



Article

Spirituality and music therapy: An action research project in clinical music therapy within the context of an anthropological theory of spirituality

Anita Neudorfer

ABSTRACT

This paper presents a metatheoretical perspective of music therapy under the lens of Karl Baier's anthropological theory of spirituality. As a tool for therapeutic encounter, this theory gives an interpretation of empirical data on the life orientation of Austrian cancer patients in the clinical environment of oncology. The data comes from an action research project as part of a Bachelor's thesis in Music Therapy at the IMC University of Applied Sciences in Krems, Lower Austria. Based in a general hospital, Wiener Neustadt, in Lower Austria, the project took place between November 2013 and March 2014. Music therapy sessions with cancer patients (n=3) were video and audio recorded, transcribed verbatim and analysed. This paper seeks to show how the core concepts of Karl Baier's anthropological theory of spirituality, such as 'situation', 'ground situation' and 'disclosure situation', offer interpretative space for the data.

KEYWORDS

music therapy, humanities, therapeutic encounter, spirituality, spiritual care, life orientation

Anita Neudorfer is an Austrian music therapist and scholar of Religious Studies holding degrees from the University of Vienna in Comparative Religious Studies (BA, MA) and Languages and Cultures of South Asia and Tibet (BA). She dedicated her Master's thesis in Religious Studies to rhythm movement, body culture and the genesis of modern spirituality at the beginning of the 20th century. She studied music therapy (BSc) at the IMC University of Applied Sciences in Krems, Lower Austria where she is currently continuing her music therapy studies at Master's level. As a clinical music therapist, she works in psychiatry and palliative care.

Email: neudorfer.anita@gmail.com

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INTRODUCTION AND PERSONAL CONTEXT

Spirituality can be seen as a cultural phenomenon in the midst of modern society (Baier 2012). Former studies in Comparative Religious Studies (University of Vienna) led me during my music therapy internships to question in what way the

dimension of spirituality may be observed in clinical music therapy and how such a dimension can be defined and described scientifically without losing oneself in non-clinical applicable humanities or in religious or alternative-religious language.

Drawing on my former studies in Comparative Religious Studies with a special interest in modern spirituality and spiritual care (Neudorfer 2012,

2013) as well as on my own experience in music therapy training and my clinical experiences with terminally ill patients, I found myself put 'on the spot' in certain situations. On one hand, as a religious scholar in an academic environment, I would have argued that music therapy definitely has a spiritual dimension. On the other hand, I realised that such a statement in a clinical context might be controversial. Once, for instance, a student of Health Studies asked me in a direct way: "Do you mean that music therapy is something... *spiritual?*"

When I considered spirituality as a potential topic for research, I received the following reactions from music therapists, which can be seen as symptomatic for the tension between music therapy and spirituality.

"Spirituality? Is this Haja Yoga?"

"Spirituality... at the end we talk about self-transcendence. That cannot be taught and cannot be decided".

"Spirituality? Where is the practical application? Do you want to make a videography? How can it be measured? *This* is what you have to deal with!"

"Music therapy *has* a spiritual dimension!"

Responses like the above and the intention to connect my background in humanities with my clinical experience led me to this action research project which explores whether academic research on spirituality can serve as a useful tool for clinical music therapy work and as a helpful orientation on a cultural and multifaceted phenomenon called modern spirituality.

My research, as explained in greater detail below, focused on anthropological spirituality in the action field of music therapy. An anthropological-hermeneutic view like Baier's (2012) theory which operates with the keywords 'situation', 'ground situation' and 'disclosure situation' seemed appropriate for this action research, because it afforded a metatheoretical interpretation of music therapy practice.

Following a brief review of the music therapy literature, I focus on Karl Baier's anthropology of spirituality which forms the backdrop for my research. Before that, however, it seems necessary to give a brief introduction to spirituality in clinical context (spiritual care), in order to illustrate the ongoing effort to establish spirituality in health care systems.

SPIRITUAL CARE AS (RE)DISCOVERY OF THE WHOLE HUMAN BEING?

Spirituality may be considered an important characteristic of hospice work and palliative care. The development of spiritual care was triggered by experiences with multi-religious and multicultural encounters. Christian chaplaincy was not able to fulfill these needs any longer. Another factor for the establishment of spiritual care was modernity's tendency towards individualisation in the contexts of religion and spirituality. Europe's generation 65+ is the last one which was socialised in a more or less Christian way. In the successive societies, the majority of people either has no religious-spiritual interests or is dominated by individual ideas without firm ties to an organisation. Individualised spirituality goes hand in hand with a tendency towards self-determination and a distance to institutionalised expert knowledge (Heller & Heller 2014).

Through confronting death and dying from the second half of the 20th century onwards, through hospices and the resulting palliative care, the focus has shifted to death as an existential key for understanding life.

The term 'spiritual care' refers to the (academic) discussion negotiating meaning and importance of death for human life beyond apparatus medicine, symptom control and a fragmented human image. Consequently, studies and theoretical reflections about spirituality in medical and clinical contexts have been established over the past few years. Spiritual care is a relatively young academic discipline at the crossroads of medicine, psychotherapy and hospital chaplaincy (Heller & Heller 2014).¹

Spiritual care can be recognised by its strong orientation to the subject and personal experiences. This approach stems from criticising a one-sided bio-medical image of man² and aims at reconsidering the correlation of body, mind and soul (Heller & Heller 2014).

According to Birgit and Andreas Heller, scholar of Religious Studies and researcher of palliative

¹ In 2010, the project group 'Spiritual Care in Palliative Care' was founded within the European Association for Palliative Care (EAPC) for researching spiritual care.

² The famous words of the founder of modern-day pathology Rudolf Virchow are the epitome of empirical-scientific medicine: "I have performed autopsies on thousands of dead bodies but I haven't found a soul in any of them" (Heller & Heller 2014: 164).

care, we desire humanity when caring for people in need in the form of attention, affection and sympathy, which is –from a religious studies perspective– reflected in the megatrend of spirituality and spiritual care resulting from it. This development is fostered by experiences with apparatus medicine, increasingly differentiated organisations and a rising “reflex-like compulsive need to control” modernity (Heller & Heller 2014: 12).

The integration of spirituality in health care was the topic of the consensus conference, held in Pasadena, California (February 2009). The conference was based on the belief that spiritual care is an essential component in palliative care (Puchalski et al. 2009). Two other Consensus conferences, *Creating More Compassionate Systems of Care* (November 2012) and *On Improving the Spiritual Dimension of Whole Person Care: The Transformational Role of Compassion, Love and Forgiveness in Health Care* (January 2013) were held with the goal of a consensus on the integration of spirituality into health care structures and to develop strategies of compassionate systems of care. Participants echoed the full integration of spirituality into health care, that will create more compassionate, person-centered health systems (Puchalski et al. 2014).

Participants developed a definition of spirituality, which shows the relevance of intrapersonal and interpersonal relationship from an humanistic point of view which is relevant in palliative care as spiritual care in order for a whole-person-care:

“Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred” (Puchalski et al. 2014: 643)

Even if the discussion of spirituality in case of sickness and death originated in the field of palliative care, it is now relevant for the entire health care industry (Heller & Heller 2014) and can be also detected in the self-positioning of clinical music therapy in health care.

BRIEF REVIEW OF THE LITERATURE

A flood of literature related to music, therapy and spirituality can be found on the (book and internet) market. But only few scholarly studies describe how spirituality can be defined in a clinical music therapy encounter with patients (for example:

Aldridge 1995, 1999, 2000, 2002, 2007; Cerny, Renz & Mao 2005; Lipe 2002; Magill 2007; Marom 2004; McClean, Bunt & Daykin 2012; Potvin, Bradt & Kesslick 2015; Wlodarczyk 2007).

Aldridge strives for a scientific discourse about spirituality in the field of music therapy (Aldridge 1995, 1999, 2000, 2002, 2007). In his article *Beyond Sense: A Transcendental Understanding of Music in Therapy* he describes modern spirituality related to medical practice as an “ineffable dimension that is separate from religion itself” (Aldridge 2007: 293). Aldridge sees spirituality as something that gives meaning and purpose to one’s life. These purposes embedded in the cultural matrix help to transcend what we are. Music can be seen as a force that animates the “dynamic process of transcendence” (Aldridge 2007: 293).

Magill (2007) points out that music therapy promotes spirituality in terminally ill patients by fostering four aspects of spirituality: transcendence, faith and hope, purpose and contentment, and peace. The empathetic presence of the music therapist plays, in addition to music, a key role and contributes to giving back a sense of identity and spirituality in the face of existential hardships.

Timmermann, a German music therapist and psychotherapist, defines music as a gift from gods. Sounds serve better than words for establishing a contact with the beyond, and music is a bridge to “the invisible world of spirits and gods” and reaches into the deepest layers of our unconscious (Timmermann 1998: 7).

Finis describes music therapy as a treatment concept which is heavily influenced by Christianity. Music therapy that is oriented towards Christianity offers a relationship with the Christian God as the creator of the universe and as a positive authority containing the treasures of wisdom. In contrast to certain humanistic worldviews, Finis sees God at the centre rather than man. Therefore, the relationship with God is also the cardinal point in therapy (Finis 2007).

Sutter and Wormit (2007) address the significance of spirituality in the field of music therapy in end-of-life care. Their study showed that spirituality is much valued as an integral part of life by music therapists who work with patients in palliative care but spiritual topics are hardly included in therapies in order to avoid role conflicts. Tasks of music therapy regarding spiritual guidance should be better defined and explored. Music therapists should not replace ministers but act as a link between psychosocial and spiritual needs.

The German music therapist and psychotherapist Baumann also views the music

therapist as a link between psychosocial and spiritual guidance. Together with Bünemann, she argues for an approach based on the principles of palliative care which involves the patient's relatives, addresses the 'spiritual level' and is oriented towards salutogenesis. The authors call their approach "music care". In order to grasp spirituality, Baumann consults the Benedictine monk and Zen master Willigis Jäger, the Dalai Lama and Monika Müller, who is a Christian-oriented psychotherapist. For Baumann, spirituality is primarily a quality available for experience, or a "good spirit" as an attitude towards humans in each person. Spirituality can also be experienced through an interpersonal encounter (Baumann & Bünemann 2009).

Based on Jung's analytical psychology, the Swiss music therapist, psychotherapist and theologian, Monika Renz, places the focus of her work in the palliative care sector on the significance and effectiveness of music therapy and spiritual guidance (Renz 1996, 2003). She defines spirituality as:

"[...] more than practice. It is experience with the eternal Other. It is not available and ultimately means being deeply moved by the secret of 'God.' In this non-availability, spirituality for me is an event of revelation" (Renz 2003: 28).

Recording spirituality in connection with religion and health in a quantitative way was the goal of Ostermann and Büssing. They developed assessments in order to register the patients' spiritual needs (Ostermann & Büssing 2007). The Austrian religious scholar and philosopher Karl Baier has investigated spirituality regarding its genesis and development (Baier 2006a, 2006b, 2008, 2009a, 2009b, 2012). Locating spirituality in healthcare as spiritual care is one of the research interests of the Austrian religious scholar Birgit Heller (Heller & Heller 2014). Gian Domenico Borasio (2011, 2013), a doctor in palliative care, is working towards the integration of physical, psychosocial and spiritual terminal care in teaching and research. He has also integrated spiritual care within the further education of medical students.

Hilliard (2005) points out the need to create an evidence-based approach to music therapy in hospice and palliative care. According to Włodarczyk (2007) music therapy can increase the spiritual wellbeing of terminally ill patients.

In the study of Cerny, Renz and Mao (2005) music therapy in cancer care is seen as an approach in an oncology setting which enhances spiritual care. They found that from 251 contacted cancer patients, 135 patients had spiritual

experiences in music therapy sessions which had a positive impact on physical and emotional wellbeing.

The study of Potvin, Bradt and Kesslick (2015) focused on the impact of music interventions (music therapy and music medicine) on the management of mood, anxiety, relaxation and pain of cancer patients. The authors found three themes pertaining to deep human experiences underlying the symptoms: relaxation, therapeutic relationship and intrapersonal relation. The study explored the role of clinical music therapy and examined the expanding perspective of music therapy as an holistic approach of symptom management which is defined as "the creative and professionally informed use of music in a therapeutic relationship with people identified as needing physical, psychosocial, or spiritual help" (O'Callaghan & McDermott cited in Potvin, Bradt and Kesslick 2015: 2)

In a qualitative study, Marom (2004) explored music therapists' experiences with spiritual moments in music therapy. Ten music therapists were asked to recall one or two sessions which they would define as spiritual in nature. The variety of defined spiritual moments in music therapy sessions included:

"[...] moments of major changes in the clients' behaviours; emotions or thoughts; moments of powerful bonding between therapists and their clients, their clients or themselves; moments of strengthened religious beliefs (of clients or therapists) and contacts with transcendent entities" (Marom 2004: 37).

McClellan, Bunt and Daykin (2012) explored the relation of spirituality, health and wellbeing with research on the healing and spiritual properties of music therapy in oncology care. The results focus on the four overarching themes of transcendence, connectedness and meaning, faith and hope. The authors highlighted spirituality as a broad-cutting theme. The researchers confirm Magill's understanding of spirituality of four overarching themes: transcendence, connectedness, the search for meaning, and faith and hope.

The approach to the phenomena of spirituality in cancer care requires more research to be undertaken which is recommended by Cook and Silverman (2013), Hilliard (2005) and Lipe (2002).

BAIER'S ANTHROPOLOGY OF SPIRITUALITY

In order to discuss the complex phenomenon of spirituality, an account of the concept of spirituality

at the foundation of this consideration is desirable. Karl Baier, Professor of Religious Studies at the University of Vienna, has developed an anthropological theory of spirituality that creates an understanding of the multifaceted term "spirituality" by way of anthropological reflection. The concept is broad but at the same time it is concrete enough to be applicable to various religions and life orientations of humankind (Baier 2008, 2012).

Baier shows that the term "spirituality" has many meanings. In conservative church circles, it can be understood as returning to a beyond-oriented religiosity (in contrary to worldly matters) while attempting to resist the alleged moral decline of fast-paced modernity. For most people, however, spirituality is the opposite: a tolerant and cosmopolitan alternative to institutionalised religions. What was called "alternative-religious" in the "new religious scene" in the 1960s and 70s, is now a synonym for spirituality (Baier 2012: 65). Sometimes, according to Baier, the sense related to spirituality is stretched so thin "that people consider themselves spiritual when they are interested in Reiki and like to drink Yogi chai" (Baier 2012: 65).

Baier uses and expands the definition of spirituality developed by the theologian Hans Urs von Balthasar. Balthasar's determination of spirituality as an individual's practical or existential attitude is based on his religious or ethically-committed understanding of existence. With the help of a hermeneutic phenomenological anthropology, the bodily situatedness of people with their situational world reference comes into focus (Baier 2012), which will be explained more in detail below.

A more detailed description has had to be omitted for want of space and shall be compensated for by a sketch of three key concepts of the theory.

Situation: A body-situated experience of human reality

In the 20th century, the *situation* term gained importance in philosophy, psychology and social science. The subject-object relation was seen as an abstraction because an isolated subject never encounters a single object. Everything that happens to us happens in contexts of situations: we do not behave towards them as neutral objects, but we are within them and go through them, while we relate to something or someone. Situations constitute a meaningful whole and necessarily require from us an opinion, because we are stuck with our body in the middle of them and have to act

in some way. As a field of practice they constitute a referential context, which is indeed determined by unchangeable limitations, but at the same time also opens up a margin of possibility (Baier 2008).

Ground situation: About the meaningful life orientation

The *ground situation* is the outermost and largest situation, which forms the foundation of all other situations in a meaningful way and is present in them. As life orientation, the ground situation carries all other situations, even if they are not always perceived consciously. Whether consciously or not, the comprehensive understanding of the world ultimately determines all individual situations in which you find yourself, and suggests certain principles of how to handle a situation (Baier 2008). One can easily imagine people who "act according to a pattern of preference, without being able to call 'last' reasons for their actions," according to the religion-sociologist Thomas Luckmann (1991: 119).

In most cases, the life-determining final orientations based on the understanding of the ground situation are in the dark and cannot simply be listed. Specific maieutics can shed light on those hard-to-reach areas, such as therapy, religious retreats or other ways to come to terms with critical situations and turning points, which make a restructuring of the ground situation seem inevitable. (Baier 2012).

Due to the situatedness of human experience of reality, even the "last" reality can only be experienced and understood from a situational position. An essential part of the ground situation appearing as ultimate reality is the appearance of its relationship to the world (Baier 2008).

Disclosure situation: Interpreting relations of meaning

The ground situation becomes accessible through the so-called disclosure situations. These typically mean that one participates with a high degree of personal involvement in revealing relations of meaning which are beyond the usual horizon of expectation and skill, normally called "experience of transcendence", "peak experience" or the like (Baier 2008: 193f; Baier 2012: 28). These moments of interpretation can gain religious importance if an absolute reality is revealed in them for the persons involved. Previous premises of open-mindedness are transgressed and life is put into a new framework. In communication theory, this disclosure can mean the appearance of two solutions (Baier 2012). Through this, people also

discover themselves anew, and unpredictable possibilities of life interpretation and planning open up. This expanded horizon refers to the possibility of a deeper identity:

“In the history of a past event or a process of here and now [...] someone learns something that is speaking to them in a very personal way and that allows a person to discover the core of themselves and their standing in the world” (Schillebeeckx cited in Baier 2008: 193).

Baier’s understanding of spirituality is the foundation of this paper:

“Spirituality can be [...] understood as the practical relation to what is more important to us than anything else. This relation is manifested in rare, intensive experiences but also in life permanently resonating with a basic attitude towards the world which surfaces in certain virtues such as sympathy or mindfulness and, furthermore, through deliberately shaping our existence in the light of what is most important for us” (Baier 2009b: 65).

RESEARCH GOALS AND QUESTIONS

In the tradition of action research and in the role as a practitioner, the aim of this study was to gain an understanding of the term ‘spirituality’ based on clinical music therapeutic encounters with patients. The intention was not to go deeper into an academic discussion in the field of humanities, but to examine the clinical application of humanities in the action field of music therapy.

The research questions are:

- Is there any interdependence given between clinical music therapy and academic spirituality research? If yes, how does it show in (music) therapeutic practice?
- Does an anthropological approach through the theory of spirituality prove useful and supportive for the practice field of music therapy?

METHODS

This study was undertaken in the tradition of French action research (Desroche) which includes the researcher as part of the research (Prieler-Woldan 1995). That means that during the music therapy sessions I had two roles at the same time: the role as the music therapist and as the researcher. Karl Baier’s anthropology of spirituality,

as outlined above, serves as the theoretical framework.

The empirical data were collected in the Landeskrankenhaus Wiener Neustadt in Lower Austria. Since 2010, the local music therapist has been in charge of providing music therapy to cancer patients. Music therapy takes place on the edge of the bed and takes an average of 30 minutes depending on the needs of the respective patient. One music therapy session can consist of conversation, using live music, stress regulation or activation. In addition to the human voice the range of instruments includes harp, guitar, oud, monochord, frame drum and Orff instruments which are transported in a mobile instrument box through the hospital.

Depending on, and defined by the duration of the stay of the patients (one to five weeks), music therapy encounters take place on average one to four times, depending on the weekly internships. The psychosocial staff of the hospital comprises three psychologists, one music therapist, one chaplain and one mobile palliative team.

Music therapy sessions with patients (n=3) were documented in internship logs, tape-recorded, transcribed verbatim and analysed by means of descriptive text analysis (Assing 2012). Statements of patients were compared with and seen under the hermeneutic-anthropological lens of the spirituality theory.

Selection criteria

From November 2013 to April 2014, 34 cancer patients were documented in internship logs. Of these, six music therapy interventions were video- and audio-recorded with the patients’ consent. Patients were selected on the basis that they had been oncology patients referred earlier to music therapy and that it should be possible to communicate with them verbally. They gave their consent to video- and audio-recording. In addition to music, the intervention included a therapeutic conversation. Out of the six sessions that were video- and audio-recorded, three could not be considered for the project: after one encounter no therapeutic conversation took place because the patient fell asleep, the sound quality of one video recording was not sufficient for further consideration, and the third was analysed too late to be considered. This left three patients with one recorded therapy session each. The names of the patients were made anonymous by replacing their names. Table 1 gives an overview of the music therapy sessions and recordings.

	First contact	Second contact
Patient 1: Mrs Franz	Video recorded	-
Patient 2: Mrs Ludwig	Internship log	Video recorded
Patient 3: Mrs Gross	Internship log (This music therapy session was provided jointly by my internship colleague and me)	Audio recorded

Table 1: Overview of music therapy sessions and video/audio recordings

Descriptive text analysis

The procedure of comparing music therapy with spirituality theory used here was a text analysis. The video- and audio-recordings were evaluated by means of descriptive text analysis (according to Assing Hvidt et al. 2012). The left margin of the transcripts was used for highlighting characteristic or noteworthy remarks, especially if these referred to an orientation of purpose in life. This process of basic coding was performed for the entire transcript, paying special attention to what the patients said (Bryan 2001). Following this step it became clear that the spirituality theory was very appropriate for further analysis. The transcripts were read against the selected framework by making notes in the right margin which make the connection to the theoretical concept. Consequently, this strategy for analysis could be labelled as deductive (Assing Hvidt et al. 2012: 38).

To enhance the phenomena of spirituality it was important not to reduce the empiric utterances to confirming illustrations of the selected theory but to read and analyse them each by themselves. Furthermore, it was essential to show in which (linguistic) way the patients expressed themselves about the situation and how they stated their needs. Therefore, paraphrasing was avoided wherever possible in order to indicate the illustrative and singular value of their words.

PATIENTS' NARRATIVES

The following section describes the therapy sessions of three patients in a narrative way and is concluded by allocating them to the key concepts.

Patient 1: Mrs Franz

First contact

Mrs Franz has uterine cancer. She is friendly and seems tired. She talks about her disease. After listening to harp music played live, she whispers: *"Very beautiful, very beautiful."* She asks for the purpose of *"this type of music"* (it was an improvisation) and says it is a nice experience. She finds it, however, difficult to concentrate due to having many thoughts in her head. She feels some inner pressure due to the disease. In order to find out, what kind of resources helps Mrs. Franz, I ask her, who or what she really likes or liked in her life. Mrs Franz names a child, grandchildren and friends. She describes the loss of hair induced by the disease. She then asks me if I am married.

As an aside, I mentioned at the end of this music therapy session that we celebrate our patron saints on the same day because we have similar first names. Then the patient says that her husband died on the day of our patron saint. What follows is a conversation about true love and about the fact that now that she thinks about it more. Mrs Franz has reached the conclusion that a *"good life"* is not necessarily *"beautiful"* but one's heart has to be open.

Patient 2: Mrs Ludwig

First contact

Mrs Ludwig is a palliative patient with uterine cancer. She is alone in a room with two beds. *"The cancer won't get me"*, is her motto. She has to be strong, then everything will work out, in that sense, that with such an attitude, the cancer will not prevail over her. She has a lot to do with body work and massage. Therefore, I suggest a guided imagery trip towards relaxation through the body, accompanied by an ocean drum and singing. For the receptive music, Mrs Ludwig states that she was able to relax very well, that she was visualising images and was on *"her journey"*: a planned holiday by bus with some girlfriends which had to be cancelled because of her hospital stay.

Mrs Ludwig mentions the window of her hospital room which is protected from pigeons by a net. On considering the net, she says that she can understand why *"surely a few people would try to jump out"*. Would she consider this? No, not her, *"[...] not because of 'something like this' – one has to be strong!"* Mrs Ludwig starts telling every detail about the above-mentioned bus trip breathlessly.

Due to her hospital stay, this trip was not possible anymore; although she had organised it all she had to cancel and the travel agency was giving her a hard time. In addition, one of her friends now has cancer as well and does not want to go on the trip without Mrs Ludwig.

Second contact (two days later)

Mrs Ludwig has just returned from radiation therapy and seems tired and introverted. She describes being admitted to the hospital and asks for harp music. She closes her eyes, her breathing slows down. After the receptive music, she starts to talk about her holiday. When she refers to solidarity among her girlfriends, Mrs Ludwig starts to cry because she has often cancelled walks with her friends without thinking much about it. After a call from her daughter it turns out that Mrs Ludwig feels the need to talk to her family about dying but they refuse to listen to her. Mrs Ludwig also has thoughts about her funeral; she could imagine an urn but her husband is against it, she should be buried in the family grave. We are laughing about the idea of being turned into a diamond. This is followed by a receptive period of ocean drum and singing.

Patient 3: Mrs Gross

First contact

My colleague and I go to Mrs Gross, a palliative cancer patient in a room with six beds. The daughter, a young adult, is with her. Both listen to music with one headphone each. When we introduce ourselves as music therapists, Mrs Gross says that music therapy is what she has actually spent her whole life with. We then ask her if she is a music therapist. "No", she answers, but she is dealing with "heart music"³. Mrs Gross is pondering how to bridge the gap between reality and hope.

My colleague and I play receptive harp and guitar. Through the music, the atmosphere in the room changes. Mrs Gross seems very quiet as if listening to her inner thoughts. Afterwards she says with a very calm voice: "Thank you, this has touched me".

³ Various providers offer transforming the heart rate variability into music with a special computer programme, for example in a harp melody. Mother and daughter have each received their own "heart melodies" this way.

Second contact (one day later)

One day later I go to see Mrs Gross alone. She seems upset and has to tell me something important regarding what happened during yesterday's music intervention. First of all, the music touched her very much yesterday, something has changed. In the evening, she realised what it was; the forgotten childhood experience of being locked into the basement by her mother. I told her that that moment yesterday was also very touching for me. Mrs Gross starts to cry. We talk for a long time and at the end I play harp for her. Mrs Gross has her eyes closed for most of this. She looks tired and falls asleep several times while I play. Despite the presence of other patients and visitors, the whole six-bed room is quiet during and after the music. A nurse comes in and calls a name very loudly. Everyday noises fade back in.

ILLUSTRATIONS AND FINDINGS OF SITUATION IN MUSIC THERAPY SESSIONS

The findings of these music therapy sessions are presented below. The emerging themes are further explored in the discussion section.

Mrs Franz (Patient 1) says after receptive harp music that her disease makes her think a lot. Looking back at her life during her hospital stay, she recognises the structure of actions in her life. There were no "great goals" that she and her husband had ever pursued. But she feels happy with her life and the way she had designed it:

I had to think a lot recently. He was always happy and I am happy too, we don't have such 'big goals', that have, I have never, never, never, no, I have got [...] Yes, well what other people strive [...] we, we just got! When I think now!⁴

Mrs Franz sends me away with words which describe her being at peace towards life and death:

Keep your eyes open! Could be in the supermarket, on the tram somebody picks up a piece of paper, you never know (i.e. when you meet your true love)... it's like death, you never know when it comes!

Not only "being at peace" with life but also various needs steer the situation of this music therapy session in a certain direction. Mrs Ludwig (Patient

⁴ Note that the patient's first language was not German so the original as well as the English translation are a bit choppy.

2) had also considered different funeral options which was a taboo topic in her environment:

Cremation, right? It might be modern though but I just saw on TV how they put you into an oven, well... I don't know [...] I also used to say I want to be cremated and you'll keep me at home.⁵ And my grandchild says, "Granny, then I won't come to that house anymore!" [...] She said she won't come anymore when she knows that I'm sitting there. I don't want that.

We both laugh in a liberating way about the many funeral options, for example being turned into a diamond instead of being buried.

In contrast, with Mrs Gross (Patient 3) the situation does not show itself through describing the disease but through looking back at life.

Because I was there for everyone, day and night and completely forgot that... (*pause*) to do something for myself. [...] always thought I had to save the world (*pause*) and now the world also keeps spinning, even if I can't do anything, no. Yes. (*pause*) I got into that too deep, to take life too seriously, no.

FINDINGS

The findings below are presented with a focus on *ground* and *disclosure situation* drawing on Baier's anthropology of spirituality.

Ground situation in music therapy

As explained above, the ground situation is the outermost and largest situation, which forms the foundation of all other situations in a meaningful way and is present in them. As life orientation, it carries all other situations, even if these are not always perceived consciously.

On the question of what was important in her life (ground situation), Mrs Franz (Patient 1) did not mention her husband and her happy marriage of 32 years. This was mentioned only later by

⁵ From the point of view of religious studies, Mrs Ludwig is addressing an interesting issue here: the idea of identity and the beyond. On the one hand she implies "not being around anymore" after her passing, on the other hand should she (she talks about her physical remains in the first person) be stored at home. The question comes up: who or what is actually dying? In the light of ideas of heaven and hell devoid of meaning and the lapse of confessional ideas about the beyond, the question of what comes afterwards is sometimes hidden behind the considerations of funeral options (Neudorfer 2013).

coincidence when we noticed that we had similar first names. Mrs Franz then answered that her husband died on the day on which our patron saint is celebrated and started talking about the 32-year love relation to her husband as "*something unique in this world*":

That was very nice. We felt so great, we were holding hands and felt the wind. We could accomplish anything. And we defined our goal. What goal? Everybody needs some kind of goal, why do you save money or go to work [...] we didn't do anything. When we were happy, we may, I worked until 2pm, he worked until 2pm [...] we had a great time, really great. Yes, yes, yes aha.

Yes! This was true love. It was. [...] We looked at each other, we knew where we were going. We always knew without any words, you know, that is something, that is something unique in this world. This, this doesn't happen often.

Due to the (situative) condition in which I encountered Mrs Franz and how she talked about her sickness, she appeared happy regardless of her sickness and pain. I gained the impression that the way in which Mrs Franz came to terms with her situation was motivated by being in a happy relationship for 32 years:

Now I have everything behind me, the children have grown up [...] I'm telling you, I have a beautiful life, you should also look for the real thing! It doesn't have to be pretty but good, it has to be a good one [...] the hearts have to be open!

Right after this, Mrs Franz mentioned the passing of and bidding a final farewell to her spouse, in which the acceptance of death and impermanence was recognisable.

But on the last, second to last day, he still hugged me, said goodbye in a nice way. Very, very, very, very, very ehm emotional was this. So tight, so, so tight, so tight holding [...] Yes. I am waiting, I am waiting for this [i.e., the husband's imminent death] But the professor didn't know but I know that, that it will come.

Triggered by this, the patient showed an altruistic attitude combined with uncertainty and acceptance of one's own mortality:

He was also just asking, have we sold the house? I said no. Oh well, then save it for the little ones, for the grandchildren. Well, now, now they have the house for the little ones because I promised to keep it for the little ones. But it's only

ten [i.e. years]! Another eight years still and I don't know if I will be able to help that long or not.

Losing the autonomy over her body revealed the underlying ground situation in Mrs Ludwig (Patient 2):

When I only remember how I went walking, I always told my friends, "Today I don't feel like going, today my back hurts a little" or "No, I don't have time today." And then I thought, why do I always make up such excuses? *(pause)* I can't... I don't even manage to *(cries)*... I can't go walking anymore.

Mrs Ludwig's loss of identity "I can't go walking anymore" expressed the underlying desire for community with the group of friends who were very important for her.

I told my friends: "You don't have to stay here with me, why don't you go down and look at that." Well, impossible: all of them stayed, all three of them, none left!! All three of them sat with me and said, "Let's head back."

During the conversation, Mrs Gross (Patient 3) expresses her ground situation using the following words:

I – I am convinced that everything is connected to everything. Some things you can perceive better than others.

Disclosure situation in music therapy

For Mrs Gross, the biggest part of the music therapy session was verbalising yesterday's experience which consisted of receptive live music featuring harp and guitar. It turned out to be a disclosure situation, triggered by the therapeutic use of live played music.

Here the patient is excited and describes what yesterday's receptive music therapy has triggered within her. The quotations are given below in chronological order. For better understanding, some of the words Mrs Gross uses to describe the disclosure situation are typed in bold in order to illustrate that Mrs Gross is talking about "the point" here:

My life! *(pause)* That's why **it** [the individual experience during a receptive intervention in music therapy] surprised me so much, why I can't get to that point, no. Oh my – once I almost drowned as a child, I went through a lot and thought by myself, actually these are near-death experiences. I had those twice but **this** totally

startled me now... that I wasn't able to get to this, no.

(Under tears): Yes, **it** was very strange. *(pause)* Because I didn't expect **this** at all, because well, I've got a pretty crappy diagnosis but I stayed perfectly calm [during yesterday's music]! I just want to *(pause)* live on.

Mrs Gross is describing now how she turned towards her own inner self through the receptive music:

But I can take it the way it is, yes. Yesterday, **that** really – *(long pause)* **that** really amazed me. And then in the evening I was, well, I turned off the light at eight and thought by myself, I'll go inside now and wait what will come, and noticed there was excitement, I couldn't breathe and then all of a sudden it was c-r-y-s-t-a-l c-l-e-a-r *(pause)* what happened there.

Relationship-oriented music as an aesthetic trigger of emotions – such as utilised in the work of music therapists – turned out to be a disclosure moment for this patient.

And – I have, when you play as a child that everything is OK, it seems much too long so I used to scream out the window. Once she came home and smacked me, so she was desperate, yes? And that, that's not it, but at some point she must have locked us into the basement. And that was it, yesterday **this** completely *(pause)* I really noticed that there is some very deep pain.

Simultaneously, talking about this moment brings patients to a level of self-distancing, from which previous strategies become visible and carry the potential of transformation:

Eh, I was paralysed! And then I have the feeling, but I don't know whether it comes from the head, whether it really *(pause)* I have the feeling that when I tell someone then *(pause)* she will lock me in again. I locked that away *(pause)* that, I mean, I cannot go into my mother, I had a very difficult relationship.

As mentioned above, the life-determining final orientations based on the understanding of a ground situation are in the dark in many cases and cannot simply be listed (Baier 2008). Living through her childhood memories again caused Mrs Gross great pain which she had felt all through her life but had been unable to locate where it had come from.

Mrs Gross explains how this disclosure moment triggered by a music therapeutic intervention

(receptive music) could result in a restructuring of her ground situation.

And I think, now I'm lying here for a week, for one week they haven't done anything with me. I am thinking the whole time, probably it makes sense on some level, no. And I'm really speechless because so many things have come up that I'm thinking the bigger picture is changing again as well, no.

Yes, a new space opened up really. And in new spaces, there are also different solutions, one also has to see that, no. Places you wouldn't have been able to reach earlier, where you... that were inaccessible to you. This is an aspect I do believe in. That depends.

DISCUSSION

Through discussing and exploring these findings further, it turns out that none of the patients mentioned spirituality by name. Table 2 illustrates examples of the topics indicated by patients in the context of clinical music therapy and connects them to the anthropology of spirituality.

What is important for the patients, what is significant and what is abhorrent, what they feel connected to, what causes them pain, what they

wish for and how they interpret their lives – this forms a basic reality. Such utterances do not just reflect feelings or the mental workings of a person, but existential views from which he or she encounters their surroundings and interprets them, as can be seen in table 2.

Ground situation or disclosure situation are not visible in each music therapy session, as can be seen in this study. In particular, disclosure situations cannot be planned. Given the small numbers of recorded therapy sessions it was mere luck that Mrs Gross experienced such a deep disclosure moment through receptive music and also verbalised it.

From the initial situation in which the music therapist finds the patients, an enquiring and empathetic therapeutic attitude is required. It was being oriented towards the patient that brought both the patient and the therapist together to current and often existential topics. Receptive live music was used as an intervention for all three patients. In the role of the music therapist I adapted melody and pace to the intersubjective atmosphere in the therapeutic relationship and to the patient's rhythm of breathing. All three patients shared experiences, memories or thoughts verbally after listening together.

Situation	Disclosure situation	Ground situation
<p>Relation to life & death: "You never know when it comes (the big love)... is like death - you never know, when it comes." (Mrs Franz)</p>	<p>Experiencing old pain: "My life! That's why it surprised me so much, why I can't get to the point." (Mrs Gross)</p>	<p>Connectedness: "Everything is connected to everything!" (Mrs Gross)</p>
<p>Needs: Want to talk about death and dying (funeral considerations) (Mrs Ludwig)</p>	<p>Self-distance as Self-transcendence: "I know, I've got a pretty crappy diagnosis, but I stayed perfectly calm! I just want to live on!" (Mrs Gross)</p>	<p>Altruism: Meaningful assistance for "the little ones" [grandchildren]: "Another eight years still and I don't know if I will be able to help that long or not." (Mrs Franz)</p>
<p>Reminiscing through looking back at one's life: "Always thought I had to save the world (pause) and now it keeps spinning, even if I can't do anything." (Mrs Gross)</p>	<p>Opening new horizons: "In new spaces, there are also different solutions!" (Mrs Gross)</p>	<p>"Good" Life: "Life does not have to be beautiful! It has to be good – good! Heart has to be open!" (Mrs Franz)</p>
<p>When ground situation disappears: "Cannot go jogging anymore!" Lack of community, autonomy and life. (Mrs Ludwig)</p>	<p>Restructuring ground situation: "Probably it (cancer) makes sense on some level. (...) So many things have come up, that I'm thinking the bigger picture is changing again." (Mrs Gross)</p>	<p>"Everybody needs some kind of goal": "We felt so great, we were holding hands and felt the wind. Everybody needs some kind of goal, why do you save money or go to work." (Mrs Franz)</p>

Table 2: Situation, ground situation and disclosure situation

In a therapeutic relationship, music does not only serve as a trigger for emotions, but also as a guiding sign towards the patient's horizon of interpretation and, consequently, for turning towards the inner self. Live music in a music therapy setting has the potential to connect to the patient's mood. Receptive music, therefore, is not just meant for "relaxation", but serves for turning towards the inner self. Furthermore, this calls for focusing on the process as the therapist's other basic quality.

In accordance with the Austrian music therapist and anthropologist Gerhard Tucek (2014), one can recognise two types of shared characteristics behind the various patterns of disease: by means of the taxing situation of a basic disease, uncertainty about the process of sickness and healing, but also the frightening conditions in a clinical setting, patients are under heavy pressure. Therefore, the first goal of therapy should be to offer a (non)verbal, musical relationship in which the patient can relax (Tucek 2014). Against the background of life-threatening situations, questions of purpose and value come up, as well as the desire for connectedness, transcendence and coherence. Identity structures, meaningfulness and survival patterns play important roles here: "*Do I feel connected with life (the way I lead it), understood by the people who play a part in it, and carried by a higher instance?*" (Tucek 2014: 140).

In the light of the recent efforts of music therapy and impact research, Baier's anthropological lens could provide a theoretical background, which helps to interpret and explain therapeutic encounters in music therapy.

CONCLUSIONS

As a social place, the hospital is a focal point of our society where the engine of work and consumption grind to a halt for the patients: when it comes to disease, death, emotional conflicts, loss of identity or moments that stir you to the core. In a clinical context, elements of the anthropological theory of spirituality can serve as backgrounds of music therapy interventions.

Combining practical experience with an anthropological approach to spirituality leads to the insight that everyday small talk about weather, patron saints' days, children or hobbies may contain coded information about the patient's inner world. In many cases, these are not manifested directly and explicitly, but implicitly. Embedded in a therapeutic relationship, live and patient-oriented music is an excellent medium and can serve as a trigger, a door opener and a signpost for traces into

the patient's inner world. To say it with the words of Sir Simon Rattle in an interview for the film *Rhythm Is It* (2004), "music is not just what it is, but is that what it means to the people".

During the course of this study, it was crucial for a therapeutic understanding to consider the relationship between sense and identity. Sense and identity require one another. The concepts of life and self in the foreground (identity) reflect moods in the sense of value and ultimate life orientation (background). A music therapist does not only enter the patient's room as an external space belonging to the patient but at the same time he also touches their *situation* (according to Baier) and with this, the music therapist also encounters their inner space. This inner world also contains the human-existential dimension which is part of the existential negotiation of sickness, pain and death as a body-situated and also as a human experience.

The encounter on this level is one of the aspects of music therapy. Not every music therapy encounter takes place on this level and yet it happens from time to time⁶. The practice of encounters such as those experienced in clinical music therapy has the potential to touch a human-existential dimension. Human striving beyond material existence falls under spirituality in the academic discourse. In the body-situated experience of the fact that death and dying do not only concern them (anymore), existential questions face one's own mortality in direct confrontation.

As mentioned above, many patients do not express themselves explicitly when it comes to such basic definitions. It cannot and should not be the task of music therapy to wait for seriously ill patients to finally start talking about their existential level. An empathic awareness and knowledge of this aspect by the therapist can, however, contribute to providing a solid and resonating foundation for the patient, and to recognise such traces for what they are.

Furthermore, (or rather hidden within), caring for the patient takes on a special role on the human-existential level. This level is basically inseparable from the others and yet it makes sense to investigate it explicitly, as a music therapist and as a human encountering other humans.

Experiencing death has always motivated people to think about life. It is this human-existential dimension – some speak of a spiritual dimension – which is nurtured by the great questions of life and

⁶ See Weiher (2011) and also Dileo and Dneaster's discussion (in Dileo 2005) about levels of music therapy in hospice and palliative care.

which cannot be developed without intensively looking at death and dying. Francois de la Rochefoucauld's maxim "Neither the sun nor death can be looked at steadily"⁷ does not match the author's experiences. Accepting death and incorporating it into one's own self-interpretation enables the development and experience of temporality – this is the root of a caring attitude which neither has to achieve a therapy "goal" nor to "accomplish" anything. Looking at death and coping with it clears space for deeper and more meaningful relationships and for being amazed by the mystery of mankind and being human.

In the spirit of the palliative researcher Allan Kellehear, the caring of the dimension of spirituality (spiritual care) in music therapy means a therapeutic-palliative attitude of partaking, stable caring and an egalitarian encounter through guiding a human search for sense in life, death and loss. After all, good spiritual care has a lot to do with acceptance of and insight into the limitations of one's own individual professional practice (Kellehear in Heller & Heller 2014: 13f).

Clinical music therapy is not a "spiritual therapy", but the underlying definitions perhaps suggest "spiritual caring". Spiritual care as the foundation of a culture of caring requires people to be extracted from their role as patients. In this, the attitude of hospice is reflected, which is founded on the respect for dignity and individuality. It is not about what we do *for* others but what we do *with* them! Through this, the hospice-palliative-music therapeutic "spirituality of caring" shows the human interspace as a place of encounter and action.

When such spiritual care is the remedy against de-subjectivising and de-personalising, when spiritual care is a synonym for mindfulness, self-care, welfare, caution, guidance and affection; in other words, for humanising the system in favour of the humans within it – then in this sense, spirituality and spiritual care is not only one aspect of music therapy but it reflects the foundations of all assisting professions in a clinical context which feel obliged to these principals. To care, listen, show empathy, appreciate without an agenda are general (spiritual) competences of guidance.

One can say that spirituality should not be instrumentalised, for example, as a means to manage contingencies or to cope with painful experiences. Spirituality must not be used as a cure-for-all when other remedies have failed, or when health insurances become interested in the

correlation of spirituality and health because they hope that "spiritual people" might generate less costs (Heller & Heller 2014: 39).

What is more important is agreeing to "what you can recognise as good and beneficial, not just in order to feel better but because opening up to it is helpful in itself and provides real comfort even in times of hardship" (Baier 2009b: 65). Here the self takes a central position as it can only be the patients' responsibility to come to terms with what seems important to them, what is meaningful and what carries them.

When a music therapist practises perceiving this anthropologic basic attitude, this can support the patients in the context of music therapy in expressing and giving space to this elementary human dimension of reality in which they feel seen, heard and understood, in a (non)verbal musical way.

The anthropological research of spirituality contributes to elaborating the foundations of spiritual phenomena, and in return spirituality can be seen as a particularly significant phenomenon of human existence.

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⁷ "Le soleil ni la mort ne se peuvent regarder en face" (cited in Heller & Heller 2014: 15).

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