

Running head: LULLABIES IN HOSPICE MUSIC THERAPY

The Use of Lullabies in Hospice Music Therapy

By

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Abstract

The purpose of this paper is to examine the use of lullabies as an intervention in hospice music therapy. A 15-question survey was electronically disseminated to board-certified music therapists (MT-BCs) with clinical experience working as music therapists in the hospice setting. Potential participants were located through the Certification Board for Music Therapists (CBMT) database. A total of 86 participants responded to the survey, and the data from 82 of the participants was analyzed. Participants indicated that they use all four methods of music therapy and many different types of music experiences as a lullaby intervention in hospice music therapy. Hospice music therapists use lullaby interventions as indicated by a variety of patient/family needs. The most common needs were those related to comfort/relaxation (73.17%), pain/discomfort (60.98%), and anxiety (57.32%). These correlate to the most common intended outcomes of lullaby intervention in hospice music therapy, which are increasing relaxation/comfort (76.83%), decreased stress and anxiety for patients and/or families (74.39%), and decreasing pain/pain perception (37.80%). Participants indicated in an open-ended question their opinions about how using lullabies differs from other hospice music therapy interventions. Themes of how these interventions differ include comfort and relaxation, family and familiarity, and meeting specific patient needs. Results of this survey indicate that music therapists are using lullaby interventions in the hospice setting to meet the needs of hospice patients and their families.

Keywords: hospice music therapy, music therapy methods, needs of hospice patients/families, lullabies.

The Use of Lullabies in Hospice Music Therapy

This study explores the applications of lullabies in hospice music therapy. Lullabies are overwhelmingly associated with infants and children. However, it is the author's opinion that the needs met by lullabies, as used with infants, are strongly correlated with the needs of hospice patients. Infants and hospice patients are both vulnerable populations with caretakers who support them. Research suggests that caregivers may have challenges bonding with patients they are caring for and they may be overwhelmed by responsibility (Loewy, 2015). Lullaby interventions can provide stress relief for the patient and caregiver, and promote bonding through shared musical experience. Hospice patients, like infants, may need soothing and emotional support (West, 1994), which can be provided by lullabies sung either by a music therapist or when used by the patient to self-soothe (Geller, 2002). Lullabies are also often a transitional object for infants and children. Lullabies can also be used as transitional objects for hospice patients transitioning through change of body and mind at the end of life (Díaz de Chumaceiro, 1995; Geller, 2002; Loewy, 2015; Loewy & Stewart, 2005).

Literature Review

Hospice Care in the United States

Hospice is a service provided to terminally ill patients of all ages (NHPCO, 2018). To be eligible for hospice care, an individual must have a life expectancy of six months or less, as certified by a doctor (Hutcheson, 2011). This service provides comfort care and symptom management rather than curative care to support patients at the end of life. Hospice care is based on the hospice philosophy, which includes "the concept of total pain, a focus on interdisciplinary care, and the recognition of dying as a potentially valuable and enriching segment of a person's

life” (Hutcheson, 2011, p. 1). *Total pain* refers to the idea that pain is not merely physical, but may come from psychosocial issues and emotional sources. For these reasons, care provided to hospice patients is not just by medical professionals, but by a diverse interdisciplinary team (Hutcheson, 2011).

The interdisciplinary team that provides care to a hospice patient may include physicians, nursing staff, social workers, spiritual counselors, bereavement counselors, volunteers, and therapists. This team collaborates with the patient and their support system to provide the highest quality of care while honoring their unique needs, beliefs and preferences. Services are provided in private residences, hospitals, hospice facilities, and nursing homes (NHPCO, 2018).

Hospice provides many services for patients. These include but are not limited to the following:

- pain management;
- patient and family support regarding emotional, psychosocial, and spiritual needs related to the death of the patient;
- medical needs such as equipment and medication;
- education to the patient’s support system about how to care for the patient;
- grief support for patient;
- in-patient care for respite of patient’s support system or during times of acute medical need;
- special services and therapies; and
- bereavement counseling for patient’s support system after death (NHPCO, 2018, p. 2).

Needs of hospice patients. Hospice patients have unique physical, psychosocial, and quality of life (QOL) needs. Garland, Bass, and Otto (1984) researched these needs as identified by their caregivers and their nursing staff. The need ranked most important was for patients' wishes to be respected, including respecting the patient's choice of where to receive care. Another identified need was preparing for their death in regards to legal matters, planning for the future, and completing unfinished business. Patients have a need for normalcy of family relations including keeping in contact with family, and not feeling as though they are a burden. The authors further noted that patients need education about their illnesses, and help coping with that illness. They also need open communication with medical staff. Hospice patients have religious and spiritual concerns. Other needs identified were help with household tasks, financial assistance, and pain management (p. 41-42).

Physical needs of hospice patients. The needs of hospice patients are many faceted, but the basis of these needs are physical needs. Pan, Morrison, Ness, Fugh-Berman, and Leipzig (2000) identify dyspnea, nausea, and pain as the most prevalent physical concerns at end of life. Dyspnea is a symptom for nearly 50% of patients before death (Seale & Cartwright, 1994). Nausea is present in 43% of patients with AIDS, 30% of patients with renal failure, 17% of patients with heart disease, and 6% of patients with cancer (Solano, Gomes, & Higginson, 2006). Moderate to severe pain was experienced by 50% of patients in their last days of life, at least half the time (SUPPORT Principal Investigators, 1995). Pain management can be challenging for end-of-life clinicians, patients, and families. Many pharmacological pain medications elicit side effects that are undesirable for the patient and family, notably lethargy (Gutgsell et al., 2013).

Psychosocial needs of hospice patients. Hospice patients and their families have a wide range of psychosocial needs at end-of-life. Hill, Evans, and Forbat (2015) identify four categories of psychosocial needs of hospice patients. The first category is “rights.” Rights revolve around the need for patient autonomy, privacy, and safety. Another category is “coping,” which encapsulates the needs regarding fear of the future and death. The category “identity,” includes needs regarding self-esteem, self-concept, and relationships. The last category is “expression.” These needs are related to how hospice patients express themselves, be it negatively or positively. Anxiety and depression were identified as psychosocial needs in the “expression” category (p. 2).

Moderate to severe anxiety is experienced by 70% of patients at end of life (Georges, Onwuteaka-Philipsen, Van der Heide, Van der Wal, & Van der Maas, 2004). Depression was documented in 10.8% of home/long-term care patients and 13.7% of patients receiving inpatient care (Irwin et al., 2008). Delirium and restlessness may also be present at end of life (Rome, Luminais, Bourgeois, & Blais, 2011). Delirium and restlessness present as “anguish (spiritual, emotional, or physical), anxiety, agitation, and cognitive failure” (p. 349).

Quality of life needs for hospice patients. An important need for hospice patients is maintenance or improvement of quality of life (QOL), an expansive, multi-faceted topic with a unique meaning to each individual. QOL consists of one's perceived overall well-being. The sense of well-being may include physical functioning, psychological health, social circumstances, as well as existential and spiritual satisfaction, (Tang, Aaronson, & Forbes, 2004; Steele, Mills, Hardin, and Hussey, 2005). Indicators of quality of life included renewal, fatigue

or energy, excitement, comfort and relaxation, connections and spirituality, enjoyment, knowledge of available services, isolation, grief, and mood (Bowers & Wetsel, 2014, p. 236).

Complementary Therapies for Hospice Patients

The National Center for Complementary and Integrative Health of the National Institutes of Health (NIH) states that complementary refers to “health care approaches that are not typically part of conventional medical care or that may have origins outside of usual Western practice” which are used in conjunction with traditional medicine (NIH, 2018, p. 1). Many hospices provide complementary therapies to work with other members of the interdisciplinary team. Patients who receive complementary therapies report that these treatments improve their quality of life by offering a sense of control, increasing their ability to cope with stress, and reducing their physical discomfort (Demmer & Sauer, 2002). Running, Schreffler-Grant, and Andrews (2008) surveyed hospice administrators and found that the symptoms treated by complementary therapies included emotional and spiritual suffering, stress, physical pain, fatigue, tension/anxiety, insomnia, nausea, and vomiting (p. 7).

Bercovitz, Sengupta, Jones, and Harris-Kojetin (2011) found that in 2007, 41.8% of hospices in the United States offered complementary therapies. Common therapies, in order of most to least often offered are massage, supportive group therapy, music therapy, pet therapy, guided imagery and relaxation, therapeutic touch, aromatherapy, art therapy, and Transcutaneous Electrical Nerve Stimulation (p. 3).

Music therapy. The American Music Therapy Association (AMTA; 2018) defines music therapy as “the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has

completed an approved music therapy program” (para. 1). Music therapy is used to address the physical, cognitive, communicative, emotional, and social domains. It is used to treat individuals across the lifespan with developmental, physical, mental health, and medical needs. Music therapists may work in a vast number of settings including schools, private practices, correctional facilities, health care facilities, nursing homes, and hospices.

Bruscia (2014) identified four methods of music therapy: improvisational, re-creational, compositional, and receptive. Improvisational music therapy interventions involve the client creating music in the moment. Re-creational interventions involve the client playing pre-composed music in some capacity. With compositional intervention, the music therapist may help the patient orchestrate music, write song lyrics,, or “create any kind of musical product” with the therapist (Bruscia, 2014, p. 133). Receptive interventions involve the client listening and responding to music played by the therapist.

Music therapy in hospice care. Music therapy is widely used in hospice care. It is provided by 62.2% of hospice agencies in the United States that provide complementary therapies (Bercovitz, Sengupta, Jones, & Harris-Kojetin, 2011). Hospice patients are often referred to music therapy for concerns about quality of life (Bowers & Wetsel, 2014). Bowers and Wetsel’s (2014) systematic review of literature indicates music therapy can improve quality of life, decrease anxiety, reduce pain, and lower depression scores .

Music therapy is used as part of pain management for terminally ill patients. Research supports the ability of music therapy to decrease both physiological and psychological pain (Rider, 1985). Music therapy can reduce pain perception (Colwell, 1997; Starr, 1999), decrease the amount of pain-reducing pharmacological interventions utilized (Colwell, 1997), improve

patient coping skills regarding pain (Colwell, 1997), help patients refocus away from pain (Magill-Levreault, 1993), and offer relaxation to a person in pain (Curtis, 1986).

There are many benefits of music therapy for hospice patients and their support systems. Music therapy helps reduce anxiety (Gross, & Swartz, 1982), and provides a space to search for hope, meaning, and a sense of purpose (Aldridge, 1999). Music therapy offers an opportunity for non-verbal communication, especially for patients with brain-impairments which limit their ability to communicate with loved ones (O'Callaghan, 1993). Music therapy also provides an outlet for emotional expression for those who are non-verbal (Salmon, 1993). Hilliard (2001) notes decreased symptoms of grieving in children who received music therapy while participating in the experimental group of a study. Music therapy improves reality-orientation (Riegler, 1980). Lastly, music therapy can facilitate improvements for patients who are withdrawn, not properly coping, those who are fearful, and those with insomnia (Porchet-Munro, 1993).

Hilliard (2003) studied the effects of music therapy on the quality of life of hospice patients with a diagnosis of terminal cancer. The tool used to determine subject's quality of life was the Hospice Quality of Life Index-Revised (HQLI-R), which measures quality of life in relation to three categories: functional well-being, psychophysiological well-being, and social/spiritual well-being. Functional well-being refers to one's ability to participate in activities of daily living. Psychophysiological well-being refers to one's combined psychological and physiological health. Social/spiritual well-being refers to one's relationship with their support system and connectivity to their religious and spiritual beliefs. Music therapy interventions used include song choice, music-prompted reminiscence, singing, live music listening, lyric analysis,

instrument playing, song parody, singing with accompaniment, using the iso-principle, planning funerals or memorial services, song gifts, and music-assisted supportive counseling, thus representing all four methods of music therapy. This study found that individuals who received music therapy had statistically significantly higher scores on the HQLI-R in the psychophysiological category.

Meeting the needs of hospice patients through music therapy. Music therapists work directly with patients and families in their homes, as well as nursing homes, assisted living facilities, and in-patient settings (Krout, 2001). Interdisciplinary team members are educated by the music therapist and trained to refer patients for music therapy services (Mandel, 1993). Patients may be referred to music therapy for a wide spectrum of symptoms including “anxiety, agitation or restlessness, caregiver role strain, impaired communication, ineffective patient and/or family coping, depression, anticipatory patient and/or family grieving, isolation or withdrawal, pain, and spiritual needs” (Maue-Johnson & Tanguay, 2006, p. 15).

Once a patient is referred to music therapy, a music therapist will complete an initial assessment of the patient. Maue-Johnson and Tanguay (2006) created the Hospice Music Therapy Assessment which follows the AMTA standards of assessment while adhering to needs related to the population. This assessment includes demographic information; physical status information including pain, motor activity, and respiration; cognitive and communication information such as mental status, memory, and whether or not the patient is verbal; psychological and emotional information about mood, anxiety, and coping; social information about the patient’s community and their needs; spiritual information; and musical information (p.

15-19). Once the assessment is complete the music therapist can create an appropriate treatment plan.

Goals specified by Maue-Johnson and Tanguay (2006) for the hospice population include

- increase relaxation,
- enhance respiratory comfort,
- increase physical comfort,
- decrease pain perception,
- reduce anxiety,
- increase sensory stimulation,
- enhance communication (within limits of disease),
- elevate mood,
- increase meaningful social interaction,
- increase social and emotional support,
- increase self-expression,
- increase non-verbal expression,
- engage in life review/reminiscence,
- increase family communication regarding terminality,
- normalize experience/environment,
- acknowledge and process life changes,
- progress in grieving by stages,
- demonstrate effective coping,
- identify caregiver role strain,

- identify coping strengths/resources, and
- increase spiritual support.

Interventions indicated by Maue-Johnson & Tanguay are

- facilitate music-assisted relaxation;
- utilize iso-rhythmic principle;
- provide opportunities for socialization, communication, and self-expression;
- provide live music for diversions/refocus;
- provide a comforting presence;
- facilitate song-writing;
- facilitate lyric analysis;
- validate emotional expression;
- facilitate music-assisted reminiscence/life review;
- utilize supportive counseling techniques;
- utilize familiar, significant songs;
- assist in creation of tangible legacy;
- promote successful experiences;
- provide means for control over environment;
- create opportunities for positive shared experiences, provide patient defined spiritual music;
- conduct music-based rituals;
- provide patient/family support during imminent death; and
- live music to facilitate release (p. 17).

Hilliard (2005) also identified music therapy interventions used with hospice and palliative care patients. These included song writing, improvisation, guided imagery and music, lyric analysis, singing, instrument playing, and music therapy relaxation techniques (p. 173).

Lullabies

Research on the origin and definition of the word “lullaby” resulted in a definition of “to rhythmically and repeatedly, sing or chant a song, in effort to either lull a child into a peaceful sleep, or lament a painful circumstance while at the same time tending to and quieting a child” (Weisner, 2000, p. 12). Geller (2002) defined elements of lullabies, including a slow tempo, at about 60-82 beats per minute (bpm), which is the approximate resting heart rate for an adult. Geller also states that lullabies are repetitive, contain no surprising musical elements, and are most effective sung in a low voice. The vocal quality of lullabies is identified as distinctly simpler when compared to other songs (Unyk, Trehub, Trainor, & Schellenberg, 1992). They often substitute verbal singing with non-verbal singing, like humming. The words to songs are commonly replaced with nonsense syllables (Hawes, 1974). A three-beat meter (3/4 or 6/8) or beat divisions of three give the lullaby a rocking feeling, which helps to facilitate relaxation (Loewy & Stewart, 2005).

Lullabies are not used only to aid children in going to sleep, but also to portray affection and feelings of safety, or arouse the imagination (O’Callaghan, 2008, p. 93). These songs can facilitate self-reflection in children. Lullabies contain archetypal patterns which may help children to develop an understanding of their place in the world both psychologically and mythically. They boost the spirit and provide psychological support (O’Callaghan, 2008).

Lullabies in music therapy. Lullabies can be utilized with any of the four methods of music therapy as defined by Bruscia (2014). Lullaby as an improvisational music therapy intervention is the spontaneous creation of lullaby within a music therapy session. Re-creative music therapy with lullabies involves the client and/or client and therapist engaging with precomposed lullabies. Compositional music therapy interventions are centered around writing lullabies in a music therapy session. Lullaby utilized as receptive music therapy is the use of a lullaby as a listening intervention.

One music therapy song intervention related to the use of lullaby is called “song of kin” (Loewy, 2015). Song of kin is defined as a piece of music which is familiar to, and holds meaning for a family. In Neonatal Intensive Care Unit (NICU) music therapy, song of kin is utilized to improve the vital signs of infants, while reducing anxiety for the hospitalized infant’s family. Other long-term benefits include improved sleep for the infant and decreased parental stress. The intervention is performed live with family involvement and facilitates a sense of containment, resiliency, and safety. These elements lead to improved and increased infant-parent bonding. This song of kin becomes familiar and can be used to soothe and orient the infant during transitional periods.

In response to the use of lullabies with adults in music therapy, Diaz de Chumacerio (1995) identified “transferential transitional songs.” A song that a client has attached emotions or meaning to can be considered a transferential song. A transitional song is used to ward off anxieties and fears during times of change, similarly to a transitional object. Geller (2005) supports the use of lullabies with adults in music therapy for the purposes of self-soothing, transition, well-being, and nurturing of self and others.

Use of lullabies as an intervention in hospice music therapy. Lullabies can be used as an intervention in hospice music therapy. Lullabies are transitional objects at the beginning of life that can foster safety (Loewy & Stewart, 2005). They can be used the same way in hospice care at the end of life. They can ease loneliness as well as relieve fear. They can provide a holding container for those who have anxiety at end of life, particularly around the uncertainty of whether they will wake up if they fall asleep. Hospice patients may also have short attention and low energy level (West, 1994). This suggests that music interventions should be short songs with simple melodies, like lullabies, which have been shown to promote relaxation.

Themes present in lullabies may be meaningful for hospice patients. This is a reasonable assumption as Hawes (1974) identified that lullabies are often about separation or places far away (p. 146). The recurring themes of loss in lullabies are also found in laments, which can be defined as a vocal expressions of grief (O'Callaghan, 2008, p. 94). Laments and lullabies are also similar in their comforting qualities. Other common themes, including "love, nurturance, imagery, storytelling, care, concern, hope, sleep, play, sustenance, symptom relief, enculturation, and empowerment" are present (O'Callaghan, 2008, p. 95). The "paradoxical and transitional" use of lullabies combined with lament is referred to as "lullament" (O'Callaghan, 2008, p. 97). These lullaments have been used to help individuals build strength in times of need.

Diaz de Chumacerio's (1995) idea of a transferential transitional song could be appropriately used as an intervention in hospice music therapy. The transferential element of attaching emotions to songs is an appropriate emotional outlet for the vulnerable emotional needs of a hospice client. The transitional element is appropriate for supporting clients through the many body/mind changes they may experience as their disease progresses.

Weisner (2000) identified three archetypal patterns of lullabies. The first pattern is psychological, which has themes related to small changes in the psychological relationships of caregivers and infants. The second pattern is transformative, related to large personality changes, unlike the small changes examined in psychological lullabies. The third pattern is cosmological, which have themes related to humankind's safety in their place in the universe, the rule of higher powers, as well as the connection of body, soul, and spirit (Weisner, 2000) These lullaby archetypes are as applicable to hospice patients as they are to infants and their caregivers.

Research Questions

The purpose of this study is to explore the use of lullabies in hospice music therapy. An online, questionnaire-based survey will be used for data collection. This study's research question is: How do hospice music therapists use lullabies in their clinical practice? The following sub-questions will be addressed:

1. What method(s) of music therapy and type(s) of music experiences are used during a lullaby intervention?
2. What patient/family needs indicate that using a lullaby could be beneficial?
3. What are some of the intended outcomes of using a lullaby intervention in hospice music therapy?
4. How does using lullabies differ from other hospice music therapy interventions?

Method

Participants

The inclusion criteria requires participants to be MT-BCs who self-identify as working in hospice. The author identified eligible participants using the Certification Board for Music

Therapists (CBMT) database. The researcher requested the contact information for MT-BCs who have experience working in end-of-life care.

Procedures and Protocols

Following approval by the State University of New York at New Paltz Human Research Ethics Board (HREB), the 15-question survey was electronically disseminated (see Appendix A). Eligible participants were contacted by email with invitations to participate in the research and links to the survey (see Appendix B). This email included an explanation of consent which explains to potential participants that the survey is voluntary and their answers will remain anonymous. Follow-up emails were sent weekly to encourage participation (see Appendix C). The survey consisted of both closed-ended multiple choice questions and open-ended short answer questions. The survey was administered through SurveyMonkey and available for three weeks. The survey took approximately five to 15 minutes to complete.

The researcher did not collect any names, identifiers, or sensitive information throughout the research process. Information included in this data was MT-BCs' personal experiences with lullabies as an intervention in hospice music therapy. The data collected on SurveyMonkey was anonymous to the researcher. Data was kept on a password protected account on the SurveyMonkey website. The researcher was the only individual with access to the raw data. The results were shared with the researcher's committee members who were aware of the process and progress of the data analysis.

Data Analysis

Responses were filtered based on how frequently MT-BCs reported that they use lullabies as an intervention in hospice music therapy. Data from MT-BCs who report that they "never" use

lullabies as an intervention in hospice music therapy were not considered in analysis.

Closed-ended questions were analyzed using descriptive statistics to identify patterns in the data.

Open-ended questions were reviewed by the author. Keywords and phrases that arose in the responses were analyzed for trends, as determined by the author.

Results

The CBMT provided the researcher with 985 emails addresses. The survey was successfully electronically disseminated to 981 of these email addresses. A total of 86 MT-BCs participated in the survey. The response rate was 8.77%. Of these participants, four responded that they “never” use lullaby as an intervention in hospice music therapy; as such their responses were discarded. A total of 82 participant responses were analyzed. Of these respondents, 30.49% of participants have been an MT-BC for 16 or more years. A total of 50% of participants have six or more years experience as a hospice music therapists (see Table 1).

Table 1

Years As a MT-BC

Years	Years as an MT-BC (%)	Years Working in Hospice as an MT-BC (%)
>1	2.44	6.10
1-5	29.27	43.90
6-10	21.95	24.39
11-15	15.85	14.63
16+	30.49	10.98

Participants responded that they used lullaby as an intervention in hospice music therapy “frequently” and “occasionally” at an equal rate of 28.05% (see Table 2).

Table 2

Frequency of Lullaby Intervention in Hospice Music Therapy

Frequency	MT-BC Responses (%)
Very Frequently	12.20
Frequently	28.05
Occasionally	28.05
Rarely	14.63
Very Rarely	17.07
Never	0.00

In terms of the methods of music therapy that incorporated the use of lullaby, participants could choose as many methods as suited their practices. Most participants used lullaby as a receptive intervention (74.39%), followed by 62.2% as an improvisational intervention, 45.12% as a re-creative intervention, and 23.17 as a compositional intervention (see Table 3).

Table 3

Method of Music Therapy Used for Lullaby Intervention in Hospice Music Therapy

Method of Music Therapy	MT-BC Responses (%)
Compositional	23.17
Improvisational	62.20
Re-creative	45.12
Receptive	74.39

Participants indicated that they most often used a lullaby intervention to facilitate therapy relaxation techniques (75.61%), live or recorded music listening (53.66%), and improvisation (41.46%). A total of 4.88% of participants responded they used lullaby as “other.” They responded that they have used a lullaby intervention as “client choice,” “humming,” “entrainment,” and “iso-rhythmic principle with chaining to promote entrainment” (see Table 4).

Table 4

Types of Music Therapy Interventions Facilitated by Lullaby Interventions in Hospice

Type of Intervention	MT-BC Responses (%)
Songwriting	7.32
Improvisation	41.46
Guided Imagery and Music	17.07
Lyric Analysis	2.44
Singing	65.85
Instrument Playing	40.24
Music Therapy Relaxation Technique	75.61
Live or Recorded Music Listening	53.66
Other	4.88

Participants indicated that they use most often use a lullaby intervention to address patient and/or family needs related to comfort/relaxation (73.17%), pain/discomfort (60.98%), anxiety (57.32%), agitation (52.44%), and terminal restlessness (36.59%). Finally, 6.10% of respondents chose “other.” They responded that they have used a lullaby intervention with the intended outcome of “family bonding activity when a baby is present in the home near the patient,” “impaired/deteriorated cognition (ex. dementia),” “validation [of] dementia client [who]

wanted to sing [a] baby doll to sleep,” “physical decline,” and “pt [patient] with dementia interacting with baby doll” (see Figure 1).

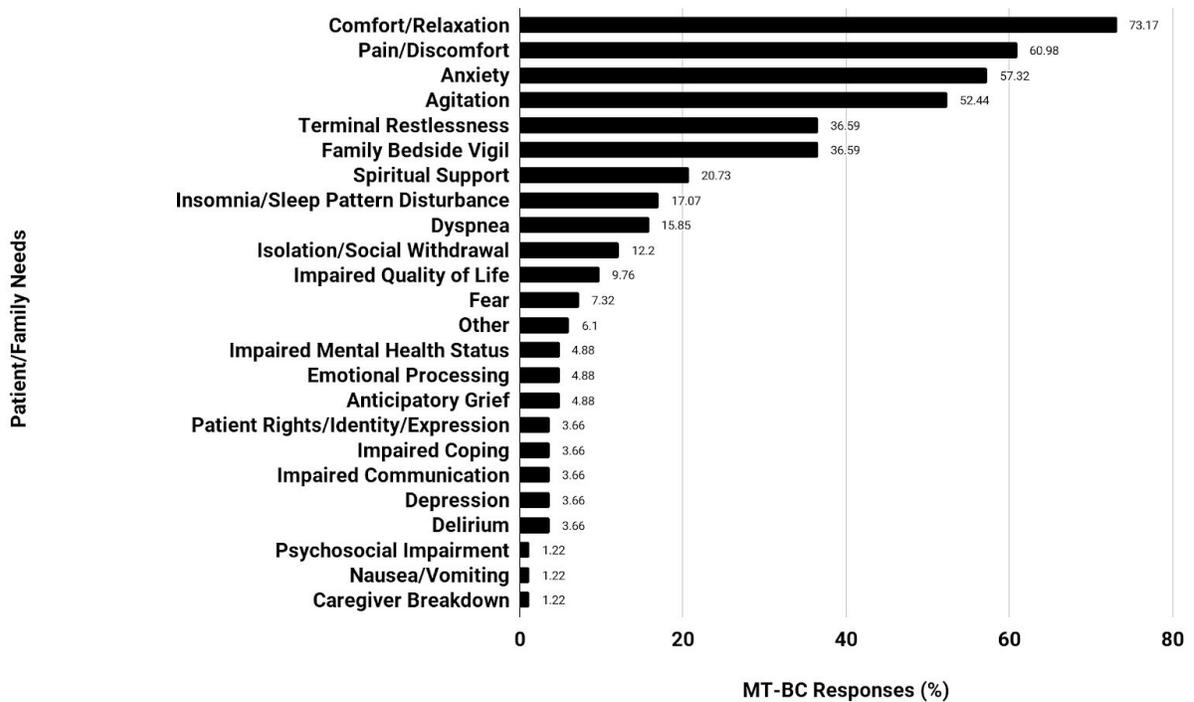


Figure 1. Patient/Family Needs Addressed by Lullaby Interventions in Hospice Music Therapy

The most frequently intended outcomes of a lullaby intervention as indicated by participants are increasing relaxation/comfort (76.83%), decreased stress and anxiety for patients and/or family (74.39%), decreasing pain/pain perception (37.80%), decreasing fear/increasing feelings of safety (35.37%), and improved sleep/decreasing insomnia (34.15%) (see Figure 2).

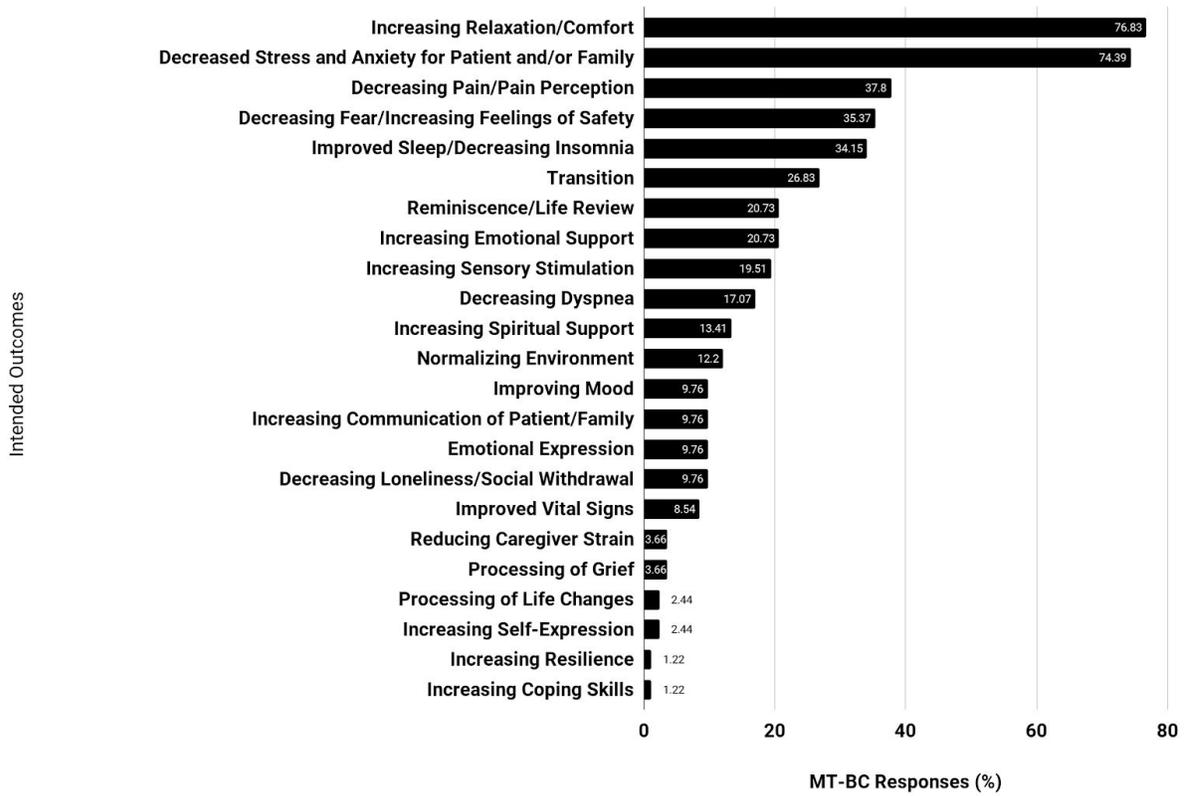


Figure 2. Intended Outcomes of a Lullaby Intervention in Hospice Music Therapy

The majority of participants indicated that lullaby interventions are successful at reaching their intended outcomes. Participants responded that they were successful “very frequently” at a rate of 14.63% and “frequently” at a rate of 63.41% (see Table 5).

Table 5

Success of Lullaby Interventions in Hospice Music Therapy

Frequency	MT-BC Responses (%)
Very Frequently	14.63
Frequently	63.41
Occasionally	18.29
Rarely	1.22
Very Rarely	2.44
Never	0.00

Regarding negative therapeutic responses to lullaby interventions, 96.34% of participants responded “rarely,” “very rarely,” or “never” (see Table 6).

Table 6

Frequency of Negative Therapeutic Outcomes of Lullaby Interventions in Hospice Music Therapy

Frequency	MT-BC Responses (%)
Very Frequently	0.00
Frequently	0.00
Occasionally	3.66
Rarely	41.46
Very Rarely	46.34
Never	8.54

Most participants responded that lullaby interventions are contraindicated in hospice music therapy “occasionally” (34.15%), “rarely” (31.71%) or “very rarely” (23.17%) (see Table 7).

Table 7

Frequency of Lullaby Intervention Contraindicated in Hospice Music Therapy

Frequency	MT-BC Responses (%)
Very Frequently	0.00
Frequently	8.54
Occasionally	34.15
Rarely	31.71
Very Rarely	23.17
Never	2.44

In contrast, 81.71% of participants responded that lullaby interventions were well-received by hospice patients “very frequently” or “frequently” (see Q11 Table 11). Most participants responded that lullaby interventions were well-received by the families of hospice patients “frequently” (56.10%) (see Table 8).

Table 8

Frequency of Lullaby Interventions Well-Received in Hospice Music Therapy

Frequency	Well-Received by Patients	Well-Received by Families
Very Frequently	21.95	19.51
Frequently	59.76	56.10
Occasionally	14.63	23.17
Rarely	3.66	1.22
Very Rarely	0.00	0.00
Never	0.00	0.00

The survey included three open-ended questions (See Appendix D). Participants were asked how they thought lullaby interventions differed from other interventions in hospice music therapy. Many participants expressed that lullabies provide relaxation (13), soothing (8), calming (5), and comforting (15). Lullabies were described as repetitive (5) and simple (3). Seven participants described lullaby interventions as passive and/or receptive. The connections between lullabies and family, family roles, and/or maternal figures was noted by eight participants. Four participants expressed that lullabies were useful to meet clients who were in a childlike or infant state or to promote regression to a childlike or infant state. Five participants connected lullabies to memories. Five participants responded that lullabies promoted safety and security. Ten participants described lullabies as “familiar”. Five participants made note of the connection between lullaby hospice music therapy interventions and sleep (Table 9).

Some participants responded that they did not feel or did not know how lullabies were different from other hospice music therapy interventions, or that lullabies were not their own specific and separate intervention (10). Several participants noted that they would only use lullabies with an infant or worried that lullabies would be perceived by adult clients as infantile (5). One participant stated that they would only use lullabies upon request. Two participants stated that they needed further definition of a lullaby. Three participants gave no answer or expressed they did not understand the question.

Table 9

Themes Regarding How Lullaby Interventions Differ From Other Hospice Music Therapy Interventions

Themes	Keywords and Phrases	Frequency
Comfort and Relaxation	Comforting, comfort, relaxing, relax, relaxation, relaxed, soothing, soothe, calming, calm, calmness, peaceful, peace, tender, reduce anxiety, gentle, sleep, asleep, space	56
Family and Familiarity	Familiar, familiarity, family, maternal attachment, parents...with child, mothers, mother, changing roles within the family, caregiving, love, nurture, nurturing, caring	24
Meeting Specific Patient Needs	Adaptable, adaptability, flexible, immediate needs, current needs, iso-principle, ISO principle, client-specific, conscious, personal, authentic, unique, very specific association, processing, raw	16
Musical Properties	Continuous, easy to transition from one song to another, soft, quieter, slow, steady, improvisation, transition	9
Regression and Connection to the Past	Child-like, child/infant, infancy, child like state, memories, connection to the past	9
Repetition and Predictability	Repetitive, repetition, repeated, simple, simplicity, simplified, predictable	9
Levels of Engagement	Receptive, passively, passive, less interactive, less active client engagement, less engaging, interactive	8
Trust and Safety	Safety, safe, security, decrease fear, trusting, support	8

Participants were asked if they believed that any song could be a lullaby. They were also asked to provide experiences they had using lullabies as an intervention in hospice music therapy. Twenty-seven participants expressed that they believed any song could be a lullaby. Twelve participants responded that most songs could be a lullaby. Four participants noted that a song must have certain qualities that lend themselves to a lullaby to be turned into a lullaby. These qualities included tempo, volume, meter, “flowing, soft melody,” and “relaxing and suitable lyrics.” Nine participants said that any song could be played in a lullaby-fashion, but they would not call it a “lullaby.” Nine participants stated that they did not think any song could be a lullaby. Twenty-one participants did not provide a definitive yes or no answer.

The survey concluded with an optional question providing space for participants to add anything that they would like to express to the researcher. MT-BCs shared a variety of experiences, opinions, and advice for other MT-BC regarding using lullabies as an intervention in hospice music therapy.

Discussion

Methods and Types of Music Therapy Experiences

The results of the survey suggest that hospice music therapists apply lullaby interventions to all four of the methods of music therapy as defined by Bruscia (2014). Results indicate that the method of music therapy that hospice music therapists use most often in lullaby interventions is receptive, with 74.39% of participants responding that they use lullabies in this way. The next most common method is improvisational, with 62.2% of participants responding that they use lullabies improvisationally. Hospice music therapists employ lullabies in a wide variety of experiences within the four methods of music therapy, but use them most often to facilitate

music therapy relaxation techniques. The research suggests the adaptability of lullaby interventions to meet the musical needs of hospice music therapy patients.

Patient/Family Needs and Intended Outcomes

The most commonly addressed patient needs aligned with the most commonly intended outcomes. The first is relaxation/comfort. Relaxation and comfort are quality of life needs that are commonly addressed by complementary therapies in hospice care (Bowers & Wetsel, 2014; Maue-Johnson & Tanguay, 2006). Next is pain/discomfort. Pain is experienced by approximately half of all hospice patients (Pan et al., 2000; SUPPORT Principal Investigators, 1995) and can be challenging to manage with pharmaceuticals (Gutgsell et al., 2013). The third is stress/anxiety. Anxiety is experienced by many individuals at end-of-life (Hill, Evans & Forbat 2015; Georges et al., 2004). This data supports Loewy's (2015) assertion that lullabies as a music therapy intervention can promote stress relief. The research further indicates that lullaby interventions in hospice music therapy are meeting the most prevalent needs of hospice patients and/or their families.

The Unique Qualities of Lullaby

There were many thoughts offered in response to the uniqueness of lullaby as an intervention in hospice music therapy. Many participants suggested that lullabies have inherent calming, comforting, relaxing, and soothing qualities. West (1994) discusses the need for soothing in hospice patients and Geller (2005) supports the use of lullabies to self-soothe in adults. Participants also indicated that emphasis on family and family roles is also present in lullabies and sets lullabies apart from other hospice music therapy interventions. Supporting the families' socioemotional needs is an important part of hospice care (NHPCO, 2018;

Maue-Johnson & Tanguay, 2006). Participants responded that lullabies as an intervention in hospice music therapy are unique in their familiarity. This supports Loewy (2015), who suggests using familiar and meaningful songs as a lullaby with infants, and Maue-Johnson and Tanguay (2006) who suggest using familiar and significant songs with the hospice population. Not all participants agreed that lullaby interventions had unique qualities; 12.20% percent of participants responded that they do not think that lullaby interventions differ from other hospice music therapy interventions or they are not sure how lullaby interventions differ from other hospice music therapy interventions.

Success of Lullaby Interventions

Most participants responded that lullaby interventions in hospice music therapy were successful; 78.04% of participants indicated that lullaby interventions were successful at reaching their intended outcomes “very frequently” or “frequently.” Participants indicated that lullaby interventions have a low rate of negative therapeutic reactions and a fairly low rate of contraindication in hospice music therapy. Lullaby interventions are often well-received by hospice patients and/or their families. However, only 40.25% of participants indicated that they use lullabies “very frequently” or “frequently.” There is a notable discrepancy in the data comparing the high rate of success compared to a much lower rate of frequency of use by hospice music therapists. The data suggests that hospice music therapists should considering increasing their use of lullaby interventions in their clinical work.

Intentions of MT-BCs and the Term “Lullaby”

A topic that arose during the course of this research is how MT-BCs used and responded to the term “lullaby.” A number of respondents called the music they provide “lullaby-like,”

saying it is similar in musical quality to this researcher's definition of a lullaby. Yet these participants would not call these interventions "lullaby," even though their intentions, often to provide relaxation, aligned with those of the researcher. Some of the terms that participants used to replace or encompass the term "lullaby" included sedative music presentation, music-facilitated relaxation techniques, iso-principle technique, music assisted relaxation, imagery. Many participants also expressed that lullabies are only for infants and children. This reflects the different perceptions of the term lullaby.

Limitations

One limitation of this study is that the survey did not have an operational definition of "lullaby" until it was added the second day of data collection after receiving feedback from several participants. The definition of "lullaby" provided was "the researcher is defining lullaby as a song played simply, slowly, and in a repetitive manner with the intention to soothe or lull." This is a universal definition of lullaby, so some misinterpretation of the terms "lullaby" and "lullaby intervention" may have occurred.

Another limitation of this study is the format of the survey. The researcher received feedback from a participant which expressed that for individuals who do not use lullabies in their clinical practice, it wasn't possible for them to fill out the survey, as not all questions had a "never" or "not applicable" option. The survey should have had an option that for individuals who answered that they "never" use lullabies in their clinical work, the survey ended. However, the data from participants who responded this way was not analyzed and is not included in the results section of this study.

Suggestions for Future Research

To further understand the use of lullabies in hospice music therapy, more research is necessary. Future researchers may consider data collection from hospice patients and/or their families to further understand their experiences with lullabies. Another area that requires future research is the term “lullaby.” There were some very significant differences in defining the term “lullaby,” and how participants of the study might apply it in describing their work. This shows a need for clarification and established definition, particularly within the music therapy community. One participant expressed interest in research in lullabies without lyrics. Another participant expressed interest in list of lullabies most commonly used by MT-BCs. These may be possible areas to be explored in future research.

Conclusion

The results of this survey suggest that lullabies are an appropriate and effective tool for hospice music therapists. MT-BCs are using lullaby interventions to meet the many different physical, psychosocial, and emotional needs of hospice patients and their families, and they are doing so using a wide array of music therapy methods and techniques. The results of this survey show that lullaby interventions bring mostly positive reactions and are often successful at meeting their intended outcomes when used in the hospice setting.

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Appendix A: The Use of Lullabies in Hospice Music Therapy

1. How many years have you been a Board Certified Music Therapist (MT-BC)?
 - a. >1
 - b. 1-5
 - c. 6-10
 - d. 11-15
 - e. 16+

2. How many years of experience do you have as an MT-BC working with the hospice population?
 - a. >1
 - b. 1-5
 - c. 6-10
 - d. 11-15
 - e. 16+

3. How often do you use lullaby as an intervention in hospice music therapy?
 - a. Very Frequently
 - b. Frequently
 - c. Occasionally
 - d. Rarely
 - e. Very Rarely
 - f. Never

4. As part of what method(s) of music therapy have you used as a lullaby intervention?
Check all that apply.
 - a. Compositional
 - b. Improvisational
 - c. Re-creative
 - d. Receptive

5. Which type(s) of music therapy experience best fit your use of a lullaby intervention?
Check all that apply.
 - a. Song Writing
 - b. Improvisation
 - c. Guided Imagery and Music
 - d. Lyric Analysis
 - e. Singing

- f. Instrument Playing
 - g. Music Therapy Relaxation Techniques
 - h. Live or Recorded Music Listening
 - i. Other _____
6. What patient/family needs have you most often addressed with a lullaby intervention? Check the five you most often address.
- a. Pain/Discomfort
 - b. Nausea/Vomiting
 - c. Dyspnea
 - d. Delirium
 - e. Agitation
 - f. Terminal Restlessness
 - g. Insomnia/Sleep Pattern Disturbance
 - h. Anxiety
 - i. Depression
 - j. Isolation/Social Withdrawal
 - k. Psychosocial Impairment
 - l. Impaired Mental Health Status
 - m. Fear
 - n. Impaired Coping
 - o. Impaired Quality of Life
 - p. Comfort/Relaxation
 - q. Anticipatory Grief
 - r. Patient Rights/Identity/Expression
 - s. Impaired Communication
 - t. Emotional Processing
 - u. Caregiver Breakdown
 - v. Spiritual Support
 - w. Family Bedside Vigil
 - x. Other _____
7. What are the most frequently intended outcomes of a lullaby intervention? Check the five you most often intend.
- a. Emotional Expression
 - b. Transition
 - c. Improved Vital Signs
 - d. Improved Sleep/Decreasing Insomnia
 - e. Decreased Stress and Anxiety for Patient and/or Family

- f. Increasing Resilience
 - g. Decreasing Loneliness/Social Withdrawal
 - h. Decreasing Fear/Increasing Feelings of Safety
 - i. Increasing Relaxation/Comfort
 - j. Decreasing Dyspnea
 - k. Decreasing Pain/Pain Perception
 - l. Increasing Sensory Stimulation
 - m. Increasing Communication of Patient/Family (Verbal and Non-Verbal)
 - n. Improving Mood
 - o. Increasing Emotional Support
 - p. Increasing Self-Expression
 - q. Normalizing Environment
 - r. Reminiscence/Life Review
 - s. Processing of Life Changes
 - t. Processing of Grief
 - u. Increasing Coping Skills
 - v. Increasing Spiritual Support
 - w. Reducing Caregiver Strain
8. How often are lullaby interventions successful at reaching your intended outcomes?
- a. Very Frequently
 - b. Frequently
 - c. Occasionally
 - d. Rarely
 - e. Very Rarely
 - f. Never
9. How often do lullaby interventions produce negative therapeutic reactions?
- a. Very Frequently
 - b. Frequently
 - c. Occasionally
 - d. Rarely
 - e. Very Rarely
 - f. Never
10. How often is a lullaby intervention contraindicated in hospice music therapy?
- a. Very Frequently
 - b. Frequently
 - c. Occasionally

- d. Rarely
 - e. Very Rarely
 - f. Never
11. How often are lullaby interventions well-received by hospice patients?
- a. Very Frequently
 - b. Frequently
 - c. Occasionally
 - d. Rarely
 - e. Very Rarely
 - f. Never
12. How often are lullaby interventions well-received by families of hospice patients?
- a. Very Frequently
 - b. Frequently
 - c. Occasionally
 - d. Rarely
 - e. Very Rarely
 - f. Never
13. How do you think lullaby interventions differ from other hospice music therapy interventions?
14. Do you think that any song can be a lullaby? If so, what are some of your experiences using non-traditional lullabies in lullaby interventions?
15. Is there anything else you would like to add that hasn't been addressed?

Questions were developed with use of:

Hilliard, R. E. (2005). Music therapy in hospice and palliative care: A review of the empirical data. *Evidence-Based and Alternative Medicine: eCAM*, 2(2), 173-178.

Maue-Johnson, E. L., & Tanguay, C. L. (2006). Assessing the unique needs of hospice patients: A tool for music therapists. *Music Therapy Perspectives* 24(1), 13-20.

Appendix B: Recruitment Email

Greetings,

My name is Samantha Lawrence and I am a graduate student studying music therapy at SUNY New Paltz. I am conducting research for my thesis about the use of lullabies in hospice music therapy. I will be analyzing how and when lullabies are used in clinical practice by hospice music therapists.

I am emailing you to ask if you would take a survey about your experiences using lullabies as a music therapy intervention in hospice music therapy. This survey is completely voluntary. Your responses will remain fully anonymous. Clicking on the link provided implies consent.

The survey should take approximately 15 to 30 minutes to complete. If you are interested in participating in the study please click this link:

If you have additional questions or comments about my study, please do not hesitate to contact me. Thank you so for your time.

Warmly,

Samantha Lawrence
Music Therapy Graduate Student
State University of New York at New Paltz
Lawrencs1@hawkmail.newpaltz.edu
(518) 630-8651

Appendix C: Follow-up Email

Greetings,

My name is Samantha Lawrence and I am a graduate student studying music therapy at SUNY New Paltz. I am conducting research for my thesis about the use of lullabies in hospice music therapy. I will be analyzing how and when lullabies are used in clinical practice by hospice music therapists.

Last week an email was sent to you inviting you to participate in the study by completing a survey. This follow-up email is being sent to remind you to complete the survey if you would like to participate and have not already done so. The deadline for participation is _____.

The survey should take approximately 15 to 30 minutes to complete. Participation in this study is voluntary. Your responses will remain fully anonymous. Clicking on the link provided implies consent.

If you are interested in participating in the study please click this link:

If you have additional questions or comments about my study, please do not hesitate to contact me. Thank you so for your time.

Warmly,

Samantha Lawrence
Music Therapy Graduate Student
State University of New York at New Paltz
Lawrencs1@hawkmail.newpaltz.edu
(518) 630-8651

Appendix D: Participant Open-Ended Responses

Question 13: How do you think lullaby interventions differ from other hospice music therapy interventions

- “Simplicity of melody and repetition.”
- “Usually, I’ve used lullaby interventions to be client-specific as to their current needs within the time that we’re together. Sometimes a soothing, repetitive, familiar melody, i.e “Jesus Loves Me”, appears to provide a safe space to be.”
- “The lullaby helps the patient/family to be calm, as opposed to reminiscence.”
- “I don’t differentiate and often include multiple interventions at once. I never sit down and “only’ use lullaby – I’m typically using lots of techniques together.”
- “They should be implemented in a quieter environment/space, there is more consideration into selecting this than other intervention options.”
- “They have a time and place just like any other intervention. I like using a lullaby type intervention because you can personal [*sic*] the experience and create something raw and authentic in the moment.”
- “I don’t.”
- “In my experience it’s a bit more passive and you rely solely on the music to do the work.”
- “They are useful in their familiarity.”
- “This question isn’t totally clear to me.”
- “More relaxing. They can take the client back to when they were a very small child/infant.”

- “For me, the intention and goal is different. Almost always when I do what you are defining as lullabies, there is a degree of anticipated [*sic*] comfort and calm needed.”
- “Responsive to immediate needs.”
- “There is a comfort inherent in lullabies that provides a sense of calm, security, love and caring”
- “It has very specific association, different from other genres.”
- “Focus on relaxation or sleep.”
- “By association with secure/maternal attachment, deep sleep, and comfort recalled by lullabies provided during infancy.”
- “I think you need to define the “Lullaby”. Some clients find hymns or slowed preferred music to be received as a ‘lullaby’. It’s the intention of the music that is more important, not what category it falls under”
- “Lullaby interventions appear to be more familiar to clients.”
- “The repetition and soft nature tends to comfort and sooth [*sic*] in those situations when music listening/iso-principle is the best choice rather than verbal conversational interventions.”
- “I think these interventions can be tools and complement hospice music therapy interventions. I can’t tell how they differ.”
- “I use lullabied [*sic*] specifically for relaxation/sleep, they tend to work.”
- “They easily lend themselves to repetition which tends to increase possibility of relaxation. Also, it is easy to transition from one song to another.”

- “I use lullabies more passively or to facilitate relaxation more often than other more active interventions.”
- “I would only use a lullaby for a child or baby. I have never had an infant as a patient. I have used children’s songs for interventions of family bonding for babies present in the patient’s home for their engagement and interaction with the patient.”
- “They are less interactive, slightly more prescriptive.”
- “Creates feelings of safety/comfort and nurture.”
- “Can be repeated and varied for significant amounts of time, very appropriate to use with ISO principle, conducive to movement/cued breathing.”
- “Not sure.”
- “Lullabies are very familiar and in some cases where you want parents to interacting with child it may be easier using a lullaby.”
- “For our older adults, they trigger memories of comfort/mothers/safety/security in a very unique way.”
- “.”
- “None.”
- “Patients associate lullabies with calmness and soothing.”
- “I think in general, they are the more appropriate choice in a Hospice environment due to the soothing nature of a lullaby.”
- “The peaceful, gentle and calming nature of a lullaby naturally transcends [*sic*] music genres and creates a soothing environment [*sic*] even without words, and can be done

vocally, instrumentally or combination without changing the overall receptiveness of the music.”

- “More of a receptive intervention with focus more on physical comfort than interaction or emotional processing.”
- “I mostly use upon request. Most requested lullaby is Irish Lullaby.”
- “It can be perceived as for babies, depending on what you do.”
- “Their soothing, predictable qualities – in melody, harmony, and rhythm, and lyrics, if included, create a trusting, comforting aural environment for both client and family/caregiver(s).”
- “I do not know that I use lullabies as a total interventions as much as an appropriate genre for relaxation.”
- “I find they more often put a patient in a relaxed state than other suggested/pt preferred music.”
- “Sense of security, can easily bring back feelings/memories of feeling safe and secure or aid in relaxation.”
- “Lullabies are familiar and thus can stimulate life review and interaction. Lullaby meters are comforting and rlxing [*sic*].”
- “More passive for pt.”
- “I don’t think they differ, end goal is comfort.”
- “Familiar but lulling.”
- “Well known songs, simple and easy to sing.”

- “They often have a lot of specific meaning to the family across generations... reminds the patients of their parents AND their children.”
- “They allow MTBC to direct tremendous support to the non verbal patient.”
- “I usually just use improvisation and maybe soft humming as a “lullaby”. To me it’s different in that it’s almost always improvised.”
- “They allow easy adaptability of stimulation level (using complexity, harmony, tempo, accompaniment/singing choices); one of the few interventions which may look almost identical in two visits, but could have two completely different goals (calming/relaxation vs. speech stim/increasing communication). Very adaptable also based on age and culture/ethnicity/nationality.”
- “Just one of many choices that may fit the clinical moment.”
- “I imagine lullaby interventions as having the specific goal of comfort and relaxation (lowered pulse and respiratory rates, relaxed muscles, less overall movement, etc.).”
- “Soothing.”
- “Provides comfort.”
- “Almost always lullabies bring memories to mind, and spur a quality of conversation that might not evolve from other interventions. Lullabies seem to bring me, a virtual stranger, almost easily inside the patient’s circle.”
- “A built in reminder of the life cycle and changing roles within the family.”
- “Lullabies, especially when chained together, provide a steady, unchanging environment that allows the Pt and family members to reduce anxiety, often without knowing it is

happening. So much is changing at end of life, that providing something soothing and continuous creates the peace that we as clinicians are trying to provide.”

- “I feel it is a more receptive technique, than active engagement in music making or conversation.”
- “Without being patronizing, they can be very nurturing.”
- “Lullaby interventions focus on creating a space and rely less on active client engagement than other forms of music therapy intervention.”
- “The familiar genre (or many simultaneous components of the genre) tend to trigger a (usually unconscious) response akin to “Oh, I know what this is/I’ve heard it before; I’ve had positive experiences with this; I know it’s okay to relax/sleep/decrease fear/etc.”
- “Lullaby is not a distinct intervention unto itself. It describes characteristics of the music being utilized, which can be applied to any other intervention. I.e., I may present a patient’s favorite gospel song in a lullaby style because more complex music may be contraindicated for their current physical state, but this song may flow immediately into lyric analysis with this patient, or may elicit reminiscence and life review. Lyric analysis, life review, and reminiscence could all be elicited by the same piece of music, presented in a non-lullaby style. Lullaby describes musical qualities of the music being utilized, not an intervention.”
- “Lullaby interventions are typically intended to increase relaxation and may cause the pt to fall asleep. Other interventions may promote interaction, stimulation, or expression which require the pt to be awake.”

- “Lullaby interventions allow for a unique, flexible, and conscious way of processing anticipatory grief and emotional [sic] memories that hospice patients have with their loved ones. They allow a tangible product to be made at the end of life.”
- “They are less engaging.”
- “It is complicated because you must make sure you are being age appropriate if the intervention is with an adult.”
- “Much more indicated with children, than grown adults.”
- “It is another avenue to use toward music therapy hospice goals.”
- “Lullabies May provide a connection between patient and memory of mother caring for child. It’s a special bond providing comfort and love.”
- “They provide chances to remember a tender time in there [sic] life, that is most likely comforting [sic]. the slow pace and soft accompaniment provides relaxing stimulus.”
- “They can bring comfort to terminal restlessness better than many other techniques, comfort a patient/family, and provide an atmosphere of peace in transition that sometimes cannot be attained other ways.”
- “I’m not sure how you’re defining lullaby interventions, so these questions are very difficult to answer. I would think of a lullaby as something that is either a traditional lullaby (Hush Little Baby) or improvised vocals with simple accompaniment if any and a limited range and gentle rhythm.”
- “Increases those cognitive links associated with relaxation – easy to generalize for the entire family within a multi-generational session – intimately familiar music from early, middle, and late life.”

- “I think using the comforting and familiar melodies help to tap into one’s memories.”
- “They are more child-like than using music from young adulthood. However, some patients respond best to kids songs and nursery rhymes.”
- “Whatever the intervention, I am seeking to meet the patient where they are and validate their sense of personhood and identity.”
- “They aren’t focused on age appropriateness or patient preference, but provide a reassuring familiar melody that is easy to recall.”
- “Simplified, significant connection to the past.”
- “They can be interpreted as infantile”
- “Depends on the patient and how it is used. It can be very effective with dementia/Alzheimer’s patients when they are stuck in either a car giving [*sic*] state or child like state. Lullabies are very effective in reaching them where they are and providing space.”

Question 14: Do you think that any song can be a lullaby? If so, what are some of your experiences using non-traditional lullabies in lullaby interventions?

- “Incorporating loved ones by role (ie father/sister) into a melody has helped calm patients struggling with anxiety about seeing deceased family members.”
- “I use whatever speaks to the client. Usually I know their likes/dislikes, but for new patients I rely on family if communication (non-verbal/verbal) isn’t possible.”
- “Yes. Spiritual songs, traditional songs such as sing-alongs, and musicals help to soothe patients/families.”

- “Sure, it’s a style that has a very specific intended impact. Many times I’ve taken one word and created a “lullaby” but you could also call that improv or music assisted relaxation or even imagery in some cases.”
- “I suppose, if you play it in the right way; Let It Be – Beatles.”
- “I have used Stand By Me before as a lullaby and facility staff gathered around the bedside of the pt and was able to receive experience. Comments and feelings were all positive and powerful.”
- “Depends on the situation.”
- “I try to use music that the resident prefers or folk songs that are age appropriate.”
- “Lullabies are useful when used to inform an improvisation.”
- “Yes – any song can be transformed into what is needed in the moment.”
- “Yes, as long as it has a flowing, soft melody, relaxing and suitable lyrics, played softly, relaxed.”
- “I would think that almost any song with supportive/loving lyrics might be appropriate as a lullaby. Many times I will slow a known song down considerably and use the basic chord progressions of a known song to transition into open vocalizing and/or singing affirmations of love.”
- Many non traditional songs that have been pt/caregiver stated preferences can be used/ modulated to lullaby format. Familiarity often provides ease, comfort, often smiles with added benefit of lullaby techniques for + physiological and emotional chsnge [*sic*].
- “Many, not all, songs can be turned into lullabies. Some lyrics simply do not work as lullabies. In such cases, lyrics might be changed to fit the situation, OR, the melody

might be maintained with different lyrics or no lyrics. Almost any melody can be switched from a duple meter to $\frac{3}{4}$ time, and the tempo slowed to a “walking” tempo.”

- “Yes, other types of music can be musically expressed like a lullaby.”
- “Yes! I once pulled a patient to a restful sleep during his discomfort by using one of his favorite songs “Respect” by Aretha Franklin.”
- “Yes, most any patient preferred song can be slowed and set to $\frac{3}{4}$ time with lyrical modification as appropriate.”
- “I’ve used Berlin’s “Always” as a lullaby using the ISO principle and had the family sing back to their loved one. Also, 1920-40 waltzes were used to slowly entrain with the breathing/moans of a client who was restless and wanting sleep.”
- “I don’t think any song can be a lullaby [*sic*].”
- “Yes, most certainly. Some genres are easier to transition to lullabies, like ballads. Non-traditional lullabies are very effective in my experience because they are usually meaningful, familiar songs or songs with meaningful lyrics that comfort family, but at a more appropriate tempo and dynamic level for pt’s physical state. The non-traditional lullaby played in the style of a lullaby also makes the moment unique and gets the family or patient’s attention.”
- “I don’t think that any song can be a lullaby but, in maybe cases just changing the tempo and mood of the song to sound like a lullaby can address different needs of the patient.”
- “Yes, using improvised techniques, slowing down the tempo and possibly changing the meter can create a lullaby effect. It is usually just as effective.”
- “Most songs can be used as lullabies. Most effective seem to be waltz tempos.”

- “Many songs can; there must be some basic elements present, but the MT can adapt many Pt preferred songs to fit these criteria.”
- “Any song can be slowed down and altered to achieve relaxation goal, so I suppose so, but I have never called this providing a lullaby.”
- “I think most songs can be a lullaby. I have taken situation-appropriate (simple) lyrics from popular or folk music and adapted it to a lullaby style (meter, tempo, melody accompanying harmony).”
- “Most any song, dependent on what is appropriate and preferred for the pt. I’ve used ‘Songbird’ and ‘Rhiannon’ by Fleetwood Mac or “I Wanna Hold Your Hand” by the Beatles paired with gentle tactile stim for soothing an agitated pt. “Somewhere Over the Rainbow”.”
- “Yes. Great way to facilitate relaxation, emotionally hold the agitated patient, create a gentle movement experience for patient and family (just by modeling). I don’t think of it as a lullaby “intervention” - rather and organic change to a comforting supportive presence for a patient/family. Sometimes it leads to memories of being rocked/held or rocking/holding, but often no words are needed. I have a couple of patients right now with advanced dementia who are agitated and/or difficult to engage. A lullaby without lyrics (such as Edelweiss or Brahm’s lullaby gents them to sway, hum or quiet. Holding someone’s hand to sway with them also powerful.”
- “Hymns.”
- “Depending on the song, yes. Just from personal experience with my own children some songs can be sung as a lullaby. It all depends on the tempo, volume etc.”

- “Yes, sometimes I string several songs together – a traditional lullaby such as All Through the Night, then another melody, then another lullaby, etc.”
- “.”
- “I think any slow soothing song can be a lullaby.”
- “Slowing tempo and singing soothingly of any song has been effective.”
- “Yes. I have only done this a couple of times but both times it yielded the intended response.”
- “Yes. I like to take a variety of popular songs and reduce them to melody and lyrics, changing the tempo if necessary to reflect a heart beat or slower breathing.”
- “Most any song can be provided in a sedative manner to elicit relaxation, for instance sedative, acoustic version of a heavy metal ballad.”
- “Tempos can change and make it more relaxing and calm, but I wouldn’t call it a lullaby.”
- “Almost any song can be changed so that it is more soothing, but not everyone would define any song as a lullaby.”
- “I don’t believe any song from any of the many genres can be transformed into a lullaby, but many of the faith-based songs (traditional, familiar hymns), as well as some folk songs, especially in ¾ tempo – can be slowed down and rendered in a gentle, soothing manner appropriate for this population and setting.”
- “No. Slower songs can be adapted to be used in the same purpose as a lullaby. I mean if you want to make “blue suede shoes” into a lullaby you could but it would be a bit odd given the context most people use that song in or remember it in..”

- “No, i think the melody needs to be simple and traditional. Recognizable is a plus but not necessary.”
- “Possibly but I don’t have much experience with that.”
- “Many songs and lyrics can be adapted to lullaby meter and styl [*sic*].”
- “Yes. Can address all ages by matching preferred song genre to effects of lullaby.”
- “I have only used it once and I sang some traditional lullabies for the moment.”
- “I improvise on a lullaby structure, so yes.”
- “Using a favorite song and playing it with a slow, tender feel on the instrument I am using.”
- “If you slow tempo most songs can work as lullabies. Waltzes are especially well-suited since you can rock to them.”
- “Yes. I often play patient preferred music in a lullaby-like manner. I utilize chord simplification, slower tempo, and a soothing (lilt-like) tone of voice.”
- “I have taken the chords and/or melodies of familiar tunes (pt – preferred if [*sic*] I know what they like) and slow it down, arpeggiating the chords.”
- “Absolutely – for me, any song which has a limited melodic range that can be sung appropriately (stylistically for the genre) can work. I have used songs like Yo Te Necesito (by Los Bukis), Brown Eyed Girl, and This Land is Your Land. As we know, many patients with cognitive decline (particularly I find my dementia patients) can need a LOT of repetition to begin responding/engaging/expressing.”
- “Nearly any. I’ve turned nearly every Beatles tune into a lullaby.”

- “I imagine that any song with the musical elements that mirror a lullaby (tempo below about 60 bpm, volume between about pp – mp, rocking or swaying rhythm, such as 6/8 time, etc.)”
- ‘No.’
- “Guitar fingerpicking and bringing tempo down.”
- “I often slow songs of early childhood and use them as a ballad or lullaby. They are universally familiar, and appear to disarm distrust and anxiety. Also, slowing down favorite gospel or traditional folk and bluegrass tunes bring about a similar effect.”
- “Yes, I prefer to use lullabies the patient heard as a child or sang to their children even if they are non-traditional, i.e. Simon and Garfunkel.”
- “Yes. I’ve sung “Satisfaction” as a lullaby at the bedside of an actively dying Pt; and have seen our interns using Metal, Glam, and Hard Rock songs, preferred music of their patients, with great success.”
- “Just like in the NICU, parents are taught to use their familiar songs and turn them into more mother ease. Same principle applies here.”
- “The Water is Wide and Goodnight Sweetheart have been powerful.”
- “Yes, most songs can be adapted and utilized in lullaby intervention if the client is flexible in their willingness to hear songs outside of their original version. In my experience, simplifying the accompaniment, slowing the tempo, and utilizing warm vocal qualities assists in creating lullabies. It has also been helpful to focus on 1-2 repetitive lines from a song that may convey a therapeutic message and incorporate improvisation based on the original song.”

- “I’m sure it’s possible, but I don’t think I’ve used this technique frequently. The closest possibly is using a religious hymn as a lullaby to provide spiritual support as well.”
- “Yes. I may begin with very upbeat, patient-preferred music (iso- principle) for someone who is agitated or anxious, and gradually transition to lullaby adaptations within their preferred music, which may be any popular genre and decade of music. I have sung gospel, rock, pop, motown, and more as lullabies. This simply means changing tempo, key, phrase length, volume, rhythmic emphasis, accompaniment patterns, and occasionally song structure to imbue the music with the musical characteristics of a lullaby. For example, I have used “Stand By Me” by Ben. E. King as a Lullaby.”
- “Yes, I use any song of pt preference as a lullaby and have generally had positive outcomes.”
- “Yes. Changing music elements of preferred music to make it more “soothing” has allowed for increased relaxation and management of pain in some instances.”
- “No.”
- “Yes any song could, but when I think of lullabies I think of traditional songs like All Through the Night, Hush Little Baby, Pretty Little Horses, etc.”
- “I would not call any song a lullaby BUT they pretty much any song could be sung in lullaby fashion.”
- “No. Some songs just can be lullabies. Lullabies are soothing, calming, and comforting.”
- “No.”
- “Yes. Changing the pace and accompaniment pattern of a patient familiar songs to reflect a lullaby tone. Such as “Love Me Tender” from 4/4 to 3/4.”

- “Yes, I do. I’ve used other songs in a lullaby manner for the same purposes. Especially if it’s a song that has deep meaning to the person or family. It can bring a real closeness to them during a stressful, anxious time.”
- “I don’t know how you’re defining “lullaby.” But sure, many songs can be played in a lullaby style.”
- “Yes. Utilizing the iso-principle, we are able to entrain to our clients’ breathing, HR, cognitive level, emotional state, etc... Non-traditional lullabies assist in increasing relaxation for my clients in a comforting, safe, and passive way.”
- “I haven’t used lullabies a whole lot in hospice music therapy but I do use songwriting with resident memories which brings them comfort.”
- “It depends on how you define lullaby. If it is Music that is intended to promote comfort and security, then almost any song could be considered a lullaby. I have one patient who relaxed to Led Zeppelin!”
- “I often use hymns as lullabies as well as a John Denver, Beatles, and even Styx. Any song could be played at a slower pace with quiet timb.”
- “Not sure. I haven’t used any.”
- “No.”
- “Songs can be modified to have qualities like a lullaby. I do not call them lullabies.”
- “Yes, most songs can be modified to a slow lulling and rocking style. I don’t believe I’m always thinking lullaby when I adjust live music to meet the needs of my patients.”

Question 15: Is there anything else you would like to add that hasn’t be addressed?

- “Important to be flexible, often using iso-principle w/agitated patients, prior to slower and lyric lullaby.”
- “No.”
- “I would like to see research regarding using lullabies without lyrics.”
- “No.”
- “I am very careful to use lullabies with elderly clients so as not to disrespect their age and experience as something juvenile or childlike.”
- “There are myriad of the similarities between birth and early life and death and end of life, thus it makes sense that lullabies are an effective modality.”
- “No.”
- “A #1 technique in my hospice toolbox.”
- “Mothers all around the world naturally arrived at the slow, rocking rhythms of lullabies. They are definitely universally loved, bringing comfort and security. Just about everyone is familiar with lullabies and, except for a few unlucky clients/patients, has the same magical response to lullabies.”
- “No.”
- “Lullabies are great for reassurance, as a mother comforts her child. Wonderful for terminal restlessness when a person can no longer express verbally such as a baby can’t express why when he/she is upset. Great topic for research!”
- “No.”
- “If using non traditional songs as lullabies it helps to preface their use with an explanation to family about the benefits.”

- “I think the definition chosen for “lullaby” is very broad and most MTs I know don’t speak about this type of song or intervention in terms of being a “lullaby” per se. I believe, colloquially, lullaby implies use with children and this term may cause some misunderstandings in a clinical setting.”
- “I found it strange to answer some of these questions due to rarely having babies as patients. Since I always use patient preferred music, and most of patients are adults, it was a little hard to relate to the questions.”
- “No.”
- “We should be able to turn any song into a lullaby! When I feel a patient needs extra emotional holding, I think this is what I often instinctively do.”
- “No.”
- “.”
- “No.”
- “No.”
- “Lullabies are a great way to ease into reminiscence and create an environment of calm and acceptance.”
- “I have not heard the terminology lullaby intervention. I usually use terms like live sedative music presentation, music-facilitated relaxation techniques or iso- principle technique.”
- “—”
- “No.”

- “Working with this population and in this setting is quite conducive to improvising gentle patterns of melody with consonant, simple harmonies, in a predictable (probably most often) slow 3/4 tempo.”
- “Great topic– you’re on to something! Looking forward to seeing your research!”
- “N/a.”
- “No.”
- “Important to keep iso principle in mind when choosing style of music. Lullaby not always so good for agitation and can make it worse. Match pt where they are first.”
- “I played an ancient, unknown lullaby today on my harp to a hospice patient, from Iceland. And it was soothing and produced a beautiful energy in the room. I kept the tempo slow, and balanced, like the music was rocking back and forth as the melodies swayed from one end of the harp to the other...and the tune was unknown, yet familiar.”
- “No.”
- “N/A.”
- “I would love to see the results of your study, and maybe a list of lullabies used by other MT-BCs.”
- “Transference is a common issue especially if the MT has a small child.”
- “I’m a believer that every song can be a lullaby. Addressing the anxiety that is so prevalent in the end of life setting, lullabies have a unique and very powerful ability to make an immediate, clinically measurable difference. Thank you!!”
- “N/a.”
- “No.”

- “Sometimes my patients with dementia with join in and interact with their baby dolls – singing, humming, rocking, etc. (and we know that some patients may occasionally perceive the doll to be a living child). These moments usually illicit smiles from the patients while interacting with both the music and their “little one.””
- “N/A.”
- “I most often think of “lullaby” interventions as “legacy songs,” which family, loved ones, or the person themselves creates a song with therapist to preserve their legacy on earth.”
- “No. But I am interested in the outcome of this survey.”
- “Lullabies are very important. Music therapists should be trained on how to use lullabies. This may be a good class to offer at a conference. I’m not sure if Russell Hilliard teaches this.”
- “No.”
- “An operational definition of “lullaby” is really important in a study like this.”
- “N/a.”
- “N/A.”
- “No.”
- “No.”
- “Perhaps a definition of lullaby at the beginning of the survey would be helpful.”