
Wone Juhn

Follow this and additional works at: https://digitalcommons.montclair.edu/etd

Part of the Music Therapy Commons
THE COMMON ISSUES IN HOSPICE MUSIC THERAPY:
A SURVEY OF HOSPICE MUSIC THERAPISTS

by

WOONE JUHN

A Master's Thesis Submitted to the Faculty of
Montclair State University
In Partial Fulfillment of the Requirements
For the Degree of

Master of Art in Music: Concentration in Music Therapy

January 2013

College/School CART
Department John J. Cali School of Music

Thesis Committee:

Thesis Sponsor / Professor, Music
Karen Goodman

Committee Member / Adjunct Professor, Music Therapy
Georgia Smith

Director, John J. Cali School of Music
Jon Robert Cart

December 11, 2012
THE COMMON ISSUES IN HOSPICE MUSIC THERAPY:

A SURVEY OF HOSPICE MUSIC THERAPISTS

A THESIS

Submitted in partial fulfillment of the requirements

For the degree of

Master of Arts in Music

Concentration in Music Therapy

by

WONE JUHN

Montclair State University

Montclair, New Jersey

January, 2013
ACKNOWLEDGEMENTS

I would like to express my deepest love to my daughter Hyeri Cho, my husband Yong-Ho Cho, and my parents Kye-Soo Juhn and Hang-Ja Kang. While studying, I have been greatly comforted by the presence of my family who supported me. Without their love and support, I could not complete my study successfully.

I am very grateful to my thesis sponsor, Professor Karen Goodman who led me to study music therapy at Montclair State University. Since the fall of 2009, she has been encouraging and guiding me to be a music therapist. I deeply appreciate her help. Also, I would like to appreciate my committee members, Professors Brian Abrams and Georgia Smith, for thoughtful advice and continuing guidance throughout my studying.

In addition, I would like to appreciate my special friend Mrs. Carolyn Lack. She was willing to proofread the first draft of my thesis right after the hurricane Sandy. I imagine that it was not an easy work but she did a great job for me. I am grateful for her magnificent effort.
ABSTRACT

Hospice patients experience physical, cognitive, psychological, social and spiritual challenges. Literature has suggested the needs of hospice patients, and the goals, methods, techniques and case examples in hospice music therapy. However, the statistical information about the general hospice music therapy practice is not sufficient. Thus, it is necessary to collect data about the common issues in hospice music therapy involving hospice patients, their family caregivers and hospice music therapists. The purpose of this study is to gather experiential information about the common issues in hospice music therapy practices. The quantitative and qualitative data were obtained from a survey of a total 50 hospice music therapists. From the data, the information about general hospice music therapy sessions (frequency, place and duration), the ranking of common issues in hospice music therapy (on patients, family caregivers and therapists), common goals and methods, and hospice music therapists' job satisfaction was demonstrated. Also, some differences depending on the participants' years of work experience were indicated. The hospice music therapy goals identified for hospice patients relatively correspond to the ranking of the five domains of hospice patients' needs. This study suggests successful outcomes about the current hospice music therapy practice, and induces some meaningful inferences.
# THE COMMON ISSUES IN HOSPICE MUSIC THERAPY

## TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACKNOWLEDGEMENT</td>
<td>3</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>4</td>
</tr>
<tr>
<td>TABLE OF CONTENTS</td>
<td>5</td>
</tr>
<tr>
<td>INTRODUCTION</td>
<td>10</td>
</tr>
<tr>
<td>REVIEW OF THE LITERATURE</td>
<td>12</td>
</tr>
<tr>
<td>Hospice and Palliative Care in the United States</td>
<td>12</td>
</tr>
<tr>
<td>The Issues in Hospice Care</td>
<td>13</td>
</tr>
<tr>
<td>The psychosocial issues</td>
<td>14</td>
</tr>
<tr>
<td>The physical issues</td>
<td>15</td>
</tr>
<tr>
<td>The family issues</td>
<td>16</td>
</tr>
<tr>
<td>The spiritual issues</td>
<td>17</td>
</tr>
<tr>
<td>Hospice Music Therapy</td>
<td>18</td>
</tr>
<tr>
<td>The effect of music therapy on hospice patients</td>
<td>20</td>
</tr>
<tr>
<td>The goals of hospice music therapy</td>
<td>21</td>
</tr>
<tr>
<td>The methods of hospice music therapy</td>
<td>21</td>
</tr>
<tr>
<td>The statistical data on hospice music therapy</td>
<td>22</td>
</tr>
<tr>
<td>STATEMENT OF PURPOSE</td>
<td>24</td>
</tr>
</tbody>
</table>
THE COMMON ISSUES IN HOSPICE MUSIC THERAPY

METHODS ............................................................................................................ 26

Development of a Survey ................................................................. 26

Procedure of Recruitment ......................................................... 27

Procedure of Collecting Data .................................................... 27

RESULTS ................................................................................................................ 28

Demographic Information ............................................................ 28

Ages and gender ........................................................................ 28

Years of experience .................................................................. 29

General Hospice Music Therapy Sessions ........................................... 30

Frequency of the hospice music therapy sessions .................... 30

Location of the hospice music therapy sessions ....................... 31

Duration of the hospice music therapy sessions ....................... 32

The Needs of Hospice Patients ....................................................... 34

The domains of hospice patients’ needs .................................. 34

The physical issues of hospice patients ....................................... 35

The cognitive issues of hospice patients ..................................... 37

The psychological/emotional issues of hospice patients ........... 38

The social and spiritual issues of hospice patients ................... 39
THE COMMON ISSUES IN HOSPICE MUSIC THERAPY

The Issues of the Hospice Music Therapists .............................................. 63

CONCLUSION ........................................................................................................ 64

REFERENCES ........................................................................................................ 68

APPENDICES

Appendix A. IRB Approval Letter ............................................................... 74

Appendix B. Email Recruitment Letter with Consent ............................ 75

Appendix C. Survey Questionnaire .............................................................. 77

LIST OF TABLES

Table 1. The frequency of hospice music therapy sessions ................. 31

Table 2. The duration of hospice music therapy sessions ..................... 33

Table 3. The rating averages of each domain ........................................... 35

Table 4. The physical issues of hospice patients ..................................... 36

Table 5. The cognitive issues of hospice patients ................................... 37

Table 6. The psychological/emotional issues of hospice patients ............ 39

Table 7. The social/spiritual issues of hospice patients ......................... 40

Table 8. The goals of hospice music therapy .......................................... 42

Table 9. The methods of hospice music therapy ..................................... 44

Table 10. The family member/caregiver’s needs .................................... 46

Table 11. The issues in working as a hospice music therapist ............... 48
Table 12. The job satisfaction rate of the respondents .........................49

Table 13. The components of the written comments upon satisfaction ......50

Table 14. The percentages of answers relating to the five domains ............59

LIST OF FIGURES

Figure 1. The participants’ age ranges ....................................................28

Figure 2. The participants’ years of work experience .............................29

Figure 3. The frequency of hospice music therapy sessions ...................30

Figure 4. The location of hospice music therapy sessions .......................32

Figure 5. The duration of hospice music therapy sessions ......................33

Figure 6. The domains of hospice patients’ needs ..................................34

Figure 7. The physical issues of hospice patients ....................................36

Figure 8. The cognitive issues of hospice patients ..................................37

Figure 9. The psychological/emotional issues of hospice patients ............38

Figure 10. The social/spiritual issues of hospice patients .......................40

Figure 11. The goals of hospice music therapy ......................................41

Figure 12. The methods of hospice music therapy .................................43

Figure 13. The family member/caregiver’s needs ...................................45

Figure 14. The issues in working as a hospice music therapist .................47
**Introduction**

Music therapy in the hospice setting has been growing since the 1980s. Hospice patients experience diverse issues including physical, cognitive, emotional, social and spiritual (Hilliard, 2005a). Hospice music therapy is offered for coping more effectively with terminal illness and the difficulties involved with the illness. Research supporting the benefit of music therapy in such issues for hospice patients and their families has increased (Anderson, 2011).

Patients in hospice programs may demonstrate various psychological difficulties such as fear, grief, emotional flooding, anxiety, isolation, depression and loss of control, depending on the progression of their illnesses (West, 1994). Nonetheless, all hospice patients share the experience of facing death. Different from any other clinical treatment, hospice and palliative care focus on ‘caring’ rather than ‘curing.’ Munro (1984) stated that “music therapy thus aims at diminishing the impact of the crises around terminal illness and death, not resolving them” (p. 79). Hospice music therapy deals with the patients’ and their families’ raw emotion of facing death by helping them prepare for a good death as well as letting them experience ‘living’ life to the full. Focusing on the ‘living’ tasks through communication, expression, socialization, motivation, and participation is important to deal with the illness and the dying process (Munro, 1984).

The amount of research concerning hospice music therapy is comparatively small. When searching articles from the database of PsycINFO®, under the subject heading ‘music therapy’ and document title ‘hospice or terminally ill,’ only 35 peer reviewed articles were found. Under the conditions of subject heading ‘music therapy’ and
document title ‘dementia or Alzheimer,’ 161 articles came up. In the same way, there were 78 articles about ‘anxiety,’ 59 articles about ‘depression,’ and 76 articles about ‘pain.’

Anderson (2011) searched the articles pertaining to music therapy research in hospice and palliative care published from 1977 to 2010 and acquired 79 articles. Of these articles, a survey research by Groen (2007) suggested some meaningful information about the common reasons for music therapy referral. However, the research is focused on the assessment and treatment practices regarding pain. There is no survey research about the common issues in general hospice music therapy practice yet. In order to understand hospice music therapy practice more clearly, it is necessary to collect data about the common issues in hospice music therapy involving the patients, their family caregivers and the music therapists.

This survey research was designed to collect quantitative and qualitative data from the hospice music therapists who are currently working in the United States. The statistical data collected through a survey of these therapists will show what the hospice patients’ and family caregivers’ needs are, what hospice music therapists do, and the challenges of hospice music therapists in the current hospice settings. These data will provide substantial information about the current hospice music therapy practice.
Review of the Literature

Hospice and Palliative Care in the United States

Hospice and palliative care is an important caring system for high quality end-of-life care of terminally ill patients and their families. Hospice was started as a voluntary movement to provide psychological and/or emotional support to patients who suffer pain near death. It has been developed in conceptualizing ‘hospice and palliative care’ and in expanding access to the holistic quality of life care.

As Carlson, Morrison and Bradley (2008) pointed out “hospice became publically funded under the Medicare Hospice Benefits (MHB) since the Tax Equity and Fiscal Responsibility Act (TEFRA) authorized Medicare to reimburse for hospice service in 1982” (p. 439); the passing of TEFRA was a remarkable turning point for the hospice movement. It was a legal declaration of the federal government about the importance of hospice care. Since then, hospice eligibility criteria under MHB is being a Medicare beneficiary having less than 6 months of life expectancy and the discontinuation of curative medical treatment (United States Department of Health and Human Services, 2011).

Since the enactment of the MHB, hospice programs and hospice patients receiving hospice care have continuously increased. Connor (2007) argued that “in 2005, the National Hospice and Palliative Care Organization (NHPCO) estimates that at least one of every three deaths in the United States was under hospice care” (p.92). The NHPCO estimated 1.65 million patients received hospice care service in 2011, and 44.6%
of all death were under the care of a hospice program (National Hospice and Palliative Care Organization [NHPCO], 2012, p. 4).

According to the report of the NHPCO, in 2011, over 5,300 hospice programs were in operation in the United States: free standing/independent hospice 57.5%, part of a hospital system 20.3%, part of a home health agency 16.8%, and part of a nursing home 5.2%. Among the patients received hospice care in 2011, 39.3% were over 85 years old, 27.6% were 75-85 years old, 16.3% were 65-74 years old, 16.0% were 35-64 years old, 0.4% were 25-34 years old, and 0.4% were less than 24 years old. Of the 1.65 million patients, 66.4% received hospice care at 'home’ including private residences, nursing homes and residential facilities, while 26.1% received care in hospice inpatient facilities and 7.4% received care in hospital (NHPCO, 2012).

The Issues in Hospice Care

Hospice care takes a holistic approach to the care of dying patients and their families. According to research done by Addington-Hall and Karlsen (2005) in the United Kingdom, most respondents rated the following fifteen aspects as very important in hospice care:

Care for the whole person, not just their physical needs, care for the family as well as the patient, respect for patient’s wishes, allowing patients to make their own decisions, providing a good quality of life, reducing distress, allowing the patient to ‘live until death,’ allowing the patient a peaceful death, providing the patient with emotional support, meeting patients’ religious/spiritual needs, providing good communication between staff and patients/families, informal and
flexible nursing, control of pain and other symptoms, bereavement support, and multi-professional working. (p. 43)

The psychosocial issues. Schulman-Green (2003) emphasized the psychosocial domain as a major part of palliative treatment. She stated that "psychosocial issues include self-esteem, insight into and adaptation to illness and its consequences (e.g. grief and bereavement), communication, decision making, social functioning, and nature of relationships" (p. 34). These issues all relate to the quality of life, emotional well-being, or respect of dignity for dying patients. The researcher criticized the perspective of low priority of psychosocial issues within the medical model of care (i.e. a symptomatic treatment approach) in hospice settings.

Elizabeth Kübler-Ross suggested the five stages of death and dying process: denial and isolation, anger, bargaining, depression, and acceptance (Kübler-Ross, 1969; West, 1994). Throughout these stages, hospice patients experience diverse psychological and emotional distress such as depression, anxiety, fear, grief, isolation and helplessness. Due to their advanced illness, numerous terminally ill patients may often experience hopelessness and depression. Major depression is a very common symptom for hospice patients. According to a study done by Irwin et al. (2008), 10.8% of home/long-term hospice care patients and 13.7% of inpatients in hospice care experience depression. Also, the hospice patients may feel fear about their loss of autonomy, loss of dignity, inadequate pain management and a painful death, as well as being concerned about becoming a burden to their family caregiver. Sometimes, the distress might create the patients’ desire to hasten death. Kelly et al. (2002) showed that 22% of 72 terminally ill
cancer patients display a significant desire to hasten death because of the existential suffering and “a wish to determine the manner of death.”

**The physical issues.** Physical symptoms in hospice are diverse depending on the diagnosis. According to the report of the NHPCO, cancer is the most common primary diagnosis. It is 37.7% of hospice admissions, followed by unspecified debility which is 13.9%. Dementia is 12.5%, heart disease is 11.4%, and lung disease is 8.5% (NHPCO, 2012). Regardless of the primary diagnosis, the most common problematic physical issues for hospice patients are pain and shortness of breath. Ng and von Gunten (1998) investigated the 100 consecutively admitted hospice patients to obtain information about their symptoms. The researchers obtained the data from direct interviews with patients, interviews with family members/primary caregivers, or assessments by nurses. The main physical complaints of the hospice patients were respiratory distress, pain, coma, fatigue, decreased mobility, sepsis, and gastrointestinal distress. The prevalent symptoms were weakness, fatigue, weight loss, anorexia (loss of appetite), dyspnea (shortness of breath), xerostomia (dry mouth), cough, pain, dysphagia (difficulty in swallowing), constipation, nausea, insomnia, and vomiting. They mentioned that inadequate pain control was not predominant, but also pointed out that “the patients were the primary reporters of pain” (Ng & von Gunten, 1998).

Terminally ill patients may frequently experience delirium which is a neuropsychiatric symptom prior death. Cohen, Pace, Kaur and Bruera (2009) stated 85 to 90 percent of advanced cancer patients, who are near death, experience delirium, and the experience is highly distressing to the patients and their family caregivers. Most patients and caregivers infer pain or pain medications may be related to the delirium. Although
pain management is the most important treatment for the terminally ill patients, most patients and family caregivers want to maintain communication until they can say their last good byes. This creates a dilemma with the frequent use of morphine, in terms of pain management and quality of life issues. The effect of music therapy intervention for pain relief or reduction of pain perception has been supported by research (Curtis, 1986; Skaggs, 1997; Gallagher, Huston, Nelson, Walsh, & Steele, 2001; Good et al., 2001; Hilliard, 2001).

The family issues. The psychosocial needs are also important for the family members of hospice patients. From accepting the death of loved one to planning for the funeral, family member(s)/caregiver(s) have to confront stressful moments. Witnessing the dying process of loved one is emotionally painful. They often experience emotional distress such as anxiety, depression, sadness, fear, loneliness, and helplessness. Also, they may experience social isolation or lack of social/family support, loss of job, financial distress, doubts about their decision making, and feelings of being burdened when they take care of their loved one. Kübler-Ross adapted her “five stages of death and dying: denial and isolation, anger, bargaining, depression, and acceptance” for a person who lost a loved one as the “grief and grieving” process and explained the stages of emotional suffering (Kübler-Ross & Kessler, 2005).

A death impacts the entire family system. The homeostatic balance within the family system may be broken by a death. As result, individual family members may experience the loss of a specific functional position in family; e.g. a girl may lose her functional position as a daughter when her mother dies (Worden, 2001). The experiential impact varies in family dynamics. Sometimes, life-threatening illness may create an
opportunity to reconnect family members, relatives and friends by expressing their concerns about their terminally ill loved one. Simultaneously, due to the life-threatening illness, the family system or the broader support system becomes strained. Especially, in cases of pediatric patients, there may be involvement of young children, adolescents and young parents who are vulnerable in accepting the traumatic events. Stress for each family member is significantly increased, especially in the face of serious illness and death (Bartell & Kissane, 2005).

Carmichael (2005) compared and analyzed the models and theoretical frameworks of bereavement. She emphasized that the assessment of the needs of family member(s)/caregiver(s) at an early stage is important, because people who have expressed and shared their feelings in open relationships in family tend to cope better during the bereavement period (Carmichael, 2005). Also, Worden (2001) argued that “functional families are more likely to process feelings about the death, including admitting and accepting feelings of vulnerability” (p. 150). Expressing emotions such as anticipatory grief, concerns related to death, and honest feelings between the patient and the family member(s)/caregiver(s) are important for their healthy process of grieving (Carmicheal, 2005; Herbert et al., 2006; Kutner et al., 2009). As West (1994) pointed out that the hospice program regards “the family as the unit of care,” the family member(s)/caregiver(s)’ quality of life is another important goal in hospice care.

The spiritual issues. Spirituality is also one of the unique issues for hospice patients. Regardless of their religious orientation, spiritual support is necessary for hospice patients in the process of accepting death and dying. Neimeyer, Currier, Coleman, Tomer and Samuel (2011) argued that “patients with an internalized religious worldview
reported less emotional suffering and greater acceptance of death" (p. 792). For hospice patients, spirituality is involved with “thankfulness and sense of gratitude for life,” “relationship with self,” “relationship with others,” “relationship with nature and music,” “relationship with God or a higher being,” and “hope, meaning and purpose in life” (Edwards, Pang, Shui, & Chan, 2010). Through semi-structured interviews to hospice patients, Hermann (2001) identified six themes of hospice patients’ spiritual needs:

(1) Need for religion – to pray, to read the bible, to use scripture, to read/use inspirational material, to go to church, and to sing/listen to music.

(2) Need for companionship – to be with family/friends, to talk with others, to help care for others, and to be with children.

(3) Need for involvement and control – to have input into one’s own life, to have information about own care, to stay as independent as possible, to have things in life stay the same, to be involved with family activities, and to be helped by others.

(4) Need to finish business – to do a life review, to finish life tasks, to come to terms with present situation, and to resolve bitter feelings.

(5) Need to experience nature – to look outside, to be outside, and to have flowers in the room.

(6) Need for positive outlook – to see the smile of others, to laugh, to think happy thoughts, and to take one day at a time.

**Hospice Music Therapy**

Hilliard has emphasized the holistic approach in hospice music therapy because of the “multidimensional aspects” of end-of-life care (Hilliard, 2001; Hilliard, 2005b). He
suggested holistic care to increase the quality of life for both the patient and the family within the interdisciplinary team in a hospice setting. He identified the multidimensional needs involving the patient and the family: a desire of a ‘good death,’ anticipatory grief, communication, pain management, anxiety reduction, emotional support, spiritual support, support for the caregiver(s), socialization, and maintaining quality of life (Hilliard, 2005b). He asserted that the effect of music therapy on hospice patients and their families has been proven by qualitative and quantitative studies (Hilliard, 2005a).

A variety of complementary therapies including massage therapy, music therapy, pet therapy, aromatherapy and hypnotherapy are provided in hospice programs throughout the United States. These complementary therapies offer to improve hospice patients’ quality of life by alleviating discomfort, altering mood states, and supporting better coping skills. A survey research (Demmer, 2004) showed that 50% of hospices are offering music therapy as a complementary therapy service in the United States. Music therapy is the second most common complementary therapy provided by hospices following massage therapy (Demmer, 2004).

Music therapy in hospice care covers diverse issues for patients and their families/caregivers as well (West, 1994; Krout, 2003; Stewart et al., 2005; Lindenfelser, Grocke & McFerran, 2008). Krout (2003) argued that “music therapy is a service modality that can help to facilitate communication between family and the patients who are actively dying, while also providing a comforting presence” (p. 129). Music can be an accessible tool for releasing emotions and sharing feelings between hospice patients and their family members. Hilliard (2001) also wrote that “music therapy is a creative and
innovative way to meet the multidimensional needs of the terminally ill and their loved ones" (p. 165).

**The effect of music therapy on hospice patients.** According to the study done by Hilliard (2003), music therapy interventions are effective for the hospice patients’ quality of life. Quality of life relates to the issues of “maintaining dignity, managing pain and physical discomfort, spending time with loved ones, engaging in spiritual practice, and maintaining emotional health” (Hilliard, 2005c). The researcher randomly assigned the hospice patients into two groups: routine hospice service plus music therapy and routine hospice service only. He measured the quality of life of the hospice patients diagnosed with terminal cancer by the Hospice Quality of Life Index-Revised (HQOLI-R) after every visit. The results showed that music therapy helps the terminal cancer patients to improve their quality of life. In this study, the significant differences in length of life between the two groups were not indicated. However, in the same researcher’s ex-post facto study in 2004, he showed that the hospice patients who had received music therapy lived longer than other hospice patients (Hilliard, 2004).

According to the survey done by Groen (2007), the most common reason for referral to music therapy, reported by music therapists, was anxiety. Home-Thompson and Grocke (2008) showed the effect of music therapy on anxiety in patients who are terminally ill. The researchers did a randomized-controlled study and measured the patients’ anxiety levels and heart rates before and after receiving a single music therapy session or volunteer’s visit. The results showed that a single music therapy session significantly reduces anxiety and increases the quality of life for the terminally ill patients (Horne-Thompson & Grocke, 2008).
The goals of hospice music therapy. Hilliard (2005a) clarified the primary goal of end-of-life care is, "to promote patients' quality of life by alleviating physiological, social and spiritual distress, and improving comfort" (p. 173). There are several different categorizations in hospice patients' needs: physical, psychological, social, and spiritual (Munro, 1984); physiological, psychological, cognitive, and spiritual (Delio & Dneaster, 2005). Hilliard (2005a) identified the five domains of the hospice patients' needs more specifically:

Needs often treated by music therapists in end-of-life care include the social (e.g. isolation, loneliness, boredom), emotional (e.g. depression, anxiety, anger, fear, frustration), cognitive (e.g. neurological impairments, disorientation, confusion), physical (e.g. pain, shortness of breath) and spiritual (e.g. lack of spiritual connection, need for spiritually-based rituals). (p. 173)

Maue-Johnson and Tanguay (2006) summarized the possible treatment goals for music therapy in hospice care: "(a) decreasing anxiety and perception of pain, (b) developing coping skills, (c) gaining spiritual support, (d) identifying and expressing emotions, (e) engaging in life review, (f) improving communication skills, (g) improving relaxation skills, (h) decreasing restlessness and agitation, and (i) orienting to reality (p.13)."

The methods of hospice music therapy. In hospice care, music therapists utilize diverse methods such as song writing, improvisation, guided imagery, lyric analysis, singing, instrument playing and relaxation techniques (Hilliard, 2005a), depending on the patient's physical and emotional status, and their family member(s)/caregiver(s)’s
willingness. According to Dileo and Dneaster (2005), there are four approaches in hospice music therapy: receptive, creative, recreative, and combined with other modalities (e.g. art, dance). Also, they distinguished the three levels of practice: supportive (e.g. regulate breathing, decrease pain), communicative/expressive (e.g. express feelings, non-verbal expression) and transformative (e.g. life review, resolution of fear).

Curtis (1986) utilized the receptive method of music listening for pain relief and relaxation. The researcher could not show statistically significant differences between music and no music conditions. However, the research showed that music may impact the physical status of each individual. Guided imagery and the Bonny Method of Guided Imagery (BMGIM) are effective in terminally ill patients' management of pain perception and relaxation (Wylie & Blom, 1986). Music provides opportunities to explore their emotions, to reminisce about their lives, and to express their feelings (Wylie & Blom, 1986; Skaggs, 1997). According to the research of O’Callaghan (1996), song writing is an effective tool for communicating messages and expressing positive feelings of the palliative care patients. The lyrical themes are messages, self-reflections, compliments, memories, reflections upon significant others including pets, self-expression of adversity, imagery and prayers (O’Callaghan, 1996).

The statistical data on hospice music therapy. As previously mentioned, Groen (2007) conducted a survey research about pain assessment and treatment for pain management in hospice settings. The researcher surveyed 72 hospice music therapists and 92 hospice nurses with differentiated questionnaires. The questionnaire for hospice music therapists includes locations of music therapy sessions, reasons for music therapy referral,
general music therapy techniques, music therapy techniques specifically for pain management, and pain assessment tools used according to the patients’ diagnoses.

According to Groen’s survey (2007), the most common places where the hospice music therapists provide services were: (1) hospitals, (2) inpatient hospice facilities, (3) in-home services, and (4) nursing homes. The reasons for referral to music therapy, reported by music therapists, were anxiety (96%), depression (94%), isolation (92%), pain (80%), coping (77%), restlessness (76%), spiritual support (76%), communication (71%), grief (69%), confusion (63%), and memory loss (54%). The nursing professionals reported that the reasons of referral to music therapy were: spiritual support (76%), anxiety (73%), pain (73%), depression (67%), isolation (60%), confusion (53%), and grief (53%). The music therapy techniques commonly utilized with hospice patients were: music listening for relaxation (93%), distraction (76%), deep breathing (68%), progressive relaxation (60%), music assisted cognitive reframing (54%), meditation (46%), autogenics (31%), and guided imagery and music (28%). All these music therapy techniques relate to pain management. Due to the research focused on pain assessment and pain management, the results of Groen's study (2007) have limitations in demonstrating other needs of hospice patients and general techniques in hospice music therapy.

In reference to Anderson’s systematic review (2011) of the published 79 journal articles, she found the 62 (79%) articles regarding qualitative/non-empirical research and 17 (22%) articles regarding quantitative research. The music therapy goals of the 62 qualitative articles concern emotional health (36%), physical health (20%), social interaction (20%) and spiritual support (18%). The music therapy goals of the
quantitative articles concern emotional health (35%), physical health (20%), spiritual support (10%) and social interaction (5%). The literature has shown that hospice music therapy has primarily focused on emotional health (Anderson, 2011). This data is very important and meaningful, but it may be hard to generalize to the current hospice music therapy practice, because the articles might not represent the whole reality of hospice music therapy practice.

Death is an inevitable event for everyone and each dying process is not the same. The academic literature suggests the unique characteristics and importance of hospice music therapy, diverse needs or symptoms of hospice patients and effective hospice music therapy interventions, as well as the goals, methods, techniques, and case examples in hospice music therapy. However, there is no survey research about the major needs of the hospice patient and the family caregiver, and the prevalent goals and methods in hospice music therapy. Groen (2007) showed statistical data about the reasons for referral to music therapy in hospice setting, but the results of her survey did not extend to the general information of hospice music therapy practice. The main foci of her research were the current trends of pain assessment in hospice care and music therapy techniques commonly utilized for pain management. Therefore, in order to obtain statistical information about the general hospice music therapy, a new survey research is necessary.

**Statement of Purpose**

The literature in hospice music therapy suggests the five domains of hospice patients’ needs including physical, cognitive, emotional, social and spiritual (Hilliard, 2005a); however it does not provide systematic data regarding the domains. This study
will provide systematic data regarding the most commonly encountered domains of need for hospice patients. The five domains of hospice patients’ needs identified in this study are physical, cognitive, psychological, social and spiritual domains (see the Methods section for further explanation). Further, this study will show the most common goals and utilized methods in hospice music therapy, the common needs of family caregivers, and the challenges in working as a hospice music therapist as well as the levels of job satisfaction. The practical information gathered from the music therapists in hospice settings will show the reality of this field. This survey research will provide helpful information for the new professional music therapists and music therapy interns who are going to work in hospice settings.

The purpose of this study is to gather experiential information about the common issues in hospice music therapy practice. The issues that this study will identify are:

(1) What are the most commonly encountered domains of need (physical, cognitive, psychological, social and spiritual) for hospice patients in music therapy?

(2) What are the most common issues of hospice patients within each domain that are observed during hospice music therapy sessions?

(3) What are the most common goals identified in hospice music therapy?

(4) What are the most commonly utilized methods in hospice music therapy?

(5) What are the family member/caregiver’s needs most commonly encountered in hospice music therapy?

(6) What is the most difficult issue in working as a hospice music therapist?

(7) What is the level of satisfaction in working as a hospice music therapist?
Methods

Development of a Survey

A survey was developed using an on-line application, SurveyMonkey.com by the present researcher. The survey questionnaire was designed to investigate general music therapy settings (frequency, place and duration), the ranking of common issues in hospice music therapy (on patients, family caregivers and therapists), common goals and methods, and hospice music therapists’ job satisfaction. Some items of each domain are referenced in adapting an assessment of hospice patients’ needs suggested by Maue-Johnson and Tanguay (2006).

This study adapted the five domains (physical, cognitive, emotional, social and spiritual) of hospice patients’ needs identified by Hilliard (2005a), but some conceptual modification and technical alteration were made. First, in categorization of domains, this study uses the word ‘psychological’ instead of ‘emotional’ because ‘psychological’ is broader term than ‘emotional.’ Second, in identifying issues and needs related to domains, this study puts ‘psychological/emotional’ together to imply specific aspects of hospice patients’ needs and/or issues. In this study, the word ‘emotional’ refers to a factor of ‘psychological’ contents. Finally, in the survey questionnaire, on the question about the common issues in ‘social’ and ‘spiritual’ domains, this study put ‘social/spiritual’ together because there are not enough items for each domains. The words ‘social/spiritual’ refer to ‘social’ and/or ‘spiritual’ contents here.
Procedure of Recruitment

Following the official procedure, the researcher requested the most recent electronic mailing lists of the music therapists who are currently working with terminally ill patients from American Music Therapy Association (AMTA). AMTA reviewed the purpose of the survey and gave the researcher the permission to use their member email addresses. Then, the researcher got the approval for the survey research from the Institutional Review Board (IRB) at Montclair State University. After receiving the permission, participants for the survey were recruited based on the email lists provided by the AMTA. A recruitment letter for the survey was sent via email with a description of the purpose of the survey, benefits and risks, and consent statement. The letter contained a forwarding request to other hospice music therapists who are not AMTA members. On the first page of the survey, the agreement to participate was selected by clicking a button; then the respondents proceeded with the survey.

Procedure of Collecting Data

The survey was directly linked from the recruitment letter upon the on-line consent. The researcher sent the letter twice, on June 9, 2012 and September 14, 2012, to 97 hospice music therapists. The survey account was open during two months after sending the first recruitment letter. All data went directly to the SurveyMonkey.com while preserving confidentiality to the extent possible. The survey was restricted to participate once per computer. Respondents could go back to previous pages in the survey and update responses until the survey was completed or until they exited the survey. Once completed or exited the survey, the respondent was not able to re-enter the
survey. The respondent’s IP address was not stored in the survey account. The data was collected from June 9, 2012 to September 12, 2012 without storing any identifiable information.

Results

A total of 59 music therapists accessed the survey. The nine therapists who clicked the “No” button on the question “Are you currently working as a hospice music therapist?” were automatically taken out of the survey. Consequently, a total of 50 respondents were eligible for analysis. Not all respondents answered all questions.

Demographic Information

Ages and gender. Of the 50 respondents, 38% \((n=19)\) are 20-29 years old, 30% \((n=15)\) are 30-39 years old, 10% \((n=5)\) are 40-49 years old, 16% \((n=8)\) are 50-59 years old, and 6% \((n=3)\) are 60 years old or older (see figure 1). Of the 50 respondents, 89.8% \((n=44)\) are female, 10.2% \((n=4)\) are male, and one respondent skipped the answer.

![Figure 1. The participants' age ranges.](image-url)
Years of experience. In reference to the years of work experience in hospice settings, of the 50 respondents, 54% (n=27) are working for 0-5 years, 36% (n=18) are working for 6-10 years, 6% (n=3) for 11-15 years, 4% (n=2) for 16-20 years and none for more than 20 years (see figure 2). Over half of the respondents are working in hospice settings less than about five years. Of the 27 respondents who have 0-5 years of work experience, 66.7% are 20-29 years old and 22.2% are 30-39 years old.

How many years of experience do you have in the hospice setting?

<table>
<thead>
<tr>
<th>Years of Experience</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>54.0%</td>
</tr>
<tr>
<td>6-10</td>
<td>36.0%</td>
</tr>
<tr>
<td>11-15</td>
<td>6.0%</td>
</tr>
<tr>
<td>16-20</td>
<td>4.0%</td>
</tr>
<tr>
<td>20+</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

*Figure 2.* The participants' years of work experience.

Based on the demographic results, in order to see the between/within group differences, the researcher divided the eligible respondents into three groups according to the age ranges (i.e. 20-29, 30-39, and over 40 years old) and two groups according to the years of work experience in hospice settings (i.e. 0-5 years and over 6 years of experience); the statistical data are displayed in tables.
General Hospice Music Therapy Sessions

**Frequency of the hospice music therapy sessions.** Because of the characteristics of hospice setting, the frequency of music therapy sessions varies depending on the patients' state and needs. Of the 49 respondents, 26.5% \( (n=13) \) chose 'other' and 24.5% \( (n=12) \) chose 'more than 3 times a week.' The respondents who chose 'other' specified their situations. Most of them described that they classify the patients into several levels of need to visit and see them '2-3 times in a week,' 'once a week,' 'once in two weeks,' or 'once in a month' (see figure 3).

![How often do you offer music therapy for a hospice patient?](image)

**Figure 3.** The frequency of hospice music therapy sessions.

Table 1 shows the differences between the respondents' ages and years of work experience. According to the results, more experienced music therapists have more frequent sessions with a hospice patient than less experienced therapists. The less
experienced music therapists have more regular sessions (i.e. once in a week, once in two
weeks, or once in a month) than more experienced therapists.

Table 1

<table>
<thead>
<tr>
<th>The Frequency of Hospice Music Therapy Sessions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ages</td>
</tr>
<tr>
<td>------</td>
</tr>
<tr>
<td>More than 3 times a week</td>
</tr>
<tr>
<td>Twice a week</td>
</tr>
<tr>
<td>Once a week</td>
</tr>
<tr>
<td>Once in two weeks</td>
</tr>
<tr>
<td>Once in three weeks</td>
</tr>
<tr>
<td>Once in a month</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

Numbers of Answers on Age Ranges and Years of Work experience

Location of the hospice music therapy sessions. Figure 4 shows the places
where music therapy sessions are offered. The most common place is basically ‘home.’
Of the 49 respondents, most of them (91.8%, n=45) chose ‘nursing home’ as the most
common place where music therapy sessions are offered; 89.8% (n=44) chose ‘patients’
home,’ 36.7% (n=18) chose ‘other residential facility,’ and 12.2% (n=6) chose ‘other
private residence.’ Hospital or inpatient units are less common. Of the 49 respondents,
32.7% (n=16) chose ‘hospital inpatient facility,’ 16.3% (n=8) chose ‘acute care hospital’
and 4.1% (n=2) chose ‘ICU’ (Intensive Care Unit). Of the 8 respondents (16.3%) who
chose ‘other,’ half of them (n=4) wrote ‘hospice inpatient facility.’ One respondent
pointed out the importance of ‘NICU’ (Neonatal Intensive Care Unit) for the premature
babies who are dying (see figure 4).
Where do you commonly have music therapy sessions with hospice patients? (select up to 3 items)

- Patient's home: 89.8%
- Nursing home: 91.8%
- Other private residence: 12.2%
- Other residential facility: 36.7%
- Hospital inpatient facility: 32.7%
- Acute care hospital: 16.3%
- ICU (Intensive Care Unit): 4.1%
- Other (please specify): 16.3%

**Figure 4.** The location of music therapy sessions.

**Duration of the hospice music therapy sessions.** According to the 9 respondents who wrote comments, the duration of the hospice music therapy sessions varies depending on the needs of the patients and the situations upon the therapists’ arrival. Of the 49 respondents, 36.7% (n=18) chose 40-50 minutes, 26.5% (n=13) chose 50-60 minutes, 22.4% (n=11) chose 30-40 minutes, and 14.3% (n=7) chose 20-30 minutes (see figure 5).
How long does each music therapy session last in general?

<table>
<thead>
<tr>
<th>Duration</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 min</td>
<td>0.0%</td>
</tr>
<tr>
<td>10-20 min</td>
<td>0.0%</td>
</tr>
<tr>
<td>20-30 min</td>
<td>14.3%</td>
</tr>
<tr>
<td>30-40 min</td>
<td>22.4%</td>
</tr>
<tr>
<td>40-50 min</td>
<td>36.7%</td>
</tr>
<tr>
<td>50-60 min</td>
<td>26.5%</td>
</tr>
<tr>
<td>More than 1 hour</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Figure 5. The duration of hospice music therapy sessions.

Interestingly, of the 27 respondents who have 0-5 years of experience, 44.4% (n=12) answered that they offer 40-50 minutes sessions in general (see table 2).

Table 2
The Duration of Hospice Music Therapy Sessions

<table>
<thead>
<tr>
<th>Ages</th>
<th>Years of working</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20-29</td>
<td>30-39</td>
</tr>
<tr>
<td>Less than 10 minutes</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>10-20 minutes</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>20-30 minutes</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>30-40 minutes</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>40-50 minutes</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>50-60 minutes</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>More than 1 hour</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>19</td>
<td>15</td>
</tr>
</tbody>
</table>

Numbers of Answers on Age Ranges and Years of Work experience
The Needs of Hospice Patients

**The domains of hospice patients' needs.** Figure 6 displays the degree of each domain of hospice patients' needs observed during sessions. Of the 49 respondents, 51.0% \((n=25)\) chose 'psychological' domain as the most common patients' needs. The rating average of the 'psychological' domain is 4.31, using a scale of 1 for rating 'less common' to 5 for 'most common.' The rating average of the 'cognitive' domain is 4.10, 'social' domain is 4.06, 'physical' domain is 3.94, and 'spiritual' domain is 3.64 (see figure 6). One of the three respondents who commented on this question wrote that “the separate categories are tied together or closely related.”

Figure 6. The domains of hospice patients' needs.
Table 3 displays the rating average upon each age group and work experience group. The hospice music therapists who have 0-5 years of experience encounter more patients with social and cognitive issues while over 6 years of experienced therapists encounter more patients with physical and spiritual issues.

### Table 3

*The Rating Averages of Each Domain*

<table>
<thead>
<tr>
<th>Domain</th>
<th>Rating Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ages</td>
</tr>
<tr>
<td></td>
<td>20-29</td>
</tr>
<tr>
<td>Physical</td>
<td>3.89</td>
</tr>
<tr>
<td>Cognitive</td>
<td>3.95</td>
</tr>
<tr>
<td>Psychological</td>
<td>4.42</td>
</tr>
<tr>
<td>Social</td>
<td>4.37</td>
</tr>
<tr>
<td>Spiritual</td>
<td>3.67</td>
</tr>
</tbody>
</table>

*Ratings of Answers on Age Ranges and Years of Work experience*

### The physical issues of hospice patients.

‘Pain’ is the most common physical issue of hospice patients observed during music therapy sessions. Of the 49 respondents, 83.7% \((n=41)\) chose ‘pain’ as the most common physical issue of the hospice patient; 81.6% \((n=40)\) chose ‘agitation/restless,’ 61.2% \((n=30)\) chose ‘lethargy,’ 46.9% \((n=23)\) chose ‘respiratory problems,’ and 6.1% \((n=3)\) chose ‘tense/rigid’ (see figure 7).
What are the common physical issues of hospice patients that you observe during sessions? (Select up to 3 items)

![Bar chart showing percentages of physical issues observed in hospice patients.]

- Pain: 83.7%
- Agitation/restlessness: 81.6%
- Tense/rigid: 6.1%
- Lethargy: 61.2%
- Respiratory problems: 46.9%
- Other: 8.2%

*Figure 7. The physical issues of hospice patients.*

Of the four respondents (8.2%) who chose ‘other,’ two respondents specified “respiratory problems in dying process” and “fatigue.” Table 4 shows the number of the respondents’ choice in each group.

**Table 4**

*The Physical Issues of Hospice Patients*

<table>
<thead>
<tr>
<th></th>
<th>Ages 20-29</th>
<th>Ages 30-39</th>
<th>Ages 40+</th>
<th>Years of working 0-5</th>
<th>Years of working 6+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>14</td>
<td>13</td>
<td>14</td>
<td>22</td>
<td>19</td>
<td>41</td>
</tr>
<tr>
<td>Agitation/restlessness</td>
<td>15</td>
<td>12</td>
<td>13</td>
<td>20</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Tense/rigid</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Lethargy</td>
<td>12</td>
<td>10</td>
<td>8</td>
<td>18</td>
<td>12</td>
<td>30</td>
</tr>
<tr>
<td>Respiratory problems</td>
<td>8</td>
<td>6</td>
<td>9</td>
<td>11</td>
<td>12</td>
<td>23</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
</tbody>
</table>

*Numbers of Answers on Age Ranges and Years of Work experience*
The cognitive issues of hospice patients. 'Confusion' is the most common cognitive issue of hospice patients that music therapists observe during sessions. Of the 49 respondents, 89.8% \((n=44)\) chose 'confusion.' 'Memory deficit' is 73.5% \((n=36)\), 'loss of verbal skills' is 71.4% \((n=35)\), 'lack of alertness' is 51.0% \((n=25)\), and 'other' is 6.1% \((n=3)\) (see figure 8).

What are the common cognitive issues of hospice patients that you observe during sessions? (select up to 3 items)

![Figure 8. The cognitive issues of hospice patients.](image)

Table 5 shows that 'confusion' is the most common issue in each group.

Table 5

<table>
<thead>
<tr>
<th>The Cognitive Issues of Hospice Patients</th>
<th>Ages</th>
<th>Years of working</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20-29</td>
<td>30-39</td>
<td>40+</td>
</tr>
<tr>
<td>Lack of alertness</td>
<td>12</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Confusion</td>
<td>16</td>
<td>15</td>
<td>13</td>
</tr>
<tr>
<td>Memory deficit</td>
<td>15</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Loss of verbal skills</td>
<td>12</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

*Numbers of Answers on Age Ranges and Years of Work experience*
The psychological/emotional issues of hospice patients. ‘Anxiety’ is the most common psychological/emotional issue of hospice patients that music therapists observe. Of the 49 respondents, 77.6% (n=38) selected ‘anxiety.’ ‘Depression/withdrawn’ is 73.5% (n=36), ‘loneliness’ is 42.9% (n=21), ‘anticipatory grief’ is 36.7% (n=18), ‘flat affect’ is 24.5% (n=12), ‘disturbance/delirium’ is 14.3% (n=7), ‘fear’ is 12.2% (n=6), and ‘detachment’ is 6.1% (n=3). Four respondents (8.2%) chose ‘other’ (see figure 9).

What are the common psychological/emotional issues of hospice patients that you observe during sessions? (select up to 3 items)

- Depression / withdrawn: 73.5%
- Flat affect: 24.5%
- Anxiety: 77.6%
- Fear: 12.2%
- Anger: 0.0%
- Disturbance / Delirium: 14.3%
- Detachment: 6.1%
- Anticipatory grief: 36.7%
- Loneliness: 42.9%
- Other (please specify): 8.2%

Figure 9. The psychological/emotional issues of hospice patients.
One of the respondents who chose ‘other’ specified “frustration related to loss of ability and loss of control.” The respondents who have 0-5 years of experience chose ‘depression/withdrawn’ most (see table 6).

Table 6

*The Psychological/Emotional Issues of Hospice Patients*

<table>
<thead>
<tr>
<th></th>
<th>Ages</th>
<th>Years of working</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20-29</td>
<td>30-39</td>
<td>40+</td>
</tr>
<tr>
<td>Depression/withdrawn</td>
<td>14</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Flat affect</td>
<td>5</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Anxiety</td>
<td>12</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Fear</td>
<td>3</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Anger</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disturbance/delirium</td>
<td>1</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Detachment</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Anticipatory grief</td>
<td>7</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Loneliness</td>
<td>10</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

Numbers of Answers on Age Ranges and Years of Work experience

The social and spiritual issues of hospice patients. In reference to the social/spiritual issues, ‘isolation’ is the most common issue of hospice patients observed during music therapy sessions. Of the 49 respondents, 83.7% (n=41) chose ‘isolation.’ ‘Lack of support system’ is 51.0% (n=25) followed by ‘worries about family’ 46.9% (n=23). ‘Unresponsiveness’ and ‘spiritual distress’ are 34.7% (n=17) each, ‘religious conflict’ is 8.2% (n=4), ‘attachment’ and ‘financial distress’ are 2.0% (n=1) each (see figure 10 and table 7). Three respondents (6.1%) chose ‘other’ and one of them specified “just don’t want to die.”
What are the common social/spiritual issues of hospice patients that you observe during sessions? (select up to 3 items)

- Isolation: 83.7%
- Unresponsiveness: 34.7%
- Lack of support systems: 51.0%
- Spiritual distress: 34.7%
- Worries about family: 46.9%
- Other (please specify): 6.1%

*Figure 10. The social/spiritual issues of hospice patients.*

**Table 7**

*The Social/Spiritual Issues of Hospice Patients*

<table>
<thead>
<tr>
<th>Isolation</th>
<th>Ages</th>
<th>Years of working</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>20-29</td>
<td>30-39</td>
<td>40+</td>
</tr>
<tr>
<td>Isolation</td>
<td>18</td>
<td>12</td>
<td>11</td>
</tr>
<tr>
<td>Attachment</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Unresponsiveness</td>
<td>5</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Lack of support systems</td>
<td>9</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Religious conflict</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Spiritual distress</td>
<td>7</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Financial distress</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Worries about family</td>
<td>8</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

*Numbers of Answers on Age Ranges and Years of Work experience*
The Goals and Methods in Hospice Music Therapy

The goals in hospice music therapy. The results show that the most common goal is ‘emotional support.’ Of the 49 respondents, 57.1% (n=28) selected ‘emotional support.’ The next prevalent goal is ‘quality of life’ chosen by 51.0% (n=25). ‘Relaxation/comfort’ is 40.8% (n=20), and ‘pain management’ and ‘life review’ are 32.7% (n=16) each. ‘Communication’ is 24.5% (n=12), ‘spiritual support’ is 22.4% (n=11), and ‘self-expression’ is 20.4% (n=10). ‘Positive experience’ is 16.3% (n=8), ‘anticipatory grief’ and ‘family relationship’ are 10.2% (n=5) each, ‘respiratory regulation’ is 8.2% (n=4), and ‘acceptance of dying’ is 4.1% (n=2) (see figure 11).

What are the most common goals you identify for hospice patients? (select up to 3 items)

- Pain management: 32.7%
- Respiratory regulation: 8.2%
- Emotional support: 57.1%
- Anticipatory grief: 10.2%
- Life review: 32.7%
- Spiritual support: 22.4%
- Quality of life: 51.0%
- Positive experience: 16.3%
- Communication: 24.5%
- Relaxation/comfort: 40.8%
- Self-expression: 20.4%
- Acceptance of dying: 4.1%
- Family relationship: 10.2%
- Other (please specify): 8.2%

Figure 11. The goals of hospice music therapy.
Among the four respondents (8.2%) who chose ‘other,’ two respondents specified "social contact" and "family support." As seen in table 8, comparing the two groups concerning the respondents’ years of work experience, the respondents who have over 6 years of experience chose ‘pain management’ more, while respondents who have 0-5 years of experience chose ‘emotional support,’ ‘spiritual support,’ ‘self-expression,’ and ‘relaxation/comfort’ more than other goals.

| The Goals of Hospice Music Therapy |
|-----------------------------|------------------|---------------------|------------------|------------------|
|                             | Ages 20-29       | Ages 30-39         | Ages 40+         | Years of working 0-5 | Years of working 6+ | Total |
| Pain management             | 3                | 6                  | 7                | 5                | 11                | 16    |
| Respiratory regulation      | 2                | 1                  | 1                | 2                | 2                 | 4     |
| Emotional support           | 11               | 11                 | 6                | 17               | 11                | 28    |
| Anticipatory grief          | 3                | 0                  | 2                | 3                | 2                 | 5     |
| Life review                 | 5                | 4                  | 7                | 7                | 9                 | 16    |
| Spiritual support           | 4                | 6                  | 1                | 7                | 4                 | 11    |
| Quality of life             | 9                | 7                  | 9                | 12               | 13                | 25    |
| Positive experience         | 5                | 1                  | 2                | 5                | 3                 | 8     |
| Communication               | 5                | 1                  | 6                | 7                | 5                 | 12    |
| Relaxation/comfort          | 10               | 4                  | 6                | 14               | 6                 | 20    |
| Self-expression             | 7                | 1                  | 2                | 9                | 1                 | 10    |
| Acceptance of dying         | 1                | 0                  | 1                | 1                | 1                 | 2     |
| Family relationship         | 2                | 1                  | 1                | 2                | 3                 | 5     |
| Other                       | 1                | 1                  | 2                | 1                | 3                 | 4     |

Numbers of Answers on Age Ranges and Years of Work experience

**The methods in hospice music therapy.** The most common method utilized during hospice music therapy sessions is ‘listening to live music.’ Of the 49 respondents,
91.8% (n=45) selected ‘listening to live music.’ ‘Singing along’ is also a prevalent method (55.1%, n=27). ‘Song discussion/lyric analysis’ is 36.7% (n=18), ‘singing with instrument’ is 28.6% (n=14), ‘relaxation induction’ is 26.5% (n=13), ‘song writing’ is 22.4% (n=11), and ‘guided imagery’ is 16.3% (n=8). ‘Playing instruments to music’ (12.2%, n=6), ‘instrumental improvisation’ (8.2%, n=4), and ‘vocal improvisation’ (4.1%, n=2) are less commonly utilized methods. ‘Listening to recorded music’ (2.1%, n=1) and ‘learning music/musical skills’ (0.0%, n=0) are not commonly utilized (see figure 12 and table 9). Among the five respondents (10.2%) who chose ‘other,’ three respondents specified “lyric and melodic improvisation,” “respiratory entrainment,” and “life review with live music.”

What are the methods most commonly utilized for hospice patients? (select up to 3 items)

- Listening to recorded music: 2.0%
- Listening to live music: 91.8%
- Vocal improvisation: 4.1%
- Instrumental improvisation: 8.2%
- Singing with instruments: 28.6%
- Playing instruments to music: 12.2%
- Song writing: 22.4%
- Singing along: 55.1%
- Guided imagery: 16.3%
- Relaxation induction: 26.5%
- Song discussion / lyric analysis: 36.7%
- Learning music / musical skills: 0.0%
- Other (please specify): 10.2%

Figure 12. The methods of hospice music therapy.
Table 9

The Methods of Hospice Music Therapy

<table>
<thead>
<tr>
<th>Method</th>
<th>Ages 20-29</th>
<th>Ages 30-39</th>
<th>Ages 40+</th>
<th>Years of working 0-5</th>
<th>Years of working 6+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Listening to recorded music</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Listening to live music</td>
<td>16</td>
<td>15</td>
<td>14</td>
<td>24</td>
<td>21</td>
<td>45</td>
</tr>
<tr>
<td>Vocal improvisation</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Instrumental improvisation</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Singing with instruments</td>
<td>5</td>
<td>4</td>
<td>5</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
<tr>
<td>Playing instruments to music</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>Song writing</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>6</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Singing along</td>
<td>9</td>
<td>8</td>
<td>10</td>
<td>17</td>
<td>10</td>
<td>27</td>
</tr>
<tr>
<td>Guided imagery</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Relaxation induction</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>13</td>
</tr>
<tr>
<td>Song discussion/lyric analysis</td>
<td>11</td>
<td>4</td>
<td>3</td>
<td>11</td>
<td>7</td>
<td>18</td>
</tr>
<tr>
<td>Learning music/musical skills</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Numbers of Answers on Age Ranges and Years of Work experience

The Needs of the Family Caregivers

‘Anticipatory grief’ is the most common need of the family caregivers observed during hospice music therapy sessions. Of the 48 respondents, 83.3% (n=40) chose ‘anticipatory grief.’ ‘Anxiety’ (64.6%, n=31) and ‘fatigue’ (54.2%, n=26) are also common needs of family caregivers. The next prevalent needs are ‘lack of coping skills’ (25.0%, n=12) and ‘burden’ (20.8%, n=10). ‘Isolation’ is 10.4% (n=5), ‘loneliness’ is 6.3% (n=3), and ‘depression/withdrawn,’ ‘fear’ and ‘detachment’ are 4.2% (n=2) each. One respondent (2.1%) chose ‘spiritual conflict/distress’ and one respondent (2.1%) chose ‘disturbance’ (see figure 13).
What are the family member/caregiver's needs most commonly encountered during the music therapy session? (select up to 3 items)

- Depression/withdrawn: 4.2%
- Flat affect: 0.0%
- Anxiety: 64.6%
- Fatigue: 54.2%
- Burden: 20.8%
- Fear: 4.2%
- Anger: 0.0%
- Disturbance: 2.1%
- Detachment: 4.2%
- Anticipatory grief: 83.3%
- Loneliness: 6.3%
- Isolation: 10.4%
- Spiritual conflict/distress: 2.1%
- Lack of support systems: 16.7%
- Financial distress: 4.2%
- Lack of coping skills: 25.0%
- Other (please specify): 8.3%

**Figure 13.** The family member/caregiver's needs.

In reference to the family caregivers' needs, the four respondents (8.3%) who chose 'other' specified "feeling of helplessness," "no benefit from music," "deep sadness," and "communication with patient." Table 10 shows the numbers of answers on each group of age ranges and years of work experience in hospice settings (see table 10).
Table 10

The Family Member/Caregiver’s Needs

<table>
<thead>
<tr>
<th></th>
<th>Ages 20-29</th>
<th>Ages 30-39</th>
<th>Ages 40+</th>
<th>Years of working 0-5</th>
<th>Years of working 6+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/withdrawn</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Flat affect</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Anxiety</td>
<td>12</td>
<td>11</td>
<td>8</td>
<td>18</td>
<td>13</td>
<td>31</td>
</tr>
<tr>
<td>Fatigue</td>
<td>7</td>
<td>7</td>
<td>12</td>
<td>13</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Burden</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Fear</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Anger</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Disturbance</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Detachment</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Anticipatory grief</td>
<td>16</td>
<td>12</td>
<td>12</td>
<td>22</td>
<td>18</td>
<td>40</td>
</tr>
<tr>
<td>Loneliness</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Isolation</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Spiritual conflict/distress</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Lack of support systems</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Financial distress</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Lack of coping skills</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

Numbers of Answers on Age Ranges and Years of Work experience

The Issues of the Hospice Music Therapists

Of the 49 respondents, 61.2% \((n=30)\) chose ‘travel distance’ as the most difficult issue in working at the hospice settings. ‘Time management’ is the next prevalent issue; 40.8% \((n=20)\) of the respondents chose this answer. These two answers are closely related with each other. ‘Emotional management’ was chosen by 32.7% \((n=16)\) of the respondents followed by ‘excessive losses’ (24.5%, \(n=12\)), ‘lack of supervision’ (22.4%,
n=11), and 'spiritual exhaustion' (18.4%, n=9). ‘Collaboration with other disciplines’ and ‘patient/caregiver’s refusal’ were chosen by 12.2% (n=6) of the respondents each. ‘Adjustment in cultural diversity’ is 10.2% (n=5), ‘ethical distress/conflict’ is 8.2% (n=4) and ‘witness of dying’ is 4.1% (n=2) (see figure 14).

What are the hardest things in working as a hospice music therapist?
(select up to 3 items)

<table>
<thead>
<tr>
<th>Issue</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time management</td>
<td>40.8%</td>
</tr>
<tr>
<td>Emotional management</td>
<td>32.7%</td>
</tr>
<tr>
<td>Adjustment in cultural diversity</td>
<td>10.2%</td>
</tr>
<tr>
<td>Witness of dying</td>
<td>4.1%</td>
</tr>
<tr>
<td>Collaboration with other disciplines</td>
<td>12.2%</td>
</tr>
<tr>
<td>Excessive losses</td>
<td>24.5%</td>
</tr>
<tr>
<td>Travel distance</td>
<td>61.2%</td>
</tr>
<tr>
<td>Lack of self-management</td>
<td>0.0%</td>
</tr>
<tr>
<td>Lack of supervision</td>
<td>22.4%</td>
</tr>
<tr>
<td>Ethical distress / conflict</td>
<td>8.2%</td>
</tr>
<tr>
<td>Spiritual exhaustion</td>
<td>18.4%</td>
</tr>
<tr>
<td>Patient/caregiver’s refusal</td>
<td>12.2%</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>20.4%</td>
</tr>
</tbody>
</table>

Figure 14. The issues in working as a hospice music therapist.

Of the 49 respondents, 20.4% (n=10) chose ‘other’ and most of them mentioned about “lack of support from company” such like “large caseloads, professional isolation, lack of time for rest, documentation within charting system, and minimal payment.”
“Musicianship/preparing repertoire” and “witnessing emotional cruelty (or lack of compassion)” were also mentioned.

Table 11 shows the numbers of answers on each group of age ranges and years of work experience. Interestingly, the respondents who have 0-5 years of experience tended to choose ‘emotional management,’ while the respondents who have over 6 years of experience tended to choose ‘time management.’ Also, ten of the respondents (37.0%) who have 0-5 years of experience chose ‘lack of supervision,’ while only one of the respondents (4.5%) who have over 6 years of experience chose the same item. Some degree of differences are also indicated in the results of ‘adjustment in cultural diversity,’ ‘collaboration with other disciplines,’ and ‘patient/caregiver’s refusal.’

Table 11

<table>
<thead>
<tr>
<th>The Issues in Working as a Hospice Music Therapist</th>
<th>20-29</th>
<th>30-39</th>
<th>40+</th>
<th>0-5</th>
<th>6+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time management</td>
<td>7</td>
<td>5</td>
<td>8</td>
<td>9</td>
<td>11</td>
<td>29</td>
</tr>
<tr>
<td>Emotional management</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>10</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Adjustment in cultural diversity</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Witness of dying</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Collaboration with other disciplines</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Excessive losses</td>
<td>6</td>
<td>3</td>
<td>3</td>
<td>7</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>Travel distance</td>
<td>12</td>
<td>8</td>
<td>10</td>
<td>17</td>
<td>13</td>
<td>30</td>
</tr>
<tr>
<td>Lack of self-management</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Lack of supervision</td>
<td>8</td>
<td>3</td>
<td>0</td>
<td>10</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>Ethical distress/conflict</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Spiritual exhaustion</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>Patient/caregiver’s refusal</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>5</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

Numbers of Answers on Age Ranges and Years of Work experience
The Job Satisfaction of the Hospice Music Therapists

Most of the respondents (89.8%, n=44) responded that they are satisfied with their job. Of the 49 respondents, 36.7% (n=18) chose ‘very satisfied,’ 40.8% (n=20) chose ‘quite satisfied,’ and 12.2% (n=6) chose ‘somewhat satisfied.’ While ‘quite unsatisfied’ was chosen by 6.1% (n=3) and ‘very unsatisfied’ was 4.1% (n=2). The scale goes from 1 at ‘very unsatisfied’ to 7 at ‘very satisfied’ and the average rating is 5.8 (see table 12). This satisfaction rate indicates that most hospice music therapists are satisfied with their current job.

Table 12
The Job Satisfaction Rate of the Respondents

<table>
<thead>
<tr>
<th>Levels of satisfaction (score)</th>
<th>Satisfaction rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very satisfied (7)</td>
<td>n=18</td>
</tr>
<tr>
<td></td>
<td>36.7%</td>
</tr>
<tr>
<td>Quite satisfied (6)</td>
<td>n=20</td>
</tr>
<tr>
<td></td>
<td>40.8%</td>
</tr>
<tr>
<td>Somewhat satisfied (5)</td>
<td>n=6</td>
</tr>
<tr>
<td></td>
<td>12.2%</td>
</tr>
<tr>
<td>Neither satisfied nor unsatisfied (4)</td>
<td>n=0</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>Somewhat unsatisfied (3)</td>
<td>n=0</td>
</tr>
<tr>
<td></td>
<td>0.0%</td>
</tr>
<tr>
<td>Quite unsatisfied (2)</td>
<td>n=3</td>
</tr>
<tr>
<td></td>
<td>6.1%</td>
</tr>
<tr>
<td>Very unsatisfied (1)</td>
<td>n=2</td>
</tr>
<tr>
<td></td>
<td>4.1%</td>
</tr>
<tr>
<td>Comments (optional)</td>
<td>n=10</td>
</tr>
<tr>
<td></td>
<td>20.4%</td>
</tr>
</tbody>
</table>

Respondents N=50 (Answered n=49, Skipped n=1) Average Score = 5.8

Ten respondents (20.4%) wrote narrative descriptions instead of choosing one of the satisfaction levels. Most of them expressed that they love the hospice work, especially working with patients and families. The key components of satisfaction are “support people,” “make a positive impact for patients and families,” “sacredness,” “rewarding work,” and “transformative experience.” However, five of them expressed some factors
of dissatisfaction. The key components of dissatisfaction are “poor support/understanding from company,” “managing/increasing caseloads,” “challenging,” “exhausting,” and “poor pay” (see table 13).

**Table 13**  
*The Components of the Written Comments upon Satisfaction*

<table>
<thead>
<tr>
<th>Written Comments related with satisfaction, n=9</th>
<th>Written Comments related with dissatisfaction, n=5</th>
</tr>
</thead>
<tbody>
<tr>
<td>I love being a hospice music therapist.</td>
<td>I just wish I didn’t have to consistently battle false stereotypes of what music therapy is at my company.</td>
</tr>
<tr>
<td>I love this work.</td>
<td>It is somewhat difficult and draining to always feel as if your co-worker may not understand what you do as an MT-BC.</td>
</tr>
<tr>
<td>Always the work with patients and families is very satisfying.</td>
<td>I always feel like I want to do more such as using different techniques/interventions or wanting to expand the program which is more of an employer and budget issue.</td>
</tr>
<tr>
<td>I’m satisfied with the work I do.</td>
<td>I put so much time and energy into my patients that I often forget to take time for creativity for myself and sometimes I tend to lose creative energy if I don’t nurture that.</td>
</tr>
<tr>
<td>Generally satisfied with my client interactions.</td>
<td>Frustrated with the lack of support from upper administration and the increased work load for poor pay.</td>
</tr>
<tr>
<td>It is gratifying to support people during this time, as well as to support the development of music therapy interns so that they can competently provide this service.</td>
<td>Some hospices expect a very unrealistic number and the frequency of visits for patients suffers so that it is not therapeutic to visit only one time a month.</td>
</tr>
<tr>
<td>It is also incredibly rewarding and a privilege, to be an internship supervisor mentoring young people who desire to do this work.</td>
<td></td>
</tr>
<tr>
<td>Working with people who are facing death is transformative experience.</td>
<td></td>
</tr>
<tr>
<td>It gives a daily reminder of what is most precious in our own lives.</td>
<td></td>
</tr>
<tr>
<td>It is highly rewarding work.</td>
<td></td>
</tr>
<tr>
<td>There is sacredness to work and a joy in service.</td>
<td></td>
</tr>
<tr>
<td>I feel like I am able to make a positive impact for patients and families.</td>
<td></td>
</tr>
<tr>
<td>It is amazing to be a conduit for music, and to witness its magical ability to transform end of life situations.</td>
<td></td>
</tr>
</tbody>
</table>
Discussion

Prior to discussion, it is important to point out one of the limitations about the statistical data of this study. In several questions of the survey, the respondents were guided to select maximum three items. The reason of the restriction is to obviously distinguish the major answers from the minor answers. It is a good strategy to discriminate major answers among the common issues and needs in hospice music therapy. However, the restriction might create some degree of limitations in the statistical data.

Demographic Information

According to the AMTA membership survey data in 2010, the proportion of music therapists who were working with terminally ill patients was about 18.6% \((n=183)\). Regarding the issue of gender, 87% of AMTA members were female and 13% of them were male (American Music Therapy Association [AMTA], 2010). The gender ratio for hospice music therapists is 89.8% female and 10.2% male, so the gender ratio for hospice music therapists is similar to the gender ratio of AMTA membership. There is no indication of influence regarding gender on the characteristics of hospice work. All music therapists are not AMTA members. Whitehead-Pleaux (2012) suggested that, “Currently, there are almost 2000 more members of CBMT (The Certification Board for Music Therapists) than there are of AMTA” on the Facebook group page for New England Region American Music Therapy Association. It means that there is a much larger pool of prospective respondents to a future study.
The survey results show that 90% of the respondents are working in hospice settings for less than ten years. The percentage of the respondents who are working for five years or less is 54%. According to the statistical reports from the NHPCO, the patients served by hospice in the United States rapidly increased between 1998 and 2008 (NHPCO, 2010a). The hospice programs in the United States also rapidly increased between 2004 and 2007 than before (NHPCO, 2010b). The reports of NHPCO (2010a; 2010b) and the present research support that the hospice music therapy service obviously grew during recent ten years along with the growth of the hospice programs. In other words, it is for just the last decade that the value of music therapy is recognized by hospice program providers or agencies throughout the United States.

**General Hospice Music Therapy Sessions**

The common places where hospice music therapy sessions are offered are the patient’s home and nursing home. These results correspond to the report of the NHPCO (2012). According to the report, during 2011, 66.4% of patients received hospice care at ‘home’ including private residences, nursing homes and residential facilities, while 26.1% received care in hospice inpatient facilities and 7.4% received care in hospital (NHPCO, 2012). Accordingly, most hospice music therapists visit home by home for providing music therapy. Every home has its unique cultural background and environment. These cultural factors provide a great deal of information about the patient and the family, and are particularly important in both assessment and treatment processes. The awareness of the patient’s culture is an important ability for hospice music therapists. Interestingly, just 10.2% of the respondents select ‘adjustment in cultural diversity’ as one of their difficult issues. The data show that the cultural issue is not a major problem for hospice music
therapists. Regardless of cultural diversity, the universality of music may play the role to reduce cultural gap.

The results about the frequencies and durations of hospice music therapy sessions are interesting. More experienced (6 years or more) respondents answered ‘more than three times a week’ (31.8%) of frequency and ‘30-40 minutes’ (31.8%) of duration the most. In reference to frequencies, the less experienced (0-5 years) respondents’ answers were scattered: ‘more than 3 times a week’ (18.5%), ‘once a week’ (14.8%), ‘once in two weeks’ (14.8%), and ‘once in a month’ (18.5%). In reference to durations, the less experienced (0-5 years) respondents chose ‘40-50 minutes’ (44.4%) the most. These results may be explained by considering that more experienced hospice music therapists see more patients who are facing impending death or who are suffering from the end-of-life symptoms, while less experienced therapists tend to see relatively stable patients. However, this inference is still doubtful. The differences might be because of the policy of company, the caseload management skills, the differences in clinical settings, or other reasons.

The Needs of the Hospice Patients

The domains of hospice patients’ needs. The order of the most common hospice music therapy goals described in the journal articles was: (1) emotional health, (2) physical health, (3) spiritual support, and (4) social interaction (Anderson, 2011). The results of the present research, however, are different from this order. The rankings of the average rates about the domains of hospice patients’ needs are: (1) psychological needs related to such as depression, fear or anxiety, (2) cognitive needs related to such as lack
of alertness or loss of verbal skills, (3) social needs related to such as isolation, financial
distress or worries about family, (4) physical needs related to such as pain, lethargy, or
respiratory problems, and (5) spiritual needs. Interestingly, the domain of physical needs
which is regarded as very important in hospice music therapy is relatively less common
than cognitive and social domains. Yet, the data supporting that the psychological
(including emotional issues) domain is the most common in hospice music therapy
correspond to Anderson’s review of journal articles (2011). Based on the results of the
present research, it might be possible to infer that appreciable physical issues of hospice
patients may possibly be controlled by medication under the approach of ‘palliative care.’
Also, psychological, cognitive, or social domains of support in music therapy might
lessen the perception of physical distresses.

The respondents who have worked for over six years in hospice settings encounter
more distress with physical issues while the respondents who have worked for 0-5 years
encounter more distress with social issues. These results might be explained by
corresponding to the previous inference regarding the frequencies and durations of
hospice music therapy sessions. The hospice patients who are in a state of impending
death or who are suffering from the end-of-life symptoms may have more physical needs
because actively dying hospice patients may show some noticeable physical changes and
declines such as uneven/shortened breath, agitation, lethargy, or coma.

**The hospice patients’ physical needs.** The respondents’ selections vary
depending upon their years of work experience. The more experienced respondents chose
‘agitation/restlessness’ (90.9%), ‘pain’ (86.4%), ‘lethargy’ (54.5%), and ‘respiratory
problems’ (54.5%). The less experienced respondents chose ‘pain’ (81.5%),
‘agitation/restlessness’ (74.1%), ‘lethargy’ (66.7%), and ‘respiratory problems’ (40.7%). There was no significant difference in the percentages of ‘pain.’ However, in the percentages of ‘agitation/restlessness,’ ‘respiratory problems’ and ‘lethargy,’ some degree of differences were indicated. The more experienced respondents showed the tendency in choosing ‘agitation/restlessness’ and ‘respiratory problems,’ while the less experienced respondents showed the tendency in choosing ‘lethargy.’ From these data, it is hard to identify what the reason is for the differences.

Uneven respiration or respiratory difficulties are commonly witnessed from actively dying patients. ‘Agitation/restlessness’ may be caused by physical discomfort (such as pain or problems in bowel movement), psychological problems (such as anxiety or delirium), neurological damages, or losses of metabolic balances and functions observed close to death (Hospice Patient Alliance, n.d.). ‘Pain’ and ‘lethargy’ are different aspects, but sometimes are related. Medication for pain control often brings lethargy or excessive sleeping.

In order to deal with these physical issues, the hospice music therapist may lead the patients to shift from their physical discomfort to being immersed in music. They may utilize the iso-principle, breathing regulation, or other techniques to make the patients be relaxed. As previously suggested, approaching/redirecting to psychological/emotional, cognitive, or social factors may be helpful to shift the patients’ perception of physical discomfort.

The hospice patients’ cognitive needs. There are no significant differences between the two groups regarding years of work experience. ‘Confusion’ was chosen by
88.9% of the respondents who have worked for 0-5 years and by 90.9% of the respondents who have worked for over 6 years. 'Lack of alertness' was chosen by 51.9% of the more experienced group and 50% of the less experienced group. 'Memory deficit' was chosen by 74.1% of the more experienced group and 72.7% of the less experienced group. 'Loss of verbal skills' was chosen by 74.1% of the former group and 68.2% of the latter group. According to the report of NHPCO (2012), in 2011, the percentages of hospice patients' age ranges were as follows: less than 24 years 0.4%, 25-34 years 0.4%, 35-64 years 16.0%, 65-74 years 16.3%, 75-84 years 27.6%, and over 85 years 39.3%. About two-third of all hospice patients (69.6%) were older than 75 years in 2011. The cognitive decline is commonly observed in aged patients, especially with dementia. Some aged hospice patients with advanced dementia do not know that they are in hospice program due to the desire of their family, but the family also desire to communicate and reminisce with their loved one. The cognitive decline also relate to medication or the end-of-life symptoms. Regardless of any occasion, it is important to maintain the patients' cognitive functioning as long as possible for the patients/families' quality of life.

The hospice patients' psychological/emotional needs. Between the items 'depression/withdrawn' and 'anxiety,' each age group and years of work experience group show interesting results. The respondents who are 30-39 years chose both 'depression/withdrawn' and 'anxiety' as the same rate (86.7%). However, 20-29 years old respondents chose 'depression/withdrawn' (74.7%) more than 'anxiety' (63.2%), while 40 years or older respondents chose 'anxiety' (86.7%) more than 'depression/withdrawn' (60%). Also, the respondents who have 0-5 years of work experience chose 'depression/withdrawn' (77.8%) more than 'anxiety' (70.4%), while the
respondents who have over 6 years of work experience chose ‘anxiety’ (86.4%) more than ‘depression/withdrawn’ (68.2%). It is difficult to analyze the reasons for the differences. The differences might be due to the symptom of anxiety as more complex than depression or withdrawal. Life experience and work experience might be related to their selections. The hospice music therapist who has seen more people with anxiety may better understand the symptoms.

Another interesting thing is that no one chose the item ‘anger.’ It does not directly mean that there is no hospice music therapist who observes the patient’s anger during the music therapy sessions. It means that ‘anger’ is not a common psychological/emotional issue of hospice patients. However, according to the Kübler-Ross’s five stages of death and dying process (Kübler-Ross & Kessler, 2005), ‘anger’ is included as one of the five stages. Based on the results of the present research, most hospice patients may express their anger indirectly. Perhaps, they might express their anger through other emotional characteristics such as ‘flat affect,’ ‘detachment,’ ‘disturbance,’ or ‘anticipatory grief.’ Even though it might not be necessary to adhere to the five stages in understanding the hospice patients’ psychological/emotional needs, music therapists need to be sensitive regarding the origin of the patients’ behaviors.

The hospice patients’ social needs. ‘Isolation’ is the most prevalent social issue regardless of the respondents’ ages or years of work experiences. Interestingly, some degree of differences in the item ‘lack of support system’ regarding the respondents’ ages are indicated; 66.7% of the 30-39 years old group, 47.4% of the 20-29 years old group and 40% of the 40 years or older group chose this item. It is uncertain whether these differences come from the differences of patients’ circumstances or come from the
differences of respondents' susceptibilities upon their own life stages. Since the hospice work includes intensive emotional factors, hospice music therapists should have a sense of objective self-observation in order to be aware of their own counter-transference.

**The hospice patients' spiritual needs.** The result regarding the hospice patients' spiritual needs is interesting. Of the 22 respondents who have over 6 years of work experience, 45% chose 'spiritual distress,' while of the 27 respondents who have 0-5 years of work experience, 25.9% chose this item. In the perspective of the Kübler-Ross's five stages of death and dying process, spiritual distress might be related with the stage of "bargaining" or "acceptance." The work experience may lead hospice music therapists to recognize the importance of spirituality for helping the patients to accept death and dying process. Otherwise, related to the previous inference, it might be because more experienced respondents tend to deal with the hospice patients who are in the state of impending death. Sometimes, hospice patients and their family member(s)/caregiver(s) request ritual (or spiritual) practice at the moment of dying.

The importance of spiritual domain is one of the unique characteristics of hospice music therapy. As previously mentioned in the literature review, spirituality often involves with relationships: relationship with self, relationship with others, relationship with life, relationship with nature, relationship with music, and relationship with a higher being (Edwards, Pang, Shui, & Chan, 2010). Indeed, music contributes for spirituality associated with conventional/non-conventional rituals. All the relationships can be touched by music and musical activities. A spiritual approach may support to solve problems in the relationships. However, a spiritual approach might bring negative
emotional reaction, if hospice patients and their family have an impression of emphasizing death and dying.

The Goals in Hospice Music Therapy

Corresponding with the hospice patients’ needs, the most common goal is ‘emotional support.’ Table 14 shows the percentage of answers on each domain regarding the related goals.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Related Goals</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychological</td>
<td>Emotional support</td>
<td>63.0%</td>
</tr>
<tr>
<td>(emotional)</td>
<td>Anticipatory grief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Life review</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality of life</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relaxation/comfort</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acceptance of dying</td>
<td></td>
</tr>
<tr>
<td>Cognitive</td>
<td>Life review</td>
<td>44.2%</td>
</tr>
<tr>
<td></td>
<td>Quality of life</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Positive experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-expression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acceptance of dying</td>
<td></td>
</tr>
<tr>
<td>Physical</td>
<td>Pain management</td>
<td>39.4%</td>
</tr>
<tr>
<td></td>
<td>Respiratory regulation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Quality of life</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Relaxation/comfort</td>
<td></td>
</tr>
<tr>
<td>Social</td>
<td>Quality of life</td>
<td>38.1%</td>
</tr>
<tr>
<td></td>
<td>Positive experience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Communication</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-expression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Family relationship</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Spiritual</td>
<td>Spiritual support</td>
<td>29.1%</td>
</tr>
<tr>
<td></td>
<td>Quality of life</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Self-expression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Acceptance of dying</td>
<td></td>
</tr>
</tbody>
</table>

*The percentage is calculated by the numbers of each response.*
The hospice music therapy goals in the survey questionnaire were not clearly divided into the five domains of hospice patients' needs. Thus, the items were reorganized and grouped into related goals in the five domains of hospice patients' needs. There might be somewhat controversial opinions in the grouping. However, table 14 shows meaningful results in thinking about the relation between the hospice patients' needs and the hospice music therapy goals.

The results closely correspond with the domains of hospice patients' needs:
(1) psychological= 4.31, (2) cognitive= 4.10, (3) social= 4.06, (4) physical= 3.94 and (5) spiritual= 3.67. The percentage of the physical related goals is a little bit higher than the percentage of the social related goals. However, considering the limitation of the restriction in choosing items, the finding is that the ranking of the domains in hospice patients' needs and the ranking of the domains in hospice music therapy goals are closely correlated with each other.

The Methods in Hospice Music Therapy

'Listening to live music' is the method mostly utilized; 98.1% of the respondents chose this item. The results show that the hospice music therapists have, with their musical ability, the sensitivity to play (or select) proper music relating to the each domain of hospice patients' needs. In the conception of Dileo and Dneaster (2005), 'listening to live music' for the hospice patients is not just a "supportive" method, but also a "communicative/expressive" method as well as a "transformative" method. It evokes the sense of comfort, pleasure or 'being-with,' and engages with music, life and the therapists emotionally, physically, socially, spiritually and cognitively. Regarding the prevalence of
‘singing along’ (55.1%) and ‘song discussion’ (36.7%), it infers that a hospice patient may sing along with the therapist several words, phrases, or refrain, and may reflect his/her feelings or memories after listening to the therapist’s live music.

The methods of ‘relaxation induction’ (26.5%), ‘song writing’ (22.4%), and ‘guided imagery’ (16.3%) are less common. This may be because these methods require more cognitive involvement and the patients well-matched with the methods may be limited. Also, the method of letting the hospice patients use instruments is less common: ‘singing with instruments’ (28.6%), ‘playing instruments to music’ (12.2%), and ‘instrumental improvisation’ (8.2%). This may be due to the physical weakness of the patients. Otherwise, it might be due to the difficulties in bringing the extra instruments to the therapy sessions. In many cases, hospice music therapists bring a guitar, music sheets of song repertoire and a computer (for immediate documentation) to each home they visit. They might bring small hand instruments such as shakers, and sanitize them for each session. However, utilizing them may be limited.

**The Needs of the Family Caregivers**

As expected, ‘anticipatory grief’ is the most common family caregivers’ need. Kübler-Ross adapted her “five stages” of “death and dying process” to a person who lost a loved one, as “grief and grieving” process (Kübler-Ross & Kessler, 2005). Expressing emotions such as anticipatory grief, concerns related to death, and honest feelings between patient and family member(s)/caregiver(s) are important for their healthy process of grieving. People who have expressed and shared their feelings in the family are able to cope better in the bereavement period (Carmicheal, 2005; Herbert et al., 2006).
It is important to deal with the family caregivers’ needs because a large number of hospice agencies are also providing bereavement service. Supporting the family caregivers’ needs (before their loved one’s death) may decrease their risk of the complicated grief. Hospice program providers could get more positive responses to their services from the bereaved families.

In reference to the common family caregivers’ need, as previously mentioned when considering the needs of hospice patients, there is no respondent who chose ‘anger’ which is one of Kübler-Ross’s five stages of grieving process. Similar to the hospice patients, the family caregiver’s anger might be suppressed or expressed to other symptoms such as anxiety or fatigue. ‘Anxiety’ was chosen by 64.6% and ‘fatigue’ was chosen by 54.2% of the respondents. The symptom of ‘fatigue’ may relate to physical, psychological/emotional, social, and spiritual factors. It could be also related with the other items such as ‘burden’ (20.8%), ‘loneliness’ (6.3%), ‘isolation’ (10.4%), ‘lack of support systems’ (16.7%), ‘financial distress’ (4.2%), ‘lack of coping skills’ (25%), and ‘the feeling of helplessness’ (specified by one of respondents).

It is occasional to provide music therapy session for family caregivers without patients. Generally, family caregivers are encouraged to participate in the session for patients. Music therapy may or may not support family caregivers’ needs directly. Sometimes, a short experience of participation in a session significantly changes family caregiver’s relationship with patient and significantly reduces family caregiver’s distress such as anticipatory grief, anxiety or fatigue. Therefore, it is necessary to make efforts to create a comfortable musical environment for both a patient and a family caregiver.
The Issues of the Hospice Music Therapists

The results show that most of the respondents are satisfied with working in hospice settings, especially working with patients and their families. However, some factors related with dissatisfaction were indicated: travel distance, time management (related with caseloads and team meetings), and lack of supervision. These issues are included in the category of poor support from the company or upper administration. In reference to the salary, according to AMTA membership survey report in 2010, the average salary of music therapists working with terminally ill patients is $47,115, while the average salary of overall music therapists is $47,889 (AMTA, 2010). According to the report, the hospice music therapists’ average salary is not significantly lower than the overall average regardless how the hospice music therapists actually feel, considering their working environment.

‘Travel distance’ is the most difficult issue in working at hospice; 61.2% of the respondents chose this item. Due to the characteristics of working with hospice patients, most music therapy sessions are offered individually at patient’s home. Also, requested on-call sessions often occur because the death and dying process are always unpredictable. Interestingly, the respondents who have 0-5 years of work experience tended to choose ‘emotional management,’ ‘lack of supervision,’ ‘collaboration with other disciplines,’ and ‘patient/caregiver’s refusal’ significantly more than the respondents who have 6 years or more experiences. According to these results, supervision for new hospice music therapists seems quite necessary. In narrative comments, some respondents expressed “feelings of stagnancy.” To provide better quality of services, hospice program providers or agencies which are offering hospice
music therapy should consider regular supervision opportunities for the therapists’ emotional support and nurturing professional skills. This may increase the level of job satisfaction and create overall virtuous cycle in hospice music therapy eventually.

**Conclusion**

This study provides a great deal of meaningful information about the current hospice music therapy practice, even though the questionnaire has some limitations in its contents and items, especially the inconsistency of categorization. For example, the category of ‘psychological/emotional’ is to support the specific aspects of hospice patients’ needs and issues, while the category of ‘social/spiritual’ is for the technical convenience of the survey. In spite of these limitations, the data show the common issues in hospice music therapy regarding patients, family caregivers, and music therapists. Also, the data support some meaningful inductive inferences. These inferences may be substantiated by further study in the future.

The present research suggests that hospice music therapy has been rapidly growing for the last decade. It seems that music therapy service was included as a valuable part of hospice and palliative care throughout the United States about ten years ago. It also suggests that there are slight differences in issues observed during hospice music therapy sessions according to the hospice music therapists’ years of work experience. Professional maturation may create some of the differences. Based on the analysis of the data, the present research makes one of potential inferences that more experienced hospice music therapists may tend to see the patients who are facing imminent death. The data about the frequencies of music therapy sessions and the hospice
patients' needs encountered during music therapy sessions (i.e. comparatively higher percentages of physical and spiritual issues) may support the inference. It is difficult to figure out statistical differences between the three groups regarding to the respondents' age ranges: 20-29 years old, 30-39 years old, and 40 years or older. However, from the data about the hospice patients' social issues encountered during music therapy sessions, the present research points out the factor of the respondents' susceptibilities regarding their own life stages.

As identified by Hilliard (2005a), it is interesting to confirm that the five domains (psychological, physical, cognitive, social and spiritual) of hospice patients’ needs are all fairly common in terms of ‘quality of life,’ even though there are some differences in degree. The findings suggest that the hospice music therapists are dealing with the individual differences in the population as well as the symptomatic diversity of each client throughout the five domains. The hospice music therapy goals identified for patients relatively correspond to the ranking of the five domains of hospice patients’ needs. The present research can conclude that the hospice music therapists are aware of the five domains of the patients' needs to set up music therapy goals.

According to the self-report from the hospice music therapists, it is indicated that the supporting systems and/or programs to manage difficulties of the hospice music therapists are still limited. It may be because the history of hospice music therapy is not long. However, since the hospice music therapists are often confronting the patients’ death and dying process, more opportunities to access to the supporting systems and/or programs are necessary. Also, the clinical modality of music therapy is not fully understood in hospice settings yet. As previously mentioned, the efforts to increase
understanding about the clinical modality of music therapy in hospice settings are still required. Thus, in order to thoroughly show its value, effectiveness, importance, benefits and details of practice, further research about the hospice music therapy is necessary.

The further research may include gathering more specific information (e.g. more detailed issues and more systematically identified items) related to the present research. It would be interesting to include the overall years of experience as a music therapist in order to compare the experience in other settings with the experience in hospice settings. Also, it may be beneficial to include hospice patients’ ages and diagnoses in order to investigate differences of patients’ needs between young patients and old patients, between diseased patients and naturally dying patients, and on the combinations of criteria such as young patients with traumatic disease and old patients in natural dying process.

With a qualitative approach, it is necessary to investigate how musical components meet each domain of patients’ needs in utilizing specific therapeutic ideas, skills, and strategies in hospice music therapy. Like the review of Anderson (2011), it could be possible to utilize the systematic review of the qualitative journal articles relating to the music therapy with hospice patients specifically focusing on the musical components met the patients’ needs. The qualitative approach may provide more detailed information throughout the hospice music therapy interventions.

The suggestions and inferences made in the present research may elicit the reader’s questions and/or opinions because the present research tried to obtain a wide range of information about the common issues in hospice music therapy practice. These
inquiries may create a motivation for future study. Finally, the researcher expects that the present research would be a helpful resource for the new music therapy professionals, interns and other trainees who are working or going to work in hospice settings.
REFERENCES


June 27, 2012

Ms. Wone Juhn

Re: IRB Number: 001227
Project Title: The Common Issues in Hospice Music Therapy: A Survey of Hospice Music Therapists

Dear Ms. Juhn:

After an expedited review, Montclair State University’s Institutional Review Board (IRB) approved this protocol on June 25, 2012. The study is valid for one year and will expire on June 25, 2013.

Before requesting amendments, extensions, or project closure, please reference MSU’s IRB website and download the current forms.

Should you wish to make changes to the IRB-approved procedures, prior to the expiration of your approval, submit your requests using the Amendment form.

For Continuing Review, it is advised that you submit your form 60 days before the month of the expiration date above. If you have not received MSU’s IRB approval by your study’s expiration date, ALL research activities must STOP, including data analysis. If your research continues without MSU’s IRB approval, you will be in violation of Federal and other regulations.

After your study is completed, submit your Project Completion form.

If you have any questions regarding the IRB requirements, please contact me at 973-655-4327, reviewboard@mail.montclair.edu, or the Institutional Review Board.

Sincerely yours,

Dr. Debra Zellner
IRB Chair

c: Dr. Karen Goodman, Faculty Sponsor
Ms. Amy Aiello, Graduate School
Email Recruitment Letter with Consent (revised)

Dear Respondent,

My name is Wone Juhn and I am a graduate music therapy student at Montclair State University New Jersey. This e-mail is an invitation to participate in a survey regarding the common issues in hospice music therapy. I hope to learn about the common issues in hospice music therapy which professional music therapists encounter. You were selected as a possible participant in this study because you are working with terminally ill patients; this project has been approved by the American Music Therapy Association.

If you decide to participate, please complete the linked survey. Your completion of this survey indicates your consent. The survey is designed to obtain information about the common issues in hospice music therapy. It will take about 10 to 15 minutes to complete. No benefits accrue to you for answering the survey. Your responses will be used to provide important information about hospice music therapy for new working professional music therapists and music therapy interns who are going to work in hospice settings.

You may feel discomfort or upset when you recall a session. These feelings could lead to inadvertently revealing patient information; please try to avoid revealing any private patient information. Since I cannot provide a reliable free phone counseling number, I recommend that you participate in this survey only if you have access to counseling if and when you need it.

Data will be collected using the Internet; no guarantees can be made regarding the interception of data sent via the Internet by any third party (i.e. your employer). Confidentiality will be maintained to the degree permitted by the technology used. I anticipate that your participation in this survey presents no greater risk than everyday use of the Internet.

Your decision whether or not to participate will not affect your future relationships with the researcher, Wone Juhn, at Montclair State University. If you decide to participate, you are free to
stop at any time. You may also skip questions if you don't want to answer them or may refuse to return the survey.

Please feel free to ask questions regarding this study. You may contact me, Wone Juhn, Graduate Student, Cali School of Music, Montclair State University, if you have additional questions: juhnwl@mail.montclair.edu / 201-927-9469. Any questions about your rights may be directed to Dr. Debra Zellner, Chair of the Institutional Review Board at Montclair State University at reviewboard@mail.montclair.edu or 973-655-4327.

Thank you for your time.
Sincerely,

Wone Juhn
Graduate Music Therapy Program
John J Cali School of Music
Montclair State University
Montclair, New Jersey 07043

P.S. Please forward this letter to other hospice music therapist working in your facility if applicable. Thanks.

By clicking the link below, I confirm that I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement, and possible risks and inconveniences have been explained to my satisfaction. I understand that I can discontinue participation at any time. My consent also indicates that I am 18 years of age. (Please feel free to print a copy of this consent.)

I agree to participate (link to survey)

The study has been approved by the Montclair State University Institutional Review Board as study #00____ on ______________.
Dear respondent,

Your completion of this survey indicates your consent. The survey is designed to obtain information about the common issues in hospice music therapy. It will take about 10 to 15 minutes to complete.

No benefits accrue to you for answering the survey. Your responses will be used to provide important information about hospice music therapy for new working professional music therapists and music therapy interns who are going to work in hospice settings.

You may feel discomfort or upset when you recall a session. These feelings could lead to inadvertently revealing patient information; please try to avoid revealing any private patient information. Since I cannot provide a reliable free phone counseling number, I recommend that you participate in this survey only if you have access to counseling if and when you need it.

Data will be collected using the Internet; no guarantees can be made regarding the interception of data sent via the Internet by any third party (i.e., your employer).

Confidentiality will be maintained to the degree permitted by the technology used. I anticipate that your participation in this survey presents no greater risk than everyday use of the Internet.

Your decision whether or not to participate will not affect your future relationships with the researcher, Wone Juhn, at Montclair State University.

If you decide to participate, you are free to stop at any time. You may also skip questions if you don't want to answer them or may refuse to return the survey.

1. By clicking one of the buttons below, I confirm that I have read this form and decided that I will participate in the project described above. Its general purposes, the particulars of involvement, and possible risks and inconveniences have been explained to my satisfaction. I understand that I can discontinue participation at any time. My consent also indicates that I am 18 years of age. (Please remind to avoid revealing any private patient information.)

- [ ] I agree to participate (link to survey)
- [ ] I decline (link to close webpage)
### Basic Information

2. Are you currently working as a hospice music therapist?

- [ ] Yes
- [ ] No
### Demographic Information

**3. What is your age?**
- [ ] 20-29
- [ ] 30-39
- [ ] 40-49
- [ ] 50-59
- [ ] 60+

**4. What is your gender?**
- [ ] Female
- [ ] Male

**5. How many years of experience do you have in the hospice setting?**
- [ ] 0-5
- [ ] 6-10
- [ ] 11-15
- [ ] 16-20
- [ ] 20+
<table>
<thead>
<tr>
<th>General Hospice Music Therapy Sessions</th>
</tr>
</thead>
</table>

### 6. How often do you offer music therapy for a hospice patient?  
- [ ] More than 3 times a week  
- [ ] Twice a week  
- [ ] Once a week  
- [ ] Other (please specify) 

### 7. Where do you commonly have music therapy session with hospice patients? (select up to 3 items)  
- [ ] Patient’s home  
- [ ] Nursing home  
- [ ] Other private residence  
- [ ] Other residential facility  
- [ ] Other (please specify) 

### 8. How long does each music therapy session last in general?  
- [ ] Less than 10 minutes  
- [ ] 10-20 minutes  
- [ ] 20-30 minutes  
- [ ] 30-40 minutes  
- [ ] 40-50 minutes  
- [ ] 50-60 minutes  
- [ ] More than 1 hour  

**Comments (optional)**
## The Main Needs of Hospice Patients

9. Please rate each domain of hospice patients' needs that you most commonly encounter during music therapy sessions.

<table>
<thead>
<tr>
<th>Domain</th>
<th>Less common</th>
<th></th>
<th></th>
<th></th>
<th>Most common</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical (e.g., pain, lethargy, respiratory problems)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Cognitive (e.g., lack of alertness, loss of verbal skills)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Psychological (e.g., depression, fear, anxiety)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Social (e.g., isolation, financial distress, worries about family)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Spiritual</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Other domain or comments (optional):
### The Common Issues of Hospice Patients

#### 10. What are the common physical issues of hospice patients that you observe during sessions? (select up to 3 items)

- [ ] Pain
- [ ] Lethargy
- [ ] Agitation / restless
- [ ] Respiratory problems
- [ ] Tense / rigid
- [ ] Other (please specify)

#### 11. What are the common cognitive issues of hospice patients that you observe during sessions? (select up to 3 items)

- [ ] Lack of alertness
- [ ] Memory deficit
- [ ] Confusion
- [ ] Loss of verbal skills
- [ ] Other (please specify)
### The Common Issues of Hospice Patients

**12. What are the common psychological / emotional issues of hospice patients that you observe during sessions? (select up to 3 items)**

- [ ] Depression / withdrawn
- [ ] Flat affect
- [ ] Anxiety
- [ ] Fear
- [ ] Anger
- [ ] Other (please specify)

- [ ] Disturbance / Delirium
- [ ] Detachment
- [ ] Anticipatory grief
- [ ] Loneliness

**13. What are the common social / spiritual issues of hospice patients that you observe during sessions? (select up to 3 items)**

- [ ] Isolation
- [ ] Attachment
- [ ] Unresponsiveness
- [ ] Lack of support systems
- [ ] Other (please specify)

- [ ] Religious conflict
- [ ] Spiritual distress
- [ ] Finalist distress
- [ ] Worries about family
14. What are the most common goals you identify for hospice patients? (select up to 3 items)

- Pain management
- Respiratory regulation
- Emotional support
- Anticipatory grief
- Life review
- Spiritual support
- Quality of life
- Other (please specify)
### 15. What are the methods most commonly utilized for hospice patients? (select up to 3 items)

- [ ] Listening to recorded music
- [ ] Listening to live music
- [ ] Vocal improvisation
- [ ] Instrumental improvisation
- [ ] Singing with instruments
- [ ] Playing instruments to music
- [ ] Song writing
- [ ] Singing along
- [ ] Guided imagery
- [ ] Relaxation induction
- [ ] Song discussion / lyric analysis
- [ ] Learning music / musical skills
- [ ] Other (please specify)
### The Common Issues of Family Members/Caregivers

16. What are the family member/caregiver's needs most commonly encountered during the music therapy session? (select up to 3 items)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Depression / withdrawn</td>
</tr>
<tr>
<td></td>
<td>Flat affect</td>
</tr>
<tr>
<td></td>
<td>Anxiety</td>
</tr>
<tr>
<td></td>
<td>Fatigue</td>
</tr>
<tr>
<td></td>
<td>Burden</td>
</tr>
<tr>
<td></td>
<td>Fear</td>
</tr>
<tr>
<td></td>
<td>Anger</td>
</tr>
<tr>
<td></td>
<td>Disturbance</td>
</tr>
<tr>
<td></td>
<td>Detachment</td>
</tr>
<tr>
<td></td>
<td>Anticipatory grief</td>
</tr>
<tr>
<td></td>
<td>Loneliness</td>
</tr>
<tr>
<td></td>
<td>Isolation</td>
</tr>
<tr>
<td></td>
<td>Spiritual conflict / distress</td>
</tr>
<tr>
<td></td>
<td>Lack of support systems</td>
</tr>
<tr>
<td></td>
<td>Financial distress</td>
</tr>
<tr>
<td></td>
<td>Lack of coping skills</td>
</tr>
<tr>
<td></td>
<td>Other (please specify)</td>
</tr>
</tbody>
</table>
The Common Issues of Hospice Music Therapists

17. What are the hardest things in working as a hospice music therapist? (select up to 3 items)

- Time management
- Emotional management
- Adjustment in cultural diversity
- Witness of dying
- Collaboration with other disciplines
- Excessive losses
- Other (please specify)
- Travel distances
- Lack of self-management
- Lack of supervision
- Ethical distress / conflict
- Spiritual exhaustion
- Patient/caregiver's refusal

2012
### Satisfaction as a Hospice Music Therapist

18. How satisfied are you with your work as a hospice music therapist?

<table>
<thead>
<tr>
<th>Satisfaction rate</th>
<th>Very satisfied</th>
<th>Quite satisfied</th>
<th>Somewhat satisfied</th>
<th>Neither satisfied nor unsatisfied</th>
<th>Somewhat unsatisfied</th>
<th>Quite unsatisfied</th>
<th>Very unsatisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comments (optional)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Thank you for your time.