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## The Effect of Music Therapy on Parents' and Pediatric Patients' Perception of the Nurse

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THE FLORIDA STATE UNIVERSITY

COLLEGE OF MUSIC

THE EFFECT OF MUSIC THERAPY ON PARENTS' AND PEDIATRIC PATIENTS'  
PERCEPTION OF THE NURSE

BY

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## **ABSTRACT**

The purpose of this study was to determine the effect of music therapy on parents' and pediatric patients' perception of the nurse. Both patient (N=40) and parent (N=40) groups were given a post-test after music therapy intervention to determine if music therapy effected perception of nurse. All subjects gave written consent prior to completing the study. The experimental group received music therapy with the nurse present and involved for 7-10 minutes and was comprised of a convenience sample based on nurse availability. The control group received no music therapy. Data were collected and measured using a two-tailed Mann Whitney U test. Results showed no statistically significant difference between either parent or patient experimental and control groups. Nurse surveys revealed that one hundred percent of nurses viewed music therapy as beneficial in generating a more positive relationship between nurse, patient, and family.

# **CHAPTER ONE**

## **INTRODUCTION**

Staff and auxiliary are an enormous part of the hospital experience for young pediatric patients and their families. Nurses have often been viewed by children as the people who come in during the middle of the night, turn on the light, and stick them with needles or perform other painful, routine procedures. It has been suggested that nursing staff can unintentionally seem cold or indifferent to a patient's emotional needs. Much of this behavior can be attributed to the overload of patient per nurse ratio. When the census of a unit is high, it is almost certain that staff will not have extra time to spend with their patients in support of emotional desires. This conduct is usually not deliberate, but necessary.

Families of youngsters may feel distanced from hospital staff in the healthcare decision making process and lack of medical knowledge can cause parents to hesitate asking questions about their loved one's prognosis. Building good rapport with families and patients through conversation and personal concern can significantly affect the way guardians view hospital staff. The purpose of this study is to examine the effect of a brief getting to know you music therapy session between nurse and pediatric patient on the child and family's view of the staff.



## REVIEW OF LITERATURE

### Role of the Nurse

“Nurses as clinical decision makers in contemporary secondary and tertiary health care settings assume several dominant roles, namely, caregiver, integrator, and knowledge worker. The caregiver role refers to those activities or tasks performed by nurses to meet client needs for dependency, comfort, monitoring, therapies, and education” (McFadden, 1989). For decades, the nurse has been conceptualized as the motherly caregiver that provides nurturing to patients. According to Robb, caregivers need to be involved with their patients. “Involvement...is defined as a person’s expression of interest, enjoyment, and genuine acceptance of a child. Involved adults are emotionally available and attend to the needs and interests of children” (Robb, ed., 2003, p. 109). “Hospital personnel must assume responsibility for the emotional care of the hospitalized child and this can only be done by communication” (Rodin, 1983).

“Children are likely to come to incorrect conclusions about the purpose of objects and the possible outcome of occurrences” (Müller, Harris, & Wattle, 1986). “Through communication, hospital personnel can help a child to understand medical procedures and so facilitate better relationships between the child, his parents and the staff” (Rodin, 1983). Müller, Harris and Wattle suggest that children in the pre-operational stage “conceive of illness as being the outcome of their wrong doing. Important aspects of hospital to children are likely at this stage to be external, observable events (e.g., equipment, lights in the OR, surface wounds, food, nurses’ uniforms and strange beds) rather than a description of what is going on in the body”. In this case, “a child’s understanding of explanations is influenced by the choice of words used. The words need to have only one possible meaning, or be very carefully explained”.

“Nurses are regularly faced with families feeling despair, fear, anger, and helplessness, and nurses are challenged to respond therapeutically, often without formal education in family dynamics or intervention” (Goodell & Hanson, 1999). The nurse is not only responsible for the welfare of the patient, but also the family. “ In pediatric

nursing we do not nurse a child; we nurse a family whose sense of well-being is disrupted because one of its members is having a problem” (Coffin, 1970). “Health care involves both the person in need of care and that individual’s family, no matter how that individual defines the composition of his or her family” ( Lynn-McHale & Deatruck, 212). “When children are unexpectedly hospitalized, the nurse is particularly cognizant of the need for client advocacy. Children and parents are bombarded with personnel and stimuli and often the nurse is the only familiar, constant presence in their time of stress” (McFadden, 1989).

“The absence of family therapists in acute care settings makes it even more imperative that nurses learn to recognize dysfunctional family interactional patterns to prevent escalation of dysfunctional coping when it occurs” (Goodell & Hanson, 1999). An example of this behavior is given in the case of Seth, “a 9-week-old pre-term infant residing in the step down unit of a level III Neonatal Intensive Care Unit. He is now recovering and discharge planning has begun. Seth’s mother has missed two appointments that were scheduled with his social worker to discuss discharge plans. Repeated phone calls to Seth’s mother have been unsuccessful in increasing her involvement.” The nurse in this situation recognized a parental role conflict and stated “Seth’s mother is responding to the demands of the situation by distancing herself from the baby. She is attempting to protect herself from the pain of forming strong attachment to a baby whom she thought might die”. This nurse suggests, “this situation could potentially have been avoided by attempting to involve the mother in Seth’s care from the very beginning” (McFadden, 1989).

### **The Hospital Environment/Experience**

According to Eaton, “the best place for sick children is at home, among familiar surroundings”. Unfortunately, being at home is not always a possibility for sick children, and they must be taken out of their comfort zone. The hospital is an unsettling environment for the pediatric patient and for the parent. Strange sounds, procedures, and people can all cause a stressful medical experience. “Unfamiliarity of the hospital

environment, changes in daily routines, unpredictability of medical tests and discharge dates, and increased dependence on others all contribute to stress appraisals” (Robb, 2003).

“A number of sources of stress create psychological upset during hospitalization that patients have to adjust to. There are nonspecific changes, i.e., those not unique for hospitalization, such as separation from things; toys, furnishings, and the home and separation from activities such as school and play as well as separation from people such as the mother and father, sibling and friends. The stress associated with these separations is complicated by the introduction to new things, new activities and new people. Children going away to summer camp often are very anxious due to these kinds of separation problems. But children who are being hospitalized are faced with these types of changes, often with little or no notice. They may be in a weakened condition due to illness. They may fear bodily harm or death. They are exposed to an often unfamiliar and frightening hospital environment complete with terrifying equipment and health specialists who perform medical procedures that can be both frightening and painful. They experience a loss of autonomy and control and are subjected to regimented hospital activities, procedures, and routines” (Yeaple, 1998).

A study completed by Bossert revealed, “Sources of stress for hospitalized children include physical harm or bodily injury, separation, the strange or unknown, uncertainty about limits and loss of control. Children fear intrusion into their bodies which may occur in the process of routine procedures such as temperature measurement and administration of an oral medication, in any procedure associated with needles such as injections, I.V.s and venipunctures or in any of the multitude of diagnostic or therapeutic procedures such as surgery, cardiac catheterization, cystoscopic or bronchoscopic exams, paracentesis, or lumbar punctures” (1990). Bossert also states, “the physical restrictions of immobilization or confinement, such as isolation are particularly stressful to the child due to hindering the child’s normal activities and preventing release of stress and tension through action”.

“Illness and hospitalization are traumatic at every stage and age of development” (Bossert, 1990). Children in different stages of development experience different levels

of fear and stress when in the hospital. “Although children between the ages of 6 months and 3 to 4 years demonstrate the most pronounced effects of separation, older children also find separation from parents to be a difficult experience”. Stress among chronically ill children can, however, decrease with the number of hospital visits. “Spinetta and Maloney (1975) found that as the number of visits to the hospital or clinic increased, the anxiety that children with chronic illness felt, decreased” (Yeaple, 1998). Interventions for anxiety and stress may include psychological preparation, play therapy, music therapy, and parental involvement. Results of a study by Prugh, Staub, Sands, Kirschbaum and Lenihans show “enhanced psychosocial care such as parental involvement, psychological preparation, early ambulation, and play therapy reduced the behavioral stress that hospitalized children experienced”.

### **Effects of family well being on the outcome of the pediatric patient**

“The impact of a loved one’s sudden illness and the intensity of the critical care unit strain families’ coping abilities and cause feelings of disorganization and anxiety that may persist even after the illness is resolved” (Goodell & Hanson, 1999). “The well-being of individuals has been shown to be dependent on the well-being of their next of kin. Family well-being makes the person comfortable, while being distressed about one’s next of kin causes discomfort. Research shows that when a family member becomes ill, the shock to the rest of the family causes various kinds of physical and mental symptoms. Usual physical symptoms experienced by family members include headache, raised blood pressure, stomach pains, loss of appetite, fatigue and a sense of weakness. Mental symptoms alternate from worry and grief to anxiety, nervous distress and depression” (Åstedt-Kurki et al., 1999). “In nursing discussions of families of children with a chronic health condition, it is frequently assumed that satisfying the health care needs of the child and preservation of family life are the two major challenges faced by families. Many families are able to adapt and find a management style that allows them to overcome these challenges. Other families experience difficulty and as a result, the child’s health and the integrity of the family may suffer” (Hulme, 1999).

“The depressive and anxious symptoms that some hospitalized children experienced could be attributed to parental distress and the enduring symptoms of the illness” (Yeaple, 1998). “Anxiety is transmitted from parent to child through the *family projection process*. Often, one child in the family becomes the focus of this projection and that child acts out the projected anxiety through illness or deviant behavior” (Goodell & Hanson, 1999). A pediatric patient may also view others as being anxious and fearful simply because he or she is nervous. “The arousal of fear in one person results in a tendency for that person to also perceive other people as fearful and anxious” (Müller et al., 1986).

One way to handle patient and parents’ anxiety is to allow parents to take part in the nursing of their child. “Participation in caring for the patient appears to be important, not only for the family members themselves but also for the patient” (Åstedt-Kurki et al., 1999). “Hospital patients look forward with enthusiasm to the visits of their family. These visits play an important part in fulfilling the patient’s social needs. Similarly, family members experience closeness to the patient in a positive way. Helping the patient in daily tasks increases the family members’ sense of well-being because they feel a need to be of help. Participation in care has also been linked to diminishing family members’ feelings of helplessness and guilt” (Åstedt-Kurki et al., 1999).

“There are several common sources of stress for parents: their child’s appearance, the strange sights and sounds of that environment, the unfamiliarity of the procedures performed, their child’s behaviors, communication with the staff, behavior of the staff and the relinquishment of their parental role. To decrease parental stress and increase trust in the staff, ... [it is important to provide] parents with information and reinforce parents’ beliefs that their parenting skills are still valuable during the child’s hospitalization” (Thompson et al., 2002).

### **Separation from parents**

“Children show their distress in different ways: some children cry and shout loudly for their favorite toy or comforter, others are silent and unable to express their needs” (Rodin, 1983). “Small children may believe their parents to be all-powerful, and

may therefore blame them for ‘letting’ hospital happen to them” (Müller et al., 1986). “Certainly, for the young child, separation from the security of his home and family has been shown to be the major cause of grief” (Rodin, 1983). If hospitalization is planned, preparation is recommended. “[The children] find themselves in an unfamiliar environment staffed by strangers, they sleep in strange beds, their food is different and they may well not have their own toys and clothes with them. They may see and hear other children who are ill and in pain. They may have to undergo medical procedures which can hurt and confuse them; especially if they do not understand their purpose”. “In recent years there has been growing awareness that patients’ beliefs and assumptions about health and illness may have crucially important affects on compliance and recovery” (Müller et al., 1986). “Many of the negative effects found by researchers can be avoided by careful preparation, and by sensitive management within [the] hospital” (Pg. 93).

“Much of how a child is able to cope with stress depends partly on how much support he receives from the nursing staff” (Coffin, 1970). “The young child is not capable of coping with constantly changing caretakers, no matter how kind each one may be” (pg. 82). “Bowlby (1953) stated that a young child always ‘should experience a warm, intimate and continuous relationship with his mother or mother substitute in which both find satisfaction and enjoyment’ and held that the young child who is immature in mind and body cannot cope with ‘maternal deprivation’. He found that this can occur in hospital when the child has no one person who will care for him in a personal way and with whom he may feel secure” (Rodin, 1983). “Each nurse should be allowed to become really familiar with a small number of children and in some instances with an individual child rather than being allocated to tasks all over the ward” (Müller et al., 1986). Much stress and anxiety caused by separation from parents can be alleviated through consistency in the nursing staff. “It’s not a question of having an adult with a child, but the same adult”.

## **Trusting Hospital Staff**

“Trust is the dependence on another person based on the congruence between the expected and actual behaviors of the trusted person”. There are several factors that either inhibit or enhance the development of trust. “The keys to developing trust are that the patient feels accepted as a person, perceives the nurse as a fellow human being, and feels recognized as a real person and not as the ‘gallbladder in 410’... Identified nursing behaviors that facilitate the development of trust are responding to the patient as a person, anticipating needs of the patient, and getting to know the family. Patients who express a secure relationship with the nurse are more relaxed and less vigilant about watching the care they receive. Patients who did not trust are more likely to manifest certain difficult behaviors such as refusing treatments or withdrawing from a mutual relationship with the nurse” (Thompson et. al, 2002).

“Trust between the family and health care provider is defined as a process, consisting of varying levels, that evolves over time and is based on mutual intention, reciprocity, and expectations” (Lynn-McHale & Deatrck, 2000). “ Interactions between families and health care providers can bring tremendous satisfaction or may be a source of great frustration”. “ Before families can trust, they need to feel that health care providers regard them as competent and intelligent...and they need to get to know each other”.

According to Shields, Kristensson-Hallström, Kristjánsdóttir, and Hunter, mothers feel the need to be trusted by hospital staff in knowing what is best for their children (2003). “Parents of children who collaborated with health care providers in decision making ‘talked about a trust in professionals that was characterized by mutual respect, as professionals were seen as viewing them as knowledgeable about their child” (Lynn-McHale & Deatrck, 2000). “The giving of information and the giving of emotional support to family members have been shown to be important forms of nursing support” (Åstedt-Kurki et al., 1999). In a study done by Thompson et al., “Nearly all parents cited the need for quick and honest answers to their questions and to be kept informed at all times as their most important need during their child’s illness”. “Medland and Ferrans

(1998) found that a structured program of regular phone calls from a nurse was effective in meeting informational needs of the family” (Goodall & Hanson, 1999). The information must, however, be “honest and anticipatory” and the nurse “should take his or her time to explain the information thoroughly”. As for patients, a study by Leske (1996) found that “specific information, when provided to patients with high preferences for information, and general information when provided to those with lower preferences for information, resulted in improved patient outcomes” (Leske, 1996).

Another area of concern is that of seeing the child behind the illness. Patients and parents alike desire personal relationships with the nursing staff. Müller et al. (1986) suggest that an act as simple as “fastening a name tag to a child’s doll or treating a bump on teddy’s head with sticking plaster after having fallen out of bed can make a surprising difference to a child’s overall attitude to hospital”. Parents’ trust is also influenced by how the nurse bonds with the child. “During the hospitalization, parental observation of the care being provided to the child and the building of a relationship with the staff over the course of the stay were crucial in the development of trust” (Thompson et al., 2002).

### **Music to Aid in Correspondence**

“When a nurse enters a ward, it is generally because she has something to do, something else from the child’s point of view” (Müller et. al, 1986). Hospital staff members are usually busy completing tasks and procedures and are too busy to devote a significant amount of time to building a relationship with the patient. “The role of the Music Therapist, [however], is to support children and facilitate coping, therefore, therapists are able to devote all their attention to the child’s emotional needs, acknowledging their feelings and supporting them during difficult procedures” (Robb, 120). One study quoted the parent of a five year- old saying about the music therapist: “it shows that not everyone in the hospital will hurt her” and “she felt safe around this person-no pokes” (Barrera, Rykov, & Doyle, 2002).

“Freedom to make choices about daily activities, sleep and meal schedules, visitation, and medical treatment are often limited in hospital environments”. Music Therapy “encourages freedom of expression by permitting children to make choices and



decisions about activities” (Robb, 2003). Barrera, Rykov and Doyle (2002), suggest that hospitalized pediatric patients engage more actively than control patients in their environments after music therapy and ratings from their studies “suggested a general improvement in the child’s play activity after music therapy”.

“Positive interactions with healthcare providers reduced children’s apprehension” (Shields et al., 2003). Before parents leave their child in the hospital for the first time it is recommended that parents have the caregiver involve their child in a favorite activity before they leave (The Long Goodbye, 2001, 93). Music Therapy may be a useful tool in incorporating healthcare providers in positive interactions with parents, families and patients.

## CHAPTER TWO

### METHOD

**Subjects:** All subjects (N=40) were selected from the Tallahassee Memorial pediatric in-patient census roster. Subjects consisted of pediatric patients ages 5-13 and their parents, legal guardians, or relatives who were watching over the patients during their stay in the hospital. Patients chosen to participate in the study had been in the hospital for more than twenty-four hours and less than three days. Nurses of the experimental subjects also participated in the study. Tables 1-3 provide subject demographics including number of admissions to hospital, subject age/age range, sex, diagnosis and also identify subjects as part of the control or experimental group. The nurses participating in the study were all female and primarily under fifty years of age. Table two displays patient demographics. The control and experimental groups had relatively the same gender distribution, however the control group had an older mean age (C= 9.2 and E= 7.1) than the experimental group. The parent groups also had a similar distribution of males and females and age ranges were relatively similar as well with the average age range being 31-50.

Table 1: Nurse Demographics

<b>Nurse</b>	<b>Male/Female</b>	<b>Age Range</b>
Nurse #1	F	31-50
Nurse #2	F	21-30
Nurse #3	F	31-50
Nurse #4	F	21-30
Nurse #5	F	21-30
Nurse #6	F	31-50
Nurse #7	F	31-50
Nurse #8	F	21-30
Nurse #9	F	51-70
Nurse #10	F	21-30
Nurse #11	F	51-70
Nurse #12	F	51-70
Nurse #13	F	51-70

Table 2: Patient Demographics

<b>Experimental/Control</b>	<b>Male/Female</b>	<b>Age</b>	<b># of Admissions</b>
Experimental # 1	F	5	>1
Experimental # 2	F	5	1
Experimental #3	F	10	>1
Experimental #4	F	7	1
Experimental #5	F	5	1
Experimental #6	M	5	1
Experimental #7	M	10	1
Experimental #8	M	8	>1
Experimental #9	F	7	>1
Experimental #10	M	6	1
Experimental #11	M	5	1
Experimental #12	M	5	1
Experimental #13	F	8	>1
Experimental #14	F	7	>1
Experimental #15	F	7	1
Experimental #16	M	9	>1
Experimental #17	F	6	>1
Experimental #18	F	10	>1
Experimental #19	M	6	1
Experimental #20	M	11	>1
<b>MEAN AGE (EXPERIMENTAL)</b>		<b>7.1</b>	
Control #2	F	7	>1
Control #3	M	6	>1
Control #4	M	9	1
Control #5	F	10	>1
Control #6	F	13	>1
Control #7	F	13	>1
Control #8	M	7	1
Control #9	M	5	>1
Control #10	F	11	>1
Control #11	M	10	>1
Control #12	M	9	>1
Control #13	F	9	>1
Control #14	F	12	>1
Control #15	M	9	>1
Control #16	M	5	1
Control #17	M	13	>1
Control #18	M	9	1
Control #19	F	9	1
Control #20	F	9	>1
<b>MEAN AGE (CONTROL)</b>		<b>9.2</b>	

Table 3: Parent/Relative Demographics

<b>Experimental/Control</b>	<b>Male/Female</b>	<b>Age Range</b>	<b>Relationship to Patient</b>
Experimental # 1	M	31-50	Parent
Experimental # 2	F	18-30	Parent
Experimental # 3	F	31-50	Parent
Experimental # 4	F	31-50	Parent
Experimental # 5	F	18-30	Relative
Experimental # 6	F	31-50	Parent
Experimental # 7	M	31-50	Parent
Experimental # 8	M	31-50	Parent
Experimental # 9	F	31-50	Relative
Experimental # 10	F	18-30	Parent
Experimental # 11	F	31-50	Relative
Experimental # 12	M	31-50	Parent
Experimental # 13	F	51-70	Legal Guardian
Experimental # 14	F	31-50	Parent
Experimental # 15	F	31-50	Parent
Experimental # 16	M	31-50	Parent
Experimental # 17	F	31-50	Relative
Experimental # 18	F	18-30	Parent
Experimental # 19	F	31-50	Relative
Experimental # 20	M	31-50	Parent
Control # 1	F	31-50	Parent
Control # 2	F	18-30	Parent
Control # 3	F	18-30	Parent
Control # 4	M	31-50	Legal Guardian
Control # 5	F	31-50	Parent
Control # 6	F	31-50	Parent
Control # 7	M	18-30	Parent
Control # 8	F	31-50	Parent
Control # 9	F	31-50	Parent
Control # 10	M	18-30	Parent
Control # 11	F	18-30	Parent
Control # 13	F	18-30	Parent
Control # 14	F	31-50	Parent
Control # 15	F	31-50	Parent
Control # 16	F	31-50	Parent
Control # 17	M	18-30	Parent
Control # 18	F	31-50	Parent
Control # 19	F	31-50	Parent
Control # 20	M	31-50	Parent

**Design:** The design was a post-test only format and included a control and an experimental group. The independent variable was a 7-10 minute Music Therapy session with the nurse present (not doing a medical procedure) versus no Music Therapy session. The dependent variable consisted of patient and parent/relative questionnaire of the perception of the nurse and nurse perception of patient relationship and effectiveness of intervention.

**Measure:** Patient's self-report of perception of the nurse was measured by a patient/nurse relationship questionnaire which was created by the researcher. The parent self-report of the perception of the nurse was measured by a parent (or guardian)/nurse relationship questionnaire which was also created by the researcher. The patient questionnaire (Appendix E) uses a Likert scale of 4 degrees. The frown face = strongly disagree and the laughing face = strongly agree. The parent questionnaire (Appendix F) uses a Likert scale of ten degrees: 1 = strongly disagree and 10 = strongly agree. A nurse survey of nurse/patient relationships was also created and administered to nurses after each experimental session (Appendix G). The nurse survey also uses a Likert scale of ten degrees: 1 = strongly disagree and 10 = strongly agree.

**Procedure:** The experimenter used the Tallahassee Memorial pediatric in-patient census roster to identify patients appropriate for participation in the research study and selected patients based on nurse availability. Once patients were identified as appropriate (ages 5-13 and 24 hour-3 day length of stay), the experimenter obtained permission from each experimental patient's nurse before obtaining consent from the patient and his/her family. After consent forms were signed, the experimenter engaged parent, patient and nurse in a 7-10 minute Music Therapy session. The music session consisted of a hello song, which introduced everyone in the room, a group game using instruments in which each person in the room was the leader, and a game using puppets in which the nurse, patient and parent/relative's puppets interacted with each others puppets and the Music Therapist provided the music to accompany the game (Appendix I). Older patients participated in two instrument activities and no puppet games. After the music session ended, patient, parent/relative and nurse were asked to complete a 10-question survey. Control subjects were also obtained using the Tallahassee Memorial pediatric in-patient census roster.

Once consent was obtained from patient and parent/relative, participants were asked to complete the same 10-question survey as the experimental group. No music was used for this group and the nurse was not present. All sessions took place in patient hospital rooms.

**Materials:** Materials used during the experimental portion of this study included a guitar, lollipop drum, kokiriko, shakers, boomwhackers, an alligator puppet and 5 monkey puppets on sticks.

## CHAPTER THREE

### Results

Data for this study were gathered using a parent questionnaire and patient questionnaire created by the researcher. The questionnaires were administered as a post-test only and data were calculated using a two-tailed Mann Whitney U test (Madsen & Moore, 1978) to determine statistical significance of the study. The parent questionnaires revealed no statistical difference with a U score of 164 in the experimental group and 236 in the control group ( $n_1=20$ ,  $n_2=20$ ,  $\alpha=.05$ , critical  $U=127$ ). The patient questionnaires also revealed no statistical difference with a U score of 185 in the experimental group and 214.5 in the control group ( $n_1=20$ ,  $n_2=20$ ,  $\alpha=.05$ , critical  $U=127$ ). The null hypothesis failed to be rejected. Group mean scores are shown in table 4.

Table 4: Mean scores

Group	Parent	Patient
Experimental	88.75	32.9
Control	83.15	31.9

Nurse surveys revealed (N=19) that 52% of nurses agreed that staff need to be reminded to build personal rapport with patients, 47% believed that their patients thought of them as a friend, 29% reported having a relationship beyond nurse with the patient, 70% of the nurses surveyed believed the patients' family trusted them and 100% of the nurses surveyed thought music therapy was helpful in generating a friendlier relationship with the patient and his/her family.

## CHAPTER FOUR

### Discussion

Trends in the data suggest that although music therapy did not significantly change the perception of the nurse as reported by parent and patient, music therapy could be beneficial in generating a friendlier relationship between parent, patient and nurse. One hundred percent of the nurses agreed that music therapy is beneficial in creating a deeper bond with patients and their families and mean scores between control and experimental parent groups varied 5 points (experimental= 88.75 and control= 83.15). Total scores also varied between patient and parent control and experimental groups. Total scores for parent groups were: control= 1663 and experimental= 1775, a difference of 112 points. Total scores for patient groups were: control= 638 and experimental= 658, a difference of 20 points. Results did show a larger effect size between parent groups than between patient groups, though neither were statistically significant.

The researcher received several positive statements from nursing staff as well as from families. Some of these statements included: “Thank you so much! You bring a smile to my patients’ faces!” “They have so much fun and I think it’s great.” “My daughter hasn’t smiled today. When I asked her why, she said it’s because you haven’t been by to do music again today.” In most cases, the nurse, patient or parent asked the music therapist to return and continue music therapy sessions.

Implications for future research would allow more time for nurse, subject, and music therapist interactions. This study allowed only 7-10 minutes for the music therapy session to take place. The session consisted of 3 activities: hello song, instrument game and puppet game. Some limitations to the study were: high census numbers, low staff numbers and time constraints of nurses. Due to these limitations, the researcher selected subjects according to nurse availability. Results may have been confounded by patients’ mean age (C=9.2 and E=7.1), which may have been caused by convenience sampling. Future researchers should collect data randomly and generate a pre-test to be administered before the session begins in addition to the post-test. Future areas of



interest may also include: Relationship between parent/patient perception of nurse and length of stay, Perception of the nurse and patient/parent anxiety levels, Perception of the nurse and reported quality of care.

This study did not take place while the nurse was performing a medical procedure. In order for the nurse to interact with the patient and the music therapist, he/she needed to be free to play instruments and interact with the child and family by participating in musical games. The researcher did notice, however, that younger children who had just received procedures were more likely to give their nurses lower scores. Perhaps another implication for research would be music therapy with the patient and nurse before the procedure takes place to create a more trusting relationship for future procedures.

## **APPENDIX A**

Human Subjects Committee Approval



Office of the Vice President For Research  
Human Subjects Committee  
Tallahassee, Florida 32306-2763  
(850) 644-8633 · FAX (850) 644-4392

## APPROVAL MEMORANDUM

Date: 11/4/2004

To:  
**Jennifer Bell**  
2000 N. Meridian Rd #314  
Tallahassee FL 32303

Dept.: **MUSIC SCHOOL**

From: **John Tomkowiak, Chair**

A handwritten signature in black ink that reads "John Tomkowiak M.D.".

Re: **Use of Human Subjects in Research**  
**The effect of music therapy on the parent's and pediatric patient's perception of the nurse**

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Human Subjects Committee at its meeting on **10/13/2004**. Your project was approved by the Committee.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals which may be required.

If the project has not been completed by **10/12/2005** you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

cc: Jayne Standley  
HSC No. 2004.675

## **APPENDIX B**

Child Assent

My name is Jennifer and I would like your help with a study that I am completing. You do not have to participate if you do not want to. You will be asked to answer a few questions and sing a couple of songs with the nurse and me. I will be asking some other kids in the hospital to answer questions and sing along with me too. If you don't know the answer to a question I ask you or if you don't want to answer them, we can stop or move on to the next question and you won't get into any trouble. Would you like to answer a few questions and sing some songs with me?

Yes\_\_\_\_\_

No\_\_\_\_\_

Please sign your name here: \_\_\_\_\_

## **APPENDIX C**

Parent Consent

Dear Parent,

My name is Jennifer Bell and I am a graduate student under the direction of Dr. Jayne Standley in the Music Therapy Department in the College of Music at Florida State University. I am conducting a research study to examine the effects of music therapy on the trust relationship between pediatric patient, parent and nurse. The purpose of the study is to observe the trust level of the parent and pediatric patient before and after a music therapy session with the nurse.

Your participation will involve completing a pre-test and post-test questionnaire and possibly participating in the music session by singing along with me (the Music Therapist), Nurse, and your child. The pre-test and post-test should take no more than 5 minutes to complete and the music session will be ten minutes. There will be an optional phone survey one week after discharge from the hospital. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, it will not affect your child's treatment or care. The results of the research study may be published, but your name will not be used. Your personal information will remain confidential at all times to the extent allowed by law. All information will be stored at my residence, where only I will have access to it. Information will be destroyed after one year. If you wish to obtain a copy of the completed research study, you may request a duplicate from me.

There are foreseeable risks or discomforts to you if you agree to participate in the study. The possible discomforts include anxiety while singing with your child, nurse, and/or myself (the therapist). If you feel uncomfortable at any time, you may stop the session.

Although there may be no direct benefit to you, the possible benefit of your participation is the contributions to the advancement of future anxiety reducing measures for pediatric patients as well as witnessing the trust relationship develop between you, your child and medical personnel.

If you have any questions concerning this research study, please call me at (850)-878-7289 or Dr. Jayne Standley at (850) 644-4565 or [jayne\\_standley@cmr.fsu.edu](mailto:jayne_standley@cmr.fsu.edu). If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at (850) 644-8633.

Sincerely,

Jennifer E. Bell

\* \* \* \* \*

I give my consent to participate in the above study.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

I agree and voluntarily consent to allow my child to participate in the research project entitled "The effect of a music therapy session on the parents' and patients' perception of the nurse", conducted by Jennifer Bell, TMH Music Therapy Intern

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **APPENDIX D**

Nurse Consent



Dear Nurse,

My name is Jennifer Bell and I am a graduate student under the direction of Dr. Jayne Standley in the Music Therapy Department in the College of Music at Florida State University. I am conducting a research study to examine the effects of music therapy on the trust relationship between pediatric patient, parent and nurse. The purpose of the study is to observe the trust level of the parent and pediatric patient of medical staff before and after a music therapy session with the nurse.

Your participation will involve completing a pre-test and post-test questionnaire and participating in the music session by singing along with me (the Music Therapist), the parent, and the patient. The pre-test and post-test should take no more than 5 minutes to complete and the music session will be ten minutes. Your participation in this study is voluntary. If you choose not to participate or to withdraw from the study at any time, you will not be penalized. The results of the research study may be published, but your name will not be used. Your personal information will remain confidential at all times to the extent allowed by law. All information will be stored at my residence where only I will have access to it. Information will be destroyed after one year. If you wish to obtain a copy of the completed research study, you may request a duplicate from me.

There are foreseeable risks or discomforts to you if you agree to participate in the study. The possible discomforts include anxiety while singing with the patient, parent, and/or the therapist. If you feel uncomfortable at any time, you may stop the session.

Although there may be no direct benefit to you, the possible benefit of your participation is the contributions to the advancement of future anxiety reducing measures for pediatric patients as well as witnessing the trust relationship develop between you, your patient and the parents.

If you have any questions concerning this research study, please call me at (850)-878-7289 or Dr. Jayne Standley at (850) 644-4565 or [jayne.standley@cmr.fsu.edu](mailto:jayne.standley@cmr.fsu.edu). If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research at (850) 644-8633.

Sincerely,

Jennifer E. Bell

\* \* \* \* \*

I give my consent to participate in the above study.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## **APPENDIX E**

### Patient Questionnaire

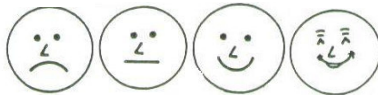
I am a Boy \_\_\_ Girl \_\_\_ I am \_\_\_ years old

Is this your first time in the hospital? Yes \_\_\_ No \_\_\_

Do you know your nurse's name? Yes \_\_\_ No \_\_\_

If you know your nurses name, write it here: \_\_\_\_\_

1. My nurse takes time to talk to me about school, toys, or hobbies.



2. My nurse makes me feel better when I am scared.



3. I feel O.K. when my parents leave me alone with the nurse.



4. My nurse is my friend.



5. My nurse answers my questions.



6. I am not scared of my nurse.



7. I would like my nurse to spend more time with me.



8. I would like my nurse to get to know me better.



9. I trust my nurse.



10. Overall, I like my nurse.



Name: \_\_\_\_\_

## **APPENDIX F**

Parent Questionnaire

Gender: M \_\_\_ F \_\_\_

Age: 18-30 \_\_\_ 31-50 \_\_\_ 51-70 \_\_\_ 71+ \_\_\_

Relationship to Patient: Parent \_\_\_ Relative \_\_\_ Legal guardian \_\_\_ Other \_\_\_\_\_

Is this your first experience with a child in the hospital? Yes \_\_\_ No \_\_\_

Do you know the name of the patient's nurse? Yes \_\_\_ No \_\_\_

If yes, please print name here: \_\_\_\_\_

How many days have you had this nurse? \_\_\_\_\_

1.) The nurse taking care of my patient takes time to give me updates and reports.

1	2	3	4	5	6	7	8	9	10
Strongly									Strongly
Disagree									Agree

2.) I have gotten to know my patient's nurse on a personal level.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

3.) The nurses take time to talk to my patient on a personal level.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4.) The nurses comfort my patient when he/she is feeling anxious.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

5.) I feel comfortable leaving my child alone with nursing staff for an extended period of time.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

6.) I feel recognized by the nursing staff as someone who can help with the healthcare of my child.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

7.) I am comfortable expressing my concerns to the nursing staff.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

8.) I am comfortable asking the nursing staff medical questions.

1      2      3      4      5      6      7      8      9      10

9.) To the best of my knowledge, my child is happy with his/her nurse.

1      2      3      4      5      6      7      8      9      10

10.) Overall, I am satisfied with the nursing staff.

1      2      3      4      5      6      7      8      9      10

Name: \_\_\_\_\_



## **APPENDIX G**

### Nurse Questionnaire



9.) I view parents/guardians as people who can help with the healthcare of their child

1    2    3    4    5    6    7    8    9    10

10.) I believe Music Therapy is helpful in generating a friendlier relationship with my patient and his/her family.

1    2    3    4    5    6    7    8    9    10

Name: \_\_\_\_\_

**APPENDIX H**  
Raw Data

### Patient Raw Data (experimental)

Subject	#1	#2	#3	#4	#5	#6	#7	#8	#9	#10
1	4	4	4	4	4	4	4	4	4	4
2	1	4	1	4	4	4	4	4	4	4
3	4	3	1	4	4	4	3	3	4	4
4	3	3	4	4	3	3	3	3	3	3
5	4	4	4	4	4	4	3	3	4	4
6	4	1	2	3	3	3	3	3	3	3
7	3	4	2	4	1	4	4	3	4	4
8	4	4	4	4	4	4	4	4	4	4
9	3	2	1	3	3	3	3	3	2	2
10	2	4	4	4	3	4	4	4	4	4
11	3	4	3	4	4	3	4	3	2	3
12	1	3	1	3	4	1	4	4	4	4
13	3	2	3	4	3	3	4	3	4	4
14	3	2	4	2	2	3	4	2	3	2
15	3	4	3	3	3	3	3	4	4	3
16	4	4	4	4	3	1	4	4	4	4
17	4	3	2	3	4	2	1	2	3	3
18	4	4	4	4	4	4	4	3	4	4
19	3	4	4	4	1	1	4	4	4	4
20	3	3	3	3	2	3	2	3	2	3

### Patient Raw Data (control)

1	1	4	2	2	3	4	2	3	4	3
2	4	3	2	3	3	3	3	4	3	4
3	2	4	2	4	4	4	3	3	4	4
4	4	3	4	3	3	3	3	4	4	3
5	1	2	2	3	4	4	1	2	4	4
6	2	3	2	3	3	4	2	3	4	3
7	1	3	4	4	4	4	2	3	4	4
8	4	4	4	4	4	4	4	4	4	4
9	3	3	4	3	4	4	3	3	4	4
10	3	4	4	4	4	4	4	3	4	4
11	3	3	3	4	2	3	4	4	4	3
12	2	3	2	3	4	4	2	3	4	4
13	4	3	4	4	4	4	1	1	4	4
14	1	2	1	2	2	1	1	1	4	3
15	3	3	1	4	3	4	2	3	4	4
16	3	4	4	4	4	4	3	4	4	4
17	4	4	4	4	4	4	1	1	4	4
18	4	4	1	3	4	4	4	4	4	4
19	4	1	2	3	3	3	4	3	3	3
20	4	3	2	3	3	1	2	4	2	3

### Parent Raw Data (Experimental)

1	10	8	10	9	9	8	10	10	10	10
2	9	6	10	9	8	8	9	9	10	10
3	7	3	5	8	5	7	9	10	8	7
4	10	5	10	10	10	9	10	10	10	10
5	10	6	7	9	6	7	10	10	10	10
6	10	9	10	10	8	10	10	10	10	10
7	10	10	10	9	9	10	10	10	9	10
8	10	8	10	10	10	10	10	10	10	10
9	10	10	10	10	3	10	10	10	10	9
10	10	6	7	10	10	10	10	10	10	10
11	10	10	10	10	10	10	10	10	10	10
12	7	7	7	6	5	7	8	8	7	7
13	7	2	9	7	10	8	10	10	8	10
14	7	7	7	8	10	10	10	10	10	10
15	10	3	3	10	10	10	10	10	10	10
16	10	9	10	10	5	10	10	10	10	9
17	9	6	8	8	5	7	10	10	9	9
18	10	10	10	10	10	10	10	10	10	10
19	8	8	8	8	3	8	8	8	8	8
20	10	6	9	10	10	9	10	10	10	10

### Parent Raw Data (Control)

1	9	3	4	1	1	10	8	9	9	8
2	4	2	4	4	2	9	5	10	4	5
3	9	1	7	8	8	8	8	8	8	9
4	10	10	10	10	10	10	10	10	10	10
5	10	6	5	5	5	10	10	10	10	10
6	8	3	8	8	10	10	10	10	10	10
7	7	2	3	6	2	7	9	9	9	9
8	8	1	3	6	5	2	8	10	10	10
9	1	4	6	10	5	10	10	10	10	10
10	10	8	8	10	10	10	9	9	9	9
11	9	3	5	7	9	9	9	8	6	8
12	10	7	9	10	10	10	10	10	10	10
13	10	5	10	10	1	10	10	10	10	10
14	8	2	7	10	8	10	10	10	10	10
15	10	8	9	10	9	10	10	10	10	10
16	10	6	10	10	10	10	10	10	10	10
17	10	10	10	10	8	9	9	10	10	10
18	10	10	10	10	8	10	10	10	10	10
19	10	10	10	10	10	10	10	10	10	10
20	10	8	7	9	8	8	10	10	10	10

### Nurse Raw Data

1	8	10	9	3	3	9	9	8	8	9
2	9	6	3	3	6	4	5	1	10	9
3	10	7	7	1	1	10	9	7	10	9
4	10	10	10	3	8	10	10	6	10	10
5	9	9	7	5	8	6	9	8	10	9
6	8	10	7	3	7	9	7	5	10	8
7	10	10	10	4	10	9	10	8	10	10
8	10	10	6	5	3	5	7	1	10	10
9	10	5	5	3	8	8	9	5	9	10
10	10	9	8	2	8	10	10	6	10	10
11	7	8	7	3	8	7	7	5	9	10
12	8	7	7	3	4	8	9	8	10	10
13	10	10	5	5	3	7	7	2	10	10
14	8	10	9	2	8	10	9	9	9	10
15	8	10	6	2	5	6	8	6	10	10
16	10	10	10	5	7	10	10	9	10	10
17	8	8	8	1	8	10	10	7	10	10
18	6	10	6	6	1	10	9	7	10	10
19	10	10	10	9	9	5	8	5	10	10

## **APPENDIX I**

### **Music Therapy Activities**



**Hello Song:**

Hello (name) how do you do today  
I'm very glad I came your way and get to see you  
Hello (name) how do you do today  
How are you today?

(Take turns asking (name) how she/he is doing)

**Instrument Activity 1****Leader of the Band**

(Name) is the leader of the band  
(Name) is the leader of the band  
(Name) is the leader of the band  
He/she tells us when to start and stop

(Person selected tells group when to begin playing instruments and when to stop.  
Everyone present gets a turn. Patient chooses who goes next).

**Instrument Activity 2** (replaces puppet activity for older children)

Using boomwhackers, have nurse and patient play one chord together (C&E) and parents/relatives play remaining chords. The music therapist plays the guitar and sings. When the music therapist looks at a group/person, the group/person plays the boomwhackers. When the music therapist looks at the next group/person, he/she/they begin playing. The following song was used with I, IV and V accompaniment. Both patient and nurse worked together to create rhymes for the end of the song.

Down by the bay  
Where the watermelons grow  
Back to my home  
I dare not go  
For if I do  
My mother will say  
Have you ever seen a (pig, wearing a wig)  
Down by the bay

**Puppet Activity** (for younger patients)

Patient and nurse are the alligator and monkeys. Patient chooses who gets what.  
As chant progresses, the alligator takes monkeys from the other participant.

5 little monkeys swinging from the tree  
Teasing Mr. Alligator can't catch me no you can't catch me  
Along comes Mr. Alligator quiet as can be and he SNATCHES that monkey right  
out of that tree.

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