A Synerdisciplinary Music Therapy Treatment Team Approach for Hospice and Palliative Care

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Abstract
The role of the clinician on the multi-dimensional palliative care treatment team continues to evolve, expand, and be re-defined as patients and families are successfully served in and by music therapy. The terms interdisciplinary, multidisciplinary, and transdisciplinary are often used to describe such inclusive treatment teams. A new term, synerdisciplinary, is offered, which builds and expands on previous terms. The stimulus for using this new term comes from the author’s personal and professional experiences working as a clinician in hospice and palliative care. The related term synergetic is also considered as it relates to music therapy teams themselves within hospice and palliative care organizations. In this case, it refers to music therapists working together as a department with differing but complementary treatment approaches, philosophies, and orientations to their work in palliative and hospice music therapy.

Key Words: music therapy; hospice; palliative; treatment team

Introduction


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function in the ways described in this book unless he or she were part of a multidisciplinary team, sharing in the complex care of the terminally ill person” (p. 62).

There are several terms that are frequently used to describe these treatment teams. I began researching this area five years after beginning my work as a music therapist as a member of such teams in palliative and hospice settings, concluding that the existing terms may not be entirely adequate. It is my own experiences and a review of the literature which have stimulated me to propose new terms. First I will examine the descriptors in current use in the literature.

**The Multidisciplinary, Interdisciplinary, and Transdisciplinary Treatment Team**

Teams are often described as being multidisciplinary when professionals from different disciplines provide their own treatments for the common good of the patient without necessarily meeting together to plan or discuss their needs and progress. The disciplines involved in the team may be diverse and include physicians, nurses and nurse assistants, social workers, physiotherapists, pastoral counsellors, and volunteers. Areas such as music, art, and drama therapy, massage, acupuncture, aromatherapy, Reiki, and others may complement these treatments. Determining the composition of the treatment team is an essential aspect of providing quality services to the patient and family. An example of an extended care team which includes complementary disciplines can be seen in Figure 1 (It should be noted that the placement of the various disciplines in Figure 1 does not suggest their relational value).

![Hospice Physician
Nurse
Pharmacist
Music Therapist
Volunteer
Nutritionist
Occupational Therapist
Children’s Therapist
Acupuncturist
Reiki Therapist
Friends
Pets/Pet Therapist
Patient’s GP
Bereavement Staff and Counsellors
Caregiver
Social Worker
Art Therapist
P
Social Worker
A
Physiotherapist
T
Horticulture Therapist
I
Aromatherapist
E
Massage Therapist
N
Pastoral Counsellor
T
Family

*Figure 1. The expanded treatment team with patient as focus of care.*
In the interdisciplinary team, members work more closely together in both the planning and providing of services. West (1990) outlined several criteria for a successful team:

The interdisciplinary team is formed from a group of individuals who will undoubtedly have been drawn to this work for a variety of reasons. Most care-givers have personal reasons for needing to care, and a wish to understand and be involved in the dynamics of patient and family as well as in team work is a good beginning. A successful working team must begin with careful selection: Professional competence, flexibility, a sense of humour, respect for others, the ability to support colleagues and above all an awareness of what is meant by trust are all needed (p. 4).

Cummings (1998) offered additional insight, stating, "the composition of an interdisciplinary team will vary depending on the stage of development of the programme, the objectives of the programme, or the needs of a given patient" (p. 20). In the centre of this team is the patient, whose wishes determine both the treatment and the way care is provided (Cohen & Leis, 2002). Kuebler, Berry, and Heidrich (2002) stated:

The interdisciplinary team, through ongoing interactions with the patient and family, as well as with each other, develops a plan of care unique to the needs and concerns of the hospice patient and family. The plan of care becomes as a quilt; each individual part ultimately affects the beauty of the whole.

There is a subtle difference between interdisciplinary and multidisciplinary, but the most distinguishing characteristics lie in the relationship between team members. Multidisciplinary team members each follow their own piece of the care plan, do the interventions, and record them in the patient’s medical record. Interdisciplinary team members are more aware of the overall plan, work collaboratively with each other, and thus often experience significant ‘role blurring’ (p. 9).

The term transdisciplinary is found much less often in the literature, and may date in usage to as recently as 1948 (Merriam-Webster, 2003). It implies a dynamic combination of many disciplines (Bruscia, 1998), and has been used in a variety of contexts. One area is the health and social sciences (Higginbotham, Briceno-Leon, & Johnson, 2001). Another is psychology, for example in exploring relationships between consciousness, dreams, and the self (Arden, 1996). In special education, various disciplines may work together directly with children with multiple disabilities (Orelowe & Sobsey, 1996). In addition to coordinating the various disciplines as with an interdisciplinary team, a transdisciplinary approach might include providing services via combined visits. Here, interaction may be even greater, as the prefix trans or across, implies. As
Opie (2000) stated, “a transdisciplinary team is characterized by integrated thinking based on the sharing of knowledge and greater blurring of professional boundaries than in an interdisciplinary team” (p. 40). This may also require professionals to develop more fluid boundaries between their own and other professionals’ roles. As Opie (2000) observed, “clinically, members are involved in the role release rather than role retention as they seek to develop a common knowledge base” (p. 40).

In summary, while these three terms have been used in the literature, my own clinical experiences stimulated me to look for a term that would more accurately capture the dynamic and creative inter-relationship of the team and its members.

The Synerdisciplinary Treatment Team

The terms synergy and synergism, although also often thought of as modern or even new age, have origins in the New Latin word synergia, taken from the Greek synergos (Merriam-Webster, 2003). Synergism can be defined as the working together of discrete agents of change so that the overall result or effect is greater than the sum of those parts (Merriam-Webster, 2003). For instance, it has been used to describe how individuals interact creatively in problem solving and generating ideas (Paulus, Laye, & Dzindolet, 2001). This relates to Koehler’s work of the 1920’s in enhancing group performance through diversity (Hertel, Kerr, & Messe, 1999). The term synergy has also been used in describing the benefits of multi-cultural health teams in geriatrics and gerontology (Waite, Harker, & Messerman, 1994). In the palliative care literature, the term has been used in reference to the interaction effects of palliative medications (DeGraumont & Kindler, 2002; Schmoll, 2002), acute and palliative nursing practice and research (Davidson et al., 2002), and the planning and provision of regional palliative care services networks (Zalot, 1989).

I have proposed the term synerdisciplinary to capture the creative ways in which music therapy and the different disciplines can come together, play off each other, and interact dynamically. For example, I have experienced how the element of the shared creative music experience between other team members, the patient, and me, during joint visits, has gone beyond trans and into synergistic. This was especially evident when working in an in-patient setting where many of my team members were on-site and able to interact with the patient and family at various times and in different combinations depending on the patient needs. It has also been the case when team members and I have made coordinated visits to the patient’s home or other place of residence such as a nursing home or retirement village.
Haghighi and Pansch (2000) described the role of the music therapist in a combined hands-on team approach to hospice care which, to me, points beyond interdisciplinary and towards synerdisciplinary, again as the energizing medium of music is shared and interacted with by patients and staff in the same space at the same time. They offer seven examples:

1. With chaplain: Bedside communion, baptism, or other religious services or spiritual work.
2. With social worker: Family session, counselling sessions supported or intensified with music.
3. With nurse: Distractive device during procedures, pain management.
4. With home health aide: Distractive device during care, relaxation tool.
5. With massage therapist: Music coordinated with massage for effective relaxation.
6. With art therapist: Combined sessions that incorporate both modalities to complement each other.
7. With bereavement coordinator: Incorporate music into memorial services for families, survivors, and staff (p. 55).

The mutual significance and effectiveness of joint interventions may be enhanced partly due to the phenomenon of music holding and connecting everyone present in the same shared time and space. For example, when a pastoral counsellor and I worked together with a patient and family, the spiritual aspects of the music seemed to have been intensified. In addition, I observed the pastoral counsellor being able to take the discussions or exploration of spiritual issues deeper than I alone as a music therapist would feel comfortable doing.

The positive effects that music therapy can have within the treatment team itself are also an example of this synergy. Although the palliative care team may be assumed by some to always be functioning and interacting in a unified, positive, healthy, creative, and energized manner, because of the nature of their helping work and dedication of the staff, this is not necessarily the case and cannot be taken for granted. In fact, phenomena such as compassion fatigue (Harper, 1994), which can stress and burn out even the most dedicated staff, can negatively affect team dynamics when so many patient deaths are experienced by those staff on an on-going basis. The team can also absorb some of the pain, anguish, and stress being experienced by the patient and their family. As West (1990) stated in describing challenges of multidisciplinary hospice care, "the original concept of the 'total' pain of patients, with its physical, psycho-social and spiritual components has now been enlarged to include staff involvement and stress together with all the pains this can arouse" (p. 3). Cummings
(1998) considered some of the hazards inherent in coordinating interdisciplinary palliative teamwork, stating, “the very diversity that gives the interdisciplinary team its potential for effectiveness makes the team vulnerable if there is ineffective co-ordination” (p. 20).

The positive and creative ways in which the music therapist can help to synergise the team are many. As Loewy (2003) observed, “music therapists can also tie teams together. Interweaving aspects of music for patients and staff in order to create community within the work setting helps us build an environment of trust and safety” (p. 3). For me, these have ranged from inclusion of music-making at staff and team meetings to working creatively together in sessions with patients and families, providing informal times and opportunities for music making, song writing, music and reflection, team memorial services for team members to recognize the common losses we have shared, and improvisation and music-facilitated relaxation at staff retreats, development seminars, and workshops. Music therapists working in palliative care have also reported that music can be a re-energizing medium for themselves and their own personal healing in the midst of on-going losses (Aldridge, 2003).

The team is a living breathing entity, not a static and fixed group. Teams may experience highs and lows in physical, psychosocial, and spiritual areas, as do families and patients. As Jackson (1990) stated, when describing successful palliative care team building and maintenance:

*The leader needs to allow for peaks and troughs in the life of a team. These do not indicate that there is anything amiss with the leadership; they are a natural occurrence, particularly heightened when dying and death are an everyday event. One has to accept when the emotions of a team run high or low and encourage the team to have ordinary time together (p. 22).*

Music therapy as a flexible medium is well-suited to accompany these peaks and troughs, and the music therapist may be able to provide opportunities for team members to move through them together. Thus, a team which includes music therapy in so many facets and aspects of the care of the patient, family, staff, volunteers, and even the team itself, can be said to be synerdisciplinary. It is much more than simply a sum of the parts, as with a piece of music, which is much more than the sum of the notes.

*Music Therapy as a Synerdisciplinary Discipline*

Although music therapy as a discipline is often thought of by the treatment team as a distinct entity it, like the treatment team, is also multifaceted and multidimensional. As Bruscia (1998) stated, “the first challenge in defining music therapy is that it is transdisciplinary in nature. That is, music therapy is not a single, isolated discipline with clearly
defined and unchanging boundaries. Rather it is a dynamic combination of many disciplines” (p. 6). Music therapy also embraces a variety of theoretical models and approaches. This is especially evident in palliative and hospice music therapy, where clinicians report the use of techniques representing a number of diverse backgrounds, training, and philosophies in serving the needs of persons with life-limiting illnesses (Aldridge, 2003; Brooks & O’Rourke, 2002; Krout, 2003). As Hilliard (2001) stated, “the literature reflects a variety of philosophical views in palliative care music therapy from professional music therapists in the United States, Canada, Australia, and Europe” (p. 162). These approaches and techniques are based on the needs of the patient, and include:

- The Bonny method of Guided Imagery and Music (Bruscia, 1991)
- Cognitive behavioural methods (Hilliard, 2003)
- Improvisation-based methods (Lee, 1996)
- Music therapy as milieu (Aasgaard, 1999)
- Medical music therapy (Aldridge, 1994)
- Music-based collage (Munro, 1984)
- Musically supported counselling (Porchet-Munro, 1998)
- Life review (Beggs, 1991)
- Physioacoustic therapy (Butler, 1999)
- Psychodynamic (Bruscia, 1991)
- Psychospiritual music therapy (Salmon, 2001)
- Receptive approaches such as music listening (Curtis, 1986)
- Supportive eclectic music therapy for grief and loss (Bright, 2002)
- Song writing (O’Callaghan, 1990)

As needs of patients can change dramatically, both between and even within sessions, the music therapists need to be aware of various theoretical models of the dying process so they can be better informed as they select and use these interventions (Hogan, 1998). As West (1994) stated:

a variety of techniques and methods may be useful in music therapy for the dying patient. The therapist selects interventions with which he or she has skill and confidence and which are appropriate for the issues or tasks facing the patient (p. 121).

As the goals of palliative care are patient-driven, the music therapist may sometimes simply be present, fully attentive, and supportive of the work the patient is doing on their own. As West (1994) described, “there are times when the therapist must know when to step out of the way, allowing the patient to solo, for dying is ultimately something the patient will do alone” (p. 119).

The patient’s perception in the overall context of their hospice and palliative care is what is paramount (Hogan, 1999). Enck (2001) described
the “importance of the customer (patient) in defining quality in the form of needs and expectations, and in judging the quality and value of the products and services the organization produces” (p. 223). This implies that the quality of services is not just what we feel we are or are not doing as therapists, including whether or not we are practicing the theoretical approach with which we most identify. In a clinically related example, Whittall (1991) described her work and therapeutic role with a woman dying with a metastatic brain tumour, stating “working from a planned theoretical orientation, in this case, would have gotten in the way of my ability to give Claudette the space she needed” (p. 610).

The Synerdisciplinary Music Therapy Team: A Personal Account

I will now use these terms to describe the evolution of a music therapy department at Hospice of Palm Beach County, Florida, a hospice organization in the south-eastern United States, and my own experiences there that stimulated this writing. Music therapy was started at this facility using referral, assessment, and treatment techniques based on a cognitive-behavioural approach (Hilliard, 1995, 2003). When I joined the staff in 1997, I came from a background with different experiences and approaches than the two existing music therapists. Following the leaving of the music therapy program’s founder later that year, another clinician was hired with still differing educational and clinical experiences, backgrounds, and approaches. Additional therapists from very diverse backgrounds have been hired since, and the program has continued to grow, expand, and diversify in terms of the music therapists, their educational and clinical training and approaches, and treatment techniques. There are now 10 full-time music therapists employed with many different backgrounds and a tremendous diversity of approaches. This diversity and expansion since 1997 has been what I would term synergetic, as it has served to allow the therapists to creatively interact for the greater good of themselves, the various treatment teams in the organization, and the patients and families they serve.

This synergy was very rewarding to me as a clinician, manager, and researcher at the organization, and through the extremely creative interactions between the music therapists I was able to grow. The interactions were evident (a) at music therapy staff meetings when ideas were shared during case conferencing, (b) when the music therapy staff worked cooperatively on large scale projects and programmes, (c) when more than one therapist was involved with the care of a patient, (d) when a patient was transferred from one therapist to another due to changes in placement, and (e) when writing songs and performing together as an ensemble for various events and programs.
The referral and assessment tools used for music therapy also changed and evolved from what had originally been designed, as did the very description of music therapy services in the organization's educational materials. A description of the philosophy of the department at the 9th World Congress of Music Therapy in 1999 had evolved to be described as follows:

The philosophy of the music therapy program is in line with the philosophy of the organization, which is holistic and patient-centred. There is not one, over-riding philosophy of music therapy (e.g., behavioural, psychodynamic, developmental, etc.). The type of treatment approach used at any given time will depend on the needs and background of the patient (Krout & Jenkins, 1999).

This is not to say that the original cognitive-behavioural model was abandoned; it just became only a part of the whole. By being open to such diversity in approaches, the music therapy team has continued to allow these synergetic relationships and interactions to develop in an organic way. This is also reflected in the music therapy internship programme at the facility, which began in 1998 and which accepts interns from various universities. They bring new backgrounds and approaches based on their recent education and training; influences which again add to the diversity and synergy of the department.

Summary

The above has been a consideration of the use of the terms synerdisciplinary and synergetic as applied to treatment teams in palliative and hospice care. I have written about hospice and palliative care because it is here that I have experienced this exciting interaction of elements. This is not to say that other teams in other settings who work with clients, patients, students, and residents, with different needs, cannot be described in this way. The topic of music therapy within the treatment team has been addressed in journal issues, monographs, books, and articles in recent years, as well as at music therapy conference such as the annual conference of the Australian Music Therapy Association in 2002 (Krout, 2002). With future clinical success, music therapy teams within organizations will continue to grow and develop. As a result, these teams may also experience the richness and diversity that these varied backgrounds, philosophies, approaches, and clinical techniques from the broad discipline of music therapy bring with them. As such, we together will be able to better serve our clients and families, our team members, and ourselves in truly synergetic ways.
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