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Theme and variations on quietness: Relaxation–focused music and imagery in aged care.

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Abstract

Addressing a resident-stated need, a relaxation-focused music and imagery (RFMI) program was devised for a 43-bed aged care hostel, based on principles of the Bonny Method of Guided Imagery and Music (GIM). In the typically stressful and disruptive setting of community living, relaxation is known to assist with the management of physical and emotional symptomatology such as sleep disorders, grief and loss, pain, anxiety, depression, and post-traumatic stress disorder. The RFMI program was reviewed after twelve months of implementation to assess clinical effectiveness, using predominantly self-report data to reveal effectiveness and impact. Review participants comprised 14 regular program attendees aged 51 to 98 years ($M = 79$ years, $SD = 11.2$ years; 4 male, 10 female). The primary evaluation tool was a self-report questionnaire (Relaxation in Music and Aged Care, RMAC), which was complemented by other existing clinical data. Analysis of data from this mixed method review process utilized descriptive statistics and thematic analysis. Results showed evidence of the RFMI program addressing clinical problems and enhancing facility-wide treatment processes via an increased awareness of relaxation and enhanced feelings of physical and emotional well-being. Despite study limitations, these results highlight the importance of relaxation and music activities in residential aged care, indicating a role in addressing symptomatology, particularly the largely hidden health issue of depression in aged care.

Key words: relaxation; music; imagery; aged care; GIM

Background and Introduction

Considerable stress may be accumulated in the process of ageing. Shakespeare's description of "the slings and arrows of outrageous fortune" (Shakespeare, n.d., Act III, Sc.i) well applies to the experiences of many

people as they age, where unexpected events including health problems may lead to major lifestyle changes. Such problems may necessitate moving from home into a residential aged care facility, thereby adding a further stress on top of the highly prevalent stressors of chronic illness, physical disability, and perceptual impairments (Schanowitz & Nicassio, 2006). Health issues necessitating such changes may occur insidiously or unexpectedly, leading to physical isolation from friends and family. Moving into a residential aged care facility may present new circumstances for the residents that are dramatically different from their past experiences, leading to considerable stress and adjustment (Cummings & Cockerham, 2004). Once situated in a residential facility, the ongoing demands of community living add a further level of complexity and stress to residents, since other residents may have impaired social skills and irritating habits or behaviours which become magnified due to frequent, close, and inevitable contact (Gruber-Baldini, Boustani, Sloane, & Zimmerman, 2004). In view of this, there is a considerable need for the individual to find ways of coping with and addressing stressors within this setting (Schanowitz & Nicassio, 2006).

Increasing attention has recently been paid to addressing mental health and psychosocial issues in the residential aged care setting (Katona, 1995; Lie, 2003). There is a suggestion that depression, frequently untreated in the elderly, is even more prevalent in residential populations (Katona, 1995; Lie, 2003). Such mental health and psychosocial issues are known as factors in a wide range of diseases and problems affecting the elderly, for example, depression has been linked to pain, sleep disorders, grief and loss, post-traumatic stress and dementia (Herrman, 2005; Ito, Tamakochi, Yamaki, Wakai, Kawamura, Takagi, Hayakawa, & Ohno, 2000; Mossey, Gallagher, & Tirumalasetti, 2000).

The current music therapy program was designed to assist with the management of stress, with particular reference to clinical symptomatology seen in the elderly, such as sleep disorders, grief and loss, pain, anxiety, depression and post-traumatic stress disorder listed above, through the use of relaxation-focused music and imagery (RFMI). Evidence exists to suggest that relaxation is an effective treatment approach for addressing a wide range of health problems (Fisher & Laschinger, 2001; Wisneski & Anderson, 2005). Relaxation techniques may be formal or informal in application, “require the cooperation of the patient and are most effective when learned and practiced” (Rakel & Herr, 2004, p. 205). Despite an extensive search of the literature, little was found about the importance of relaxation in aged care, with most studies focusing on the need for physical activity rather than relaxation. Also, most studies highlighted the perspectives of staff rather than the self-reported

observations and viewpoint of residents. Considerable difference in these viewpoints has been noted (Tiesinga, Dijkstra, Dassen, Halfens, & van den Heuvel, 2002), and hence the current study emphasized the resident perspective.

Relaxation is more than sitting quietly or being asleep, as it requires active engagement for maximum effectiveness. There is a clear differentiation between active and passive relaxation, with the former involving the patient in spending time with a stress management expert to engage imagination and narrative, and the latter involving for example sitting quietly in a comfortable chair with a magazine (Teixeira, Martin, Prendiville, & Glover, 2005). In fact, to the untrained observer, an elderly person apparently sitting quietly in a lounge area and potentially described as relaxed may equally be described as depressed, withdrawn, or psychotic pending further clinical assessment and observation of passive and active behaviour, and related factors. Hence it is possible for busy staff to miss, or misunderstand the need by residents for active relaxation experiences.

Carefully selected music is known to support an active relaxation process (Grocke & Wigram, 2007), and imagery may also be inextricably linked to promoting relaxation (Sahler, Hunter, & Liesveld, 2003; Wisneski & Anderson, 2005). The rationale for this particular application of relaxation and music was based on the author's knowledge and experience of the Bonny Method of Guided Imagery (GIM), a method in which the author is an established and competent practitioner. Further information about the Bonny Method of GIM is available elsewhere (Bruscia & Grocke, 2002).

The Bonny Method of GIM has previously been modified in various ways for group applications in aged care (Short 1992a, 1992b; Summer, 1988), however, such groups were largely closed (i.e. selected people only). In the current setting, an open-group environment included residents experiencing a wide range of clinical presentations, for example limited insight, poor cognitive skills, limited ego-strength, severe physical illness, mind-affecting medication, hallucinations and confusion, all of which are known to be classic contraindications for the use of GIM (Cohen, 2002; Marr, 1998). Therefore, modifications were undertaken in order to address contraindications, such as those noted by Short (1992a), and provide a professionally responsible relaxation and stress management focus. Given such a situation, careful consideration was given to the design of the program. Clearly, further modifications of existing group GIM techniques with the elderly (Short, 1992a, 1992b, 2002; Summer, 1981) were required. In particular, limited screening of residents was addressed by clinical observation, brief conversations in the group setting and careful choice of

music. Variability in the physical and mental state of attendees was anticipated and accepted. Concentration was enhanced via the use of physical activity as a prelude to relaxation, following Ventre's (1981) work with autistic children and the current author's experience in using music and imagery with preschool children.

The music therapy program under review in this paper was presented as simply a music and relaxation session (MRS) to residents and staff. This avoided complications in understanding around the word "imagery" and presented a clear health-related rationale to staff. However in no way was the use of imagery hidden or covert. In emphasizing relaxation aspects of the program, relevance to the facility and national reporting-systems such as Resident Classification Scale (RCS [Commonwealth Department of Health & Ageing, 2003]) was underscored, highlighting the links between music-related relaxation and pain management, anxiety and so on, based on established healthcare literature (Wisneski & Anderson, 2005).

Review focus and questions

The current quality review project primarily focused on whether the RFMI program was successful from the viewpoint of the residents.

Constituent questions were:

- 1) What was the nature and importance of relaxation as viewed by residents?
- 2) What factors interfered with relaxation and did talking about this help?
- 3) Did residents exhibit symptomatology which justified the use of relaxation with music as a treatment modality?
- 4) Did residents achieve relaxation and imagery during the program sessions, and did they feel different because of this?
- 5) Did residents participating in this program show an awareness of their own state of relaxation, and did they use relaxation/images outside of session?
- 6) Were residents satisfied with the music and relaxation program, and were improvements suggested?
- 7) Did the relaxation-focused music and imagery sessions promote clinical change and relate to standard assessment and documentation?

Method

Design

Residents in this facility frequently participated in quality review via questionnaires. Review and evaluation of this music and relaxation program took place after 12 months of implementation in a 43-bed aged care hostel. The Relaxation in Music & Aged Care (RMAC, Short, 2004) was specifically designed for this purpose for the program in question. Data collection took place over two weeks in early 2004. Results of this were also examined in the light of other routine assessment data undertaken in the facility. Data were collected with attention to confidentiality and with appropriate facility and individual permissions for such a quality improvement review, in line with ethical principles.

Participants

For the review, participants were drawn from fifteen then long-term residents who had been attending the music and relaxation program. Respite care patients were not included due to the short-term nature of their residency and limited clinical information available with regard to their health and psychosocial circumstances. One regularly attending long-term resident did not consent to be involved in the review, however all others participated enthusiastically in the review process. The fourteen residents participating in the program review process were aged 51 to 98 years ($M = 79$ years, $SD = 11.2$ years). As is common in this age group, there were more females than males (four male, ten female). Average attendance at the MRS over the 12 months was nine residents, with a range of six to twelve attendees per session. Figure 1 shows regular attendance patterns.

Applied clinical method

Based entirely on recorded music, details of the RFMI program in terms of clinical method are discussed elsewhere (Short, 2004). In summary, a regular and well-accepted “gentle exercise” video program provided a suitable vehicle for modification into a weekly open-attendance RFMI program. After a period of carefully designed but similar non-video physical exercises with music (ultimately fulfilling part of the role of the standard GIM “induction”), the topic of relaxation was introduced with general explanatory comments and then a group discussion of places and activities that are relaxing, with individual input. Residents were then encouraged to focus on

their own (real or imaginary) favourite place or activity which was relaxing and reminded to remain quiet during the music. The music used for this program was generally three to five minutes in length, mostly “classical” in its content, often familiar to residents and generally not from established depth-oriented GIM programs since the aim of the program was supportive rather than depth-oriented. Sometimes the music included ambient sounds such as birdsong or sounds of the rainforest. The return or “waking up” after the relaxation took place in the same way as standard GIM, with the therapist facilitating the process via language, pacing, and voice tone. Facility-induced noises and interruptions also often occurred at this point.

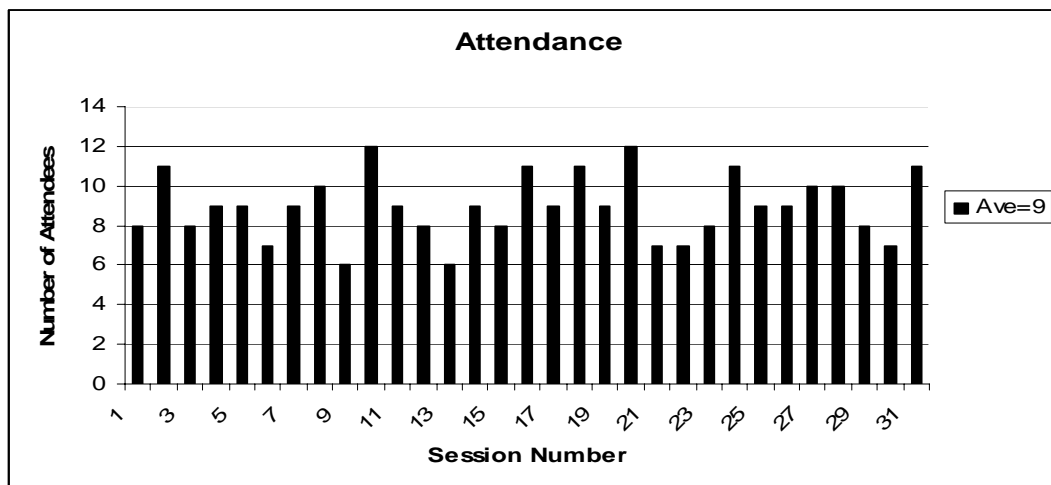


Figure 1. Attendance at relaxation-focused music and imagery sessions

After waking up, therapeutic discussion was encouraged, in line with GIM principles. However, often group discussion was not forthcoming and hence it was difficult to judge the alertness of group members. An additional strategy was then used, which consisted of using popular music to initially match the relaxed state and gradually stimulate the group by increasing the familiarity and rhythmic tempo and complexity to assist with a return to a “normal” state of consciousness, following the isoprinciple (Altschuler, 1948; Short, 1992c). The one-hour session concluded with morning tea. At the beginning of the morning tea break, the music therapist observed resident responses to assess the need for any further follow-up related to the residents’ experience (for example, ongoing emotional issues or non-normal state of consciousness) and to make contact with each person individually. Such observations and contact were in line with GIM principles. Further details about the implementation of this clinical method may be found in Short (2004).

Data sources

The main data source for this review was a self report questionnaire completed by the participants. Such questionnaires were very familiar to residents and were routine within this facility, which strived to promote ongoing high quality standards in all programs. Since there were no pre-existing questionnaires appropriate to this situation, a questionnaire was specifically designed for this review (Relaxation in Music and Aged Care, RMAC, Short, 2004). This 29-item questionnaire in two sections (general, and relaxation and music program) was designed to maintain interest for people with potentially short attention spans, and thus it comprised a mixture of yes/no, ratings and open-answer questions. The design of the questionnaire included ideas derived from Nachmias and Nachmias (1981) and Kane (1993), the latter suggesting that it was acceptable to vary the style of questions, and that it was important to have an introduction, bridging statements, and instructions to participants regarding how to fill in the form. Assistance was also found with regard to the devising of filter questions and how to score multiple selections. A copy of the questionnaire may be obtained by contacting the author.

The questionnaire was individually implemented as a self-report questionnaire, as were other questionnaires in the facility. The questionnaire was administered to residents a minimum of one week after their last participation in the RFMI session. Some residents asked for assistance with writing in this process, including those from culturally and linguistically diverse (CALD) backgrounds who expressed a lack of confidence in their written literacy skills. Even if assisted, all residents were encouraged to express themselves freely and openly and were reminded that there would be no negative repercussions as a consequence of any of their answers. A number of residents took this opportunity to also critique the questionnaire, and their feedback was treated with consideration and respect. Some residents actively pursued and reminded the music therapist to make sure they had their form to complete so that they were not left out. Even residents who were anticipated to have difficulty answering questions responded well. Residents were given as much time as necessary to complete the questionnaire, and where necessary there was a brief break when concentration waned so that each resident was able to function at their highest level possible.

Data were also reviewed from routine facility assessments including the MiniMental (Rover & Folstein, 1987), Geriatric Depression Scale 12 Residential (GDS12-R, Sutcliffe et al., 2000; Jongenelis et al., 2005), pain assessment, sleeping assessment, behavioural and cultural issues (from the

RCS) and clinical progress notes. Such retrospective data were used to explicate results from the RMAC questionnaire.

Data analysis

Following administration of the self-report RMAC questionnaire, data were collected, collated and entered into a database. Questions were identified as qualitative or quantitative in nature. Numerical data were analyzed with simple descriptive statistics (using SPSS 14) and language-based (qualitative) data were reviewed for themes. Data were cross-tabulated where possible and appropriate. Clinical materials such as the geriatric depression scale (GDS12-R) and ongoing progress notes were also reviewed for clinical content and scored as appropriate according to standard procedures for the test and examined in the light of results from analysis of the RMAC questionnaire data. Missing data points in the GDS12-R were pro-rated according to standard statistical practice.

Results

In this section, the findings of the RMAC questionnaire illustrate basic resident understandings and experiences of relaxation and its disturbance, current symptomatology, experiences in the RFMI sessions, awareness and post-session impact, resident satisfaction and suggestions for changes. The relationship of self-report to clinical assessments and notes and two clinical linkage case examples are also explored.

Relaxation

When looking at attitudes to relaxation and experience and understanding of being relaxed, results of this questionnaire suggested that 64% of residents thought that they were a very relaxed person, compared to 36% who did not. However, only 42.9 % thought that relaxation was *extremely* or *very important*, compared to 50 % who answered *slightly* or *fairly*. In addition, only 21.4% said that they *frequently* or *always* felt relaxed, compared to 50% who *occasionally* or *sometimes* felt relaxed, and 28.6% who often felt relaxed. Cross-tabulating this data, there was no apparent linkage between whether the person thought they were relaxed or not and the reported frequency of their achievement of relaxation. Residents described the feeling of being relaxed in many different ways, as shown in Figure 2, relating it to quietness, sleeping, music, inactivity, activity, memories, and peace of mind.

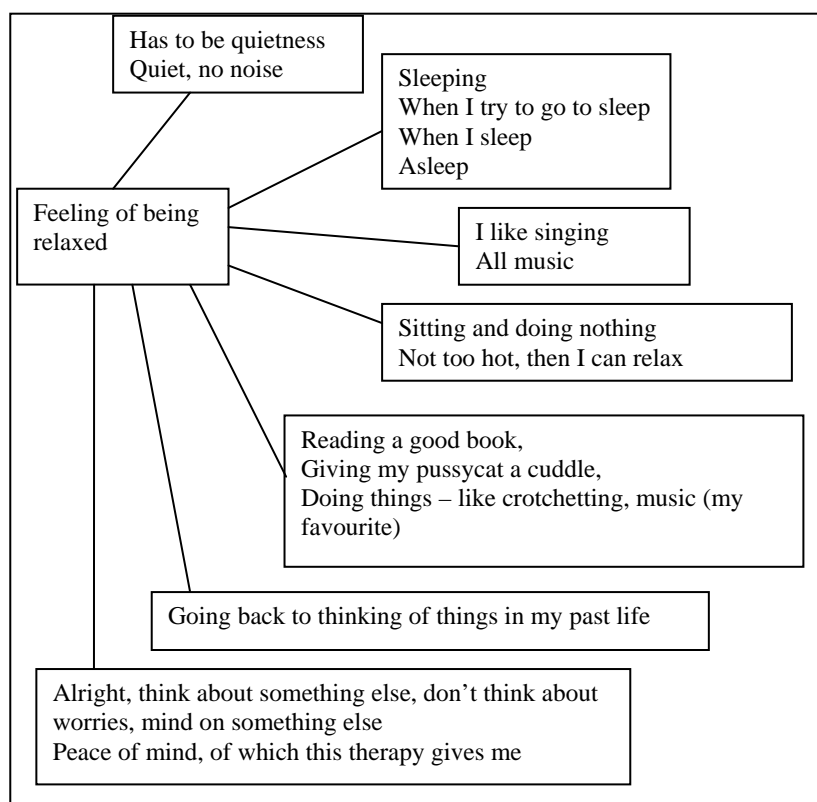


Figure 2. Resident descriptions of the feeling of being relaxed.

Challenges to relaxation

Residents indicated a wide range of internal and external factors which upset their feelings of relaxation, as noted in Figure 3. These included social, environmental, behavioural, health-related and situational factors. In addressing such challenges, residents were asked how important it was to them to talk about these feelings. Many (57.1%) answered *slightly* or *never*, with only 28.6% saying *extremely* or *very*. Cross-tabulating data, it was found that those residents claiming that they were not a relaxed person were less likely to talk about things that upset them than those who saw themselves as a relaxed person.

Presenting problems

The questionnaire elicited information about the range of difficulties experienced from the residents' point of view. Residents reported a range of day-to-day symptomatology. Sadness and depression were the most frequently reported symptoms, followed by grief or loss, worries or anxieties, and sleeping difficulties. More than a third of residents reported having

difficult memories (such as wartime) and there were a wide range of other individualized difficulties reported (Table 1). It was common for residents to have multiple concurrent day-to-day difficulties. Many (71%) residents reported three or more problems in the listed categories, while only two residents reported having one or less problems. Combining similar categories, 71% of residents admitted to sadness/depression or grief/loss in daily life. Additionally, the combined total of worry/anxiety or stress/PTSD was 64%.

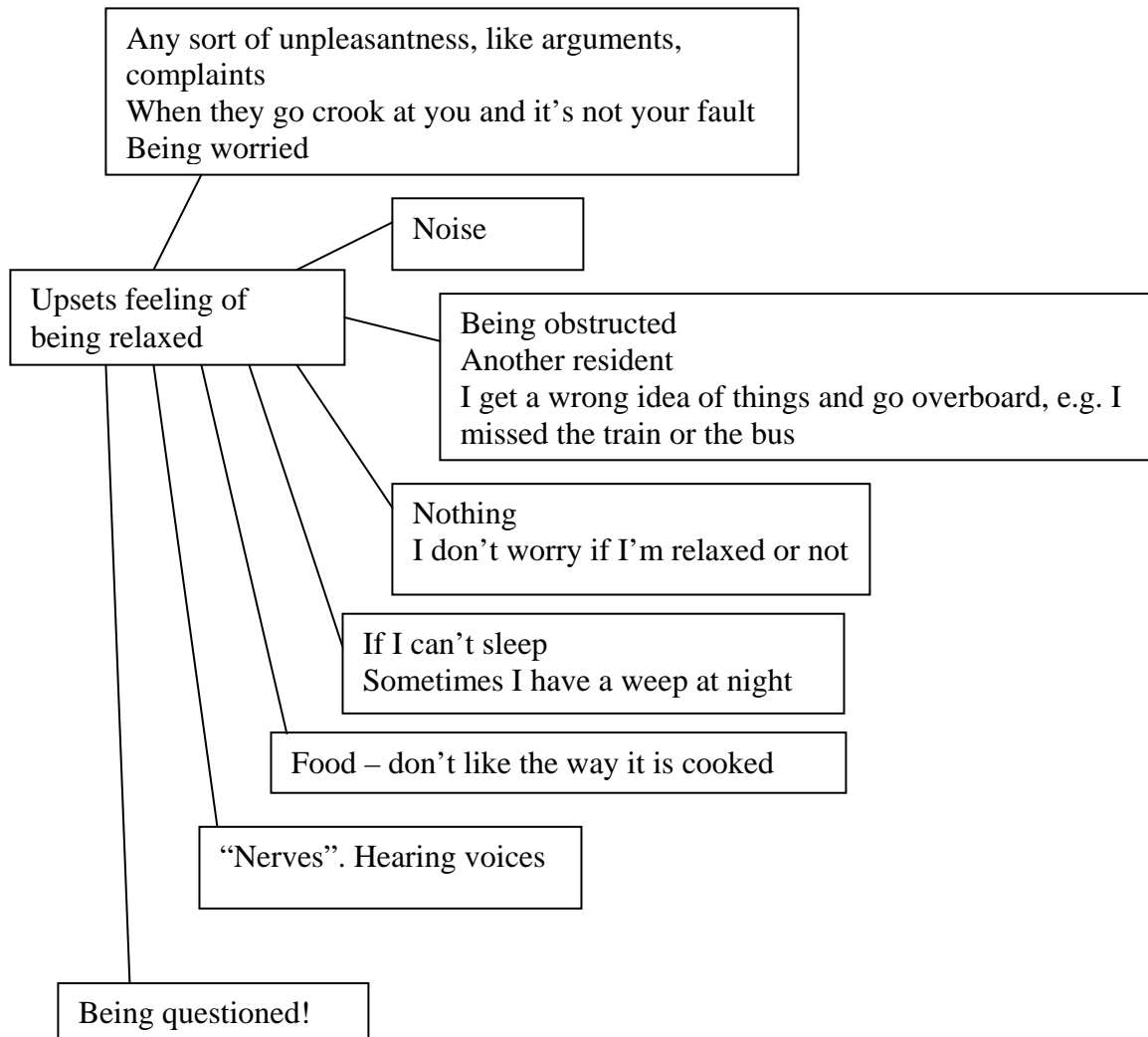


Figure 3. Resident views of factors upsetting their feeling of being relaxed.

Table 1.
Current symptomatology reported by elderly residents.

Difficulty	N=14	Percentage
Sleeping at night	6	46
Pain	6	46
Sadness or depression	8	62
Grief or loss	7	54
Worries or anxieties	7	54
Difficult memories e.g. wartime	5	39
Other#	7	54

comprising: hearing voices, lack of money, stress, puffing and blowing (dyspnea), forgetfulness, severe visual impairment, unpleasantness (resident behaviour).

Relaxation-focused music and imagery sessions

A high proportion of residents (78.6 %) reported images or memories during the MRS according to the RMAC questionnaire. Further, 57.1% said that they experienced imagery during the RFMI sessions *sometimes, often, frequently, or always*.

Seventy one percent of residents said they felt different after the MRS. This figure was high, given that there was often little indication from the minimal post-music discussion in the RFMI program. Residents' descriptions of their changed feelings after the MRS included responses to the music itself, improved mood and sense of well-being, sense of comfort, feeling relaxed, rested and calm, and a feeling of being born again (Figure 4).

Awareness and Application

The main aim of the program was to assist residents with the management of stress and symptomatology through the use of RFMI. Most (78.6 %) residents in this review said that the music and relaxation program helped them notice when they were relaxed or not. In addition, 64.3 % of residents reported that they could relax at other times when they choose to, even in stressful situations, and 71% said that they had images and memories that stayed with them outside of the therapy session. Residents' descriptions of images and memories remaining with them after the MRS included memories of childhood and family, pleasant activities, stressful memories, music, and positive feelings about current everyday activities (Figure 5).

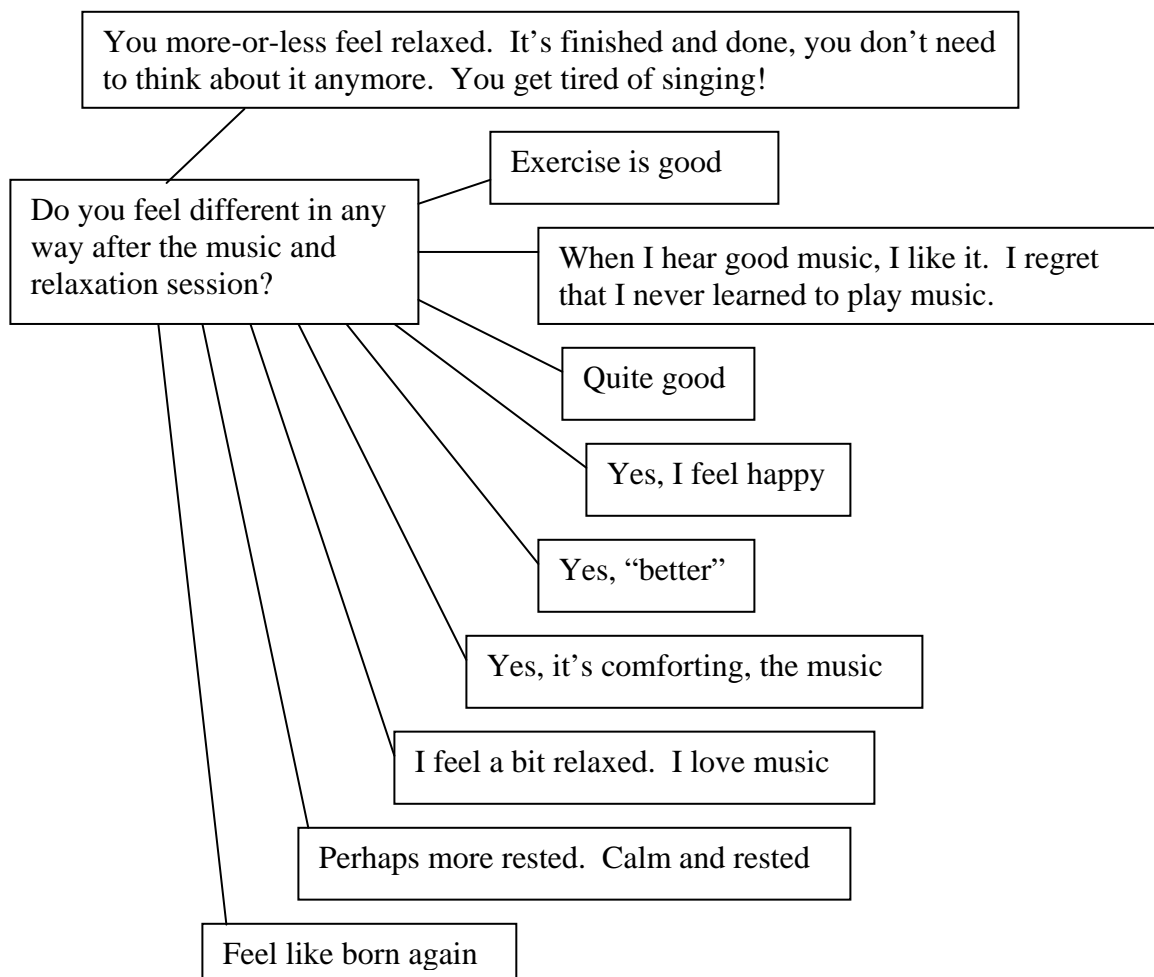


Figure 4. Resident perception of different feelings after the music and relaxation sessions.

Cross-tabulating the data, those who had earlier reported relaxation as important also increasingly noted their own relaxation after the MRS, a trend which appears to be based on awareness. In addition, residents who had a greater awareness of their state of relaxation also experienced imagery outside of the program more frequently. Those residents experiencing imagery outside of the program also reported low levels of worry. There were no apparent differences for other categories of symptomatology, however since numbers were small even such suggestions are inconclusive.

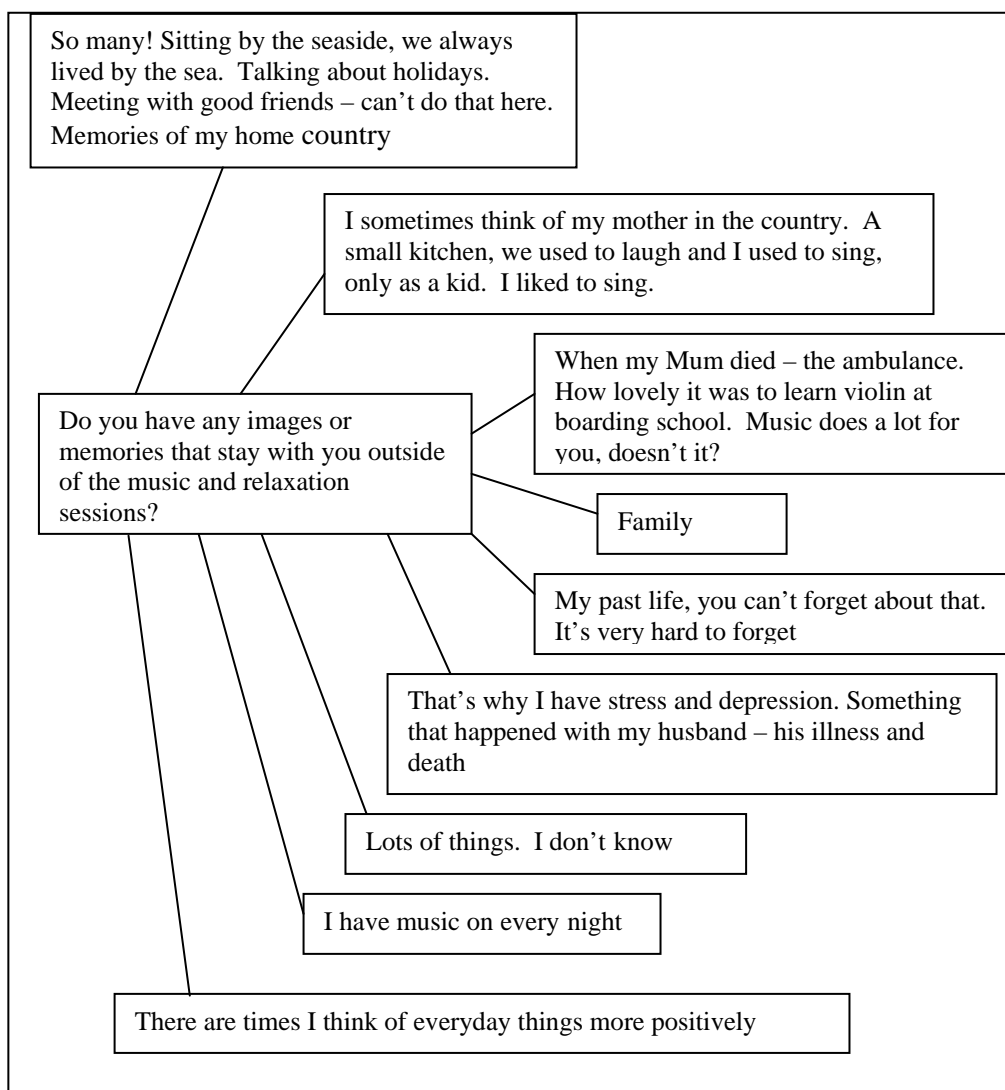


Figure 5. Resident reporting of images and memories outside the music and relaxation session.

Clinical assessment and documentation

Clinical documentation was most helpful in exploring the two clinical linkage (case) examples which follow. Results of the routinely applied Geriatric Depression Scale 12-Residential (GDS12-R), using Sutcliffe's clinical cut-point of 3/4 (Sutcliffe et al., 2000) suggested that 64.3% of participants in this study were experiencing depression. Results of the GDS12-R were similar to self-report symptomatology scoring of the RMAC questionnaire, suggesting considerable insight by residents into their own symptomatology. This also supported the accuracy and validity of the RMAC questionnaire.

To the knowledge of the researcher, no formal medical treatment for depression was implemented for these residents, given that it was an aged care hostel and not a psychiatric unit. Hence, the music therapy program at least gave an outlet for talking about issues and provided professional support from a music therapist who was experienced in aged care psychiatry. The MiniMental assessment, when it was further explored as part of case material, had been incorrectly applied and completed, and hence could only be interpreted descriptively rather than as a validated assessment tool. Two case examples will now be presented in order to further explore clinical linkage as evaluated in this innovative music therapy program.

Clinical linkage – Example One

An 83-year-old female resident typically used language eloquently and confidently to express her views and was assessed in the clinical files as having no cognitive difficulties. She described the feeling of being relaxed as “quietness”, saying that any sort of unpleasantness, like arguments and complaints with or between residents upset her feeling of relaxation. She said that she tried not to talk about such feelings of upset and she chose instead to solve her feeling of upset by walking out of the room. This resident also routinely suffered from problems with sleeping and pain (due to severe arthritis, osteoporosis and deformities) and described her pain as “all the time”. Clinical notes and assessment indicated that her self-reported pain score was typically 8 (out of 10), that pain medications may ease it, and that she took medications for sleeping. This resident was also assessed by staff as having no dementia or behavioural problems. Her GDS12-R score was 6.5, suggesting depression.

During the course of the RFMI program, this resident was able to use the MRS very effectively to generate relaxing imagery and to in turn apply it to pain management situations. This is evidenced in three excerpts from the ongoing progress notes of this resident.

Excerpt 1, two months into the program

Although appearing aggravated at first and directing many challenging statements towards the music therapist, she joined in at times with gentle exercise activities and with relaxation with music, later reminiscing with obvious meaningful enjoyment about a place in her home country (Sri Lanka) which was beautiful and peaceful and she used to frequently visit in summertime. She was encouraged to use this

peaceful image at other times when she might be feeling “stressed”, in order to help herself relax.

Excerpt 2, eight months into the program

Attended music therapy session, at first clutching at and supporting her shoulder due to obvious pain. She was offered emotional support after she acknowledged that she was in pain. Nevertheless (this resident) joined in with gentle exercise, modifying the exercises where necessary. After the subsequent relaxation with music she said “that was not enough!” She appeared much less drawn in the face and more relaxed at this point, asked a couple of spontaneous questions and began to smile.

Excerpt 3, final month of program

Attended music therapy session, requesting quiet music and indicating that she was in pain. Despite this (this resident) imagined a favourite and relaxing place where she spent holidays in her native country of Sri Lanka, going on to talk about her happy childhood. She was further encouraged to use this sense of relaxation to assist in pain management, and appeared happier after the session.

This influential resident lived next to the main lounge area. Not only did she feel the brunt of difficulties in the facility, but she also contributed substantially to the emotional atmosphere in the facility. By assisting her with pain and stress management via RFMI, she personally gained benefits and there were also flow-on effects to the entire facility.

Clinical Linkage – Example Two

An 82-year-old female resident with moderate to severe dementia frequently presented with challenging behaviour and often demonstrated an aggressive attitude, confusion, and intermittent paranoia. She also tended to wander, often stopping unexpectedly for no apparent reason, and when she was again ready to move, would follow the next person who passed her, causing considerable irritation to other residents. Her basic language skills appeared intact but she rarely initiated conversation herself. This resident responded poorly on a cognitive test (MiniMental), describing the residential facility as “a village”, the suburb as “near a butcher shop”, and the season as “winter”, all of which were inaccurate. Her routine GDS12-R score was 2.2, suggesting an absence of depression. This resident attended the music and relaxation program on a regular basis of her own volition, saying little and

often leaving quickly at the end of the session. When approached to complete the questionnaire, she showed a clear memory of the RFMI program. As questions were asked, care was taken not to influence her responses.

This resident showed remarkable insight in answering the questionnaire, giving clear and unequivocal answers to questions read out to her even when given options. She described the feeling of being relaxed as “when I try to go to sleep”, and said that music helped her when she was upset about not sleeping. When asked about her daily life, she said that she was bothered by difficulties with sleeping at night, pain, sadness or depression, grief and loss, and worries or anxieties, stating “yes, I worry a lot”. This was quite remarkable from a woman who did not routinely talk about her emotions or concerns and had limited verbal interaction with other residents. In fact, issues of low grade pain and disturbed sleep were documented in clinical notes. This resident indicated that she had experienced imagery during the MRS, and that typically after the session, “I feel happy”. Her final comment about the MRS was a spontaneous “Oh, I like it very much!”

Discussion and Recommendations

Clinical method – relaxation focused music and imagery

The results of this clinical review indicate that even under difficult situations such as an open group and clinical contraindications, the Bonny Method of GIM can be adapted successfully and effectively for group work with elderly residents, especially by modifying an existing and accepted program. In this current program the expected negative effects to concentration and focus of apparent interruptions in an open lounge-room group did not eventuate, suggesting a resilient attitude by residents. This is surprising given staff (and music therapist) views of interruptions as being disruptive and detrimental to the therapeutic process. It is thought that perception may well depend on familiarity and “what you are used to”.

Cognitive difficulties have frequently been considered a barrier to the use of imagery in healthcare. A high proportion of residents reported images or memories during the MRS in this evaluation, according to the RMAC questionnaire. This also supports other findings suggesting that age is not a barrier to imagination (Short, 1992a, 1992b). However, this result extends the realm of imaginative abilities to suggest that disabilities (such as dementia) may not be as much a problem as would have normally been expected

(Cohen, 2002; Summer, 1988), as half of the residents had significant difficulties with dementia.

Residents typically did not appear to request or suggest changes to the RFMI program. For example, extending the relaxation program out of its current time-spot into individualized music was not viewed favourably by residents in this study (less than half). This is in marked contrast to individualized programs which are standard practice in areas such as palliative care (Munro, 1984) utilizing relaxation and music to help with sleeping, pain management, and so on. Likewise, less than half of residents indicated that they would like their own music for relaxation at night-time or other times (42.9 %) which seems very low compared to similar programs, for example in palliative care (Munro, 1984).

Around a quarter of residents already possessed music audio equipment and of those without such equipment only 14.3% were willing to purchase a player. This very low result may have been related to financial issues as this facility has in the past accepted many residents on the basis of need despite being unable to pay the usual financial bond. It may be that a further question about their willingness to use a player if it was provided for them could have further elucidated this issue, as issues of access may have clouded the question. Another interpretation is that residents were already accessing sufficient musical activities. There may also have been a deficiency in interest and understanding about the possibilities of using music to address symptomatology in a manner helpful to the individual person.

Reported symptomatology

This program review also included self-report information about symptomatology, suggesting high rates of mental health issues in elderly populations, especially in residential care. Especially high levels of residents reported experiencing sadness, depression, grief or loss, which is also reflected in the literature. Katona states, that “despite being common and life-threatening, depression in old age is hardly ever treated” (Katona, 1995, S232) and suggests that around 30% of elderly residents in institutional settings may be experiencing clinical depression. Other literature consistently supports the notion that depression is frequently under-diagnosed and untreated in such settings (also see Lie, 2003, who investigated the Australian situation). Other studies indicate high levels of co-morbid pain and depression (Mossey et al., 2000), and depression is also linked to sleep disturbance (Ito et al., 2000) and dementia (Hancock, Woods, Challis, & Orrell, 2006).

Application of relaxation for symptom management

It is interesting to note that those residents reporting an enhancement of awareness of their state of relaxation after the MRS also tended towards having a higher frequency of reported images remaining outside the session. This suggested that both proprioceptive awareness and specific imagery were potentially available for the resident to use for addressing symptomatology. A question remains about the nature of such remaining imagery and a subsequent version of the RMAC questionnaire needs more specific questions in order to understand the nature, generation, and emotional impact of these images.

There was an apparent linkage of increased awareness of relaxation and the individual's importance placed on relaxation. This suggested that cognitive engagement in understanding the importance of relaxation via a further carefully designed educational program may assist residents with using relaxation to manage symptomatology, a situation already suggested by Stinson and Kirk (2006).

Despite the stressors and problems, there is a need for enhancing psychological wellbeing with elderly residents, in order that they may grow and adapt to cope with new circumstances (Schanowitz & Nicassio, 2006). Reminiscence has recently been used to decrease depression and increase self-transcendence in older women (Stinson & Kirk, 2006). In this current study, residents generally reported a reluctance to talk about problems. This is juxtaposed against the fact that participants generally did talk about problems upsetting them during both group and individual music therapy sessions, and leads to a conclusion that perhaps this question in the RMAC was not sufficiently clear and detailed. However, results of this survey also suggest that if residents do not wish to talk about issues, perhaps the non-verbal nature of the RFMI session may be a good vehicle for addressing feelings of upset in the residential aged care facility.

In a busy facility, the nature of and need for relaxation in aged care may not immediately be apparent to staff and others not trained in aged care psychiatry. In addition, there may be multiple and/or contradictory interpretations of behavior seen. For example, residents experiencing withdrawal, depression, and sleep disorders may be mistaken as relaxed by the naïve observer when they are not relaxed at all. Self-report of symptomatology in this study combined with anecdotal evidence suggests that staff may need specific education about psychosocial needs of residents in the aged care setting.

Limitations

Without a clear pre-test/post-test design with an established baseline, self-reports from residents about their use of relaxation in other stressful situations could not be clearly tracked as a result of the current RFMI program. Further studies should incorporate such a baseline into their methodology and develop a more targeted question around this issue.

A major limitation of this study was the small number of participants in the program and subsequent small numbers participating in the program review and evaluation. Thus, broader statistical significance with a view to generalizing to other populations cannot be deduced. Simple descriptive statistics were adequate to describe responses. In addition, the RMAC questionnaire had not yet been validated. Based on survey responses, it would seem that this tool needs to be expanded and developed to further address an understanding of relaxation that is suitable for use in such an aged care population. There is no apparent way of avoiding the subjective nature of a self-report measure such as RMAC, if the views and experiences of residents are to be captured, however it is acknowledged that language and physical barriers exist in the administration of such a self-report questionnaire.

The standardized and validated assessment tool of the GDS12-R provided additional information about symptomatology, and suggested that 64.3% of participants in this study were depressed. There were some missing data points which were pro-rated. Again, the small numbers of residents involved were a major limitation to this study.

Another limitation of this program is that it is not an off-the-shelf solution, and music therapists and other staff are reminded that attempting this type of RFMI program without training and experience in the Bonny Method of GIM is not advisable. Difficulties may occur in the areas of 1) post-traumatic stress and memories, 2) particular health issues, 3) choice of appropriate music, 4) non-directive discussion, and 5) need for reassurance about the nature of imagery. Training and experience are necessary in order to ensure the safety of clients and high standards of professional behaviour.

Final comments

In conclusion, this review indicates that RFMI sessions can be successfully applied to the aged care facility, however considerable thought needs to be applied to modifications in order to address cognitive and other clinical problems. A review process to assess clinical effectiveness may

effectively use self-report data to reveal effectiveness and impact. A review process to assess clinical efficacy may successfully use self-report data to reveal effectiveness and impact. Results from this study show evidence of addressing clinical problems and enhancing facility-wide treatment processes via increased awareness of relaxation and enhanced feelings of physical and emotional well-being. This quality review project could conceivably form the basis for a larger research project investigating the effectiveness of a RFMI program in addressing symptomatology in residential aged care, particularly the hidden health issue of depression in aged care.

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