THE EFFECTS OF MUSIC AND GUIDED IMAGERY ON SELF-ESTEEM OF ELDERLY FEMALE CARE HOME RESIDENTS

by

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ABSTRACT

The purpose of this study was to determine the effectiveness of using a music and guided imagery procedure to increase self-esteem in elderly females residing in residential care homes.

The subjects were 26 females, aged 69 to 100 years old, of which 14 were randomly assigned to the experimental group, and 12 were randomly assigned to the control group. Each of the women met with the researcher individually for 30-minute sessions twice weekly, for three weeks. The women in the experimental group listened to a tape recording of music and guided imagery, while the women in the control group listened to a tape recording of poetry.

Eight women in the experimental group, and six women in the control group, were randomly selected to receive the Rosenberg Self-Esteem Scale as a pretest. The scale was administered to all 26 women as a posttest.

Analyses of the pretest and posttest scores were completed using the chi-square test of homogeneity, which indicated that the two groups were homogeneous; the Wilcoxon signed-ranks test, which indicated no significant change from pretest to posttest scores for the experimental group; and the Mann-Whitney U-test, which indicated no significant difference in posttest scores between the experimental and control groups.

Although the statistical results showed no significant gain in self-esteem, there are indications that further research is needed to determine more conclusively the effects of individual music and guided imagery sessions in this population.

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CHAPTER I

With the increase in the proportion of older people in the population, there is a growing awareness of the problems that the aging individual faces, and a growing need to provide the aged with appropriate services.

The number of persons over 65 years of age is increasing at a faster rate than ever before (National Council on Aging, 1978). Currently over five percent of the elderly population in the United States resides in residential care homes (Lieberman & Tobin, 1983). If that proportion of the population remains the same and longevity increases, the need for adequate care for the infirm will remain a serious issue for the aged (Stub, 1982).

Providing "adequate care" for the aged means recognizing and meeting the special needs of the elderly. Many of these needs center around loss. The aged must face retirement, decreased income, loss of status, impaired physical abilities, and sensory deficiencies. In addition, the deaths of a spouse and peers contribute considerably to losses already sustained (Charatan, 1975). Often, as a result of one or several of these losses, the aged must move into a supervised living situation, a change which constitutes another severe stress (Lieberman & Tobin, 1983). Those individuals who need special care and reside in residential care homes, sustain all of these losses. Furthermore, they must endure an attitude of society that generally regards care home residents as useless individuals, merely awaiting decline and death

(National Institute on Aging, 1978).

While physical and emotional losses create stress for any aged person, those still in the community can often maintain independence and control over life, which are central components of self-image (Stub, 1982). For the care home resident, independence and control over life are lost as well. The care home resident often sees himself as a person of no worth at all (NIA, 1978).

Among the results of these losses are depression and damaged self-esteem (Charatan, 1975). Typically, self-esteem is defined as a sense of self-worth; that is, a belief that one is basically a person of value (Rosenberg, 1965; Coopersmith, 1967). Rosenberg (1979) describes one with low self-esteem as an individual who "lacks respect for himself, considers himself unworthy, inadequate, or otherwise seriously deficient as a person." Lieberman & Tobin (1983) suggest that situations that "tax a person's ability to cope with adaptive demands," and changes that reduce a person's ability to maintain a positive self-image, all cause a diminution of self-esteem.

Several researchers have suggested that anxiety is a symptom which often accompanies low self-esteem. Rosenberg (1979) has determined that persons exhibiting depressive affect and anxiety often have low self-esteem. Chaplin (1975) lists anxiety and self-depreciation as characteristics of depressive reactions precipitated by loss. Lieberman & Tobin (1983) report that anxiety and diminished self-esteem are among the reactions to stress caused by loss in old age.

If depression, anxiety, and low self-esteem are symptoms commonly found in older people, then alleviating anxiety and depression, and increasing self-esteem, are major needs in the elderly.

Music is one of a variety of media available to meet these needs.

Music is a powerful therapeutic tool which can fulfill the need for self-expression and provide opportunities for success through making choices and accepting responsibilities (Sears, 1968). Such positive experiences can enhance pride in self, and increase the individual's feelings of self-worth (Sears, 1968). Music is also an effective medium for increasing awareness and creativity, and for promoting relaxation which, together, can improve a person's overall sense of well-being (Bonny & Savary, 1973). Furthermore, music is a potent instrument in working with the elderly (Watts, 1980). The need by the elderly for decreased inner anxiety can be met in part by "sustained, non-rhythmical music which makes no demand for physical activity, but rather induces esthetic fantasy" (Gaston, 1968).

Although there is widespread use of music in residential care homes, few of the procedures are being researched scientifically (A.C. Gibbons, personal communication, February, 1984).

Over twenty years have passed since Boxberger (1960) stated that one of the greatest needs in the field of music in therapy is "a concerted effort to provide more knowledge about, and procedures for working with geriatric pātients based upon scientific

study." Research studies and controlled observations are the means for determining why and how music might be most useful (Boxberger, 1960).

The purpose of this study was to provide an empirical basis for using a music and imagery procedure to increase self-esteem in the elderly residing in residential care homes. Moreover, the results of this study contribute to the knowledge and understanding of music therapists who work with the elderly population.

This study answered the following questions:

1. Will six individual sessions utilizing music and guided imagery with elderly, female care home residents, significantly increase their self-esteem scores, as shown on the Rosenberg Self-Esteem Scale?
2. Will music sessions and non-music sessions differ significantly in raising levels of self-esteem in elderly female care home residents, as shown by a comparison of scores on the Rosenberg Self-Esteem Scale?

CHAPTER II

RELATED LITERATURE

The Aged Population in the United States

In the past several decades, the number of Americans aged 65 and over has grown rapidly. Furthermore, the population over 65 years of age is steadily enlarging as a proportion of the total population. At the turn of the century, only four percent of the total population was 65 or older. Currently, 11.2% is over 65. It is expected that this proportion will continue to grow, so that by the year 2030, nearly one in every five persons, or 18.3% will be at least 65 years old (White House Conference on Aging, 1981).

Meanwhile, elderly people are getting older. In the next twenty years, the group 75 years and older will expand by 52.5%, and the 80 years and above group will increase by 56.4% (WHCA, 1981).

With the increase in the elderly population, there is a growing awareness of the problems of the aged, and a concern for providing appropriate services to meet their special needs. For example, as the older population expands, it is expected that the number of elderly people residing in residential care homes will increase as well (National Council on the Aging, 1978). The care home resident, while unable to function without the help of professional caretakers, often possesses abilities which, with proper guidance, could be utilized to enhance the quality of his or her life in the residential care home. Music is well suited for use with geriatric clients because of the socialization and personal gratification that often

results from creative experiences with it (Boxberger & Cotter, 1968). With the assistance of a music therapist, the lives of many elderly residents could be enhanced by cultivating new interests, participating in activities, and re-establishing social bonds (Boxberger & Cotter, 1968).

Attitudes Toward the Elderly

In its assessments concerning the older population, the National Institute on Aging has stated that the views of the aged widely held by Western societies include the notion that the old are useless. This prejudice against the aged, known as ageism, is manifested in several ways: through an obsession with youth and looking young; through the media's emphasis on extraordinary achievements of the aged, instead of on ordinary, satisfying lives; and "in the poor general understanding of the value of old age" (NIA, 1978).

Ageism also exists in the system of forced retirement. When a person reaches the age of 65, he is frequently forced out of the job market for the sake of someone younger and, supposedly, more capable of doing the work (Butler & Lewis, 1977). Such a practice precipitates the view that a person's economic value, or how much someone will pay him to work, is a true measure of human worth (NIA, 1978).

So widespread is the prejudice against the elderly, that one national survey shows that even the older public have negative images of old age: that life is difficult for most people over 65, and that they are, themselves, exceptions to the rule (NCOA, 1975).

An important implication of this pervasive negative attitude

toward the elderly is that it fosters a climate which may well affect those who work with the aged. According to Bennett (1976), training makes little difference in attitudes toward the aged, "which are uniformly negative in graduate medical, nursing, and social work students." It should be noted, however, that there is a current trend in programs involving direct contact with the well elderly, which encourages training for dealing with the elderly more effectively, and which yields more positive results in attitude surveys (Bennett, 1976).

Music therapists who work with geriatric clients need to examine their personal feelings toward older people. In addition, the therapist should study the facts concerning aging processes, for a better understanding of the geriatric client. Through self-awareness and accurate knowledge of his client, the music therapist can practice in a positive framework for success.

Theories of Aging

There are several theories of aging, each of which give some insight to understanding the aging individual. Two of these theories have direct implications for the music therapy profession.

The first and best known is the disengagement theory of Cumming and Henry (1961). This theory claims that older people and society mutually withdraw from each other. Neugarten (1973) explained the disengagement theory in the context of societal disengagement and individual disengagement. The societal theory maintains that it is necessary for society to cope with the mortality of its members. That is, the death of active individuals is

disruptive to productivity, because it is difficult to replace them. Therefore, society has institutionalized disengagement through mandatory retirement and other procedures, in which the aged are forced out of the mainstream of society.

The individual theory contends that the older person voluntarily limits his activities and disengages himself from the mainstream, as a response to a lower energy level and as a preparation for death. Also, the individual becomes introverted and narcissistic, and reverts to a stage similar to that of childhood (Neugarten, 1973).

Chellam (1978) offers an extension of Neugarten's interpretation of the disengagement theory. She suggests that there is an "engagement continuum" encompassing social engagement, disengagement, and finally self-engagement. Self-engagement, as explained by Chellam (1978), is a type of meaningful involvement with life for the aging individual, when his resources in time and energy are limited. It is a process reflecting the inner recesses of the personality, and involving activities which are self-directed, expressive, and inner-oriented. The onset of self-engagement is a function of an awareness of approaching death (Chellam, 1978). Both awareness of death and self-engagement are intensely personal experiences, and over time, grow in meaning for the individual (Chellam, 1978).

If elderly people become self-engaged, then perhaps self-expressive activities and self-gratifying experiences would offer the most positive results when working with these individuals. Music can conform to the needs of individuals who are self-engaged,

because it is an avenue through which the innermost emotions can be expressed. Through music, the individual may participate in his own growth and change (Gaston, 1968).

Another aging theory, developed by Havighurst (1963), is the activity theory. This theory emphasizes engagement as opposed to disengagement. The basic premise of the activity theory is that it is the active elderly who are the successful agers. The theory proposes that older people should remain active as long as possible, and when roles must be given up, substitutes should be found. Another concept basic to the activity theory is that active roles are necessary in order to preserve mental health and satisfaction (Butler & Lewis, 1977).

Music can be adapted to the activity theory as well. Musical activities can be designed to meet the needs of individuals on any level (Sears, 1968).

It seems there are many possible patterns of aging. According to Butler & Lewis (1977), it is the older person's personality that is the key element in determining individual reactions to biological and social changes.

Since music therapists' perceptions of the aged can strongly influence the potential effects of music's therapeutic value (Watts, 1980), then the aging theory to which therapists subscribe affects the work they do with the elderly. For example, if one believes solely in the disengagement theory he might provide only inner-oriented activities, such as stimulating creative fantasy. However, if the music therapist relies only on the activity theory for

direction, he might provide only group activities, with no provision for inner emotional needs. Therefore, the music therapist must be influenced by, and incorporate ideas from, many theories, in order to provide the most effective treatment for geriatric clients.

Problems of the Elderly

Older people face multiple difficulties. The consequences of longevity include physical, psychological, and social problems that must be identified, as well as understood, to meet the special needs these difficulties create. Some of the common problems are: physical handicaps; lethargy and apathy; depression; loss; and ageism.

Physical Handicaps

Physical handicaps are frequently caused by acute traumatic illnesses, such as heart attacks and strokes. However, the normal aging process also causes the common symptoms of failing sight, loss of hearing, and varying degrees of immobility (Allen, 1977). Palmer (1977) names arteriosclerosis as the most common physiological problem of the elderly, which often results in the loss of bodily functions. Arthritis is another serious problem which can cause an inability to perform the simplest tasks.

Lethargy and Apathy

Lethargy and apathy are encouraged by the attitude that the elderly can do little or nothing for themselves. As a result, the older person may not attempt to do anything for himself, and in effect, will fulfill his "roleless role" (Brocher, 1978). This results in a decrease in energy, awareness, and alertness (Allen, 1977; Brocher 1978).

Depression

Moss (1966) names depression as the most common non-organic ailment of the elderly. Busse (cited in Rosenfeld, 1978) proposes that depression in older adults stems from a loss of self-esteem, due to lessened ability to obtain basic gratifications, and to defend themselves against threats to security. General disillusionment with how life is ending leads to depression and deterioration (Rosenfeld, 1978).

Loss

It is generally agreed that loss is prevalent in old age. Studies indicate that personal loss in later life can cause serious psychological difficulties for the aged (NCOA, 1978; Butler & Lewis, 1977; Lieberman & Tobin, 1983). Elderly people frequently experience multiple losses, often in rapid succession, of a marital partner, friend, and relatives. The ensuing bereavement and loneliness constitutes severe stress for the grieving individual. The death of a spouse, which is considered the most stressful event with which most people are confronted, imposes additional stresses caused by radical changes in living arrangements and loss of income (NCOA, 1978). So destructive is the loss of a spouse that it has been shown statistically that the risk of death increases for the grieving survivor (Charatan, 1980). Butler & Lewis (1977) assert that enormous amounts of energy are expended in resolving grief, and in adapting to the changes brought on by loss. Older persons who are handicapped by their own bodies, due to major illnesses and loss of physical abilities, have less energy and strength with

which to cope with new losses. Simultaneous losses, then, can leave the aged with layers of unresolved grief, as well as fatigue and a sense of emptiness (Butler & Lewis, 1977).

Social loss can be damaging to the emotional health of the elderly as well. Old age has been called the "roleless role;" that is, the elderly are deprived of meaningful functions in their social group, and they are left feeling "useless, isolated, and lonely" (Brocher, 1978). Furthermore, in a technological society, retirement (frequently forced) brings a loss of role, prestige, and status (Brocher, 1978). The lack of social pressure or expectations to find replacement roles creates the impression of loss and rejection (Stub, 1982). This rejection generates stress for the aged at the same time there is a general slowing down of physical abilities and a narrowing of social interests (Boxberger, 1960).

Ageism

Ageism, or prejudice against the aged, is displayed in society's obsession with youth and in the poor general understanding of the values of old age (NIA, 1978). There is a persistent, and commonly accepted attitude, even among older persons (NCOA, 1975), that once a person is old, he is useless and of diminished value to society (NIA, 1978). Some old people feel that their lives are over, that society and their loved ones have rejected them, and that they are all alone with nobody to understand them or to communicate with them. Their self-esteem is gone; they are insecure. In the absence of ambition, melancholy prevails (Moss, 1966). Boxberger

(1960) reports that rejection precipitated by such prejudice in society creates stress in addition to that resulting from other disabilities. Such rejection can result in another common, serious problem for the aged, a lack of self-esteem (NIA, 1978).

Stress, Depression, and Self-Esteem

Studies indicate that age-related events and stresses in later life may alter the self-esteem of the older person (George & Bearon, 1980; NIA, 1978).

It has been established that the aging process involves loss, and that losses are very stressful experiences. Even the threat of loss can cause significant emotional stress (Lieberman & Tobin, 1983). These new stresses require new attitudes and new coping approaches (Stub, 1982). Some elderly people are better equipped than others to handle stressful situations, due to lifelong patterns of successful coping strategies for negotiating personal and environmental change. Even successful adaptors, however, can become overloaded with stress. One serious consequence is an increased vulnerability to lowered self-esteem, and depression (Solomon, 1981). Individuals with poorer coping strategies, and especially those who are also physically disabled, are even more likely than successful adaptors to become depressed (Salzman & Shader, 1978).

There are other contributing factors to depression in the elderly. According to Butler & Lewis (1977), some older people have incorporated the negative cultural view of themselves. That is, many elderly people perceive themselves in the same way as many younger people perceive them. The reaction that occurs has been

called "self-hatred," and takes the form of depression (Butler & Lewis, 1977).

One of the characteristics of depression is self-depreciation and feelings of inadequacy (Chaplin, 1968). Rosenberg (1979) describes a person with low self-esteem as "one who lacks respect for himself, considers himself unworthy, inadequate, or otherwise deficient as a person."

It appears, then,that there is a close relationship between depression and self-esteem. Feelings of inadequacy or low self-esteem are characteristic of depression, while depression is one reaction to feelings of inadequacy.

Schwartz (1975) believes self-esteem is increasingly important with the transition from middle to old age. Those people who have less successful environmental interactions and adaptations to environmental change will be less likely to have positive self-esteem than those with effective coping strategies. Therefore, an elderly person's inability to cope with stress contributes not only to depression, but also to the accompanying lowered level of self-esteem.

The aged living in residential care homes are especially likely to have low self-esteem. Not only do the majority of care home residents have several disabilities, but they have also encountered the severe stress of radically changed living arrangements (Stub, 1982). Furthermore, life in a care facility requires that residents yield much of the control over their lives to professional helpers. Solomon (1981) contends that a person's decreased ability to master his or her environment also leads to reduced self-esteem and depression.

Many elderly people in care homes must even give up control of the simple routines of everyday living (Rosenfeld, 1978). Consequently, depression and low self-esteem are prevalent in care home residents.

To facilitate appropriate intervention, professionals who work in a residential care home setting must understand the losses and stress these clients have experienced, and recognize their resulting feelings of helplessness, depression, and lowered self-esteem. Only through such recognition can meaningful and positive therapeutic relationships be developed, in which the aged person's sense of self-esteem can begin to be restored.

Music Therapy with the Elderly

Music has been shown to be a potent influence in working with the elderly (Watts, 1980). This is true, at least in part, because of the feelings of gratification that often result from creative experiences with it (Boxberger & Cotter, 1968).

While a variety of musical activities are used with the aged in care facilities, as well as in community senior centers, little research has examined music therapy applications in this population. Riegler (1980) reported the successful use of music in a reality orientation program, while Kartman (1977) found that music was effective in reinvolving elderly patients in their environment.

Although there is a lack of scientific research in the field of music therapy, many practitioners have described the benefits of various music therapy programs. In his work with the elderly, Shapiro (1969) observed that music therapy activities seem to increase mood and feelings of well-being. Palmer (1977) contends positive

experiences with music can enhance the self-concept.

These observations, and those from other music therapists, are nearly always made in the context of group-oriented activities. Since the elderly who live in residential care homes are likely to have several disabilities, and, in all probability, are disengaged or self-engaged (Chellam, 1978), there is a need for individual activities which provide for personal avenues of emotional expression. Perhaps activities that stimulate the senses, are inner-oriented, and encourage self-expression could be especially useful with care home residents. Allen (1977) suggests that efforts to stimulate the mind, memories, and the imagination are therapeutic priorities.

Such priorities are amenable to the use of music. Sears (1968) characterized music as having the ability to increase the use of the senses, and to elicit extramusical associations. These associations may range from memories of long ago to a creative journey in the imagination. In other words, music can aid in evoking imagery (Bonny & Savary, 1973).

Imagery and Music

Imagery has been used with a variety of therapy techniques (Singer & Pope, 1978). It is an effective tool in re-creating affective experience and altering mood states (Schultz, 1978).

Although there are various types of imagery,and several methods of employing it, imagery can generally be defined as a daydreaming technique which gives rise to spontaneous optical phenomena of an imaginative nature (Leuner, 1978). A common therapeutic technique called guided imagery is one in which the client is told to imagine

a meadow, or similar theme. The meadow is a common starting point for imagery, because of its overwhelming pleasant connotations for most people (Leuner, 1978). The daydream is usually initiated in combination with some suggestions for relaxation.

In a study completed by Jarvinen & Gold (1981), it was found that imagery can be useful in replacing negative thought processes with positive ones. Furthermore, it was found that positive daydreams reduced levels of depression (Jarvinen & Gold, 1981). Schultz (1978) demonstrated that severely depressed, hospitalized males reduced their levels of depression after a ten-minute imagery induction procedure. It was also reported that directed imagery was more helpful than non-directed imagery,perhaps because the depressed individual's habitual negative thought patterns were discouraged by the directed imagery procedure.

Several therapists have used music with directed or guided imagery. It has been found that the addition of music yields more responses than imagery without music (Bonny & Savary, 1973).

The method employed in this study was based largely on the work of Helen Bonny (1973). It combines the listening of music with verbal suggestions, in a relaxed atmosphere, to guide the listener to creative awareness and new depths of imagination.

The question may be asked, "Can the elderly individual, who may be disabled and/or depressed, participate in such an activity?" Boxberger (1968) answers that verbal associations, interpretations of meaning, and recognition of relationships have less tendency to decline than speed of working and similar skills. There are

intellectual changes in the elderly; however, "imagination is ageless" (Boxberger, 1968).

Summary

As the elderly population expands, there is an increasing demand to meet the special needs of older people. These needs include providing care for the substantial number of elderly persons residing in care homes.

To facilitate beneficial therapeutic interventions for care home residents, several factors need consideration: (a) First, the therapist must guard against ageism, or prejudice toward the elderly, in order to establish positive therapeutic relationships. (b) Then, a knowledge of the engagement continuum and personal styles of aging can aid the therapist in choosing appropriate experiences for aged clients. (c) Next, an awareness of the physical, emotional, and social losses encountered by the elderly provide the therapist with a basis for a better understanding of older people. (d) Finally, the therapist must recognize that depression and self-esteem are interrelated effects of loss, and furthermore, that they are prevalent in care home residents. Such recognition can help the therapist in planning positive experiences, in which depression and low self-esteem can be alleviated.

Some studies have found that depression is decreased through the use of imagery techniques. Since it has been established that depression and self-esteem are closely related, the purpose of this study was to determine whether self-esteem is increased through the use of imagery techniques. Studies have indicated that imagery used

in conjunction with music is especially useful in stimulating creative awareness and imagination. Therefore this study was designed to utilize music with guided imagery to determine effects on self-esteem in elderly clients.

The Questions

1. Will six individual sessions utilizing music and guided imagery with elderly, female residential care home residents, significantly increase their self-esteem scores, as shown on the Rosenberg Self-Esteem Scale?

2. Will music sessions and non-music sessions differ significantly in raising levels of self-esteem in elderly,female residential care home residents, as shown by a comparison of scores on the Rosenberg Self-Esteem Scale?

CHAPTER III

PROCEDURES

The purpose of this study was to determine changes in self-esteem of female residents of care homes, through the use of a music and guided imagery procedure.

Subjects

The subjects in this study were 33 female Caucasian residents of four care homes in the Lawrence, Kansas, area. Of these, 26 completed all six experimental sessions.

Of the 26 women who completed the project, 15 were fully ambulatory or could use a walker, nine were confined to wheelchairs, and two were bedridden. Three of the women had significant hearing losses; i.e., they could not understand some of the words on the tapes.

The age of the women ranged from 69 to 100 years old. The average age was 82 years. Each of the women was a resident in her respective care home for at least six months. The education level attained by the women ranged from eighth to twelfth grade. All of the women were alert and reality-oriented, and they were non-musicians.

Selecting the Subjects

Initially, the administrator of each residential care home was telephoned by the researcher, who explained the project. The selection process began with the help of the social worker or the activity director in each home, who was given a list of criteria which the prospective subject would need to meet.

The researcher had established the rather strict criteria for

eligibilty to offset the need for locating subjects in several settings. It was therefore important to equate subjects on the basis of specific characteristics, since there would be considerable variation between environments. Those criteria for subject selection were: (a) female; (b) Caucasian; (c) American; (d) age 65 years or more; (e) a resident of the care home for at least six months; (f) alert and reality-oriented; (g) at least eight years and no more than twelve years of education; and (h) non-musician.

After a list of possible subjects was formulated, the researcher interviewed each person individually to explain the project. Since it was not appropriate to reveal the purpose of the study, which was to determine changes in self-esteem, the women were told that the study was an attempt to learn which methods were most effective in helping elderly people relax. About one-half of those interviewed agreed to participate. The sessions began approximately one week following the interviews.

The women were randomly assigned to the experimental and control groups. The women were also randomly assigned to receive both the pretest and posttest, or to receive only the posttest. Table 1 displays the subject distribution by group.

Table 1

Subject Distribution by Group

Group	Setting I	Setting II	Setting III	Setting IV	Total
Experimental					
Total	2	5	5	2	14
Pre & Post	1	4	2	1	8
Post only	1	1	3	1	6
Control					
Total	1	3	4	4	12
Pre & Post	1	2	1	2	6
Post only	0	1	3	2	6
Total	3	8	9	6	26
Pre & Post	2	6	3	3	14
Post only	1	2	6	3	12

The Experimental Group

There were 14 women, of the original 16 who were randomly assigned to the experimental group, who completed all six sessions. Of these, eight were randomly selected to receive the pretest and posttest, and six were randomly selected to receive only the posttest.

The ages of the women in the experimental group ranged from 69 to 97 years, with an average age of 84 years old. Eight of these women were fully ambulatory or used walkers, five required wheelchairs, while one woman remained in bed. All three women in the study who had a noticeable hearing loss were in the experimental group.

The Control Group

There were 12 women, of the original 17 who were randomly assigned to the control group, who completed all six sessions. Of these, six had been randomly selected to receive both the pretest and posttest, and six, the posttest only.

The ages of the women in the control group ranged from 70 to 100 years old, with and average age of 81 years. Seven of the women were fully ambulatory, four were confined to wheelchairs, and one was bedridden.

The Settings

The settings were four intermediate care homes in the Lawrence, Kansas, area. All were considered equivalent in services provided and in physical environment. Rooms used for testing generally were the sleeping rooms for two residents. The furniture in each room consisted of two beds, two night stands, two chairs, and two built-in dressers. Floors were tile, walls were painted, and windows were along one wall. Most of the rooms had been personalized with pictures and other mementos belonging to the residents.

Setting I

This residential care home was a facility with 61 beds. Three of the women were residents in this setting. The sessions for these three women were conducted in their own rooms. The atmosphere in the home was rather relaxed and quiet; however, the activity director had developed a full schedule of activities from which the residents chose to participate.

Setting II

This care home had 96 beds. There seemed an air of busyness at all times, although the setting was not at all unpleasant. This home offered skilled care, as well as several other services, such as physical and occupational therapies. Eight of the women in the study lived in this home. The sessions for one woman were conducted in a

small lounge, as her roommate was opposed to having the sessions in the room. All the other sessions were conducted in the women's own rooms.

Setting III

This setting was a residential home with 56 beds. Although the home was filled to capacity, the spacious lounging and activity areas created a feeling of tranquility. Of the nine women in the study who lived in this home, three women had their sessions in the small quiet room available for private conferences. The other six had their sessions in their rooms.

Setting IV

This residential care home was the largest, with 100 beds, which were all filled. Six women from this home participated in the study. Only one woman had her sessions in her room, since she was unable to leave her bed. The other five women were quite active, and they spent little time in their rooms. Therefore, it seemed appropriate and convenient for these five women to have their sessions in the quiet room provided for private conferences and other activities.

It was necessary to utilize several facilities to have an adequate sample for this study. There was an effort to make the sessions as similar as possible for each woman in the study. Also, there was an attempt to select women with homogeneous characteristics. Though the settings were not identical, they were considered equivalent for purposes of this project.

Materials and Equipment

The Experimental Tape

The experimental tape consisted of quiet, classical music with guided imagery spoken by a female voice. It was 21 minutes in length. The music and speech were recorded simultaneously on a cassette tape, using a stereo component system and a unidirectional microphone. The music used was the first nine minutes of Daphnis and Chloe, Suite No. 2, by Maurice Ravel (Columbia, ML 6154), and the second movement of Symphony No. 6 (Pastoral) by Beethoven (Epic, BC 1249). The script that was used may be found in Appendix A.

The Control Tape

The control tape consisted of 17 poems by 14 authors. They were recorded on a Wollensak cassette recorder/player, Model 880, with a female voice, using an external microphone. The tape was 21½ minutes long.

Since the purpose of the study was to determine the effects of music and imagery on self-esteem, the poetry was used as a placebo treatment in the control group. Consequently, the two testing conditions were similar, and music was the experimental variable. Poetry was selected for the placebo tape because it has rhythm and meter, but no melody. Also, the poems used described nature and/or memories of the past, providing some imagery, but no music.

The poems on the tape were as follows:

Rudyard Kipling: The Way Through the Woods

Rachel Field: If Once you Have Slept On an Island

Boris Pasternak: March

Boris Pasternak: Spring Floods

John Greenleaf Whittier: Indian Summer

Thomas Bailey Aldrich: After the Rain

Elizabeth Barrett Browning: Sonnets (The poet...; The dog, Flush)

Thomas Moore: The Bird Let Loose

Arthur Guiterman: Hills

Robert Burns: My Heart's in the Highlands

Rudyard Kipling: Seal Lullaby

James Russell Lowell: The Fountain

Nancy Byrd Turner: Planting a Tree

Eugene Field: Long Ago

Stephen Foster: Come, Where My Love Lies Dreaming

Robert Browning: O, the Wild Joys of Living

The Playback Equipment

The cassette tape player used during the sessions was a Wollensak, Model 880. To improve the sound quality, an external speaker was used; EQL Acoustics, Model 802, 8" two-way.

Pretest/Posttest: Rosenberg Self-Esteem Scale

To acquire scientific knowledge regarding geriatric music therapy, appropriate and effective testing procedures are necessary. The National Institute on Aging, in recognizing the special characteristics of the elderly, emphasizes that effective tests must be used to allow for shorter attention spans, slower assimilation, and other mental changes (NIA, 1978). The Rosenberg Self-Esteem Scale is a short test that fits such parameters. It consists of ten items with responses reported along a four-point continuum from "strongly agree" to "strongly disagree." The ten items are:

1. On the whole, I am satisfied with myself.
2. At times I think I am no good at all.
3. I feel that I have a number of good qualities.
4. I am able to do things as well as most other people.
5. I feel I do not have much to be proud of.
6. I certainly feel useless at times.
7. I feel that I'm a person of worth, at least on an equal plane with others.
8. I wish I could have more respect for myself.
9. All in all, I am inclined to feel that I am a failure.
10. I take a positive attitude toward myself.

Research Use

The Rosenberg Self-Esteem Scale was developed by Rosenberg (1965) as a measure of self-esteem for a study of high school students. The item content is also applicable for samples of other age groups, including the elderly. Cottrell and Atchley (1969) and Atchley (1969; 1976) demonstrated such applicability when they used the instrument in a large survey of older adults to determine self-esteem in adjustment to retirement. Other researchers employed the Rosenberg Self-Esteem Scale in studies with older populations. Using the instrument, Kaplan and Pokorny (1969) reported that age is unrelated to self-esteem; and Ward (1977) found that attitudes toward old age were the best predictors of self-esteem. Ward further reported that significant predictors of self-esteem in women were age-related losses, current activities, and health (Ward, 1977).

Because of its somewhat extensive use with older subjects, the

ease of administration, and brevity of the instrument, the Rosenberg Self-Esteem Scale is an appropriate measure for use in this study.

Measurement Properties

Reliability. There are two types of reliability which are available for the Rosenberg Self-Esteem Scale. Regarding internal consistencey, Rosenberg (1965) has reported a Guttman scale reproducibility coefficient of .92 and a scalability coefficient of .72. In terms of test-retest reliability, Silber and Tippett (1965) showed a correlation of .85 between measures administered to college students at two-week intervals. Rosenberg (1979) reports that McCullough found a two-week test-retest reliability of .88, also using a small college sample. In addition, a factor analysis completed by Kaplan and Pokorny (1969) confirms that the Self-Esteem Scale is unidimensional.

Validity. Evidence of convergent validity is provided by Silber and Tippett (1965), who showed correlations ranging from .56 to .83 between the Self-Esteem Scale and other measures of self-esteem. Rosenberg (1965), using a criterion group design, reported strong evidence of predictive validity. A group of 150 normal volunteers, who completed the Self-Esteem Scale, were rated by nurses in terms of depression. There was a significant correlation between the Self-Esteem Scale scores and the nurses' ratings (George & Bearon, 1980).

Use in This Study

The Rosenberg Self-Esteem Scale was administered as a pretest in this study at the beginning of the first session. It was also used as the posttest, and was administered to all of the women at the conclusion of the sixth session.

Although this scale was designed to be self-administered, it can be effectively used by having the researcher present the items orally to the subject.

Since many of the women in this study had impaired vision and subsequent reading difficulty, the researcher administered the pretest and posttest orally to all 26 women, and recorded their oral responses.

The Individual Sessions

Each of the 26 women who completed the study received six individual 30-minute sessions with the researcher. The sessions were administered twice a week for three weeks.

All of the sessions were conducted either in the resident's own room or in the quiet room of the residential care home, except for one woman whose sessions were conducted in a small lounge.

This researcher preferred to use the women's residential rooms, believing that the familiar environment contributed comfort and ease in the experimental procedure. Often the woman's roommate objected to this arrangement, however, so another quiet, private area was found in the respective residence. Consequently, quiet rooms and a lounge were used for some subjects. All of the women who had their sessions in areas other than their own rooms seemed as comfortable as those who were tested in their residential rooms. They seemed satisfied with the alternate testing locations.

The procedure during a typical session was as follows:

The first three minutes were used for positioning the tape player and speaker, closing the curtains, and helping the woman be as comfortable as possible. During this time the researcher and the woman

exchanged pleasant conversation. Each woman had a choice of whether she would lie on a bed or sit in a chair for the sessions. Once that choice was made, it was continued for the remaining sessions. The next two minutes were spent in helping the woman physically relax. This was accomplished by asking the woman to close her eyes and breathe in deeply, and then to exhale while visualizing tension leaving the parts of the body suggested by the researcher. Usually, parts of the body were suggested in this order: feet, legs, hands, arms, shoulders, neck, and face.

Once the woman appeared at ease, the tape was started. The researcher sat in a chair a few feet away from the woman during the ensuing period of listening. At this time, general observations were noted, such as whether or not the woman remained quiet with eyes closed, and whether or not she feel asleep.

Following the tape, the woman was asked to open her eyes. The concluding five minutes were used for discussion. The researcher said, "Tell me what you thought about during the tape today." What the researcher said next depended on the woman's response to the first question. For example:

"Were you alone in the meadow?

"Did you see anything else?"

"What other memories did you have?"

The researcher also asked:

"How did you feel while the tape was playing?"

"Were you uncomfortable at all?"

"Were you bored?"

"Was the listening enjoyable for you?"

The researcher asked these questions merely to determine whether the woman was attending to the tape recording. While her specific answers were not recorded, notes were made, following the session, on general attitudes and typical responses made by the woman.

While the tape player and speaker were being re-packed and curtains re-opened, pleasant conversation was once again exchanged to end the session.

At the end of the last session, following the posttest, the researcher gave each woman a note of thanks and included the titles of the music or poems to which the woman had been listening.

Further information concerning the individual sessions may be found in Appendix B.

CHAPTER IV

ANALYSIS AND RESULTS

The Rosenberg Self-Esteem Scale (Rosenberg, 1965) was administered as a pretest to eight women in the experimental group, and to six women in the control group. The scale was administered as a posttest to all 26 women in the study. The frequency distribution of pretest scores for both groups is displayed in Figure 1. The frequency distribution of posttest scores for both groups is displayed in Figure 2.

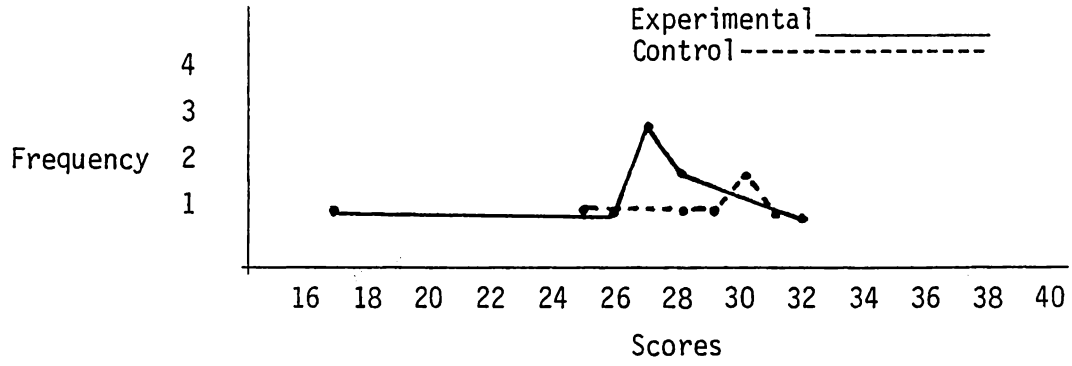

Figure 1.
Pretest scores for
the experimental and control groups.

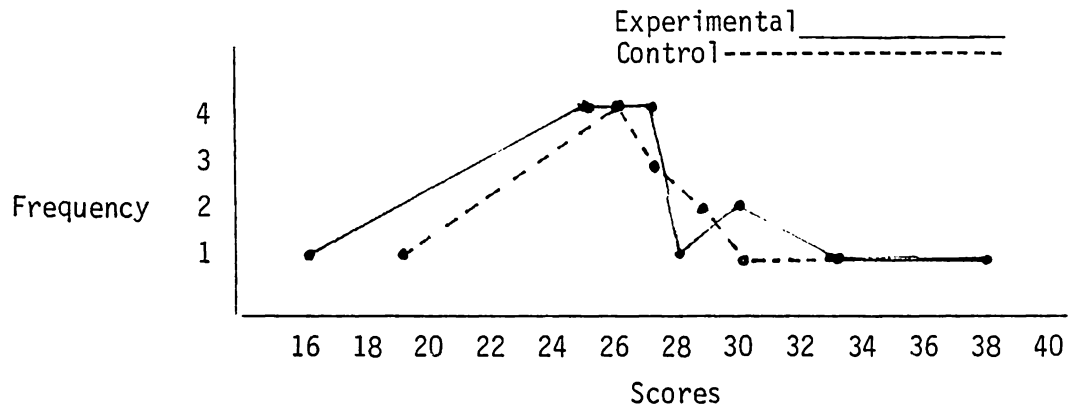

Figure 2.
Posttest scores for
the experimental and control groups.

The frequency distributions show a wide range of scores, especially within the experimental group where there is a range of 16 to 38 in the posttest scores. This distribution may indicate that the two groups are not homogeneous. In order to determine homogeneity within the two samples, the chi-square test of homogeneity was computed. It yielded a $\underline{x}^2$ value of 2.94, which did not meet the criterion at the .05 level for significant difference; therefore, the two groups are homogeneous.

The Wilcoxon signed-ranks test was used to determine changes from pretest to posttest scores in the experimental group. This yielded a computed value of 17, which did not meet the .05 level of significance for a two-tailed test. This lack of significant results indicates that the music and imagery sessions did not increase self-esteem statistically in the experimental group.

The Mann-Whitney U-test was computed to determine differences in posttest scores between the two samples. The computed U value of 82.5 did not reach significance at the .05 criterion level for a two-tailed test. Therefore, it is concluded that there were no

significant differences in the effectiveness of music and non-music sessions in raising levels of self-esteem.

These statistical tests answered the research questions in this study. It is concluded that under the conditions applied in this study, the experimental treatment had no effect on levels of self-esteem.

CHAPTER V

DISCUSSION

Summary of the Study

The aging process involves personal and social loss, which constitutes severe psychological stress for the aging individual. One common result of such stress is lowered self-esteem. Low self-esteem is prevalent among elderly people who reside in care homes due, in part, to the additional loss of independence and mastery over life. Because low self-esteem is often the result of a series of stressful, negative events, there is a need to provide pleasurable and positive experiences in which elderly care home residents can participate. Through successful participation in these experiences, self-esteem may be increased. Though many media can provide opportunities for positive experience, music is one which is particularly viable. Research studies indicate that music is an effective medium in working with the elderly; however, the parameters of its usefulness in this population are not known.

There is a need, therefore, to test the effects of music with the elderly. The purpose of this study was to develop an empirical basis for using a music and imagery procedure to increase self-esteem in elderly care home residents.

The subjects in the study were 26 elderly females who resided in four care home facilities. Each of the women met with the researcher individually for a 30-minute session twice weekly, for three weeks. During each session, the 14 women randomly assigned to the experimental

group listened to a tape recording of music and guided imagery; the 12 women randomly assigned to the control group listened to a tape recording of poetry. The Rosenberg Self-Esteem Scale was administered as a pretest to eight women in the experimental group and to six women in the control group. The scale was also administered as a posttest to all the women in the study.

Analyses of the pretest and posttest scores were completed using the chi-square test of homogeneity, which indicated that the two groups were homogeneous; the Wilcoxon signed-ranks test, which indicated no significant change from pretest to posttest scores for the experimental group; and the Mann-Whitney U-test, which indicated no significant difference in posttest scores between the experimental and control groups.

Conclusions and Implications

Lack of significant results leads to two principal conclusions: Music and guided imagery sessions did not raise self-esteem under the conditions used in this study; also, music and imagery sessions were no more effective than poetry sessions in raising self-esteem.

An analysis of the pretest and posttest scores alone does not adequately describe the results of this study. While posttest scores on the Rosenberg Self-Esteem Scale did not reflect significant change, most of the women in the study reported being "more relaxed," feeling "better," and enjoying the sessions very much. Of the 26 women in the study, 24 expressed such positive reactions. The other two women said they did not enjoy listening (one to music, the other to poetry), but they were doing it to help the researcher.

Positive statements by the participants in the study indicate

that the sessions were, on the whole, satisfying and enjoyable experiences. There are several implications from such reports.

One implication, in view of the overwhelming positive responses from the women in the study, is that there may have been significant changes, but not in self-esteem. Possible changes may be in areas such as level of mental functioning or in degree of life satisfaction.

Since reports were similar from both the experimental and control groups, another implication is that the poetry sessions were too similar to the music and imagery sessions to manifest a measurable difference between the groups.

One final implication which should not be overlooked is that spending time with elderly care home residents with no specific intervention whatsoever, may constitute a positive experience which, in itself, may produce changes in self-esteem, life satisfaction, or related concepts.

Limitations and Recommendations

This study concerned research on an individual basis with a geriatric population. A search of the literature revealed no other attempts to examine the effects of music and imagery on elderly persons' self-esteem. As a result, the method in which to proceed was not always clear. This researcher gained knowledge in working with the elderly in residential care home settings on an individual basis. Perhaps this increased knowledge in procedural development was the most beneficial product from the study.

Following is a list of the limitations and related recommendations for replication of the study.

Limitations	Recommendations
1. The small sample size did not provide a broad base for valid results.	1. Fewer criteria for determining eligibility for participation in the study would provide a more appropriate sample pool. The education criterion of one to five years of high school eliminated more subjects than any other criterion. It should be expanded to allow a broader sample.
2. The use of several settings, however equivalent, introduces a great number of variables.	2. Less limiting criteria for possible subjects may allow for the use of more subjects in one setting.
3. Sessions scheduled twice a week inhibited continuity. Any benefits gained may have been lost from week to week.	3. Sessions scheduled on consecutive days for one week may provide continuity.
4. Sessions scheduled twice a week for only three weeks may not have allowed sufficient time for significant results to occur.	4. Sessions scheduled twice a week, for six or eight weeks, may allow significant changes in results.

5. Self-esteem may not change over short time periods, or may not readily change in elderly persons over any time period.	5. Measurements of life satisfaction, or some other relevant concept may provide more appropriate information.
6. The experimental and control tapes had many similar characteristics.	6. A no treatment control group or a wait-list control group may provide conditions appropriately dissimilar from the music and imagery experimental condition.

Self-esteem is dependent on many factors, including physical and mental condition, age-related events, and personal coping strategies. Lifelong patterns of behavior are not easily changed. Perhaps procedures utilizing music over time would yield more conclusive results. Further research is needed to make such a determination regarding the effects of music on self-esteem in the geriatric population.

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APPENDIX A

THE SCRIPT FOR THE EXPERIMENTAL TAPE

As the music begins, I want you to close your eyes and relax.

(wait one minute)

Now I'd like you to imagine a meadow - any meadow that comes to mind.

(wait two minutes)

Now I want you to notice all the important details in the meadow.

(pause)

What flowers do you see?

(pause)

What color are the flowers - what do they look like?

(wait two minutes)

Is there a breeze?

(pause)

Is the grass blowing?

(pause)

Look at the sky - are there clouds?

(wait two minutes)

What else is in the meadow?

(pause)

Let the music help you to enjoy the meadow.

(wait two minutes)

As the music continues, let it bring back images and feelings to you -
feelings which are very satisfying to you.

(pause)

Let the music suggest what to think and feel.

(wait five minutes)

You may feel as if you are in the meadow now.

(pause)

I hope that you feel very relaxed and content.

(wait one minute)

The music will stop in not too long.

(pause)

I hope your meadow has been a very relaxing place to visit.

(wait one minute)

The music will stop soon.

(pause)

When the music stops, remain very relaxed and quiet.

(pause)

Enjoy for a moment more the relaxed feelings that you are having right now.

(pause)

Now, please open your eyes.

APPENDIX B: ADDITIONAL OBSERVATIONS

During the course of this project, many observations were made which may be of interest to the reader. These observations have been divided into two general categories: (1) various responses; and (2) helpful hints. Some observations are of more importance than others, but they are presented here in no particular order. It is hoped that this anecdotal information may provide the reader with a more complete understanding of this study.

Various Responses

The most common response to both the experimental and control tapes was one of past memories. The most common memory evoked was of childhood, followed closely by memories of husbands and early marriage.

One 97 year-old woman said, with eyes shining, "I enjoyed visiting the past today!"

Some of the women who listened to the music and imagery tape answered aloud the questions on the tape, while the tape was playing. (See script, Appendix A). These women seemed to have the most imaginative descriptions of meadows. Furthermore, these were the women who were the most eager participants in the study. It may be important to consider having subjects answer in this way, in future studies of this kind. The researcher believes it is important to let the subject know at the beginning of the first session, whether or not the subject should answer the questions aloud.

An 82 year-old woman in the experimental group cried during every session when the Beethoven Symphony began (approximately half-way through the tape). She said, after the first session, that

she could "hardly stand to listen to that music." She could not explain why whe felt that way, but it was learned that she had been widowed seven months before. Even though the listening seemed painful for her, the woman said she enjoyed the sessions.

During one session, an 85 year-old woman in the control group cried following the playing of the poetry tape. She said it made her remember how lonely she was. That session lasted 45 minutes, while the woman talked of the past, and gradually regained her composure.

One 69 year-old woman in the experimental group, who made it clear she loved "to go to the meadow," asked the researcher to help her walk following the fourth session. The woman had an illness that had kept her in a wheelchair for nearly a year. She took a few steps, much to her elation. The woman wanted to try to walk with the researcher after each of the remaining sessions.

It was not uncommon for the women to go to sleep during either tape. Eight of the women slept some, during at least one session. All the women who slept, except one, were in the control group. No attempt was made to wake them.

There was an unusual response from two of the women when they took the pretest. Both of them felt that to answer positively would be boasting, or, as one said, "too prideful." Both of these women said they were very religious.

Helpful Hints

When interviewing prospective subjects, it helps to be introduced by a person familiar to the resident, such as the activity director,

or some other staff member.

It is important to be flexible, in terms of scheduling, and to be prepared to offer alternative times for sessions.

Subjects seem to respond well when told they will be "helping" the researcher.

The best subjects for this type of project are the Bingo players, because they are alert and enjoy participating in activities.

It is important that all staff are informed about the project, and the presence of the researcher. For example, custodial help are usually willing to delay room-cleaning if they understand that a session is being conducted which requires privacy.

A "Please Do Not Disturb" sign on the door tends to diminish interruptions.

To facilitate meeting schedules, remind the subjects about when the sessions will begin. The activity director is usually willing to do this the day before the first session.

Some subjects may need to be reminded before each session. The researcher should do this upon arrival at the facility each day.

Noises in the hall are more annoying to the researcher than to the residents.

Some subjects may not be able to keep eyes closed because of various reasons. Allow subjects to open their eyes if they are more comfortable that way.

If the subject wears a hearing aid, check to make sure it is turned on.

The tape must be of excellent quality: speech must be clear; music must have high fidelity.

Varying personalities of the subjects can influence the sessions. Be prepared to remain in charge of the sessions.