Music Therapy Assessment for Alert Hospice Patients:

An Ecomap Approach for Assessing Music Preferences

by

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ABSTRACT

Individuals receiving hospice care at the end of life have a unique set of needs, requiring interdisciplinary assessment and treatment to meet their multidimensional circumstances and create a supportive and comfortable experience. Music therapy is often an integral component of hospice care utilized to treat the whole person. While there are published music therapy assessment tools for use with the hospice population, there is no assessment tool specifically aimed at understanding the role of music preference in the context of the hospice patient's multidimensional musical ecosystem identity. The purpose of this thesis was to create an assessment tool to understand and document the individualized connections between a hospice patient's familiar and preferred music and their musical identity, in order to increase cultural awareness and to utilize music selection with purpose while supporting and empowering the patient. The proposed music preference assessment tool utilizes an ecomap structure and combines theories and philosophies from the fields of music therapy and social work. The needs of the hospice population are identified and music therapy is discussed as a treatment modality in hospice. Existing music therapy and social work assessments are identified and examined and elements of each are utilized in the creation of the proposed music preference assessment tool. A template and example assessment tool are provided with considerations for clinical implications and uses.

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INTRODUCTION TO THE PROJECT

Assessing music preference can be more complex than it may seem at first glance. There is, first, the issue of distinguishing between familiar music and preferred music. While familiar music may be preferred for some individuals, preferred music may be quite different from familiar music for others. For instance, a person who grew up in a church may be familiar with the music and hymns used in their church; however, if this individual left the church as an adult and has negative associations with the church or its related music, the individual may not prefer this music. Another example is an individual who is familiar with classical music, having played professionally in an orchestra for thirty years, but prefers to listen to current popular music, as orchestral music induces feelings of stress and anxiety associated with work. Assessing music preference in hospice care is essential to providing effective music selection and music therapy intervention for individuals at the end of life and their families.

In my clinical work as a hospice music therapist I strive to provide compassionate care to all the patients and families I meet. I have often received referrals for music therapy that listed music preferences, which were provided by other interdisciplinary team members or family and friends of the patient. Occasionally, the person reporting saw a patient's religious affiliation as a music preference, but I subsequently learned when I met the patient that their music preferences were significantly different than what was reported upon referral. Sometimes the listed preferred music is accurate, but not appropriate for the context of the patient's current needs. For example, one patient was referred for music therapy with a reported preference for classical music and the reason for referral was due to insomnia. The patient had been a professional orchestral musician

and did enjoy listening to classical music but found it difficult to relax to classical music because he was analyzing it. In this case, while the reported preference was correct, it was not useful to meet the patient's needs. In other cases, such as reports of preferences based solely on patient age or religion without discussing preferences with the patient, the reported music preference was not accurate. The reason for the discrepancy between reported and actual preferences is not always evident. It could be possible that assumptions were made based on the patient's generation, religion/spirituality, previous music experience, or preferences of family members.

Music preference and past musical experience are part of many music therapy assessments in hospice and are often obtained through very brief discussions or interviews with patients and families, chart reviews, or are gathered from other interdisciplinary treatment team members (Adler, 2001; American Music Therapy Association [AMTA], 2015; Haghighi & Pansch, 2001; Krout, 2000; Maue-Johnson & Tanguay, 2006; Starr, 1999). Although ascertaining accurate music preferences through a brief interview with the patient or from a patient's family members or other interdisciplinary team members is possible, the best source of information is the patient directly, when possible, through a more in-depth interview. The patient can put their experience, preferences, and familiar music and it's personal meaning to them into context within their own ecosystem. The interview could provide insight for the music therapist and interdisciplinary team on how to most effectively utilize music for the benefit of the patient and how to provide music therapy interventions in a more empathic, compassionate, and person-centered manner. The more deeply the hospice team

understands the patient's relationship with music and their ecosystem, the more robust and meaningful all aspects of hospice treatment will be.

LITERATURE REVIEW

Hospice Population

Hospice care and palliative care are terms that are often used interchangeably, as both are philosophies that address the needs of individuals as they near the end of life. Individuals may qualify for hospice and palliative care services when two physicians estimate that the individual has a life-limiting condition with a prognosis of six months or less if the disease process follows typical progression (National Hospice and Palliative Care Organization [NHPCO], 2020). The philosophy of care in hospice and palliative medicine is holistic, treating the needs that accompany a terminal illness in physical, emotional, and spiritual domains. Due to the multidimensional needs of hospice patients and their loved ones, hospice agencies provide a multidisciplinary approach to patient treatment including physicians, nurses, psychosocial team members such as social workers and chaplains, home health aides, pharmacists, volunteers, and adjunctive therapists such as music therapists, occupational therapists, or massage therapists (Hilliard, 2005). Common clinical need areas of patients in hospice care include anticipatory grief, communication, pain management, anxiety reduction, emotional support, spiritual support, support for caregivers, socialization, and maintenance of quality of life (Dileo & Loewy, 2005; Hilliard, 2004; Hilliard, 2005; Krout, 2000; Maue-Johnson & Tanguay, 2006; NHPCO, 2019; Starr, 1999). While music therapy is not a Medicare-mandated or required treatment discipline in hospice and palliative care, music therapy can provide effective interventions to meet patient and family needs in multiple

domains such as physical, emotional, and spiritual (Groen, 2007; Hilliard, 2005; Magee, 2007; Magee et al., 2016; Maue-Johnson & Tanguay, 2006). Although live music intervention is generally more efficacious, music therapists utilize live or recorded music in a variety of interventions such as music listening, music assisted cognitive reframing, progressive muscle relaxation, song choice, lyric analysis, instrument playing, song writing, improvisation, and using the iso-rhythmic principle, depending on the individualized needs of each patient (Groen, 2007; Haghighi & Pansch, 2001; Hilliard, 2005; Krout, 2000; Maue-Johnson & Tanguay, 2006; Starr, 1999).

The assessment process for music therapy begins when a music therapy referral is made for a hospice patient or family member; referrals can be made by a member of the interdisciplinary hospice team or by a loved one or caregiver of the patient. Often a referral includes basic patient information such as patient name, age, hospice diagnosis, reason for music therapy referral, and occasionally cursory information on the patient's preferred music. Upon receiving a referral, the music therapist assesses the patient and determines whether continued music therapy treatment is indicated and, if so, develops a treatment plan to address the assessed areas of need. Many hospice organizations and music therapist contractors implement their own templates for music therapy assessment documentation. There are also multiple published music therapy assessments available for the hospice population (Haghighi & Pansch, 2001; Krout, 2000; Maue-Johnson & Tanguay, 2006; Starr, 1999).

Music Therapy Assessment Tools

Although research on the development of specific music therapy assessment tools for music preference is scarce in music therapy literature (Chlan & Heiderscheit, 2009;

Han, 2018), ample literature exists on the development of music therapy assessment tools in hospice and for other populations and treatment domains (Haghighi & Pansch, 2001; Krout, 2000; Maue-Johnson & Tanguay, 2006; Starr, 1999). Many existing assessment tools briefly measure music preference but the information gathered on music preference in these assessment tools is limited. One assessment tool specifically designed for determining music preference is the Music Assessment Tool (MAT) (Chlan & Heiderscheit, 2009). This tool measures music preferences in nonverbal patients in the Intensive Care Unit (ICU). The MAT implements an interdisciplinary approach to assessment, with the music therapist consulting with nursing staff to gather patient demographic information and other relevant psychosocial background on file. One benefit to collaboration in this setting is that the patient would not need to repeat information to the music therapist that was already provided to another team member; the music therapist could then focus on gathering other data related to music preferences. Patients in the ICU are often easily fatigued and can experience periods of altered states of consciousness so it is imperative to gather information as quickly and efficiently as possible while the patient is able to provide information (Chlan & Heiderscheit, 2009). This assessment model parallels hospice in the areas of interdisciplinary collaboration and assessment efficiency. Each treatment team member has information on the patient that helps the whole team to understand the patient and view the patient from a whole-person perspective. Hospice patients can experience sudden and rapid decline as their terminal disease processes progress. Decline can cause increased fatigue and altered states of consciousness as well.

One published assessment tool for hospice music therapy that measures music preferences and background is the Hospice Music Therapy Assessment (Maue-Johnson & Tanguay, 2006). The tool includes a brief section labeled "Musical" that leaves space to document narrative data for musical background, musical preferences, specific songs requested, and observed responses to music (Maue-Johnson & Tanguay, 2006, p. 17). This is all useful data in determining appropriate and effective music to utilize in music therapy treatment; however, it does not provide enough insight into the purpose or role of music in the patient's life. For example, a patient might have previous experience playing piano in a church choir, but is no longer interested in church music. Musical background, preferences, and requested songs do not necessarily translate to effective musical selections for music therapy treatment. It is imperative to understand the role these musical selections play in the patient's ecosystem in order to determine which music will be most effective in meeting the patient's treatment goals. Even a simple inquiry as to why the patient requested a song or requested to avoid a song can provide insight into the patient's relationship with their musical identity (Parker et al., 2014).

Development of Music Therapy Assessment Tools

A variety of data collection methods are utilized in existing music therapy assessment tools including open-ended or closed-ended survey questions, questions to which people respond on Likert-type scales, observations, family and patient interviews, patient record review, and collaboration with treatment team members (Jacobsen et al., 2019; Krout, 2000; Magee, 2007; Magee et al., 2016; Maue-Johnson & Tanguay, 2006; Mitsudome et al., 2013; Norman, 2012; Scalenghe & Murphy, 2001). Maue-Johnson and Tanguay (2006) gather assessment information through review of medical records,

interview with a patient and family, and observation of a patient before and during music therapy interventions that occur during the assessment. Information gathered directly from the patient is ideal in understanding their unique perspective, experience, and identity but the indirect methods for assessment such as review of records and collaboration with the interdisciplinary team provide insight into needs and strengths that the patient may not identify themselves.

Some literature documents the process of creating music therapy assessment tools and protocols. The Music Therapy Assessment for People with Dementia (MTAPD) (Mitsudome et al., 2013) measures behaviors of persons with dementia in response to musical and non-musical stimuli. The authors took the following steps in the development of the assessment tool: used video recordings of subjects' behaviors and responses, categorized responses into assessment items, created a scoring system for the items, and tested the assessment tool with eight music therapists and their clients. Following the testing, the researcher ran an inter-rater reliability analysis and recommended further reliability and validity testing (Mitsudome et al., 2013).

Chlan and Heiderscheit (2009) discuss the uniqueness of the Intensive Care Unit (ICU) setting for patients, especially the "lack of choice and little, if any, control or involvement with their care. Often they have no opportunities to express their desires or make choices. In the complex, high-tech environment of the ICU, patients can feel depersonalized" (p. 46). The same sentiments often apply to the hospice environment for many patients and music is an accessible vehicle to allot patients opportunities for control of their environment, treatment, stimulation, and engagement with others. Chlan and Heiderscheit (2009) share a case study of a patient in the ICU who was referred for music

therapy due to difficulty sleeping. The music therapist utilized the information gathered in the MAT to create discs of recorded music for the patient to utilize to relax and increase quality of deep sleep. The patient in this case implemented the music listening himself, then discussed the results with the music therapist and engaged in reminiscence with the music therapist during the subsequent visits. According to the case study of patient, Scott, the music therapist provided an assessment question regarding when Scott prefers listening to music and the purpose(s) for which he listens to music, in order to create an appropriate selection of music to meet the patient's needs (Chlan & Heiderscheit, 2009).

Although the MAT was designed for use with patients who are unable to communicate verbally, elements of the tool are relevant to the assessment tool proposed in this thesis, which is intended for use with verbal patients. The MAT is designed to include interdisciplinary collaboration. The MAT takes into account the patient's background information such as previous musical experience, level of musicianship, genres of music, instrument preferences, and musical dislikes (Chlan & Heiderscheit, 2009). These items are considered in this proposed assessment tool as well, although they are documented primarily indirectly through a visual representation of the patient's answers to assessment questions.

Due to the individualized needs of patients and the personalized approach to treatment in hospice care, music therapy assessments in hospice focus on domains relating to comfort and quality of life (Groen, 2007; Hilliard, 2005; Krout, 2000; Maue-Johnson & Tanguay, 2006; Starr, 1999). Hospice music therapy assessment should focus on the following need areas:

> (a) decreasing anxiety and perception of pain, (b) developing coping skills, (c) gaining spiritual support, (d) identifying and expressing emotions, (e) engaging in life review, (f) improving communication skills, (g) improving relaxation skills, (h) decreasing restlessness and agitation, and (i) orienting to reality. An assessment of current functioning in these areas assists the music therapist in formulating an appropriate focus for treatment (Maue-Johnson & Tanguay, 2006, p. 13)

The authors discuss the complexities of creating an appropriate assessment tool for this population due to expected and sometimes rapid physical and cognitive decline of patients. The spiritual and existential questions that often occur in hospice can be difficult to define and translate into treatment goals or a plan of care (Mau-Johnson & Tanguay, 2006).

Social Work Assessment

While many of the theories and philosophies guiding music therapy and social work are similar, social work seems to take a more whole-person perspective in assessment of patients and the development of a treatment plan. Dean and Poorvu (2008) describe assessment as the process of:

> eliciting information considered relevant to the issue with which the client presents…We define formulation as a focused, brief conceptualization of the client or situation, based on the assessment. It highlights central issues, offers a tentative understanding of them, and sets the groundwork of the plan for intervention that follows…In most models of contemporary practice, the way social workers formulate their cases is developed in collaboration with clients, privileging their views and supporting their strengths (pp. 596-597)

Since its founding in the nineteenth century, the field of social work has been influenced by a wide variety of theories, models, and approaches in human sciences. As new ideas came forth, social work adopted them and implemented them into assessment and formulation (Dean & Poorvu, 2008). Due to their consideration of this wide range of information, social workers utilize a variety of assessment formats including narrative

and diagrammatic assessments. A commonly used diagrammatic assessment and data collection tool, the "ecomap," is derived from the term ecology, "the study of the connection between a living thing and its environment, and how that connection is maintained and enhanced…An ecomap is a visual representation of relationships through the depiction of the network that exists between members of a social group and their connections with larger social networks (Wright & Leahey 2000), providing the researcher with evidence of the size, structure and function of that network (Tracy et al. 1994)" (Ray & Street, 2005, p. 546). When ecomapping is utilized, the patient's needs and strengths are more clearly identified, which leads to effective and efficient intervention that utilizes a patient's strengths (Early et al., 2000). The ecomap presents a patient's current relationship to elements in their ecosystems. In his "Developing a Spiritual Assessment Toolbox…" article, Hodge (2005a) acknowledges that although the ecomap only depicts the present relationships, those relationships are affected by the patient's history and experiences within their ecosystem.

Other disciplines in the helping professions have utilized ecomaps in assessment and treatment for patients. Ray and Street (2005) advocate for the use of ecomap assessments and data collection outside of the field of social work. The ecomap process was conducted by nurses with patients and families to identify needs of patients and social support available to care for patients and social and community resources available to help caretakers. A visual representation of relationships provided insight and communicated ideas and emotions that were difficult to put into words (Ray & Street, 2005). The absence of the use of ecomaps in other helping professions in the literature suggests that it may be a relatively new idea to utilize diagrammatic assessments outside

of social work and that those who do utilize such tools may do so informally or sporadically.

Some strengths of ecomapping include relatively easy and quick construction and readability, a standardized data collection format, flexibility to include additional information as relevant, focus on the patient's current and most pressing needs and strengths, visual representation of that which is difficult to describe in narrative form, and a safe venue for clients to express difficult topics due to the focus on the map as a concrete object (Hodge, 2005a, 2005c). Hodge's (2005a) example of a spiritual assessment ecomap in *Health and Social Work* is included in Figure 2 for reference. Ecomaps can be points of departure for deeper discussion and exploration of patient needs and history. The act of constructing this diagram can prompt better-informed follow-up questions from the clinician and subsequently more detailed responses from the patients.

On the other hand, according to Ray and Street (2005), information divulged by the patient about relationships can fluctuate depending on the patient's current situation or mood and qualifying questions should be asked to clarify whether the information provided is situational or permanent. Another potential downfall of ecomaps is the limitation placed on describing relationships by the graphic design used. Patients might possibly create their own additional graphic elements in order to illustrate a unique situation or relationship. If the patient creates a new element or line for the ecomap it would be helpful to include a note or key directly on the ecomap to define it for other team members reading the ecomap.

Considering that a major factor in music preference for many individuals is religion or spirituality (Han, 2018; Parker et al., 2014), appropriately addressing the meaning of religion or spirituality to each patient is essential. Some people explicitly and openly share about their spiritual and religious beliefs while others are uncomfortable discussing the topic or view it as a personal or private experience. Hodge (2013) describes spirituality as "a fundamental human drive for transcendent meaning and purpose that involves connectedness with oneself, others, and ultimate reality" (p. 224). As such, it can be very impactful on a patient's music preferences and music identity. According to multiple studies, clients wish to involve their spiritual and religious views into their treatment; however, there are instances in which patients are more comfortable sharing about their spirituality in an indirect manner. To some patients, the typically accepted language surrounding spirituality does not align with their understanding of the transcendent, which makes discussion surrounding the topic difficult. Other patients may find it difficult to trust the therapist's spiritual competence. In these cases, an implicit, rather than explicit, spiritual discussion would be warranted. Some ways to implicitly assess spirituality are listening for patient language that alludes to the spiritual or divine, attending to emotional shifts during conversation, and asking existential questions to explore spirituality, being careful to avoid direct questions regarding spirituality (Hodge, 2013). Questions such as "How do you commemorate special occasions/accomplishments?...What sustains you through difficulties?...After you are gone, what legacy would you like to leave behind?" allow patients to freely express their spirituality in their own terms (Hodge, 2013. p. 227).

Interdisciplinary Team Collaboration

The complex and wide-ranging needs of hospice patients and their families require excellent interdisciplinary communication and collaboration between all team members involved in the patient's care. Since patients can experience rapid changes in condition, their needs can change just as quickly. Each team member needs to be prepared to advocate for changes in the patient's plan of care; collaborating with the other team members is integral to ensuring the patient receives consistent and congruent care across the board. The previously discussed Music Assessment Tool (MAT) (Chlan & Heiderscheit, 2009) was collaboratively developed by a board-certified, PhD-trained music therapist and an experienced ICU nurse researcher and includes the patient's background information, previous musical experience, level of musicianship, genres of music, instrument preferences, and musical dislikes. The MAT views music intervention as a team approach, guided by the music therapist, with the treatment carried out by the music therapist as well as other team members including the nurses (Chlan & Heiderscheit, 2009). In this model, multiple team members are prepared to assist in providing or facilitating music in a way that is beneficial to the patient. This is particularly helpful in situations where the music therapist has worked with the patient to create a playlist of music for relaxation. Other team members may be able to prompt the patient to engage in relaxation with their selected music when the music therapist is not present. Maue-Johnson and Tanguay (2006) also cite the importance of interdisciplinary collaboration to meet the overall needs of the hospice patient. Continuity of care contributes to patient satisfaction with hospice care and overall quality of life.

Gaps in Current Assessment Tools

One main piece of information missing from assessments of music preference is the real-life significance of the preferences. For example, the MAT focuses on assessing the preferences of the patient but does not address the meaning or role these preferences hold in the patient's life historically or in his/her current life situation (Chlan & Heiderscheit, 2009). For instance, although a patient might disclose a favorite song, the patient may not prefer to hear the song due to memories associated with the song. Cuddy et al. (2017) looked at the nonmusical memories that are associated with music stimuli, which they called music-evoked autobiographical memories (MEAMs). MEAMs are spontaneous memories that effortlessly occur during music listening. This study particularly focuses on the positivity effect in which older adults tend toward recalling positive memories over negative memories and younger adults recall less positive or more negative memory content in response to a variety of stimuli including music. The positivity effect is "considered by many to be a hallmark of successful aging" (Cuddy et al., 2017, p. 3). The definition of successful aging varies from researcher to researcher but many experts agree that successful aging involves components of physical health, absence of disability, meaningfulness of experiences, and connections with others and community as an individual ages. These factors contribute to an overall sense of quality of life (Martin et al., 2015). It had previously been hypothesized that older adults with dementia may not exhibit the positivity effect due to the decline in emotional regulation and executive functioning, cognitive processes believed to be integral in the positivity effect. Even without direct questioning during exposure to music, older and younger adults experience spontaneous memories in response to musical stimuli, including but not

limited to music with lyrics, instrumental music, preferred music, and even unfamiliar music (Cuddy et al., 2017). This provides further reason to create a music preference assessment tool that analyzes the role music plays in the patient's life so as to better understand and prepare for memories and reactions brought on by musical stimuli. Considering the tendency toward positivity effect in successful aging, it is prudent to consider that some patients in the hospice population may not fall in the category of "successful aging." Other patients may literally be young adults. Patients who fall into these categories of younger adults or older adults who have not experienced successful aging may experience increased occurrence of negative memories or fewer positive memories.

Parker et al. (2014) acknowledged that musical preference can be affected by cultural and community contexts as well as music that the patient listened to as a young adult. There were contradictions in the literature regarding which music is generally preferred in older adults and in the hospice population (Parker et al., 2014, p. 11). Given the contradictions in the literature regarding general music preference, patients need to be assessed as unique individuals and address ecosystems involved in the patient's past musical experiences and musical preferences in order to collaborate with the patient in selecting music that meets their treatment goals and needs in the moment. It is common practice for some clinicians to assess music preference indirectly, based on certain cultural or other background information about the patient provided by other treatment team members or the patient's family members (Kim & Whitehead-Pleaux, 2015; Magee et al., 2016; Maue-Johnson & Tanguay, 2006; Norman, 2012; Parker et al., 2014; Stige, 2002). "Musical preferences may be determined from a number of sources, including

statements by the patient, requests for specific songs, information provided by the family, or inference from the patient's spiritual or cultural background" (Maue-Johnson & Tanguay, 2006, p. 19). There are acute treatment circumstances in hospice care when there is not time to acquire or thoroughly assess music preferences but music therapists and other treatment team members should exercise caution when inferring preference based on a patient's culture or background. Each individual has a unique relationship and understanding of their culture and past experiences; there is an increased risk for unintended microaggressions or other insensitive and naïve assumptions based on a patient's culture.

Some music therapy assessment protocols call for musical preferences and history to be obtained from a patient's social history, typically gathered by the social services department. "When this information is inadequate, the music therapist should follow up with a verbal interview with the resident or his or her family" (Norman, 2012, p. 10). This seems shortsighted, since often, information about music experience or preferences garnered by others can be incomplete or inaccurate. Due to the need for brevity in assessment with this population, Norman (2012) attempted to gather as much information as possible from sources other than the patient. Perhaps an effective compromise might include gathering the information from social services but also confirming it with the patient or asking the patient to describe it in more detail. Another potential issue with Norman's (2012) method of assessment of music preferences described above is that the term "inadequate" is subjective. The music therapist may not realize that the social services department's music preference assessment was "inadequate" unless the music therapist followed up with their own assessment of music preferences. It seems a

disservice to patients to make assumptions about music preferences. At the very least the music therapist should verify with the patient the preferences provided by the social services department. There are contradictions in the literature as well regarding which music is generally preferred among older adults in the hospice population (Parker et al., 2014). Each hospice patient should receive individualized assessment and treatment, as music preferences, experience, and culture are unique to each person.

The ecomap approach to assessing patients has some inherent limitations due to its graphic nature. According to Hodge (2005a) in *Health and Social Work*, the "diagrammatic approach may hold little appeal to clients who want to talk. Although relatively quick and simple to construct, ecomaps may not appeal to more creative individuals, but clients can be encouraged to express their creativity by adding symbols and other material to the ecomap (pp. 320-321). Because the ecomap typically depicts current relationships in the patient's ecosystem, the use of the ecomap as an exclusive assessment tool may neglect to recognize significant patient history. This downfall may be avoided by including a brief narrative assessment on patient history in addition to the ecomap. Another option to include important historical context in the ecomap is to allow the patient flexibility to include additional information via notes, systems drawings in the map, or other creative means to depict meaningful historical context.

Cultural Considerations

While creating an ecomap-type assessment inherently involves exploring the patient's cultural background and identity, there are additional considerations to ensure that each patient's identity and wishes are fully understood and respected. This requires a proactive effort from every hospice team member, since each person within any

preconceived cultural group has their own understanding of their culture, values, beliefs, and identity based on their unique ecosystems and personal life experiences. One way for helping professionals, including music therapists, to approach cultural identities and needs of patients and their families is to view the patient as the expert in their own experience, identity, and meaning. In order to exemplify cross-cultural sensitivity, therapists should assess patients from a "not-knowing" position and maintain awareness of the therapists' prejudices, attitudes, and distortions so that the clinician will be open to new ideas and have an empathetic understanding of the patient's position. A systematic approach to assessing the client's systems and subsystems including family, work, community, or religious beliefs is also recommended to recognize the individual and personal meanings to the patient (Bahcivan, 2017; Belgrave, 2018; Dean & Poorvu, 2008; Hadley & Norris, 2016; Mahoney, 2015).

Unfortunately there are major disparities between the care received at the end of life by patients of different ethnicities. Older adults who are people of color or who belong to an ethnic minority have higher morbidity and mortality rates than their white counterparts (Stein et al., 2009). Stein et al. (2009) postulate that low rates of help-seeking and utilization of services across racial and ethnic groups may be due to the lack of knowledge and skills in cultural competence of the service provider. This means that music therapists need to be educated and knowledgeable in cross-cultural practice in order to provide the best care possible to all patients so that the clinicians themselves are not a barrier to service or enhanced quality of life. Terminal illness, death, and grief are topics that make many people uncomfortable. Many hospice practitioners also experience difficulty discussing end-of-life issues, regardless of cultural differences. Cultural

barriers can make discussions of end-of-life issues even more difficult and may prevent some patients from seeking hospice and palliative care (Stein et al., 2009). For this reason, it is imperative that music therapists and other practitioners implement assessment tools that illuminate the ecological perspective of the patients, demonstrating how each system including family, religion, generation, heritage, community, and other factors, feed into the patient's personal identity and needs. In music therapy, this directly translates to the need for an assessment of music preference that accounts for the patient's personal relationship to the music involved in each of these systems. This helps to ensure that cultural barriers are overcome during treatment and helps to realize the culturally-informed gold standard of care at the end of life.

Previous negative healthcare experiences and discrimination affect patients' views on end-of-life care and their level of trust in the treatment team. "Many minority patients are reluctant to let their needs be known. This is particularly true for those who have been discriminated against within the medical or health care system in the past…African American patients use hospice care at disproportionately lower rates than Anglo-American patients, even after controlling for sociodemographic and clinical characteristics. Mistrust was alluded to as a factor of influence" (Stein et al., 2009, p. 1011). African Americans also reported significantly lower satisfaction with medical care at the end of life (Stein et al., 2009). Providing a comprehensive, culturally-sensitive, and collaborative assessment approach will help foster an atmosphere of trust in the treatment team during end-of-life care. Stein et al. (2009) conclude that the interdisciplinary team needs to be culturally proficient in order to provide meaningful and competent care to patients. This proposed music therapy assessment tool will aid in providing cultural

information regarding the use of music to the entire interdisciplinary team. Access to this information will deepen each team member's understanding of the patient's personal understanding and relationship to their systems and how it may affect their wishes, choices, and experience in end-of-life care. The implementation of this assessment will demonstrate to patients the dedication the entire interdisciplinary team brings to understanding and respecting the role of the patient's identity in their care. Such a message can potentially attract more people to consider hospice and palliative care and foster a sense of trust in the interdisciplinary team. This will hopefully increase accessibility of hospice and palliative care to minority groups.

PROPOSED MUSIC THERAPY ASSESSMENT

Project Statement

This project aims to create, for alert hospice patients, a new tool for assessing music preferences that adequately provides insight into and supports the hospice patients' understanding of music within their individual ecosystems. This insight will inform the selection of music for hospice patients and allow the music therapist to provide more individualized intervention creation and overall meaningful care. This assessment tool incorporates components of existing social work assessments and music therapy assessments (Chlan & Heiderscheit, 2009; Early et al., 2000; Hilliard, 2005; Hodge, 2005a, 2005b, 2005c; Magee, 2007; Magee et al., 2016; Maue-Johnson & Tanguay, 2006; Ray & Street, 2005). The format of this proposed assessment tool is modeled after the social work assessment ecomap, which provides the opportunity for a more holistic, person-centered approach to treatment. Dean and Poorvu (2008) describe the ideas of "person-in-environment" and the ecological model used in social work assessment. "The

ecological perspective emphasizes the dynamic transactions between people and the multiple social systems, subsystems, and environments in which they participate…to determine if clients' interactions with their environments are enriching and supportive, or limiting and destructive" (p. 599). This proposed music therapy assessment tool combines the person-in-environment and ecological models in that it explains the patients' music preferences in their current environment. This tool parallels the person-in-environment idea, as well as its relation to other aspects of life, religion, culture, family, for examples, representing the ecological model. Among the music therapy concepts utilized in this proposed assessment tool are the knowledge of a wide variety of repertoire, musical elements, and training of music therapists to recognize how music may elicit emotionally positive or negative memories such as described regarding music-evoked autobiographical memories (MEAMs) (Cuddy et al., 2017).

Music Therapy Theory and Philosophy Background

Going along with the holistic approach to hospice care, music therapy is used to treat the whole person and the wide array of needs that arise as people near the end of life. Among the ideas guiding the philosophy of care for hospice patients in music therapy are patient autonomy, patient experience, non-malfeasance, benevolence, and non-judgment. These ideals are regarded as paramount in both the fields of music therapy, social work, and best practices in human subjects research (AMTA, 2015; Hilliard, 2005; Hodge, 2005a, 2005b, 2005c). Regarding patient autonomy, patients have the right to self-determination. In hospice care, respecting patient autonomy becomes crucial given that many hospice patients have lost control of their abilities, functioning, living arrangements, and choices among many other aspects of daily life; patients still

have the right to autonomy regardless of what the therapist thinks about the patient's decisions. Another guiding principle for treatment is that the patient's experience is what the patient communicates it to be. Within the philosophies of non-malfeasance and benevolence, the music therapist strives to do no harm to the patient and family and strives to do good for them. The music therapist abides by the philosophy of non-judgment by striving to respect the patient's wishes, beliefs, values, culture, identity, and religious or spiritual practices regardless of the therapist's personal beliefs and values (Hilliard, 2005).

Many music therapists working with hospice patients and families utilize a combination of humanistic and person-centered approaches with cognitive-behavioral music therapy to increase quality of life for patients (Hilliard, 2005). Hilliard (2005) explains the role of cognitive-behavioral music therapy with the hospice population:

> music therapy interventions are designed to treat identified problems and to allow for the expression of emotions while respecting the process inherent within the live musical dialogue. Psychotherapy techniques such as active listening, empathy, validation, cognitive reframing, cognitive-behavioral modification and behavior modification are commonly used within this approach (pp. 47-48)

The humanistic and person-centered approaches are encompassed in the philosophies of patient autonomy, patient experience, non-malfeasance, benevolence, and non-judgment, maintaining that the patient's needs and desires are the top priority. The assessment tool presented here is influenced by the aforementioned philosophies as well as the qualities of the "virtuous music therapist" including qualities such as caring, empathy, prudence, and courage, which undergird a sense of responsibility to clients that, in turn, prioritizes communication, dignity and respect, non-judgment and acceptance, and facilitating client autonomy (Dileo, 2000).

Musically speaking, the music therapist needs to maintain a constant awareness of the effect of music on the patients in order to maintain the ethical philosophies of non-malfeasance and benevolence. While music can evoke many positive emotions, memories, and experiences, it can also elicit negative or even traumatic emotions, memories, and experiences, as demonstrated through MEAMs (Cuddy et al., 2017). Although the positivity effect is thought to be dependent on individuals aging successfully (Cuddy et al., 2017), many patients on hospice care have not aged successfully due to issues such as poor health, loss of independence, isolation, and emotional distress (Dileo & Loewy, 2005; Hilliard, 2004; Hilliard, 2005; Krout, 2000; Maue-Johnson & Tanguay, 2006; NHPCO, 2019; Starr, 1999). This provides further reason to create a music preference assessment tool that analyzes the role music plays in the patient's life so as to better understand and prepare for memories and reactions brought on by a variety of musical stimuli including music with lyrics, instrumental music, preferred music, and even unfamiliar music. A thorough assessment of music preferences will help to provide the best care for hospice patients and avoid harm through accidental evocation of negative memories. Assessment of the ecosystems involved in the patient's past musical experiences and musical preferences in collaboration with the patient will lead to music selection that meets the patient's treatment goals and needs in the moment.

Social Work Theory and Philosophy Background

Dean and Poorvu (2008) discuss the social work idea of "person-in-environment" that transformed into the ecological model. "The ecological perspective emphasizes the dynamic transactions between people and the multiple social systems, subsystems, and

environments in which they participate…to determine if clients' interactions with their environments are enriching and supportive, or limiting and destructive" (p. 599). The perspectives of person-in-environment and ecological model are useful in music therapy assessment to understand and accurately assess the role of music for the patient and family. Rather than selecting a song because the patient likes the song, the music therapist can select a song because it is supportive to the patient and their goals. This proposed music therapy assessment tool combines the person-in-environment and ecological models in that it explains the patient's music preferences in their current environment, paralleling the person-in-environment idea, as well as its relation to other aspects of life, religion, culture, family, etc., representing the ecological model. This music therapy assessment tool is developed within the social work postmodern or constructionist orientation in that "multiple perspectives are utilized, based on the belief that all views are partial and that no single theory or perspective has a monopoly on the 'truth' of a situation. Clients' understandings and meanings are privileged, and the process of formulation involves collaboration between workers and clients" (Dean & Poorvu, 2008, p. 597). Another framework that informs this proposed assessment is the bio-psycho-socio-spiritual model, in which the four named dimensions of existence are explored (Graybeal, 2001). A strengths-based approach combined with the bio-psycho-socio-spiritual model empowers the patient to maintain dignity, autonomy, and self-determination throughout their treatment process.

Development of Music Preference Ecomap Assessment Tool

The current music therapy literature reflects a trend toward providing assessment and treatment in a population-specific manner, recognizing that a universal or global

assessment approach is often not the most appropriate and beneficial to inform individualized music therapy treatment (Churchill & McFerran, 2014). The Music Therapy Assessment Tool for Awareness in Disorders of Consciousness (MATADOC) and the Music Therapy Assessment Tool for Low Awareness States (MATLAS) are prime examples of music therapy assessments designed for specific population needs (Magee, 2007; Magee et al., 2016). The MATLAS states that generalizing the assessment across populations may not be appropriate (Magee, 2007). The same likely applies to the MATADOC, but there are ideas presented in both assessment tools that can be considered when assessing patients in hospice and palliative care such as patients' potential difficulty with communication and altered states of consciousness, especially in patients who are receiving artificial life support measures or are actively dying and no longer responsive to external stimuli. Churchill and McFerran (2014) offer suggestions for implementing assessment, which are relevant to the hospice population: keeping the assessment session brief, scheduling for a time when the patient is most wakeful and alert, allowing the patient ample time to respond, and collaborating with other team members.

Although this proposed assessment tool focuses on the area of musical experience and preference, it takes into account all the other areas of the client's culture discussed by AMTA, regarding assessment including race, ethnicity, language, religion/spirituality, socioeconomic status, family experiences, sexual orientation, gender identity, and social organizations (AMTA 2.0, 2.1, 2.2). This proposed assessment tool takes a holistic and community/systems approach to determining music preference. It goes beyond "what music do you like?" and truly seeks to identify the cultural work of music in their lives to

date. Though this project did not set out to focus on religious needs and preferences of hospice patients, research led to several social work studies, which focused on the religious component of care. This narrative reflects these findings.

The line of assessment questioning implemented in the Music Assessment Tool (MAT) (Chlan & Heiderscheit, 2009) leads directly to the goal of the present proposed music preference assessment tool: determining the role of a patient's music in their past and current life situations in order to discern, not only the patient's preferred music, but to collaborate with the patient to provide meaningful music selections and interventions that simultaneously align with the patient's musical preferences and work toward the patient's plan of care. In a manner similar to that of the MAT (Chlan & Heiderscheit, 2009), this proposed assessment tool is also meant to be utilized by an interdisciplinary team in order to inform treatment approaches from all disciplines involved in the patient's care.

The assessment tool proposed in this thesis will help to prepare the music therapist and patient to select music that will address the emotional and spiritual needs of the patient as well as foster open communication about these topics as they arise in relation to the music. Due to the short average stay of 48 days in hospice care, it is important to obtain assessment information quickly and efficiently (Maue-Johnson & Tanguay, 2006). This proposed assessment tool will lead directly into treatment during a single session or it can be flexible and act as a process-oriented form of treatment if the patient engages in verbal processing, reminiscence, or life review during the assessment process.

Norman (2012) suggested gathering as much information as possible from other treatment team members' assessments and background information on the patient in order to make the music therapy assessment quick and efficient. One drawback to this approach is that social service workers are not trained to properly assess music experience and preference. They may not know what questions to ask in order to obtain more specific information such as:

Are there any instruments or songs you do not like?

What is appealing to you about this singer?

Tell me what comes to mind when you hear this song.

Why do you prefer this singer over that singer?

Assessment of music preferences is included in many music therapy assessments. Assessing music preference is important in the assessment process according to its frequent appearance in existing assessment tools (Churchill & McFerran, 2014). Although the assessment tools referenced "provided opportunity to document an individual's musical preferences…" (Churchill & McFerran, 2014, p. 21), the assessment tools do not appear to provide an opportunity to document the role of musical preferences within the clients' ecosystems. Welch (1974) reported that preferred music can vary dependent on the purpose of the music. "Music for worship may be the basis for one set of preferences, while music for relaxation may constitute another set of preferences" (Welch, 1974, p. 6). In this example, music preferences are considered within the context of the use or purpose of music, performing medium, mood, or musical elements such as tempo, dynamics, rhythm, and melody.

Besides acknowledging the context and role of music in a patient's ecosystem, a key element in determining music preference is discerning the difference between familiar music and preferred music. Familiar music can be defined as "a piece of music a client previously listened to" and preferred music as "a piece of music a client likes more than other pieces of music" (Han, 2018, p. 28). Although some music therapists use these two terms interchangeably, it is important to note that although a client may be familiar with a piece of music, the client may not prefer this music. The author also notes that a person's musical preferences can change throughout a lifetime and vary with personal circumstances. "For the music therapist, it is important to understand the difference between familiar music and preferred music, and to consider what music is best for the client in the specific context when choosing and offering music choices, rather than using music that music therapists think clients may know" (Han, 2018, p. 38). This thesis aims to take a more individualized approach to determine preferences based on a systems approach and to provide opportunities for patient autonomy and self-determination.

The current literature on development of music therapy assessment tools outlines the process for creating and testing assessments. The steps involved include reviewing relevant literature, drafting and editing the assessment tool, presenting the assessment tool, and providing a case example of the assessment tool in use. Following the use of the assessment tool, its effectiveness should be determined in a process that identifies strengths and limitations and provides recommendations for further standardization of the assessment tool and need areas for further research (Economos et al., 2016).

Proposed Assessment Guidelines

While other assessments have recommended music therapists seek some information regarding music preference and music experience from patients' family and close friends, information from these sources can often be incomplete or incorrect. Family and friends could easily confuse familiar music and preferred music and provide suggestions for familiar music, which could dredge negative MEAMs for the patient (Han, 2018; Cuddy et al., 2017). During my own clinical practice, I frequently treat patients whose supposed music preferences were listed on a referral form or provided by family members. Often these provided "preferences" were found to be incorrect when the patient was assessed for music therapy. Many times the preferences provided by a patient's loved ones were familiar music but loved ones were not always aware of the patient's actual musical preferences. Of note, the guidelines of the MAT suggest that prior to assessing the patient, the music therapist should consult with the nurses and treatment team to gather as much information as possible so as to not ask the patient for information that has already been communicated to the team. This may include information such as how the patient is able to communicate: eye blinks, head nods, written communication, verbal expression, or any other information that may be pertinent to conducting the music preference assessment. The MAT assessment tool includes a variety of question types including yes/no questions, closed-ended questions, and open-ended questions in order to accommodate different communication abilities and styles.

One consideration for which the MAT allows is determining which information is most pertinent and which can be only obtained from the patient. The author suggests that the music therapist focus on these questions first with the patient and gather other

information as possible from treatment team members, family members, or others who are familiar with the patient's preferences (Chlan & Heiderscheit, 2009, p. 46). For patients who are experiencing fatigue or altered states of consciousness, these tactics would be helpful in gathering information for music preference assessment. For this proposed assessment tool, collaboration between the music therapist other treatment team members, including but not limited to, social workers, chaplains, hospice volunteers, nurses, and physicians as well as the patients' loved ones is recommended. Although information gathered from these sources may not be as reliable as information gathered from the patient directly, collaboration with team members to gain a deeper understanding of the patient's needs is necessary; the music therapist should understand that collaboration with interdisciplinary team members and a patient's family does not replace direct assessment of the patient by the music therapist. Each team member has a unique relationship and experience with the patient and may be able to offer information or insight that other team members have not gleaned from the patient.

The music preference assessment presented in this thesis is not intended for use with all hospice patients and families although there are ways to modify the interview questions to utilize the assessment with a wider scope of patients in hospice care. This thesis focuses only on the use of the assessment tool with alert, verbal hospice patients who are able to answer a mixture of yes/no questions, closed-ended questions, and open-ended questions. For the purpose of this use of the assessment presented, the hospice patient should be *oriented to person*, at the least. The patient does not necessarily need to be oriented to place, time, or situation in order to actively participate in this assessment. It is advisable to conduct this assessment during the initial assessment visit due to the

nature of hospice care; patients may decline quickly, making it difficult to participate in the assessment during subsequent visits or the patient could die before the next scheduled visit. During assessments, music therapists generally create their own interview questions and utilize structured or free flowing interview styles depending on the therapeutic style or client's needs (Jacobsen et al., 2019). The interview questions provided in the Musical Preference Ecomap Assessment Tool Manual in Appendix C on pp. 54-57 are suggestions but each music therapist may revise these questions or create their own questions relevant to the patient's needs and situation.

Ecomap Construction

The ecomap will be completed in collaboration with the patient. In order to ensure validation of the data represented in the ecomap, the ecomap should be completed in view of the patient so they can verify the interpretation of the data collected (Ray & Street, 2005). The music therapist can provide general information on the process of ecomapping so that the patient can be empowered to participate in the creation of the diagram and in the creation of their treatment plan. The ecomap can be completed in one visit or over the course of multiple visits with the patient. The advantage to completing the assessment over multiple visits is that the patient can process the elements and relationships involved in their music identities and can add or edit information in subsequent visits. A drawback to completing the assessment over multiple visits in the hospice setting is that the patient could experience a rapid decline or pass away before the ecomap is completed. The music therapist should decide on a timeframe for ecomap completion based on the patient's clinical presentation of needs and whether or not the

patient requires more time to engage in verbal processing during the completion of the ecomap.

The general format of the ecomap involves a circle in the center of the paper depicting the patient and their musical identity. In keeping with conventional ecomap construction, the significant systems related to the patient's musical identity will be placed in circles on the outer edges of the paper surrounding the patient's central musical identity circle. Several musical ecosystem factors influencing a patient's musical identity include musical ecosystems of heritage, generation, religion or spirituality, location, and experience (Belgrave, 2018; Kim & Whitehead-Pleaux, 2015). Figure 3 demonstrates an assessment template with the musical ecosystem and identity circles included. Table 1 describes the type of information included in each identity circle, which can be gathered through assessment questions such as the ones provided in Appendix C on pp. 54-57 in the Music Preference Ecomap Assessment Tool Manual. Hodge (2005a) describes in his "Developing a Spiritual Assessment Toolbox…" article that in regard to including additional information in the diagram, "descriptive encapsulations, significant dates, or other creative depictions, can also be incorporated onto the map to provide more information about the relational dynamics" (p. 320).

An example of a completed music preference ecomap assessment is provided in Figure 4. The use of the lines and arrows in this example demonstrate that the patient has a strong relationship between music experience and current musical identity. This patient has a conflicted relationship between religious musical identity and current musical identity. The notes provided indicate that the patient is currently an atheist and finds religious music aggravating. This is essential information for the music therapist; it may

trigger a need for verbal processing of past experiences with religious music and it also informs the selection of music for this patient. The music therapist would avoid utilizing familiar religious music with this patient. The ecomap also features a dotted line between the generation ecosystem and identity, suggesting that the patient does not particularly identify with popular music from his early adult years. The bi-directional arrow between the location ecosystem and identity communicates that the music from the patient's home in Alabama influenced the patient's musical identity and the patient also influenced the local music culture by performing in bluegrass groups. The patient's heritage ecosystem shows an arrow toward his identity because his family's background in bluegrass music directly influenced his own musical identity. The ecomap depicts a thick line between the experience ecosystem and identity to show a strong relationship between his music experiences and his current musical identity.

From a brief review of this sample music preference ecomap assessment, some clinical determinations can be made about which music might be effective or ineffective with this patient depending on the patient's treatment goals. For instance, if a family member had suggested that the patient might enjoy some religious music because he grew up listening to it and the music was familiar, it would be apparent by looking at this ecomap that this familiarity does not equate to preference. The music therapist may also want to consider whether or not to utilize bluegrass music; this may involve a conversation and verbal processing with the patient. If the patient is no longer able to play the music himself and is grieving the loss of his performance ability, it may not be prudent to utilize bluegrass music for relaxation; however, if the patient wants to verbally process this loss, it might be appropriate to utilize this music.

While there are some variations in the literature on the types of lines used to illustrate relationships on the ecomap, the line key shown in Figure 1 are the lines utilized in this proposed music preference assessment. The thickness of the lines used depicts the strength of the relationship with the thickest line representing the strongest or most intimate relationship and the dotted line representing a tenuous relationship. The zigzag line is utilized for conflicted or troubled relationships. The arrowheads are used to demonstrate a flow of energy or resources and two arrowheads can be used to denote a bidirectional or reciprocal relationship. A jagged or squiggly line is used for conflicted relationships (Hodge, 2005a; Ray & Street, 2005).

Implications for Practice

This proposed assessment tool may be useful to implement in conjunction with other assessments for the purpose of gaining a deeper understanding of music preferences in the context of a broader music therapy assessment. The MATADOC provides subscales for each assessment category including items such as responses to type of auditory stimuli (voices, single musical sounds, more complex musical stimuli) and familiar music known to be meaningful to the patient. Magee et al. (2016) does not describe how information on familiar music was obtained or assessed. In cases of patients in hospice care with low states of consciousness, it would be useful to complete a modified version of this proposed assessment with the patient's family system in order to determine music that would be familiar and have personal meaningfulness for the patient prior to completing an assessment such as the MATADOC with the patient, as the "preferred" music would be utilized in the MATADOC.

The goal of presenting an assessment tool like this in the field of music therapy is to further the thinking of clinicians about the dynamic relationships in the patients' ecosystems and environments that affect treatment. Music preference is not a simple assessment item that can be determined with a generic and vague question. As music therapists strive to provide culturally-informed and truly individualized care for hospice patients, it is crucial to understand the role that music plays in the patient's ecosystem. This deeper understanding allows the music therapist to provide competent care that will support and empower the patient by facilitating self-determination and autonomy. Because clinicians in other helping professions can easily read an ecomap, this assessment tool is inherently collaborative and will inform the care provided by the other members of the patient's hospice team. Music therapists may find that by increasing their literacy of ecomaps and other assessment tools in related fields, they will glean more information from other interdisciplinary team members and have enhanced collaboration with the team. Through a deeper understanding of patients' relationships to music, music therapists can facilitate a more meaningful experience and increase quality of life for patients in hospice care.

Using the Assessment Tool

Located in Appendix C is a manual for using the assessment tool including a sample of how to use this assessment with considerations for completion during one session, post-session, and across multiple sessions. Suggestions include utilizing questions developed by this author as well as prompts for how to develop questions on your own. Considerations for validity and reliability are provided.

Next Steps

Now that this assessment tool has been created, future research can be conducted to refine the assessment tool and collect data. In order to test face validity, a panel of music therapists can provide their opinions on whether the assessment tool measures the intended concept (Heale & Twycross, 2015). Validity can also be tested in the following ways: triangulation, member-checking, thick description, prolonged time, and peer briefing as described by Phillips (2008):

> Triangulation: three concurrent analyses used to verify any given set of data. Member-checking: accuracy of data checked using feedback from participants. Thick description: conveys the findings in such a rich format that readers can experience the setting….Prolonged time: researcher spends in-depth time understanding the topic by spending a greater amount of time in the field. Peer briefing: involves another person (a peer debriefer) to review and ask questions about the data (p. 88)

Triangulation can be achieved through collection of data from multiple sources such as chart review, interviews with family, collaboration with interdisciplinary team members, and interview with patient. Member-checking can be achieved through active listening techniques during the assessment. The music therapist can reflect the patient's responses through paraphrasing, summarizing, and asking for clarification. Periodically, the music therapist should check in with the patient and ask questions such as "Is that right?" "Do you feel like this represents your relationship to the music?" Thick description can be achieved through a multidimensional approach to documenting responses including graphic, textual, and pictorial representations of the patient's responses. Prolonged time can be achieved when the assessment tool is administered across multiple sessions. Peer briefing can be achieved through interdisciplinary collaboration with other team members. The team members can ask clarifying questions of the music therapist or the

patient. In terms of reliability, the attribute of stability, in which repeated use of the tool will provide consistent results, can be used (Heale & Twycross, 2015). Stability can be tested through rephrasing questions and completing the assessment over multiple sessions to confirm the patient's responses.

The next step toward the clinical use of this assessment tool would be to create a focus group of interdisciplinary hospice team members including social workers, chaplains, nurses, physicians, and music therapists to provide input on which items should be included or excluded from the assessment tool and to rate the user-friendliness of the tool. Following the focus group, field-testing can be completed (O'Kelly & Bodak, 2016). After implementations of the assessment tool in the field, the interdisciplinary team should reconvene to discuss the results and discuss the effectiveness of the assessment tool including its strengths and need areas, which will lead to further standardization of the assessment tool and documentation of patient responses (Economos et al., 2016). At this point, needs for further research would be identified in order to ensure reliability and validity of the assessment tool. Considering the personal and individualized subject matter explored through this assessment tool, both qualitative and quantitative data would be necessary to fully evaluate the effectiveness of the assessment.

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APPENDIX A

TABLES

Table 1
Cultural Identity Items

Culture of Location	Culture of Heritage	Culture of Religion	Culture of Generation	Culture of Identity	Role of Experience
• Places lived • Local music traditions and styles	• Where parents or grandparents were born and raised • Musical traditions in family • Other ancestral information	• Musical traditions or rituals • Types of instruments involved • Music for holidays and celebrations	• Decade of birth • Decade during patient's 20s • Popular music during patient's 20s	• Music to which or with which the patient listens or engages currently	• Previous music making experience • Previous music listening experience • Instruments played • History of songwriting or performance • History of music education

Belgrave, 2018; Kim & Whitehead-Pleaux, 2015

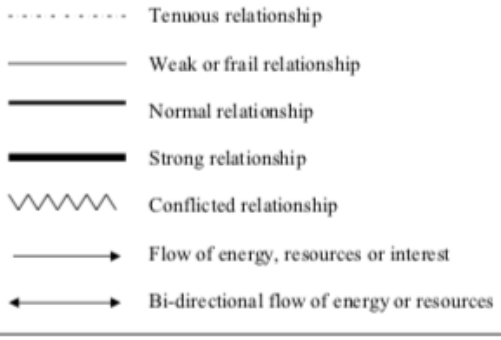
Note. The first five areas of culture are taken from Kim & Whitehead-Pleaux (2015). This author added the Role of Experience.

APPENDIX B

FIGURES

Figure 1
Ecomap Relational Diagram Key

Table 3
Depicting Relational Information in Diagrammatic Form



Hodge, 2005a, p. 348

Figure 2
Social Work Spiritual Ecomap Assessment

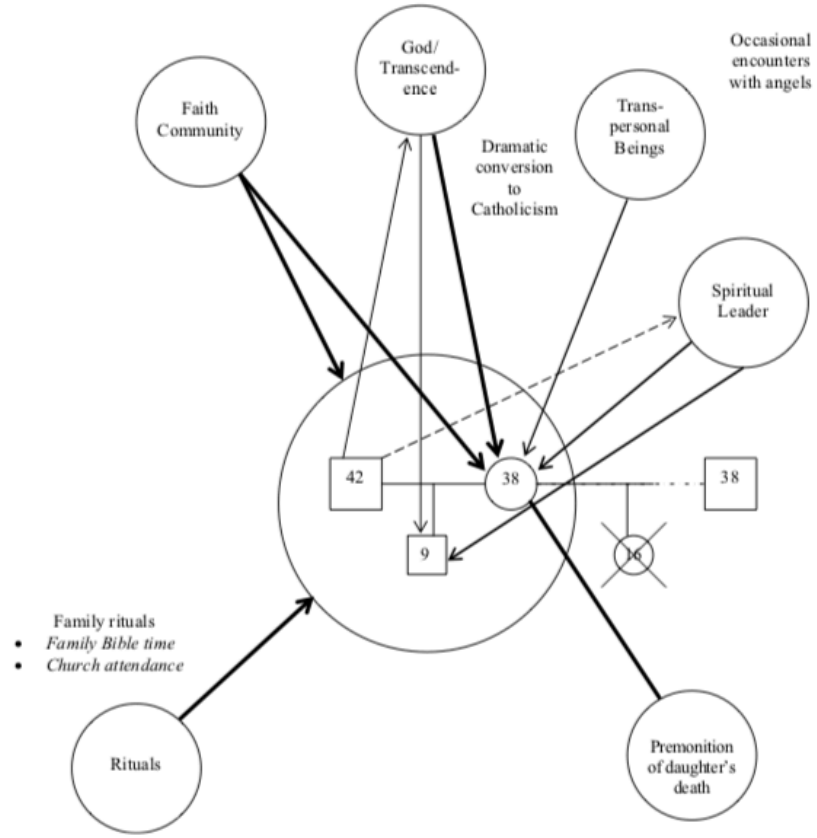


Figure 3. Adapted from Hodge (2000)

Hodge, 2005a, p. 349

Figure 3
Music Preference Ecomap Assessment Template

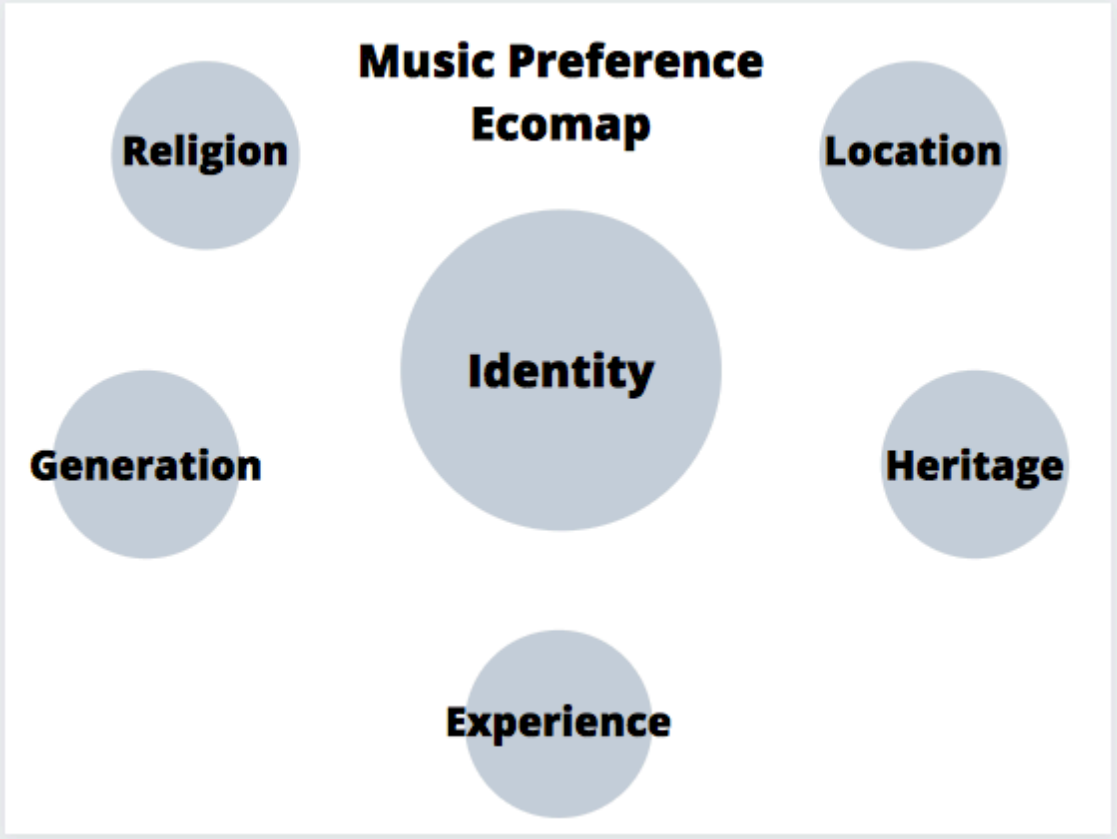
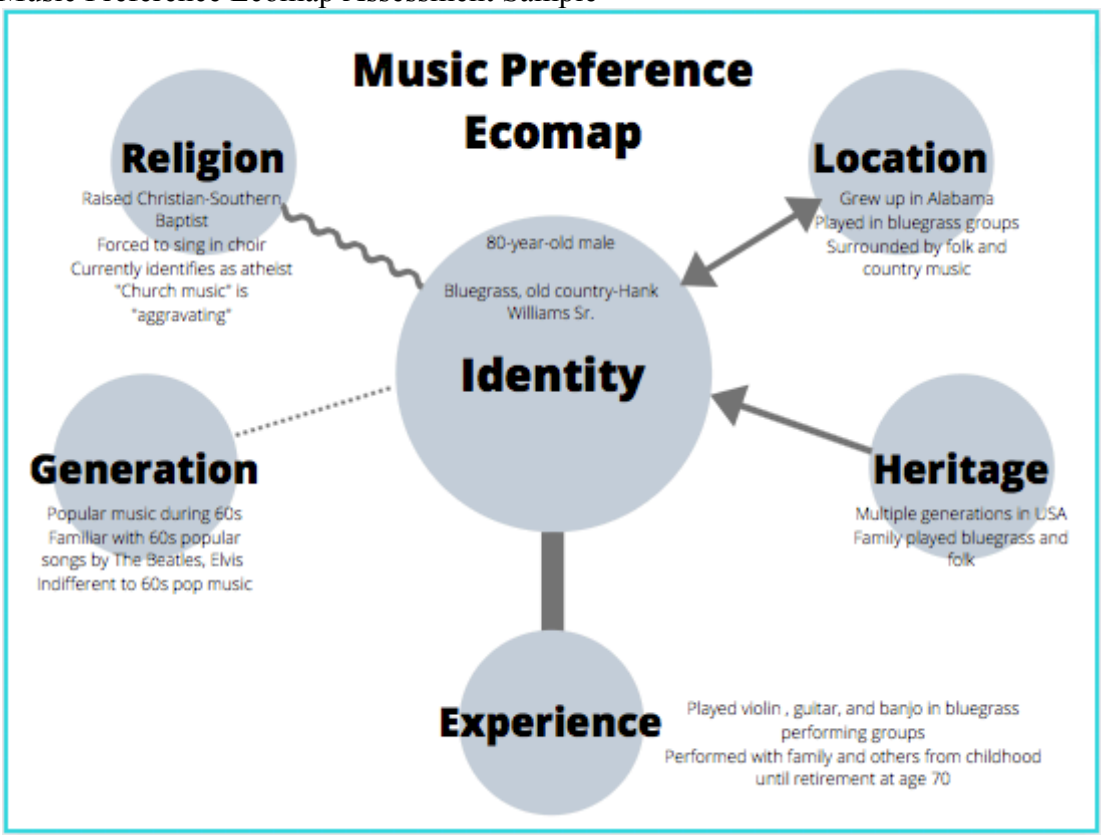


Figure 4
Music Preference Ecomap Assessment Sample



APPENDIX C

MUSIC PREFERENCE ECOMAP ASSESSMENT TOOL MANUAL

Music Preference Ecomap Assessment Tool Manual

This manual describes the process of implementing and constructing the Music Preference Ecomap Assessment Tool. It provides guidelines and suggestions for compiling materials, gathering assessment information, utilizing and creating assessment questions, and creating the ecomap. Included are figures and explanations for an assessment template, ecomap elements key, an example of a completed assessment, timelines for completion of the ecomap, implications for clinical practice, and considerations for validity and reliability for the assessment tool.

Materials:

- Music Therapy Referral: Depending on the policies and procedures of your organization, you will need a formal music therapy referral before proceeding with the music preference ecomap assessment.
- Patient's Chart: You will need to review the patient's chart including background and demographic information, interdisciplinary team assessments and treatment notes, and the patient's plan of care.
- Patient Communication: If the patient needs any additional technology or materials to communicate, arrange to have those items for the patient during the assessment. Some examples include pen and paper for written communication, iPad or Augmentative Communication Device, or a translator.

The Music Preference Ecomap Assessment Tool can be completed digitally or by hard copy. Required and optional materials for hard copy and digital creation are listed below. Materials are required unless specified as optional.

- Hard Copy
    - Paper: Typical 8.5”x11” copy paper will suffice but the music therapist can utilize other sizes and types of paper such as cardstock or construction paper. Due to the amount of information included in the assessment tool paper smaller than 8.5”x11” is not recommended. For patients with visual impairments, consider utilizing a larger sized paper or even a poster board so that the patient may see the ecomap.
    - Pen or Pencil: Any color pen or pencil can be used so long as it is clearly visible on the paper you are using.
    - Crafting Supplies (optional): You may wish to utilize additional craft supplies such as colored pencils, markers, stickers, stamps, or any other craft supplies you or the patient deems fit. Color-coding of each musical identity ecosystem may be helpful in organizing the assessment tool. If the patient is actively participating in the construction of the ecomap, you can offer artistic choices such as drawing meaningful symbols or illustrations, using different fonts or calligraphy, or utilizing construction paper or other embellishments.
- Digital Copy
    - Device: You may be able to use a computer, tablet, or smart phone to construct the ecomap. Be mindful that whichever device you select should provide the patient with the ability to see the ecomap to provide feedback about the validity of the information included. Being able to

enlarge the graphic might be useful for patients with visual impairments.

- Program, Application, or Website: You will need a platform that supports the utilization of a combination and variety of text and graphics included in the key such as circles, several types of lines with varying thicknesses, and arrows. The platform should allow you to change the size and position of each element.
- HIPAA Compliant Storage: When serving hospice patients in the United States of America, the ecomap assessment must be saved and stored in a manner and location that is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). More information can be found on the U. S. Department of Health & Human Services webpage at https://www.hhs.gov/hipaa/index.html

  If you are serving hospice patients in other countries, you should adhere to the policies and regulations in the country where you are serving the patient.
- External or Cloud Backup (optional): If you plan to save the ecomap electronically, backing the file up to an external drive or cloud-based drive is important in case of corruption or loss of the original file. All backups should comply with HIPAA rules as described above.

Gathering Assessment Information

Chart Review: Reviewing the patient's medical chart and records can provide a jumping-off point for selecting or developing interview questions for the patient. You may

find demographic information or important life events and relationships described in the chart. Interdisciplinary assessments and the patient's existing plan of care can provide insight into the patient's current status and needs. This will guide your interview of the patient and will help you avoid asking the patient for basic information they have already provided to the hospice team.

Primary Source: The patient is the primary source for assessment data. No one knows or understands the patient's musical identity and preferences better than the patient. If you are provided with information related to the patient's musical identity and preferences from secondary sources such as a patient's loved ones, chart review, or an interdisciplinary team member, it is prudent to review this information with the patient. The patient will be able to confirm or deny this information and provide context in regards to their connection with the music.

Patient Orientation and Alertness: The patient needs to be awake, alert, and oriented to at least the self in order to engage with this assessment tool. The patient should be able to respond and engage with yes/no questions, closed-ended questions, and open-ended questions.

Efficiency of Assessment: Due to the inherent nature of hospice and the expectation that patients will experience decline and death, assessments should be completed thoroughly but quickly. This assessment is ideally completed in one session but it can be completed over multiple sessions. If you are completing the assessment over multiple sessions, attempt to gather a base of information for each ecosystem during the initial session; then, gather in-depth information and add symbols and other artistic items during subsequent sessions.

Assessment Questions

The assessment questions in this manual include general questions about music preference as well as ecosystem-specific questions. Assessment questions were written by this author based on questions and cultural identity information developed by Belgrave (2018) and Kim and Whitehead-Pleaux (2015).

The general questions in the Initial Music Preference Brief Assessment section should guide the music therapist in which questions to ask in the Musical Identity Ecosystem-Specific questions section.

These provided questions are suggestions. You can utilize these questions, revise them, or create your own to meet the assessment needs of each patient. In order to develop rapport with patients, questions should be asked in a conversational manner when possible, asking follow-up questions as appropriate based on patient responses. Utilizing active listening techniques such as validation, paraphrasing, summarizing the patient's responses, as well as appropriate body language including head nods and facial expressions will help build rapport with the patient also. Use the patient's language when possible. For example, if the patient refers to a higher power as "God," use "God" when asking questions regarding a higher power. If the patient uses the term "speed" instead of tempo, adopt "speed" in your language with the patient.

Please refer to the Reliability and Validity section of this manual for considerations when changing or creating assessment questions.

Initial Music Preference Brief Assessment Questions and Prompts:

- Tell me about any music you currently experience (i.e. recorded music listening, live music listening, experiential music).
- Do you have a favorite song? Artist? Band? Genre?
- What music helps you to relax?
- What music do you find to be energizing?
- On a scale of 1 to 5 (1 being very relaxed and 5 being very energized), how do you feel when you hear your favorite music as answered above.
- Tell me about any music or instruments that you dislike or would not prefer to hear.

Musical Identity Ecosystem-Specific Questions and Prompts

- Location
    - Tell me about where you have lived.
    - What music surrounded you in these locations?
    - Tell me about the connection you felt with the music in these places.
    - Do you feel supported by this music?
    - What memories come up for you when you hear this music?
- Heritage
    - From where are your parents? Grandparents? Where did they grow up? Is there a history of immigration?

    - What music (songs, styles, genres, artists, instruments, music experiences) was associated with your parents' and grandparents' heritage?
    - What songs do you remember singing or playing with your family?
    - What memories to do you associate with music and your family growing up? How do you feel when you think of these memories?
    - Tell me about any other musical traditions or experiences you had with your family.
    - How does the music from your family tie into your current musical identity?
- Religion
    - Tell me about the role religion, faith, or spirituality plays in your life.
    - What music (songs, styles, genres, artists, instruments, music experiences) is associated with your religion, faith, or spirituality?
    - Is there any music you consider sacred?
    - What music makes you feel the most connected to your higher power?
    - Is there any music that you find offensive or inappropriate?
    - Does your religious music support your current musical identity?
- Generation
    - In what decade were you born?
    - What music was popular during your 20s?
    - Did you listen to popular music during your 20s? If not, what music were you listening to as a teenager and young adult?

    - What memories do you associate with the music you listened to in your 20s?
    - Do you still listen to this music?

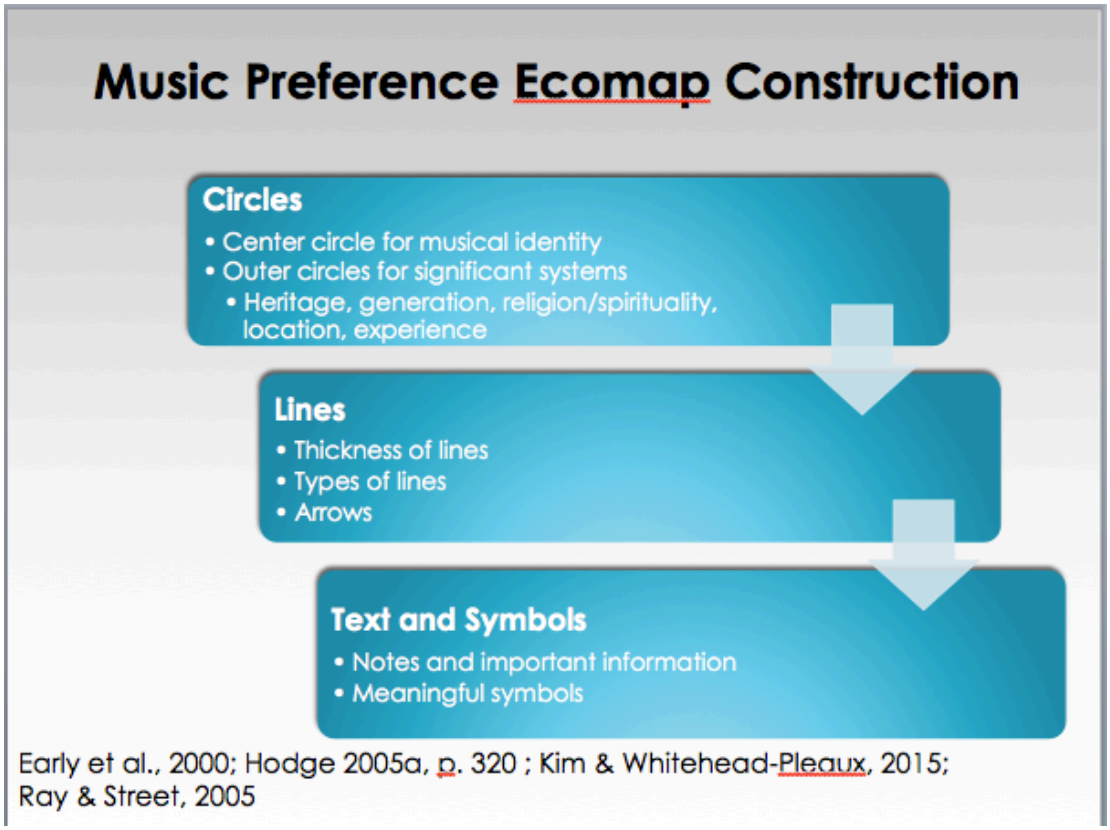
- Identity
    - What music do you listen to or participate in currently? Why?
    - What impact does music have on your life?
    - How do you use music to support yourself?
    - Musical Elements
        - What draws you to the music you enjoy?
        - Do you like the original recording or a cover?
        - Are the lyrics in a song important to you?
        - What is the most important thing to you about music (i.e. musical elements: tempo, instruments, melody, lyrics, rhythm, etc.)?

- Experience
    - What formal or informal experience do you have in active music making? Include participation in choirs, bands, orchestras, karaoke, drum circles, school music classes, musical theatre, music lessons, etc.
    - Tell me about your experience listening to music. Did you attend live performances, listen to recordings, etc.?
    - Have you played any musical instruments?
    - Have you composed any music or performed music?

Construction of the Ecomap

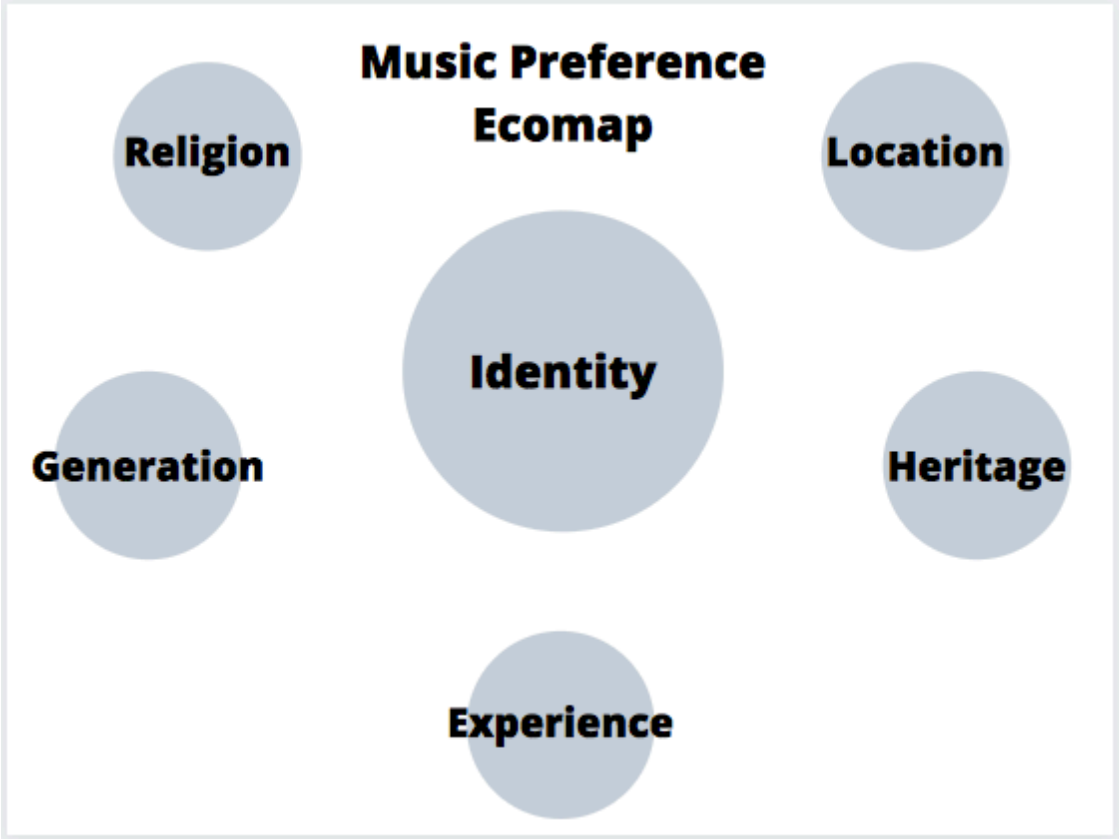
Ecomap Elements: The ecomap consists of circles for musical identity and related ecosystems, a variety of lines and arrows, and text, as described in the slide below. It is optional to include meaningful symbols or other pictorial and creative elements in the ecomap. Figure 1 shows the elements of the ecomap.

Figure 1



Assessment Template: Below, in Figure 2, is an example of a template for this assessment tool including the circles for musical identity and the related ecosystems. Lines and text will be added to describe relationships between musical identity and each ecosystem.

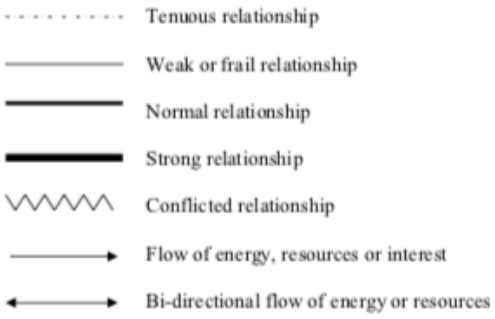
Figure 2
Music Preference Ecomap Assessment Template



Relational Diagram Key: The types of lines and arrows utilized to describe relationships between ecosystems and musical identity are defined in Figure 3. Patients might possibly create their own additional graphic elements in order to illustrate a unique situation or relationship. If the patient creates a new element or line for the ecomap it would be helpful to include a note or key directly on the ecomap to define it for other team members reading the ecomap.

Figure 3
Ecomap Relational Diagram Key

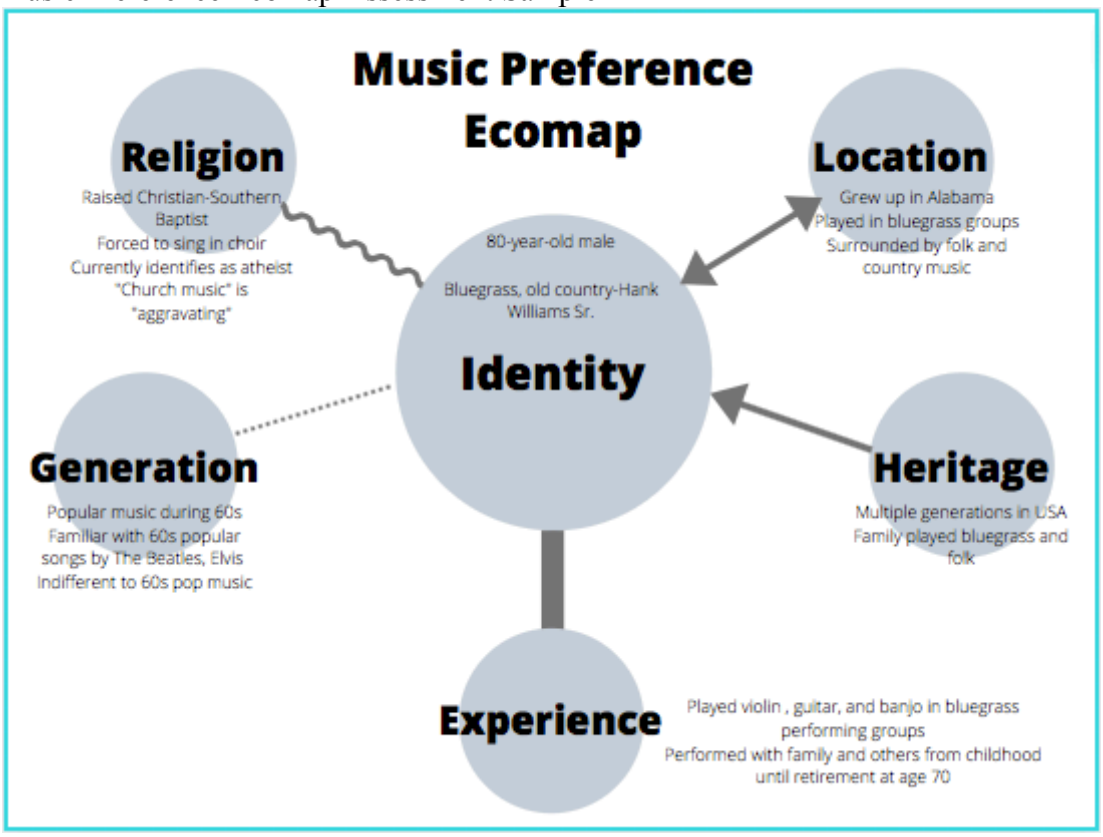
Table 3
Depicting Relational Information in Diagrammatic Form



Hodge, 2005a, p. 348

Completed Assessment Example: Figure 4 shows an example of a completed Music Preference Ecomap. An explanation of the elements used follows Figure 4.

Figure 4
Music Preference Ecomap Assessment Sample



Identity: Included in the patient's Identity circle are basic demographic information and his self-reported preferred music. The patient is 80 years old and prefers bluegrass music and old country music such as Hank Williams Sr. The relationships between his musical identity and his musical ecosystems are described below.

Religion: This patient reported that he was raised in a Southern Baptist family and was forced to sing in church choir against his wishes as a child. He finds religious music aggravating and currently identifies as an atheist. The zigzag line between the patient's Identity and his Religion ecosystem represents the conflicted relationship due to the conflict between his upbringing and his current belief system. Religious music would be contraindicated for this patient.

Generation: Popular music during the patient's adolescent and young adult years included popular music of the 1960s. The patient reported that he is familiar with songs by The Beatles and Elvis but that he is indifferent toward 1960s popular music. The dotted line between the patient's Identity and his Generation ecosystem indicates the tenuous relationship, as the patient does not identify with the music of his generation.

Experience: The patient shared that he played violin, guitar, and banjo in bluegrass performance groups with family and others. He has played music since he was a child and continued until he retired at the age of 70. The strong relationship between the patient's Identity and Experience ecosystem is shown by the thick line between the circles.

Heritage: The patient's family played bluegrass and folk music. They have been in the United States of America for multiple generations. The arrow

pointing from the Heritage ecosystem to the patient's Identity demonstrates the flow of resources and interest from the Heritage ecosystem that affected his musical Identity.

Location: The patient grew up in Alabama and played bluegrass music. He was surrounded by folk and country music. The arrows placed at each end of the line between Identity and the Location ecosystem illustrate the bidirectional flow of energy and interest between the patient's current musical identity and his location. His performances provided support to the local music scene in Alabama and the Location ecosystem affected his musical identity, as he reported his preferred music to be country and bluegrass music.

Timeline for Completing and Documenting the Ecomap

During one session: The Music Preference Ecomap Assessment Tool can be implemented and documented during one visit with a patient. Completing the assessment tool within one session ensures that the needed information is gathered prior to patient decline or death. In this scenario, the music therapist documents the ecomap during the session with the patient. The patient can verify the information documented throughout the process and actively engage and collaborate with the music therapist to depict the patient's musical identity and preferences.

Post-Session: The ecomap can be documented following the session. The assessment questions would be asked during the session. This option can be beneficial if documenting the ecomap interrupts the development of rapport with the patient or the natural flow of conversation as the assessment interview progresses. An important consideration if you are documenting following the session is that it may be difficult to remember important details. If at all possible, the music therapist should review the completed ecomap with the patient during the next session to ensure validity and understanding of the patient's musical identity and preferences.

Across two or more sessions: This assessment tool can be completed over multiple sessions. First, consider that hospice patients' ability to engage with this assessment tool can change rapidly due to factors such as decline, change in location, and death. If you complete the assessment tool over multiple sessions, it is important to gather enough information during the first session to inform music therapy treatment in case the patient is not able to engage with the assessment tool after the first session. An advantage to this method is that it allows for the patient to have ample time to engage in verbal processing and deeper exploration of topics that arise during the assessment. This method also provides an additional opportunity to establish reliability by asking the same assessment

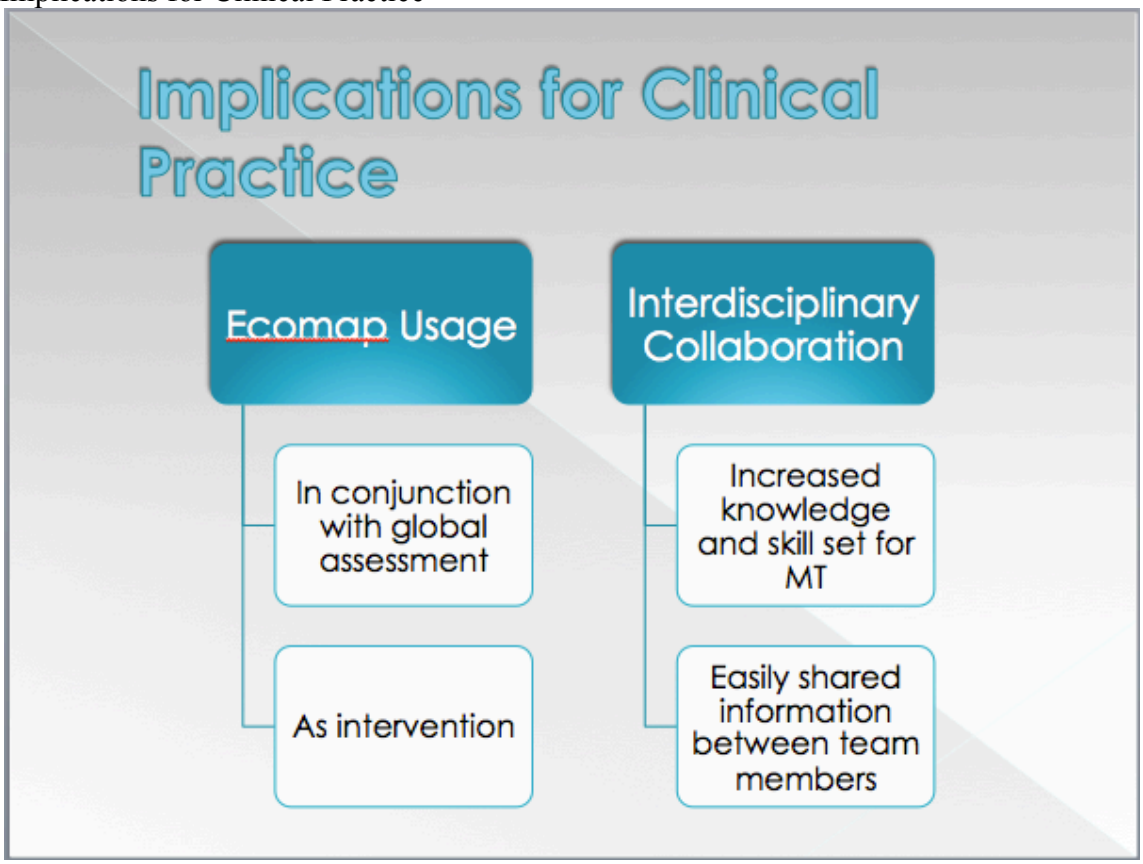
questions over multiple sessions to demonstrate stability in patient responses. Refer to the Reliability and Validity section on pp. 66-68.

Implications for Clinical Practice

Ecomap Usage: The ecomap is not a global assessment for hospice patients. This tool assesses the role of music preference in the context of the hospice patient's multidimensional musical ecosystem identity. This assessment tool should not replace a thorough music therapy assessment but should be used to augment the understanding of how to effectively utilize music with the patient. This assessment tool can also be utilized as an intervention. The questions used in this assessment tool can lead to reminiscence, life review, and verbal processing to work toward goals such as life closure, increased quality of life, and increased feelings of personal meaningfulness.

Interdisciplinary Collaboration: The knowledge and skill set required of music therapists to utilize this assessment tool also allow music therapists to read and interpret ecomaps in patient charts that were completed by interdisciplinary team members. Since some other interdisciplinary team members understand the ecomap structure and documentation, this assessment tool provides accessible information for other team members that they may not have noticed in a solely narrative assessment.

Figure 5
Implications for Clinical Practice



Reliability and Validity

Reliability: The attribute of reliability that applies best to this assessment tool is stability. Stability is when the repeated use of the tool provides consistent results (Heale & Twycross, 2015). Stability can be tested through rephrasing questions and completing the assessment over multiple sessions to confirm the patient's responses.

Validity: The validity categories and definitions are directly quoted from Phillips (2008, p. 88). Strategies for validity testing in this assessment tool are created by this author.

- Triangulation: three concurrent analyses used to verify any given set of data.
    - This can be achieved through collection of data from multiple sources such as chart review, interviews with family, collaboration with interdisciplinary team members, and interview with patient.
- Member-checking: accuracy of data checked using feedback from participants.
    - This can be achieved through active listening techniques during the assessment. The music therapist can reflect the patient's responses through paraphrasing, summarizing, and asking for clarification. Periodically, the music therapist should check in with the patient and ask questions such as "Is that right?" "Do you feel like this represents your relationship to the music?"
- Thick description: conveys the findings in such a rich format that readers can experience the setting.
    - This can be achieved through a multidimensional approach to documenting responses including graphic, textual, and pictorial representations of the patient's responses.
- Prolonged time: researcher spends in-depth time understanding the topic by spending a greater amount of time in the field.

    - This can be achieved when the assessment tool is administered across multiple sessions.
- Peer briefing: involves another person (a peer debriefer) to review and ask questions about the data.
    - This can be achieved through interdisciplinary collaboration with other team members. The team members can ask clarifying questions of the music therapist or the patient.

APPENDIX D

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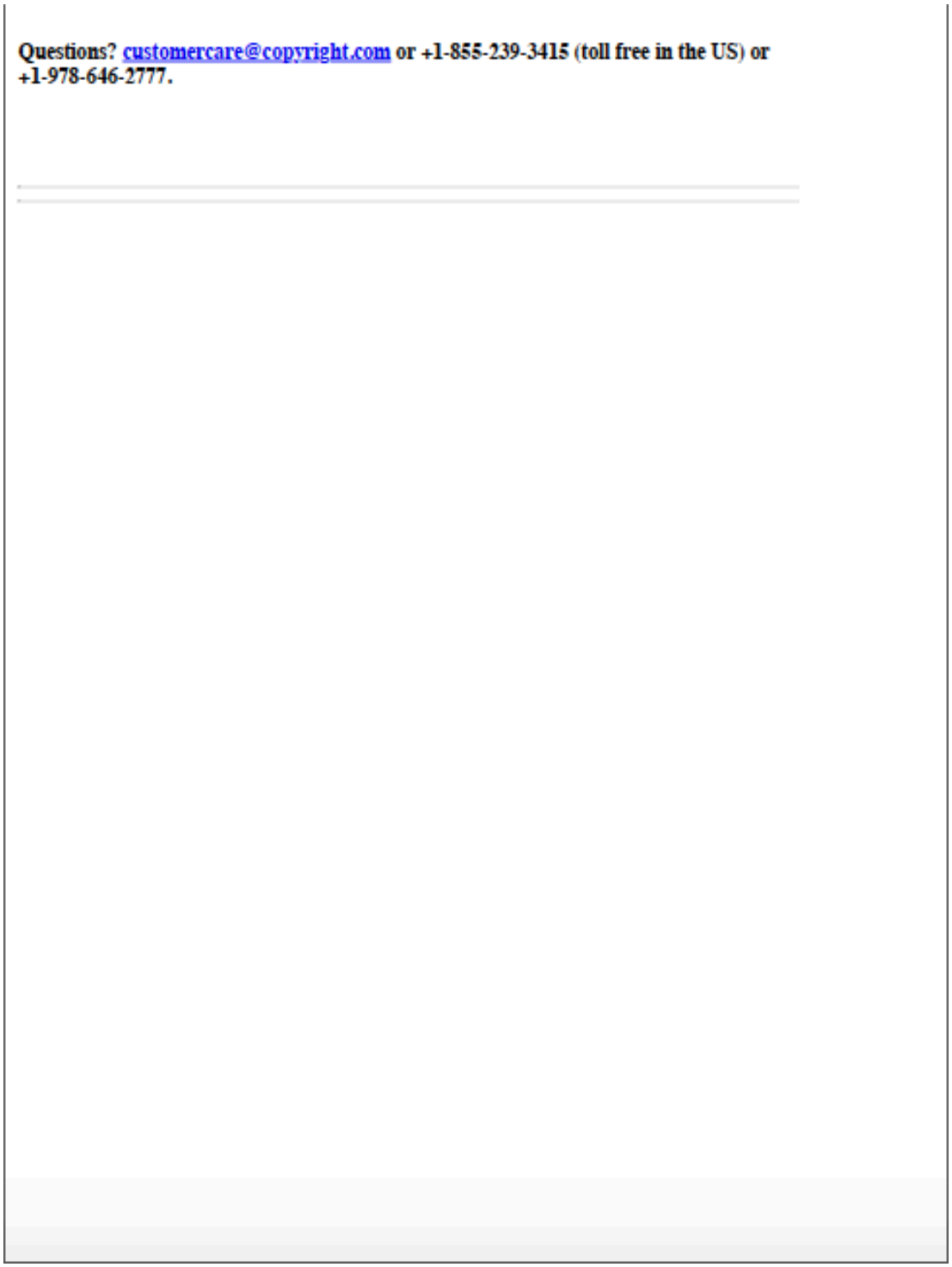

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