CONTENT ANALYSIS OF REASONS FOR SONG CHOICES AMONG

INDIVIDUALS RECEIVING HOSPICE CARE

By

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Abstract

The purpose of this study was to describe the reasons for song choices of patients and their loved ones in a hospice setting. In all, 21 patients and caregivers participated in semi-structured interviews that were embedded in music therapy sessions at a Midwest hospice. A content analysis applied to participants' interviews revealed four categories and 14 subcategories related to participants' reasons for their song choices. Categories included (a) concrete connections, (b) intangible connections, (c) music, and (d) relationships. Subcategories related to the four main categories were organized as follows: under concrete connections (a) connections with the past, (b) connections with the present, and (c) connections with the future; under intangible connections (a) beliefs, (b) feelings and desires, and (c) images and stories; under music (a) affective responses and beliefs about music/songs, (b) general references to music/songs, (c) instruments, (d) lyrics, (e) structural elements, and (f) style; and under relationships (a) loved ones and (b) self. These categories and subcategories provide a framework that may be useful in expediting assessment processes and clarifying areas where there is a need for musical or verbal validation by the therapist.

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Chapter One

Introduction

Hospice is a service dedicated to the care of individuals with life-limiting illness or injury (National Hospice & Palliative Care Organization [NHPCO], 2012). As a patient-centered service, hospice works with patients and their loved ones to create and enact an individualized plan of care. Because hospice is only available to individuals with a prognosis of six months or less, the hospice philosophy focuses on comfort care, or palliation, rather than aggressive curative measures. Thus, pain management and the promotion of quality of life and wellbeing in both patients and family members is of primary concern (Clair & Memmott, 2008; Hilliard, 2003; Lee, 2011; Hilliard, 2005; NHPCO, 2012; Walker & Adamek, 2008).[1] This orientation to holistic care is aligned with the vision of Dame Cicely Saunders, the founder of the hospice movement. Saunders believed in treating the "total pain" of patients and their loved ones, meaning not just their physical needs, but their emotional, psychosocial, and spiritual needs as well (Clair & Memmott, 2008; Lee, 2011; NHPCO, 2012; Walker & Adamek, 2008). The provision of such holistic care requires the efforts of an interdisciplinary team of physicians, nurses, home health aides, social workers, chaplains, and trained volunteers, often supplemented by complementary and alternative medicines (CAM) such as massage therapy or music therapy (Lee, 2011).

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1 The Institute for Patient-and Family-Centered Care (2010) defines family as those who are related to a patient in any way: biologically, emotionally, or legally. In this model, the patient has the right to determine who is part of their family. Therefore, while the term family frequently will be used in this study for the sake of brevity, it does not necessarily refer solely to the traditional nuclear family.

Music Therapy in Hospice Care

Music therapy is "the skilled use of music by a certified music therapist to meet the physical, psychological, spiritual, and social needs of patients and their families" (Starr, 1999, p. 739). As of 2007, 62.2% of hospice providers with CAM services offered music therapy to patients, making it the third most common CAM behind massage therapy (71.7%) and supportive group therapy (69.0%) (Bercovitz, Sengupta, Jones, & Harris-Kojetin, 2011). In their surveys of CAM providers, both Demmer (2004) and Kozak et al. (2009) found music therapy to be the second most common complementary therapy behind massage therapy. In addition to being a "popular" therapy with patients (Kozak, et al., 2009, p. 465), a review of empirical literature by Hilliard (2005) illustrates how music therapy has effectively addressed many of the needs of the whole person (e.g., physical, emotional, spiritual) in a way that closely aligns to the hospice model of care. Thus, the prevalence of music therapy in hospice settings may be due to both its popularity and its clinical effectiveness.

Goals and outcomes. In a study of hospices in Northeastern Illinois, Lee (2011) found music therapists most frequently addressed patients' emotional needs, followed by social, physical (e.g., ability to walk and perform activities of daily living), physiological (e.g., symptom management), cognitive, and spiritual. Common emotional goals might include aiding in the bereavement process (Lee, 2011; Walker & Adamek, 2008), improving emotional identification and expression (Clements-Cortés, 2004; Gallagher & Steele, 2001; Walker & Adamek, 2008), improving mood (Gallagher & Steele, 2001; Lee, 2011), or stimulating life review (Clair & Memmott, 2008; Clements-Cortés, 2004; Starr, 1999; Walker & Adamek, 2008). Referrals for cognitive goals, though less common according to Lee (2011), often represent another mode through which emotional needs may be addressed. Examples of cognitive goals

may include developing coping skills (Lee, 2011) or providing decision-making opportunities (Gallagher & Steele, 2001; Walker & Adamek, 2008). Finally, team members often refer patients to music therapy for social goals, which may include decreasing isolation (Clements-Cortés, 2004), improving communication (Clair & Memmott, 2008; Clements-Cortés, 2004), or supporting patient-family bonding (Gallagher & Steele, 2001; Starr, 1999).

There are several studies describing music therapy's role in the emotional, cognitive, and psychosocial domains. For example, Hilliard (2001) described four hospice case examples in which cognitive-behavioral music therapy aided in the bereavement process; facilitated reality orientation, reminiscence and interactions with loved ones; helped patients and families cope with grief and loss; and helped provide meaning and hope for participants. Clements-Cortés (2004) highlighted three hospice case studies in which music therapy decreased anxiety and agitation, decreased social isolation, increased self-expression, improved communication, and stimulated life review. Music therapy also elicited significant improvements in mood in both patients with advanced illness (Gallagher, Lagman, Walsh, Davis, & LeGrand, 2006; Gallagher & Steele, 2001) and their family members (Gallagher et al., 2006). Krout's (2003) case study analysis revealed how music therapy aided family members in establishing meaningful connections with patients who were imminently dying. Finally, case studies by O'Callaghan, McDermott, Hudson, and Zalcberg (2013) and Magill (2009) explored how pre-loss music therapy engendered meaningful communication among patients and their loved ones, and how these positive experiences enhanced coping and resilience in caregivers following the death of their loved ones.

Music therapy not only elicits improvements in the psychosocial and emotional domains; it may also aid patients with physical and physiological needs. Music therapy goals in these areas

are frequently related to pain (Clair & Memmott, 2008; Gallagher & Steele, 2001; Hilliard, 2003; Lee, 2011; Starr, 1999; Walker & Adamek, 2008) and symptom management (Gallagher & Steele, 2001; Lee, 2011). There are several empirical studies highlighting music therapy's ability to aid in pain management (Gallagher et al., 2006; Gallagher & Steele, 2001; Gutgsell et al., 2013; Horne-Thompson & Grocke, 2008; Krout, 2001) and anxiety reduction (Gallagher, et al., 2006; Gallagher & Steele, 2001; Horne-Thompson & Grocke, 2008). For example, Krout (2001) found improvements in pain management, physical comfort, and relaxation for hospice patients (*N*=80) following a single music therapy session. Gutgsell, et al. (2013) found significant improvements in perceived pain levels of palliative care patients participating in music therapy while receiving standard medical care over pain levels of patients receiving only standard medical care (*N*=200). Horne-Thompson and Grocke (2008) determined patients experienced reduced anxiety (*N*=25) following a single music therapy session. Furthermore, a post hoc analysis revealed significant reductions in pain, drowsiness, and tiredness in the music therapy group. Finally, in an extensive ex post facto study of 200 palliative care patients, Gallagher et al. (2006) determined there were statistically significant improvements in anxiety, pain, and shortness of breath for patients participating in music therapy.

Providing spiritual support was the least frequent reason for referrals according to Lee (2011) likely because the chaplain primarily fulfills this role. However, there is substantial literature that suggests music therapy significantly supports spiritual needs. In a study by Wlodarczyk (2007) in which patients acted as their own control (*N*=10), patients experienced greater spiritual wellbeing in sessions with music therapy than in sessions without music therapy.

Magill (2009) also determined music therapy facilitated meaningful experiences for caregivers, as themes of connectedness, remembrance and hope emerged in interviews with caregivers who took part in pre-loss music therapy sessions.

Finally, all goals—emotional, cognitive, psychosocial, physical, physiological, and spiritual--are directed toward improving quality of life for patients and their loved ones. Hilliard (2003) found music therapy contributed significantly to this area, as well. Using a randomized-control group design, Hilliard (2003) investigated quality of life in patients with terminal cancer (*N*=80). Patients receiving music therapy services scored significantly higher on the psychophysiological subscale of the Hospice Quality of Life Index-Revised than those who did not receive services.

The studies highlighted above illustrate how music therapy can be used to affect positive changes in the lives of patients and families. A skilled music therapist can design interventions that target needs specified in an individual's plan of care, though these needs are often diverse. In this way music therapists are able to improve patients' and family members' overall quality of life.

Interventions. Designing interventions to meet patient and family needs is an important element of a music therapist's practice. Interventions used by music therapists in end-of-life care may include (but are not limited to) improvisation (Clements-Cortés, 2004; Magill, 2008; Pierce, 2009; Walker & Adamek, 2008), instrument playing (Hilliard, 2003; Walker & Adamek, 2008), lyric analysis (Clements-Cortés, 2004; Gallagher, et al., 2006; Hilliard, 2003; Lee, 2011; Pierce, 2011; Walker & Adamek, 2008), music listening (Gallagher, et al., 2006; Hilliard, 2003; Lee, 2011; Magill, 2008; Pierce, 2009; Walker & Adamek, 2008), musical life review (Gallagher, et al, 2006; Hilliard, 2003; Lee, 2011; Magill, 2008; Pierce, 2009), planning funerals or other

memorials (Gallagher, et al., 2006), relaxation accompanied by music (e.g., guided imagery or muscle relaxation) (Gallagher, et al., 2006; Lee, 2011; Pierce, 2009; Walker & Adamek, 2008), singing (Clements-Cortés, 2004; Gallagher, et al., 2006; Hilliard, 2003; Lee, 2011; Pierce, 2011; Walker & Adamek, 2008), song choice (Clements-Cortés, 2004; Gallagher, et al., 2006; Hilliard, 2003; Lee, 2011; Pierce, 2011; Walker & Adamek, 2008), songwriting (Clements-Cortés, 2004; Gallagher, et al., 2006; Magill, 2008; Pierce, 2011; Walker & Adamek, 2008), using the iso-principle (Hilliard, 2003), or using multi-modal stimulation (Pierce, 2009). Of these, interventions that require less physical exertion tend to be the most common (Lee, 2011). In a study of non-cancer hospice patients (*N*=120) Lee (2011) found that 78% of care plan interventions required limited physical exertion, the most common interventions being music listening (93%), music discussion (e.g., life review, song choice) (35%), and music expression (i.e., singing or playing an instrument) (33%). In a survey of forty music therapists, the most common interventions used with the majority of clients were singing, musical life review, and song choice (Pierce, 2011). These findings are supported by Gallagher and Steele (2001), Gallagher, et al. (2005), and Hilliard (2003), who found interventions such as music listening, musical life review, singing, and song choice were used with the greatest frequency in their studies. Furthermore, in the study by Hilliard (2003) all five facilitating music therapists and interns stated they used song choice and music listening interventions in their final sessions with patients, implying these interventions are appropriate even as patients near the end of life.

Song Choice

Song choice is one of the most frequently cited interventions used by hospice music therapists, and yet research on song choice is limited. Dileo (1999), Dileo and Parker (2005), and Magill (2008) describe the use of song methods with patients with serious or terminal

illnesses and their families, but only Bailey (1984), in a study with cancer patients, focuses solely on the themes that emerge when using song choice. Bailey (1984) notes, "Valuable information about the physical, emotional, and spiritual needs of patients and families can be gained by paying close attention to the songs they choose and the reasons for their choices" (p. 7). The verbal messages present in preferred songs can encourage grief processing, resolution, and closure (Bailey, 1984). Familiar songs can comfort patients and provide a sense of normalcy (Walker & Adamek, 2008). Furthermore, songs aid in the recall of significant relationships and meaningful memories (Bailey, 1984; Dileo, 1999; Dileo & Parker, 2005; Walker & Adamek, 2008).

The purpose of this study, then, was to describe the reasons for song choices of patients and their loved ones. The researcher used qualitative content analysis to determined categories and themes based on participants' interviews. This approach provides a clear and concise summary of participants' insights regarding their choices. With a greater understanding of the reasons behind patients' and family members' song choices, music therapists can better assist them in processing what is meaningful as they embrace transition and approach transcendence.

Chapter Two

Literature Review

In reflecting on her role as a palliative music therapist, Zabin (2005) states: "If you think about it, there are few choices patients actually have in hospitals, other than the television channels. Few choices involve real changes to the environment and even fewer involve other people" (p. 71-72). Patients with declining health are repeatedly reminded that they are unable to function as they desire, especially as support is often required for even the simplest tasks (Proot, et al., 2004). The disease process not only robs patients of physical control, but also of opportunities for independent action and choice making. This may leave patients and family members feeling helpless, frustrated, overly dependent on others, or conflicted by their changing roles. Proot, et al. (2004) found the most common recurring theme in interviews with patients who were terminally ill was a need to "direct" (p. 55), that is, to have a say in one's life and one's health, and the ability to contribute meaningfully to the lives of others. Loss of patient autonomy is also distressing for patients' loved ones. In a study involving the families of advanced cancer patients, Dumont et al. (2006) concluded that as patients lose autonomy, psychological distress in caregivers significantly increases. Therefore, it is important for care teams to have therapeutic strategies in place that reinforce a patient's sense of autonomy and provide the patient opportunities for independent action (Chochinov, 2002). By offering musical choices, a music therapist is able to give patients and their loved ones an opportunity for control, however small, in a way that is safe, expedient, and meaningful (Walker & Adamek, 2008).

According to Clements-Cortés (2004), the song choice intervention may encourage choice making, increase self-esteem, promote social interactions, and help patients regain a sense of identity. Because music has the ability to simultaneously express diverse themes and

emotions, patients and their loved ones may actively express and receptively experience both simple and complex emotions through their choices (Salmon, 1993). Furthermore, the song choice intervention may enable patients and family members to express those feelings of grief or loss that they are uncomfortable directly verbalizing. Paradoxically, the indirect expression of feelings through song choice gives grieving individuals the necessary distance to recognize and approach their own emotions (Salmon, 2001). Finally, it is notable that these choices may not always be intentional, as music is a symbolic language capable of communicating with both the conscious and unconscious mind (Salmon, 1993, 2001). Salmon (1993) notes, "it is not uncommon for a patient to show surprise when the lyrics of a casually requested song reveal a more profound feeling" (p. 50).

In a review of song treatments with oncology patients, Dileo (1999) discusses several benefits of song-based interventions.[2] The author highlights the value songs have to the therapeutic process because of the life events, emotions, and meanings associated with them by individuals. Certain songs or styles of music can become linked with particular feelings by repeated pairings over an individual's lifetime (Gfeller, 2005). Thus, certain songs may enhance positive feelings. In this way, songs can positively influence the whole person (e.g., physically, cognitively, emotionally, etc.) (Dileo, 1999). Song methods can also provide patients in hospice care with opportunities to explore and seek resolution in relationships with self, with God, and with others (Dileo & Parker, 2005; Magill, 2009). This definition of relationships, then,

2 Song choice was only one type of song method described by Dileo (1999), and Dileo and Parker (2005). Others may include song dedication, song discussion, song improvisation, song narratives, song writing, and the creation of song legacies (Dileo & Parker, 2005).

encompasses the ability to enhance self-awareness (in the relationship to self) (Bailey, 1984; Dileo, 1999) as well as facilitate intimacy, connectedness and communication with others (Dileo, 1999). Finally, songs can provide a means for patients to communicate regarding their present needs and desires as well as their past unresolved issues (Bailey, 1984). Song lyrics are one possible venue for such self-expression; they can provide individuals with a template onto which they can project their own meanings and feelings (Dileo, 1999).

Musical Preferences of Patients and Family Members

For interventions to be effective, knowledge of patients' and family members' musical preferences is necessary. Using preferred music "has the greatest potential to evoke emotional reactions," (Clair & Memmott, 2008, p. 12) thereby encouraging commitment, motivation, and participation (Clair & Memmott, 2008; Thaut, 2005). Preferred music is typically that which the patient listened to in their young adult years (Clair & Memmott, 2008; Flowers & Murphy, 2001; Gibbons, 1977; Jonas, 1991; Lathom, Peterson, & Havlicek, 1982). Preferred music may also be integrated into individuals' lives through cultural or community contexts such as religious services or patriotic events (Clair & Memmott, 2008; Lathom, et al., 1982).

Musical preferences of older adults. According to the National Hospice and Palliative Care Organization (2012) in 2011, 83.3% of hospice patients were 65 or older, and more than one-third of hospice patients were 85 or older. "As the average life span in the United States has increased, so has the number of individuals who die of chronic progressive diseases that require longer and more sustained care" (NHPCO, 2012, p. 6). Because older adults make up such a significant portion of hospice care patients, an examination of the musical preferences of older adults is in order.

In studies of older adult preferences, participants consistently cited Big Band music and other popular music from the 1930s and 1940s as favorite genres. Other preferred genres included Classical music, country music, musicals, patriotic music, and religious music (Flowers & Murphy, 2001; Jonas, 1991; Moore, Staum & Brotons, 1992; VanWeelden & Cevasco, 2009). However, while there was a moderate consensus among studies, some results differed significantly, and were occasionally contradictory. For example, while Flowers and Murphy (2001) found Classical music was one of the most preferred genres of older adults, Lathom, et al. (1982) found it to be the least preferred style of music. Jonas (1991) observed that older adults seemed to prefer music from the 1930s and 1940s regardless of genre. However, VanWeelden and Cevasco (2009) found the hypothesis that individuals prefer the music of their young adult years limiting, as many of the songs favored by older adults in their study were from the 1910s and 1920s, well before the participants' young adult years. These examples illustrate that while a music therapist may make general assumptions about the musical preferences of a population, there are no absolutes.

In their study on older adult preferences, Flowers and Murphy (2001) asked participants to explain why they liked their favorite music. Forty-eight percent of participants gave affective responses (e.g., the music was beautiful, relaxing, or soothing); 25% of responses were related to familiarity and reminiscence; 16% to musical characteristics such as dynamics or harmony; and 12% to other extramusical connotations, such as the ability to dance or work to the music. The authors also found that some participants expressed adverse feelings to loud/noisy music, modern music, rap, and repetitious music. Finally, Moore, et al. (1992) established that older adults preferred songs at slow to moderate tempi over fast tempi, and that older adults tended to vocalize comfortably in low to moderate ranges. These examples, though far from definitive,

can provide music therapists with some general guidelines when choosing appropriate repertoire for hospice settings where older adults comprise the majority of the population.

Music literature in hospice. While there is a significant amount of literature on the musical preferences of older adults, there is very limited literature on the preferences of individuals in hospice. In a study by Pierce (2011), forty music therapists completed a survey in which they recommended repertoire most frequently used in hospice care. Responses indicated the most common recommendations were for popular music (25%) (defined as music popular from 1950 to present); followed by oldies (24%) (defined as music popular before 1950); religious music/spirituals (19%); country/Western (18%); and musicals (13%). The analysis did not include a survey of reasons for therapists' song choices, though the author speculated certain songs might have been used more frequently because (a) they contained lyrical-emotional content to which individuals were responsive, (b) they prompted reminiscences, (c) or they were well-known and popular within their genre.

Musical Properties

Music can be conceptualized in two ways: both as a structure, possessing specific, measurable properties and as a source of highly personalized meanings and associations. Both musical properties and extramusical learned associations contribute to patient preference, and both serve to stimulate arousal and affective responses in individuals (Thaut, 2005). The meanings patients attribute to chosen songs, therefore, are rooted in a perceptual and experiential basis. While it is the marriage of these elements that contribute to a patient's responses, each property will be discussed separately, beginning with a brief overview of musical properties.

The structural elements that comprise a musical selection are essential to a listener's perception of the music. Madsen and Geringer (1990) identify four major constituent elements

of audible music: dynamics, melody, rhythm and timbre. While these elements describe audible music at its most fundamental level, this model lacks perspective. Gfeller (2005) contextualizes the experience of listening to music when she describes it as a form of communication. Both speech and music have structural similarities such as pitch, duration, intensity, and timbre, and both are interpreted based on cultural context and personal experience. In another model described by Thaut (2005), there are two categories of musical properties that affect musical perception: (a) psychophysical elements, or those elements related to energy and arousal, such as dynamics, intensity, tempo, and rate of change, and (b) collative elements, or those elements related to the structural properties of form, harmony, melody, or rhythm that influence perceptions such as clarity, comprehension, or novelty.[3] This model is based on the work of Berlyne (1971) in which the author describes the ability of an aesthetic work to arouse interest and influence affective responses. Finally, more specific to this study is Gardstrom and Hiller's (2010) description of instrumental song accompaniments, adapted from Bruscia's (1987) Improvisation Assessment Profiles (IAP). The authors point out that while the IAP was originally meant to describe improvised music, it can just as effectively be applied to song material. Elements of song accompaniment include (a) congruence (i.e., the stylistic relationship between instrumental accompaniment and lyrical content), (b) salience (i.e., elements in the accompaniment that capture the listener's attention, potentially influencing how various musical elements are heard), (c) tension, and (d) variability (how frequently musical elements--

[3] The model described by Thaut (2005) has a third component: ecological properties. Ecological properties describe those learned or extramusical associations a listener acquires. This component of the model was omitted from this section, since ecological properties are not intrinsic to musical structure, but rather defined by acquired, personalized, associations.

accompaniment patterns, harmonic rhythm, instrumental timbres, etc.--change over the course of a song) (Gardstrom & Hiller, 2010).

Text. Text is another important musical element in songs. Frequently, it is the lyrics that act as a bridge between musical and extramusical properties, for although a listener may identify primarily with a song text, it is the music that acts to intensify, amplify, or even alter the meaning of the text (Gfeller, 2005). Much of the literature on musical preference in hospice and palliative care focuses on lyrics and the extramusical associations that arise from textual identification (Bailey, 1984; Dileo & Parker, 2005; Magill, 2008; Pierce, 2011). According to Bailey (1984), individuals choose songs that support their needs, represent their feelings, and convey the messages they want to hear. Therefore, the content of a song is significant. A listener may identify with or feel empathy for a character or object as it is described in the lyrics. Discrete elements of the character or object, such as attitudes, feelings, personal characteristics, physical attributes, or function, may also resonate with the listener (Gardstrom & Hiller, 2010). Furthermore, lyrics can help give form to the thoughts of individuals who are emotionally fragile by providing a structure onto which thoughts and feelings may be projected (Dileo, 1999; Gardstrom & Hiller, 2010; Magill, 2008).

Extramusical Properties

The personal connection a patient or family member develops with a song is important to the furthering of the therapeutic process (Bailey, 1984; Gardstrom & Hiller, 2010). "Songs link feelings to thoughts, images to events, and people to people.... Messages within songs can provide support for inner needs and can help people process loss and grief" (Bailey, 1984, p. 12). Bailey (1984) and Magill (2008) particularly note the importance of music as a conduit for reminiscence among patients and families. According to Bailey (1984), the most common song

choice theme among cancer patients and their families is reminiscence. A remembered song "may evoke the time, place, and especially the emotional state of the situation where the tune was originally heard" (Salmon, 1993, p. 51). Reminiscence affords hospice patients and their loved ones the opportunity to look for patterns of meaning in their remembered joys and sorrows (Salmon, 1993). This is significant in music therapy, as reminiscence is considered a therapeutic way for older adults to "review life events, heighten awareness of past accomplishments, and facilitate social interactions" (Gfeller, 2005, p. 48).

Another common theme related to song choice is the exploration of relationships through the facilitation of loving words and gestures (Bailey, 1984; Magill, 2008). Music can develop meaningful communication and help resolve issues between patients and families (Bailey, 1984). Song-based interventions may even assist patients and their loved ones in the task of relationship completion by allowing individuals to express love, gratitude, forgiveness, and valediction through music (Dileo & Parker, 2005). For family members, those sentiments expressed in music therapy sessions can continue to facilitate a sense of connection with their loved one, even after their death (O'Callaghan, et al., 2013). In addition to personal connections, another important theme is connectivity with the larger world (Bailey, 1984). World music allows patients and families to explore connections with their ancestral roots or other cultures, thus enabling them to see beyond their immediate needs.

The exploration of feelings is also important. Transcendent themes such as hope, pleasure, and peace may be explored. Other times, patients and families choose to hear songs that express the fears and anxieties they are otherwise unable to name. In such cases, song choices may have central themes of loss or death (Bailey, 1984). Music can simultaneously convey complex, multi-layered, subtle, or even contradictory emotions (Dileo, 1999; O'

Callaghan, et. al., 2013; Salmon, 1993, 2001). Because of this, chosen songs often serve to integrate the apparent polarities of the patient's or family member's inner world, in this way bringing further insight and greater meaning into the complexities of deep emotional experiences (Dileo, 1999; Salmon, 1993, 2001). Finally, an exploration of needs and desires is an important theme, as it allows patients and families to express their concerns and obtain support (Bailey, 1984). This form of exploration is evident when patients or family members identify with phrases such as "I am, "I need," or "I want" (Bailey, 1984, p. 9). While a music therapist can inspire and support a patient's musical insights, the precise memories, meanings, and associations an individual brings to a musical encounter will always derive from his or her personal experiences.

Personal Attributes

Human beings are complex, and it is not possible to discuss all the personal attributes that contribute to patient preference, but this section will address the more relevant ones. Age (Clair & Memmott, 2008; Gardstrom & Hiller, 2010), or more accurately, cognitive development (i.e., developmental age rather than chronological age) (Gardstrom & Hiller, 2010), is a primary contributor to patient preference. Ability, level of education, and level of music education, may impact patient preference as well (Gardstrom & Hiller, 2010; Madsen & Geringer, 1990). For example, Lathom, et al. (1982) found older adults who had graduated from college preferred operatic and symphonic music significantly more than non-college graduates, and Jonas (1991) found older adults with a lower education preferred country music and popular music more than older adults with higher levels of education. Jonas (1991) also established a significant correlation between the size of the community in which an individual grew up and their musical preferences. Older adults from smaller rural communities had a significant preference for

country music over older adults from larger urban communities likely because of cultural influences. Culture is another attribute that has a strong impact on personal preference (Clair & Memmott, 2008; Thaut, 2005). Feelings, memories or other extramusical associations individuals have with music, possess not only personal connotations, but cultural ones as well, especially in musical forms associated with practices based on strong cultural conventions (e.g., religious hymns or patriotic songs) (Gfeller, 2005).

Another factor that contributes to preference is an individual's arousal needs (Thaut, 2005). According to Thaut (2005), to achieve desired responses, a music therapist must be aware of the arousal potential of a song (in both direction and intensity) within the framework of a participant's preferred music. A study by Kopacz (2005) supports this supposition. Kopacz (2005) found that stimulative musical properties, such as meter, rhythm, tempo, number of melodic themes, and sound voluminosity (e.g., the range and variety of instrumentation), had the strongest influence on client preferences. Levels of arousal are also related to the familiarity and complexity of a musical piece. According to Berlyne (1971) individuals have the most positive affective responses to aesthetic works possessing an optimal level of familiarity (i.e., neither too novel, nor overly familiar) and complexity (i.e., neither too complex, nor too simple). Within the hospice model, it is important to also consider how the disease process or a patient's level of functioning may affect his or her arousal needs.

Finally, it is notable that what may appeal to a patient during one session may not appeal to a patient in another session. Variable factors, such as the patient's mood (Gardstrom & Hiller, 2010) or the relationship between the therapist and patient may affect a patient's perspectives, preferences, and responses at any given moment (Bruscia, 1998; Gardstrom and Hiller, 2010). In summary, age or cognitive development, ability, education, musical experience, culture, arousal

needs, familiarity, disease process, level of function, and mood are all factors that function within the therapeutic context. These factors define not only a patient's preferences but the relational aspects of music therapy, as well. The interactions that occur in a music therapy session may be interpersonal, intrapersonal, intermusical, intramusical, sociocultural, or environmental (Bruscia, 1998). Consequently, in order to facilitate meaningful responses, music therapists must be sensitive to the multivariate relationships among and between patient, family, therapist and music when discussing thoughts and experiences related to musical choices.

Conclusion

There is a significant amount of literature that explores hospice and palliative care patients' song experiences; however, studies specifically about song choice are minimal. While Bailey (1984), Dileo (1999), Dileo and Parker (2005), and Magill (2008) explore the use of song methods with cancer and palliative care patients and families, with the exception of Bailey (1984), none exclusively focus on song choice. Bailey's study provides an insightful analysis of song choice themes that emerge from music therapy sessions with cancer patients; however, the author provides only a minimal explanation of the methodology informing this analysis. The purpose of this study was to describe the reasons for song choices by patients and their loved ones in a hospice setting. Using qualitative content analysis the researcher attempted to answer the following questions:

1. What categories, musical or extramusical, emerge based on patients' and family members' responses about their song selections?
2. What are the most prevalent musical categories?
3. What are the most prevalent extramusical categories?
4. What are the most prevalent categories based on patients' responses?

5. What are the most prevalent categories based on family members' responses?

6. What are the most prevalent categories based on participants' primary responses to an open-ended question about song choice?

7. What themes emerge based on the content analysis?

A deeper understanding of the reasons for patients' and family members' choices can better inform the therapeutic process by providing music therapists with a more intimate look at the experiences of grief, dying, and transcendence. For music therapists, knowledge of how patients and family members use those rare opportunities for choice to process grief, transcend loss, and find meaning can aid the therapist in framing discussions, structuring interventions, and making choices about what music can best aid patients in the tasks associated with the dying process.

Chapter Three

Method

Participants

This study took place at a large Midwest hospice, where the researcher served as an intern for six months. Before proceeding with this study, the researcher sought and was granted approval from the Institutional Review Board of a large university in the Midwest and the hospice facility where the study took place. To be eligible for the study, patients and caregivers first had to be referred for music therapy services by a member of the hospice interdisciplinary team (e.g., nurse, social worker, chaplain). Second, potential participants had to be 18 or older and capable of informed consent. Finally, patients and caregivers who were unconscious, had late-stage dementia, had significantly impaired communication skills, or had other significant cognitive, emotional or physical impairments, were not considered candidates for this study. These judgments were made on a case-by-case basis, based on either prior knowledge of the patient or on initial interactions with potential candidates.

All patients referred to music therapy services at the Midwest hospice were assessed and interventions were designed to meet goals in individuals' care plans. During this assessment, the researcher also established suitability for inclusion in the study and requested consent of patients. (Occasionally, solicitation of consent was postponed until later visits, but no data was used until consent was obtained.) Caregivers, though not subject to a formal assessment, were also typically solicited during the first music therapy session for which they were present if they clearly met inclusion criteria (i.e., were 18 or older and able to consent). Participants were given an information statement providing an overview of study protocol, privacy protection measures, withdrawal procedures, and risks and benefits of the study. As this was a low-risk study, verbal

consent was sufficient for participation. The researcher noted the date of consent for each participant in a Word document.

Participants were recruited and interviewed across an approximately three-month time span. Twenty-one individuals took part in this study. Seven participants were patients and 14 were family, friends, or caregivers of patients. Three participants were male; the rest were female. One patient had mild dementia and another had moderate dementia. Patients' ages ranged from 78 to 94. Caregivers were not asked to give their ages.

Research Design

Data were collected within sessions through semi-structured interviews featuring both open-ended and directive questions. Typically, interviews were held at the beginning of sessions. Following interviews, music therapy sessions proceeded as usual. In addition to being an ethical method for data collection, this format encouraged the authentic expression that arises from immersion in a therapeutic process. Within this framework, the music therapist acted as a facilitator to help the participant clarify personal values, develop self-awareness, and foster self-empowerment and spirituality. Thus, the participant's musical choices; how the participant processed their choices; and the therapist's validation of feelings, thoughts, and moods; aided participants in dealing with the psychosocial, emotional, and spiritual tasks at hand (Scovel & Gardstrom, 2005).

Originally, the researcher planned to interview participants throughout the predetermined timeframe of the study or until services with participants were terminated. In this model, the number of interviews with each participant depended upon his or her length of stay with hospice. However, it soon became evident that some individuals would be over-represented in the data. Therefore, the researcher chose to do only three interviews with each participant. Most

participants were able to give all three interviews, though in some instances, it was deemed inappropriate to ask for more than one or two interviews (e.g., participants seemed fatigued or overly emotional).

Measures

A mixed-method qualitative content analysis was used for this study. "Qualitative content analysis is a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns" (Hsieh & Shannon, 2005, p. 1278). A mixed-method approach uses both inductive and deductive coding techniques. Where inductive coding entails deriving original patterns of meaning from data (Braun & Clarke, 2006), deductive coding involves applying codes based on pre-determined categories, often established in previous research (Forman & Damschroder, 2008). The objective of qualitative inquiry was to provide a comprehensive description of song choice in hospice care by "capturing the views, motivations, and experiences of participants; and explaining the meaning they make of those experiences" (Forman & Damschroder, 2008, p. 40).

The process of content analysis may be divided into three phases: immersion, reduction, and interpretation (Forman & Damschroder, 2008). **"**During immersion, the researcher engages with the data and obtains a sense of the whole before rearranging it into discrete units for analysis" (Forman & Damschroder, 2008, p. 47). Immersion is achieved by maximizing one's exposure to the data, to the point where a profound familiarity with the "depth and breadth of the content" is achieved (Braun & Clarke, 2006, p. 18). Reduction involves systematically reducing the amount of raw data through the process of coding (Forman & Damschroder, 2008). The third phase of content analysis—interpretation—begins with the process of categorization (Forman & Damschroder, 2008). "This phase…involves using the codes to help re-assemble data in ways

that promote a coherent and revised understanding or explanation of it" (Forman & Damschroder, 2008, p. 57).

In this study, strategies to ensure immersion included (a) audio recording interviews using Garage Band (b) transcribing pertinent data in Excel, and (c) reading transcriptions numerous times (Forman & Damschroder, 2008). The researcher then used line-by-line coding to capture key concepts, insights, or thoughts (Hsieh & Shannon, 2005). This began the process of reduction, in which significant ideas in interviews were highlighted and potential codes were noted next to each phrase (Hsieh & Shannon, 2005; Strauss & Corbin, 1990). The researcher typically separated phrases for coding by clause, that is, related ideas containing a subject and a verb. When clauses were ambiguous the researcher separated them only if they represented two different codes.

The researcher initially used inductive analysis to develop labels for codes, which were both parsimonious and representative of the "richness of information" contained in the text (Forman & Damschroder, 2008, p. 53.). Once codes were inductively established, they were deductively applied to the rest of the transcription. The process of inductively and deductively coding interviews was fluid, as even in the initial stages of coding themes represented in similar studies influenced the researcher's decisions (e.g., Bailey, 1984; Dileo, 1999; Dileo & Parker, 2005; Magill, 2008). After a process of revision (i.e., editing, developing, and re-defining codes) related codes were grouped together to establish categories and subcategories. Data transcriptions, codes, categories, and subcategories were organized using Excel. The summary and organization of code clusters into categories and subcategories was guided by the research questions.

To ensure reliability two supervising music therapists from the Midwest hospice read through a portion of the coded interviews. Interviews were randomized using www.random.org and assigned to the supervising therapists. The supervising therapists were also given category and subcategory definitions to ensure all parties were using the same language in interpreting the data. Each music therapist reviewed approximately 10% of the coded interviews; meaning inter-rater reliability was established for a little over 20% of the data. The therapists and researcher communicated via e-mail regarding questionable codes until there was agreement on all coded material.

The final step in the process of content analysis was interpretation. To interpret the data, the researcher used percentage-based comparisons of categories and subcategories established through content analysis to answer research questions:

1. What categories, musical or extramusical, emerge based on patients' and family members' responses about their song selections?
2. What are the most prevalent musical categories?
3. What are the most prevalent extramusical categories?
4. What are the most prevalent categories based on patients' responses?
5. What are the most prevalent categories based on family members' responses?
6. What are the most prevalent categories based on participants' primary responses to an open-ended question about song choice?
7. What themes emerge based on the content analysis?

To answer question one, the researcher surveyed all categories. For questions two and three, musical and extramusical categories were examined, respectively. For question four, responses given by patients were considered, and for question five, responses given by family

members were examined. To answer question six, the researcher analyzed (a) responses given to the open-ended question about song choice and (b) spontaneous statements made by participants before any research questions were asked.

A thematic analysis was performed to answer research question seven. For the purpose of this study a theme was described as an overarching pattern of meaning, often representative of multiple categories (Braun & Clarke, 2006). The process of thematic analysis was similar to that of the content analysis for categories and subcategories, but on a larger scale. First, important overarching ideas were noted next to each interview. Typically, only one or two ideas were noted per interview. These were then clustered into related themes, and revised and reduced until they best expressed each concept. The thematic analysis was not subject to a reliability check. An abbreviated example of a coded transcript, including categories, subcategories, and a possible theme is given below. While each phrase is given a separate category and subcategory label, only one thematic idea is ascribed to this example.

Table 1

Example of Transcription

Transcription	Category	Subcategory	Thematic Ideas
I like the words	Music	Lyrics	Lyrical messages are meaningful
I think they are inspiring	Music	Lyrics	

Procedure

The researcher began the procedure for data collection after obtaining consent from participants. The interview began with the researcher asking participants if they had any requests. If a participant did not specify a particular song, the researcher then asked him or her to choose between two songs. In the latter instance, the participant's preferences defined the choices offered by the researcher. The researcher ascertained the participant's favorite songs and musical styles during the initial assessment. This knowledge was the basis for choices offered to patients throughout the study. The researcher then sang the chosen song with guitar accompaniment, or played a recording of the song, if live performance was not practical (e.g., orchestral music).

Following this rendition, the researcher interviewed the participant about his or her choice. Interviews typically began with an open-ended question: "Why did you choose that song?" Occasionally, this question was omitted or phrased in a different way depending on participants' behaviors, needs, or verbalizations (e.g., "Why do you like that?" or "What do you find meaningful about that?"). If more information was desired after the participant's initial response, the researcher asked more directive questions, such as, "Is there any specific element of the music you enjoy/find meaningful?" "Do you like/find meaningful any of the lyrics?" "Can you relate to what is being said?" "Does this song remind you of a special person, place, or event?"

According to Hsieh and Shannon (2005), when using a mixed-method approach (i.e., inductive and deductive coding) it is appropriate to first ask an open-ended question, followed by more directive questions that target predetermined categories. The open-ended question allows participants to direct the conversation, that is, to explore what is of primary importance to them

(i.e., their "gut reactions"), while more directive questions encourage participants to both process their initial reactions further and to discuss secondary reasons for their song choices. An informal structure for interviews was adopted; therefore, discussions followed a different course than that outlined above if a departure from the structure better served a therapeutic function.

Because of this informal structure, it was necessary to put inclusion/exclusion criteria in place for interviews, as it was sometimes difficult to determine where an interview ended. Questions used to determine whether data should be included were: (a) Is the participant answering a research question? (b) Are references to the song still being made? (c) Is a topic related to the reason for the participant's choice still being discussed? Also included were spontaneous statements given before research questions were asked because often these statements represented participants' "gut reactions."

Inclusion criteria were also necessary for the sixth question (i.e., What are the most prevalent categories based on participants' primary responses to an open-ended question about song choice?). Because interviews were conversational in nature, the researcher often asked questions or made comments on participants' responses. As long as the researcher's questions and statements were used to clarify a point or validate participants' verbalizations, the researcher deemed it appropriate to include participants' responses in the frequency count for question six. In other words, responses were considered "primary" until the researcher intentionally re-directed participants.

Chapter Four

Results

Interviews

The researcher attempted to acquire three interviews from each participant. However, due to time constraints, fatigue, or other circumstances, some participants were unable to meet this goal. One participant gave only one interview and two participants gave only two. Also, it was occasionally deemed therapeutic to simultaneously interview participants. Three different pairs of participants were interviewed together. In all, 47 interviews were given. The mode time for interviews was one-to-two minutes, but interview length largely depended on how much the participant wished to disclose. Interviews ranged from 0:32 seconds to 8:06 minutes. Patients' interviews comprised 31.67% of the data, while family members' interviews comprised 68.33% of the data.

Categories and Subcategories

All together, the researcher coded 1,206 phrases. From the codes, four categories and 14 subcategories were established. Saturation was achieved in this study, as later interviews ceased to elicit new codes (Kuper, Lingard, Levinson, 2008). Categories included (a) concrete connections, (b) intangible connections, (c) music, and (d) relationships. Table 2 shows definitions of categories.

Table 2

Definitions of Categories

Categories	Definitions
Concrete Connections	Connections to people, places, things, or activities
Intangible Connections	Connections to beliefs, desires, feelings, stories, or images
Music	References that are primarily musical
Relationships	Statements, reflections or stories about loved ones or self

Subcategories related to the four main categories were organized as follows: under concrete connections (a) connections with the past, (b) connections with the present, and (c) connections with the future; under intangible connections (a) beliefs, (b) feelings and desires, and (c) images and stories; under music (a) affective responses and beliefs about music/songs, (b) general references to music/songs, (c) instruments, (d) lyrics, (e) structural elements, and (f) style; and under relationships (a) loved ones and (b) self. Table 3 shows definitions of subcategories.

Table 3

Definitions of Subcategories

Categories	Subcategories	Definitions
Concrete Connections	Connections to the past	References or reflections made regarding people, places, things, or activities most closely associated with the participant's past
	Connections to the present	References or reflections made regarding people, places, things, or activities most closely associated with the participant's present; also encompasses connections that are not time-sensitive, (e.g., subjects that are descriptive in nature)
	Connections to the future	References or reflections made regarding people, places, things, or activities, most closely associated with the participant's future
Intangible Connections	Beliefs	Statements of belief about faith and life
	Feelings/Desires	Often "I feel…" or "I want…" statements that reflect feelings or desires; also includes reflections on the nature of feelings
	Stories/Images	The use of stories, hypothetical situations, or figurative language to illustrate thoughts or beliefs about faith, life, or music

Music	Affective Responses/Beliefs	Statements of feeling and/or belief about the chosen song or music in general
	General References	General comments about the chosen song or music
	Instruments	References to instruments, instrumentation, or instrumental techniques
	Lyrics	Comments related to song content, messages, or themes, as well as quotes from the chosen song
	Structural Elements	References to formal musical elements
	Style	References to musical styles; also includes comments on performance quality and interpretation
Relationships	Loved Ones	References to loved ones, past or present; also encompasses questions or statements in which the primary function is the inclusion of loved ones
	Self	References to self, or reflections upon one's own actions or insights, unrelated to beliefs, desires, or feelings

In addition to categories and subcategories the researcher also took note of topical descriptions that led to the development of subcategories. These are illustrated in Table 4. Descriptions were not pertinent for all subcategories. For example, while a variety of familial references are encompassed in the subcategory of loved ones (e.g., grandparents, parents, spouses), the subcategory of self encompasses only references to oneself. Therefore, there is no need to delineate topical descriptions.

Table 4

Topical Descriptions of Subcategories

Subcategories	Descriptions
Connections/Past	Church, Death/Burial, Education, Home, Illness, Literature/Media Connections, Musical Activities, Nature, Non-musical Activities, People,[4] Time, Work/Service, Youth
Connections/Present	Current Events, Death/Burial, Illness, Literature/Media Connections, Musical Activities, Nature, Non-musical Activities, People, Time, Work/Service
Connections/Future	Death/Burial, Musical Activities
Beliefs	Communication is challenging, Cross, Death is a journey, Death is unpredictable, Eternal life, Faith, God's love, God's omnipotence, God watches over loved ones, God's word, Grace, Hidden things have value, Hope, Human beings are limited, Importance of being present-centered, Inspiration, Investing in relationships takes work, Jesus, Life has a purpose, Life is a journey, Life is busy, Life is not always satisfying, Life has trials, Love, Need to overcome hardship, Need for continued growth, Need to be close to God, Need to surrender to God, One may pursue illusory things, Peace comes from faith, Pervasiveness of temptation, Prayer, Providence, Quest for meaning is important, Self-expression aids in the quest for meaning, Trials of life are minimal
Feelings & Desires	Depression/Sadness, Desire for eternal life, Desire for support at time of death, Desire to be free of pain, Desire to be with nature, Distress, Excitement/Feeling uplifted, Feeling protected, Gladness/Joy, Gratitude, Hope, Love, Recovery, Regret, Sense of freedom, Sense of loss, Sense of peace, Sentimentality, Stress/Frustration
Stories & Images	Chasing rainbows, Freedom as flight, Hope, Human knowledge as a "drop in the bucket," Joy of singing, Life as a journey/race, Life has trials, Miracles, Music like a book, Songs like sermons

4 "People" refers to individuals with whom participants do not share a relationship, for example actors, musicians or other public figures.

Affective Responses & Beliefs about Music	Art is born of experience/hardship, Desire to perform, Dislike of certain songs/styles, Love of chosen song, Music opens one up to transcendent experiences, Song aids in coping, Song is a reminder to pray, Song is catchy, Song is dramatic/exciting, Song is familiar, Song is special for loved one, Song/music expresses beliefs/affirms faith, Song/music has a message/story to which people can relate, Song/music inspires memories/good thoughts, Song/music is beautiful, Song/music is comforting/soothing, Song/music is meaningful/moving, Song sets a tone, Traditional music is meaningful
Structural Elements	Chords, Dynamics, Harmony, Melody, Phrasing, Range, Rhythm/Beat, Tempo, Texture
Style	Baroque/Classical music, Bluegrass/Country, Contemporary music, Hip hop, Hymns/Gospel, Jazz, Performance interpretation, Performance quality, Three-chord songs, Traditional music, Waltz
Loved Ones	Children, Friends, Grandchildren, Grandparents, In-laws, Parents, Patients, Siblings, Spouses, Sweethearts

Research Question One: What categories, musical and extramusical, emerge based on patients' and family members' responses about their song selections?

Qualitative content analysis elicited the following categories based on interviews with patients and family members: (a) concrete connections, (b) intangible connections, (c) music, and (d) relationships. Concrete connections, intangible connections, and relationships are extramusical categories, while music, naturally, is the musical category. For question one, extramusical categories accounted for 72.39% of the data, while the music category accounted for 27.61% of the data.

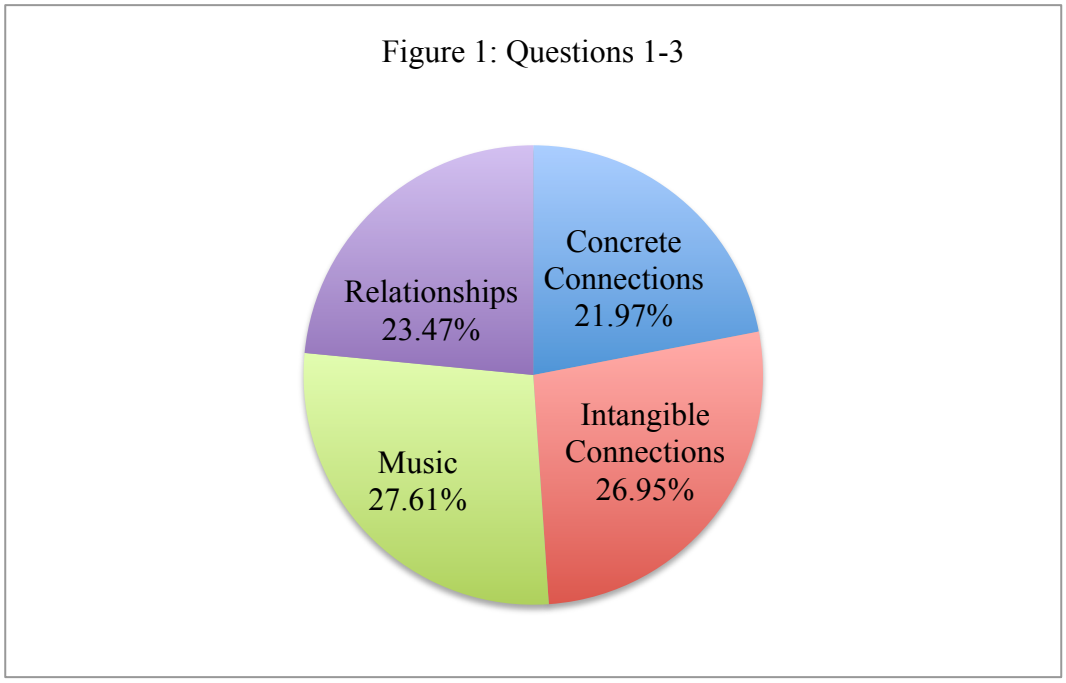

Figure 1. Frequency distribution of categories based on complete interviews with both patients and family members

Research Question Two: What are the most prevalent musical categories?

Of the four categories only one can be described as musical. The music category comprised 27.61% of the data for complete interviews, and was the second-most prevalent category behind intangible connections (26.95%) (see Figure 1). Musical subcategories for complete interviews, ranked from greatest to least, were affective responses and beliefs (38.74%), followed by lyrics (23.72%), style (15.02%), general references to music (9.31%), structural elements (9.01%), and instruments (4.20%). Table 5 illustrates the frequency distribution of subcategories within each category for complete interviews with both patients and family members.

Table 5

Frequency Distribution for Subcategories Within Each Category for Questions 1-3

Categories	Subcategories	Frequency
Concrete Connections	Connections to the past	67.17%
	Connections to the present	29.43%
	Connections to the future	3.40%
Intangible Connections	Beliefs	72.62%
	Feelings/Desires	11.08%
	Stories/Images	16.31%
Music	Affective Responses/Beliefs	38.74%
	General References	9.31%
	Instruments	4.20%
	Lyrics	23.72%
	Structural Elements	9.01%
	Style	15.02%
Relationships	Loved Ones	72.44%
	Self	27.56%

Research Question Three: What are the most prevalent extramusical categories?

The most prevalent extramusical category for complete interviews was intangible connections (26.95%), followed by relationships (23.47%), and concrete connections (21.97%). (See Figure 1.) Intangible subcategories, ranked from greatest to least, were beliefs (72.62%), stories and images (16.31%), and feelings and desires (11.08%). Under relationships, loved ones (72.44%) was the predominant subcategory, followed by self (27.56%). Finally, the largest subcategory under concrete connections was connections to the past (67.17%), followed by connections to the present (29.43%), and connections to the future (3.40%). (See Table 5.)

Research Question Four: What are the most prevalent categories based on patients' responses?

The distribution of categories in Figure 2 is based on interviews with patients. The most prevalent categories from patient interviews were concrete connections (37.70%), followed by music (26.44%), intangible connections (22.25%), and relationships (13.61%). For question four, extramusical categories accounted for 73.55% of the data, while the music category accounted for 26.44% of the data.

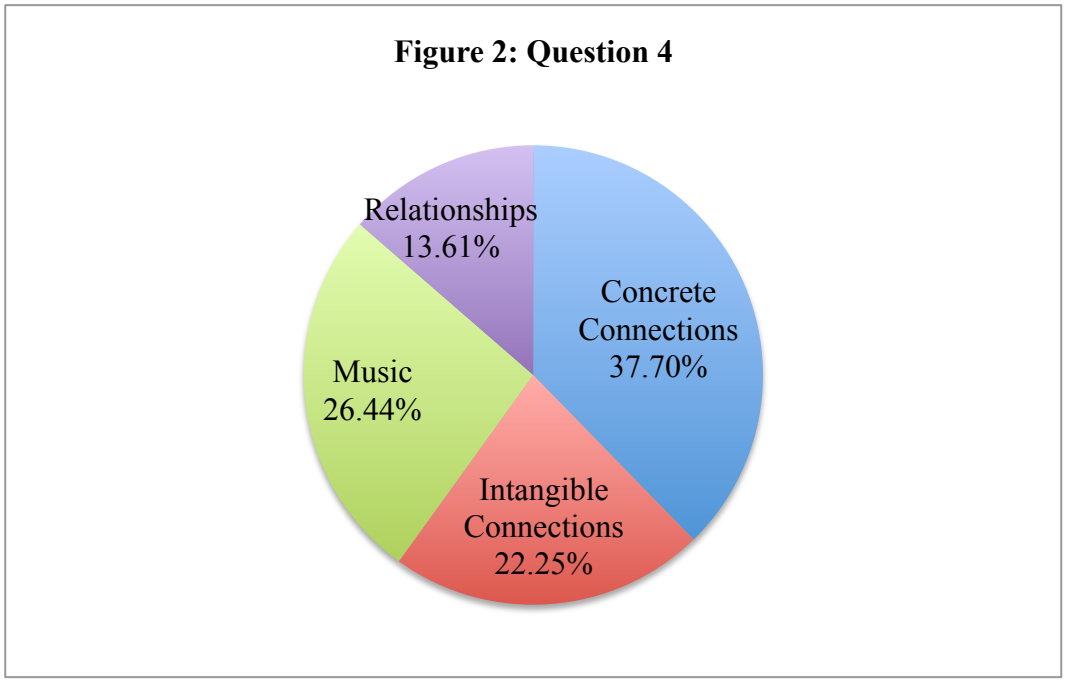

Figure 2. Frequency distribution of categories based on complete interviews with patients

Table 6 illustrates the frequency distribution of subcategories within each category for interviews with patients. The largest subcategory under concrete connections was connections to the past (78.47%), followed by connections to the present (19.44%), and connections to the future (2.08%). The most prevalent musical subcategory was affective responses and beliefs (31.68%), followed by lyrics (22.77%), structural elements (12.87%), style (11.88%), instruments (10.89%), and general references (9.90%). Intangible connections, ranked from greatest to least, were beliefs (44.71%), stories and images (30.59%), and feelings and desires (24.71%). Finally, the most prevalent subcategory under relationships was loved ones (69.23%), followed by self (30.77%).

Table 6

Frequency Distribution for Subcategories Within Each Category for Question 4

Categories	Subcategories	Frequency
Concrete Connections	Connections to the past	78.47%
	Connections to the present	19.44%
	Connections to the future	2.08%
Intangible Connections	Beliefs	44.71%
	Feelings/Desires	24.71%
	Stories/Images	30.59%
Music	Affective Responses/Beliefs	31.68%
	General References	9.90%
	Instruments	10.89%
	Lyrics	22.77%
	Structural Elements	12.87%
	Style	11.88%
Relationships	Loved Ones	69.23%
	Self	30.77%

Research Question Five: What are the most prevalent categories based on family members' responses?

The distribution of categories in Figure 3 is based on interviews with family members and other loved ones. The most prevalent categories from caregivers' interviews were intangible connections (29.13%), followed by music (28.16%), relationships (28.03%), and concrete connections (14.68%). For question five, extramusical categories accounted for 71.84% of the data, while the music category accounted for 28.16% of the data.

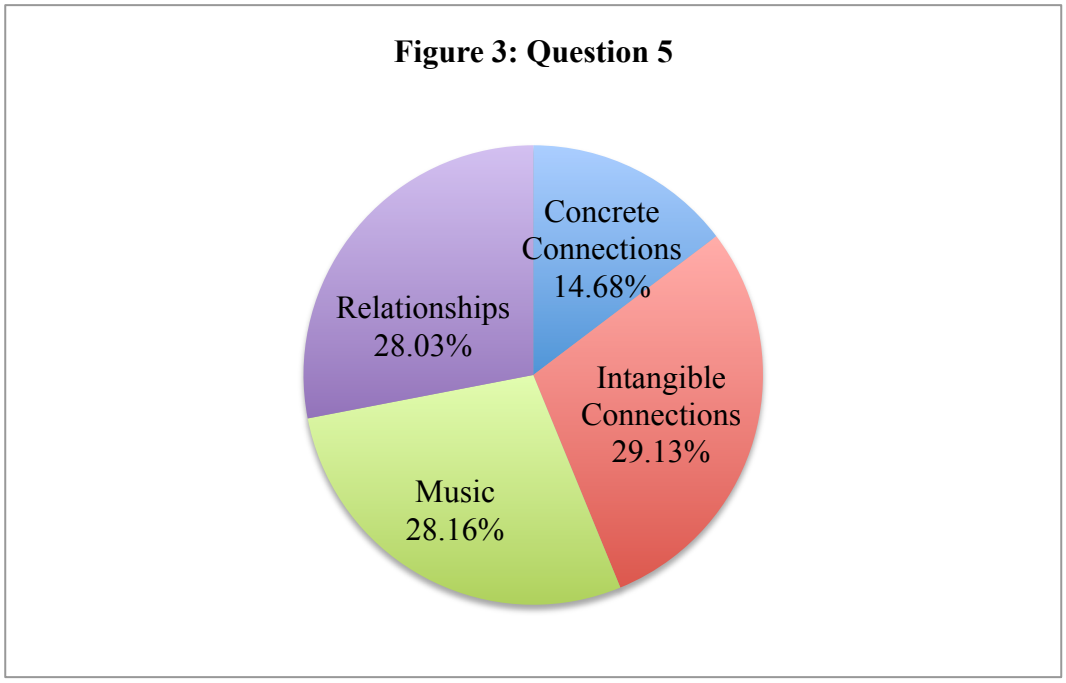

Figure 3. Frequency distribution of categories based on complete interviews with families

Table 7 illustrates the frequency distribution of subcategories within each category for interviews with family members. The most prevalent subcategory under intangible connections was beliefs (82.50%), followed by stories and images (11.25%), and feelings and desires (6.25%). Musical subcategories, ranked from greatest to least, were affective responses and beliefs (41.81%), lyrics (24.14%), style (16.38%), general references (9.05%), structural elements (7.33%), and instruments (1.29%). The largest subcategory under relationships was loved ones (73.16%), followed by self (26.84%). Finally, under concrete connections, the most prevalent subcategory was connections to the past (53.72%), followed by connections to the present (41.32%), and connections to the future (4.96%).

Table 7

Frequency Distribution for Subcategories Within Each Category for Question 5

Categories	Subcategories	Frequency
Concrete Connections	Connections to the past	53.72%
	Connections to the present	41.32%
	Connections to the future	4.96%
Intangible Connections	Beliefs	82.50%
	Feelings/Desires	6.25%
	Stories/Images	11.25%
Music	Affective Responses/Beliefs	41.81%
	General References	9.05%
	Instruments	1.29%
	Lyrics	24.14%
	Structural Elements	7.33%
	Style	16.38%
Relationships	Loved Ones	73.16%
	Self	26.84%

Research Question Six: What are the most prevalent categories based on participants' primary responses to an open-ended question about song choice?

The distribution of categories in Figure 4 is based on spontaneous responses and responses to an open-ended question about song choice (e.g., "Why did you choose that song?").[5] The most prevalent categories based on participants' "gut reactions" were music (31.66%), followed by intangible connections (24.67%), concrete connections (23.09%), and relationships (20.58%). For question six, extramusical categories accounted for 68.34% of the data, while the music category accounted for 31.66% of the data.

[5] Though the phrasing of question six does not necessarily suggest the inclusion of participants' spontaneous comments, the researcher chose to incorporate them for two reasons. First, the question "Why did you choose that song?" was not asked in every interview. For example, by the third interview in a set, participants often anticipated the question and initiated the interview process themselves. Second, the inclusion of spontaneous comments is more representative of the researcher's original intention, which was to illustrate participants' reasons for their choices without any prompting from the researcher.

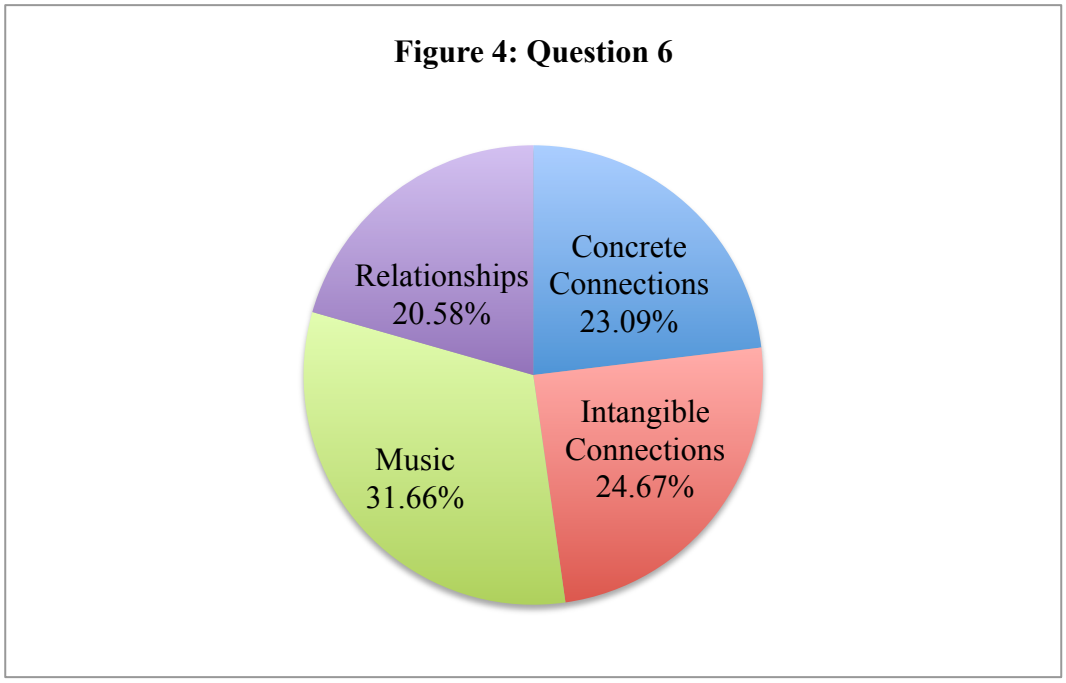

Figure 4. Frequency distribution of categories based on spontaneous responses and responses to the open-ended question

Table 8 illustrates the frequency distribution of subcategories within each category for responses to an open-ended question about song choice and spontaneous responses by all participants. The most prevalent subcategory under the music category was affective responses (37.92%), followed by lyrics (25.83%), style (13.33%), general references and structural elements (both 10.00%), and instruments (2.92%). The largest subcategory under intangible connections was beliefs (63.10%), followed by stories and images (24.06%), and feelings and desires (12.83%). The largest subcategory under concrete connections was connections to the past (60.00), followed by connections to the present (34.86%), and connections to the future (5.14%). Finally, the most prevalent subcategory under relationships was loved ones (73.72%), followed by self (26.28%).

Table 8

Frequency Distribution for Subcategories within each Category for Question 6

Categories	Subcategories	Frequency
Concrete Connections	Connections to the past	60.00%
	Connections to the present	34.86%
	Connections to the future	5.14%
Intangible Connections	Beliefs	63.10%
	Feelings/Desires	12.83%
	Stories/Images	24.06%
Music	Affective Responses/Beliefs	37.92%
	General References	10.00%
	Instruments	2.92%
	Lyrics	25.83%
	Structural Elements	10.00%
	Style	13.33%
Relationships	Loved Ones	73.72%
	Self	26.28%

Research Question Seven: What themes emerge based on the content analysis?

Five overarching themes were identified based on participants' interviews: (a) Meaningful messages and significant images within songs impact participants, often more profoundly than mere verbal communication. (b) Preferred songs heighten feelings of hope and joy and inspire positive associations and memories in participants. (c) Songs affirm participants' beliefs about faith, life, death, and eternal life. (d) Songs prompt self-reflection and inspire

participants to express insights regarding those things that are meaningful to them. (e) Relationships with loved ones are explored through participants' musical choices.

Chapter 5

Discussion

Participants in the study identified reasons for their song choices, which were described categorically by the researcher as concrete connections, intangible connections, music, and relationships. For all research questions, extramusical categories and subcategories comprised the majority of data, 68.34% to 73.55%, and musical categories and subcategories comprised 26.44% to 31.66% of the data. The larger percentage of extramusical associations seems to support the literature indicating music therapy in hospice leads patients and family members to meaningful expressions of their beliefs, feelings, and memories (Bailey, 1984; Dileo, 1999; Dileo & Parker, 2005; Flowers & Murphy, 2001; Magill, 2008; Magill, 2009; Sato, 2011). The smaller, though still substantial percentage of categories and subcategories related to music, may suggest participants in this study recognized the importance of music as a catalyst for such meaningful expressions. These suppositions are reinforced by one of the themes from this study: Preferred songs heighten feelings of hope and joy and inspire positive associations and memories in participants.

Concrete Connections

The category of concrete connections encompassed 14.68% to 37.70% of the data for all research questions including extramusical categories. Questions four and five, which illustrate patients' and caregivers' responses, represented the extreme ends of the range, with patients' responses comprising 37.70% of the data and family members' responses comprising 14.68% of the data. This variance between patients' and caregivers' responses may suggest a correlation between the category of concrete connections and the category of relationships for questions four and five. This will be discussed in greater depth in the following section.

Connections to the past. This study supports the idea that song methods are a conduit for life review and reminiscence for patients and their families (Bailey, 1984; Magill, 2008; Salmon, 1993), as connections to the past was the predominant subcategory under concrete connections for all research questions featuring extramusical categories.[6] However, in this study 78.47% of patients' concrete connections were connections to the past, while only 53.72% of family members' concrete connections were connections to the past. Since life review seems to occur naturally as individuals approach death, these results are not surprising (Butler, 1968; Sato, 2011). It should be noted, however, the distinction between codes for concrete connections and codes for relationships was sometimes very fine. The challenge of distinguishing these two categories was overcome by establishing the following criteria: When reminiscing, if a participant referenced himself or herself, typically it was coded under the subcategory of connections to the past (e.g., "We all used to dance in my house"). However, if a participant's reminiscences were exclusively about another person, typically it was coded under the subcategory of loved ones (e.g., "My father used to tap dance"). Caregivers' reminiscences were more often exclusively about their terminally ill loved one, which may partially account for the reduced emphasis on connections to the past by caregivers.

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[6] Life review and reminiscence are distinct processes. While reminiscence may be described as a process of recalling past experiences, life review entails a further examination and evaluation of those memories in an effort to resolve and integrate past conflicts. (Haight & Burnside, 1993; Sato, 2011). The subcategory "connections to the past" does not discriminate between life review and reminiscence, but it is likely comprised more of reminiscence, as self-evaluative statements would most often be categorized elsewhere.

Connections to the present and future. In most instances, the percentage of responses for connections to the present and future were notably smaller than the percentage of responses for connections to the past. For all research questions including extramusical categories, connections to the present ranged from 19.44% to 41.32%, and connections to the future ranged from 2.08% to 5.14%. Interestingly, patients' responses accounted for the smallest percentage of connections to the present (19.44%) and family members' responses accounted for the largest (41.32%). This discrepancy may suggest that while patients in this study were more likely to engage in life review and reminiscence, family members were more likely to focus on present concerns. The higher percentage of the present tense subcategory for question five may also be the natural counterbalance for the lower percentage of past tense responses.

A few descriptions within the category of concrete connections were notable because of their prevalence (see Table 4.) The first of these, musical activities, was a common topic among patients and caregivers, and it was the only description present under every subcategory for concrete connections (i.e., past, present, and future). Often, participants discussed the joy they took in certain musical activities such as singing, dancing, or playing a musical instrument. Because these discussions were non-threatening and directly related to the music, they often functioned to build rapport between the participant and the researcher.

Another noteworthy set of descriptions was death/burial, present under connections with the past and the future, and illness, under connections with the present. The presence of these descriptions--past, present, and future--support the assertion that song choice and other song methods aid patients in exploring loss, illness, and death (Bailey, 1984; Dileo, 1999; Salmon, 1993). According to Byock (1996), accepting and expressing personal loss and the finality of one's existence are important end-of-life tasks. In this study, patients were sometimes motivated

to talk about their own death or burial. For example, one patient, after requesting "In the Garden," reflected on how the thought of being buried in a garden gave her a sense of peace and security. Furthermore, participants were sometimes reminded of other loved ones' deaths. It was not uncommon, for example, for patients or caregivers to choose songs they had heard at the funerals of other family members.

Intangible Connections

The category of intangible connections encompassed 22.25% to 29.13 % of the data for all research questions including extramusical categories. It was the largest extramusical category for all research questions, except question four, which represents patient's responses. For patients, intangible connections (22.25%) ranked behind concrete connections (37.70%).

Beliefs. Beliefs represented the greatest percentage of intangible connections for each question, ranging from 44.71% to 82.50% across questions one, three, four, five, and six. One factor that may have contributed to the prevalence of this subcategory is its breadth, as it encompasses not only faith-based expressions, but also more general beliefs about life. For example, the song "Sentimental Journey" led one participant to explore the significance of his lifelong quest for meaning, while another participant, following the song "When the Roll is Called Up Yonder," stated "Oh, that makes me want to clap! I'll be there. You'll be there. She'll be there too." Though the inclusion of both theistic and non-theistic reflections resulted in a broad definition for this subcategory, both types of reflection were rooted in ideals that were meaningful and valuable to participants. Therefore, the researcher felt it would be inappropriate and arbitrary to dichotomize between faith-based and life-based beliefs.

Once again a notable disparity existed between the frequency of patients' responses regarding beliefs (44.71.%) and family members' responses (82.50%). According to Magill

(2009), caregivers frequently find comfort and support in expressions of faith and meaning when witnessing the death of a loved one. While this was certainly true of this study, the unusually high percentage of caregiver responses may also partially be explained by the extensive interviews with one particular caregiver, which centered largely on her faith. This participant gave three interviews which ranged from around 3:30 minutes to 8:00 minutes in length. Her responses related to beliefs account for 67.17% of the subcategory of beliefs. Therefore, while beliefs were a significant topic of discussion among many participants, the contributions of this particular participant may account, in part, for the greater response of family members.

Feelings and desires. Feelings and desires was the smallest subcategory under intangible connections for all research questions including extramusical categories. However, this may be due in part to the fact that feelings and desires were only coded as such if they were explicitly referenced (i.e., "I was very depressed for awhile"). Many interviews had emotional overtones, but participants did not necessarily overtly discuss their emotions. Furthermore, this subcategory only encompassed emotional expressions related to extramusical topics such as relationships or reminiscences. Affective responses related to music were coded under a separate subcategory. In any event, the descriptions of feelings and desires suggest participants in this study expressed a range of emotions, encompassing sadness and depression to joy and hope (see Table 4).

Feelings and desires is another subcategory in which there was a disparity in the frequency of the data for patients and family members. Feelings and desires accounted for 24.71% of patients' intangible connections, and only 6.25% of family members' intangible connections. This may suggest patients in this study expressed their feelings and desires more readily than caregivers. While interviews with patients were often one-on-one, caregivers

always interviewed in the presence of their terminally ill loved one. Thus, caregivers may have been more reserved in their expressions so as not to cause their loved ones distress. Patients, on the other hand, had no such restrictions.

Stories and images. Though stories and images represent a form of expression rather than a reason for choices, this subcategory was deemed necessary as stories, hypothetical scenarios, and images were the primary subject of some interviews. The subcategory of stories and images accounted for 11.25% to 30.59% of responses for all research questions including extramusical categories. As with the other subcategories of intangible connections, patients' responses represented the highest percent (30.59%) and family members' responses represented the lowest percent (11.25%). The reason for this disparity is unclear. One possible explanation is that as patients neared death they more frequently used stories and images to help them deal with difficult feelings. According to Salmon (1993), the symbolic nature of images may allow participants the space to approach threatening material. Another possible reason is that as patients approached death, they tended to speak in more universal terms. Just as music provides a template onto which thoughts and feelings may be projected (Dileo, 1999; Gardstrom & Hiller, 2010; Magill, 2008), images and stories may also provide a template broad enough to encompass the depth and complexity of individuals' beliefs and emotions. Finally, the reason for the discrepancy between patients and family members in this subcategory may partially be accounted for by the fact that the beliefs subcategory is so prominent for caregivers (82.50%). Once again, because of the weight of the beliefs subcategory, a more equitable distribution between beliefs, feelings and desires, and stories and images, was not possible for caregivers.

In this study, participants used stories and images to illustrate beliefs and ideas. Images and stories were sometimes based on lyrical descriptions. For example, after listening to "I'm

Always Chasing Rainbows," one participant spoke of how he sometimes "chased rainbows" rather than appreciating the relationships he already had. Another participant, after listening to "I'll Fly Away," spoke of how the image of flying represented freedom from pain and illness. Other times the music inspired stories or images not directly expressed in the song. For example, after listening to "Sentimental Journey," one participant was reminded of the book "Of Human Bondage" and how it influenced him to consider life as a journey for meaning.

In fact, the image of the journey was markedly prevalent throughout this study. This image was associated with death, life, and faith by both patients and caregivers. As Campbell (1949) asserts in *The Hero with a Thousand Faces*, the hero's journey is a seemingly universal theme that runs throughout myths regardless of culture. Campbell (1949) suggests this theme is ubiquitous because all people undergo a psychological journey in their lives, fraught with trials and transformation. As individuals are nearing death it is an opportunity for both patients and family members to look at the deeper structures of their lives.

Music

Musical connections comprised 26.44% to 31.66% of all responses. Music was the preeminent category for questions one and two (27.61%) and question six (31.66%). For questions one and two, less than 1% separated the music category from the next-largest category. However, for question six, almost 7% separated the music category from the next category. This may imply that music-related subjects were a natural and safe place for patients and caregivers to begin discussions of song choice, as question six captures participants' initial and spontaneous responses. On the other hand, since questions one and two encompass both participants' initial responses and responses to more directive questions, the data may also indicate the researcher's follow up questions were more frequently about non-musical topics.

Structural elements and lyrics. The subcategories within the music category range from the purely musical to the predominantly musical. The subcategory of structural elements, which only comprises 7.33% to 12.87% of the music category, represents the essence of musical responses, that is, observations regarding dynamics, harmony, melody, texture, etc. "I like 'His Eye is on the Sparrow' because it has that drop for an octave" is an example of a statement coded in this subcategory.

The subcategory of lyrics is also essentially musical. In fact, the lyrics subcategory feasibly could have been subsumed under structural elements, since text is an important component of musical forms. However, the researcher chose to make it as a separate subcategory, since the significance of lyrics as a catalyst for meaningful expression is widely acknowledged in the literature (Bailey, 1984; Dileo, 1999; Dileo & Parker, 2005; Magill, 2008; Salmon, 1993, 2001). Indeed, the lyrics subcategory was the second-most prevalent musical subcategory behind affective responses for all research questions, comprising 22.77% to 25.83% of responses. As Magill (2005) observed, "…[L]yrics can lead the mind to other places, times, meanings and purposes, thereby lifting one from the perceived state of affliction into a state of inspiration" (p. 12). One of the themes of this study supports Magill's assertion: Meaningful messages and significant images within songs impact participants, often more profoundly than mere verbal communication. This theme is based on both participants' verbalizations regarding the significance of lyrics and the researcher's observation that participants' reminiscences, beliefs, feelings, and stories were almost always related to song content.

Instruments and style. The subcategories of instruments and style were not as essentially musical as the subcategories of structural elements and lyrics. Instruments, which only represented a small percentage of the music category, encompassed participants' statements

about instruments and instrumentation. Though small, this subcategory was necessary, as comments made about instruments could not appropriately be coded under any other subcategory. One patient in particular, a former hornist, spoke extensively about instruments and instrumentation. Thus, while this subcategory comprised less than 5% of the data for questions one, two, five, and six, it comprised 10.89% of the data for question four, which represents patients' responses.

Style comprised 11.88% to 16.38% of the music category. Typically, this subcategory represented participants' expressions regarding preferred genres of music. Comments on style were both positive, such as "I love the waltz," and negative, such as "I can skip that hip hop stuff." Because participants often commented on the performance of a chosen song, observations related to performance quality and interpretation were also coded under style (e.g., "You have a really pretty voice").

General references and affective responses. General references and affective responses/beliefs about music are better described as music-related subcategories than essentially musical subcategories. The subcategory of general references, which comprised 9.05% to 10.00% of the music category, encompassed any statement about music or a song that did not have affective or descriptive overtones. "I'll tell you what, let's do 'Moon River'" is an example of a general reference. To some degree this was a "catch-all" subcategory. If a statement about music could not be coded in any of the other subcategories it was coded as a general reference.

Affective responses and beliefs comprised the largest percent of responses for all research questions including musical categories: 31.68% to 41.81%. A study by Flowers and Murphy (2001), in which 45 older adults were asked to explain why they liked their preferred music, also found the largest percentage of responses (48%) were affective or emotional in nature. In both

this study and the study by Flowers and Murphy (2001), music was described as "comforting," "soothing," or "beautiful." However, such simplistic reflections were only a portion of the responses given by participants in this study. On several occasions participants affirmed that chosen songs reflected what they were feeling or thinking. As one participant stated, "[The music] gets down in words what I can't." According to Salmon (1993), individuals nearing death often experience a wide spectrum of emotions, finding resonance in musical choices that give voice to the emotions being experienced.

In addition to encompassing affective responses, this subcategory also represents participants' beliefs about music. Expressions of belief were both personal and universal. The following statement is an example of a personal statement from this study: "…[M]usic just opens me up. It just says something to me, and I just become one with the music." In contrast, "I think music makes you have…memories of when you first heard [the song]" is a more universal statement. Like the beliefs subcategory under intangible connections, participants expressed both theistic and non-theistic beliefs about music. An example of a faith-based belief about music is the belief in the power of traditional hymns, which one participant described as "anointed." As explained by Clair and Memmott (2008) and Walker and Adamek (2008), patients often seek comfort in music as a form of prayer, ritual, or worship, especially when they are no longer able to attend services.

Finally, there is a notable range between the percentage of patients' responses (31.68%) and family members' responses (41.81%) represented in this subcategory. This trend may be due to the tendency of family members to comment on how the music impacts their terminally ill loved ones. As Magill (2008) notes, caregivers' believe in the power of music to both sooth and energize loved ones. Indeed, family members in this study frequently expressed they felt music

"was good for" patients or "comforting" to patients. Furthermore, caregivers often intentionally chose songs because they felt they would be therapeutic for patients.

Relationships

The relationships category ranged from 13.61% to 28.03% for all questions including extramusical categories. Question four, which encompasses patients' responses, represented the low end of the range (13.61%), and question five, which encompasses family members' responses, represented the upper end (28.03%). As noted previously, patients seemed to focus more on concrete connections (37.70%) than relationships, while caregivers focused less on concrete connections (14.68%) and more on relationships. Though a direct correlation cannot be stated, it is notable that where the category of concrete connections is smaller the category of relationships is larger and vice versa.

Loved ones. One of the themes of this study illustrates the importance of song choice as an intervention to be used with caregivers: Relationships with loved ones are explored through participants' musical choices. On more than one occasion, when asked why they chose a song, a family member would respond, "It tells his/her story." An example of this may be seen in the caregiver who identified with "Amazing Grace" because it "told the story" of her father, who was able to overcome alcoholism with the help of God's grace. "You know that kind of lifestyle really shakes a family up, and we've all had to live out the life of forgiveness." She was able to express the reality of her father's alcoholism, as well as the certainty of forgiveness experienced by herself and her family. In this way, her musical choices were able to aid in the task of relationship completion (i.e., expressing love, forgiveness, gratitude, and leave taking) (Byock, 1996; Dileo & Parker, 2005).

It is also noteworthy that family members sometimes used musical choices to connect with loved ones. For example, one caregiver in this study solicited her mother's opinions on her song choices through questions such as, "Don't you think it's pretty on guitar mother?" Statements in which the participant's main intention was to reach out to a loved one were also coded under "relationships." In this study, coding according to intention was rare, as subject matter was usually the preeminent consideration. However, in the example given, the content of the question was less important than its spirit. The caregiver's intention was not to discuss instrumentation, but to connect with her mother, who had late-stage dementia, through the music. As Bailey (1984) states, while music therapy cannot heal all relational ills, song choice can be used to develop communication between patients and loved ones.

Not only can song choice promote interaction, musical choices are also important for caregivers even when patients are actively dying. For example, when one family member in this study was asked why she chose the song "Sentimental Journey," she responded, "For mom's journey she's taking. Mom loves that song, but she's on a journey." Though her mother was unresponsive, this caregiver still found meaning in choosing a song on her behalf. According to Krout (2003) and Sato (2011), it is most critical to include family and friends in music therapy when a loved one is imminently dying. Through music therapy, caregivers can address their own feelings by choosing music that is important to the patient.

Though much of the discussion has focused on how song choice can help caregivers relate to their terminally ill loved ones, the relative lack of variance between the frequency of patients' responses (69.23%) and caregivers' responses (73.16%) for the subcategory of loved ones illustrates patients also related to their loved ones through chosen songs. Less emphasis has been placed on patients' relationships with loved ones, however, because of the disparity noted

previously between the frequency of patients' (13.61%) and caregivers' (28.03%) responses in the relationships category. Furthermore, the nature of patients' verbalizations was significantly different than that of caregivers. Even when categorized as relationships, patients' responses frequently took on the character of reminiscences. While caregivers engaged in task completion, expression of self through choices, and deliberate use of inclusive language, patients often spoke about beloved family members in the same breath in which they spoke of significant activities from their pasts.

Self. The subcategory of self comprised 26.28% to 30.77% of responses for all questions including extramusical categories. References to self were coded in this subcategory. Often these references had little intrinsic meaning, encompassing statements such as, "That's my perspective." To some degree, this subcategory might be considered the "catch-all" code for extramusical responses. As stated in the definition, this code encompasses self-reflections unrelated to beliefs, desires, or feelings. Thus, many statements that might be considered self-reflections were subsumed under other subcategories.

Limitations and Biases

One limitation of this study is that not all individuals referred to music therapy services were eligible for participation because of cognitive, physical, or emotional needs that made solicitation difficult or consent impossible. This means that a significant portion of the hospice population was not represented in this study. There were also times when environmental circumstances impacted the researcher's decision regarding whether to solicit individuals for participation. For example, the researcher was more reticent to ask individuals to participate when there were several people present in a room or when the environment seemed hectic or confused.

Another possible bias stems from the fact that interview durations varied a great deal between participants. Thus, some participants' responses had greater weight in the frequency count than others. This was largely due to the fact that interviews were only loosely structured, which meant different questions were asked of each participant. While this served a therapeutic value, it meant that responses (aside from those represented in question six) were somewhat dictated by the researcher. Furthermore, the researcher herself was influenced by a variety of environmental and personal factors that made it difficult to consistently maintain the same level of structure for each interview. Finally, participants' responses were likely influenced by the level of rapport they had with the researcher. Some participants had taken part in music therapy sessions with the researcher before participating in the study, while others had no prior history with the researcher. Participants who had an established relationship with the researcher often responded with more openness and depth than those who did not.

A final limitation was lack of repertoire, since occasionally the researcher did not know the requested song and did not have access to a recording of it. When that happened participants were offered other choices based on their preferences. Even so, the fact that the researcher was sometimes able to supply the preferred song and other times had to fall back on secondary choices undoubtedly influenced participants' responses.

Future Research

The analysis of reasons participants give for their song choices can serve as a platform for future research. This study provides a broad framework based on participants' interviews. A more detailed exploration of any individual category or subcategory, as they are described in this study, may prove a valuable area of research. For example, one subcategory that particularly interests the researcher is that of stories and images because it is not found in previous literature

on song methods in hospice. Therefore, more research about the spontaneous use of figurative language and how to better musically and verbally validate these expressions is recommended. A study of the differences in the reasons patients and caregivers ascribe to their song choices is another potentially valuable area of research, as such differences were frequently noted in this study. In particular, applying an experimental method to a similar research design may validate or refute some of these findings and allow researchers to more appropriately generalize findings to other settings.

Conclusion

This study served three main purposes. The first was to support and expand upon previous literature about song choice in hospice music therapy. While this study was inspired in large part by the article by Bailey, published in 1984, this study differs from Bailey's, in that, in this study analysis was applied to participants' interviews regarding their song choices, while in Bailey's study analysis was applied to the thematic material of participants' chosen songs. For example, when Bailey stated that "relationships" was a common song choice theme, she meant clients frequently chose songs about relationships. On the other hand, in this study the category "relationships" was based on participants' verbalizations linking important people in their lives to the chosen music. However, even with the differences in method, this study largely upholds what Bailey and other song-method authors observed (Dileo, 1999; Dileo & Parker, 2005; Magill, 2008).

The second purpose of this study was to view the statements of patients and family members participating in hospice music therapy through the lens of song choice. Though there is significant literature about the importance of music in stimulating life review, spiritual expression, emotional expression, and tasks related to relationship completion, there is minimal

literature specifically relating such end-of-life tasks to song choice. This study indicates that in discussing the reasons for their choices participants were frequently able to engage in these important processes. Indeed, the researcher found that simply asking the question, "Why did you choose that song?" often elicited responses that were rich and full of meaning.

The final purpose of this study was to provide a framework by which to improve the therapeutic process. Since this study is qualitative in nature, these findings are not necessarily generalizable. However, at the very least, this study provides an example of a framework that can function as a checklist for music therapists. Specifically, this framework, or ones like it, may enable hospice music therapists to better (a) assess concerns, moods, and needs of clients (Bailey, 1984); (b) frame discussions, particularly those related to therapeutic outcomes such as emotional expression and reminiscence; (c) structure interventions around insights related to song choice; and (d) make repertoire choices based on insights about patient preferences (e.g., genre, style, content, musical attributes).

During the assessment process, information about a patient must be gathered quickly and efficiently (Magill, 2005). Using pre-established categories and subcategories may serve to expedite the assessment process. Not only could a checklist based on this framework aid in the initial assessment, but it could also function in later sessions to evaluate how a participant's focus may change. A pre-established framework may help therapists identify clients' primary subjects of interest and modes of expression with more depth and clarity than simple observation. In this way, music therapists may be better able to reflect and validate clients' expressions through both verbal re-statement of thoughts and feelings and musical experiences that help normalize clients' emotions (Clair & Memmott, 2008; Krout, 2003; Magill, 2005; West, 1994). In noting how a

client's focus changes over time, the music therapist can appropriately adapt interventions, discussions, and music to meet their clients' changing needs.

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