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Preferences of Chinese Alzheimer's Patients for Music Therapy Activities: Singing, Instruments, Games, Dance/Movement, and Composition/Improvisation

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PREFERENCES OF CHINESE ALZHEIMER'S PATIENTS FOR MUSIC THERAPY
ACTIVITIES: SINGING, INSTRUMENTS, GAMES, DANCE/MOVEMENT, AND
COMPOSITION/IMPROVISATION

by

Karen Kwok

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PREFERENCES OF CHINESE ALZHEIMER'S PATIENTS FOR MUSIC THERAPY
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COMPOSITION/IMPROVISATION

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Western Michigan University, 2004

This research, based on Brotons and Pickett-Cooper's 1994 study, examined the preferences of Chinese Alzheimer's patients for music therapy activities. Fifteen Chinese senior residents residing in a Toronto, Canada ethnic nursing home participated in this study. Five different language and culturally appropriate music therapy activities were used, which included singing, dance/movement with music, musical games, instrument manipulation and improvisation/composition. Subjects met in small groups of 3 for a total of five 30-minute sessions in two weeks. During each session, one of the five music therapy activities was presented. At the end of each session, subjects were asked to state how much they had enjoyed the type of activity presented that day. Sessions were videotaped for post hoc analysis of subjects' responses. Preference was determined by analyzing the proportion of active participation time and by verbal report. The behavior observation results indicated that Chinese Alzheimer's seniors seem to prefer more musical games and improvisation/composition over other activities. Although this result is different from Brotons and Pickett-Cooper's 1994 study with Caucasians, both studies seem to illustrate that behavior and verbal report do not concur in these individuals. Implications for music therapy practice with Chinese senior immigrants from Hong Kong and China are discussed.

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Karen Kwok

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CHAPTER I

INTRODUCTION

Research Problem

Currently there is very limited research-based literature investigating the relationship between music therapy and the Chinese population, particularly involving Chinese immigrants residing in North America. To demonstrate the effectiveness of multicultural music therapy and to expand music therapy service into ethnic minority groups, this type of research is needed. This study will serve as a pioneer project to evaluate multicultural music therapy in an ethnic nursing home with Chinese Alzheimer's disease residents. Alzheimer's disease is a common disease occurring in all cultural geriatric populations. Based on the result, the author will also discuss and provide recommendations towards using music therapy with Chinese seniors population.

Purpose for Research

The primary purpose of this research was to determine the preference of Chinese Alzheimer's disease patients among five different music therapy activities: singing, dance/movement with music, musical games, instrument manipulation and improvisation/composition. The investigator was using Brotons and Pickett-Cooper's (1994) study, "Preferences of Probable Alzheimer's Disease Patients for Music Activities," as a basis for the research.

The two main research questions were:

(1) What were the subject's preferences for musical activities? The assumption was Chinese Alzheimer's participants would prefer more singing, instrument manipulation, dancing/movement, and playing musical games than improvisation/composition.

(2) Was there an agreement between verbal preferences and observed behavioral preferences? The assumption was that there would be no agreement between the two variables of verbal preferences and behavior.

CHAPTER II

REVIEW OF THE LITERATURE

Alzheimer's Disease

The recent growth in professional literature relating music therapy services to the needs of the elderly is a reflection of a broad and growing societal interest in aspects pertaining to aging and the aged. Since 1988, the number of data based articles in all journals has increased several hundred percent, and countless more appear each year (Prickett, 2000). Problem areas associated with the geriatric population often include physiological and memory considerations, physical strength and coordination, socialization, community integration and depression resulting from diagnosis of dementia, Alzheimer's disease and other causes.

The high percentage with incidents of dementia among nursing home residents is well documented in the literature. At least half of these people living in residential care facilities have some form of dementia, and 60 to 80% of persons over the age of 65 have a probable diagnosis of Alzheimer's disease (AD) (Prickett, 2000). *The Diagnostic And Statistical Manual Of Mental Disorders* (DSM-IV-TR, 1987) defines Alzheimer's disease as a progressive degenerative brain disease with an insidious onset. Affected individuals have long-term and short-term memory impairment, and problems in other areas of cognitive functioning, including abstract reasoning, judgment, language, visual/spatial ability, and/or personality change, which interfere with the individual's

functioning. As the disease progresses, patients become increasingly confused, disoriented, and unaware of their surroundings or behavior. A variety of behavioral problems commonly accompany cognitive deterioration including irritability, withdrawal, depression, anxiety, fear, paranoia or suspiciousness, aggression, delusions, hallucinations, wandering and pacing, and agitation. These behavioral disturbances have been reported to occur in up to 90% of people with moderate and severe dementia, with agitation, specifically, the most frequently observed (Prickett, 2000).

Although at the present time there is no cure for people affected with AD and other dementias, alleviation of their behavioral problems can often result in improvement in their quality of life and decreased stress for both patients and caregivers. Music therapy has been shown to be an efficacious and valid treatment with older persons who have deficits in physical, psychological, cognitive or social functioning. Research results and clinical experiences support the viability of music therapy even for those individuals who are resistive to other treatment approaches. As a form of sensory stimulation, music can provoke responses due to the familiarity, predictability, and feelings of security associated with it. It can relieve stress, improve mood, promote relaxation, help alleviate pain and provide an outlet for physical activity and for improving motor skills. Under the direction of a music therapist, active or passive music experiences are designed to help maintain or enhance older adults' level of function.

The use and benefits of music and music therapy for people with dementias has been acknowledged in the literature. Studies have measured the efficiency of music as a treatment modality to (a) increase reality orientation; (b) increase rhythmic walking gaits; (c) increase quality of life issues; (d) increase sensory awareness; (e) assess cognitive,

affective, and behavioral changes; and (f) increase hand-grasp strength and task performance. Starting in the late 1980s, several studies (Pollack and Namaz's, 1992; Hanson, Gfeller, Woodworth, Swanson, and Garand's, 1996; Groene, Zapchenk, Marble, and Kantar's, 1998) evaluated the effect of music therapy treatments on clients with dementia. In addition, literature review on the relation of music therapy and the Alzheimer's disease population can also be found, Smith, (1990), Smith, (1991), and Prickett, (2000).

Music therapy has been found to improve functional skills and life quality of Alzheimer's patients, an element of which is the preservation of cognitive skill, and to increase verbalizations. Research using Positron Computed Tomographic (PCT) Scan shows that participation in an active music-making experience such as drumming provides sensory input to a large portion of the brain (Mazziotta, 1982). Such widespread brain stimulation could have major implications for the use of music with individuals whose cognitive functioning is being destroyed. In a study of the effects of three treatment interventions on the cognitive functioning of 12 AD patients, Smith (1986) reported that music alone significantly increased total scores on the Mini Mental Status Questionnaire, and that musically and verbally cued reminiscence significantly increased language scores. Prickett and Moore (1991) conducted research involving ten patients with probable Alzheimer's disease who resided in an intermediate care facility in a state hospital. Each participant received three individual 20 minute assessment sessions focusing on the recall of material, both sung and spoken, interspersed with new material and a few orientation questions. Overall, patients recalled the words to songs dramatically better than they recalled spoken words. The study suggested that patients

diagnosed with probable Alzheimer's disease could be stimulated to responsive participation with the use of old-familiar songs. Furthermore, with consistent practice, some patients apparently are capable of learning a new song, even when they do not seem able to recall new spoken material. Evidence found that AD patients retain musical perception abilities (Crystal, Grober, & Mauser, 1989) and that musical skills were preserved in an Alzheimer's patient into the late stages of the disease as well (Beatty et al., 1988). Many musical skills may be mediated in the lower and middle portions of the brain that are not affected until late in the disease progression. These findings suggest that music may be an alternative method of communication for AD patients, when the cognitive ability to process receptive and expressive language has deteriorated.

Beside preserving cognitive and verbalization skills, music therapy was also found to increase the socialization skills of AD patients. Millard and Smith (1989) compared the effects of singing and discussion sessions on the physical and social behaviors of 10 subjects. They found significantly higher levels of vocal and verbal participation during music sessions and a significant change in sitting and walking with others behaviors after music, indicating that music is one means of intervention that seems to be effective in nursing homes for AD patients. Later Clair and Bernstein conducted two separate studies with very low functioning male patients. They found that subjects maintained basic rhythmic responses to vibro-tactile stimulation (1990a) and demonstrated the ability to sit unrestrained for durations of 30 minutes while improving in at least one other behavior such as communication, watching others, singing, interaction with the instrument or sitting in their chairs (1990b). Another study conducted by Pollack and Namaz (1992) examined the relationship between music

participation and social behavior of moderately to severely impaired Alzheimer's individuals residing in a 24-bed facility for Alzheimer's care and research. Each subject participated with the music therapist in one or more music activities, selected according to preferred music responses and adapted to cognitive and motor functioning level. Evaluation of behavioral observations at the close of the treatment period indicated a 24% increase in social behavior for the group and a varying rate of increase for all subjects. The results suggested that individualized music activity with Alzheimer's patients might facilitate interaction during music and encourage further social contact after music. Abad (2002) conducted a five-year case study with an 82 year-old Alzheimer's disease senior residing in an Australian nursing home. The client attended the music therapy stimulation session four times a week, and an evening music appreciation session at least once weekly. It was found that the level of social interaction of the subject during and after music therapy remained higher than non-music therapy times. Also, the client showed consistently higher attendance in music therapy groups than other activities, despite the inevitable progression of his disease. It is evident that the client's social participation precluded the aggressive and/or agitating behaviors that were often evident in his interactions outside of music therapy. The above studies clearly indicated the benefits of music therapy towards the social skills of AD patients.

In addition to many improvements and maintenance on functioning skills, music therapy is also found to increase the purposeful response skill of Alzheimer's patients. A number of neurologists have speculated about the impact of music on cognitive functioning. Dr. Oliver Sacks, theorized that dementia patients can respond to music activities because the rhythmic structure of music provides an organization for behavior

and response that is lost internally during the course of dementia (U.S. Special Committee on Aging, 1991). Hanson et al. (1996) compared the effectiveness of three different types of music activities (movement, rhythm, and singing) presented at two levels of difficulty (high demand and low demand) for persons in early, middle, and late stages of cognitive functioning associated with Alzheimer's disease and related disorders. Participants at all three stages of cognitive functioning showed a significantly greater amount of response during movement activities than during singing activities. However they were more purposefully involved in rhythm and singing activities when those activities were presented at lower levels of demand. The results suggested that music therapists can present movement-type activities at a more challenging level than is warranted for rhythmic or singing activities across the stages of decline to increase participation responses from the geriatric clients. Another recent study conducted by Groene et al. (1998) examined the efficacy of individual therapy sessions on the purposeful responses of probable Alzheimer's disease participants. Sixteen sing-along sessions of 25 to 45 minutes with live guitar playing and singing were conducted by the music therapist. The results indicated that the six dementia participants' purposeful responses occurred significantly more during the intervals of time when music was actually playing whether live or taped, than when no music was playing. Participant's purposeful sing along responses were significantly higher than the exercise purposeful responses.

In addition to the aforementioned benefits, music therapy is also an effective tool to increase attention span, and decrease agitation and wandering behavior for the AD patients. Groene (1993) directed a study on the effectiveness of music therapy individual

intervention with 30 individuals having senile dementia of the Alzheimer's type residing in a health care facility. Participants were randomly assigned to either mostly music attention or mostly reading attention groups and received 7 individual sessions with the music therapist. Results indicated that participants remained seated or in close proximity to the session area for longer duration during music sessions than for reading sessions under all conditions, which indicated the use of music to decrease wandering behavior. In the same year, Lord and Garner (1993) examined the effect of music on the participative behavior of 60 Alzheimer's disease elderly patients residing in a nursing care facility. A questionnaire was given to three groups of subjects to measure their mood and mental state after being exposed to different music and non-music activities. After six months, results showed that subjects from the group that was exposed to "Big Band" music from the 1920s and 1930s during their daily recreation period were more alert, happier, and had a higher recall of past personal history than did subjects from the other two groups with exposure to non-music activities. Christie (1995) observed the influence of a highly participatory peer on motivating group behaviors of lower functioning persons who have probable Alzheimer's type dementia. A variety of music therapy interventions were designed to stimulate the participation of the residents. Over a period of 42 sessions, group participation rate was found to fluctuate from 55% to 69%. Results indicated that adding a more highly participatory peer to a small group of lower functioning persons with dementias could positively influence the participatory behaviors of other group members. On the other hand, Brotons and Pickett-Cooper (1996) examined the effects of live music therapy on agitation behavior of Alzheimer's disease patients during and after music therapy intervention, and to determine if there was a

difference in the effect of music therapy between those patients who had a musical background and those who did not. Subjects, grouped by three or four, participated twice a week for 30 minutes for a total of five music therapy sessions. Their behavior was then observed for the 20 minutes following the music therapy sessions. Results revealed that these subjects were significantly less agitated during music therapy and after music therapy than before music therapy, indicating the potential of music therapy to decrease agitation behaviors and consequently, staff stress. Different types of music therapy activities may produce different responses from AD patients too. Structures have shown that structured drumming activities, which provide vibro-tactile as well as auditory stimulation, can motivate active participation, lengthen the duration of participation (Clair, Bernstein, & Johnson 1995), and keep residents participating as their dementia progresses (Clair, 1991; Clair & Bernstein, 1990b).

Music Therapy and the Chinese Population

The above studies illustrated the effectiveness of music therapy with Alzheimer's patients who were mainly Caucasians residing in North America. In the past 10 years, the profession of music therapy has been developing rapidly all over the world. In China, although annual nation-wide meetings on music therapy have been held since 1984 and over 200 general hospitals, convalescent hospitals, and psychiatric hospitals across China provide music therapy to their patients (Tang, Yao, & Zheng, 1994), very limited music therapy programs and research had been conducted with Chinese Alzheimer's disease seniors residing in nursing homes thus far. Clinical reports in the Chinese medical literature are mainly focused on the description of passive music intervention application on the psychiatric and hospital populations, and the management of depression in the

elderly, psychosomatic illness and schizophrenia

From the Chinese literature, music interventions have been described as improving the overall mood and mental status of Chinese elders and psychiatric patients. Some modern Chinese music interventions include Music Electrotherapy (MET), Music Electro-accupuncture (MEA) and Music Electro-accupuncture Anaesthesia (MEAA) (Tsing, 1998). Luk ; Wang ; Jin ; Ma ; Chang & Wu (1992) conducted research on music therapy with 68 geriatric Chinese patients diagnosed with depression staying in a hospital in China. Both control and experimental groups received medical treatment of an anti-depression drug, but only the experimental group received eight weeks of active music therapy treatment, which included playing a song on instruments and sharing their feelings during improvisation. Each experimental group participant received one hour of music therapy six times a week for eight weeks, and psychologists obtained the Hamilton Rating Scale for Depression (HAMD) scores every week from them. Results showed that the experimental group's scores improved significantly after the first week of treatment where the control group score showed improvement only after four weeks. As compared to the control group, the overall score for the experimental group was significantly better at the end. The study concluded that music therapy greatly improved the overall mood and emotion of the patients, provided them with a peaceful feeling while staying at the hospital and generated positive effects. In 1997, Chang and Or studied the effect of Music Therapy on 32 patients with chronic schizophrenia residing in a Chinese mental health hospital. Control group participants only participated in medical treatment where experimental group participants received both medical and music therapy treatment. The music therapy treatment consisted of both passive music listening in a room, and the

active treatment of attending four weekly music appreciation workshops. Special measurement tools used were Brief Psychiatric Rating Scale and Scale for the Assessment of Negative Symptoms was used to measure the participants' mental status prior and after the treatment. Results showed that both groups had a decrease in their measurement scores, which indicated an improvement on the mental status, and the experimental group also had a significant improvement of emotional state and motivation as compared to the control group. Sheung (1996) examined the effect of passive music therapy on 261 patients with schizophrenia in China. The control group participants were required to listen to the music through headphones along with the color light treatment where the experimental group participants participated in music listening along with color light treatment, behavioral treatment and attendance of social activities such as dancing after the treatment. The nurses who implemented the music listening were trained to interact with the patients during the implementation and to observe their affected behavioral change. Results showed that the cooperative level of the control group patients was 62% and the experimental group was 96.5%. The researchers therefore concluded that the implementation of active client-centered music therapy demonstrated a very positive effect on the patients' cooperation. Another study conducted by Tang et al. (1994) investigated the rehabilitative effect of music therapy on 76 Chinese patients who had the residual subtype of schizophrenia. Both control and treatment group received standard medication, but the treatment group also received a one-month course of music therapy that included both passive listening to music and active participation in the singing of popular songs with other patients. The outcome was evaluated by four nurses using the "Chinese Versions of the Scale for Assessment of

Negative Symptoms” and the “In-patient Version of the World Health Organization’s Disability Assessment Scale”. Music therapy was found to significantly diminish patients’ negative symptoms, increase their ability to converse with others, reduce their social isolation, and increase their level of interest in external events.

Besides geriatric and psychiatric populations, positive results from Chinese medical reports also indicated that music interventions are effective in treating Chinese medical populations physiologically and psychologically. In 2001, Cai, Li & Jiao reported their research of music therapy in treatment of Chinese cancer patients. One hundred eighty-two inpatients diagnosed as having a malignant tumor were divided into two groups. The study group had 128 cases, which received music therapy in addition to chemotherapy, and the control group (54) cases received chemotherapy only. Both groups were assessed by Self-rating Anxiety scale (SAS), Self-rating Depression Scale (SDS) and Hamilton Rating Scale for Depression (HAMD) before and after chemotherapy, and all of the subjects had the tests of distribution of subgroup of T lymphocytes and of NK cell anti-tumor activity. Results showed that the study group had fewer scores in SAS, SDS and HAMD than the control group and their immunological function was better than that of the control group. The article concluded that music therapy is effective in additional to therapy in treatment of cancer patients. In the same year 2001, Chai et al. conducted a clinical observation of music therapy combined with anti-tumor drugs in treating 116 cases of Chinese tumor patients. Music therapy combined with anti-tumor drugs, including chemotherapy and Chinese drugs, was given to 162 tumor patients according to syndrome differentiation to observe the change of Self-rating Depression Scale (SDS), Self Rating Anxiety Scale (SAS), Minnesota

Multiphasic Personality Inventory (MMPI), Hamilton Rating Scale for Depression (HDMD), T lymphocyte subsets (immuno-histochemical assay) and NK cell anti-tumor activity (NAG) method, etc. The 46 cases that didn't receive music therapy were taken as the control group. Results showed significantly improved scores on the treatment group, therefore the authors concluded that music therapy could regulate the emotion of tumor patients, optimize the emotional effect, improve the somatic symptoms, enhance the immune function, motivate the active principle and raise the self-regulating power in the body. Lai (1999) investigated the physiological and psychological effects of music listening on 30 depressed women in Taiwan through the measurement of heart rate, respiratory rate, blood pressure, and immediate mood states before and after a music sound intervention. A qualitative questionnaire was administered to participants to elicit information related to the subjective experience of music sound listening. Significant posttest differences were found on experimental group participants' physiological and psychological variables. The results supported the use of music listening as a body-mind healing modality for depressed women. In 2001, Wong studied the effects of music therapy on anxiety in 20 ventilator-dependent patients in Hong Kong. Patients were randomized to receive 30 minutes of uninterrupted rest and then 30 minutes of relaxation music listening and vice versa. Subjects selected the music of their choice from a selection of Chinese and Western music and physiologic measures were taken immediately before and throughout the intervention at five-minute intervals. The Chinese version of Spielberger's State-Trait anxiety inventory was also completed before and after the intervention. Findings indicated that music therapy was more effective in decreasing state anxiety than was the rest period. Significant differences were observed

at the end of the intervention between the two conditions, with music therapy being superior to the rest period.

Culturally Appropriate Music Therapy

As the population of Chinese immigrants rapidly increases in major cities of North America, there is a need for more research and development of cultural and linguistic relevant services for the Chinese senior immigrants residing in the community and nursing home. According to Liu and Siu (1997), there is a great demand for culturally and linguistically appropriate services for Chinese seniors in the city of Toronto. Speaking from a music therapy perspective, Brown (2001) emphasized the need for culturally centered music therapy practice and examined the areas of ethnical considerations, cultural empathy, the need for music therapists to understand and explore their own and their clients' worldviews and the concept of music as a universal language. Kenny and Stige (2001) also stated "music is deeply rooted in culture", they believe that it is important that each region has an opportunity to develop its own traditions of music therapy based upon local knowledge and the cultural and social history of that region" (p.1). Wheeler (2004) commented that there is a need to make efforts to hear all the voices from different ethnic music therapy communities, such as Latin American, Asian and African. Currently very little research on multicultural music therapy practice or cultural competency measurement has been conducted. This is probably due to the measurement challenges faced by the researcher and many of the mental health professions, including music therapy, that have emerged from a Western European and Northern American World view. Geron (2002) states the importance of measuring cultural competency and the basic measurement issues and challenges. The challenges

often include failure to define what cultural competence means, failure to consider client and patient perspectives in the design of the measures and testing of reliability, validity, and psychometric properties of the measures. Therefore, in reference to the Chinese seniors' needs in Toronto, Canada, if a cultural music therapy program and research is to be conducted with the Chinese seniors, it becomes very important to first understand the Chinese senior immigrant's cultural background, stereotype, musical preferences and the Chinese cultural and social history in Toronto.

Significant difference has always been found between Chinese and Western cultural value, stereotype and attitudes towards seniors. Silverman ; Hecht & McMillin (2000) states, "Looked at from a historical perspective, no two peoples could differ more dramatically than American and Chinese with respect to the role and treatment of the aged, one with its passion for everything youthful, the other often described as a gerontocracy" (p.289). He conducted a survey on the comparison of Chinese and American's modeling life satisfaction among the aged. The focus was on health status and selected social network characteristics as they relate to life satisfaction. On all the major variables, they found a significant difference between the Chinese and Americans. After his visit to China, Moreno (1997) discovered that "[i]n Chinese culture, people are not nearly as open about discussing and sharing their problems as in the West. Therefore, the music therapy process was very helpful in opening the door for them to begin confronting the conflict" (p.61). Lewis (1997) mentioned that Western therapy assumes that the world shares one view on what constitutes normal and abnormal behavior, and the Western ideas of independence, self-sufficiency, and social conformity are not readily accepted by other family and community-oriented Asian, African, and Latino cultures, to

name a few. There is also a significant cultural difference in musical preferences between Chinese and Caucasians. Good; Picot; Salem; Chin; Picot & Lane (1998) used Western music to test its acceptability and effectiveness in reducing postoperative pain in 38 Taiwanese patients. The findings indicated that the most frequently chosen type of music by Asians to relieve pain in the Taiwan sample was harp, the least frequently chosen was popular piano music. Unlike the Caucasians, none chose jazz and several suggested Buddhist hymns, popular music heard in Taiwan, and music with lyrics. Wong and Mok (2003) in Hong Kong also assessed the effectiveness of music as a relaxation modality by measuring Chinese patients' vital signs and self-reported anxiety before and after surgery. Study results indicated that patients who listened to their choice of classical, popular contemporary and Chinese music during surgery experienced significantly lower anxiety levels, heart rates, and blood pressure than patients who did not listen to music. However, special attention should be paid to the choice and taste of music to optimize the relaxation effect. Wong et al. (2001) in their research also stated that for Chinese patients, culture and language were the predominant factors in their choice of music.

This author believes that both the understanding of therapeutic music activity preference of Chinese AD seniors, and the implementation of traditional music value in Chinese culture will help develop a culturally relevant music therapy program for this specific population. According to Zhuo (1992), Chinese music therapy has its roots in the ancient history of the country and is continuing influence on the healing practices of modern China. The use of music therapy in China was psychologically oriented and utilized for the development of a sound mind, for mental health, and also for the curing

and stabilization of psychological and emotional disorders. Playing or listening to the lute was an important form of music therapy in ancient China for keeping a peaceful and relaxed mind. Aside from achieving psychological purpose, music therapy such as lute playing, conducting and singing are used to maintain and improve the physical and cognitive functions of a person as well (Chang, 1991). In modern China, music therapists prefer music listening to music playing. Many Chinese institutions prefer to use national folk music or traditional instruments in music therapy, rather than Western music (Zhuo, 1992).

With the vision to develop culturally relevant music therapy services for the Chinese seniors immigrants residing in Toronto, this research was conducted to investigate the therapeutic music therapy activity preferences of the Chinese residents residing in Yee Hong Center of Geriatric Care diagnosed with Alzheimer's disease.

Null Hypotheses

- (1) There will be no difference in preference for singing, playing instruments, dance/movement, playing musical games, or improvisation/ composing among Chinese Alzheimer's seniors.
- (2) There will be no difference between observed preferences and verbal preferences among Chinese Alzheimer's seniors for singing, playing instruments, dance/movement, playing musical games, or improvisation/composing.

CHAPTER III

METHODOLOGY

This study is based on an earlier study of the musical preferences of elderly individuals who were diagnosed with Alzheimer's disease (Brotons and Pickett-Cooper, 1994). The research design, subject recruitment, method of data collection and analysis were similar in both studies. Major differences in the current study included a smaller scale of subject's recruitment, and the use of communicative language and music due to the subjects' background. Minor differences included the omission of one musical game, and the use of different props and musical instruments in the instrument manipulation, improvisation / composition and movement with music activities.

Subject Selection

The research was conducted at Yee Hong Center for Geriatric Care in Greater Toronto Area (GTA), Ontario, Canada. As in the Brotons and Pickett-Moore study, only female residents who were residing at the nursing home were recruited. Although the research was on a smaller scale than the Brotons and Pickett-Moore study with only 15 subjects, eligibility criteria for subjects was the same. Participants had to be (a) at least 49 years of age; (b) with primary diagnosis of Alzheimer's disease; (c) with verbal ability sufficient to answer simple social and activity questions and to comply with requests to speak, participate, or sit down; (d) able to hear and attend small group music therapy sessions without schedule conflicts and with written consent of the patient's guardian or

representative. For the current study subject eligibility was modified to ensure that all subjects were Chinese and could understand the language of Cantonese or Mandarin. Subjects who were diagnosed with level five and six of the Reisberg scale (Reisberg; Ferris; Leon & Crook 1982) were then referred by the social worker and activation supervisor to the therapist for participation in the research. Patients placed on level five have moderate dementia (moderately severe cognitive decline), can no longer survive without some assistance, were unable to recall a major relevant aspect of their current lives, and are frequently disorientated to time or to place. Patients at this stage retain knowledge of many major facts regarding themselves and others, and invariably know their own names. Patients with level six are classified as moderately severe dementia (severe cognitive decline), they will be largely unaware of all recent events and experiences in their lives, and generally unaware of their surroundings, the year and the season. They will also require some assistance with activities of daily living, and personality and emotional changes will occur.

Research Design

Each subject's level of functioning was determined by the therapists' observations during pilot music therapy sessions, based on the clinical characteristics listed under different level of Reisberg scale (Reisberg et. al., 1982). As with Brotons and Pickett-Cooper's (1994) research, all subjects participated in five different types of music therapy activities, and were randomly assigned to five small groups, each consisting of three people. The order of the five music therapy activities was counterbalanced by a Latin square design, with five different groups and activity sessions on each day. Subjects met five times in two weeks for a maximum of 30 minutes with the music therapist, always at

the same time, in the same room free of distraction. Totally twenty-five sessions were conducted. All sessions were videotaped and viewed using a continuous observation procedure to determine the duration of participation for each participant in each music activity, as well as the duration of other on- and off-task behaviors. On-task behaviors included participating, watching therapist and/or activity during all music activities. Off task behaviors included off-topic verbalizations and daydreaming/head down in all music activities.

Procedure

Due to the fact that the subjects were all Chinese immigrants with very limited English understanding and verbal skills, all sessions were conducted in verbal and written Chinese and included Chinese music. This was a major change from Brotons and Pickett-Cooper's 1994 study, which used English as the communicative language. Subjects' preference of music was also Chinese music instead of English North American Music. As in the Brotons and Pickett-Cooper's 1994 study, all music therapy activities were presented by, and each session was led by, the same music therapist (the researcher). Two volunteers assisted in operating the video camera and gathering of subjects. Each session always started with a "Hello and warm up song" and then the music therapy activity for the day was introduced. The therapist instructed the clients on what to do and modeled the expected behavior by physical and verbal cues prompting. Some subjects required more promptings than others during the sessions. Subjects were encouraged to participate and were reinforced as needed throughout the session by hands clapping, smiling, eye contact and verbally praising their behavior. When subjects did not participate independently, the therapist used physical and verbal prompts to assure

some participation. No specific behavioral control measurement was used. At the end of each session, subjects were asked to state or choose from the words and faces picture card how much they enjoyed the type of music therapy activity of the day (did not like, ok, like a lot, see appendix F). They were then thanked for attending music therapy and reminded of upcoming sessions. All sessions were videotaped for post hoc analysis of subjects' behavior.

Music therapy activities conducted in this study included singing, instrument manipulation, movement, improvisation and musical games. Chinese music and lyrics was used in all activities.

- (1) Singing activity: Ten Chinese folk songs, popular songs, patriotic songs, Cantonese opera or art songs from 1930s to 80s were chosen according to the subjects' preference. The therapist introduced the session by saying; "We'll sing some songs today. Let's sing these familiar songs together..." and the therapist would start singing. Songs were accompanied by guitar and usually sung twice so that subjects could re-familiarize themselves with the lyrics.
- (2) Instrument manipulation activity: The same songs from the singing activity were used as the basis of this activity. Musical selections were in quadruple and triple meter. All songs for this activity were performed live by the therapist with guitar accompaniment. Subjects were reinforced to play the instruments by the musical, verbal, facial and physical cues given by the therapist. When subjects did not participate independently, the therapist prompted the subjects with these cues to assure some participation. The

instruments used for this activity included rhythmic sticks, drums, tambourines, maraca, jingle bells and jingle tabs etc.

- (3) Dance/movement activity: Four Chinese musical selections were chosen and included classical Chinese music, folk music and popular songs from the 1920's to 1970s. These four songs were "Lover In The Past" 舊歡如夢; "Lo Sun Happy Song" 蘆笙歡歌; "Farewell At Night" 夜送別 and "Thinking About You" 想您想斷腸. As in the 1994 study, two of the selections were in quadruple and two were in triple meter. These selections were all CD recorded, and ordered so that the quadruple selections alternated with the triple ones. Movements included simple patting with both hands, toe tapping, clapping, arm movements to the right and left alone, moving scarves or ribbons, and arm movements up and down while holding objects. The movement patterns performed with each selection were modeled before playing the music to insure that clients could imitate them.
- (4) Improvisation/composition activity: Subjects were given the pentatonic scale of a glockenspiel or a small keyboard with sticker indicated on pentatonic notes to play their own melody, while the therapist provided beating via the distilled water bottle drum. Instruments given to the subjects were modified from Brotons and Pickett-Cooper's 1994 study as the tone bars and bass bar used in previous study were not available in the nursing home.
- (5) Musical games: Four games (Musical Bingo, Concentration, Pictionary and Name that Tune) were prepared and used in this study. Name That State was not included since there was not a comparable song related to China. For

Musical Bingo, each subject was given a board that included a total of 12 pictures of musical symbols and instruments. The therapist then held a card with one of the symbols on the boards, and asked participants who had the same picture. The first participant that filled his or her board with the individual cards was the winner. For Concentration, four pairs of cards with pictures of musical instruments were prepared and placed in front of the group face down. The therapist showed the participants that each card has its pair. Subjects were asked to turn over the cards and to find the match. For Pictionary, 10 of the most familiar Chinese songs were chosen and the title of each song was drawn on an individual card. Each individual was given a card and was asked to name the objects he/she saw on that card. While they were verbalizing words that belonged to the title of the song, the music therapist would prompt the participants to name the title by humming the melody of the song with guitar accompaniment, and singing some words until the title of the song would come in the lyrics. For Name that Tune, the therapist sang and played the first 25-35 seconds of a song, which the participants were prompted to name, and to sing along with it afterwards.

CHAPTER IV

DATA ANALYSES AND RESULTS

Videotapes were analyzed by the investigator and a volunteer using a continuous observation procedure to determine the duration of participation for each participant in each music activity, and to establish inter-rater reliability. The independent observer analyzed 20% of all 25 sessions, totally 5 sessions, with a different activity session from each group. The correlation coefficient as a measure of inter-observer reliability was calculated to be 88.6%.

Based on the results, the first null hypothesis of this study (there will be no difference in preference for singing, playing instruments, dance/movement, playing musical games, or improvisation/ composing among Chinese Alzheimer's seniors) is rejected. Data were reported in number of seconds of participants participating in each of the five music activities and exhibiting each of the on- and off-task behaviors. The duration of the hello and goodbye songs was subtracted from the total duration of the sessions so that behaviors were only observed during the actual portion of the activity assigned for the day. Data were analyzed using the computer program, Minitab, with which means and standard deviation of proportion of time participating in on-task and off-task behaviors in each of the music activities were calculated (see Table 1). Musical game was the activity in which subjects participated most (76.35% of the time), followed by improvisation/composition (67.5%), dance/movement (59.34%), instrument manipulation (50.81%), and to a lesser degree, singing (35.5%).

Table 1: Means and Standard Deviations of Percentages of Time Participating in Each of the Music Activities

	Instruments	Dance	Games	Singing	Compos/ Improv
M	50.81	59.34	76.35	35.30	67.50
SD	26.13	28.70	24.53	26.17	11.41

A one-way analysis of variance with repeated measures was calculated, followed by the Fisher PLSD test. Results show that participation in singing was significantly lower than involvement with dance/movement, musical games and improvisation/composition ($F = 6.39, p=0.0001$)

Tables 2 and 3 show the proportion of time each of the other on- and off-task behaviors was exhibited for each of the music activities. Watching therapist and/or activity was the on-task behavior most exhibited during all music activities. Watching occurred most during musical games and improvisation/composition, and to a lesser degree, during dance/movement, singing and instrument manipulation. Off-task behaviors exhibited most were off-topic verbalizations in all music activities. Off-topic verbalizations seemed to occur more during instrument manipulation.

Table 2: Mean Proportion of Time Exhibiting Other On-Task Behaviors in Each Music Activity

On-task Behaviors	Music Activities				
	Singing	Instrument	Dance	Games	Composition
Watching	59.81	54.12	63.58	75.68	69.12
Interaction w/Instruments/Materials	0	54.34	60.23	40.52	68.13
Tapping/Clapping	9.70	0	2.35	1.74	0.14

Table 3: Mean Proportion of Time Exhibiting Other Off-Task Behaviors in Each Music Activity

Off-task Behaviors	Music Activities				
	Singing	Instrument	Dance	Games	Composition
Sleeping	0	0	5.59	0	0
Yawning	0	0	0	0	0
Crying	0	0	0	0	0
Verbalizations	4.47	9.11	4.42	5.86	4.78
Wandering	1.16	1.45	0.17	0.51	0
Day dreaming/head down	3.21	0	0.87	0	0.58

Based on the results, the second null hypothesis (there will be no difference between observed preferences and verbal preferences among Chinese Alzheimer's seniors for singing, playing instruments, dance/movement, playing musical games, or improvisation/composing) is rejected. The number of verbal responses for each type of music activity under the three categories of responses (like OK, like a lot, did not like) was tallied. An "omit" category was added for those responses that did not clearly fall under one of the above classifications, or when responses were not available. Overall, the "like a lot" category had a greater frequency of responses for all music activities (73 %) followed by the "like OK" (15 %), then "did not like" (7%) and the omit category (5%). Data shown in Table 4 indicates that individuals enjoyed instruments playing and music games more than other activities. A two-way Chi-square test was used to calculate whether preference was related to type of music activity. Results indicate no agreement between preferences and type of music activity ($\chi^2 = 10.59, p > .10$) All music activities were rated similarly by these individuals at the verbal level.

Table 4: Number and Percent of Responses in Each Music Activity

<u>Music Activity</u>	Preferences			
	<u>A Lot</u>	<u>Ok</u>	<u>Did Not Like</u>	<u>Omit</u>
Singing	9 (12%)	3 (4%)	2 (3%)	1 (1%)
Instruments	13 (17%)	2 (3%)	0 (0%)	0 (0%)
Dance/Movement	10 (13%)	3 (4%)	1 (1%)	1 (1%)
Games	14 (19%)	0 (0%)	1 (1%)	0 (0%)
Composition/ Improvisation	9 (12%)	3 (4%)	1 (1%)	2 (3%)

CHAPTER V

DISCUSSION

The purpose of this study was to examine preferences of Chinese Alzheimer's patients for five types of music therapy activities: singing, instrument manipulation, dance/movement, musical games, and improvisation/composition on instruments. The results show that these patients participated in all types of music activities, but music games was the activity in which subjects participated more, followed by improvisation/composition, dance/movement, instrument manipulation and, to a lesser degree, singing. Participation in singing was significantly lower than involvement with dance/movement, musical games and improvisation/composition. These results are different from the previous Brotons and Pickett-Cooper's 1994 study, in which more time was spent manipulating instruments, on dance/movement, and musical games than improvisation/composition by the Caucasian Alzheimer's seniors. Singing in this study did not evoke high participation, perhaps due to the progressively decreasing skill as dementia progresses (Clair & Bernstein, 1990a) and the passive role singing activity plays in this selected Chinese generation group. Games were specially designed to adapt to the seniors' functioning, required lesser musical skills, and may share similar structure to other games that the seniors were exposed to in the nursing home (such as Bingo), which may serve as a reason why they were welcomed by the Chinese Alzheimer's patients. Although improvisation/composition required some instrument playing skills, its free flowing structure, sense of group cohesion experience, opportunity of non-verbal self-expression and experiences of trying melodic instruments which the seniors have

very limited exposure to during young age did attract the participation of patients in a very positive way. All of these may explain the different results generated in this study as compared to the Brotons and Pickett-Cooper's 1994 study.

Similar to the results of Brotons and Pickett-Cooper's study with Caucasians, Chinese Alzheimer's seniors are capable of participating in a variety of active musical activities given when the activities are properly structured, culturally appropriate, interesting and adapted to their level of functioning. Although the response level varied depending on the activity or the person, all music activities evoked interest and participation. According to the results of the verbal responses, subjects did not manifest significant verbal preferences for a specific type of music therapy activity. As suggested by Clair and Bernstein (1993), this may be due to their lack of ability to discriminate and make purposeful choices due to their disabling condition and, therefore, do not express their preferences. As was the case for the Caucasian Alzheimer's subjects, the choices of "like OK" and "like a lot" may have been confusing for some participants to discriminate their preferences. Although more verbal preferences were given to instrument manipulation and musical games, the subjects generally enjoyed all types of music therapy activities, as evidenced by their consistent eye contact and interaction with the therapist, instruments and materials, and the fact that the majority stayed in the group area for the entire duration of the activities. The first null hypothesis of this study (there will be no difference in preference for singing, playing instruments, dance/movement, playing musical games, or improvisation/ composing among Chinese Alzheimer's seniors) is rejected. The second null hypothesis (there will be no difference between observed preferences and verbal preferences among Chinese Alzheimer's seniors for

singing, playing instruments, dance/movement, playing musical games, or improvisation/composing) is also rejected. The results indicate that, frequently, behavior and verbal report do not concur. The results of this study in which there is no significant verbal response preference between activities, but significant observed behavioral preferences on musical games and improvisation/composition indicate that, when working with patients with Alzheimer's no matter Caucasians or Chinese, it is not enough to rely on their verbal choices and preferences. This confirmation is similar to the results of Brotons and Prickett-Cooper's study, in which seniors would refuse to sing along or participate, but with additional prompts they would progressively get involved in the activity.

Suggestions for working with Chinese Alzheimer's patients in music therapy, specifically from Hong Kong and the Canton region of China are as follows:

1. Although active music making is not common with most Chinese senior citizens, they seem to enjoy all types of culturally appropriate music therapy activities and are capable of participating at some level. It is important for music therapists to have a creative broad repertoire of activities, knowledge and awareness of Chinese culture and music to maintain interest during the sessions and stimulate different senses and areas of functioning.
2. It is important for music therapists to select appropriate music selections for the music therapy activities. For example, Cantonese opera, which is a popular genre in the Canton region of China, may serve as a good selection for music listening, but not for singing, movement and dancing, generally due to its non-rhythmic structure base and extremely high pitch.

3. It is important for the music therapist to be aware of the different languages used in China when designing appropriate activities. For example, many music therapists may think folk songs in Mandarin (the main language in China), are common among Chinese, but may actually not be as popular as Cantonese pop songs from 1970's to 1990's for Cantonese seniors. Many Cantonese seniors may have never been exposed to Chinese songs from other regions in China in their whole life, and may not be interested in Mandarin songs at all.
4. Different from the music preferences of Caucasians seniors, Chinese seniors' music preferences may vary from a big range of 1920's to 90's, due to the media technology boom of radio and TV after the 1960's in Hong Kong, the majority of citizens had the opportunity to be exposed to many popular songs at that time.
5. Music therapists working with Chinese Alzheimer's disease patients must be aware of the patients' needs, clients' responses and languages used by the clients. Main Chinese dialogues used by Chinese senior immigrants in North America may include Cantonese, Mandarin, Taiwanese, Beijing Mandarin, Chiu Chou and Hak Ka, among others. All of these dialogues can be very different from each other and require substantial knowledge to understand each of them.

Further research in the area of multicultural music therapy and in the geriatric population is highly recommended as it provides valuable references for music therapists who are working with these populations. Only females were recruited due to the fact that

this study is using Brotons and Pickett-Cooper's (1994) study as a basis. The author suggests that in the future, a larger subject pool with both males and females can be used in order to enhance the validity of the study. On the other hand, the generalization of this study is limited due to the specific gender and cultural background of the participants. It is therefore recommended that more Chinese senior participants with different backgrounds can be invited to share in future studies, such as seniors from mainland China and Taiwan, who may have very different musical preferences from seniors in Hong Kong. In addition, future research can examine the difference between preferences of Chinese residing in China and immigrants, Chinese and other cultural seniors groups, and the difference between gender groups as well.

Appendix A

Protocol Clearance from the Human Subjects Institutional Review Board

Date: March 23, 2004

To: Brian Wilson, Principal Investigator
Karen Kwok, Student Investigator for thesis

From: Mary Lagerwey, Ph.D., Chair

Re: HSIRB Project Number: 04-02-18

This letter will serve as confirmation that your research project entitled “Preferences of Chinese Alzheimer’s Disease Patients for Music Therapy Activities” has been **provisionally approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. *Before you begin collecting data at Yee Hong Center for Geriatric Care, Ontario, Canada, you must provide us with the appropriate site letter.* The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: March 23, 2005

Appendix B

Informed Consent Form in Chinese

美國西密芝根大學
音樂治療系
研究領導人: Brian Wilson
碩士學生研究員: 郭嘉穎

閣下被邀請參與一項名為“中國籍老人痴呆症患者對音樂治療活動: 歌唱, 音樂動作或舞蹈, 樂器演奏, 音樂遊戲及即興音樂發揮或作曲之取向”研究。此項研究之目的乃研究十五位護老院內患老人痴呆症之中國籍院友對上述五類音樂治療活動之取向次序。此研究乃美國西密芝根大學音樂治療碩士學生郭嘉穎之碩士論文研究課題。

研究中, 閣下將被邀至頤康中心內之活動室參予由郭嘉穎小姐主領之五個三十分鐘三人小組音樂治療活動, 包括音樂聆聽, 唱歌, 音樂運動或舞蹈, 樂器演奏, 音樂遊戲, 及即興音樂發揮或作曲等。每次活動完結後, 閣下將利用圖畫示意卡表達對活動之喜愛程度, 同時每次活動將進行錄影以作觀察及研究分析用, 又每次活動將用廣東話或普通話進行, 音樂方面將有中國古典音樂, 民歌, 純音樂, 流行曲及藝術歌曲等。活動進行中, 如有不適可隨時停止, 離開或退出不參與。如閣下拒絕或中途退出, 閣下在頤康中心接受之一切服務及參予音樂治療之權利保證絕不受影響。

過往之研究指出參予各項音樂治療活動肯定對痴呆病患之老人在各層面上皆有裨益。雖然裨益未必即時可見, 然期諸日後在對中國籍老人之護理及社會服務方面均有幫助。

正如過往所有研究一樣, 當中皆可能有參與者發生未能預期之意外, 如有此情況發生, 有關人員將採適當措施應付而無需對你作出賠償或治療, 除非同意書列明。研究員在每次音樂治療小組所應用之方法或技巧將盡量不致引致不適或受傷。

閣下所有資料將全部保密, 各項文件上將不記錄姓名而以密碼記錄。研究生郭嘉穎將保存一份參與者姓名及相關密碼名單, 直至資料分析後連同錄影帶將予立刻銷毀。其餘表格將由美國西密芝根大學保留至少三年。

中途如閣下改變意向, 可隨時退出上述研究。如有任何查詢, 請撥電 416-321-6333 與郭嘉穎小姐聯絡, 或電 1-269-387-8293 向美國西密芝根大學音樂治療系主任 Brian Wilson 或撥電 1-269-387-8298 向 Human Subject Institution Board 主席查詢。

此同意書經美國西密芝根大學 Human Subjects Institutional Review Board 批准, 由戳印日期起計為期有效一年。如戳印之日期已超一年, 請勿參與。閣下之簽名表示已閱讀或經清楚解釋此研究之目的及有關安排而閣下同意參與。

簽名: _____ 日期: _____

核准者: _____ 日期: _____
(研究員簡簽)

Appendix C

Informed Consent Form in English

Western Michigan University
Department of: Music Therapy
Principal Investigator: Brian Wilson
Student Investigator: Karen Kwok

You have been invited to participate in a research project entitled "Preferences of Chinese Alzheimer's Disease Patients for Music Therapy Activities: Singing, Movement/Dance, Instrument Manipulation, Music games and Improvisation/composition." The purpose of this research is to study the preference of fifteen Chinese Alzheimer's disease nursing home residents for five different music therapy activities. This project is Karen Kwok's Master thesis project.

You will be asked to attend five small groups in 30 minutes music therapy sessions with Karen Kwok, Music Therapy placement student at Yee Hong Center for Geriatric Care Nursing Home activity room. Each session will involve one of five specific music therapy activities: singing, movement with music, instrument manipulation, music games and improvisation/composition, which you will be participating in with three group members. You will be asked to rate your preference of the activity at the end of each session with "Like a lot", "OK" and "Not like" using the picture response card. You will also be videotaped in each session for participation observation and data analysis. All sessions will be conducted in Cantonese or Mandarin language. You will be instructed to stop any movement activity if you feel any discomfort, and be free at any time, even during the music therapy session to choose not to participate. If you refuse or quit, there will be no negative effect on the services you are receiving at Yee Hong and you are always welcome to participate in other music therapy services.

Although there may be no immediate benefits to you as indicated in other music therapy research with Alzheimer's disease seniors, there may eventually be benefits to the academic field, and expansion of music therapy service into Chinese geriatric service.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or treatment will be made available to you except as otherwise specified in this consent form. All of the usual methods employed during music therapy session to minimize discomforts and injuries will be employed in this study.

All of the information collected from you is confidential. Your name will not appear on any papers on which this information is recorded. Once the data is collected and analyzed, the master list will be destroyed. All other forms will be retained for at least three years in a locked file in Western Michigan University, U.S.A.

You may refuse to participate or quit at any time during the study without prejudice or penalty. If you have any questions or concerns about this study, you may contact Karen Kwok at 416-321-6333. You may also contact the faculty advisor, Brian Wilson at 1-269 387-4679, chair of Western Michigan University Human Subjects Institutional Review

Appendix D

Guardian Consent Form in Chinese

美國西密芝根大學
音樂治療系
研究領導人: Brian Wilson
碩士學生研究員: 郭嘉穎

閣下之母親/親人/受託監護者獲邀請參與一項於頤中心名為“中國籍老人痴呆症患者對音樂治療活動:歌唱,音樂動作或舞蹈,樂器演奏,音樂遊戲及即興音樂發揮或作曲之取向”研究..此項研究之目的乃研究十五位護理老院內患老人痴呆症之中國籍院友對上述五類音樂治療活動之取向次序.此研究乃美國西密芝根大學音樂治療碩士學生郭嘉穎之碩士論文研究課題.

研究中,閣下之母親/親人/受託監護者將獲邀至頤康中心內之活動室參予由郭嘉穎小姐主領之五個三十分鐘三人小組音樂治療活動,包括音樂聆聽,唱歌,音樂運動或舞蹈,樂器演奏,音樂遊戲,及即興音樂發揮或作曲等.每次活動完結後,閣下之母親或被監護者會利用圖畫示意卡表達對活動之喜愛程度,同時每次活動將進行錄影以作觀察及研究分析用,又每次活動將用廣東話或普通話進行,音樂方面將有中國古典音樂,民歌,純音樂,流行曲及藝術歌曲等.活動進行中,如有不適可隨時停止,離開或退出不參與..如閣下之母親/親人/受託監護者中途退出,她在頤康中心接受之一切服務及參予音樂治療之權利保證絕不受影響.

過往之研究指出參予各項音樂治療活動肯定對痴呆病患之老人各層面上皆有裨益.雖然裨益未必即時可見,然期諸日後在對中國籍老人之護理及社會服務方面均有幫助.

正如過往所有研究一樣,當中皆可能有參與者發生未能預期之意外,如有此情況發生,有關人員將採適當措施應付而無需對參與者作出賠償或治療,除非同意書列明.研究員在每次音樂治療小組所應用之方法或技巧將盡量不致引致不適或受傷.

閣下所有資料將全部保密,各項文件上將不記錄姓名而以密碼記錄.研究生郭嘉穎將保存一份參與者姓名及相關密碼名單,直至資料分析後連同錄影帶將予立刻銷毀.其餘表格將由美國西密芝根大學保留至少三年.

中途如閣下之母親/親人/受託監護者改變意向,可隨時退出上述研究.如有任何查詢,請撥電416-321-6333與郭嘉穎小姐聯絡,或電1-269-387-8293向美國西密芝根大學音樂治療系主任 Brian Wilson 或撥電1-269-387-8298向 Human Subject Institution Board 主席查詢.

此同意書經美國西密芝根大學 Human Subjects Institutional Review Board 批准,由戳印日期起計為期有效一年.如戳印之日期已超一年,請勿參與.閣下之簽名表示已閱讀或經清楚解釋此研究之目的及有關安排而同意閣下之母親/親人/受託監護者_____參予.

簽名:_____日期:_____

核准者:_____日期:_____
(研究員簡簽)

Appendix E

Guardian Consent Form in English

Western Michigan University
Department of: Music Therapy
Principal Investigator: Brian Wilson
Student Investigator: Karen Kwok

Dear guardian, your parent/relative/friend has been invited to participate in a research project at Yee Hong Center for Geriatric Care entitled "Preferences of Chinese Alzheimer's disease patients for Music Therapy Activities: Singing, Movement/dance, Instrument Manipulation, Music games and Improvisation/composition." The purpose of this research is to study the preference of fifteen Chinese Alzheimer's disease nursing home residents for five different music therapy activities. This project is Karen Kwok's Master thesis project.

Your permission for your parent/relative/friend to participate in this project means that they will be attending five 30 minutes small group music therapy sessions in two weeks with Karen Kwok, Music Therapy placement student at Yee Hong Center for Geriatric Care Nursing Home activity room. Each session will involve one specific music therapy activity such as singing, movement with music, instrument manipulation, music games and improvisation/composition. Your parent/relative/friend will be participating in the session with two group members. She will be asked to rate her preference of the activity at the end of each session with "Like a lot", "OK" and "Not like" using the picture response card. She will also be videotaped in each session for participation observation and data analysis. All sessions will be conducted in Cantonese or Mandarin language using Chinese folk, popular, classic, art and instrumental music. Your parent/relative/friend will be instructed to stop any movement activity if they feel any discomfort, and can leave at any time during the music therapy session to choose not to participate. If she refuses or quits, there will be no negative effect on the services she is receiving at the nursing home and she is always welcome to participate in other music therapy services at Yee Hong.

Although there may be no immediate benefits to your parent/relative/friend as indicated in other music therapy research with Alzheimer's disease seniors, there may eventually be benefits to the academic field and expansion of music therapy service into Chinese geriatric service.

As in all research, there may be unforeseen risks to the participant. If an accidental injury occurs, appropriate emergency measures will be taken; however, no compensation or treatment will be made available to the participant except as otherwise specified in this consent form. All of the usual methods employed during music therapy session to minimize discomforts and injuries will be employed in this study.

All of the information collected from you is confidential. This means that your parent/relative/friend's name will not appear on any papers on which this information is recorded. Once the data is collected and analyzed, the master list will be destroyed. All

other forms will be retained for at least three years in a locked file in Western Michigan University, U.S.A.

You may withdraw your parent/relative/friend from this study at any time without any prejudice or penalty. If you have any questions or concerns about this study, you may contact Karen Kwok at 416-321-6333. You may also contact the chair of the Western Michigan University Human Subjects Institutional Review Board at 1-269-387-8293 or the vice president for research 1-269-387-9298 with any concerns that you have.

This permission document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Do not permit your parent/relative/friend to participate if the stamped date is more than one year old.

Your signature below indicates that you, as guardian of _____, at Yee Hong Center for Geriatric Care can and do give your permission for _____ to participate in the research

_____	_____
Signature	Date
Permission obtained	
by: _____	_____
Initials of researcher	Date

Appendix F

Preference Symbol Card



I Like It A Lot
我很喜歡



OK
還可以



I Don't Like It
我不喜歡

Appendix G

Song Selection

Singing & instrument manipulation activity:

1. Love is Everywhere 萬水千山 總是情
2. Ali Mountain 阿里山
3. Flower in snow 踏雪 尋梅
4. Flower Drum 鳳陽花鼓
5. Chinese Birthday Song 生日歌
6. Lover in the past 舊歡如夢
7. Dance of youth 青春舞曲
8. Flower of love 情花開
9. It's a small world 世界真細少
10. Flower of Spring 迎春花

Dance/movement activity:

1. Lover in the past (Quadruple) 舊歡如夢
2. Lo Sun happy song (Triple) 蘆笙歡歌
3. Farewell at night (Quadruple) 夜送別
4. Thinking about you (Triple) 想您想斷腸

Appendix H

Letter of Consent from the Yee Hong Centre for Geriatric Care

Chair
HSIRB
Western Michigan University
Walwood Hall,
Kalamazoo, MI
49008-5456
U.S.A.

Dear Sir/Madam:

This is to confirm that the Research Committee of Yee Hong Centre for Geriatric Care has reviewed the research protocol submitted by Karen Kwok and has approved the research to be conducted at Yee Hong's nursing homes.

Yours sincerely,

Kwong Y. Liu, M.Soc.Sc., R.S.W.
Director of Social Services

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