

THE FLORIDA STATE UNIVERSITY

SCHOOL OF MUSIC

THE EFFECTS OF MUSIC THERAPY INTERVENTIONS ON GRIEF AND
SPIRITUALITY OF FAMILY MEMBERS OF PATIENTS IN A HOSPICE
SETTING

By

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A Thesis submitted to the
School of Music
in partial fulfillment of the
requirements for the degree of
Master of Music

Degree Awarded:
Spring Semester, 2005

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For the patients and their families, for showing and telling me how precious a life is and how wonderful music is.

ACKNOWLEDGEMENT

First of all, I would like to express my appreciation to Dr. Standley for her thoughtful advices and encouragements through the entire process. Second of all, I would like to take this opportunity to thank Melanie Harms, Darcy Walworth, Linda Robert, and Karle Gordon for their tremendous supports. I would also like to give special thanks to Natalie Wlodarczyk, Sarah Kerr, Jara Stull, Dave Sinton, and other hospice staff of Big Bend Hospice for their help and assistant in data collection. Last, I would sincerely give my appreciation for my parents, my brother, and Yuko for their understanding and support, which I will never forget.

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ABSTRACT

The purpose of this study was to investigate the effects of music therapy interventions on grief and spirituality of family members of patients in a hospice setting. The subjects (N = 60) were the family members or significant others of hospice patients who had been in the hospice program for at least 2 weeks. The subjects were divided into a control group (N = 30), the family members of patients previously with no music therapy visit, and an experimental group (N = 30), the family members of patients receiving music therapy interventions. Three imminent patients were also included in both groups. A self-report questionnaire was used for a post-test only in this study and had 5 categories: grief, coping strategies, spirituality, satisfaction with hospice care, and satisfaction for family members' or significant other's perceptions of the loved one's quality of life (QOL). A multivariate analysis of variance (MANOVA) was applied to analyze data in each subtest. There was a significant difference in mean scores of QOL between the control and experimental groups. Although the mean scores of grief and spirituality in the experimental group were higher than the scores of those with no music therapy, a significant difference was not found in the 4 subtests. However, there was a tendency that those who received music therapy showed higher scores than those who did not in each subtest. In addition, the mean scores of family members of imminent patients were much higher than those with no music therapy in all 5 categories. The results in this study support that music has a potential to provide a positive influence for patients and their family members in a hospice setting. Further quantitative research for family members of imminent patients were suggested to provide better music therapy services in a hospice and palliative care.

INTRODUCTION

The number of hospice programs in the United States has dramatically increased since the hospice movement in the early 1970's (Smith, 2001). This is because many people today realize and believe that those who have been diagnosed with terminal illness should live with dignity, free of physical, social and spiritual pain, and respect and support from their loved ones as well as significant others at any given time. According to the National Hospice and Palliative Care Organization (2004), hospice and palliative care is defined as a total care that focuses on the physical, emotional, social, and spiritual needs of not only patients, but also their family and significant others with a deep understanding that terminal illness greatly affects them. In this total care, patients and their family are considered as a whole and receive warmhearted and generous support via a natural, patient-centered approach by an interdisciplinary team (Callana & Kelley, 1992).

Buckingham (1996) states, "Dying is part of the process of living." Perhaps, it is the most difficult reality to accept and confront (Kemp, 1995). In fact, a variety of difficult and intense situations related to the dying process of a family member with terminal illness bring difficulties for all concerned to meet their needs in their daily activities and maintain their social status in society as well. In addition, while devoting themselves to caring for their loved one, the family members of a terminal patient must physically and mentally prepare for a tragic moment as their loved one takes his/her final journey.

Locke (1994) defines grief as an emotional and physical reaction to loss. Grief implies "intense sorrow, especially caused by someone's death", according to The Oxford Dictionary of English (2002). Grief can be expressed physically, cognitively, affectively, or behaviorally. Cognitively, grief may take the form of disbelief, confusion, preoccupation with thoughts of the deceased and perhaps of the dying process, and perceived encounters with the deceased in ways that make that person seem still alive. Effective ways to express grief may be depression, sadness,

sorrow, relief, guilt, anger, or denial (Olson, 2001; Locke, 1994). Physical expressions of grief may be such symptoms as a hollow feeling in stomach, a tight feeling in the chest, breathlessness or shortness of breath, or lack of energy. In addition, behavioral expressions of grief may include sleep disturbances, lack of appetite, social withdrawal, crying, and/or sighing a great deal (Sendor, 1997).

The grief process that the family begins long before death is called “anticipated grief.” The grief process may begin at the moment of recognition of the symptoms of illness or even at the moment of suspicion of a life-threatening illness (Bright, 2002). In other cases, the grief process begins at the moment of the acceptance of the implications of the illness and the recognition that the member will be progressively lost in the family setting and ultimately lost as a living person. The reasons and period of onset of this anticipated grief are various and different in each family (Siebold, 1992). Although the degree of grieving of the family members of a dying person depends on dynamics related to closeness of their relationship with their loved one, the reactions of the family with anticipatory grief may be the same as the ones mentioned above.

One of the reasons why hospice and palliative care are referred to a person with terminal illness or their family is that these programs can provide more emotional and spiritual supports for these individuals than do any other facilities (Beresford, 1993). In a medical or mental health care setting, for example, spiritual care is rarely included as a treatment (Conner, 1997). On the other hand, in a hospice setting, a significant amount of attention is given to ensuring that patients as well as their family, if needed, receive spiritual support. For many dying patients, spiritual care is the most important aspect of care regarding their fear, anxiety, or grief during the dying process. Therefore, addressing spiritual concerns of patients as well as their family is quite important to help them find hope and coping strategies, thereby enhancing their quality of life (QOL).

Music therapy has been recognized as an important intervention to meet patients and their family members’ needs (Bright, 2002; Krout, 2003). For instance, music encourages patients to express their feelings, thoughts, hopes, and fears. Specific music requested by patients and/or their family members may be used to stimulate, to evoke reminiscence, or to facilitate interaction and communication between the patients and their family members (Whittall, 1989). Instrument play may be used to increase patient’s mood and motivation and, therefore, decrease isolation that is very common among patients with terminal illness (Bright, 2002). The music

therapist may be able to maintain a peaceful environment or increase comfort measure via soothing music. In addition, Munro (1986) states that patients and their family members may receive spiritual support through religious music.

It is not uncommon that music therapists who provide support for a patient's family in the process of grieving often confront difficulties and challenges due to the tremendous impact of terminal illness on their loved one. Although many researchers have discovered that music has been successfully used to meet patient's needs in hospice and palliative care, no quantitative research has been found regarding the effects of music therapy on family members of terminal patients. Therefore, it is important to know how family members or significant others of a patient with terminal illness receive or find hope or coping strategies. This research study is to investigate the effects of music therapy interventions on grief and spirituality of family members of a patient in a hospice setting.

LITERATURE REVIEW

According to the report from the National Hospice and Palliative Care Organization (NHPCO) in 2003, there are more than 3,300 hospice programs across the country today. These programs include hospitals or health systems, independent facilities, non-profit agencies, and for-profit companies. The statistics compiled from NHPCO also show that about 950,000 people received hospice/palliative care in 2003. These numbers represent 20% growth since 2001 and 500% in the last two decades. This is because many people today realize and believe that those who have been diagnosed with terminal illness should live with dignity, with freedom from physical, social and spiritual pain, and with respect and support from their loved ones as well as significant others. Bookbinder and Kiss (2001) define a good death as “one free from avoidable stress and suffering for patients and families and caregivers; in general accord with patients’ and families’ wishes; and reasonably consistent with clinical, cultural, and ethical standards” (p. 91).

Hospice is not a place or a building. It is rather a philosophy, a special kind of caring when cure is no longer possible (Smith, 2001). Hospice consists of a coordinated interdisciplinary program of humanistic care and supportive services for terminally ill patients, their families, and significant others (Siebold, 1992). The interdisciplinary team includes attending physicians, nurses, family support counselors, bereavement counselors, home health aides, chaplains, and trained volunteers (Eustler & Martinez, 2003; Buckingham, 1996). Other services may be available upon request from patients or the family, such as occupational therapy, speech therapy, music therapy, art therapy, and massage therapy (Connor, 1998).

The primary goal in hospice care is to help the dying and their loved ones maintain the dignity and humanness of the dying process and make them as comfortable and calm as possible (Beresford, 1993; Kubler-Ross, 1969). Hospice also considers the ill person and the family as a whole. Parry (2001) states that the patient and family are considered to be the “unit of care.” Hospice addresses the physical, emotional, spiritual, and social needs of patients, their families,

and significant others (Bennahum, 2003; Robert & Buckingham, 1996; Connor, 1998). The concept and approach of hospice and palliative care are often called, “total care”, “humanistic care”, or “a natural, patient centered approach”(Matzo & Sherman, 2001; Parry, 2001; Siebold, 1992; Smith, 2001).

History of the Hospice Movement

The idea of hospice origin has a long history and deeply relates to the religious custom and practice in the ancient period. According to The Oxford English Dictionary Second Edition Volume VII (pp.414, 1989), hospice is defined as “a house of rest and entertainment for pilgrims, travelers, or strangers, especially one belonging to a religious order, as those of the monks of St. Bernard and St. Gotthard on the Alps; also, generally, a ‘home’ for the destitute or the sick”. Historically, the terms, *hospice*, *hospital*, *hotel*, *hostel*, *host*, *hostess*, were used interchangeably (Buckingham, 1996). All these words have the same root as the Latin word, *hospes*, hospitality (Amenta, 1986; Bennahum, 2003; Connor, 1998; Putnam, 2002). The concepts of these words are welcoming for strangers or guests with kindness and generosity.

The early Egyptians, Orientals, Greeks, and Romans in the ancient period used their temples or churches as places for those who were poor, sick and dying, in labor, orphaned, or a religious pilgrimage (Seplowin & Seravalli, 1983). Manning (1984) mentions that in Greek of Homeric Times, all travelers and strangers were treated as a guest, and they were considered to be placed under the protection of Zeus Xenios. These guests were given food, clothes, and a place to stay by the host without being asked their name or background until the hospitality was adequate for their satisfaction (Cohen, 1979). A similar practice was seen in India around 225 B. C. The emperor, Asoka, offered a special facility for the dying who came to the Ganges River (Siebold, 1992). The same practice was also found in Rome at the same period. Private hospitality for guests was more likely to be established in Rome than in Greece (Amenta, 1986).

The Port of Rome was one of the examples of the early hospices in the world in A. D. 475 (Siebold, 1992). The Great Saint Bernard (A.D. 962) is another famous example of the early hospice (Amenta, 1986; Cohen, 1979). This facility, which is still operated by Augustinian monks and located in the Swiss Alps, was used for refuge when the travelers and pilgrims who became sick or lost while traveling through the mountain. Their lives were saved by Saint Bernard dogs’ rescue (Bennahum, 2003; Siebold, 1992).

It was the Crusades that brought a significant impelling force to the hospices during the Middle Age period (Connor, 1998; Putnam, 2002). Travelers to and from the Holy Land, as well as the sick and the dying, were cared for at the hospices (Buckingham, 1996). The Knight Hospitallers of St. John of Jerusalem helped the religious to build hospices throughout Europe (O' Connor & Gleeson, 1989). The Knights developed a special structure and facilities for caring of the sick and the dying in Rhodes. During this time, the sick and dying received particular attention and were honored and treated with the greatest dignity and care that the order could offer. However, the dying or incurably ill were treated separately from the pilgrims and travelers (Amenta, 1986; Cohen, 1980; Buckingham, 1996).

Due to the expansion of scientific knowledge and the emphasis of research and cure, new hospices were seldom built during the seventeenth century (Siebold, 1992). Therefore, caring for the sick and dying was no longer taking place in a private or religious place but at the facilities in a public or government site. Along with this inclination, university-trained physicians only focused on a scientific approach to treating disease to improve their status and their credibility with the public (Buckingham, 1996). As a result, the older hospices were renamed as hospitals and others ceased to exist. However, these hospitals in this period were not open for everybody. Researchers and physicians working in the hospitals believed that their job was only to cure disease, not to provide supportive services for the dying poor or respite for weary travelers (Putnam, 2002).

Despite the health care trends in the 17th century, some religious groups still maintained a level of hospice care at the same time. For example, Saint Vincent de Paul (1581-1660) founded the order of Sister of Charity and opened hospices throughout France with a mission to care for orphans and the poor as well as the sick and dying (Amenta, 1986). The efforts of St. Vincent de Paul had a great deal of empathy for those in need. In addition, his splendid achievement made the hospice tradition of the Middle Ages pass into hospice history.

During the nineteenth century, hospices experienced a rebirth along with the public trend of dying with a terminal illness. In 1897, Sister Mary Aikenhead, who was a member of the Irish Sisters of Charity and had spent time in the St. Vincent de Paul hospices in France, opened Our Lady's Hospice for care of the dying in Dublin (Backer, Hannon & Russell, 1994). The Irish Sisters also founded a convent in London's East End in 1900 and two years later, they established St. Joseph's Hospice for the dying poor (Connor, 1998). Cicely Sanders, who is

known as the founder of today's hospice philosophy, devoted herself to care of the patients at St. Joseph's Hospice and developed her approaches of total care for the dying as well as their loved ones.

The hospice movement in the United States was brought to the United States by the effort of British physicians Dame Cicely Saunders and Dr. Elisabeth Kubler-Ross (Backer, Hannon & Russell, 1994). They broke the old traditions concerning death, often labeled as a "taboo", and developed holistic approaches to enhance well-being and quality of life of dying persons and their families as well as significant others (Smith, 2000). More importantly, it was by Dame Cicely and Elisabeth Kubler-Ross's work that people became aware of the importance of providing care with respect, understanding of individual's uniqueness as a human, and sympathy.

The first hospice in the United States was established in New Haven, Connecticut in 1974, shortly after a lecture at Yale Medical Center (Bennahum, 2003). Following this first hospice, several hospices were built across the country: New York, California, Arizona, and New Jersey (Connor, 1998). Along with this hospice movement in the United States, the Medicare Hospice Benefit was made permanent in 1986, and today, most states provide hospice Medical coverage (Parry, 2001). To be admitted into a Medicare certified Hospice program, patients' prognosis of death is diagnosed as six months or less by physician. Hospice offers care to people of all ages and not only to cancer patients, but also to end-stage respiratory, neurological, cardiovascular, AIDS, Alzheimer's Disease, cystic fibrosis, or other life-threatening conditions. In addition, hospice provides extended care to support grieving family members and significant others before and during bereavement.

Grief

Loss of a loved one has a tremendous impact on family members. Issues involve seeing the dying face and the progressive loss of everything, including health, occupation, body image, pleasures, significant relationships, and the future. The family members who will be left behind face the loss of their loved one who has been an integral part of their family system and have to learn to adjust to this reality. An understanding of grief is, therefore, an essential part of working with terminally ill persons and their families to provide good care in hospice care.

Grief, mourning, and bereavement are words commonly used by researchers, clinicians, and grieving people to describe the feelings and behaviors that follow significant loss. Although

these terms are often used interchangeably, certain idiosyncratic differences exist (Kemp, 1995). Many authors describe grief as a normal and natural way to respond to loss although it is often deeply painful (Bright, 1996; Bruth & Schultz, 2001; Doka, 1997; Locke, 1994). The most tragic loss that people think of could be death of a loved one. However, grief involves many other significant changes in one's life. The lost "object" does not necessarily have to be a person. Bruce & Schultz (2001, p.31) state, "it could be the characteristic response to the loss of a valued object, be it a loved person, a cherished possessions, a job, status, home, country, an ideal, a part of the body". For example, if one gives up a habit such as smoking, a loss is experienced (Parry, 2001). The subject's significance and meaning of the loss is, therefore, of central importance to the individual.

Each individual experiences and expresses grief differently. For example, one person may withdraw and feel helpless, while another might be angry and want to take some action (Small, 2001). No matter what the reaction, the grieving person needs the support from others. It is important that a helper needs to understand and anticipate the characteristics of emotions and behaviors of grief, accept the grieving person's reactions, and respond accordingly (Shuchter, 1986). Therefore, it is also useful for the grieving person and for the helper to have knowledge about the concept of grieving process.

"Whenever one experiences loss, certain reactions are common in normal grief" (Doka, 1997, p.8). Grief can be expressed physically, cognitively, affectively, or behaviorally. Cognitively, grief may take the form of disbelief, confusion, preoccupation with thoughts of the deceased and perhaps of the dying process, and perceived encounters with the deceased in ways that make that person seem still alive. Pine (1974) mention that affective ways to express grief may be depression, sadness, sorrow, relief, guilt, anger, or denial. Physical expressions of grief may be such symptoms as a hollow feeling in the stomach, a tight feeling in the chest, breathlessness or shortness of breath, or lack of energy. In addition, behavioral expressions of grief may include sleep disturbances, lack of appetite, social withdrawal, crying, and/or sighing a great deal (Sendor, 1997). Grief also creates spiritual distress (Olson, 2001). In general, the most common spiritual reaction to loss may be the search for a sense of meaning or sense of well-being. For instance, "what did my life mean to me?" or "what is my dignity?" are often expressed (Sanders, 1999). Additionally, other common spiritual reactions toward loss may

include anger at God, feeling distant from God, emptiness of faith, questioning of one's basic beliefs, or withdrawal from the place of worship (Bright, 2001; Locke, 1994).

Anticipatory grief is another type of grief. According to Pine (1975), it is a normal mourning reaction that occurs when individuals confront an anticipated loss. The characteristics of anticipatory grief might be the same symptoms as the ones of normal grief mentioned above although the degree of family members' grief depends on dynamics related to closeness of their relationship with their loved one (Aldrich, 1975; Sendor, 1997). The difference between normal and anticipatory grief is that people with anticipated grief have more opportunities and time to slowly get used to the reality of the loss and to develop coping strategies (Barton, 1977; Kemp, 1995).

Abnormal grief reactions are more complex than normal/anticipated grief reactions. Experiencing unexpected or sudden death or losing someone in a very close relationship may cause abnormal grief. Some of the common problems in abnormal grief may include such symptoms or behaviors as major depression, severe anxiety, or substance abuse (Barton, 1977). The length of the grief period is also extended compared to these of normal/anticipated grief. Since the intensity of abnormal grief is tremendously strong, it causes maladaptive behaviors, such as contemplation of suicide (Sanders, 1999). Individuals with abnormal grief are often treated with drugs and psychotherapy.

Many psychologists and researchers expound theories about the grief process that the bereaved is likely to go through although it is not necessarily the same for everyone. Kubler-Ross (1969), for example, mentioned the five phases of dealing with death: denial, anger, depression, bargaining, and acceptance. In Sanders' theory (1999), there are also the five phases proposed: shock, awareness of loss, conservation-withdrawal, healing, and renewal. The theories of both Bowlby (1982) and Parkes (1986) are quite similar; they delineate four phases: numbing, yearning and searching, disorganization and despair or depression, and reorganization. Freud (1957) also described these processes in his article, "Mourning and Melancholia" although he did not specifically create phases or processes.

According to the theories of Kubler-Ross (1969), Sanders (1999), Bowlby (1982), and Parkes (1986), feeling emotionally numb is often the first reaction to a loss. Parkes mentioned that this reaction can occur immediately upon hearing of the loss or some minutes later and will last for a few hours, days or longer. Bowlby (1982) explained that at this stage, the bereaved

feels stunned and is unable to process the information. Denial is also a common reaction of the bereaved (Kubler-Ross, 1969). However, numbing protects the individual from experiencing the intensity of the loss (Freud, 1957).

The numbness may be replaced by a deep yearning for the person who has died. The survivor may feel agitated or angry and find it difficult to concentrate, relax, or sleep at this stage. In Bowlby's theory (1982), searching and other behaviors, such as intense pining, and persistent yearning begin at this moment (Bruce & Schultz, 2002). Parkes (1986) described the characteristic of searching behavior as restless hyperactivity. He also discussed that the bereaved often have difficulty focusing on anything but the lost person. In addition, the bereaved may feel guilty as well.

Due to the intensity of the pain and longing for a relationship that cannot be retrieved, the bereaved person may feel a need to pull away from social contacts and spend more time alone. The bereaved has to confront and deal with overflowing emotions in the third phase of Sanders' theory, "conservation-withdrawal" (Sanders, 1999; Small, 2001). During this time, the survivor may be prone to sudden outbursts of tears, set off by reminders and memories of the dead person. Therefore, a feeling of overwhelming depression that may include feelings of total despair, intense loneliness, and helplessness causes tremendous amounts of fatigue for the survivor (Locke, 1994). Locke (1994) also mentions that these feelings are especially intense for those who live alone or have few friends or family to turn to.

The process of grieving in response to a significant loss requires time, patience, courage, and support. Through these processes mentioned above, gradually, the pain, sadness, and depression start to lessen (Sanders, 1999; Small, 2001). Although the bereaved may not completely overcome the feeling of loss, he/she is able to find a way to gain control and handle things without his/her loved one. The bereaved accepts the environment and learns how to live in the future (Bowlby, 1982; Parkes, 1986). The bereaved also manages physical needs for oneself and becomes more confident and stronger than before. Finally, the bereaved becomes ready for "letting go", the most painful task, before and moves on with a new life (Locke, 1994).

Spirituality

Spirituality is another important intervention to enhance the quality of life of patients and their family members in hospice and palliative care. Confronting dying often brings with it

questions such as, “Why me?” or “What will happen to me when life ends?” or “What has my life meant?” Physical or emotional pain from life-threatening illness also becomes spiritual distress not only for patients themselves, but also for their families and significant others.

Although the terms *religion* and *spirituality* are often used interchangeably, there is a difference. Both have to do with attempting to understand one’s place in the world and life’s meaning or purpose. According to the Oxford Dictionary of English (p1799, 2003), the word, spiritual, is defined as, “relating to or affecting the human spirit or soul as opposed to material or physical things” and “relating to religion or religious belief.” Spirituality prompts individuals to make sense of their universe and to relate harmoniously with self, nature, and others, including God. On the other hand, religion is a formalized system of belief and worship. It offers an individual a specific worldview and an explanation that seeks to provide answers to the questions of ultimate meaning. The Oxford Dictionary of English (p.1487, 2003) describes the term, religion, as “the belief in and worship of a superhuman controlling power, especially a personal God or gods.”

The concept of spiritual pain has been identified, described, and analyzed by many writers and researchers (O’Brien, 1999). Just as some patients with terminal illness suffer from serious physical pain, some patients experience pain in their inner being that can be a greater deterrent to comfort than physical pain. Spiritual pain is definitely a factor in total suffering, not only from physical and emotional pain, but also from feeling and thinking of the loss or separation from God and/or institutionalized religion.

Ross (1994) noted that spirituality consists of three components: meaning, hope, and faith. The search for meaning in life is facilitated by the questions the patient is asking, such as “what would you like to be if you had one more life?” The search for meaning includes the individual’s life, the purpose of life, and the belief in a primary force in life. In hospice setting, the patients as well as their family members are often seen suffering from the search for the meaning of death or for the remainder of their remaining of life. The absence of meaning in one’s life may cause hopelessness or despair.

Hope is an important factor in spirituality to deal with stress, in maintaining quality of life, and in some other cases in continuing life. Olson (2001) states, “hope is a vital spiritual need”. Kemp (1995) explains that hope relates to anticipation that something desired will occur. In Beckman and Northrop’s study (1996) among 94 chronically ill elders, hope is one of the most

important sources to find meaning, joy, and a positive sense of well-being.

Well-being has been defined as a multidimensional construct. Most studies investigating religious involvement and well-being have uncovered a strong association between the two constructs. In a study of Plante and Boccaccini (1997), the college students with high strength of religious faith had higher self-esteem, hope, and adaptive coping and less interpersonal sensitivity. Positive associations with well-being may be due to the impact of faith on both positive and negative emotions, such as increased forgiveness or reduced guilt (Pargament & Brant, 1998; Patton, 2000).

The idea of well-being is also closely related to the concept of hope. The specific things to hope for may be confidence in the outcome, ability to cope with others, life after loss, spiritual beliefs, finding meaning, and so forth. When people feel that their hope is well founded, they are more likely to describe themselves as peaceful, happy, strengthened, blessed, joyful, or warmer than people whose hope appears to be unrealistic and inadequate.

There are some other types of spiritual needs. O'Brien (1999) described, as nursing diagnoses, several terms of spiritual needs other than spiritual pain in her previous research study. "Spiritual Alienation" is defined as expressions of spiritual loneliness due to the feeling of being away from God and any other worship activities. The term, "Spiritual Anxiety", includes an expression of fear of God's wrath and punishment. She also mentioned the individual's regression about things that were against God as "Spiritual Guilt". Frustration or anguish toward God is described as "Spiritual Anger". "Spiritual Loss" causes individuals to feel distance from God and to fear that they are not attached to God. The indication of "Spiritual Despair" is evidenced by the expression of individuals that it is no longer possible to build relationship with God and that, therefore, they are not under God's protection.

Religion and spirituality play an important role in how the patients as well as their family members cope with the tragic moment of death (Aldridge, 1995). Hope is one of the key factors for coping strategies. In Bennet, Deluca, and Allen's study (1995), attending worship activities increased the positive coping mechanisms and provided strength and hope for the families of children with disabilities. Mickley, Pargament, Brant, and Hipp (1998) state that religious coping mechanisms and religious appraisals played a key role in susceptibility to depression in caregivers responsible for the care of terminally ill family members. Siegel & Schrimshaw (2002) found in their study that religion appears to play a similar role for both men

and women patients with HIV/AIDS as a coping mechanism.

Taylor (2000) mentions that it is important to encourage activities that increase individuals' sense of meaningfulness, self-awareness, and spiritual sensitivity when confronting end-of-life decisions. McCullough and Larson (1999) found that 90% of North Americans pray at least occasionally. Prayer may be one of the resources that the patients as well as their families can develop for inward awareness and spiritual sensitivity. Armatowski (2001) explains that many people who pray receive greater hope, security, peace, meaning, tension reduction, and increased subjective well-being. Thomson (2000) also found in her study among 6 hospice patients that spiritual well-being was an important factor to maximize physical well-being and, therefore, enhance QOL as an over-all effect.

Music Therapy in Hospice and Palliative Care

Although music therapists often confront difficulties and challenge in terms of providing care due to the impact of life-threatening illness, music therapy has been recognized to play an important role not only for patients with terminal illness, but also for their family members and significant others in hospice and palliative care (Hilliard, 2001; Hogan, 1999; Krout, 2003; Munro, 1986; Bright, 2002). The needs of patients with terminal illness and their family members have a wide variety of physical, emotional, mental, and spiritual characteristics. Patient's family members may feel depression, fatigue, or hopelessness upon their loved one's admission into hospice care (Locke, 1994). Family members' grief and spiritual distress are one of the primary tasks for music therapists to understand, respect, and provide support for (West, 1994).

The family members of patients are often involved in music therapy sessions. Music therapy has been recognized and successfully used as a great intervention to meet their multidimensional needs (Hilliard, 2001; Krout, 2003). One of the important interventions of music therapy in hospice and palliative care is to facilitate interaction between patients and their family members. Krout (2003) found out in his study that music selection or patient preferred music helped the hospice patients and their family members reminisce about life memories and encouraged sharing of feelings and thoughts. Several studies have also shown that participating in music therapy activities, such as instrument playing, encourages families to maintain meaningful communication with their loved ones with dementia (Clair & Ebberts, 1997; Gardner,

1999).

It is not uncommon, however, that elderly hospice patients live alone and are isolated, especially at facilities, such as nursing homes or assisted living facilities, due to the loss of their loved ones or the work-related demands of their other family members (Smith, 2001). In many cases, music is used to improve mood elevation and decrease isolation. In the qualitative research written by Hilliard (2001), the hospice patient who has been separated from loved ones exhibits positive facial and verbal expression through music listening. Maintaining or enhancing patient's well-being also brings happiness and strength to their families when they visit (Bright, 2002).

In music therapy in hospice and palliative care, a variety of music therapy techniques are used to meet the needs of both patients and their families. The integral use of music is to elicit the expression of feelings, according to Krout's report cited in 88 clinical reports (2000). Improvisation plays a great role for individuals to explore unconscious thoughts and to be aware of their inner feelings. For therapists, it is a useful technique to observe individuals' needs and help them find coping strategies, such as hope, meaning, and strength (Hartley, 1999; West, 1994).

Bright (2002) states, "music can express all kinds of feelings: happiness, sadness, pain, anger, and so on". She also mentions that music therapists can observe individual's inner message, catch non-verbal conversations, and meet their needs via improvisation. Martin (1989) mentions that therapists can improvise music to meet and enhance patient's physical needs, such as providing breath support and reducing agitation, via the Iso-principle. As a result, reducing such distress of patients also helps reduce family members' physical, emotional, and spiritual distress. Therapists also can meet individuals' psychosocial needs via improvisation (Bruscia, 1989). Hartley (1999) describes in her case study of a patient with HIV that improvising music helped build rapport between the patient and the therapist, open the patient's inner most thoughts, share the patient's feelings, and find a positive sense of the patient's well-being. In Neugebauer's case study (1999), the hospital patient with HIV enjoyed a variety of music styles accompanied by the therapist as opposed to improvisation and was motivated to participate in music therapy session as opposed to being depressed about his life situation.

The use of patient's preferred music genre is another important therapeutic technique to reduce physical and psychological distress. In Walworth's study (2003), the 2 groups of college students who listened to either their preferred genre of music or a specific song showed less

anxiety than the people with no music. Weits (1999) also examined in her study conducted among terminally ill cancer patients if preferred music listening activity reduced pain reception. Her study showed that preferred taped music as well as preferred nature sounds and live music produced a significant change in the subjects' pain perception.

The impact of the family members' stress from confronting their loved one's dying process is tremendous. The effects of this stress are generally carried over into family interaction, which increases distress and coping difficulties (Munro, 1986). Music is often used as a tool to facilitate verbal and emotional expression of grief for the family members of terminally ill patients (Gilbert, 1977). In Bailey's case study (1984) among cancer patients and their families, it was demonstrated that the use of songs greatly improved inner expression. She also mentioned that the anger, mourning, and grief appeared to be resolved by music. Bailey (1984) agrees in her conclusion that it is a very important task to use appropriate song materials to meet and achieve therapeutic goals for patients and their families.

"Song choice" is a great music therapy technique in hospice and palliative care programs (Martin, 1991). This technique not only gives patients and their care givers a chance to reminisce, but also provides opportunities to help the patients gain control over the environment, which is often difficult for terminally ill patients and a very important matter in terms of maintaining well-being (Martin, 1989). Creating an environment that patients are able to feel comfortable and maintain control builds confidence and strength for using coping strategies with their grief. The concept of this approach is called, "a natural, patient-centered approach" (Callanan & Kelley, 1992). Martin (1994) also states that therapists can elicit expressions of inner feelings of patients and their families by choosing songs related to the situation they are facing. Similarly, singing spiritual music requested by patients or their families helps them find a source of spiritual well-being and improve their spiritual growth (Munro, 1986; West, 1994).

Music for relaxation or muscle relaxation techniques is also useful methods to create a peaceful environment for both patients and their families. Wexler (1989) mentions that music can be used for relaxation, which positively affects patients' pain reception as an over-all effect. It is also helpful for other problems, such as anger management, insomnia, agitation, anxiety, restlessness, fear, and so forth (Bright, 2002). Lai (2001) found in her study that the use of sedative music enhanced the sleep quality and lowered the respiratory rates of the elderly people in the experimental group. Similarly, in the research study examined by Iwaki, Tanaka, Hori

(2003), listening to the participants' preferred music appeared to create a peaceful and natural environment that promotes sleepiness in the participants. Whittall (1989) conducted a quantitative pilot study among 8 palliative patients to investigate whether music actually affected positive physiological and psychosocial change. The results showed a decrease in heart and respiration rates. The study also mentioned that music appeared to decrease the anxiety level of the participants.

Guided Imagery and Music (GIM) developed by Helen Bonny is one of the techniques successfully used in hospice and palliative care (Hogan, 1999; Salmon, 1993). GIM is a method of facilitating self-awareness (Bruscia, 1991; Clark, 1991). In the Bonny Method GIM, specific music is used to elicit and support the spontaneous imagination process in a deeply relaxed state. Throughout this experience, individuals are encouraged to share their inner feelings and imagination with a facilitator and helped to become aware of their internal responses.

In Skaggs's case study (1997), the specific music chosen and the music-evoked imagery guided by the therapist brought physical changes that eventually reduced the pain of the patient who complained of severe pain. GIM is also used as a psychotherapeutic medium. Bruscia (1991) states that the GIM technique helped a client who was recently diagnosed with AIDS to gain insight into his past life and to find coping strategies for his future life. Hammer's research study (1996) showed that the GIM training created a relaxed environment and reduced stress and anxiety levels of the participants in the experimental group.

O' Callaghan (1996) states that song writing is a very beneficial music therapy technique. In her study, 8 themes from 64 songs written by 39 palliative care patients were categorized into: "self-reflections", "compliments", "memories", "reflections upon significant others", "self-expression of adversity", "imagery", and "prayers". She also mentions that people can express their inner feelings, including their physical, psychosocial, and spiritual needs, through song writing. Smith (1991) found in her study that a song-writing activity helped the suicidal client to share her thoughts and feelings to develop positive self-regard. In addition, the process of song writing facilitated evoking her unconsciousness and gaining insight about herself.

Many researchers have found that terminally ill patients and their families as well as their significant others can benefit from music therapy interventions for their multi-dimensional needs, using therapeutic techniques in hospice and palliative care. Nguyen (2003) conducted her study among terminally ill patients (N = 20) and their family members in a medical setting. Music

therapy interventions were applied for patients' QOL, anxiety level, and family satisfaction in the experimental group (N = 10) in two time music therapy sessions. Song writing, patient's preferred music, a sing along, and counseling were used as music therapy techniques in this study. Nguyen (2003) found that the anxiety levels of the patients in the experimental group were significantly lower than the ones of the patients in the control group as evidenced by the Visual Analog Scale used in her study. She also reported that both terminally ill patients and their families were highly satisfied with music therapy interventions in a medical setting.

Hilliard (2003) investigated the effects of music therapy on QOL and length of life of hospice patients diagnosed with terminal cancer. There were 80 subjects involved in this study. A random assignment was used to divide the subjects into 2 groups: an experimental group with 2 music therapy visits and a control group with no music therapy service but with regular hospice care. Each group had the same numbers in the gender and age categories. The music therapy interventions for this study were based on a cognitive-behavioral approach. The researcher reported that the music therapy techniques used the most during a music therapy session were song choice, music listening, singing, the Iso-principal, counseling, reminiscence, and lyric analysis. The Hospice Quality of Life Index-Revised (HQLI-R), a self-report questionnaire, was used to measure the QOL of the patients involved in this study. The results showed that regardless of gender or age, the scores on the QOL of those who received a music therapy visit were significantly higher than the scores of the subjects with no music therapy services. This study also found that although patients' physical function declined through the dying process as measured by the Palliative Performance Scale (PPS), the scores of patients' QOL in the experimental group remained higher. The researcher states, therefore, that music therapy interventions can positively affect the patients' QOL.

Music therapy interventions also play an important role for spiritual well-being and growth for patients and their family members in hospice and palliative care. Wlodarczyk (2003) investigated the effect of music therapy on spirituality of patients in an in-patient hospice unit where adequate care is available for patients and their family members during the entire stay. A total of 10 patients with terminally illness were involved in her quantitative research. A variety of therapeutic techniques were also used to meet patients' spiritual needs, including the use of pitched/non-pitched instruments, patient's preferred music, song choice, improvisation, a sing along among family members and significant others as well as patients, song writing, and song

gift. In this study, each subject received a total of 4 music therapy visits with 2 music and 2 non-music visits. The results showed that when music therapy was provided, each subject was likely to express higher scores for his/her spiritual well-being as evidenced by a self-report questionnaire. The researcher also found that the patients requested spiritual music on 75% of the music days to promote enjoyment or interaction between the therapist and the patients themselves. More importantly, music was a great resource to build a rapport between the patients and the therapist (Włodarczyk, 2003)

Kerr (2004) examined the effects of music therapy on non-responsive hospice patients as measured by heart and respiratory rate. The subjects (N = 10) for her study were terminally ill patients diagnosed with comatose or verbally non-responsive. The researcher evenly divided the total number of subjects into 2 groups and alternatively used 2 different types of recorded music, classical and new age music, for each group through the 2-day experiment. The researcher found that regardless of music genre, the subjects' heart and respiratory rates were significantly lowered and more stable after listening to music. The researcher also concluded that although these patients were "non-responsive", music was successfully used to evoke their inner response and, therefore, effected their physical well-being.

There are also several qualitative studies that explain the importance of music therapy for patients diagnosed with a terminal illness and their family members when patients approach death. Hilliard (2001) explains in his case study that music therapy was successfully used to decrease a patient's physical distress via the Iso-principal and to provide comfort. The anxiety of the family members who visited the patient was also reduced by music and by the patient's appearance after music. The researcher states that music therapy helped to create an environment for a peaceful death for the patient and the family members. Krout (2003) reports in his case study among 5 hospice patients with terminal illness that music was a great tool to facilitate communication between family members and their loved one a few hours before their loved one's final journey.

Since hospice care considers a patient and his/her families as a "unit", supporting patient's families is an essential task for the music therapist as a member of the interdisciplinary team. Music, often labeled as a "universal language", is always closely related to human life and has power to touch, move, and affect people. As the previous studies have indicated, the therapeutic use of music in hospice and palliative care can meet physical, psychosocial, and

spiritual needs of both patients and their family members. A variety of music therapy techniques also helps to develop coping strategies and to enhance the patient's and their families' well-being. Although there are several case studies, no quantitative research has been found regarding the effects of music therapy on family members of terminally ill patients. Therefore, it is important to know how family members or significant others of a patient with terminal illness receive or utilize coping strategies via music therapy interventions for better understanding and services.

PURPOSE OF STUDY

The purpose of this research study is to investigate the effects of music therapy interventions on grief and spirituality of family members of patients in a hospice setting. The questionnaire used in this study has 5 research questions:

1. Does music effect grief of family members or significant others of patients?
2. Does music facilitate the family members or significant others of patients to enhance their spiritual growth and well-being?
3. Does music help the family members or significant others find coping strategies for the situations they are confronting?
4. Does music therapy service effect satisfaction of family members or significant others of patients so that they feel their loved one receives adequate support from hospice program?
5. Does music therapy service affect the family members or significant others so that they feel their loved one's QOL is maintained or enhanced?

Hypotheses

H_0 : there will be no significant differences of scores on the questionnaire between the experimental and control groups.

H_1 : There will be significant differences of scores on the questionnaire between the experimental and control groups.

METHOD

Subjects and Setting

All subjects (N = 60) for this study were over age 20 years and either the family members or significant others of the hospice patients. The subjects were recruited from Big Bend Hospice, a local non-profit organization in the Northern part of Florida. The patients were diagnosed by the hospice physicians with a terminal illness whose prognosis was 6 months or less. The patients' age ranges and diagnoses were diverse (see Appendix C). The places for music therapy visits and the study included patients' houses, facilities such as nursing homes or assisted living homes, hospitals, and the Big Bend Hospice facility, the "Hospice House" at which 12 beds are available for extended care for patients and their families. These places were in Leon, Wakulla, Franklin, Madison, Taylor, Jefferson, Godsdon, and Liberty County, where the Big Bend Hospice program is provided.

All subjects were divided into 2 groups: experimental group (N = 30) and control group (N = 30). The subjects in the experimental group were the family members or significant others of the patients regularly receiving music therapy sessions by the researcher or the other music therapists of Big Bend Hospice since their admission. The subjects in the control group were the family members or significant others of the hospice patients who had no music therapy visit previously. The patients of both groups had been in the hospice program for at least 2 weeks for qualification in this study. This allowed the patients and their family members to fully receive hospice care by the interdisciplinary team staff and, therefore, allowed the researcher to investigate family members' satisfaction for the research question, "does music therapy service affect satisfaction of the family members or significant others of patients so that they feel their loved one receives adequate support from the hospice program?"

Research Design

The experimental procedure was conducted once for each subject, and a post-test only was used for data collection in this study. The independent variable for this study was music therapy interventions versus no music therapy interventions. The dependent variable was family members' or significant others' self report for their grief and spirituality as measured by the questionnaire used in this study.

Measurement

All data for patient's family member's or significant other's grief and spirituality were collected by a self-report questionnaire (see Appendix E), adapted from Hospice Quality of Life Index-Revised (Hilliard, 1998), Big Bend Hospice Spiritual Care Assessment, Big Bend Hospice Interdisciplinary Care Plan, and Big Bend Hospice Psychosocial Assessment, by the researcher. The questionnaire had 28 questions and was divided into 5 categories: grief (13 questions), coping strategies (8 questions), spirituality (3 questions), satisfaction for hospice service (3 questions), and satisfaction of QOL of patient (1 question). Each question consisted of a Likert Scale format from 1 to 10, and all questions were in order from negative (1) to positive (10) responses. The maximum score for grief is, therefore, 130 points, 80 points for coping strategies, 30 points for spirituality, 30 points for satisfaction for hospice service, and 10 points for satisfaction for family member's or significant other's perceptions of the loved one's QOL.

Procedures

For the experimental group, the researcher selected the patients who had been in the hospice program for 2 weeks or longer and had received music therapy sessions at least twice by the researcher or the other music therapists. The researcher first contacted the family members or significant others of the patients by phone, explained the purpose of this study, and asked if they were willing to participate. Upon their agreement, the researcher made an appointment for a visit. The subjects were briefly informed about this research study by the researcher and, upon their arrival, were given an informed consent form to sign (see Appendix B), which was approved by the Florida State University Human Subjects Committee (see Appendix A) and Big Bend Hospice. After receiving a signed consent form, the researcher provided a music therapy session along with patient's care plan. The subjects were asked to be with their loved one during the

music therapy session. The length of an actual music therapy session was diverse due to a variety of situations and patient's needs that the researcher confronted at given time. However, a common time period spent for a visit was approximately 30 to 45 minutes. After the session, the subjects were given a questionnaire and asked to fill it out with signature and date by the researcher.

For the control group, the researcher individually met the family support counselors of Big Bend Hospice and asked if they had any patients who previously had no music therapy visit. The researcher eliminated patients with no music therapy experience from the control group if these patients did not live with their family members or their family members or significant others were not available due to work or other reasons. In addition, two week stay or longer into the hospice program was required for qualification of the control group. If the family support counselors had patients who met these criteria, they were given ample sets of consent forms and questionnaires. The family support counselors were asked to explain the purpose of this study to the family members of patients when they made a visit. The family support counselors were also asked to give a consent form and questionnaire to those who agreed with participation for this study. After completion, the family support counselors put the data into a provided envelope for confidentiality and brought the sealed envelope back to the researcher.

The researcher also recruited subjects for the control group at the "Hospice House". This is a Big Bend Hospice owned facility where continuous care is available for patients and their family members. Patients are admitted into the Hospice House for a variety of reasons, such as a peaceful death, when a caregiver can no longer manage symptoms of their loved one due to rapid decline, need for a short break for caregivers, and so forth. The researcher explained the purpose of this study to the Hospice House family counselor and music therapist and asked them to follow the same procedures as mentioned above when patient's family members or significant others came to visit their loved one at the Hospice House and were willing to participate in this study. If the Hospice House family counselor and music therapist were not available, the researcher completed the same procedures.

Music Therapy Interventions

The primary task as a music therapist was to enhance each patient's and his/her family member's QOL. In order to accomplish this goal, a variety of music therapy techniques were

used to meet patients and their family members' needs. The interventions used in this study were for physical, psychological, and spiritual needs, such as reducing somatic pain and distress, providing breath support, decreasing anxiety, agitation, or fear, enhancing social interaction, creating a peaceful environment, improving comfort measures, improving reality orientation, stimulating reminiscence, and providing spiritual growth as well as spiritual well-being. The music therapy techniques also included a sing along with pitched instruments, use of non-pitched instruments, use of patient's preferred music, the Iso-principal, improvisation, therapeutic touch, sensory stimulation, song analysis, life review, and song arrangement. Recorded music was also used for relaxation. Genres of patient's preferred music were categorized into hymns/gospel, contemporary Christian music, countries, oldies, folk songs, jazz, classical, bluegrass, showtunes, pop, and general music. These songs were available at the Bid Bend Hospice Music Therapy Department where about 8,200 songs were stored during the time that the researcher was conducting this study.

RESULTS

A self-report questionnaire was used to investigate the effects of music therapy interventions on grief and spirituality of family members of patients in a hospice setting. All data were completed by the family members or significant others of hospice patients with terminal illness. The questionnaire had 28 questions and was divided into 5 categories: grief (13 questions), coping strategies (8 questions), spirituality (3 questions), satisfaction of hospice care (3 questions), and QOL (1 question). Each question utilized a Likert Scale format from 1 to 10. All questions were rated on a negative (1) to positive (10) continuum. The maximum score for grief was, therefore, 130 points, 80 points for coping strategies, 30 points for spirituality, 30 points for satisfaction for hospice service, and 10 points for satisfaction for family member's or significant other's perceptions of the loved one's QOL.

A multivariate analysis of variance (MANOVA) was used to analyze data in this study. Table 1 shows descriptive statistics for mean, standard deviation, and the numbers of each category in the control and experimental groups. Group 1 indicates a control group (N = 30), the family members or significant others of patients not receiving music therapy visits. Group 2 represents the family members or significant others of patients with music therapy services in the experimental group (N = 30). In all subtests, the experimental group showed higher mean scores than did the scores of the control group.

Table 1 **Descriptive Statistics for Control and Experimental Groups**

		Mean	Std. Deviation	N
Grief	Group 1	5.684	2.317	30
	2	6.789	2.056	30
	Total	6.237	2.242	60
Coping	Group 1	6.195	2.158	30
	2	6.541	1.564	30
	Total	6.368	1.876	60
Spirituality	Group 1	7.700	1.952	30
	2	8.500	1.592	30
	Total	8.100	1.811	60
H_Care	Group 1	8.366	1.824	30
	2	8.833	1.824	30
	Total	8.600	1.948	60
QOL	Group 1	7.866	2.556	30
	2	9.100	1.373	30
	Total	8.483	2.127	60

*H_Care—Satisfaction for Hospice Care

In this study, 3 imminent patients were included in each of the control and experimental groups. Due to the small sample, however, statistical analysis was considered inappropriate. Descriptive statistics are in total. Table 2 describes that the family members or significant others of the imminent patients with music therapy visits showed much higher scores on every subtest than those of imminent patients who did not receive music therapy sessions. This would seem to indicate greater support for music therapy as death approaches.

Table 2 Descriptive Statistics for Imminent Pts in Control and Experimental Group

Group1		Mean	Std. Deviation	N	
Group1	Grief	Type 1	5.803	2.226	27
		2	3.179	3.250	3
		Total	5.543	2.411	30
	Coping	Type 1	6.319	2.182	27
		2	3.541	2.773	3
		Total	6.041	2.349	30
	Spirituality	Type 1	7.543	1.996	27
		2	7.333	3.179	3
		Total	6.041	2.349	30
H_Care	Type 1	8.432	1.684	27	
	2	7.666	8.355	3	
	Total	8.355	1.819	30	
QOL	Type 1	7.814	2.572	27	
	2	5.000	4.000	3	
	Total	7.533	2.788	30	
Group2	Grief	Type 1	6.814	2.048	27
		2	6.564	2.588	3
		Total	6.789	2.056	30
	Coping	Type 1	6.375	1.538	27
		2	8.041	.970	3
		Total	6.541	1.564	30
	Spirituality	Type 1	8.370	1.620	27
		2	9.666	.577	3
		Total	8.500	1.592	30
	H_Care	Type 1	8.864	2.069	27
		2	8.555	2.501	3
		Total	8.833	2.069	30
	QOL	Type 1	9.037	1.427	27
		2	9.666	.577	3
		Total	9.100	1.373	30

*H_Care—Satisfaction for Hospice Care

Table 3 shows MANOVA results for the 5 categories. There was a significant difference ($F = 2.848$; $df = 5, 54$; $p = .024$) between groups. A significant difference was found in subtest for QOL between the subjects with music therapy and no music therapy interventions ($F = 5.420$; $df = 1, 58$; $p = .023$). Large differences were identified in the subtests of grief ($F = 3.817$; $df = 1, 58$; $p = .056$) and spirituality ($F = 3.026$; $df = 1, 58$; $p = .087$). However, these were not statistically significant. On the other hand, music therapy interventions were less likely to

influence coping strategies and satisfaction of hospice care for the subjects in the experimental group as evidenced by these F values respectively ($F = .505$; $df = 1, 58$; $p = .480$; $F = .859$; $df = 1, 58$; $p = .358$).

Table 3 **Multivariate Tests**

	Value	F	Hypothesis df	Error df	Sig.
Effect	.975	420.252	5.000	54.000	.000
Group	.209	2.848	5.000	54.000	.024

Source	D. Variable	Df	Mean Square	F	Sig.
Group	Grief	1	18.320	3.817	.056
	Coping	1	1.794	.505	.480
	Spirit	1	9.600	3.026	.087
	H_Care	1	3.267	.859	.358
	QOL	1	22.817	5.420	.023
Error	Grief	58	4.800		
	Coping	58	3.552		
	Spirit	58	3.173		
	H_Care	58	3.805		
	QOL	58	4.210		
Total	Grief	60			
	Coping	60			
	Spirit	60			
	H_Care	60			
	QOL	60			

* H_Care = Satisfaction for Hospice Care

In this research, a significant difference was found on the subtest for QOL. This result implies that a majority of family members or significant others in the experimental group was satisfied with the fact that their loved one's QOL was well maintained through music therapy interventions (see Appendix D). However, there were no significant differences in the other 4 categories, although the results from the subtests of grief and spirituality showed higher scores in the experimental group than in the control group.

A t -test was used to analyze the difference in mean scores between the control and experimental groups on the total score of the questionnaire. There was no significant difference in mean scores ($t = 1.829$, $df = 52$, $p = .073$). This indicates that families' perceptions of the

benefits of music therapy distinctly focus on QOL issues. This replicates other research conducted on patients' perception of benefit.

In addition, the mean scores of the family members of imminent patients were compared between the control and experimental groups. The results described that in each subtest, the family members of imminent patients receiving music therapy showed much higher scores than the mean scores of those of imminent patients with no music. However, statistical analysis was not made due to the small sample.

DISCUSSION

The main purpose of this study was to investigate the effects of music therapy interventions on grief and spirituality of family members of patients in a hospice setting. A self-report questionnaire, adapted from Hospice Quality of Life Index-Revised (HQOLI-R; Hilliard, 1998), Bid Bend Hospice Spiritual Care Assessment, Big Bend Hospice Interdisciplinary Care Plan, and Big Bend Hospice Psychosocial Assessment, was used for data collection. This questionnaire was also designed to measure how music exercises positive influence on coping strategies for the anticipated future and on family members' or significant others' satisfaction with hospice services and their loved one's QOL. Therefore, the questionnaire was divided into 5 categories: grief, coping strategies, spirituality, satisfaction with hospice care, and satisfaction for family members' or significant other's perceptions of the loved one's QOL so that they feel their loved one's QOL is maintained or enhanced?

A multivariate analysis of variance (MANOVA) was used to investigate whether significant differences were found in the mean scores of each category between the control and experimental groups. The results showed a significant difference in the subtest for QOL between the subjects with music therapy and no music therapy interventions ($F = 5.420$; $df = 1, 58$; $p = .023$). Another quantitative study regarding the effects of music therapy on QOL was conducted by Hilliard (2003). In his study, 80 subjects, who were diagnosed with terminal cancer, were randomly assigned into either a control group with no music therapy or an experimental group with music therapy interventions. The results showed that higher scores were indicated by those who received music therapy visits and that a significant difference was found between the control and experimental groups. As mentioned earlier, the mean scores for QOL from the family members of imminent patients in the experimental group were higher than the scores from those with no music therapy interventions. These findings support the previous research showing that music positively influences individual's well-being and enhances people's QOL in a hospice

setting. Therefore, these results show that the family members of patients were satisfied with their loved one's QOL and felt it was well maintained through music therapy interventions.

There was no significant difference found in the other 4 subtests between the control and experimental groups. However, the mean scores of the experimental group were slightly higher than the scores of the control group in all 4 categories. In addition, a great difference was identified on the subtests for grief ($p = .056$) and spirituality ($p = .087$). These tendencies were also seen in the mean scores of the family members of imminent patients between the control and experimental groups.

One reason why there was no significant difference on the subtests for grief and spirituality between the control and experimental groups might be that the family members or significant others of patients were well treated by other hospice staff. The results of family members' satisfaction with hospice care also support this concept. Since hospice philosophy considers patient and family as a "unit", it is important and necessary to provide adequate support for the patient's family in hospice and palliative care. Music therapists, registered nurses, family support counselors, and chaplains regularly visit patients and their families. For example, the patient's physical distress was almost perfectly under control by the medication the clinical staff provided. Many family members mentioned that family support counselors came to visit patients' families and confronted their family issues with compassion. Chaplains also visited patients and prayed for patients as well as their families if necessary. These things provided many opportunities for family members to maintain communication with their loved one and reduced anxiety or any psychological issues. Additionally, seeing their loved in a good mood also maintained family members' social activities, such as going to church to pray. As a result, all of these things facilitated not only patients' but also the family members' well-being. In fact, psychological and spiritual pain or concerns were often not primary issues that the researcher had to confront during music therapy sessions. These issues might be reasons why there was no difference in grief and spirituality between the control and experimental groups.

Music was often used as an intervention to facilitate interaction between patients and their family members. For example, singing songs that a patient and his/her family were familiar with elicited important memories in their lives and enhanced the conversation during the music therapy session. Also, encouraging family members to play "air instruments" along with their loved one's singing was often appreciated and responded to with smiles. On the other hand, the

use of music for counseling was rarely applied into sessions during the entire study. It was simply because many patients and their families liked listening to music rather than receiving “fragmented music”. Music also played a great role to build rapport and close relationships with patients and their families. In fact, they always looked forward to a music therapy visit and treated the researcher as a family member. One of the patients gave the researcher a strong hug and stated, “I love you to death!”

There were difficulties and challenges that the researcher had to confront when the patients became imminent. Patient’s families as well as relatives and friends were usually present, anticipating saying farewell in a few hours. The family members were deeply overwhelmed with sadness when the time was close to the final moment. The environments surrounding these situations were tense and lots of tears were often involved. Despite the intensity of these hours, it was interesting to see the comparison of the mean scores between the family members of imminent patients with music therapy interventions and with no music. The mean scores from the family members of imminent patients with music therapy interventions were higher than the family members of both imminent and non-imminent patients with no music in all 5 categories. The mean scores of coping from the family members of imminent patients receiving music (Mean = 8.041) essentially were much higher than the means scores of the family members of imminent patients with no music (Mean = 3.541). A great difference was also found in the mean scores of grief between the family members of imminent patients in the control (Mean = 3.179) and experimental groups (6.564).

As mentioned earlier, confronting a loss of someone close tremendously impacts bereaved family members as well as significant others. Music, such as the patient’s preferred music, spiritual music, and soothing music, was often applied to create a peaceful environment in these situations. Music was also a key factor to enhance communication with the patient’s family members and elicit inner feelings and thoughts. “Song choice” was another important therapeutic technique to meet their needs and bring the family members to a stage where they could find hope or meaning for coping strategies.

The effective use of music in hospice and palliative care has been reported by many researchers in the recent decade. The results in this study support that the use of music clearly enhances individual’s QOL in hospice care. In addition, music gives a positive influence to other needs, such as grief or spirituality, as evidenced by the statistical data in this study. Music also

appeared to play a great role in the tense environment where family members anticipated being separated forever from their loved one in a few hours. Therefore, it is suggested that the effects of music therapy on imminent patients and their family members would be a primary area for future study to provide better music therapy services for patients as well as their families.

APPENDIX A
HUMAN SUBJECTS COMMITTEE APPROVAL



Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2763
(850) 644-8633 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 3/26/2004

To:
Minoru Okamoto
315 Pennell Circle #3
Tallahassee FI 32310

Dept.: MUSIC THERAPY

From: John Tomkowiak, Chair

A handwritten signature in black ink that reads "John Tomkowiak, Chair".

Re: **Use of Human Subjects in Research**
The effects of Music Therapy on Grief and Spirituality of Family Members of Patients with Terminal Illness in A Hospice Setting

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Human Subjects Committee at its meeting on **3/10/2004**. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.

If the project has not been completed by **3/9/2005** you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc: Jayne Standley
HSC No. 2004.162

APPENDIX B
CONSENT FORM

INFORMED CONSENT

I, _____, freely consent to participate in this research experiment entitled "The Effect of Music Therapy Interventions on Grief and Spirituality of Family Members of Patients with Terminal Illness in A Hospice Setting." I understand that this study is conducted by Minoru Okamoto, who is a graduate student of the Music Therapy Department at Florida State University. I understand that this research is being conducted to fulfill the requirements for a master's degree in music.

I understand that the purpose of this study is to examine the effect of music therapy interventions on grief and spirituality of family members of patients with terminal illness in a hospice setting. I agree to fill out the provided questionnaire that takes approximately 6 minutes for this research study. I understand that the questionnaire includes questions regarding my feelings and emotions related to my relative.

I understand that my participation is voluntary. I understand that there will be no risks or discomforts for me or for my family member while participating in this study. I understand that I can withdraw from this research study at anytime without any prejudice, penalty or loss of benefits to which I am otherwise entitled. I also understand that my personal information will never be used outside of this study and confidentiality will be maintained.

I understand that I may contact Dr. Jayne Standley, Florida State University, School of Music, 32306-1180, (850) 644-4565, the researcher, Minoru Okamoto, 315 Pennell Circle #3, Tallahassee, Florida, 32310, (850) 576-3435, or the Human Subject Committee, (850) 644-8633, for answers to questions about this research or my rights. The results will be sent to me upon my request.

I have read and understand this consent form. I have been given the right to ask and have answered any inquiry concerning the study. All questions have been answered to my satisfaction.

Participant's signature

Date



APPENDIX C
SUBJECT DEMOGRAPHICS

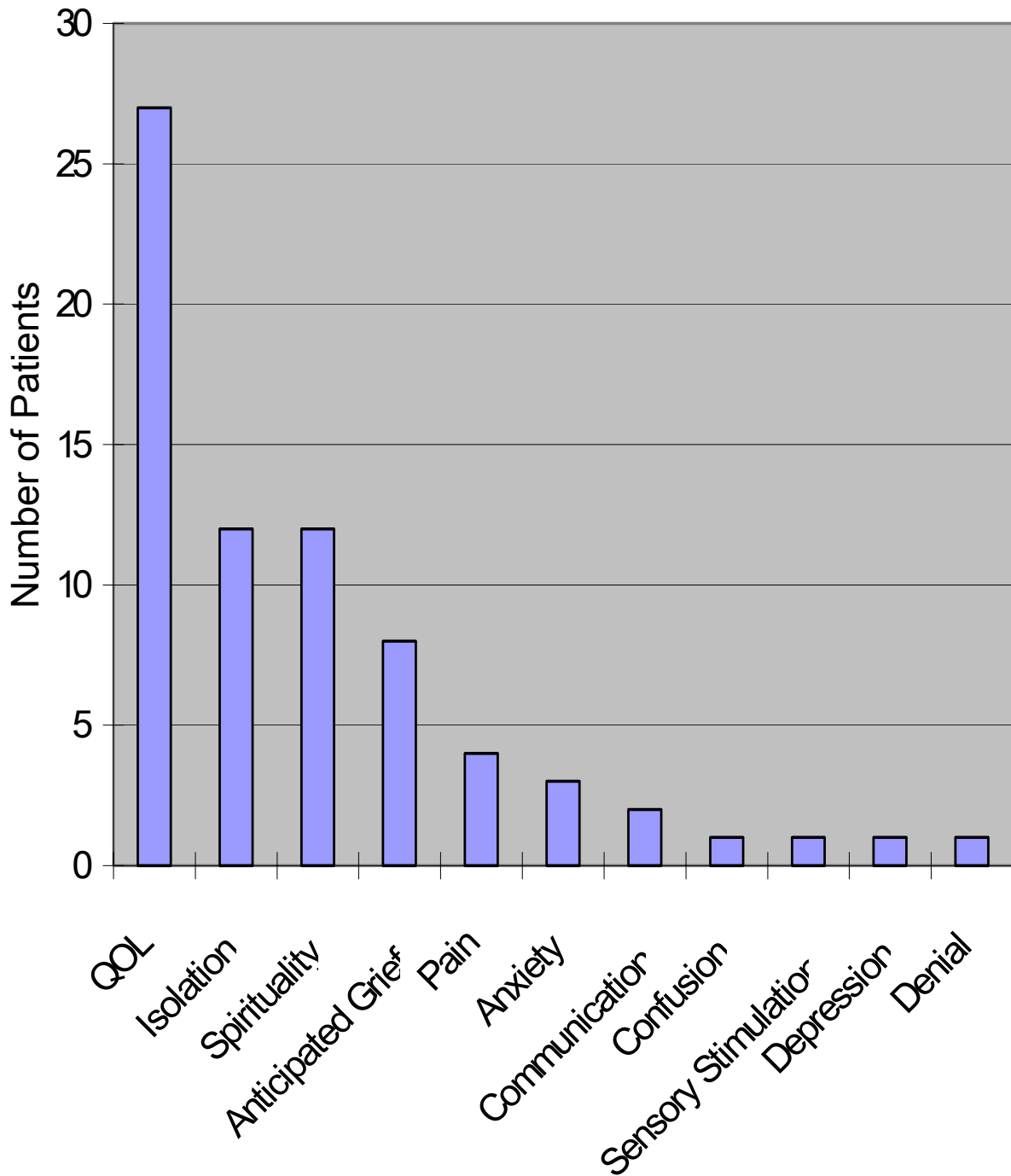
Subjects	Relation	Group	Patient's diagnosis	Age	Gender	Race
1	daughter	control	heart disease	84	female	caucasian
2	son	control	cancer	90	male	caucasian
3	wife	control	idiopathic fibros alveolits	60	male	caucasian
4	husband	control	chronic airway obstruct	69	female	caucasian
5	daughter	control	cancer	80	female	caucasian
6	s. others	control	enlargement of lymph nodes	57	female	caucasian
7 *	wife	control	cancer	39	male	african american
8	son	control	debility unspecified	83	male	caucasian
9	sister	control	renal failure	57	male	caucasian
10	daughter	control	cancer	65	female	caucasian
11 *	wife	control	chronic airway obstruct	85	male	african american
12	s. others	control	cancer	57	male	caucasian
13	daughter	control	senile dementia	82	female	caucasian
14	husband	control	cancer	59	female	caucasian
15	daughter	control	cancer	70	female	caucasian
16	wife	control	cancer	59	male	caucasian
17	s. others	control	cancer	64	male	caucasian
18	s. others	control	cancer	56	male	african american
19	daughter	control	cancer	67	female	caucasian
20	son	control	cerebral vascular accident	83	male	caucasian
21	wife	control	cancer	88	male	african american
22 *	son	control	heart disease	49	female	caucasian
23	daughter	control	cancer	68	female	caucasian
24	wife	control	debility unspecified	58	male	caucasian
25	daughter	control	Alzheimer's disease	86	male	african american
26	son	control	senile dementia	86	male	caucasian
27	wife	control	senile dementia	75	female	caucasian
28	wife	control	cancer	57	male	african american
29	daughter	control	heart disease	83	female	caucasian
30	son	control	heart disease	75	female	caucasian
31	daughter	exp.	cancer	68	female	caucasian
32	wife	exp.	cancer	44	male	caucasian
33	son	exp.	congestive heart failure	86	female	caucasian
34 *	daughter	exp.	senile dementia	77	male	caucasian
35 *	daughter	exp.	senile dementia	94	female	caucasian
36	wife	exp.	heart disease	86	male	caucasian
37	wife	exp.	heart disease	82	male	caucasian
38	husband	exp.	Alzheimer's disease	55	female	caucasian
39	daughter	exp.	cerebral vascular accident	88	female	caucasian
40	wife	exp.	chronic airway obstruct	78	male	caucasian
41	son	exp.	cancer	84	male	caucasian

42	wife	exp.	senile dementia	90	male	caucasian
43	daughter	exp.	congestive heart failure	98	female	caucasian
44	wife	exp.	idio periph neurphy	69	male	caucasian
45	wife	exp.	senile dementia	85	male	caucasian
46	s. others	exp.	cancer	67	female	caucasian
47	sister	exp.	senile dementia	47	female	caucasian
48	daughter	exp.	cerebral vascular accident	84	male	caucasian
49	daughter	exp.	debility unspecified	89	female	caucasian
50	wife	exp.	cancer	66	male	caucasian
51	daughter	exp.	cancer	91	female	caucasian
52	daughter	exp.	senile dementia	88	male	caucasian
53	husband	exp.	cancer	69	female	caucasian
54 *	wife	exp.	Alzheimer's disease	75	male	caucasian
55	daughter	exp.	cerebral vascular accident	77	female	caucasian
56	wife	exp.	pulmonary tuberculosis	64	male	hispanic
57	mother	exp.	cancer	10	male	african american
58	mother	exp.	Edward' syndrome	1	female	caucasian
59	son	exp.	cancer	78	female	caucasian
60	niece	exp.	Alzheimer's disease	99	female	african american

* Family members of imminent patients

APPENDIX D
MUSIC THERAPY INTERVENTIONS

Music Therapy Interventions



APPENDIX E
QUESTIONNAIRE

QUESTIONNAIRE

This questionnaire will be used to examine your feelings at this given moment. Please read the questions below and check the appropriate number to express your feelings.

1. How anxious do you feel?

Highly	1	2	3	4	5	6	7	8	9	10	Not at all
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2. How fearful do you feel?

Highly	1	2	3	4	5	6	7	8	9	10	Not at all
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3. How sad do you feel?

Highly	1	2	3	4	5	6	7	8	9	10	Not at all
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4. How isolated do you feel?

Strongly	1	2	3	4	5	6	7	8	9	10	Not at all
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5. How frustrated do you feel?

Strongly	1	2	3	4	5	6	7	8	9	10	Not at all
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6. How hopeless do you feel?

Strongly	1	2	3	4	5	6	7	8	9	10	Not at all
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7. How difficult is it to express your feelings at this moment?

Difficult	1	2	3	4	5	6	7	8	9	10	Not at all
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8. How discouraged do you feel?

Highly	1	2	3	4	5	6	7	8	9	10	Not at all
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9. How physically affected are you by what is happening to your family member?

Highly	1	2	3	4	5	6	7	8	9	10	Not at all
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10. How helpless do you feel?

Strongly	1	2	3	4	5	6	7	8	9	10	Not at all
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11. How depressed do you feel?

Strongly	1	2	3	4	5	6	7	8	9	10	Not at all
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12. How regretful do you feel?

Strongly	1	2	3	4	5	6	7	8	9	10	Not at all
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13. How much do you feel fatigue or exhaustion?

Strongly	1	2	3	4	5	6	7	8	9	10	Not at all
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14. How strong do you feel enough to deal with this situation at this moment?

Weakly	1	2	3	4	5	6	7	8	9	10	Strongly
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15. How at peace with yourself and your situation in life are you at this moment?

Not at all	1	2	3	4	5	6	7	8	9	10	Sufficiently
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16. How difficult is it to accept what is happening to your family?

Difficult	1	2	3	4	5	6	7	8	9	10	Not at All
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17. How difficult is it to maintain an environment that is familiar and natural?

Difficult	1	2	3	4	5	6	7	8	9	10	Not at all
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18. How difficult is it to plan the future?

Difficult	1	2	3	4	5	6	7	8	9	10	Not at all
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19. How hard is it to recall memories with your family member?

Hard	1	2	3	4	5	6	7	8	9	10	Not hard
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20. How difficult is it to cope with others?

Difficult	1	2	3	4	5	6	7	8	9	10	Not at all
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21. How difficult is it to do social activities to deal with your feeling?

Difficult	1	2	3	4	5	6	7	8	9	10	Not at all
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22. How satisfied do you feel with your family member's spirituality?

Not at all	1	2	3	4	5	6	7	8	9	10	Highly
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23. How satisfied do you feel with your own spirituality?

Not at all	1	2	3	4	5	6	7	8	9	10	Highly
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24. How difficult is it to discover a sense of peace in your spiritual belief?

Difficult	1	2	3	4	5	6	7	8	9	10	Not at all
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25. How much relief do you receive through the Hospice support?

Not at all	1	2	3	4	5	6	7	8	9	10	Highly
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26. How satisfied are you with the spiritual support provided through the Hospice?

Insufficient	1	2	3	4	5	6	7	8	9	10	Sufficient
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27. How much joyfulness or hopefulness do you receive through the support of Hospice?

Not at all	1	2	3	4	5	6	7	8	9	10	Sufficiently
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28. How much are you satisfied that your family member's quality of life is maintained with peace and comfort?

Not at all	1	2	3	4	5	6	7	8	9	10	Highly
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Thank you very much for your time and participation.

Participant's signature

Date

Researcher's signature

Date

* Adapted from the Hospice Quality of Life Index-Revised, BBH Interdisciplinary Care Plan, BBH Psychosocial Assessment, and BBH Spiritual Care Assessment.

APPENDIX F
RAW SCORES

Subjects	Group	Grief	Coping	Spirituality	H_Care	QOL	Total
1	control	52	35	12	24	5	128
2	control	98	65	28	30	10	231
3	control	92	53	24	30	10	209
4	control	84	60	24	26	9	203
5	control	97	69	26	30	9	231
6	control	67	41	21	12	6	147
7 *	control	14	8	11	27	1	61
8	control	107	72	21	30	10	240
9	control	107	55	26	30	10	228
10	control	111	67	25	29	9	241
11 *	control	20	25	28	12	5	90
12	control	55	38	12	16	6	127
13	control	52	42	28	28	10	160
14	control	86	62	26	19	7	200
15	control	28	26	15	24	9	102
16	control	100	73	25	24	10	232
17	control	71	59	30	17	8	185
18	control	130	80	30	20	10	270
19	control	29	26	22	25	9	111
20	control	103	64	30	27	10	234
21	control	72	52	28	22	8	182
22 *	control	90	52	27	30	9	208
23	control	59	49	23	29	8	168
24	control	43	30	20	30	7	130
25	control	77	48	21	28	10	184
26	control	53	40	18	23	4	138
27	control	86	45	17	29	9	186
28	control	45	29	15	22	7	118
29	control	113	65	30	30	1	239
30	control	76	57	30	30	10	203
31	exp.	61	40	23	27	10	161
32	exp.	127	66	29	30	10	262
33	exp.	117	58	25	18	8	226
34 *	exp.	50	58	27	30	9	174
35 *	exp.	117	73	30	17	10	247
36	exp.	105	52	24	27	10	218
37	exp.	90	43	27	30	10	200
38	exp.	64	53	24	30	10	181
39	exp.	73	47	19	30	8	177
40	exp.	62	51	30	30	10	183
41	exp.	116	59	22	30	10	237
42	exp.	96	63	20	27	9	215

43	exp.	113	79	30	30	10	262
44	exp.	110	58	30	26	10	234
45	exp.	92	33	20	30	7	182
46	exp.	119	60	30	30	10	249
47	exp.	96	49	30	30	10	215
48	exp.	95	50	30	30	9	214
49	exp.	95	52	24	25	8	204
50	exp.	28	16	22	21	6	93
51	exp.	91	58	30	30	10	219
52	exp.	114	65	28	30	10	247
53	exp.	114	50	26	28	8	226
54 *	exp.	89	62	30	30	10	221
55	exp.	60	45	30	25	9	169
56	exp.	100	62	11	30	7	210
57	exp.	103	40	18	3	5	169
58	exp.	59	38	28	14	10	149
59	exp.	46	48	27	27	10	158
60	exp.	46	42	21	30	10	149

*Family member of imminent patents

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