Connecting through music: A study of a spousal caregiver-directed music intervention designed to prolong fulfilling relationships in couples where one person has dementia

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Abstract
Maintaining meaningful relationships in ageing couples where one spouse has dementia may lead to improved wellbeing in the caregiving spouses and increase the probability that caregivers will be able to maintain the care of their partners. Our study piloted a home-based music intervention designed to stimulate meaningful interaction between the spouses and discover its value in affecting the quality of the spousal relationship, satisfaction with caregiving, and caregiver wellbeing. Five couples consented to participate in the study and were provided with an education and demonstration session designed to train the caregiving spouse to use music with their spouse. They were asked to self-direct a program involving three sessions per week for six consecutive weeks. Measures of anxiety, depression, spousal relationship, and measures of caregiving experiences were administered pre-post program. Spousal caregivers completed a diary during the six weeks and participated in a post-program interview. A thematic analysis of the data indicated that music-sharing experiences were beneficial to the spousal relationship, satisfaction with caregiving, and caregiver wellbeing, and enhanced the mood of both the caregiver and spouse with dementia. The sample size was too small to generate significant quantitative results and is used in this paper to support the qualitative data.

Key words: Caregiver, dementia, home-based intervention, spousal relationship
Introduction and Literature Review

Accessible and innovative care for people with dementia and their spousal caregivers is crucial as the number of those diagnosed with dementia increases. In 2008 the number of Australians with dementia reached 230,000; but by 2050, this number will exceed 730,000 (Access Economics, 2009). Quality of care for people with dementia is best achieved by continued dwelling in the family home, surrounded by important memories, sentimental artefacts, and familiar loved ones (Alzheimer’s Australia, 2003). However, spousal caregivers experience significant burden, increasing physical, emotional and social strain, and an increased risk of death as they care for their spouse over long periods of time (Access Economics, 2009). Maintaining the quality of the spousal relationship and the wellbeing of the caregiver is vital to compassionate and effective care for people with dementia (deVugt et al., 2003).

Guidelines for dementia care put forward by Alzheimer’s Australia (2003) emphasise the importance of relating to the person rather than the illness, maximizing participation in line with the individual’s capabilities, and providing a meaningful environment, preferably within the family home. Around two thirds of people with dementia are cared for at home (deVugt et al., 2003); 23% of such caring relationships involve spouses (Access Economics, 2009). Spousal caregivers experience greater burden, as well as increased anxiety and depression, compared with those caring for a person with a physical disability (Kolanowski et al., 2004; Schofield, 1998). Excessive and prolonged burden can lead to health problems in caregivers; notably, depression rates in this group are substantially higher than in sociodemographically comparable individuals (Eager et al., 2007; Schulz et al., 2008). Decreases in cellular immune function have also been noted (Kiecolt-Glaser et al., 1991). Further, caregivers from ethnic minority backgrounds, and caregivers living in rural and remote areas, are at a distinct disadvantage because they are less likely to have access to or seek professional support (Access Economics, 2009; Vos, Barker, Stanley, & Lopez, 2007). Existing support programs such as information-giving, respite care and support groups are of limited benefit in relieving caregiver burden, while psycho-educational and multi-component interventions have more positive effects (Eager et al., 2007). Further, interventions that target both the caregiver and the spouse with dementia (SWD) are more effective (Schulz et al., 2008) because the health needs of one spouse often affects the health of the other spouse. The positive benefits of focusing on the marital dyad were demonstrated in the
Medicare Alzheimer's Disease Demonstration and Evaluation Project, where there was a 42% lower incidence of hospitalisation in the treatment group (a psycho-educational intervention) (Shelton et al., 2001).

A focus on the marital relationship seems to be missing from theories of caregiver health and wellbeing (Davies & Gregory, 2007). Apathy in people with dementia leads to diminished amounts of reciprocity between spousal caregiver and SWD, and can lead to an imbalanced marital relationship and reduced marital intimacy (devugt et al., 2003). According to social exchange theory (Baikie, 2002), when relationships become inequitable, individuals become distressed with a negative flow-on effect on caregiver wellbeing (Adams et al., 2008). Caregivers may sustain care-giving relationships and experience pleasure through experiencing even the smallest moments of meaningful shared events (devugt et al., 2003). Interventions specifically addressing the quality of the spousal relationship in ageing caregiver/care-recipient couples are noticeably absent from the literature (Whitlatch, 2001).

Music therapy is recognized as a therapy that reduces apathy and agitation in people with dementia (Dileo & Bradt, 2005; Helmes & Wiancko, 2006; Holmes et al., 2006; Ledger & Baker, 2007), and facilitates the sharing of meaningful experiences between caregivers and people with dementia in residential care settings (Brotons, & Marti, 2003; Clair & Ebberts, 1997). A meta-analysis of medical music therapy by Dileo and Bradt (2005) provided a solid basis to predict positive change in people with dementia and their spouses. In their analysis, large effect sizes were found for music therapy studies in gerontology (r=.56, p<.01) across a range of dependent variables, including: agitation (r=.7, p<.05), aggression (r=.57, p<.01), social interaction (r=.63, p<.01), speech/communication (r=.75, p<.01), mood (r=.76, p<.01), state anxiety (r=.3, p<.01), distress (r=.39, p<.01), depression (r=.26, p<.01), and wellbeing/quality of life (r=.27, p<.01).

Active music interventions have the potential to increase positive interactions between spousal caregivers and SWD, reduce apathy in SWD, and reduce spousal caregiver burden because:

a) Music is largely a social phenomenon that has high impact when shared between people, and stimulates the person with dementia to interact with others (Brotons, Koger, & Pickett-Cooper, 1997);
b) Memory for familiar music is retained in people with dementia despite deterioration in other areas of functioning and regardless of whether they have had formal musical training (Vanstone & Cuddy, 2010);
c) Music facilitates autobiographical recall in people with dementia thereby increasing meaningful communication with others (Cady et al., 2008; Foster et al., 2001); and
d) Listening to music provides an emotional experience that may enhance the mood of the caregiver. Intensely pleasurable responses to music lead to activation in sub-cortical brain regions connected with emotion and motivation (Salimpoor et al., 2009). These factors suggest music is well suited to address the needs of spousal caregiver/SWD dyads.

Five music therapy intervention studies with spousal caregivers/people with dementia have been conducted, providing preliminary evidence for the value of active music therapy in improving the wellbeing of caregivers. Positive effects on caregiver loneliness, depression, anxiety, and burden were found following 40-60 minute group music therapy sessions provided daily (Brotons, & Marti, 2003), twice weekly (Berger et al., 2004; Clair, 2002; Clair & Ebberts, 1997), or weekly (Clair, Tebb & Bernstein, 1993). Daily sessions were more effective than less frequent sessions (Brotons, & Marti, 2003) because short inter-session intervals increase the likelihood that memories recalled on one occasion will be recalled on subsequent occasions (Clare et al., 2000; McGilton, Rivera, & Dawson, 2003). As people with dementia improve memory recall over frequent music therapy experiences, being able to share these memories increasingly rewards caregivers. If these “rewards” are experienced more frequently, caregiver loneliness, depression, and anxiety may decrease. This notion is supported by findings that mutual engagement (Clair, 2002) and satisfaction with spousal visits to residential units (Clair & Ebberts, 1997) improved following group music therapy programs for caregivers/people with dementia.

The aforementioned studies indicate that active music therapy interventions provided by a trained music therapist within a residential care setting promote improvements in caregiver coping and satisfaction with the caregiving role. However, there have been no studies to date that have examined home-based music programs that focus on couples’ wellbeing. Given that spousal caregivers may benefit from using this type of intervention in the home environment, a pilot study was designed to trial an active music intervention (AMI) in preparation for implementing a larger scale randomised control trial. We explored whether the spousal caregiver could be trained and empowered to implement an intervention based on an initial music therapy session conducted within their home environment by a Registered Music Therapist, and to gain the spousal caregivers’ perspectives of its effects on the spousal caregivers’ and SWDs’ health and wellbeing. Specifically, our investigation aimed to determine whether caregivers:

1) Perceived a change in the quality of the spousal relationship following implementation of a 6-week home-based music program (as measured on the Mutual Communal Behaviours Scale)
2) Were more satisfied with their caregiving role following implementation of a 6-week home-based music program (measured on the Positive Aspects of Caregiving Questionnaire).
3) Perceived any change in wellbeing following implementation of a 6-week home-based music program (as reported in diaries and an interview).
4) Perceived any change in their spouses’ wellbeing during the 6-week home-based music program (as reported in diaries and an interview).
5) Experienced a change in mood and anxiety between the pre and post data (Geriatric Depression Scale short-form, and the Geriatric Anxiety Inventory).

Method

Participants

Couples living at home where one partner had dementia were eligible to participate in the study if the caregiver could read and write English well enough to record a diary of his or her experiences while involved in the project. Participants were recruited in Brisbane and Melbourne via several avenues – through providing information sessions to Alzheimer’s Australia caregiver support groups, via advertisements and short articles published in aging-related newspapers and magazines, and through direct contact with community workers.

Overview of the design

To answer our research questions, we evaluated a home-based 6-week active music intervention (AMI) program where the spousal caregiver was instructed to use music effectively and strategically to facilitate interaction with his/her spouse. The study used a mixed methods research design. Based on a philosophical stance of pragmatism, the central premise of mixed methods is that the use of quantitative and qualitative approaches in combination, provide a better understanding of a research problem than either approach alone (Plano Clark & Creswell, 2008). Further, the study was a concurrent triangulation design. It involved the concurrent but separate collection and analysis of data, merging the two data sets during interpretation of results (Plano Clark & Creswell, 2008).

Ethical approval was obtained through The University of Queensland’s Central Ethics Committee (approval number #2007000123) and participants gave informed consent to participate. We evaluated the spousal caregivers’ perceived effect of the intervention by studying their responses to semi-structured interview questions and their written responses recorded in a diary they kept during the 6-week program. We analysed their responses using thematic analysis (Braun & Clark, 2006) to draw out statements that assisted us in answering the research questions.
Procedure

After couples had consented to participate in the study, a music therapist administered demographic details and standardised questionnaires over the phone. The music therapist also collected information about music preference, musical history, current music listening behaviours, and the availability of music playback equipment. She arranged a time to visit the couple in their home to provide the AMI instruction session.

The emphasis of the instruction session was to provide strategies for music use that were within the caregiver’s abilities so that they would feel confident to implement them once the music therapist had left. The music-based activities comprised: 1) singing familiar/preferred songs unaccompanied or accompanied by a CD/DVD/mp3 player; 2) gentle movement-to-music, encouraging the person to move to some stimulating music e.g., dancing, swaying etc; and 3) listening to quiet relaxing music with eyes closed. These activities were designed so that they could be repeated as necessary during the 20-30 minute session. At the end of each activity, the caregiver was encouraged to ask the SWD to recall memories with prompted questions such as “Do you remember when [e.g. we danced to that song at the church hall]?” Spousal caregivers were educated about being flexible in implementing the intervention by encouraging them to work within the functional status of their spouse on that day. A decision tree was provided to allow flexibility in the ordering of activities. For example, if the SWD’s energy was low, the order of the intervention activities would be 3-2-1, however if agitated, the order could be 2-1-3. It was also made clear to caregivers that if the SWD was becoming agitated, it might be better to attempt to engage with the music at a later time.

Following the initial AMI session with the music therapist, the spousal caregivers engaged their spouse in music sharing sessions 3 times per week for 6 weeks, using the suggestions provided for them in the AMI session. In addition, the spouse made diary/journal entries following each session with the SWD.

Measures

Pre and post program measures were administered to the spousal caregivers to gain a picture of their level of anxiety, depression, their perception of the quality of the spousal relationship and their satisfaction with their caregiving role:

1. *Geriatric Depression Scale short-form* (GDS-SF, Yesavage et al., 1983) is a 15-item depression scale assessing the degree of depression experienced. Out of a possible range of scores from 0 - 15, the higher the score, the greater the level of depressive symptoms reported.
2. *Geriatric Anxiety Inventory* (GAI, Pachana et al., 2007) is a 20-item anxiety scale assessing the degree of anxiety experienced by the caregiver-participant that has strong reliability (Chronbach’s alpha 0.81) and concurrent validity ($r_s = 0.48$, $p<0.01$). Out of a possible range of scores from 0 - 20, the higher the score, the greater the level of anxiety symptoms reported.

3. *Mutual Communal Behaviours Scale* (MCBS, Williamson et al., 1998) is a 10-item measure assessing perceived quality of the spousal relationship between spousal caregiver and the SWD. It has high reliability (Chronbach’s alpha 0.86) and strong test-retest measures (0.67). Scores range from 0 - 40. The higher the score, the more benefit/satisfaction the spouse is receiving from the relationship.

4. *Positive Aspects of Caregiving Questionnaire* (PACQ, Boerner et al., 2004) is an 11-item measure assessing caregiver satisfaction of the caregiving role, particularly self-esteem, with a high measure of reliability (Chronbach’s alpha 0.89) and convergent validity ($r=0.24$). Scores range from 0-55. The higher the score, the more positive the caregiver experiences his/her caregiving role.

Measures of the neuropsychiatric symptoms of the SWD were also administered:

5. *Neuropsychiatric Inventory Questionnaire* (NPI, Kaufer et al., 2000): a 12-item measure assessing neuropsychiatric symptoms and behaviours associated with dementia. Scores range from 0 - 48 when part A and B are completed; higher scores indicate increasing severity of problematic behaviours.

**Diary entries**

Spousal caregivers were provided with a diary containing guiding questions to complete during the 6-week music program. Guided questions were designed to generate responses that would assist in answering the research questions. Examples of guided questions include: Describe how you interacted together as a couple; Describe how your spouse responded after the music session; Did you notice any changes physically, in his/her communication, was he or she more or less chatty, was he/she more relaxed?. They were asked to comment on observed responses of their SWD (verbal and non-verbal communication, energy level, agitation, distress etc), the specific music selections and reasons for choosing these, and their own feelings and experiences of the music intervention.

**Semi-structured interview**
After completing the 6-week music program, couples were visited by the researchers and invited to participate in a 30-minute interview. Interviews were brief and semi-structured, and designed to elicit descriptive data about the caregivers’ experience of the shared music activity. Interview questions focused on 1) what the caregivers gained from the shared music activity, 2) what helped, 3) what didn’t help, 4) what more could have been offered, 5) what they liked most, and 6) what they liked least. Interviews were audio recorded with permission and transcribed for analysis.

Analysis

Due to the small number of participants, quantitative scales were not tested for significance but are reported in tabular form to illustrate changes in the individuals’ scores. The transcribed interviews and texts from the spouse caregivers’ diaries were analysed using simple thematic analysis (Braun & Clarke, 2006) by authors 1 and 2. Guided by the research questions, statements reflecting each spousal caregiver’s perceptions about 1) changes in the quality of their spousal relationship, 2) changes to their satisfaction with caregiving, 3) the effect the AMI had on them and their wellbeing, and 4) the effect the AMI had on their SWD, were identified and coded. Discrepancies were discussed between author 1 and 2 until a consensus on the interpretation was reached. Generally the participants’ meaning was self-evident and there were few instances of different interpretations by authors 1 and 2. While participant verification of the authors’ interpretations is recommended in qualitative analysis, this was not possible due to ethical restrictions placed on the investigation. Further, some participants had died since data collection had taken place.

Results

Participants

Five couples consented to participate in the study in 2009. There were three female caregiving spouses (aged 81, 81 and 61) and two male caregiving spouses (74 and 59). The spouses with dementia (SWD) were aged between 59 and 88 (females= 59 and 70, males= 81, 88, and 62). Time since diagnosis of dementia ranged from a few months to 10 years. Pseudonyms have been used to describe participants and spouses below.

Results of psychometric measures

A summary of the measures taken pre-post intervention is detailed in Table 1. The data indicate that scores on the depression scale for the caregivers were low at the pre-test (mean=5.6, SD=1.82) and there was little to no change at the post-test (mean=6.2, SD=1.64). The same is true for symptoms of anxiety (GAI), which were generally low at the pre-test (with
the exception of the participant named “Claudia”, mean=6.0 SD=7.55) and at post-test (mean=3.0, SD=2.74). All participants perceived the quality of the spousal relationship (MCBS) as high at the pre-test (mean=37.6, SD=1.82) so there was little possibility for increases at the post-test (mean=38.4 SD=1.67, ceiling effect). Satisfaction with the caregiving role (PACQ) was moderately high at the pre-test (mean=41.8, SD=5.26) and there was a slight increase in satisfaction in three of the five participants (mean=43.0, SD=4.3).

There was little change in the neuropsychiatric symptoms of the SWD from pre to post-test. Table 1 outlines the pre and post measures for each participant.

<table>
<thead>
<tr>
<th>Caregiving Spouse</th>
<th>GDS</th>
<th>GAI</th>
<th>MCBS</th>
<th>PACQ</th>
<th>Spouse with dementia</th>
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Qualitative analysis of interview and diary data

Guided by our research questions, the interview data and diary entries revealed that the caregiver-directed music intervention had positive affects on both the caregiver and spouse with dementia. The thematic analysis generated four themes: 1) engaging in music enhanced enjoyment and relaxation, 2) enhanced quality of spousal relationship 3) strengthened reciprocity and 4) increased satisfaction with care-giver role. Each of these themes is reported in turn.

1) Engaging in music enhanced enjoyment and relaxation

All five caregivers reported that the music had an affect on their own wellbeing, particularly that engaging in music had a relaxing effect:
Music helps both of us to relax, and it is so beautiful to listen to. We both love classical music and are very much enjoying the Andre Rieu concerts. His music is just so beautiful and relaxing. It lets you close your eyes and relax. (Iris)

... we enjoyed listening to the music, and ... it definitely helped me relax. I think just being able to stop and sit was great and this project helped me to do it. It was nice to sit down together and listen to the music. (Geoff)

Claudia commented that she used music strategically to facilitate her own relaxation:

[I listen to] all kinds [of music]. Sometimes I turn on a CD of music I like, other times I turn on radio until I find songs I like. Songs from when I was growing up are great. I was very relaxed. And also, when things were a bit dicey, I just turned on the music.

Claudia also found pleasure in witnessing Charles’ responses. She said: “When he sings, he smiles. And he remembers the words, which I think is good for him. When he smiles it makes me happy and I can relax a bit.”

Jim indicated that when music relaxed him, he felt more invigorated: “Music helped me relax a great deal. I thoroughly enjoyed it...the relaxing of tensions, and I find this invigorating”.

Similarly, all caregivers reported that the music had a relaxing affect on their spouse. Jan considers the music to have been the trigger to enhanced mood in her spouse Ian because she noticed that no other unusual events took place on those days other than engaging in the active music intervention.

Well, if he was in a bad mood, or if he was quiet, and we would listen to music, [then] after music he was a lot better. Sometimes I think [music] helped brighten his mood or changed him and helped him feel a bit better. And I think it was the music because we did nothing else out of the ordinary that I think could have had that effect.

2) Enhanced quality of the spousal relationship

Four of the spouses (Jim, Iris, Geoff and Jan) indicated that the music intervention enhanced the quality of time spent together and that listening to music, dancing, or talking shaped these moments. Jim commented:

We often listened to it [music] together, mainly with the radio. Sometimes I would put on a CD if we were in the same room together, ... and [Betty] would come over and ask what I put on, and I would ask [Betty] to name it for me and she would. Sometimes, we would try
to dance together but [Betty] has trouble moving now so we don’t get to do it as often as we’d like.

Iris stated that music provided space for them to share – it was a “common ground”:

...just being able to be together and enjoy and listen to something we both love is a benefit. To share something is a good thing and this is still something we want to do and are able to do. ...we also came to enjoy spending this time together. It was nice to sit and listen to the music together and just enjoy it...There were no words or anything...We didn’t need to talk. The music did enough. It was our common ground as such so we didn’t need words.”

The music intervention affected the quality of Geoff and Helen’s relationship because it directed them to stop and take time to share time together: “It was nice to sit down together and listen to the music. Just to share some time together was good. I mean, it’s harder to do this now.”

For Jim and Betty, the music intervention facilitated reminiscence and a form of interaction that was typical of their relationship in their earlier years together as a couple – such as dancing. Jim explained:

Yes. It helped us relax and reminisce. Yes, definitely helped us reminisce. Especially with the old time music, reminiscing was great to talk about the old songs we knew. Yeah, if we could we would interact together and occasionally have a dance together. But, with [Betty]’s legs and hips it makes it hard for us to dance now. It was something we have always done and really enjoy. We still listen to the songs we used to dance to so [they are] good memories and when [Betty] feels up to it we dance occasionally.

3) Strengthened reciprocity (Iris, Jan and Geoff)

Three caregivers spoke of a strengthened reciprocity in their relationship. Iris described the quality time spent together as rekindling the feelings of intimacy in her relationship through the sharing and purposeful act of being in the moment with her partner, to “forget everything else”. “It was lovely to share some ‘us’ time and forget everything else. It was something we can both do which is easy”... “We felt close.”

Iris and Bill experienced shared humour: “We had fun dancing – we both laughed about how we cannot move like we used to”, and shared verbal interactions, “The best part about today’s session was being able to hold a conversation.”

There were noticeable increases in reciprocity within the relationship consequential to engaging in music sharing. Iris’ diary entries revealed
increases in the number of times Bill initiated musical interactions. Before implementing the program, Iris was the sole initiator of all interactions. Jan commented that music sharing enabled her and Ian to “share experiences as equal partners”.

Jan commented that music sharing strengthened her relationship with Ian by facilitating her memories of her relationship with him before he became ill:

It certainly helped me relax and just listen to the music and enjoy his company. It was nice to sit down like on an even playing ground so to speak, like before his illness, and spend some time together. It helped me remember what it was like before the memory troubles started. It was a really nice thing to remember...I think maybe you could say from my perspective it has strengthened it [the relationship] in some ways, as it helps to remind me that he is still the same person.

Similarly, Geoff experienced sharing with Helen in ways that were similar to their experiences before her diagnosis of dementia: “It was like sharing moments like we had before she became sick.”

4) Increased satisfaction with caregiving role

One of the questions posed in the post-interview was focused on how the caregivers may have perceived a shift in their satisfaction with their role as caregiver. Geoff was the only caregiver who suggested the music intervention had an effect and this was more in relation to him having a stronger connection with himself, which he viewed as key to being a better caregiver. He said:

Being able to relax together has helped me take time away from being the caregiver as you call it, and this has helped me in who I am and that means that I can have a better perspective on things and be a better person for my wife to lean on when she needs.

Discussion

The results showed that at the commencement of the study the caregivers were not presenting with symptoms of depression or anxiety and were not unsatisfied with the relationship with their spouse, or with their role as caregiver. Therefore, pre-post measures were not indicative of the benefit that the intervention provided, despite the caregivers having described these benefits in interviews and their diaries.

The qualitative analyses revealed that the music intervention enabled couples to spend quality time together. Feelings of intimacy were fostered, humour and memories were shared which led to perceived increases in reciprocity between the partners, and enabled the spouses to engage with
their partners in similar ways as they had before the onset of dementia. As intimacy is the most important factor in determining quality of life (Cummings, 1996), the present study provides preliminary evidence that music sharing can play a role in couples’ quality of life. The data revealed that sharing moments of meaningful experiences with the SWD are important for the spousal caregivers (de Vugt et al., 2003). Caregivers reported pleasure in interacting with their spouses in ways that resembled relationships pre-onset of the illness (deVugt et al. 2003) and experiencing pleasure and reciprocity may sustain caregiving relationships (Baike, 2002). The present study therefore contributes to the small literature of caregiver/care recipient studies in music therapy and more generally (Whitlatch, 2001).

All of the participants acknowledged the role music served in relaxing the caregivers and SWD. However, as one caregiver (Claudia) reported high anxiety at the outset, more research is needed to determine whether this translates into changes in levels of anxiety.

It was evident that the spousal caregivers were able to use the AMI successfully in their home context. Previous research with people with dementia involved fixed numbers of music therapy sessions implemented by a qualified music therapist and overlooked the need for long-term management (Koger, Chapin, & Brotons, 1999). The intervention used in the current study reduced reliance on ongoing music therapy services, by training the spousal caregiver to implement the program in the home context. Given the expected increase in people with dementia being cared for in the future, the results of this study are encouraging, as the benefits extended to the caregiver, SWD and the couple as a unit. Further, the results suggest that music therapists may be effectively utilised as consultants in training caregivers to provide music experiences. The potential for music therapy consultants may extend beyond the needs of people with dementia, to any context in which a caregiver is supporting a person with special needs, for example, those with physical disabilities or mental health problems.

The literature on spousal caregiver wellbeing reports that spousal caregivers experience very high levels of depression and anxiety compared with those caring for a spouse with a physical illness (Eager et al., 2007; Schulz et al., 2008). However, in the present study, participants only scored high on the GAI, and not on the GDS, indicating depression and anxiety symptoms were negligible. Similarly, all the spousal participants reported relatively high satisfaction with the spousal relationship (MCBS) and their experiences of being a spousal caregiver (PACQ) therefore providing little possibility for detecting any substantial change in their standardised measures (ceiling effect) following engaging in the program. The challenging behaviours were largely absent in the SWD (NPI scores) and when behaviours were present, they were only mildly problematic to the spousal caregiver. This may indicate that the SWD were in early stage dementia. Future research should compare the benefits of this program at different
stages of the disease to understand at what point the intervention is best suited.

The study implemented a mixed method design, in which quantitative and qualitative data were viewed equally. As the quantitative data generated little evidence due to small numbers, the qualitative data became the principal source of data. Mixed methods therefore gave options for reporting the outcomes of the study, and are recommended for future studies.

Limitations

This study explored the experiences of only five spousal caregivers and therefore results cannot be generalised. However the encouraging responses of all spousal caregivers provides a firm foundation for implementing a randomised control trial which studies outcomes of wellbeing including levels of depression, anxiety, burden, and coping.

References


music to cue autobiographical memories of different lifetime periods. *Psychology of Music, 36,* 157-177.


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**A response to Felicity Baker, Denise Grocke and Nancy Pachana’s article (AJMT 2012 Vol 23)**

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The authors are commended for conducting a well-designed mixed methods study based on a sound theoretical framework. This study concerns a vital component of life satisfaction for spousal couples living together with dementia, the quality of the relationship. It is especially important to study relationships in couples who share the dementia experience since stress and burden in the home environment often lead to residential care placement for the spouse with dementia. Previous research of spousal couples, in which one member of the couple has dementia, indicates poor relationship quality is associated with care giving stress, care burden, and depressive symptoms resulting from the burden; therefore, couples often have serious need for dyadic interventions that help caregivers manage relationship losses (Davis, Gilliss, Deshefy-Longhi, Chestnut, & Molloy, 2011). The researchers in this study provided an excellent dyadic intervention that functioned to revive characteristics of a spousal couple’s interpersonal relationship through engagement in reciprocal and meaningful experiences using music. The researchers designed the intervention to provide ready access to music and trained caregivers to successfully adapt and implement the intervention at home without need of supervision. Outcomes demonstrated the caregivers’ had abilities to provide the intervention, were empowered to deliver the intervention, and found great value in their couple relationship engagements with the intervention.

The mixed methods research design of this study incorporated both qualitative and quantitative measures that were pertinent and appropriate. Qualitative outcomes of the study strongly suggest the benefits of music and the quality of life value for couples who engage conjointly in music
experiences. Quantitative outcomes showed no statistically significant differences before and after the intervention implementation; however, the small sample size may have limited the power of the statistical analyses to determine outcomes that actually occurred. Additionally, the quantitative measures may have not been sufficiently robust to identify small changes from pre- to post test, or the spouse caregivers may not have had symptoms the measures were designed to determine. It seems that the caregivers in this study were functioning well from the beginning and did not manifest symptoms of depression or anxiety. They further had high measures of relationship quality and care giving satisfaction before the intervention began. Of the five couples, three caregivers were women and gender may have influenced the outcomes of the quantitative measurements used in this study.

The major contribution of this study is a feasible intervention that can be used by caregivers to regain reciprocal spousal interactions through meaningful musical experiences. This study seems to indicate the intervention has potential to improve relationship quality even when caregivers express satisfaction with the status quo. It is important to test the intervention in larger population samples of spousal couples including those who continue to live at home and those who are separated by the need for residential care. It would be interesting to know how couples who use music to enhance their relationship maintain life quality over the course of the disease process.

Reference