. These nine themes are here presented in *Figure 9*.

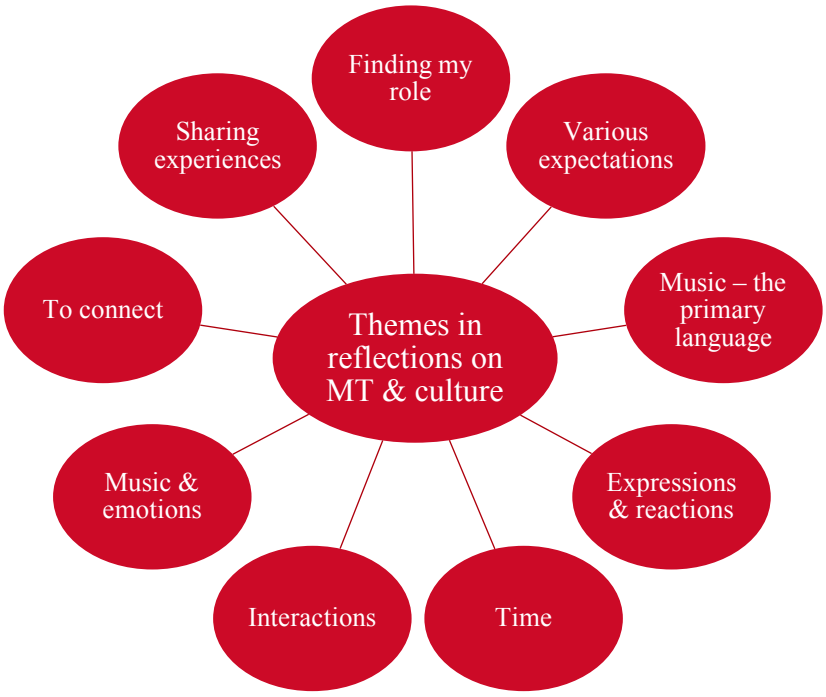


Figure 9. *Themes in personal reflections of music therapy practice in a new culture*

4.2.5 Explication

The next step was to develop a broader understanding of the topic by combining, comparing and contrasting my reflections, with new perspectives that had appeared during this process and inspiration from literature. Reading about the connection between culture and music therapy, the complexity of this relationship was confirmed to me. Music is an important part of culture, as well as the other way around. In the article by Morris (2010) the complexity of the topic as well as the importance of balance between cultural considerations and the spontaneous connectivity of music was highlighted. As the author presents, having a common cultural background might make a communication easier and therefore in meeting with other cultures, cultural considerations are needed. But having a cultural understanding is not enough, both in the case of sharing the same culture or having a different one than the patient. An openness to the culture of the patient is important together with setting assumptions aside and not imposing them on the patient.

As Baines, (2016) highlights, music has many purposes in a person's life and are connected to the identity of the person. As I see therapy to be a personal exploration, I find it important to try and be respectful and open to the cultural background of the patient. Also from the perspective Stige presents (2002) culture is both a personal matter and a phenomenon

connected to and regulated by a group of people. In music therapy, there are meetings of different cultures and new cultures are created in the interactions. With music therapy as culture being a social resource and culture being also a personal description, confirms the complexity of the topic, as well as the connection between culture and music therapy. It is not only a meeting between two cultures, but between two identities having a personal and a social cultural background influencing the interaction and the creation of the culture in this new meeting.

This view is also presented by the description of Pavlicevic (1997) who explains therapy being a mutual meeting where the patient and the therapist create their own musical culture. I found this statement to be a beautiful way of describing the phenomenon. This is also connected to my experiences of the importance of being observant and listening to what is happening in the moment, in the interaction with the patient. It is based on this moment, the *here-and-now*, that I create the interaction together with the patient. Here we bring our two personal cultural backgrounds into a meeting where we create a third, shared culture, as presented by Yehuda (2002).

After reading about Baines's (2016) comparison between music and communication, I began to reflect on the impact it had on my work as I gained more experiences of the culture of Peru during my time in the country. How had I experienced the impact on my work with learning the language, both the verbal and the musical one of Peru? From the idea that Baines (2016) presented of music being, as communication, a culturally derived phenomenon, it is constructed of sounds and its reception is based on understanding this structure. And at the same time, music is a universal phenomenon able to transfer emotions across borders of cultures, countries and languages.

It was affirming to read the study conducted by Laurel J. Trainor (1996) describing musical parameters not as the essentials, but rather the emotions that are communicated through the music. This was what I had experienced in my work in Peru, and reading about it was a form of acknowledgement of my experiences that the patient could feel the support and compassion brought in the music. Music was the means used, not to (only, as in some situations) present our personal cultural background, but to be in that moment together where the needs of the patient were the baseline for our interaction. As Baines (2016) also speaks of the importance of a self-reflection on the therapist’s own sense of culture, I was inspired to reflect more on

my cultural background and its meaning in my work as a music therapist. I wanted curious also to examine my personal experience of the statement by (Morris, 2010) that a shared cultural background might make an interaction easier. When exploring my own cultural background, many aspects to the topic arose. I am a Swedish-speaking Finn, meaning I grew up in a country with two very different cultures existing next to each other. Swedish-speaking Finns are a small minority of Finland, only 5% of the population and while sharing the same language as people of Sweden, those cultures are also quite different.

During my adult life, I have lived in several countries and encountered several cultures. For me this has provided the possibility of examining culture, a personal interest of mine. It has also influenced me in many ways and in the development of my personal culture. In some moments, I feel a connection to my Swedish/Finnish roots, in other situations, I might feel like a stranger in the cultures in Finland. My experiences of and education in music therapy, as well as developing my identity as a music therapist have involved many languages and cultures. My studies have been in Danish, as well as my music therapy sessions in both the role of the client and the therapist. In my experiences, there is a special connection to one's native language, as singing or expressing personal thoughts in Swedish offers a special, personal and emotional connection to these expressions for me. This connects to Yehuda's (2002) statement that when we understand the structures and terms of the music based within a cultural framework, the music becomes more communicative and opens for emotional attachment.

4.2.6 Creative synthesis

This analysis has given a more conscious and disciplined way to explore and better understand my experiences working as a music therapist in a new culture. My aim was to begin this process with describing my reflections on my experiences, openly without analysing (the mind-map). Then, through highlighting significant themes which appeared in my reflections and adding a perspective from relevant literature I had come across, I explored this complex phenomenon of culture and its relation to music therapy. Culture is truly personal and at the same time a phenomenon shared by a group. Culture has an influence on one's identity. In therapy, we are able to get in touch with our truly personal core and it is the therapist responsibility to support, respect and listen to the patient in his/her self-discovery. In every meeting between people, there are many personal aspects influencing and creating a unique culture for each person. It may be obvious to recognize in meetings across borders of

cultures and countries that differences are present, but it is as important to recognise that in meeting within similar cultures that there are cultural considerations. Openness is the key in both instances and the therapist needs to listen to, observe and follow the patient and his/her expressions, putting assumptions aside.

My experiences in Peru revealed that music is a universal language. In music, there is a meeting between personal cultures interacting. When sharing a cultural background, some signs of culture might be unnoticed but they are still there. In meeting across different cultures, some signs might be easier noticed as well as more difficult to read and understand. But what I also experienced, being open to those signs, are the ways that enable interaction across any borders. We might not understand all aspects of the other person's culture or being able to respond in a same way as the other person does or expect, but this does not mean an interaction cannot be created. In music, we can share and express elements that are created from our culture and that we have built in our interaction in music.

Finally, in meeting across cultures there will always be misunderstandings. These can be of various degrees, some more challenging than others, but misunderstandings cannot be avoided. I find that it is important together with being open, to dare to try and not being impeded by fear in meetings across cultures. Respect and considerations are important, but then trying to meet the other person with openness is the most critical. In my experiences, it is when we try that we can learn, and in all interactions, being open to try is the key.

4.3 A summary of the chapter

The outcome of the thematic analysis presents three emergent themes describing music therapy having an impact on *attention*, *enjoyment* and *relaxation*. Between and during medical procedures, music therapy can provide a supportive distraction from the challenging environment. With active and receptive music therapy intervention, relaxation or musical activities can be created helping the child to better cope with the situation. From the heuristic analysis, the importance of self-reflection, cultural sensitivity and the therapist's responsibility to stay open to the patient's personal-cultural-musical background are presented. Music and culture are both personal and phenomenon shared with others, therefore awareness of the therapist's and the patient's cultural background are needed.

CHAPTER FIVE – Evaluation

In this last chapter, I will discuss the main findings from the two analysis, as well as methodical choices, which leads to the conclusion of this thesis.

5.1 Discussion of the impact of music therapy in the ambulatory chemotherapy unit

From the perspective of the needs of the paediatric patients in the ambulatory chemotherapy unit, the first research question focuses on how to integrate music therapy in this clinical setting to contribute to the patient's treatment. Within this intensive and high-tempo clinical setting, there is a need for experiencing meaningful and enjoyable moments, as well as receiving support to cope with the situation. These patients are struggling with two potential traumas, the diagnosis and the treatments. The every-day life of this young person involves uncertainty, stress, painful procedures and side effects. A holistic approach is important when treating the patient, therefore also when integrating music therapy in this setting. This approach involves helping the child to cope with the time at the hospital, between and during medical procedures with the option of focusing on what is going on the *here-and-now* or helping them to shift focus. As presented in the theory chapter, music can regulate attention and arousal in the brain, as well as regulate heart rate, muscle tension and emotional state. Music is directly having a psychological, physical and emotional impact. This was also presented in the Cochrane review (Bradt et al., 2016) with music therapy reducing pain and anxiety in oncology patients, and reducing the need for anaesthetics and analgesics, as well as decreasing duration of hospitalization and time of recovery (ibid.).

When looking at the outcome from the thematic analysis, there were three emergent themes in the interviewees' responses on the impact of music therapy in this setting. Music therapy was found to work as a distraction, shifting the *attention* and proving moments of *enjoyment* and/or *relaxation*. When combining the results of the thematic analysis with the needs of these patients, music therapy can provide a supportive interaction where the child can share and express reflections, thoughts and fears, as well as receiving support to cope with the situation. In the study conducted by Whitehead-Pleaux et al., (2007), music therapy was found to help the patient to better cope with the time at the hospital, between and during unpleasant and painful medical procedures, as well as facilitating the patient's collaboration

during the procedures. Improved collaboration, as well as more participation and interaction were described in the questionnaire-based interviews by both the volunteers and the medical team. This facilitated their work experiences which helped them to better care for the patients. This correspond to the outcome of the studies by Sundar et al (2016) and Whitehead-Pleaux et al., (2007) where the staff expressed that when the patient and the surroundings around the medial procedure are calmer it facilitates the staff in performing the procedures. Aasgaard (2002) highlights that the hospital environment involves patient, family members and staff, therefore the music therapist needs to take the whole perspective into consideration as music therapy has an environmental impact. With music therapy improving the environment and creating a distraction during medical procedures, it can help the patient being less anxious, stressed and feeling less pain (Bradt et al., 2016; Whitehead-Pleaux et al., 2007). This follows the outcome of the thematic analysis, where all participants found music therapy to have a positive impact on the environment. Several participants pointed out that the music therapy intervention did not only help the patient, but also had a positive impact on the others in the room as well as on the environment. Music therapy motivated and inspired others to play along or the music could reach them and provide support, joy and relaxation.

At INEN, music therapy was in many ways a shared experience. Interviewees described both observing and experiencing the joy of music, which was a new and surprising experience in this setting. Enjoyment was an emergent theme in the thematic analysis, with music therapy providing a positive and joyful activity, where focus is shifted from the treatment to an enjoyable interaction. As both found in literature (Wildman, 2010) and in responses in the questionnaire-based interviews, this can be a rare experience for both the patient and the family. Through music therapy the patient can interact in a meaningful and enjoyable moment, either by playing instruments or listening to the music. Between medical procedures, music therapy intervention can provide an activity, where playfulness and creativity can be supported in an interaction with the therapist. The music can also provide a moment for relaxation, a break from the hospital environment, sounds and stress. Tiredness is a common side effect from the treatment. The patient, as well as family members need a break from worrying, being scared, anxious, feeling pain and many emotional reflections. As one mother described music therapy to help her clear her mind from worrying, there is a need for moments to calm down, relax and maybe even to get some sleep. Music therapy can in this way become a meaningful and joyful distraction, that can also help to create a relaxed space for the patient. Music therapy has a strength in being flexible, which is essential in this

clinical setting with many changes and various needs present. The music therapist has to be aware of the surroundings and improvise not only musically, but also according to changes in the environment and in the patient.

5.2 Discussion of cultural considerations in clinical music therapy

Music is often described as the universal language of mankind. Music has a beautiful way of creating a spontaneous connection and bringing people together, despite not sharing a mutual language, culture or background. But as Brown (2002) highlights, even though this description of the ability of music is true, it can also give a false impression that cultural considerations are not needed or that multicultural concerns might not be an issue in music therapy. In my experience, there are cultural influences and differences present in meetings across borders of cultures. But first of all, it is a meeting between two people and although considerations are needed, it is important to use the *here-and-now* focus as a source for the interaction and putting assumptions aside. This connects to Morris (2010) statement of the importance of seeking a balance between cultural considerations and the spontaneous connectivity in music. It is based on that moment that the interaction is being created between the therapist and the patient, bringing two personal cultural backgrounds into a meeting where a third shared culture evolves. This connects to the idea presented by Stige (2002) and Yehuda (2002), that the therapist is not an observer, but just as the patient, bringing his/her own culture into music therapy. The therapy becomes a mutual meeting where the therapist and the patient together create their own musical culture based on that moment and their backgrounds.

Stige (2002) describes music therapy as a cultural engagement – a social resource and a way to work with and strengthen communities as well as individuals. Both music and culture are complex phenomenon, providing a sense of the person's identity and background. Yehuda (2002) describes a connection between these two phenomena, by saying communication is based on learning a system of signs, customs and tendencies, which is unique to every culture and understood after repeatedly experiences, so is also our musical understanding developed. When we understand the structures and terms of the music based within a cultural framework, the music becomes more communicative and opens for emotional attachment. Baines (2016) follows this statement with music being sounds that is a structure of vibrations and these can be universally felt understanding music means knowing these vibration structures in a culture,

which means also knowing that culture. Through acculturation, we learn the structure of the tradition, being e.g., music, languages or cultures. I experienced that when coming into a new culture, I have to take time to learn the way to communicate in that setting. Communication is not only about learning the language, it is also about the non-verbal signs and expressions and the musical language of the culture. There are many things being said, in various ways of which some are more observable to a person of that culture, while other signs are only noticeable to a foreigner.

As Yehuda (2002) describes, culture is both universal and personal, connected to our identity, our view of the world and our ontological and epistemological beliefs. In music therapy, there are much more communicated than by using words. There are many other things being shared and expressed between the therapist and the patient, as well as personal matters the patient becomes in touch with. The therapist has a responsibility to respect and support the patient is his/her process. Openness is truly an important way when meeting a patient, regardless if it is a meeting with a person from the same or a different culture. As all people have their own personal-cultural background, cultural considerations are not only important in music therapy when meeting a patient from another country. When coming into a new country it can be easier sometimes to meet people with an openness, but putting assumptions aside and listening to what the patient is bringing into therapy is equally important in meeting a patient from the same culture as the therapist.

It is important to know one's own culture, as well as similarities and differences to the patient's culture, as these factors influences the situation and the interaction. Knowing and being aware of the patient's culture is also informative, as it can provide a glimpse of how the person experience and react to music. Just as culture is contextual, so is music. Interpretations of culture are both diverse and personal and the cultural differences can be both challenging and enriching for the patient and the therapist. According to Baines (2016) and Foronda (2008), it is important for the therapist to respect, support and keep an openness to the personal-cultural-musical background of the patient, together with an awareness the therapist's own personal background and how it may influence the therapy. When I met the children at the hospital, I also found our cultural differences to be a way for us to interact. It was not *only* a challenge, but a resource of sharing with each other our personal background. This gave the patient some control, contact with their identity – their life and identity beside being a patient at the hospital – and a resource in being able to show and teach someone else.

I also experienced that me being quite exotic for many was a "distraction" in itself. Once a blond girl coming into the room with a guitar (that most kids never seen before) and starting to sing, was all very exotic and distracting from the hospital setting.

During my time in Peru, I tried keeping an awareness of the balance between adjusting to their ways and sticking to my own ways. I needed to stay authentic to myself, especially in working in this field of personal interactions. Silence was one "tool" I wanted to use in my work. I felt that was a "more Nordic" approach, than Peruvian way of communicating. But there is a strength in silence. I needed time to translate both verbal and non-verbal signs and expressions to know how to respond. Therefore, there was more silence than if I would have been able to respond in my native language. But the time within the silence was found to be a powerful equipment in music therapy. With so much going on in the ambulatory unit, with many changes providing a moment where the child could choose the tempo of our interaction was very meaningful and helpful. In a non-verbal interaction, there can be so much said and shared.

With music becoming my first language with these patients, I got to experience the wonderful power of music. Where verbal expressions were not always a possibility, in music it could be possible. Challenges in expressing oneself with words are not only connected to language barriers. It can be difficult to find words to express what is going on inside and the kids did not always want to express with words. Even once I learned more Spanish and started to communicate more with the kids, there was not needed so many words but rather going into the music quite fast was an easier way to interact. I recognized many reflections presented in the interview conducted by Gadberry (2014), where the American music therapist described her experiences from working in Ecuador. Especially, how music facilitated engagement and the role of music increased, as it became her primary language. I agree with her idea of music being a guide for the session and provided a structure, keeping the child's attention, building anticipation and creating playful interactions. In music, emotions being communicated is the primary purpose, not the degree of success of adjusting to or knowing the musical parameters that distinguish a typical musical style.

This is also a truly important experience for the therapeutic process. Even in regularly scheduled therapy sessions, where the therapist will probably meet the patient during a longer period, it is important to be in that moment and in that session. The process is continuing but

cannot be planned out and followed by a step-by-step detailed plan. The therapist needs to meet the patient with an openness and respect and listen to the where the patient is today. But just as in musical interactions, so as well in verbal communication there should be a balance between considerations and spontaneity.

5.3 Discussion of methodical choices

The purpose of this thesis was to gain a deeper understanding on music therapy in this clinical setting. I wanted to hear how others perceived and experienced the interventions – if they saw a reason for music therapy in this setting and if so, which impact did they found the intervention to have? Through questionnaire-based interviews I wanted to explore how they describe their experiences of music therapy. Therefore, the data for this thesis was about those specific interactions that happened those days between those people, which is also an essential part in interpretivist study. It is about the participants' unique descriptions of their experiences and these cannot be generalized beyond the context in which they are discovered. Through this process of analysing the interviewees' descriptions as well as my own experiences, I gained a broader understanding of how music therapy interventions can be experienced in this setting and how people can perceive music therapy. These descriptions are very meaningful to put together with both my own reflections and literature on this topic. Together it creates a broader understanding of the phenomenon. Furthermore, it was inspiring to read the participants' responses, especially since most of them never expressed or shared verbally their experiences with me.

Through both analyses, I have gain a deeper understanding of my role as a music therapist and a deeper understanding of the meaning of the dynamic process. The therapist is not an observer, but music therapy is an interaction between the patient and the therapist, together creating their culture in their interaction. Based on both analysis, I find a purpose for integrating music therapy in this clinical setting. As a new music therapist, it is interesting to hear how others experience what you provide and if they can see a reason for you being there. Through the thematic analysis, there was a deeper understanding both as the therapist providing the intervention back in the fall of 2017 and as a researcher now analysing the data during the spring of 2018. Through the heuristic analysis, I also got to reflect on the cultural perspective that I felt relevant to add in order to better understand the thematic analysis as well.

The chosen data created a focus on integrating music therapy in this setting, in Peru. It would have been wonderful if it would have been possible to conduct another data collection in another culture as well. It would have been a big change in the focus for this thesis, as well as much more data to work with. Although, it would have created a possibility to compare data from different cultures, where it was now a focus on Peru with the perspective of a Nordic music therapist bringing her culture into this country.

5.4 Conclusion

The purpose of this interpretivist study, with a phenomenological and hermeneutic approach, was to explore the music therapy interventions that took place in the ambulatory chemotherapy unit for paediatric oncology patients at the hospital INEN in Lima, Peru during the fall of 2018. This phenomenon was explored based on these research questions:

1. **Based on a thematic analysis of questionnaire-based interviews, how can music therapy create meaningful moments and contribute to the patient's treatment in the ambulatory chemotherapy unit for paediatric oncology patients?**

2. **Based on a heuristic analysis, how is culture playing a role in music therapy practice – and which considerations are needed in multicultural clinical practice?**

Through thematic analysis of questionnaire-based interviews with caregivers, members of the medical team and the volunteers at the hospital, music therapy interventions in this clinical setting was found to have a positive impact on the environment. Music therapy provided a supportive distraction, where the patient's attention could shift into a moment of enjoyment and/or relaxation. The music therapy intervention provided an activity where the child could be motivated, creative and engaged in a supportive interaction, and where family members could be involved as well. The intervention helped the young patient to better cope with the time at the hospital. During medical procedures, music therapy provided support to the patient in which facilitated the patient's collaboration as well as the staff in treating the patient.

The second research question was explored through a heuristic analysis and presented multicultural considerations to be needed, with a perspective both on the personal-cultural background of the patient and of the therapist herself. An awareness of one's own culture as

well as the patient's culture is important. Culture, as music as well, is a complex phenomenon, both personal and shared by a group. Assumptions must be put aside in meeting with a patient, both when sharing a cultural background and in meetings across borders of countries, cultures and languages. Cultural sensitivity is needed and with time more signs can be noticed and learned, which can facilitate communication. But the importance is to meet the person with openness and respect, rather than focusing all on gaining knowledge of the person's cultural background. It is important to find a balance between considerations and the spontaneous connectivity in music therapy.

5.5 New perspectives

This thesis has focused on culture, with both the perspective of a person's personal culture and the one shared with others, e.g., with the same language, ethnicity, region. Discussing cultural considerations, there has still been the overall view of the therapist coming into a new culture, meeting people living in their country where they know the language. It would be interesting to look at this from another perspective – if the patient would come into a new country, with an unfamiliar culture and language, how would culture influence the music therapy interaction and therapeutic process? Within this focus, it would also be interesting to continue exploring the connection between music therapy and culture, when addressing culture in the therapeutic process of working with existential subjects and identity as a theme. How would the patient experience being in music therapy, where e.g., the language spoken in the session would not be the patient's native language. This would be interesting and relevant to further explore as our society become more multicultural, especially with immigrants and refugees needing to find a safe and supportive environment in their new country.

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