

ARTICLE

Music therapy and spiritual care: Music as spiritual support in a hospital environment

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ABSTRACT

This paper is a personal essay that offers reflection on professional experiences of music therapy practice with a focus on emotional and spiritual care in the hospital context in Australia. There is a growing need to map the terrain of music therapy in relation to spirituality. Music can deepen spiritual experiences and holds broad potential for addressing ‘the spiritual’ across contexts. Music therapy within a pastoral care context is considered, with spiritual and emotional support as the primary focus. After a brief discussion of spirituality in the music therapy literature, a context and background is provided for the establishment of a music therapy program within the pastoral care department of a regional hospital. Examples of ‘the spiritual’ in patient responses to music therapy are discussed. Professional challenges surrounding a more direct recognition of a spiritual aspect to music therapy are explored. Vignettes from clinical experiences across two different hospital settings are shared with reflection on the place of spirituality in the author’s practice. Practice-based experiences are considered against existing notions of spirituality in the music therapy literature, to see what they may offer in mapping this field. The relationship between body, mind and spirit is briefly explored, with a reflection on the position of spirituality in relation to health and culture.

KEYWORDS

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INTRODUCTION

In this article I argue for the relevance of spirituality to music therapy practice, and that music therapy is inherently spiritual in nature. This argument draws from my music therapy training and a little over six years’ clinical practice as a music therapist in the pastoral care department of a regional hospital in Australia.

Although music therapists bracket out spiritual values and beliefs, those we work with perceive and respond to a deeper dimension that we access and share in and through music, as “the human propensity to use music for transcendent purposes is not rendered inactive just because it may not

be an overt clinical focus of music therapists" (Aigen, 2008, p. 30). A broad music therapy training does not necessarily equip us to deal with the full depth of existential connection that can occur in music therapy or to be comfortable working with 'the spiritual' in all its manifestations.

Music therapy discourse has sharpened its focus on the spiritual aspect of the work with calls to 'map' the terrain of music therapy in relation to spirituality (Tsirir, 2017). At the ground-breaking 10th World Congress of Music Therapy (Oxford, England) in 2002, where community music therapy was a prominent topic of discussion (Stige, 2002a), '*Music, Spirituality and Healing*' was also a key topic, bringing to the table this tentatively emerging aspect of music therapy. Although the 'most controversial' topic presented (Bunt, in Wheeler, 2012), it elicited a significant response. Mayne's (2002) inspirational keynote had 'opened the door' (Amir, 2002) to new conversations about a spiritual dimension in music therapy. Fifteen years after the World Congress, the conference '*Exploring the spiritual in music: Interdisciplinary dialogues in music, wellbeing and education*', which was held in London in December 2017, was an opportunity to grapple with this unfolding discourse (Tsirir, Ansdell, Spiro & Coggins, 2017).

When attempting to construct a map, it is important to consider that maps are "never value-free" (Harley, 2002, p. 53) and there is an undeniable link with power in constructing one. A map is often designed with a particular audience or user in mind and so the question arises – who is the map for? A key aspect of mapping is map projection, the process of transferring three-dimensional relationships across the surface of a sphere onto a two-dimensional plane. In this process, some spatial properties are preserved, while others are sacrificed, as moving from a sphere to a flat surface will necessitate a level of distortion. This seems pertinent when seeking to capture 'the spiritual' in music therapy, as it reaches the less tangible and more mysterious dimensions of existence. As we attempt to make the intangible accessible through tangible means we need to consider what compromises we are making in translation and what are the limitations of our representation.

DEFINING 'SPIRITUALITY'

There is complexity around defining spirituality within music therapy literature, as Potvin and Argue (2014) have already identified, with 'spirituality' being seen as:

- Transcendence
- Connectedness, relationship and unity (self, others and/or higher power)
- Sense of meaning
- Sense of hope
- Soul and spirit
- Altered states of consciousness

Tsirir (2017) compares different notions of spirituality as "an inherent component of individual and collective human existence", one that is "intangible and multidimensional", with other views that spirituality relates to "quest for truth [...] values [...] worldviews" (p. 2). He argues against reducing the concept of spirituality to a single definition, seeing spirituality as "an open space [...] a floating

concept” that “comes into being in and through relations” (p. 5), drawing from Cobussen’s (2008) sense of ‘inbetweenness’ to describe where spirituality exists (Tsirir, 2017, p. 5).

Certainly an expansive, rather than limiting, understanding of spirituality is desirable to encompass the diversity that this entails across beliefs and traditions. Considered as a liminal space, spirituality exists beyond more usual, clearly defined spaces. In the hospital, people find themselves in transition, with a lot of waiting and uncertainty. They exist in between what was and what is yet to come – also a liminal space. It is no wonder that many find themselves searching for meaning in this space. Music “has the possibility of creating a liminal space” and “takes us out of everyday consciousness” (Boyce-Tillman, 2009, p. 188). My clinical experiences support this.

This article considers music therapy within a pastoral care context. Spirituality is defined within the field of pastoral care, which focuses primarily on emotional and spiritual support of the person. Spirituality is, according to Spiritual Health Victoria¹:

a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices. (Pulchalski, Vitillo, Hull & Reller, 2014, p. 646)

I established a music therapy programme within the pastoral care² department of one of the hospitals described below. Music therapy was seen to have the potential to meet the kinds of spiritual needs described above (Pulchalski et al., 2014).

CONTEXT AND BACKGROUND FOR ESTABLISHING MUSIC THERAPY IN PASTORAL CARE

I began negotiating the possibility of a music therapy programme at a Catholic hospital in regional Victoria, Australia, in 2011. The Catholic ethos of holistic care was embraced, with the spiritual dimension of each patient seen as contributing to overall healing and health. At the time I approached this particular hospital there had never been a music therapy programme or music therapist. We were treading new ground.

I walked into the hospital to volunteer my services, initially offering to trial music therapy on the rehabilitation ward by offering a weekly one-hour group singing session. After the agreed trial period was completed, there was no funding to continue, though the programme was well-received by patients and staff. I remained a presence at the hospital on a monthly basis, playing in the general public spaces around the hospital voluntarily. I came to the attention of the pastoral care

¹ Spiritual Health Victoria is the peak body for the provision of spiritual care in health service settings in Victoria, Australia.

² In Australia, pastoral care is differentiated from ‘chaplaincy’ or ‘ministry’. Pastoral practitioners and associates do not ‘represent’ a particular religion but rather, they are present for others in offering spiritual and emotional support, having undergone an intense training process that helps each person to understand and bracket their own perspective and gain insight into how this may affect their support of others.

coordinator³, who recognised that something more than musical performance was occurring. She noted I was interacting and engaging with people as I played, listening to them, offering encouragement. This intentional use of music was having an impact. I was offered casual work, individual sessions of music therapy, and I was to recommence the group session on the rehabilitation ward.

At the hospital I wanted to encourage creativity and create opportunities for freedom that deeply respected each person, holding them in 'unconditional positive regard' (Rogers, 1942). My approach aligned strongly with Aasgaard's (1998, 2001) 'milieu', or music environmental therapy, in my aim to help patients triumph over the restrictive hospital environment they found themselves in, reclaim who they were and 'overturn' conventional expectations. I saw creative expression and freedom in this and felt I could subtly impact the environment itself using music.

In Australia, many music therapists have a flexible and eclectic approach to practice. This is the result of needing to work in various contexts, often as freelance music therapists, generating work by going out and finding the need in the community itself. Music therapy in Australia still struggles for professional recognition, and music therapists have to continually advocate for their role and the value of what they offer (Lehmann & Threlfall, 2018). We are still striving to be accepted as mainstream health providers. Music therapy is not currently included in the National Registration and Accreditation Scheme for health professions (NRAS)⁴, and is therefore not accessible via the national Medicare system, though recognised as a self-regulated allied health profession.

It is understandable that music therapists who have managed to find reasonably secure positions within health care and other institutional contexts are keen to hold on to these, framing their work in a way that meets the overarching model and expectations of those who have the power to support or discontinue their programmes. This allows continued access to music therapy. There have been innovations and a changing culture in health through greater openness to the notion of holistic care, but compromises still need to be made by music therapists to accommodate the directives of the 'hands that feed us'. Often this means conforming to a more functional approach, one that 'ticks boxes' or meets key performance indicators.

If we consider music therapy pioneers like Paul Nordoff and Clive Robbins, a strong sense of adventure and exploration permeates their work (Simpson, 2009) with emancipatory and creative concerns prioritised over pragmatic ones. Nordoff and Robbins showed a courage that "made them abandon their previously well-established careers and enter unknown territory" (Kim, 2004, p. 335). It is this adventurous, creative spirit that fuels music therapy as a unique and meaningful profession amidst practical, real-world considerations. It is important music therapists stay connected to the essence of this as we navigate the practicalities of our profession.

³ I reflect that the openness of this coordinator and her personal appreciation for music was a contributing factor in developing the programme.

⁴ The NRAS includes chiropractic, occupational therapy, optometry, osteopathy, pharmacy, physiotherapy, podiatry, psychology and, since 2012, acupuncture (Allied Health Professions, Australia, 2018; Australian Acupuncture and Chinese Medicine Association, 2018).

RESPONSES TO MUSIC THERAPY – A SPIRITUAL DIMENSION

At the particular hospital described above, with the support of pastoral care, an eight-week evaluation of music therapy took place on each of the rehabilitation and medical wards, with music therapy offered to patients in their rooms. As the data⁵ forms part of an internal, confidential document, a detailed account of results is not given here. Instead, I reflect on spontaneous responses from those included in the evaluation and anecdotal feedback from staff and the patients who received music therapy at this time, taken from my personal clinical journal. These showed a distinctly spiritual dimension. I have summarised these under broad theme headings.

Patients communicated that:

- i) *Aesthetic qualities of the music afforded experiences of 'beauty'*: De Nora's (2000) application of the term 'affordance' refers to music as an object that can offer or 'afford' certain possibilities. Whether or not these are taken up or appropriated depends on various factors. A music therapist has some agency to impact this. A musical experience was offered, and from this patients derived an experience of beauty. Hearing music reminded patients of their own love of music. They used words like 'intriguing', 'beautiful' and 'soothing' to describe the experience. Some likened the sounds they heard to those found in nature – 'water trickling over stones' for example.
- ii) *Music therapy meaningfully supported the passing of life*: In moments of dying, some families, aware of music on the ward, invited me into the room to play a favourite song for their loved one, referring to these moments as 'very special time' shared together. Some communicated (through letters or emails) that music therapy experiences provided a bridge between saying goodbye at the hospital and honouring their loved one at a funeral service, where the same song was played again.
- iii) *Music therapy afforded hope*: Music therapy brought a sense of hope to some patients who were discouraged, providing 'beautiful music' unexpectedly at a time when they 'really needed it'. Sometimes this sense of hope and the spontaneous timing of visits connected with their personal belief in God or something beyond themselves and their sense that they were being provided for.
- iv) *Music therapy created a space for the appropriate expression of sadness*: Music connected deeply with people's emotions, with meaningful music allowing patients to explore sadness. Often, patients expressed this was 'a good sadness'.
- v) *Music therapy afforded experiences of peace, joy and happiness*: Patients who had expressed sadness through their musical experiences commented that they felt 'happier and more peaceful'. For some, music therapy alleviated their sense of being 'stuck' in hospital, helped them cope and brought 'joy and happiness' into their lives at this time.

Staff offered that patients seemed "much brighter in spirit" after music therapy; the ward "more peaceful". Despite responses of patients showing a distinct spiritual component, I was uncertain about representing this spiritual aspect of the work. At this point I did not know if music therapy

⁵ Data included a pre-post session tick sheet designed by the author to measure six mood states and patients' perceptions of pain. (Five female and 11 male patients participated in the formal evaluation). Results were encouraging and were used to argue the case for funding the music therapy programme. Funding was eventually granted to maintain a permanent music therapy position.

would remain connected to pastoral care, gravitate towards allied health⁶ or receive independent funding.

There was a sense that this spiritual dimension should not be overtly acknowledged as this may be perceived as unprofessional. Though I am deeply connected to spiritual practice in my own life, I had not yet trained as a pastoral associate and did not feel comfortable with discussing the spiritual depth of the work. At around this time I completed a course in neurologic music therapy, initially thinking music therapy would gain greater acceptance on rehabilitation with this more functional approach.

ACKNOWLEDGING THE SPIRITUAL IN MUSIC THERAPY: CHALLENGES

The hesitancy to explore spirituality in music therapy is not without reason. Survival as a legitimate profession (Erkkilä, cited in Stige, 2003) and music therapy's alignment with evidence-based practice in the medical model (Aigen, 2015) forms a tension with the desire to explore spirituality as an integral aspect of our work. Tsiris (2017) names some authors (Abrams, 2013; Aldridge, 2000; Bonny, 2001; Lee, 1995; Magill, 2002; Potvin & Argue, 2014; Shrubsole, 2010) who continue to bring 'the spiritual' to the forefront and there are others who have contributed (Aigen, 2001; Amir, 1993, 2002; Lipe, 2002; McClean, Bunt & Daykin, 2012; Salmon, 2001). Is the broad inclusion of a spiritual aspect to music therapy, considered with other movements towards expansion beyond clinical and institutional contexts (Schwabe & Haase, 1998; Stige, 2002a, 2002b, 2003) just going to create too much of a 'mess' and undermine the legitimacy of music therapy, especially in institutional health contexts? What is this mess exactly? Aigen (2015) identifies that music therapy, in order to establish itself, has often developed towards a scientific, medical model (especially in health care) as this "held the key" to acceptance (p. 3), and therefore music therapy research was "guided more by pragmatic commercial concerns than by a pure desire to learn more about...music therapy processes" (p. 3). Aigen purports that the "philosophical assumptions" of the medical model actually conflict with creative and improvisational approaches in music therapy (p. 2) and observes (Aigen, 2007) "fundamental areas of tension" related to music therapy as "a health-promoting discipline that takes place through an art form" (p. 112). Music therapy in the Australian context has often put forward a more functional, clearly measurable 'face'. Less tangible aspects of the work (the more intuitive, creative, transcendent, aesthetic, sensed, internal or spiritual) are toned down so that professionalism and validity, according to the overarching model, is not compromised.

Less tangible aspects, present in music itself, are also present in the work. There is, for example, a strong connection between aesthetic musical experience and religious experience (Aigen, 2008). The 'mess' relates in part to music therapy changing tack by now openly and more broadly acknowledging the intuitive, creative, transcendent, aesthetic, sensed, internal and spiritual in the work and making more substantial claims in this area. This brings music therapy into territory that overlaps with pastoral care, especially where there is an overarching 'holistic care' model. In my experience, the presence of music therapy in this space is valid. My work as a music therapist was often deeper and more transformative spiritually and emotionally than what I was able to offer as a

⁶ Music therapy is considered an allied health discipline and is typically located within the allied health department in an Australian hospital setting.

newly trained pastoral associate in the same context. (I currently hold a dual qualification as a pastoral associate.) This is an area of practice ripe for development and collaboration.

Another element in the potential 'mess' is the further broadening of the identity of the music therapist. Given the impact of culture-centred (Stige, 2002a) and community music therapy approaches (Stige, 2002b, 2003; see also Aarø & Stige, 2012; Aasgaard, 2004; Ansdell & Pavlicevic, 2004) and their expansion of the identity and boundaries of our profession⁷, how will music therapy consolidate its professional identity if also moving into the realm of spirituality more directly?

VIGNETTES FROM CLINICAL PRACTICE

The first vignette comes from a pertinent moment in my music therapy training. The setting was a Catholic hospice in an inner suburb of Melbourne.

Vignette 1 – 1000 Paper Cranes

'Daniel'⁸, a man in his 50s, was actively dying. I walked past his room noticing he was uncomfortable. Loud music was on the radio with lots of crackling. I walked in, uncertain what to do. Had he tried to turn the radio off or knocked it? He was tangled up in the radio cord. He looked like he was 'falling' and trying to hold onto the bed.

'Hello, Daniel. My name's Astrid...it seems like this radio is a bit loud? I'm just going to turn it off for a bit'. I untangled the cord, placing it out of the way. There was less tension in Daniel's face. I turned to go, not sure he wanted music. I stood in the doorway, but something stopped me leaving. Should I stay? I wasn't sure...I turned back around: 'I'm not sure if this is what you want, Daniel, but...' ...I offered to play 'just one song', to be a human presence after his being tangled up with the radio. I felt he could hear me.

A song came to mind. I played the song lightly, rather than drawing Daniel into a relaxed state, it seemed like he needed to 'hold on', to stay alert to some degree. I used a slow jazzy style, keeping the rhythm sprightly but sang and played softly. I played 'Over the Rainbow' by his bedside, improvising a large cardboard box in one corner of the room as a table to rest a music folder on, as this was a spontaneous visit and I did not have a stand.

Outside the window, a car pulled up erratically in the car park. A worried-looking woman got out and walked across to the hospice. I got a strong sense she was here to see Daniel, though I'd never seen her before. After a few minutes she entered the room – it was Daniel's wife. Daniel seemed calmer after the song and aware his wife was there. I explained how I found Daniel and that I'd sung a song to calm him. She asked, 'Is that your box?'. I told her no. She opened it. Inside were many folded coloured paper cranes. One of the nurses said it had been dropped off for Daniel. It was from his students to let Daniel know they were thinking of him.

⁷ Which this author embraces.

⁸ Patients' real names are disguised in the vignettes.

About 15 minutes later, after leaving Daniel and his wife together, the nurses were called to the room. Daniel had just passed away.

The second vignette comes from an experience in the regional hospital where I had begun to establish a music therapy programme. The programme by this stage had aligned itself with pastoral care and I was seeing an increasing number of palliative patients.

Vignette 2 - The Northern Lights

Magnus, a patient with a Scottish background had become suddenly unwell and was now palliative. Nurses were hoping his wife would make it back from a trip overseas in time to be with him. Magnus heard me on the ward and requested a visit. He agreed to my playing Scottish songs, joking my accent was 'not Scottish enough'. He requested a particular song. I said I would find the words and come back to sing it for him (in my best Scottish accent).

I didn't see Magnus again that day and didn't work again until later that week. When I drove past the hospital on my days off, I sensed he may be close to dying and determined to return first thing with the song he'd asked for. When I arrived at work the next day, I was informed Magnus had passed away overnight. His wife hadn't made it back in time. His adult daughter had arrived early that morning. I was encouraged by staff to make contact with her... I tentatively knocked and walked into Magnus' room. His daughter was sitting next to where he lay on the bed, weeping. She welcomed me. I mentioned Magnus' request for the song. His daughter accepted my offer to sing it.

The song was from the place where Magnus had grown up. The words reflected on the singer's childhood, his mother showing him the Northern Lights and stating how they felt like 'home'. Magnus' daughter wept as I sang and hugged me afterwards.

Although I initially felt like I'd failed him, I later came to see that although the song did not serve Magnus himself it was a meaningful message for his daughter after his passing. Through the timing of events I was the bearer of this message. I later sang this and other songs he had requested at a service organised by his wife. She expressed this provided a much-needed sense of connection for her, being unable to be there during his last hours. Magnus' daughter was from a previous marriage and was not at this service. The song Magnus requested connected with both his wife and daughter, even though this occurred separately.

OPENNESS TO THE SPONTANEOUS AND THE UNIQUE TIMING OF EVENTS

In both of these examples, sacred moments were co-created by remaining open and responsive to the unique timing of events. This is something beyond our control but we can accept what 'is' and work with it to bring a sense of meaning. Often meaning is found in perceived failures and the

messiness of circumstances. A sense of not knowing, working with intuition, embracing paradox, and mystery (MacKian, 2012, 2019) also play a part here. This connects with aspects of my own spirituality and approach to life, which are based on the Catholic faith. It also connects with music therapy as music is intuitive, spontaneous and mysterious, and music therapists frequently use intuition and sensing to navigate moments of uncertainty. I propose that some key strengths of music therapy in supporting spirituality also include accepting the moment, working with imperfection, transcending barriers and transforming perceived failures. Openness to the intuitive and a sense of being 'led' through listening deeply allows us to respond to unfolding circumstances, working with these in the moment with a sense of 'wonder'. This draws us towards transcendence where we experience "connections to things 'higher' or beyond everyday life" (Ansdell, 2016, p. 252).

The vignettes highlight an approach that I believe is integral to music therapy as spiritual support – openness to the spontaneous and the unique timing of events. Many times I seem to have been 'in the right place at the right time'. This has been due to various factors - intuition, keen observation, working with circumstances and resources available at the time.

I wondered what my role had been, why had I felt the urge to stay and offer Daniel music in the '1000 Paper Cranes' vignette described above? It seemed like I stepped into that moment to help 'hold' Daniel until his wife could be there. He was waiting for her. There was a sense of beauty in the timing of being there to calm and reassure Daniel after the harshness of the blaring radio, offering something else in his last moments. My improvised use of the box in a corner of the room highlighted its existence, causing Daniel's wife to open it, just moments before Daniel's life came to a close, revealing a gesture of love and symbol of peace and healing offered by his students.

The third vignette below relates to a referral for a patient on the medical ward in the regional hospital context. This patient's chronic health condition caused her to struggle with breathing at times. She was considered 'difficult' as she was agitated and frustrated by hospital processes and was very vocal about this. She had few visitors and seemed stressed. Nursing staff wanted to try 'something different' that may connect with and help this patient.

Vignette 3 - Jerusalem Chant

When I first met Beatrix it was just after breakfast. I introduced myself, but before I could go any further Beatrix, already frustrated by the day's events, began to express these frustrations with great verbal facility. I stood and listened as actively as I could. She was pleased when I guessed sometime later in the conversation that she was a writer. She was curious about music therapy and agreed to my returning.

Beatrix had been in choirs before and enjoyed singing in our sessions. She was proactive, often breaking into various songs and asking if I knew them. I would follow as best I could or source the music.

Often these were pieces from the classical repertoire. When she felt too unwell, and singing was difficult, Beatrix allowed me to offer music for her as she rested, but it wasn't until I revealed my own vulnerability that some of the most powerful moments in music therapy occurred.

Beatrix had become seriously unwell and was now declared to be 'on a palliative pathway'⁹. She had requested the song 'The Holy City'¹⁰ as it reminded her of choir-singing during her earlier life in England. I called in towards the end of a particular day as dinner was arriving. Beatrix had ordered a wine to enjoy with her meal. She wanted me to stay and help her enjoy the sense of 'living it up'. She asked if I'd found the music for 'The Holy City' yet.

I had it, but had not yet looked over it. Whatever my level of preparedness, I recognised that this may be the only moment I would have to play it when Beatrix would be able to enjoy it. I offered to 'give it a go'. I then launched into a truly awful rendition, messing up the piano part, losing a sense of the main vocal melody, flashing red in embarrassment but holding on desperately to honour Beatrix with this music. She seemed to sense this act of dedication and was also amused by my desperation. One of the ward's volunteers, hearing some fragment of the song they knew entered the room and proceeded to sing the chorus with me. Beatrix, amidst fits of laughter joined in at times. Arms around shoulders, we three stood at the keyboard, unified in our determination to stay on this ship until it sank and we finished the song.

It was from this moment that Beatrix began to reveal a deeper aspect of her self. Over subsequent sessions she shared quite unexpectedly that she had become a Buddhist as a young woman. She spoke about dreams that she'd had in relation to this and the sense of meaning she drew from them. She shared with me some of the chants she knew and spoke of the plans she had in place for a Buddhist burial, trusting me with lively discussions about the Buddhist versus Catholic perspective (the overarching ethos of the hospital she now found herself in). Her awareness I was also Catholic (she had asked me about this) seemed secondary to her sense that I would listen to and accept her perspective. The humorous moments we'd shared also contributed to this trust. If she tried to seek my personal perspective I would redirect things back towards Beatrix. On increasingly rare days when she was determined to walk down to the hospital's coffee shop for an outing, Beatrix would call in to the pastoral care office nearby and invite me to come and sit with her to talk.

The act of trying to offer my best for Beatrix (and failing on certain levels) seemed to resonate with a sense of the imperfection of life itself, and finding meaning in this. This has a particular potency during the time of dying. Something in my show of vulnerability and imperfection mirrored life itself, that it is possible to come to acceptance, to experience joy and connection, even amidst imperfection and disappointment.

⁹ Meaning no further active medical treatment would take place, but rather a management of the patient's condition to keep them comfortable physically and maximise their quality of life (this may include continuing some treatments if the patient chose to do so). Patients would also be connected with other services like pastoral care, for emotional and spiritual support.

¹⁰ This music also contains the cry 'Jerusalem!...', hence the title for this vignette.

Working with vulnerability and strength

As music therapists we acknowledge the importance of vulnerability. Often there is first a need to establish confidence in one's reliability, musical skill and therapeutic presence, but the therapist's willingness to show vulnerability mirrors something the patient may be experiencing and creates a point of human connection. The patient may keenly feel their own vulnerability, even if there is a layer of bravado covering this. Seeing the therapist as both strong and vulnerable makes strength seem more of a possibility and vulnerability a normal part of existence¹¹.

This is particularly powerful in the hospital context, where the general *modus operandi* for staff is to show how capable, efficient and professional they are. The wonder of music is that we can still convey a sense of beauty through our musicality even if things are not 'perfect'. Playing music requires us to be emotionally vulnerable. This promotes authenticity and encourages acceptance.

The dance in the therapeutic relationship between vulnerability and strength holds enormous potential to mobilise the patient's inner resources and bring healing. The skill of the therapist lies in ascertaining when it will be most advantageous to offer strength or vulnerability in the therapeutic process. When the therapist reveals both strength and vulnerability it creates a space for the patient to also reveal and explore these qualities.

The use of music acts powerfully within this dance. Many times I have first shown vulnerability – getting the day wrong, tripping over something. I often have to overcome an intense shyness and awkwardness I feel. Moments later I might improvise music that finds an aesthetic space people describe to me as “powerful”, “transcendent” or “beautiful”. There are times as therapist that I have a personal need to draw from the strength I find in music itself so that I can remain in situations of intense pain and suffering.

The therapeutic relationship is central: “the relationship *is* in fact the therapeutic event” (Pavlicevic, 1997, p. 140). Initially the patient is highly vulnerable, they think the therapist is there to ‘do’, in a more functional sense, as so many others are in the hospital setting. Being the vulnerable one, the one receiving these ‘things done’ is disempowering. Eventually, particularly with spiritual and emotional care as a primary focus of the work, it becomes apparent that the music therapist is there to ‘be’ and to be present, openly offering music as a “container”, a “sacred space” (Salmon, 2001, p. 142) for the patient to explore themselves, or experience aesthetic or spiritual dimensions of their being.

The author agrees with Salmon's (2001, p. 142) sense that we create this “containing space” in music therapy broadly through the therapeutic relationship between patient, therapist and music, even when our overt focus is not spiritual (Aigen, 2008). There is, however, a particular potency to working with vulnerability when people are very unwell or palliative as this resonates strongly with our vulnerable condition as human beings and life's overall meaning, at a time when spirituality also becomes prominent. This need not remain exclusively in the domain of ‘end of life’ experience. There is huge potential for music therapy as spiritual support across the health and life journey.

¹¹ The importance of vulnerability has been a topic of research in other fields, like social work (Brown, 2010, 2013a, 2013b).

MAPPING THE TERRAIN – WHAT DO THESE SPIRITUAL EXPERIENCES OFFER?

If we return here to Potvin and Argue's (2014, pp. 118-119) summary of the various meanings of spirituality across the music therapy literature (listed previously), what do the vignettes I have offered contribute towards 'mapping the terrain' of a spiritual aspect that is present in music therapy? The experiences captured resonate to varying degrees, particularly with the first five meanings of spirituality offered as a summary of the literature by these authors. Although there is not space here to explore these to a satisfying level there is a sense that the experiences shared here affirm the categories mentioned. I would also include the words 'beauty' and 'sacred', perhaps as 'sense of beauty' and 'sense of the sacred', as these seem present through the vignettes given.

For Daniel, an unfolding of events brought to a close a story that I was only partially aware of. The timing of events was key and, as someone present in this space at this time, I felt both the gravity and beauty of circumstances. Although Magnus' circumstances were different, there was also this sense of sacredness and beauty in the unfolding of the timing of events, that I only later came to understand and appreciate. For Beatrix, the experience of beauty was of a more rugged kind, but nonetheless still beautiful in the way that frustration, imperfection, vulnerability and humour were all part of the journey towards self-acceptance, trust and a willingness to share sacred personal and deeply held beliefs. Music and the therapeutic relationship underpinned and contributed to activating this unfolding.

The examples given might also offer aspects of what it looks like to be 'spiritual' in practice as a music therapist. There is a sense of the 'dynamic' (Pulchalski et al., 2014) in the work that relates to something beyond self and is connected to timing and circumstances. Music therapy, that focuses on spiritual support, involves: being led; intuition; vulnerability; spontaneity and flexibility; openness to, and acceptance of, unfolding circumstances; trust; embracing paradox and mystery.

With regards to the last point (embracing paradox and mystery), we do not know the reasons for the way events sometimes unfold. Sometimes they just do not make sense, but there needs to also be a trusting that when circumstances present opportunities, or barriers we have no control over, we need to remain alert and willing to play a part in supporting a story we may not know the beginnings (or later fruits) of. In this there is a sense of mystery and wonder.

HOLISTIC CARE: BODY, MIND AND SPIRIT

The idea of holistic care has gained some traction in Australia, even outside religious-based institutions. A search on the national Department of Health website shows some 3,029 documents containing the term 'holistic care' across mental health, aged care, indigenous health and youth health services (Australian Government Department of Health, 2018).

A music therapist offering spiritual and emotional care in a hospital needs to have a sense of the relationship between body, mind and spirit. The relationship may seem to be about equanimity, balance and symmetry – but is that real? Viewing health as a continuum, we can expect to be challenged across each of these aspects (body – mind – spirit) in our lifetime, through the

continuous backward and forward journey between health and illness. Ageing and death are a natural part of this journey.

Though it makes sense that when one of these areas (body-mind-spirit) is challenged or failing, the others may also be challenged or fail, it may not be that simple. If we are unwell physically, this also impacts our mental outlook negatively – or does it, always? Is there something in the physical challenge that focuses our resources to overcome this with our mental attitude? The relationship is more complex and my clinical work offers another perspective. I have met many people whose body is failing but whose mental capacity and insight is highly attuned in spite of, and maybe even because of, their physical challenges. Sometimes when both mind and body are severely challenged, a spiritual dimension comes to the fore with the person choosing to embrace their situation, to ‘trust’ or ‘let go’. This seems to indicate a spiritual awareness beyond tangible measures of ‘wellness’.

Although there is an argument that spiritual experiences are themselves embodied as they are experienced through our felt sense (Grocke, 1999), in the hospital context, people are sometimes at a moment where it is too painful¹² to be in their body. At these times they may be in spiritual ‘crisis’ and overwhelmed by circumstances. What they may need in the moment is a form of escape. Music can provide this. My work does, then, also support the sixth sense of ‘spirituality’ identified in the music therapy literature (Potvin & Argue, 2014, p. 119) – ‘altered states of consciousness’.

To achieve healing there has to be a connection between body, mind and spirit. Various religions and spiritual traditions see that suffering in the body is valuable for the spirit and the mind, for example. There comes a time, though, when the body will be left and the mind and spirit or soul will be ‘elsewhere’. This seems to take spirituality beyond concepts like ‘health’ and ‘culture’ – but what is spirituality outside of these? Can spirituality be defined uniquely, beyond culture and beyond health? Where does it intersect with these exactly? I look forward to the ongoing discourse about ‘the spiritual’ in music therapy.

SUMMARY

In this article I have argued for the relevance of spirituality to music therapy practice, and that music therapy is inherently spiritual in nature. Patient responses to music therapy in the Australian hospital context reveal a distinctly spiritual aspect. On reflection, broad themes in these responses are summarised as:

- Aesthetic qualities of the music-afforded experiences of ‘beauty’
- Music therapy meaningfully supported the passing of life
- Music therapy afforded hope
- Music therapy created a space for the appropriate expression of sadness
- Music therapy afforded experiences of peace, joy and happiness

Vignettes from clinical practice across two different hospitals demonstrated that sacred moments were co-created by remaining open and responsive to the unique timing of events. A sense of not knowing, working with intuition, embracing paradox, and mystery was important. Working with

¹² This pain can be physical, emotional, spiritual or psychic (such as deep and intense emotional and/or mental anguish or suffering).

vulnerability and strength in the therapeutic relationship was particularly relevant to supporting spirituality, especially at end of life.

Key strengths of music therapy in offering spiritual care included acceptance of the moment, working with imperfection, transcending barriers, transforming perceived failures and connecting deeply. Examples from practice also showed what it can look like to be 'spiritual' in practice as a music therapist: being led, using intuition, being vulnerable, spontaneity and flexibility, openness to and acceptance of unfolding circumstances, trust, and embracing paradox and mystery.

I have also identified a 'sense of beauty' and 'sense of the sacred' as facets of spirituality. It is hoped that this discussion provides insight into spiritual care in the Australian context and highlights the potential of music therapy in the spiritual domain.

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Ελληνική περίληψη | Greek abstract

Μουσικοθεραπεία και πνευματική φροντίδα: Η μουσική ως πνευματική υποστήριξη σε ένα νοσοκομειακό περιβάλλον

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ΠΕΡΙΛΗΨΗ

Αυτό το άρθρο είναι μια προσωπική έκθεση με αναστοχαστικές προεκτάσεις σχετικά με τις επαγγελματικές εμπειρίες από τη πρακτική της μουσικοθεραπείας, με έμφαση στη συναισθηματική και πνευματική φροντίδα που παρέχεται στο νοσοκομειακό περιβάλλον στην Αυστραλία. Υπάρχει μια αυξανόμενη ανάγκη να χαρτογραφηθεί το έδαφος της μουσικοθεραπείας σε σχέση με την πνευματικότητα. Η μουσική μπορεί να εμβαθύνει τις πνευματικές εμπειρίες και έχει ένα εύρος δυνατοτήτων ώστε να συναντά το «πνευματικό» σε διαφορετικά πλαίσια. Το άρθρο εστιάζει στη μουσικοθεραπεία εντός ενός πλαισίου ποιμαντικής φροντίδας [pastoral care] όπως προτεραιότητα αποτελεί η πνευματική και η συναισθηματική υποστήριξη. Μετά από μια σύντομη συζήτηση για το πώς παρουσιάζεται η έννοια της πνευματικότητας στη βιβλιογραφία της μουσικοθεραπείας, προσφέρεται ένα πλαίσιο και ένα υπόβαθρο για τη δημιουργία ενός προγράμματος μουσικοθεραπείας στο τμήμα ποιμαντικής φροντίδας ενός περιφερειακού νοσοκομείου. Επίσης, συζητιούνται παραδείγματα για το «πνευματικό» σε σχέση με τις ανταποκρίσεις των ασθενών στη

μουσικοθεραπεία. Στο άρθρο αναζητούνται ακόμη οι επαγγελματικές προκλήσεις που περιβάλλουν την πιο άμεση αναγνώριση των πνευματικών πτυχών της μουσικοθεραπείας. Επίσης παρουσιάζονται κάποιες ιστορίες από τις κλινικές εμπειρίες από δύο διαφορετικά νοσοκομειακά περιβάλλοντα, με μια αναστοχαστική ματιά που αφορά τη θέση που κατέχει η πνευματικότητα στην πρακτική της συγγραφέα. Οι εμπειρίες που βασίζονται στην πρακτική αναλύονται εδώ σε συνάρτηση με έννοιες για την πνευματικότητα που εντοπίζονται στη μουσικοθεραπευτική βιβλιογραφία, με σκοπό να διαφανεί το τί μπορούν αυτές οι εμπειρίες να προσφέρουν στη χαρτογράφηση του πεδίου αυτού. Τέλος, διερευνάται εν συντομία η σχέση μεταξύ σώματος, νου και πνεύματος, με μια αναστοχαστική ματιά απέναντι στη θέση της πνευματικότητας σε σχέση με την υγεία και τον πολιτισμό.

ΛΕΞΕΙΣ ΚΛΕΙΔΙΑ

μουσικοθεραπεία, πνευματικότητα, πνευματική φροντίδα, νοσοκομείο, ίαση [healing], θεραπευτική σχέση