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# A Pilot Music Therapy-Centered Grief Intervention for Nurses and Ancillary Staff Working in Cancer Settings

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**Abstract**

A unique problem faced by clinical staff who work in cancer centers is finding a way to adequately and appropriately grieve the death of patients. Engagement in rituals such as funerals and family ceremonies are usually not considered within the scope of work responsibilities. Providing appropriate and effective ways to support the needs of staff to express their grief is challenging within the fast-paced hospital environment. This article describes the development of a music therapy-multidisciplinary intervention known as the "Remembrance Ceremony," based on Running's 4 elements of ritual. The intervention was developed by an interdisciplinary inpatient team at a comprehensive cancer center with the aims of facilitating the processing of grief in a group setting. The intervention consisted of live reflective music, readings, a platform for expressing loss and emotion, and a ceremony to bless the healers' hands. Programmatic evaluation provides preliminary evidence supporting the face validity and acceptability of the grief intervention. This suggests that a music therapy-multidisciplinary intervention based on ritual may show promise as a grief intervention for cancer nurses and other staff.

**Keywords**

grief, music therapy, interdisciplinary team, cancer, nurses, medical music psychotherapy, palliative care, compassion fatigue, bereavement

## Introduction

Recurring exposure to multiple deaths is a significant issue in oncology settings,[1] but in a fast-paced cancer hospital, many nursing and ancillary staff do not have time to address their own emotional responses or express grief. Nurses and other professionals report significant grief-related symptoms that impact on their relationships with other patients and their families.[2,3] Over time, this may lead to burnout or compassion fatigue which is found in roughly one third of oncologists and nearly half of oncology nurses.[4] Symptoms include emotional exhaustion (ie, feeling depleted and overextended); depersonalization (ie, emotional and cognitive detachment from the work); and reduced personal accomplishment (ie, perceived lack of effectiveness,[5] as well as depression.[6,7] Secondary traumatic stress, which can occur as a result of giving care to traumatized individuals, may also be a related issue of concern.[8-10]

It is important to note that it is not just licensed professionals who experience significant issues related to caregiver stress and burnout.[11] Individuals at the front desk, nursing assistants, telephone operators, and housekeeping staff all contribute to the care of the same patients and, therefore, are also exposed to emotionally distressing situations. These ''forgotten team members'' often have less access to information than physicians, nurses, and social workers and may be unintentionally excluded from clinical updates when a patient becomes more ill and dies.

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**Table 1.** Outline of the Grief Intervention

| | |
|---|---|
| 1. Improvised music on harp and guitar | 5 minutes |
| 2. Welcome and explanation of the aims of the ceremony. Each person introduces him/herself | 3 minutes |
| 3. First reading | 2 minutes |
| 4. Participants reminisce on patients that have died under their care. This is modeled by a PCT member who starts by saying, "I would like to remember . . . . She or he was important to me because . . . ." | 25 minutes |
| 5. Second reading | 5 minutes |
| 6. Hand washing and blessing ceremony that validates the work and the healing of medical staff's hands. Improvised music in harp and guitar | 5 minutes |
| | Total 45 minutes |

Thus, our research goals were (1) to develop and pilot a bereavement intervention for hospital staff working in high-mortality cancer settings and (2) to gather qualitative and quantitative data to evaluate the success of the intervention.

## Methods

### Setting

The pilot study was carried out in a 350-bed metropolitan comprehensive cancer center. Because psychosocial issues affect patients with cancer but are frequently unrecognized, patient care teams (PCTs) were introduced to each oncology unit or floor.[12] A PCT is multidisciplinary and comprises representatives from psychiatry, palliative care, music therapy (MT), social work, and chaplaincy, as well as nurses and physician specific to that unit.

The leukemia and lymphoma inpatient unit where the study was carried out specializes in treating patients with leukemia and lymphoma. It has 43 beds with a registered nurse-to-patient ratio of 1:4. There are generally 3 to 4 nursing assistants per shift. Nurse practitioners work closely with physicians and nurses. Patients are admitted to receive intensive chemotherapy regimens and for treatment of side effects and complications. Due to the complex course of these diseases, hospitalizations can be complicated by comorbidities that can affect functioning of multiple organ systems. In addition, many individuals become immunocompromised and must remain in hospital with protective isolation measures in place to prevent infection. Length of stay can vary from a few days to many weeks. The average length of stay for patients with lymphoma is 3 to 5 days and the average length of stay for patients with leukemia is 15 to 30 days. Readmissions are common. Medical staff develop pleasant and valued relationships with patients and their families over the course of months and years.

While patients are usually treated with curative intent, some eventually transition to palliative goals of care and end-of-life care is delivered at times on this unit. At times, there may be several deaths per week, losses that are particularly difficult as often these are patients who are well known to one and all.

Nursing staff who attend dying patients anecdotally and in administrative feedback reviews often describe a profound sense of loss and grief despite feeling appreciated by patients and families for their untiring efforts. Additionally, regular opportunities for guidance and peer support to manage compassion fatigue and secondary traumatic stress have been identified as effective management practices.[13,14]

For these reasons, the PCT set about to collaboratively design a grief intervention for nursing and ancillary staff.

We designed it based on the principles of ritual on which humankind relies in times of grief and loss.[15,16] Rituals help the bereaved to attribute meaning to life and death and help caregivers to integrate loss experiences into their personal world.[17,18] One challenge was to create an intervention that respects the pluralistic, secular, and nondenominational hospital environment that is meaningful to attendees yet is not dependent upon one particular culture or religion.

Running et al, identify 4 basic elements for ritual: (1) Symbolic elements such as music, readings, and objects; (2) A safe context for expressing emotion; (3) Time-limited structured process; and (4) The act of reminiscing.[19] Our intervention was, therefore, designed to incorporate these 4 elements of ritual which are detailed below and outlined in Table 1.

#### Symbolic Elements

*Music therapy.* Music therapy (MT) has been recognized on the unit for its unique ability to allow people to reconnect with aspects of themselves, which are often neglected during stressful hospitalizations.[20] One participant commented to a music therapist that music "makes hospital time into human time." Additionally, MT facilitates sharing and interaction,[21] reminiscence and life review, and a focus on meaning in life.[21-23] The concept of "music as container" is realized as individuals find the ability to express difficult emotions such as loss through their musical choices.[24-26] Furthermore, reactions by staff members are frequently supportive of MT interventions for caregivers as well as patients.[27] It has been reported that a significant number of staff find the musical experiences to be relaxing or uplifting. O'Callaghan and Magill found that staff bystanders receive an incidental yet significant benefit of support.[15]

We, therefore, designed the intervention to begin with music. Two music therapists provided improvised music on harp and guitar as nursing and ancillary staff members entered the room and took their seats. The decision to use live, improvised music allowed the music therapists to provide novel music which could be free to follow cues from participants and which would not access associations for staff members. The intervention took place at midday and the music therapists were cognizant of the fact that staff would be returning to their responsibilities after the ceremony.

The choice of instrumentation was based upon the skills of the therapists as well as a preference for the timbre of the guitar and harp together. In addition, these instruments were already familiar to staff on the unit as many had witnessed session work

**Table 2.** Reading

We can shed tears that they are gone
And then we can smile because they have lived.
We can close our eyes and pray that they will come back.
And then we can open our eyes and see all they have left to us.
Our heart may be empty because they will not come back
And then we can see all the wonderful moments that we have shared.
We can turn our backs on tomorrow and live in yesterday.
And after a while we can be happy for tomorrow because of yesterday.
We can be sad because there was no cure for them.
And then we can see that we could make a difference in their lives and give them comfort and hope.
May their memory strengthen our hearts and our hands for our work with everybody who is under our care now . . .
*- Unpublished reflection by Rabbi Nina Redl*

with patients. The therapists played at walking tempo in the key of G major chosen for its warm sound and harmonic compatibility for the harp and guitar. The use of common Western chord progressions (ie, I-IV-I/I-vi-ii7-V-I) was intended to promote a sense of ease and calm so that participants would feel welcome and connected. An additional function of the music at the starting and concluding portions of the ceremony was to mark the timing and pace of the session, lending form to the experience. The aim of the music itself was thus to create a sense of openness and gentle movement.[19]

*Readings.* An example of a reading can be found in Table 2. The reading aimed to encourage reflection on the person as well as the death and the loss.

*Objects.* The concluding portion of the ceremony was the Blessing of the Hands. The Blessing of the Hands was introduced by the former director of the chaplaincy department at MSKCC and has been widely used by many different settings within the hospital over the years (eg, the Compassion Fatigue Program, Nursing Week, etc). Its practical and spiritual intent is to emphasize that sometimes the healing hands of nurses and ancillary staff (including housekeeping and ward clerks) themselves need healing and nourishment. In this ceremony, a chaplain member of the PCT gently took the participant's hands and poured water scented with a blend of frankincense and myrrh over them. The chaplain then gently dried the each participant's hands with a fresh towel. Following this came the nondenominational blessing which reflected that even when no cure is possible, healing can be brought. The blessing was spoken softly to each participant to ensure the privacy of that moment:

May your hands be blessed in what they hold and what they let go.
May the work of your hands be blessed in gentleness and strength.
May your work be blessed with care and love.
Thank you so much for all the work and care you give.
*Rabbis Nina Redl and Harry Rothstein*

*A Safe Context for Expressing Emotion.* The Remembrance Ceremony was designed to give nursing staff a time and place to grieve that is protected from the competing pressures of nursing duties. Senior nurses arranged for each participant to be covered by a colleague for the duration of the intervention. The environment was nonjudgmental. Participants sat in a circle in a quiet conference room that was free from interruptions, located on the leukemia and lymphoma floor so that attendees did not have to leave the ward. Attendance was voluntary but also supported by nurse managers who validated its importance during prior staff meetings. It was decided not to display a list of deceased patients that might overwhelm the participants with sadness. Instead, participants were encouraged to share memories of a patient that had died under their care for whom they had formed an attachment. Thus, a focused approach on patients perceived by participants to be more memorable or meaningful was chosen. It was felt that by leaving a "blank slate," staff would be better able to enter into the ceremony space, deriver peer support and share stories about their patients.[28]

A unique aspect of conducting a grief intervention on an inpatient unit is that there must exist a sensitive balance between acknowledging, remembering, coping, and moving forward. The PCT designed this particular ritual to help create a place for loss-based coping,[29] allowing the staff to acknowledge and process their feelings of grief, while also encouraging restoration-oriented coping[29] by supporting engagement with their current work and moving forward. After the intervention, staff returned to work and therefore needed to be in a frame of mind that facilitates work and problem resolution. Interventions that overly focus on sadness risk-inducing regression. Music, with its elements of tempo, melodic line, and harmony can be created to set the tone for this balance between reflection and moving forward.

*Time-Limited Structured Process.* The PCT designed the ceremony to be held biannually. In the case of this study, 2 back-to-back ceremonies were conducted. This cross-coverage was arranged to ensure continuity of patient care. Each session was 45 minutes in duration and within this time frame, the structure was fixed and rigid with predefined lengths for each element, as can be seen from Table 1. This allowed a predefined limit to the expression of grief that is important for return to work, immediately after the session, as previously mentioned.

## The Act of Reminiscing

One important aspect of group grief interventions or rituals is the normalization of the grief process. Normalizing the experience of work-related grief and bereavement in the workplace has been shown to facilitate coping in oncology nurses.[1] There is a role for interprofessional sharing of personal reactions to loss as a way to build resiliency in staff and ensure quality care for patients.[1,18] Thus, the group acts as a vehicle for individuals to reminisce.

**Survey: Remembrance Ceremony**

Please assign a number (1-5) for each question below with 1 being least effective and 5 being the most effective. Thank you.

1. How would you rate the effectiveness of the ceremony to help participants in their grief over patient deaths?
2. How effective overall was the use of the ceremony for you?
3. How effective were the readings?
4. How effective was the music?
5. How effective was the reminiscing?
6. How effective was the Blessing of the Hands?

Comments: Was there anything else you found helpful or would like to change in the future?

**Figure 1.** Survey: Remembrance Ceremony.

### *Program Evaluations*

The intervention was evaluated using a retrospective survey that was sent to members of the PCT who facilitated and participated in the grief intervention. The institutional review board of the cancer center granted an exemption to allow results of the survey to be published.

They were asked to rate the efficacy of the intervention in assisting nursing and ancillary staff with the grief process and to rate the level of effectiveness of its ceremony elements on a 1 to 5 Likert scale with "1" being *least helpful* and "5" being *most helpful*.

The items were how would you rate the effectiveness of the ceremony to help participants in their grief over patient deaths? How effective overall was the use of the ceremony for you? How effective were the readings? How effective was the music? How effective was the reminiscing? How effective was the Blessing of the Hands? Following the 6 questions, there was also a comment section for participants to write in their own words anything they might like to change or have remain the same in the future.

## Results

Attendees, which totaled between 10 and 20 for each of the back-to-back sessions, were mainly nurse practitioners, nurses, and nursing attendants; however, representatives of pharmacy and housekeeping also attended as did the ward clerk. Members of the PCT who attended included the following professions: psychiatry, MT, social work, palliative care, and chaplaincy. No physicians from the leukemia/lymphoma service attended. No representatives of the night nursing shift were present because the intervention was held during mid morning.

Each participant was invited to introduce themselves because the large size of the unit, which was itself divided into different teams, and the presence of a variety of multidisciplinary providers, meant that not everyone knew one another well.

Bereavement reflections focused on both the patient as a person and the difficulty of the dying process. Some recollections reflected on humorous incidents, while others expressed sadness and heartfelt admiration for the patients and family members. While some individuals were forthcoming with their thoughts, others appeared to be more receptive and spoke less.

One participant shared that loss in her personal life had been making patient losses even more difficult to bear. She was embraced by another staff member and offered support. Another told of how the patient had counseled her about family difficulties that she was having and how much that advice had helped her. This reflects how well nursing staff and patients get to know each other over weeks and months of intimate treatments.

Many of the participants expressed thanks to the PCT. One commented, "I am so glad I went. It helped me to remember that I am surrounded by kind people." The emotional responses to the Hand Blessing varied from tears to calm demeanor to laughter. Some individuals left right after the blessing, while others stayed for a few additional moments listening to the music until its conclusion.

### *Survey Evaluations*

Of the eight members of the PCT, 6 returned the surveys (Figure 1). Of the 6 respondents, all ratings were in the moderately, very, or highly effective range, that is 3 to 5/5 on the Likert scale. There were no ratings in any category lower than "3." All respondents reported that the ceremony overall ranged from very helpful to most helpful.

In particular, evaluations reflected that the ceremony was very to extremely effective in helping participants process their grief over patient deaths (Figure 2). Similarly, PCT members found it very to extremely effective in helping them to process their own grief. Here are some of their feedback comments:

> Because I work on a lot of different floors, I sometimes have difficulty remembering which patients were lost in the past year from each floor, but I would (in a way) like to have all their names read at the beginning of the ceremony (or perhaps at the end as a transition to the hand washing). The names do not have

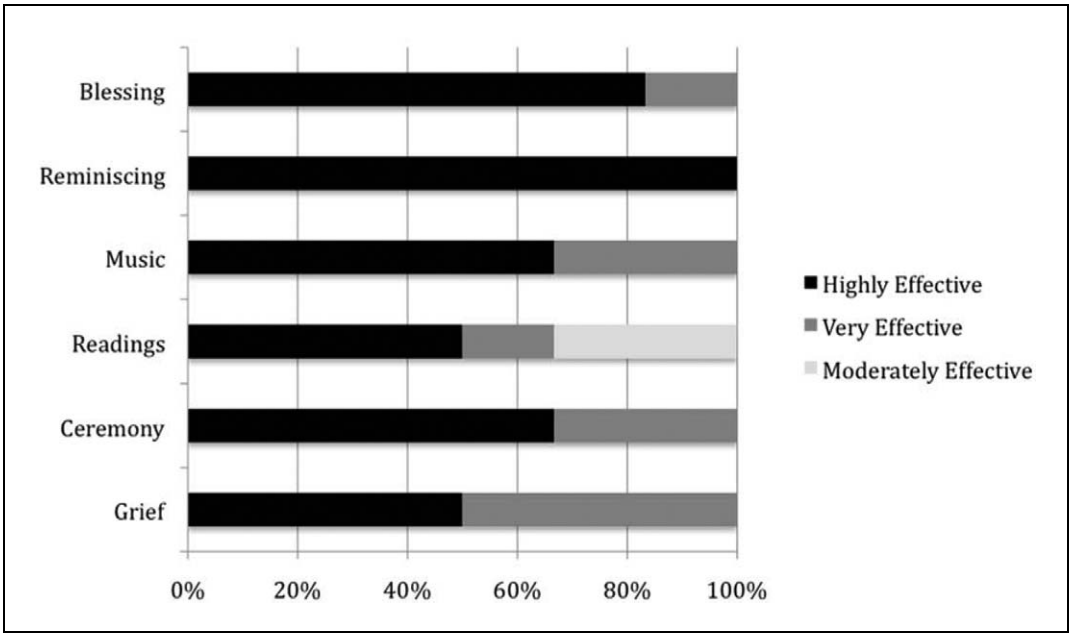


**Figure 2.** Remembrance Ceremony survey results.

to be acknowledged individually, but it would offer a chance to reflect privately. A chime could be rung after every name to provide a little space. I understand the concern of having a list to look at, because it might be too overwhelming, but it might help stimulate reminiscing.

The effectiveness of the reminiscing is different every time: I think the most powerful one I have witnessed involved peer support that was very moving and cathartic. Sometimes the reminiscing is only skin-deep and does not probe, but the fact is that most of us do experience grief. The way we cope is perhaps to avoid examining it too closely.

I wish the readings (from chaplaincy) would have some variation but perhaps that is because I hear them about 3 times a year and it starts to feel formulaic. The Blessing of the Hands can be very powerful—I think that is one thing I would not want to change.

Ceremony was useful as an "open" context for safe conversations about doubts nurses had about their profession in hospital center. Safe environment aided other nurses to address these doubts during the reminiscing period.

I thought that the ceremony promoted a sense of group that facilitated healthy expression of grief within the framework of ritual and emotional support. It should definitely be repeated. It should focus on nurses, attendants and other floor staff but not MDs who should have their own peer specific groups.

I liked the sense of community and the notion that my participation was for me and my co-workers. I felt that the components of the ceremony (readings, music, reminiscing, etc) blended well with one leading to the next. This created a safe feeling for me.

## Limitations

The survey was administered retrospectively to a small sample of PCT members, which limits our ability to generalize the findings. In the next phase of testing, a pre- and postintervention evaluation of all participants will occur. Of note, physicians did not participate in the ceremony. It may have been due to the fact that the time and location was not conducive to their schedules. Another possibility was that physicians did not necessarily identify with the broader nursing group, given that physician rotations result in a different level of patient and staff interactions. In the future, we hope to test the intervention on physician groups.

## Conclusion

We designed and pilot tested a MT-based, multidisciplinary intervention, the Remembrance Ceremony, founded on the theoretical perspective that rituals can facilitate the grieving process.[16] Preliminary results suggest that the intervention was highly acceptable and appears to have a promising effect on grief processing for staff. This study demonstrates the important role of MT in facilitating grief interventions for oncology staff. Because the intervention is structured, spiritual yet nondenominational, requires few resources, and relatively little facilitator training, it can easily be adapted within medical settings and across different cultures. Given the importance of supporting nurses and ancillary staff in processing their work-related grief and the promise of the Remembrance Ceremony, we plan to further refine and evaluate this intervention with more rigorous research approaches in future studies.

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