A CONTENT ANALYSIS OF MUSIC THERAPY INTERVENTIONS TO SUPPORT A GOOD DEATH CONCEPT IN THAI PALLIATIVE CARE PATIENTS WITH CANCER

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This research is done between a truly losing moment that makes me deeply understand the grief. Even if I could not know, what is a good death in the perspective of dying person, but I have learned perfectly from a survivor perspective who have to encounter grief from the enormous losing with the passing of king *Bhumibol Adulyadej*, the king Rama 9 in the kingdom of Thailand, since October 13, 2016. Thus almost every word in this research waterlogged with my tears, being the tears of grief and tears of pride. Moreover, I asked for the consecration of this research to honor his majesty the king of Thailand.

Lastly, if a good death is the result from living a good life, king Bhumibol Adulyadej is the best role model of good death.

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ABSTRACT

The aim of this study was to collect and analyze existing research documentation regarding music therapy intervention that may be used to support good death concept in Thai palliative care patients with cancer. The interventions reviewed correlated with the Thai culture context and Thai medical practice. A content analysis method was used to analyse the documentations.

The result of content analysis through 16 studies indicated a relationship between music therapy and good death is the relationship between therapeutic function of music and the element of good death. The music therapy intervention that were found to be good methods in supporting good death practice included (1) Instrument playing and/or improvisation, (2) Music listening, (3) Singing, (4) Song writing, (5) Song lyrics interpretation or analysis, (6) Music assisted counselling, (7) Song parody, (8) Song choice, and (9) Music-Meditated active. In conclusion, music therapy intervention was found to be beneficial to Thai cancer patients undergoing palliative care, however, more clinical-evidence based and a professionally trained music therapist is required to support this concept.

KEY WORDS: PALLIATIVE CARE/ GOOD DEATH / MUSIC THERAPY INTERVENTION / CANCER / THAI PATIENT

139 pages

ดนตรีบำบัดเพื่อสนับสนุนแนวคิดการตายที่ดีในผู้ป่วยมะเร็งชาวไทยระยะประคับประคอง
A CONTENT ANALYSIS OF MUSIC THERAPY INTERVENTIONS TO SUPPORT A GOOD DEATH CONCEPT IN THAI PALLIATIVE CARE PATIENTS WITH CANCER

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บทคัดย่อ

งานวิจัยนี้มีวัตถุประสงค์เพื่อรวบรวมและวิเคราะห์เอกสารงานวิจัยเพื่อค้นหากิจกรรมดนตรีบำบัดที่ดีสำหรับการสนับสนุนให้เกิดการตายดีในผู้ป่วยมะเร็งชาวไทยระยะประคับประคองภายใต้บริบทวัฒนธรรมและการแพทย์ไทยผ่านการวิเคราะห์ความสัมพันธ์ระหว่างดนตรีบำบัดและองค์ประกอบของการตายที่ดีด้วยระเบียบวิธีวิจัยแบบวิเคราะห์เนื้อหา

ผลการวิเคราะห์เนื้อหาจาก ๑๖ งานวิจัยชี้ให้เห็นว่าความสัมพันธ์ระหว่างดนตรีบำบัดและการเสียชีวิตที่ดี คือ ความสัมพันธ์ระหว่างการทำงานขององค์ประกอบดนตรีอันมุ่งผลทางการรักษาที่สอดคล้องกับองค์ประกอบของการตายที่ดี กิจกรรมดนตรีบำบัดที่ดีสำหรับการสนับสนุนให้เกิดการตายดีในผู้ป่วยมะเร็งชาวไทยระยะประคับประคองภายใต้บริบทวัฒนธรรมและการแพทย์ไทย ประกอบด้วย (๑) การเล่นเครื่องดนตรี และ/หรือ การเล่นดนตรีแบบด้นสด (๒) การฟังเพลง (๓) การร้องเพลง (๔) การเขียนเพลง (๕) การตีความหมายหรือการวิเคราะห์เนื้อเพลง (๖) ดนตรีร่วมการให้คำปรึกษา (๗) การแปลงเพลงเชิงล้อเลียน (๘) การเสนอเพลงให้เลือก และ (๙) การใช้ดนตรีเพื่อเหนี่ยวนำให้เกิดการสมาธิ บทสรุปคือกิจกรรมดนตรีบำบัดมีคุณประโยชน์ในการสนับสนุนให้เกิดการตายที่ดีในผู้ป่วยมะเร็งชาวไทยระยะประคับประคองแต่จำเป็นต้องใช้หลักฐานทางคลินิกที่มากขึ้นและการฝึกทักษะความเชี่ยวชาญด้านดนตรีบำบัดอย่างมืออาชีพกับผู้ปฏิบัติงานดนตรีบำบัด

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CHAPTER I
INTRODUCTION

1.1 Background of the study

The Cancer Annual Report (2015) produced by Bureau of Non-Communicable Disease (NCD), Ministry of Public Health, Thailand revealed the premature mortality of Thai people between 30-70 years because of four types of Non-Communicable Disease; Coronary Artery disease, Cancer, Diabetes, and Chronic Obstructive Pulmonary Disease (COPD). Moreover, a survey between 2012 to 2014 show that most Thai people were killed by Cancer has is the higher rank among four type of that disease; 43,829 in 2012; 45,892 in 2013 and 47,086 in 2014. Data from the Hospital-Based Cancer Registry Annual Report (2012) of National Cancer Institute, Thailand presented the number of the new cancer patient in 2012 separated by sex and age group, from 0 years to upper 75-year-old reported that 3,917 people were diagnosed with cancer 1,554 people is male and 2,363 people are female. Cancer Index website of World Health Organization (WHO) reported cancer statistics in Thailand, in the 2012 year, shows that Thai populations, 69.9 million people, were newly diagnosed with cancer were 123,800 people, and 85,000 people dying from cancer (WHO, 2016).

Cancer being a chronic disease which led patient to a suffering and have to go through agonies caused by it, patients would have to go through a long term treatment some of the patients developed strength to fight it, however some get worse during the treatment severely, and those who gets worse are recommended to this alternative treatment of palliative care unit after curative care to end-of-life care until death.

Number of palliative care patients go through both psychological and physical illness, the cause of their illness is most likely to happen from their physical disease and psychological condition. Palliative care patient usually suffers the stages of this disease worsen down from terminal stage to the stage of death, in the case

under examination patient needs many special attentions to minimize the pain, to lower the depression, reduce fatigue and to support them on ways to manage their grief, these are the measures taken in the palliative care to support a ‘ good death’ concept. The National Consensus Project for Palliative care stated that the primary goal of palliative care patient is to prevent and support them to the best possible quality of life (QOL)WHO defines it as “individuals perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards, and concerns… ” (WHO, 2016), for patient and their family (NCPP, 2004) by alleviating a psychological disease, support social skill, maintain cognitive skill, pain management, improving comfort, and ameliorate spiritual distress that leads them to has a good death in every stage of a disease until the last moment of their life, dying stage. Music therapy has used to promote quality of life with hospitalized patients in palliative such as improve relaxation, well-being, acute pain, triggering of a physiological relaxation response, and improvement in health-related quality of life. (Warth, Kessler, Hillecke, & Bardenheure, 2015).

Referring from The World Federation of music therapy (WFMT), music therapy goals is used in an individual need with different goals include physical, social, communicative, emotional, intellectual, and spiritual health and well-being in an individual or group session (WFMT 2016). Music therapy goals for palliative care includes (1) physical, (2) psychological, (3) social, and (4) spiritual that all for promoting quality of life (Hilliard, 2005).

The Physical goal is one in the palliative care patients of the most commonly found symptoms, managing their general distress such as anxiety, depression and fear helps them get relief from pain this will reduce pain through a direct influence (Hokka et al ,2014) hence relief from pain by symptom management becomes an important objective in the music therapy it is used not only physical but also in the psychological goal.

Psychological goal of palliative care patients is to manage their psychological symptoms such as reducing anxiety, reducing depression and relief from fatigue and to lessen their grief ,this is what are being emphasized in the palliative care approach, emotional needs would help the patient relax this was use as a support too, this helps many patient with significant anxiety relief which usually interfere with

sleep, helps enjoyment of life , interpersonal relationship and overall daily activities (Archie,Bruera & Cohen).

Social goal refers to the relationship between patients and their caretaker or family which is the main influences for their quality of life (QOL) which includes the physical need and psychological need.

For the spiritual Goal many health care professional and physician recognizes their spiritual needs as an important issue of palliative care they uses the psychotherapy, relaxation exercise technique, and music therapy approaches for the spiritual care of patient in palliative care (Renz, Mao, & Cerny, 2005).

In Thailand, several studies in the medical field makes use of music therapy as a primary intervention to support treatment, professional in the medical field such as physician, nurse and multidisciplinary team are also using this method to support treatment for the patient this show that music therapy are being use in medical setting. For variety curing purpose such as reliving anxiety in patients who is weaning from mechanical ventilation (Chontichalaluak, Malathum, Hanucharunkul, & kredboonsiri, 2008), to reduce pain in the Post –operative patient (Imerb kongchoom, Rimsued,&et al 2013) to reduce pain and anxiety in cancer patient receiving chemotherapy (Juangpanich, Onbunreang, lulled, khansorn and Vatanasapt, 2012) Not only in research and study but also in palliative care manual, however, not many music therapy research done with palliative care while it is a part of healing for many patients in Thailand.

In the music therapy interventions ,music therapist uses method such as songwriting, instrument improvisation, rhythmic improvisation, vocal improvisation, (Hilliard, 2004), listening to live music of the patients preferred choice of songs (Hilliard, 2003)lyric analysis, Music Guided imagery (GIM)(Burns,2001), and music therapy relaxation techniques (O' Callaghan, 2004) will improve with individual subjects to treat individual needs of patients and their families receiving care, the treatment strategy uses multiple interventions for support the needs of their individual subjects.

Music therapy assessment and evaluation tools were developed based on researched in several kinds of participants related to the domains of music therapy such as Individual Music Therapy Assessment Profile (IMTAP) for pediatric and

adolescent settings that cover both of physical and mental domain. The pain scale by patient's self-report, Profile of Mood States (POMS) that is a psychological tool rating-scale self-report assessment of mood used to assess and monitoring the quality of emotional (Martin, Andersen, Gates, 2000) as same as the Visual Analogue Scale, (VAS), visual analog scales, that music therapist were used to measuring pain level using separate scales for different problems (i.e. mood, pain, anxiety, and shortness of breath (Hilliard, 2005). To measure the quality of life in cancer patient the Quality of Life-Cancer (QOL-CA) questionnaires were used for assessing both of physical and emotional status of them (Burns, 2001) as same as the Hospice Quality of Life Index-Revised (HQOLI-R), a self-report measure was used to assess the quality of life in cancer patient by music therapists (Hilliard, 2003). Moreover, other standard medical assessment tools have been used in music therapy session to assess and evaluate patient progression.

For evaluating a quality of dying and death, the 33 item Quality of Death and Dying Questionnaire (QODD), the most widely studied and best validated, were used to assess the quality of death that separate in 3 aspect include for patient, for physician, and for family with three domain include symptom control, social connectedness, preparation for death, and transcendence (Downey, Curtis, Lafferty, Herting, & Engelberg, 2010). The QODD cover three aspects of treatment goals, physical, psychological, and spiritual. Nevertheless, the assessment form above could develop and translate to Thai and to appropriate with Thai population.

The correct music therapy in palliative care is not widely use in Thailand, further than this not mush of music therapy research and study are done by trained music therapist due to music therapy knowledge were not extensive Therefore, to increase the knowledge of music therapy in Thailand through collecting and analyzing music therapy intervention as an approach to support quality of life for palliative care patient with cancer to support a good death. Nevertheless, the study will be beneficial to medical, and music therapist industry for Thai population.

The study aims to collect music therapy data and suggest the use of music therapy approaches in palliative care following music therapy theories, and principle not only to support good death concept but also other knowledge about music therapy will be beneficial to other students and researcher especially in the medical field.

Hence expected outcomes that answer the questions on how the music therapy address palliative care patient with Cancer, which in this study focuses on music therapy interventions that support all aspect of good death.

1.2 Research question

The research question is what music therapy intervention that decent for support of good death in Thai palliative care patients with cancer within Thai culture context and medical practice in Thailand.

1.3 Objectives

To answer the research question of the study the research objectives must be as following:

1. To collect and analyze the use of music therapy interventions, assessment tools, and results that support good death in palliative care patients with cancer base on music therapy theory, principle, research, and dissertation.

2. To suggested the use of music therapy interventions that support good death, and assessments tools are able to apply to Thai palliative care patients with cancer within Thai culture context and medical practice in Thailand.

1.4 Scope of the study

The scope of the study will follow the criteria of Data gathering and analysis as the following

1. This research will focus on music therapy research that relates to palliative care patient with cancer and the good death.

2. This research will use theories and principles include cancer, music therapy, palliative care, good death concept, Antiparty Grift to explain how music therapy interventions support good death.

3. A good death concept in this research will separate into two group, medical perspective includes physician and nurse; religious perspective includes Buddha, Islam, and Christian.

4. The research was done collecting and analyze in this study on searching throughout Mahidol University and international database both Thai and English through an online database.

5. This research will present the result of music intervention most used in palliative care patient with cancer and suggested music therapy intervention applying to Thai context through analyzed, from the result.

1.5 Definition of terms

Cancer (CA): Cancer defined as the uncontrolled growth of cells, which can invade and spread to distant sites of the body. If the spread is not controlled, it can result in death.

Palliative Care: Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (WHO, 1998a). In this study, palliative care refers to an approach to maintain the quality of life for people with serious illnesses by focusing on prevention and pain relief and other problems (physical, psychosocial, and spiritual problems) through social and their families.

Music Therapy: Music therapy is the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts (WFMT, 2011). To make clear for the study, the researcher actually created the definition of music therapy to describe meaning as music therapy is the clinical and evidence-based use of music interventions to improve individual needs to

reach non-music goals, social, physical, psychological, emotional, and intellectual, by a professionally trained music therapist.

Intervention: according to music therapist is the interaction with clients or patient. In addition, interventions uses words as strategies, procedures, protocol, process, these practice has the same meaning.

Good death: The definition of good death appeared since 1997 by the Institute of Medicine (IOM) as " a decent or good death is one that is free from avoidable distress and suffering for patients, families, and caregivers; in general according to patients' families' wishes; and reasonably consistent with clinical, cultural, and ethical standards." (Institute of Medicine, 2003; Fortney & Steward, 2014). In this study, a good death or a peaceful death combined personal, medical, and social elements and the domains of good death should be including physical, psychological, social functioning, spiritual and meaningfulness of life, cognitive functioning, overall perceived quality of life, and quality of dying of patients in all aspect, individual, physician and multidisciplinary team, and family (Granda-Cameron & Houldin, 2012).

CHAPTER II
LITERATURE REVIEW

2.1 Cancer

2.1.1 Definition, diagnosis, and stage of cancer

The term Cancer (CA) define as the uncontrolled growth of cells, which can invade and spread to distant sites of the body and the aberrations was occur at the Deoxyribonucleic acid (DNA) or genetic material (WHO, 2016). If the spread is not controlled, it can result in death. According to American Cancer Society, the external factors such as tobacco, infectious organisms, and an unhealthy diet, and internal factors, such as inherited genetic mutations, hormones, and immune conditions are cause of cancer (American Cancer Society, 2015).

Cancer is diagnosed from the growth of tumor size these cell spread to adjacent organs, lymph nodes and or distant organs (Morris, Ramiez, Cool, Parikh-Patel, Kizer, Bates&Snipes, 2013). The different kinds of screening tests includes (1) physical examination and past records to see the general sign of health, patient's past health record, habits and previous illnesses and treatment would also be taken. (2) The laboratory test steps which are tissue test, blood test, urine test and testing other substances in the body. (3) Imaging procedures to make details of pictures inside of the body thus doctors will use a different strategy such as X-ray (plain X-Rays), Ultrasonography or computed tomography (CT- Computed Tomography), to screen he suspected cancer (Chabner &Thompson, 2016). (4) Genetics tests to search for certain gene mutation that are link to some types of cancer (National cancer Institute, 2016) when there is no sign of symptoms doctors will be screening to check for stages of and progress of the disease, each type of cancer has a different type of test strategy. For example; prostrate-specific antigen (PSA) blood level testing for prostate cancer and Genetic tests.

The stages of cancer can be specified by the size and growth of tumor and also its spread to the adjacent organs, distant organs or lymph nodes besides these steps the duration of the development of cancer cell is one of the element. Cancer stages are classified based on TNM system these three capital letters has three significant points which are characteristic progression, size and Extent of tumor. The T stands for primary tumor that spread to N ,regional lymph nodes and the presence of distant metastasis is M and these capital letters would be written down in front of the level of stages that which is 5 level which are 0 , 1 ,2 ,3 and 4. the stage 0 or Carcinoma is the first stage of cancer ,the tumor has not extended through the basement membrane ,At stage 1the tumor hasn't been spread into the nearby tissue and hasn't been spread into another lymph node ,the cell is still in small size and usually not invasive .The stage 2 and 3 is classified by the size of tumor. At stage 2 the tumor has grown deeply into nearby tissue and spreads to lymph nodes but not yet to other body's part unlike the stage 3which the tumor grows large and advances. The Final stage 4 is described as "Advanced" or "metastatic" the cancer cell has already spread to other parts and organs of body (Morris, Ramirez, Cook, Parikh-Patel, Kizer, Bates, Snipes, 2013; Chula Cancer, 2016).

2.1.2 Type of Cancer

There are 200 types of cancer mentioned to cancer Research UK, those type of cancer were separated from the parts of body that cancer arises (2015). Nevertheless, the different type of cancer growth has spread in different ways (Cyllene R. Morris) there has been death of 8.2 million people in 2012 due to cancer, lung cancer having the highest number of death (1.59 million) followed by liver (745,000), stomach (723,000), colorectal (649,000), Breast (521,000), and esophageal cancer (400,000) referring from the world cancer report 2014 by WHO. Many of the Thai population were killed by cancer, diabetes and chronic obstructive pulmonary disease; refer from Ministry of public health, Thailand, the Cancer Annual Report 2015 produced by bureau of Non Communicable disease (NCD) (2015). Its shows that breast cancer was the first type of cancer Thai people suffer from, second was the colon and rectum cancer followed by trachea, bronchus and lungs cancer (NCI, 2012).

2.1.3 Causes and prevalence

WHO had reported that chemical carcinogens and viral consist with tobacco and alcohol use, insufficient of fruit and vegetable intake, overweight and obesity, physical inactivity, chronic infections from helicobacter pylori, hepatitis B virus (HBV), hepatitis C virus (HCV) and some types of human papilloma virus (HPV) , environmental and occupational risks such as ionizing and non-ionizing radiation were risk factors that leading to cancer (WHO, 2010) internal factors such as inherited genetic mutations, hormones, and immune conditions were cancer causes (American Cancer Society, 2015). Moreover, some kind of herpes viruses as the Epstein-Barr virus were cause infectious mononucleosis, immunodeficiency virus or HIV, and Human papilloma viruses (HPVs) (American Cancer Society, 2014). Nevertheless, the world Health Organization' s International Agency for Research (IARC) report that it has more than 100 chemicals, physical, and biological carcinogens.

Chronic Non-communicable disease was the cause that people death, the global statistic report in 2008, 44% death at the age below 70 years old in order that 80% (17 million deaths per year) of death caused by four type of Non-communicable disease include cancer 7.6 million death per year, 4.2 million deaths per year from respiratory diseases, and 1.3 million deaths per year from diabetes (Global status report on Non-communicable diseases 2010, 2011). According to Thai Non-communicable disease statistic, the research of Non-communicable disease produced by WHO in 2010 found that 70% of Thai people death caused by Non Communicable disease include 27% coronary artery disease, 12% cancer, 7% Respiratory tract disease, and 6% diabetes (Institute of Medical Research and Technology Assessment, 2014). The death rate per hundred thousand of Thai population death with four types of cancer shows 3,984 people death from liver cancer in 2010 and getting more as 15,306 deaths in 2014 followed by 9,217 people death from lung cancer in 2010 and 12,001 deaths in 2014, breast cancer and uterine cancer were followed (Bureau of Non Communicable Disease, 2014).

2.1.4 Treatment and prevention

In this century can be treated by several methods this include surgery, radiation, chemotherapy, hormone therapy, immune therapy and use of medicine that intervene with the cancer cell growth directly by targeting specific molecules, this is called targeted therapy (American cancer Society, 2015) in addition psychosocial support is one of the cancer treatment that WHO emphasized and suggested on cancer controlling guide manual (WHO, 2008). Cancer treatment can be effective related to several factors such as knowing the stage of cancer and types of cancer associated with treatment method.

The cancer surgery instrument, fiber optic technology and miniature video cameras were developed to look inside the body and search for tumor tissue, this technology is known as laparoscopic surgery (American Cancer2016). Beneficial of radian therapy to treat cancer is it helps reduces many symptoms such as pain, prevent blindness, and helps prevent the chance to lose control over the bowel and bladder, by the use of External beam radiation and/or Internal radiation or Brachytherapy (National institute of health 2016). Chemotherapy (chemo) is the use of drug to destroy cancer cells, stops it from spreading, and slows the growth of cancer cell (national Cancer Institute 2008). Besides curing cancer chemo therapy may have its side effect to patient going through treatment by chemo therapy, these are normal side effect such as nausea, vomiting, hair loss, bone marrow changes associated with all blood cells, the red blood cell, white blood cell and platelets; mouth, throat and skin changes; low sexual desire; memory and emotional change may occur (American cancer Society, 2016; National Institutes of Health, 2008).

Hormone therapy, immune therapy and targeted therapy are the other drug therapy, Hormones drugs are use to change the action of sex hormones by slowing breast cancer prostate cancer and endometrial (uterine) cancer growth. There are two different type of immune therapies, one is to use the drug to stimulate the body own immune system to make it active to fight with the disease, another type is the immunotherapies is that they are immune system components, antibodies created outside the body then given inside the body to fight with the cancer cell. The drugs that was created to attack cancer cell directly has two main type which are Monoclonal antibodies or antibody drugs and small molecules. The monoclonal antibodies attacks

directly to the cancer cell by catching with antigen on the surface to stop the growth and destroy it easily, while the small molecules are use to adjust DNA or gene to stop cancer cell growth (American Cancer Society, 2016; Sirichaikul, 2011).

Because chemical carcinogens and viral are the main cause of cancer, associated with the behavior such as tobacco and use of alcohol, diet, physical activities, and environmental risk factors such as virus infection long-term exposed with radiation. WHO suggest the key strategies of preventing the substantial proportion of cancer which are; Cancer could be prevented by controlling the use of tobacco, encouraging healthy diet and physical activities, avoiding the harmful use of alcohol, vaccination against hepatitis B Virus and Human or Papilloma Virus, and reduce exposure and promote protective action (WHO, 2010). The National Control program manual of 2013 to 2017 were presented by the department of medical Service Thailand suggested that prevention and control strategies consist of two factors, carcinogen, and health promotion including seven strategies (1) Cancer information, (2) Primary Prevention to prevent Cancer, (3) Secondary prevention to screen and detect cancer in the early stage, (4) Tertiary prevention-treatment, (5) Palliative care (6) Cancer control research, and (7) ability of building an organization to prevent and control cancer (Thailand Department of medical Service, 2013).

2.2 Good Death Concept

All Creatures are striving to stay alive until the journey ends by death, we may be unable to choose how we are born, but may get the opportunity to design the death, most of the people avoid to talk of the word “Death” and “Dying” especially in the Thai culture though it is the truth of all being, no one wants to leave or lose their love ones, thus the quality of death should be emphasized for all life, both dying and survivors. If the quality of death could be chosen by all, people would request a ‘good’ quality for death leading to the word ‘good death’ at the present the medical care has emphasized on this and contained it as a part of the treatments.

2.2.1 Defining a good Death

Defining of the quality of good death depends on the attribution of elements of death. Thus to define a good death which came from a different individual

perspective of health care provider, patients, and families the elements is the key. In addition, good death concept was not fixed in meaning but may have some factors could help to shape the definition include people' s personal experiences, spiritual beliefs, and cultural backgrounds. The American Institute of Medicine were defining the word good death as "decent or good death is one that free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, culture, and ethical standard." (Institute of Medicine, 1997). The Definition of good death appeared in many Thai medical Textbooks such as End of life Care: Improving care of the Dying, available at Ramathibodi Hospital and Siriraj Hospital (Nimmanit 2007).

Health care Provider in this case could be a nurse or a physician even though they work together as a team but may have a different definition for a Good Death among them. Those people who have the likeliness of staying close to the patient in the palliative care unit are Nurses who mention on the concept analysis study of Good Death in a Terminally Ill Patients shows that high standard care are associated with symptom management involving pain control and Holistic care are Factors Of Good Death from a nurse perspective. The main Person That has an important role for a patient dying process is a physician, Good Death from a physician perspective is a peaceful and timely death; rational/coherent ,appropriate comfort care ,and effective communication with patient, their family, and other providers such as nurse and multidisciplinary team are the concept of Good Death for patient from a family perspective, they expect to have that there will be an appropriate way for pain and symptoms management, avoiding the prolong dying process, attaining a sense of control, alleviating burden, and strengthening relationship with family and friends, moreover they have requested for clear and compassionate communication by clinicians, respecting patient' s decisions, physical comfort and family care (Granda-Cameron & Houldin 2012).

According to John Costellos's studies with dying well, good death means the person is aware of his death coming, understanding the occurrence of death in this situation and it should be with relief from pain and other suffering, the patient should have the right to choose a place of death, receive psychological and spiritual support, get enough time to say goodbye, manage legacy or burden, appropriate prolong-life,

deserve human dignity, has ability to make decision by themselves such as no CPR and wean (Costello, 2005; Smith, 2005). An another interesting studies about good death concept mention to the first model of ‘a good death’ provided by Emanuel and Emanuel (1998) presented that good death include freedom from pain and suffering, awareness of the incoming death, ability to make decisions related to the imminent death both of medical treatments and psychological support, and ability to restore broken relationships such as granting and receiving forgiveness (Balducci, 2012).

The attribute of good death has several components that alike among health care provider, patients and families include pain, timing factor, clear communication, appropriate prolong life that aim to peaceful and good death. It has more detail for healthcare providers, physician needs were effectiveness communication not only with patients and family but also with other providers, nurse, and multidisciplinary team while family factor was an individual ability that related with other factors from health care provider and individual factors such as alleviating burden, and strengthening relationship with family and friends, and respecting patient’ s decisions. Furthermore, not only medical aspect defining the meaning of good death but also religions aspect.

The religion aspect the Good Death is define in a different meaning depending on religion’s principles ,practice and sect ,following the Buddhist Principle, Tripitaka has mention the good death as *“Death with Awareness”* which make emphasis on the Mind at the dying moment such as the good mind would be with the previously good experience in life, and the mind staying in a good surrounding such as religious chanting or peaceful place this would be considered the result of Good Death and associated with good living in two dimension the physical and mental (Lexicon of Death, 2015). Islam believes death is not the end but a transition of life and Allah’s desire followed Al-Quran, Islam’ s Scripture peaceful death is the result of following the path, Faith and constitution of Allah, summarized as *“Death within the Embrace of Allah”* to reborn. From the Evaluation of The good death concept of Iranian Studies. The Good Death from the Islam Perspective means a peaceful death is natural, family knows about the patient disease progression and also has opportunity to facilitate and care using Islam s principle, with spiritual care and without prolong life (prolong life means to be against Allah’ s desire) thus Muslim would not refuse and be afraid of

death and dying (Iranmanesh, Hosseini, & Esmalli, 2011; Thongdam, kongsuwan & Nilmanat, 2015; Srijandon, 2013).

From The Christian Perspective "Death means going back to your Hometown" (Wattanajantarakul, 2015). Christian believed that Agony Ailment and death are the punishment and trial of God or Jesus Christ and Christian catholic believed that death is the succession between body and spirit, humans have only one life, spirit judgement is instant after death. In addition, Society and Health institution of Thailand suggest the spiritual needs appropriate according to Christian include respect of dignity, needs of discovering the purpose of life and want of dying in peace thus from the Christian perspective good death relates to the condition of mind which is connected to God (Society and Health, 2006).

These three religion, Buddhism, Islam and Christian had a different perspective defining a Good Death. The same attribution among these religions are the spirituality support, mind Condition at the last moment of breath was the major point. Moreover, all the three religion believed in the future reincarnation or the future existences but where the spirit of deaths people would go is still a mysterious.

2.2.2 Surrogate terms

It's not only the word god death that is use to define the quality of good death its surrogate term is Peaceful Death it is a surrogate terms and relates to use for good death and dying is deformed, is the opposite side that is used when death has negative outcome such as altering the dying process, suicidal, community living, period of suffering before death (Callahan, 1993). Peaceful death is factor of good death mention in Buddhism perspective as preparation for death not only on the physical side but also the acceptance of death inside the mind that is equally a significant thing, the last stage of grief produced by Elisabeth Kubler-ross combined with let one self on. On the other hand, dying without awareness even though peaceful, without pain and suffering such as execution penalty by injection would not be considered a good death .Furthermore (2004) had suggested the phrase 'Dying with panache' referred to more realistic way of dying than having a good death, die on one' s own terms that disapproval condition and uneasiness may appeared (Walter, 2004), unlike "smooth Death" that is a positive word define by physician which means

to die comfortably and the dying is not prolonged (Granda-Cameron &Houldin, 2012; Lexicon of Death, 2015). The dignified death is a death that is largely free from dependency or physiological affronts that are not usually perceived as dignified (Field &Cassel 1997).

In conclusion the concept of death has changed over time that related to several factors according to the above research, good death has many attribute from a medical, religion and individual perspective. Thus to define the definition of good death the essential subject, the attribute of good death that has a relationship with the elements of good death will explained at the next section.

2.2.3 Elements of a good death in medical perspective, physician and nurse

In the health care provider field, nurses are like the profession who had stayed most closes to the patient and observed death more than other in the same field (Granda-Cameron & Houldin, 2012). Mention by Mark and Clinton (1999) nurse studies, promoting a good death, there are seven elements that promoted a good death concept that is truly use in a medical care that include; (1) comfort or relief from pain and suffering; (2) openness or being aware of dying; (3) completion or acceptance of the timing of one's death; (4) control and autonomy; (5) optimism and keeping hope alive; (6) readiness or preparing for departure; and (7) living with one's choice about where to die. In addition, Mak and Clinton (1999) another factor related to good death elements that " the factors may include relief from pain and suffering, awareness of dying, accepting dying of love one, timing, acceptance, and autonomy, keeping hope alive, preparing for death, the decision about place to die" (Mak & Clinton, 1999). Furthermore, the important health professional who has the major role for dying process was a physician.

The quantitative study conducted with two large group of academic hospitals in the United States shows the physician expected that good death consist with peaceful, and timely death; rational/ coherent, appropriate comfort care; and effective communication with patient, family, and providers (DelVechio-Good, Gadmer, Ruopp, & et al, 2004). Moreover, the qualitative open interview and quantitative attitudinal measures with 163 physicians from two major academic

medical centers in the United States studies presented a good death in physicians' perspective were describing as time and process, medical care, treatment decisions, communication and negotiations leading to peace full of death, timely death, appropriate comfort care, and the effective of communication with patient, family, and others providers (DelVecchio-Good, Gaddmer, Ruopp, Lakoma, Redinbaugh, Arnoid, & Block, 2004). Resemble with Mak and Clinton (1999) nurse studies', promoting a good death, that presented the seven elements to promote a good death concept that truly used in a medical care that include; (1) comfort or relief from pain and suffering; (2) openness or being aware of dying; (3) completion or acceptance of the timing of one' s death; (4) control and autonomy; (5) optimism and keeping hope alive; (6) readiness or preparing for departure; and (7) living with one's choice of where to die (Mak & Clinton, 1999).

Because Good Death is perceived from an individual perspective. The Thai health care provider perspective Siriyaporn (2005) had suggested an Interesting Good Death element in Enhancing Knowledge for end of life care meeting to suggested the appropriated knowledge about End of Life Care that good death may include (1) relief from pain, (2) has enough time to deserved better quality of life, (3) stop any curative care that anticipated to healed, (4) has power to chooses the place to die also with their families, friends, and love one. (5) has enough of time to stay with families or managed duty and, (6) has enough time to celebrated an important event such as wedding ceremony IN summary ,the quality of good death is related to acceptance , good preparation of death and caring factors from families and medical teams (Siriyaporn ,2005;Sapinan2005).

For the physician, the attribute or element of good death while the physician is more concerned about the biomedical aspects. On the other hand, families, patients and other health providers such as nurse are concerned about other perspective like psychological, social and spiritual.

For the health care provider' s perspective, they are not only having the element of good death, but they do not have a definite framework Emanual, Ezekiel and Linda, created a Framework for a good death from Healthcare providers point of view through the promise of good death studies that includes four elements; (1) the fixed characteristics of the patient consist with clinical status such as disease,

prognosis and socio-demographic characteristics; (2) the modifiable dimensions of the patient's experience, or elements that may respond to events or interventions include physical symptoms such as pain syndromes, neuropathic and visceral pain; psychological and cognitive symptoms, more than haft of advanced cancer patients has some psychological syndromes, depressed, sad, anxious, irritable and also inadequate pain control (Seal & Cartwright, 1994; Breitbart, Bruera, Chochinov, & Lynch, 1995; Allebeck, Bolund, & Ringback, 1989); social relationships and support; hopes and expectations; economic demands and caregiving needs and; spiritual and existential beliefs how to find meaning, purpose, and value of life was an essential question of this issue, religious faith and belief (Institute of Medicine, 1997). (3) The potential interventions available to the family, friends, health-care providers, and others; and (4) the overall outcome (Emanuel, 1998).

The elements of good death among health care provider has several similar among them separated in three aspects (1) physical; pain, effectiveness manage symptom, physical condition; (2) psychological; depression, and any psychological syndrome that may occur caused by physical illness; and (3) spiritual needs that consist with individual' factor such as religious faith and belief.

Several kinds of medical research, studies, and textbooks always mention t religious aspect, especially Buddhism which is related to Thai culture, referring from Official Statistic Thailand survey, Thai population age upper 13-year-old found that 94.6% Buddhism followed by 4.6% Islam, 0.7% Christianity, and 0.1% was another religion (Official Statistic Thailand, 2014) thus be said that Buddhism has influence for most Thai people Indeed when surveyed, the concerns of patients seem to be as much, if not more, about loss of dignity, being dependent, not being a burden, and loss of control, than about physical or psychological symptom.

2.2.4 Elements of a good death: Religions perspective, Buddhism, Islam, and Christian

Religion is a sensitive topic for all cultures Buddhism talked about life cycle before born till born to death until born again, a round of existences or the cycle of birth and death, and karma is the major key followed Tripitaka, Buddha's teaching

divided into three parts; Pitaka, Suttanta Pitaka, and The Supreme Grantham Pitaka, or Buddhist Scriptures.

Buddhism believes in mental state at the last moment of life, the dying, is called the Kam-ni-mit or karma premonition, the dying people will reminisce about their past life that is within their mind and memories, and Ka-ti-ni-mit is the vision about reborn to the next existences. A good death for Buddhist perspective is death in peace, focus is on peaceful mind, a cause of death, and death process (Onsri, 2014).

Phra Paisal Visalo, a Thai Buddhist monk presented a new perspective of death that "death is a part of life, not end of life" and also suggested that, good death might include not sudden death, but accepting of death has the power to make decision by self, deserve good quality of care to mind and spirituality (Sapinan, 2005). Moreover, accepting of death is directly related to good preparation for death, including four aspects, physical, psychological, social, and spiritual (Lexicon of Death, 2015) compliance with the research concerning death discovered by Thai Buddhist monk showed that good death has three elements, (1) death without suffering has minor elements including not prolong life, no unbowed, and death as sleep; (2) normal cycle of birth and death meets with Buddhism principle called "Vat Ta Song San" or round of existences consist with two minor elements, natural death or naturally die, and death with good karma. Each human has their own lifespan different in an individual and the natural death means to die in the given lifespan such as death due to old age; and (3) understanding of death that is one of Buddhism principle, "death is truth", include with three minor elements; accepting of death; prepare for death before death and; death without worry (Ngamgam & Sangchart, 2016).

In addition, freedom from pain, not unbowed, not distaste physical, was not killed or died from accidents is an attribute of a good death and delight following Buddhism ways (Visaro; End of life care, 2007). Buddhism believes in "karmic law" means to the consequence of action both physical and mental action that usually use the quote as "You get what you give" or "You reap, what you sow" thus karma is one factor of good death following the Buddhism principle (Punyataro, 2010). Moreover, to define good death following the Buddhist religious beliefs Buddhika Network for Buddhism managed by Pha Paisan Visaro, Thai Buddhist monk, suggested the attribute of good death followed by Buddhist religion beliefs including as following:

1) Patients acceptance of death and ready to die
2) Death with self-awareness
3) Knowing and understanding of death
4) Deserved of dignity respect and privacy
5) Clear communication from physician and other health care providers
6) Deserved good enough curative care
7) Has decision-making power to choose the place to die
8) Deserved good enough emotional and spiritual care
9) Has decision-making power to choose one or many family members or people who will stay with at the last moment
10) Advance directive
11) Timely: to say goodbye, forgiveness, and manage burden
12) Peaceful death on time and appropriate prolong life

Muslims or Islam believe in God, Allah, and death is the purpose of Allah. According to the qualitative studies in-depth interview method, Thai Muslim Nurses' Perspective of a Peaceful Death, presented six elements of peaceful death that to die peacefully the attribute of death were consist with six elements; (1) death without agony, (2) live life by followed Islam's religious principles and beliefs, (3) being with family and loved ones in peaceful environment, (4) the adoption, sickness, and death to reach, (5) no dispatches life, and (6) has prepared for death.

Christian believe that human has just one life and the spirit and would go to heaven or hell due to the consequence of action moreover they believed that life is given from God so death means to turn back to God that the caused the Christ not to be afraid of death. Ben Quash (2016) presented the art of death in the studies of Christian Visualizations of Death by talking about showing the goodness of death and *" the dying is its ability to help dying people imagine their union with Christ in whatever death they must undergo"* (Quash, 2016). Even if Quash did not directly specify what the good death is or showing some good death elements but this is an interesting clue to help sharpening the elements of good death from Christian perspectives for this research. Christian Bioethics (1998) *"suggested that everything about this life has its goal or aim in a mystical reality, the Kingdom of Heaven, for which earthly life is a preparation"* to disciple about natural death and the work of

perfection moreover pain or suffering and death is emblazed in this studies in deferent perspective while modern secular obsession with avoidance of pain but, traditional was not (Bioethics, 1998).

According to Society and Health Institute of Thailand suggested that understanding the essence of human dignity was a primary Christian principle. This principle alike respected to God because Christian believed that life was created by God until the end of life and God did not only give the commutable life but also connected to spirituality, suffering, and death. Even if Society and Health Institute did not specify the element of good death but suggest the approaches to support spiritual needs in the end of life care that include respect in dignity, needs to discover purpose of life, release any mistake such as confessions with God, surrounded by family and love ones, immortal hope to future life, and wanted to die in peace thus for Christian perspective good death related to mind condition that connects with God (Society and Health Institute, 2006).

Comparing, between healthcare professional who is focused on physical symptom control such as optimal pain control, communication effectiveness standard care, time and process more than psychological but on the other hand, religious principle focused on psychological aspect as mind and spirituality more than physical aspect, except for Buddhism which mention on dying physical condition, Even the healthcare professionals are focused on physical aspect but it doesn't mean health care professional are not paying attention to psychological aspect because of psychological needs is emphasized in medical care especially in palliative care and end of life care. Thus to define the clear definition of good death, medical and religious factors should have to be combined to analyzed. On the way to end of life and dying, the optimum care for patients should start at curative care until moved to palliative care for support a good death.

2.3 Palliative Care

Throughout of research it was found that most of palliative care studies and research was done by nurses more than physicians and other health care providers. This part is included with four major topics; (1) The definition of palliative in general

and Thai medical practice; (2) goals and needs of palliative care consist with three aspect of needs, physical, psychological, and spiritual, (3) palliative care unit in Thailand hospital and Euthanasia such as palliative care unit in hospital setting, frame work, standard care, limitation, and other factors in palliative care, and (4) palliative care assessments include PPS: Palliative Care Performance Scale, and Quality Of Life assessment (QOL).

2.3.1 Definition

Because Cancer is a chronic illness the patients must encounter the agony caused by the disease and some patients have to go through an along term treatment, some patients developed the illness to severe level thus many patients is referred to palliative care unit after Curative care of physician diagnosed.

The WHO definitions of palliative care, *" Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."* (WHO, 1998a).

Sakol Singha (2007), palliative medical physician, presented the definition which refer from World Health Organization on Palliative care: how to improve your care of the dying as palliative care is the specific curative care process for patients and family that has different procedure and purpose in an individual. Moreover, palliative care has different practice from other care because of palliative care is the life-threatening condition care by holistic care to promote the optimum quality of life in an individual and their family (Singha, 2007). Thailand Priest Hospital, Department of Medical, define the meaning of palliative care to suggested for health care providers that palliative care means to all kind of medical and nursing care for each patient needs by not anticipating to be completely cured of disease ,all care consist three aspects; psychological, social, and spiritual in an individual need, patients and family, throughout palliative care unit including with bereavement care or after patient' death (Thailand Priest Hospital, 2008).

As Prof. Dr. Pattama Komutbhut (2014), Thai family practice physician, explained that palliative medicine is the medical science that educate and research in

intensive chronic illness patient that has threat to their life the goals are to promote the quality of life, and to alleviate the suffering cover both of physical, and psychological aspects also patient' s family in all dimensions in Medical Care Relief Operations manual (Komutbhut, 2014). Kittiphon Nagaviroj, department of family medicine, Ramathibodi Hospital, Thailand, define that palliative care is an approach to care for patients suffering at the end stage of the disease and their families. To prevent and relief from suffering, as well as areas that may have occurred. Palliative care is focused on holistic care, covering all aspects of health, including physical, mental, social and spiritual aspects of patients' care is the main goal, reducing the suffering of patients, enhance the quality of life of patients and their families, and that the patient would die peacefully or "good death" (Nagaviroj, 2016).

In this study, palliative care is referred to an approach to maintain quality of life for people with serious illnesses by focusing on prevention, pain, relief, and other problems (physical, psychosocial, and spiritual problems) through social and their families. The maintaining of palliative care approach is promoting quality of life including two major symptoms which are physical symptoms, and psychological symptoms. The research defines palliative care in this study based on hospital standard care of palliative care unit in Thailand.

Several physical symptoms of palliative care patients both are progressive condition and non-progressive condition are all leading to chronic illness. For the psychological symptoms such as anxiety, mood disturbance, dysthymic disorder, depressive disorder in patient with cancer are common report by self-reported of depressive symptoms, (Archie, Bruera, & Cohen, 2013). The effect of those condition is not only each patient problems but also their family, caretaker, social function, relationship, and lutein facilities. According to two maintaining approach, the goals of palliative care approach including (1) maintaining physical condition to help patients manage their pain, (2) psychological condition to reduce psychological symptom, improve social and family relationship to support emotional needs, and (3) facilitate spiritual need to help patients find their meaning of life, dignity, and well that all are to improve quality of life and support a good death, both side of patient and their loved one.

2.3.2 The goals of palliative care

WHO shows that palliative care meets the needs of all patients requiring relief from symptoms, and the needs of patients and their families for psychosocial and supportive care especially in advanced stages and low chance for cured. in addition, palliative care service can be addressing patient and family needs include emotional, spiritual, social and economic that suffering from cancer, to improve quality of life, and facilitate the ability to cope effectively (WHO, 2005).

National Cancer Institute presents that palliative goals are to prevent or treat the symptoms, side effects of the disease, and its treatment, also to the psychological, social, and spiritual problem these to promote the quality of life. In addition, comprehensive palliative care, patient and family, include; physical, patients may have common physical symptoms such as pain, fatigue, loss of appetite, nausea, vomiting, shortness of breath, and insomnia; psychological and emotional coping, depression, anxiety, and fear which has chances to occur as consequence ; practical supports consist with financial, legal, insurance questions, employment concerns, and concerns about completing advance directives, counseling, understanding medical forms for legal advice; spiritual supports such as faith and religious beliefs, to improve sense of peace and reach a point of acceptance (National Cancer Institute, 2010) . William Blahd (2015), a board-certified emergency medicine specialist, revealed that the main goal of palliative care is to improve Quality of Life followed palliative care team goal that aim to relieve pain and other symptoms, address emotional and spiritual concerns, and also those caregivers, coordinate care, and improve quality of life during illness (Blahd, 2015).

From Thai medical perspectives, alike Thongprasert and Chockjam (n.d.) suggest that the main goal of palliative care is to promote the optimum quality of life, facilitate the normal life for patients while providing treatment, help patient and their family to understanding and accept death (Thongprasert, Chockjam, n.d.). Resemble with Thailand Priest Hospital practice (2008) defined that palliative care aim to facilitate patient to modulate themselves with their illness, and relieve from pain to promote the quality of life (Thailand Priest Hospital, 2008). Looking at physician aspect, Kittiphon Nagaviroj, department of family medicine, Ramathibodi Hospital, Thailand, define that the main goal of palliative care is to reduce pain and suffering,

promote quality of life for patient and their family, and facilitate a peaceful death or good death. Moreover, Nagaviroj emphasized that palliative care provides holistic service that cover physical, psychological, social, and spiritual of patient and family (Nagaviroj, n/a).

According to above, it was consensus that the main goal of palliative care is to promote the optimum quality of life (QOL), cover in all dimensions of three major aspects, (1) physical, (2) psychological, (3) social, and (4) spiritual.

Physical being the primary goal that health care provider tends to focus on good death associated with near death physiology in this century. Several physical conditions and syndrome may occur while near death from day per day and hours per hours to final hours at the end. Pain is a major component among physical condition in cancer patient and also has different classification including acute, chronic, breakthrough and episodic pain that needs different curative (Hilliard, 2005). Three causes of pain in cancer patient are as follow; (1) 60% -80% of pain in cancer came from spread to bone, nerve, and viscera, (2) 20% -25% of cancer treatment process such as surgery, lesion, and (3) 3%-10% came from another pain was not caused from cancer or cancer treatment but came from another pain that patients have before receiving cancer treatments.

There are two types of pain, nociceptive pain, and neuropathic pain. Nociceptive pain caused from nociceptive afferent nerves are directly stimulated usually occur at Metastasis cancer stage. Neuropathic pain causes from chronic destroy and press peripheral nerves the character of pain which include sharp, burning, shooting combine with paresthesia allodynia dysesthesia. To assess pain levels, physician and other health care provides use pain assessment such as Numerical Rating Scale (NRS), Visual Analogue Scale (VAS), and Quality of Life (QOL) (Boonsong, 2013). 78% of cancer patient suffer from cancer progression pain. To reduce and relieve physical pain, there are two method including pharmacologic management such as NSAIDs and acetaminophen, Opioid analgesics, adjuvant analgesics (WHO, 1996), and non-pharmacologic management include; physical modulation such as cutaneous stimulation; psychological interventions such as psychotherapy; and invasive therapist such as surgery and radiant (Paiboonvorachat,

2013). Thus physical symptoms in palliative care patient with cancer maybe caused from psychological symptom.

Psychological is one in four major problems that palliative care patient are suffering from including the chronic disease, and psychological it self. Research found that depression, anxiety, and delirium are the psychological problem most found in palliative care patients and two-third is Adjustment Disorder with Depression or Anxious Mood. In the past Physician used Hospice Anxiety and Depression Scale (HADS) produced by Zigmond and Snaith since 1983 that has already been translated in Thai language version by Tana Ninchaikovitm, Thai physician, and others (1996) (Zigmond & Snaith, 1998; Ninchaikovitm & et al, 1998). Supranee Niruttisat, physician, suggest three approaches to reduce depression, causes of depression may came from several factor such as uncontrolled physical symptoms, long term in-patient in hospital, lacking of social support, physical disabilities, cancer disease its self, Carcinoid and adrenal cancers, and medicine side effect, and psychopathy and anxiety; pharmacologic management such as Antidepressant ilk for depression, and Benzodiazepine ilk for anxiety; psychosocial support by the use of psychotherapy, relaxation technique counseling; and alternative medicine such as herb therapy (Niruttisat, 2015; Emaneul, Gunten, & Ferrise, 1999; Lipman & et, al, 2000; Chochinov, Breitbart, & Passik, 2003).

Delirium symptom or Acute Confessional State, a transient organic brain syndrome or neuropsychiatric complication, was highly prevalent in cancer patients especially in advanced disease (Miriam, Friendlander, & Breitbart, 2004) causes of several physical problems include brain system, organ failure, treatments' side effect. The research shows that approximately 30% of palliative care patients has Delirium symptom (Caraceni, Martini, & Simonett, 2004). To assess Delirium Rating Scale produce by Trzepacz and others and publish since 1988 and Thai Mental State Examination (TMSE) produced by Nipol Poungvarin and others that created especially for Thailand (Poungvarin, 1993; Trzepacz, Baker, & Greenhouse, 1988). Haloperidol were most used to reduce Delirium symptom, medicine Antipsychotic ilk, Risperidone, Olanzapine, and Quetiapine combine with psychosocial support and appropriate environment such as window light room, temperature, and peaceful.

Psychological problem in palliative care is an effect of cancer disease that came from several factor and has difference in an individual. In the medical system in Thailand, social worker take role in this part to help patient and family cope with all situation. Social worker or others health care professional who take this role will assess needs and problem effected to patient care system, assess acceptance and management after medical report. Psychological problem inseparably related with family area/ relatives/ friends, professional caregiver, religions, residence and its environment, and family's needs (Jantaradee, 2007).

Spiritual needs seem to be the last topic mentioned in medical perspective, spirituality refers to religious and faith support to patients and their family that has already been explained above in the elements of good death from religions' perspective topic but spiritual and religion is not the same thing because of different elements. While religion tends to focus on beliefs, ethics, rituals and traditions, spirituality is an individual perspective and it has different meaning among people, also intangible and subjective (Wynne, 2013). According to Wynne (2013), spirituality refers to the human search for meaning, hope, and purpose in life and death (Wynne, 2013; Catterall, et al, 1998; Royal College of Nursing (RCN) (2011) that Wynne (2013) presented in the studies. Spiritual care at the end of life. Moreover, Wynne suggest the effective spiritual care in palliative care, recognizes the need for individualism, self-expression and faith support through ongoing human contact, and compassion and understanding (Wynne, 2013; NHS Education for Scotland, 2009).

The definition of spiritual has changed meaning to religious and cultures (Rattanakul, 2004). In this century, the word 'spirituality' for nurses' perspective has a wide definition and it is not limited in the religions area but also include love, and human connecting to the other things, to help people find meaning and purpose of their life, and improve strength of mind, forgiveness, religious practice support, and hope (Thongparteep, 2010; Fawcett & Noble, 2004; Reed, 1992; Tanyi, 2002). In addition, Tatsanee Thongparteep summarized that for nurse's practice, spiritual needs may consist with five domains; love and connectedness; meaning of life and illness, forgiveness, religions practice, and hope (Thongparteep, 2010). The spiritual assessment has been designed based on a limited medical perspective and involved with complicate culture. The result of literature review of spiritual measurement shows

eight questionnaires were used for spiritual assess in the medical setting; Patients Spiritual Needs Assessment Scale (PSNAS); Spiritual Needs Inventory (SNI), Spiritual Interests related to Illness Tool (SpIRIT); Spiritual Needs Questionnaire (SpNQ); Spiritual Needs Assessment for Patients (SNAP); Spiritual Needs Scale (SNS); Spiritual Care Needs Inventory (SCNI); and Spiritual Needs Questionnaire for Palliative Care (Seddigh, Akhlaghi, & Azarnik, 2016) . Another interested spiritual assessment is the Faith, Importance and Influence, Community, and Address (FICA) that has several item correlated with the QOL tools assessing spirituality aspect (Borneman & Puchalski, 2010).

Because spiritual is an individual perspectives and people have different needs, also the needs could change by time especially with people who is near death. Therefore, there is never a spiritual ilk medicine to cure spirituality problem so the best way to cure spirituality are facilitating mind, giving. In conclusion, WHO suggest standard care and goals for palliative care with cancer patients briefly that can summarize all above as following:

1) Provides relief from pain and other distressing symptoms;
2) Affirms life and regards dying as a normal process;
3) Intends neither to hasten nor to postpone death;
4) Integrates the psychological and spiritual aspects of patient care;
5) Offers a support system to help patients live as actively as possibleuntil death;
6) Offers a support system to help the family cope during the patient's illness and in their own bereavement;
7) Uses a team approach to address the needs of patients and their families, including bereavement counselling, if indicated;
8) Will enhance quality of life, and may also positively influence the course of illness;
9) Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy;
10) Includes the investigations needed to better understand and manage distressing clinical complications (WHO, 2007).

2.3.3 Palliative care unit in the hospital in Thailand

Palliative care unit in Thailand is an initial phase compared with world wind general standard, set by WHO. Thai Palliative care development focuses on holistic care, and humanized health care. Despite this century health care system tend to focuses on physical more than holistic care, psychology, and spiritual because of social context has directly influence to attitude and several factors involved with human life as the consumerism era (Pungratsamee, 2013).

To develop palliative in Thailand Temsak Pungratsamee (2013), physician, suggested changing the paradigm shift following professor doctor Pravat Vasi include provide knowledge base, social mobility, and political policy.

Palliative Care Network in Medical School. There are eight hospitals that registered to join the meeting of Medical School Palliative Care Network (MS-PCARE) year 2006, Siriraj, Ramathibodi, Chulalongkorn university, Phramongkutklao Hospital, Vajira Hospital, Ching Mai University, Songklanagarind University, and Khon Kaen University, to find solutions and develop palliative care course for physician and other health care providers. The conclusion of this meeting was the integration between medical, Thai culture, religious to provide the high standard quality of palliative care in Thailand (Pungratsamee, 2003). Furthermore, Rama Palliative Care Day 2015 conference conferring about palliative care situation in Thailand by presented under topic Palliative Care: Moving Forward Together to structure the comprehensive care throughout lifetime.

Several issues were conversed including figure of palliative care patient and older adult, chronic illness, development barrier and problem, situation, palliative goals, and strategy and tools. Health care provider in hospital has encountered several barriers at palliative care practice, the main reason was lack of knowledge to cure patients and several health care providers who worked in the unit has not been trained for work with palliative care patients and also lack of awareness about good death. The situation of palliative care in Thailand summarize as following: physician does not know about palliative definition and importance when compared with nurses who will has more knowledge than physicians; unbalance development between medical technology and palliative care approach; lack of resource, learning program, professionals especially for physicians; health care providers, physician, and nurses,

lack of experience; social context: lack of awareness about good death; patients has lack of ability to access information, and decision for advance care planning; problem of ability to access Opioids ilk medicine; lack of seriously supportive from Thai government; culture believing about guilt of self.

To solve the problems; (1) to reduce pain, patient should have abilities to access required medicine, morphine, reduce cumbersome process, and allow patient to take those medicine at home; (2) physician have to provide required information and optional to family about treatment process, limited, and side effect; and (3) spiritual care support in individual needs. In addition, two essential tools advance paling, and living well. The major key of advance planning is effectiveness communications to patient and family who should have time to realize, assess, and make decision with their illness involved to the second tools, living will, the legal rights of patient to make decision about their treatments and care related to National Health Act 2007, section 12, such as prolong life. The direction to developing palliative care approach in Thailand; should have direct health system; to provide education, high quality manpower of multidisciplinary team urgently; network; opioids ilk access system; create awareness of palliative care to people; create awareness of palliative care to physician, nurses, and multidisciplinary team; to improved high standard of palliative care system and also have continuity (Ramathidobi, 2015). Compliance with important principle of palliative care provide by Kittiphon Nagaviroj; provide holistic care, physical, psychological, and spiritual; not only patient but also family; respect patient right and decision making by allowing them to access all information, this philosophy is not only a medical tool to promote the quality of life or suffering prolong life but, not to expediting death too; effective coordinate between multidisciplinary team (patient' family was a team member too) ; continuously care since initially till bereavement care (Nagaviroj, 2015).

Thai health care providers is concern with several factors that relate to high standard quality to promote quality of life to their patient from health status till health insurance. For health care providers' perspective, the core of palliative care consists of four C protocol; (1) centered at patient and family, (2) Comprehensive, (3) Coordinated, and (4) Continuous. Moreover, health care providers, physician, nurse, pharmacist, social worker, religious leader, volunteer, and also patient' family, worked

as a team so that each has an individual mission (Pungratsamee, 2005). The essential principle consists of respect in an individual dignity, patient decision, effectiveness communication with patient, family, and other providers.

Some patient who do not receive any curative care in the Hospital anymore have to turn to their homes or other hospice care center to receive the end of life care. due to many limited factors in the hospital settings; manpower in the healthcare provider profession; potentiality; experience of healthcare providers, financial or expenditure of hospital; and facilities in the hospital which are not good enough to improve ultimate quality of life and good death for patient and family (Vajaman, 2007). In Thailand, palliative care approach provided in hospital setting, palliative unit, such as Ramathibodi Hospital, Siriraj Hospital, Maharaj Nakorn Chiang Mai Hospital, Songklanagarind Hospital, and other notable hospitals, and also realize an essential of palliative care. According to above, several hospitals tend to create palliative care center and hospice care center to support palliative care patients especially End of Life care outside the hospital to facilitate more quality of life and good death. The center such as Mahidol Hospice and Elderly care: Research and Learning Center, Huahin district, produce by Mahidol University network; Karunrak Palliative Care Center produce by Srinagarind Hospital, Khon Kaen university; and Thammasat Hospice Palliative Care alongside with International Palliative Care Collaborating Center: IPCCC, these the prior projects. Moreover, the village health care volunteer has their role after patient changes from non-patient to patient who needs care outside the hospital for those who needs care of hospitals by the wish of their family and care taker. For the Palliative care outside the hospital in Thailand it's not only physician nurses and multidisciplinary undertake to provide health care in palliative care patient in the hospital but also village health volunteer provides health care in the palliative care patient, also the families provide it at home as a hospice care. In Deep interview of 27 village health care volunteer needs education from professional healthcare providers, knowledge and experience, because they lack the skill of effective communication, and lacking reliability, from the patient point of view (Luvira, Srikha & Pairojkul, 2013).

2.3.4. Palliative Care Assessment

Palliative Performance Scale (PPS) tools, prognostication assessment, developed by Victoria Hospice Society, British Columbia, USA that based on the Karnofsky Performance Scale (KPS) used to assess patient's ability daily lutein of self-care and measurements of physical status in palliative care patient, published in 1996. PPS has 11 level, from 100% - 0% to separate patient into three groups include (1) stable (100%- 70%), (2) transitional (60%-40%), and (3) end-of-life (< 30%). PPS use for assess 5 domain include (1) ambulation is the item used for assess Self-Care to help decide the level; (2) activity and evidence of disease, to help decide the level; (3) ability to do self-care; (4) food/fluid intake; and (5) conscious level. The Victoria Hospice has developed the second edition of PPSv2, published on 2001, by still uses five observer rated domains as same as PPSv1: ambulation; activity and evidence of disease; self-care; intake; and conscious level by has some new different detail. The reason PPSv2 has been developed because of population factor that older adults are growing at unprecedented rates (Cleary, 2015). Beneficial of PPS used to follow treatment result, assess quality of care to do treatment planning, use the result to communicate between healthcare providers, and assess of disease cursory usually used both of hospital and home but should assess by professional healthcare providers.

Meta-analysis, a reliability and validity study by Downing and et al. collated 1,808 patients from four studies shows that PPS has ability to predicting disease precisely in times, the life span of patients from palliative care till death, less or more of PPS score will shows number of the day patients will survive and the results of the reliability study demonstrated that PPS is a reliable tool. The number of the day that patient will survive relate to PPS score shows at figure 1 as following (Ho, Lau, Downing, & Lesperance, 2008; Nimmanvoravong & Jaturapattaraporn, 2010):

Table 2.1 Number of the day that patient will survive relate to PPS score

PPS	Number of the day
10	2-5
20	4-10
30	13-24
40	24-36
50	37-47
60	48-77
70	78-90

The PPS has been translated into other languages, French, Japanese, German (Cleary, 2015) and also Thai refer from private correspondence of Downing (2008). PPS version 2, PPSv2, was translated in Thai language published and used in by MD Associate Professor Busyamas Chewaskulyong, department of internal, faculty of medicine, Chiang Mai university knows as Maharaj Chiang Mai Hospital and changed the name of assessment tool as *Palliative Performance Scale Adult Suandok* or *PPS Adult Suandok*. Furthermore, Suan Dok Hospital provided by Maharaj Chiang Mai Hospital develop and translate PPSv2 in Thai language and publish used in 2008 and has research to support that reliability and validity enough to assess Thai patient, the research shows that Thai PPS Adult Suandok translated tool has good inter- and intra-rater reliability and can be used regularly for clinical care (Chewaskulyong & et al, 2011). Several hospitals in Thailand used this version to assess palliative care performance. Not only PPS were used to assess in palliative care performance but also Edmonton Symptom Assessment System (ESAS), and Edmonton Classification System for Cancer Pain (ECS-CP), cancer pain assessment tools. The systematic review study on clinical assessment tools for quality of life found 39 existing tools used to assess palliative care performance but only two of them has comprehensive and performance, PPS and Edmonton Functional Assessment Tool (EFAT), the clinical assessment tool used to measure physical impairment and functional performance in palliative care patient. On the other hand, Edmonton Symptom Assessment System (ESAS), 10 item rating scale questionnaire done by health care

provider or care giver by asking to patients, were used to assess for the same reason especially at the end of life care.

The ESAS designed for assess nine symptoms common in cancer patients including: pain, tiredness, nausea, depression, anxiety, drowsiness, appetite, wellbeing and shortness of breath, and also have a line labelled for ‘other problem’ by rating with number from 0-10, 0 means to the symptom is absent and 10 means the worst possible severity. Not only English version ESAS already translated in Thai by MD Darin Jaturapatporn, MD Montarat Chinda and team as same as with ECS-CP assessment that was developed and renamed from Edmonton Staging System (ESS) to reflect the intended use for cancer pain classification and distinguish as a standardized assessment aid to guide clinical management done by medical team (Kaasa & Wessel, 2001; Nakviroj, 2015; Ngwa & Koech, 2012; Woelk & Harlos, n/a). ECS-CP Thai version was translated by MD Darin Jaturapatporn, and team (Capital Health, 2001; Kaasa & Wessel, 2001; Nakviroj, 2015). Because cancer pain has complicated and has several factors to inferences pain level so ECS-CP was designed to classify pain particularly cancer pain comprised of five features include mechanism of pain, incident pain, psychological distress, addictive behavior, and cognitive function, each features will have a capital letter as an abbreviation; N (mechanism of pain), I (incident pain), P (psychological distress), A (addictive behavior), and C (cognitive function). The cancer pain classification, ECS-CP, is the medical assessment used by physician, nurses, and other professional health care provider who trained to use it in anytime while curative care (Fainsinger, Nekolaichuk, & Lawlor, 2012; Nakviroj, 2015).

2.4 Music Therapy

Music Therapy appeared in 1789 (AMTA, 2016) and became a part of palliative care setting in several continent, Europe, North America, Australia and Asia, by American Music Therapy Association members (AMTA) since 2000 (Hilliard 2005). Music therapy had functioned on many aspect of medical care unit such as people with disability, pre and post-surgery, NICU and palliative care unit for

rehabilitate legally and according to medical science procedure for palliative care patient in many countries, and up to the requirement of each individual which has a different goal, consisting of physical, social, emotional, communication, cognitive and spirituality.

2.4.1 Music Therapy definition and principle

Music Therapy has been used correctly in several countries around the world, America, Europe, Australia, and Asia, each country have their own definitions that based on various factors such as cultural. According to American Music Therapy Association (AMTA) defined music therapy as, "Music Therapy is the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program." (AMTA, 2016). Despite Canadian Association for Music Therapy define as music therapy is the skillful use of music and musical elements by an accredited music therapist to promote, maintain, and restore mental, physical, emotional, and spiritual health. Music has nonverbal, creative, structural, and emotional qualities. These are used in the therapeutic relationship to facilitate contact, interaction, self-awareness, learning, self-expression, communication, and personal development (Canadian Association for Music Therapy, 1994).

In the European side, The British Association for Music Therapy (BAMT), the professional charity for music therapy in the UK defines music therapy as Music therapy is an established psychological clinical intervention, which is delivered by Health and Care Professions Council (HCPC) registered music therapists, to help people of all ages, whose lives have been affected by injury, illness or disability through supporting their psychological, emotional, cognitive, physical, communicative and social needs (BAMT, 2016). Austria has stronger music therapy community and practiced in many sectors of the health care system, the definition of music therapy in Austria was defined based on psychodynamic and humanistic methods and definite direction towards psychotherapy since 1992 (Geretsegger, 2012).

Moving to Asia, many countries in Asia has long History on music therapy, there's already the existence of music therapy association by themselves in Korea, Japan, India, China and Taiwan, they also have their own definitions of Music

therapy (AMTA,2016). Mention to the study of defining music therapy for Chicness perspective produce by Bing Li shows the translated definition of music therapy of Korean Music Therapy Association, South Korea, in English as Music therapy is a relatively new profession that achieves and contributes health-related issues to improve the quality of life. Having a meaningful music experience with music therapists will not be limited to an individual' s body physically, but expand to a healthy holistic environment emotional, social, and spiritual." Next, China has founded Chinese Society of Music Therapy (CSMT) since 1989 to provide the mission as "Discussing, studying and advocating music therapy, as well as creating and developing the music therapy with Chinese characteristics by cooperating closely with professionals from the disciplines of music, medicine, psychology, science and medical equipment making." Because of China is an enormous country and has numerous of population who has different cultural make China has many organizations about music therapy and Chinese Music Therapy Association is the one of them that managed as professional organizations. CMTA provide the definition of music therapy as following: Music therapy is a systematic process of intervention wherein the therapist helps the client to promote health, using music experiences and the relationships that develop through them as dynamic forces of change." (Li, 2015; Zhang, Gao, Liu, 2016).

Moving to the world class music therapy which is defined as *" Music therapy is the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seeks to optimize the quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing , Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts"* Mention by the world Federation of Music Therapy, a non Profit Corporation organized under the law of the state of North Carolina USA (WFMT, 2011) Thailand do not have an officially music therapy Organization yet, but already have a music therapy training program, a Master degree produced by Mahidol University since 2013 till now. Most of music therapy program in Thailand is a behavioral approach following American .The definition of music therapy in Thailand wasn't define perfectly right, so most of

trained music therapist used the definition of American Association of music therapy (AMTA) to introduce and referring in research.

Thus the definition of music therapy still does not have any final answers because defining music therapy is an individual acknowledging (Darrow, 1998). To make clear this study, the researcher actually created the definition of Music Therapy to describe meaning as music therapy is the clinical and evidence-based use of music interventions to improve individual needs by trained music therapists following AMTA mixed with defining detail of WFMT.

2.4.2 Music therapy Approaches

Music therapy interventions contains many kind of approaches. Mention by Darrow (2008) whom collated several approaches following American Music Therapy association presented the introduction in approach of music therapy second edition as the term of approach has various terms and are related, such as intervention, strategy, procedure, protocol, process, or practice and in music therapy field it means to therapists' interaction with clients. The relationship between music and curative has been acknowledged in very long period time but may not formal collected until 18th century. Music therapy approach were developed through several music therapists who collated their experience for a long time. The category of approaches generally falls in three categories: (1) approaches adapted from music education include Dalcroze approach, Kodaly approach, and Orff approach; (2) psychotherapeutic approaches to music therapy include The Bonny Method of Guide Imagery and Music, Nordoff-Robbins music therapy, psychodynamic approach to music therapy, and behavioral approach to music therapy, and (3) medical approaches to music therapy include music therapy in wellness, Neurologic music therapy, and Biomedical Theory of Music Therapy (Darrow, 2008).

Each approaches designed appropriate to different needs, variation, procedure, and technique to shape interventions and model. Bruscia (1998), professional music therapist, identified music therapy interventions into six areas: didactic, medical, healing, psychotherapeutic, recreate, and ecological (Bruscia, 1998) thus these all closer with Darrow in different name.

Psychodynamic approach to music therapy, Bruscia (l998c) suggest four levels of engagement used in music psychotherapy include (1) *music as psychotherapy* is the use of music listening and/or creating music but no need for verbal discourse because music experience itself is considered to be the agent of change; (2) *music-centered psychotherapy*, is the use of music as same as music as psychotherapy but added verbal discourse to guide, interpret, or enhance the music experience and its relevance to the client and therapeutic process; (3) *music in psychotherapy* is the use of both musical and verbal experiences as Psychodynamic; and (4) *verbal psychotherapy with music*, verbal is a primarily discourse by using music to facilitate or enrich the discussion. Both Priestley (1994) and Helen Bonny (2002) who developed the Bonny Method of Guided Imagery and Music (BMGIM) approach is one of music therapy intervention under umbrella of psychodynamic music therapy approach. Psychodynamic thought in psychodynamic music therapy is an important part for music therapy as therapist have to ask themselves with *"How does it allow us to understand"* 1) the patient's inner world, 2) the expression of this inner world within the unfolding therapeutic process, and 3) the musical process within therapeutic context, to guide practice direction.

These are the example of the use of music to making the unconscious to conscious as psychodynamic music therapy intervenes in a different case study and theme and interventions include as following:

Jim, 49-year-old client received music therapy Bonny Method of Guided Imagery and Music (BMGIM) under the theme "Working through" an issue through music experiences.

Warja (1994), a music therapist, use Music Imagery by client-selected music through improvisation to make the unconscious to conscious by the use of music and verbal experiences and music receive the split-off parts of self and other.

Elinor was a 26-year-old single client in medical resident who received BMGIM, Improvisation, and Music Imagery interventions under "Working through" defenses theme to uncover and release of repressed feelings, and music serves as a container or holding environment.

Elinor, a 26-year-old single, a client in medical resident, received music therapy improvisation to Accessing, " working through," and resolving an issue

through music and verbal experiences music, received the split-off parts of self and other, and music holds and expresses transference and countertransference responses

Nancy, a 38-year-old single, received client-selected music listening, lyric analysis to accessing, "working through", and resolving issues through music and verbal experiences, resistance and intersubjective collusion, transference and countertransference, music as a container and holding environment, and music as a transitional object.

The concept of Psychodynamic music therapy separates into two parts, Extra musical and Music-related, explained as following: (1) extra musical consist of six concepts; unconscious, transference and countertransference, defenses resistance, verbally-mediated insight, abstinence, and unconscious conflict. Music-related consist of music can serve as a form of free association, music can help make the unconscious conscious, music can receive split off part of self or other or can receive projections, music as transition object, container or holding environment, serve a mirror, and music can hold transference, countertransference and Intersubjective responses (Isenberg, Goldberg, Dvorkin, 2008).

In conclusion, main concept of psychodynamic music therapy in the past have an impact in the present and that unconscious material drive current behavior and the goal of therapy is to uncover and work through the past and unconscious element.

Cognitive-Behavioral Counselling Techniques is a techniques used under Behavioral Approach of Music Therapy that used music with counselling as problem solving in adult social skill, diagnosis/ medication management issues, and assertiveness training, modeling, self- monitoring, role-playing, anger management, and behavioral activation psychological, biofeedback and promote relaxation. Music therapy interventions under cognitive-behavioral counselling techniques included listening to music with gradual relaxation and imagery to reduce pain; music assessed relaxation technique to improve sleep quality and alleviate stress (Lasswell, 2001) and anxiety in terminal illness, positive affected pain. Physical comfort and quality of life (Hilliard, 2005). Improvisation drumming techniques to improve assertiveness and anger management (Slatoroff, 1994); song and lyrics analysis increased the perceived locus of control (Standley, Johnson, Ribb, Brownell, and Kim, 2008).

Medical approach based on biological science include three methods: music therapy in wellness, Neurologic music therapy, and Biomedical theory of music therapy,

1. Music therapy in wellness focuses on holistic balance, means to balance between the internal and external of emotional, social, cultural, physical, and environmental stimuli to achieve and maintain the optimum personal health. Wellness emphasize health of mind, body, and spirit as holistic balance that consist with six domains followed Travis (1977) as following: self-responsibility, nutritional awareness, physical fitness, stress management, and environmental sensitivity (Travis, 1977). Music therapy as wellness program is use to enhance quality of life, increase self-awareness, alleviate depression, prevent the impact of chronic stress-related diseases, and reduce the chances of hospitalized treatments. Music interventions and benefit suggested in wellness program include: group drumming music therapy or drum circle to improved mood states also effectiveness to immunological functioning and recreation music-making as well (Bittman et ai., 2001; Bittman, Bruhn, Stevens, Westengard, & Umbach, 2003); listening to relaxation music with verbal suggestions for relaxation, vibrotactile stimulation, or progressive relaxation exercises to reversed stress responses (Pelletier, 2004); amateur singing lessons can reduced arousal, and improved joyful mood (Grape, Sandgren, Hansson, Ericson, & Theorell, 2003); listening to music based wellness exercise to improve stress management; drum circles, to decrease isolation, improve social support, and strengthen healthy self-identity; and active music making decreases mood disturbance (Bittman et ai., 2003).

Moreover, for older adult some of music therapy interventions such as deep breathing exercises, suggestions for relaxation, progressive muscle relaxation, slow stretching movements, or music and imagery techniques used to reduce stress, anxiety; as well as "Music Making and Wellness Project" (Bruhn & Clair, 1999; Koga, 2005) has effect to decreases in anxiety, depression, and perception of loneliness (Ghetti, Hama, Woolrich, 2008).

2. Neurologic Music Therapy (NMT) define as "the therapeutic application of music to cognitive, sensory and motor dysfunctions due to neurologic disease of the human nervous system" followed Thaut (1999b) who developed this method. NMT based on four scientific knowledge as neurologic rehabilitation, neuropediatric

therapy, neurogeriatric therapy, and neurodevelopmental therapy. Music therapy interventions in this method created based on four essential paradigms that structured music function to recognize synaptic connections include Neuroscience-guided Rehabilitation, Learning and Training Models, Cortical Plasticity Models, and Neurological Facilitation Models (Thaut, 2005). The principle of NMT is relationship between music, brain function, and interaction of physical and psychological. NMT interventions designed fit into three types of NMT training that consist with several minor methods.

3. Biomedical Theory of Music Therapy, mention by Dale B. Taylor explain Biomedical Theory of Music Therapy as " Biomedical Theory of Music Therapy is not a set of procedures or a way of doing music therapy with any specified population group. It is instead a way of understanding and explaining why and how music is therapeutic in any intervention. (Taylor, 2008)". This theory trying to explain and interpreting the relationship between music and human brain that reflex to physiological behaviors.

In addition, an important principle has been used to discover appropriate music therapy intervention for patient with cancer is music therapist have to have good enough knowledge and skill about Psychoneuroimmunology (PNI), is the psychology science of mind-body interactions that examine interactions of behavior, neuro and endocrine function, and immune process of adaption (Winram, Pedersen, & Bonde, 2002) or the interactions between mind-body and immune system , because immune system bring changes in cancer patient diagnosis and treatment, because immune system has effect to psychological states, street, anxiety, fear, tension, anger, and sadness and also have an impact on some types of cancer (Kiecolt-Glaser, Robles3, Heffner1, Loving, & Glaser, 2002). Physician will assess PNI by blood test to find hypothalamic-pituitary-adrenal axis, and ACTH Cortisol Interleukin (Supadej, 2016) and/or Street Anxiety Depression scale questionnaire, and pain scale. Music therapist will have a known status of PNI by being observant of patient's physiological changes such as heart rate, blood pressure, and sweating or reading form medical history chart.

2.4.3 Music therapy knowledge and research in Thailand

There are many researches related to *music* and *music therapy* used in medical, in a different kind of population, method, and education major of researcher in Thailand such as Siriporn Phumdoung (2005). A nurse, who chose the word 'Music Therapy' to define research topic to presented music' affects to physical, psychological, and spiritual related to nervous system and chemical process in human body to promoting well-being by the use of recorded music or live listening. The research was collected as a literature review to meet the purpose of research (Phumdoung, 2005). The quasi-experimental research of the effects of music therapy on post-operative pain provided by Penprapa Im-erb, and others, nurses, shows that 48 hours' post-surgery, the mean score of pain level in the experimental group was significantly less than the control group ($t = -2.27$, $p = 0.04$) by the use of music listening, but not found to be appropriate references through music or music therapy part (Im-erb, Kongchoom, Rimsueb and et al, 2005). Music for Bridges the Gaps in Cancer Care, this research study about using music in oncology, done by Patravoot Vatanasapt (2014), a physician, this is in English. The research presented about describes the opportunities of using music with cancer patients at the university hospital of Khon Kaen, Thailand with several reliable sources in the music therapy or music as medicine parts such as American Music Therapy Association (Vatanasapt, 2014).

The Family perspective' and support needs in caring for end-of stage cancer patient done by Thai master degree of nursing science mention the use of music therapy to reduce anxiety in cancer patient with Dyspnea and also could facilitate dyspnea itself as an alternative medicine choice for patients and their facility. In addition, the researcher explained in a few words, the use of music therapy, that music be used with patient should based on patient needs and this is the correctly stated referring to the music therapy principle (Pasri, 2014). Another study is the effect of music therapy on anxiety, physiological responses, and weaning parameters in patients during weaning from mechanical ventilation, done by Jiraporn Chontichachalalauk, nurse, and others (2008) with 20 in-patients in intensive care units at Ramathibodi Hospital with 30 minute of listening to recorded music with headphone, measured by assess of anxiety level, and physiological responses (heartrate, respiratory rate, and

blood pressure) and weaning parameters (oxygen saturation, tidal volume, and rapid shallow breathing index) through weaning process. The result shows positive level of measured but did not found any music therapy theory or principle mentioned in this research (Chontichachalalauk, Malathum, Hanucharurnkul, & Kredboonsri, 2008).

In End of life care: new dimension for nursing care on palliative care unit, a manual provide by Praboromarajchanok Institute of Health Workforce Development suggest the use of music therapy to improve peaceful death in palliative patients with end of life care provided in physical symptom of near death, nausea and vomiting, that music therapy may help redirect and facilitate orientation on death for patient and family (Kurat, Parako, Suwannakot, 2013). Siriwan Khongthong (2013) mention to Callahan (2011), dance therapist, a dance movement therapy exploration in child lose as movement with music can improve relaxation tend to be fundamental of self-awareness created, it also improve well-ness referring from grief experience of Thai Buddhist spouses of death patients from critical illness, in the topic of participating with each other can reduce grief (Khongthong, 2013). The article of Nursing Service System for Palliative Care in Tertiary Hospitals presented by Pilaiporn Sukcharoen, and Wasinee Wisesrith, registered nurse, to explore a nursing service system for palliative care from physicians and nurses the result shows that Nursing Service System for Palliative Care should have 61 items cover with 9 aspects proved in the tertiary hospital and music as therapy were a one of attribute in a high level of priority needs (Sukcharoen & Wisesrith, 2014).

According to above all research and study which were made by physician and nurses, some of them may not be appropriate and reliable because of barrier of Data source.

2.5 Music Therapy with good death in palliative care patient with cancer

According to Russell E. Hilliard a music therapist who were concern with hospice and palliative care patient presented a desire for a good death in his hand book, hospice and palliative care: a guide to program development and clinical care, to provide a shortly good death concept and music therapy that dying in the best possible

way, not only training vestiges of what made life important and valuable, but also surviving with personal significance and self-esteem, along with minimal distress and few intractable symptoms, as long as possible (Hilliard, 2005). Moreover, the study of Hilliard (2003) that closely related to a good death was the study of quality and length of life of people with terminal cancer that studies the effect of music therapy that related with physical status, and relationship of death occurrence to the final music therapy interventions and the result shows higher score of Quality of Life Index-Revised (QOLI-R) in participants who received music therapy (Hilliard, 2003). The experimental music groups, cancer patients receiving chemotherapy, shows exhibited lower visual analog scale anxiety scores by the use of music therapy intervention guided relaxation (Lin, Hsieh, Hsu, Fetzer, & Hsu, 2013).

An ex-post facto design with 40 patients at nursing homes, 9 were cancer patients, referral to music therapy session the result shows no significant differences on the time of death in relation to last visit by hospice professional, but there were significant differences in the length of life for those receiving music therapy (Hilliard, 2004). To facilitate life review and spiritual growth the Guided Imagery and Music (GIM) were discussed as relationship between music and spiritual in end of life care with cancer and other terminal illness (Marr, 1998). Music functions may be validating social institutions and religious rituals mention to Merriam (1964) as same as Gaston and Sears (1968) presented that music, religion and spirituality has relationship among them and were a primary reason effective of music as therapeutic medium (Merriam, 1964).

Lipe (2002) suggested that music was designed and anoints to an individual dying people to facilitate them to crosses the threshold between life and death (Lipe, 2002) as same as O'Callaghan (1996) through a qualitative research study analyzed themes in 64 songs composed by individuals in palliative care with multiple serious illness and cancer patients, 39 patients, as messages, self-reflections, compliments, memories, reflections upon significant others, expressions of adversity, imagery, and prayers. In addition, the positive message from feeling that found in lyrics include love, care and that one needs people; memories of relationships with people, both living and deceased; existing in the future; expressions of the adverse experiences resulting from living with the illnesses of multiple sclerosis and cancer

descriptions of stories and nature imagery scenes; and gratitude to family members, staff, and God (O'Callaghan, 1996). A systematic review of hospice and palliative care literature related with relationship between music, death, and dying shows most researches was studies with adult patient served ranged age between 26 to 100 years' old. Another interesting result of 63 qualitative articles was the goals, emotional was the number one (36%), followed by physical, and social (20% in each one), quality of life (12%), mixed goals (5%), and spiritual (3%). Related with quantitative research goals as emotional 35%, physical; and Clinical Investigation (20% in each one); quality of life, and spiritual (10% in each one); and social (5%) (Anderson, 2001). According to the result above, emotional seem to be the primary goals the palliative care patient' needs.

Ranjani Sukumaran (2016), Indian board-certified music therapist (MT-BC), created an interesting topic as music therapy interventions for end-of-fife care to relevant music therapy interventions in end-of-life care and also provide in a manner useful for practicing clinicians, year between 2000 - 2016, research found that 49% was involved with adult patients, 25% was children, 22% was an individuals of varied ages, and 4% was adolescents. In addition, research shows that most studies took place in United States of America 43%, Australia 22%, Canada 22%, the United Kingdom 3% , and other countries included Ireland, Japan, Spain, Tanzania, and England 2%. Most of studies took place at a hospice center 31% , hospital 24% , or home setting 18%, mixed setting 13%, senior living center and nursing home 5%, homeless shelter 2%, health region 2%, and bereavement center 2%. Moreover, research shows and 36 music therapy goals for adult patient that 16 score was an emotional expression, catharsis, and validation, followed by spiritual connection reduce, anxiety/depression/agitation, reduce/release pain 11 score in each one, acceptance of death/closure, and Quality of life (QOL) 10 score in each one, and followed by each other. Music therapy interventions for end of life care adults in the research shows 23 interventions as following: the number one was singing (score= 14); followed by songwriting and composing, instruments playing (score=12 in each one); counselling verbal processing, legacy work (score= 11); instrumental improvisation, vocal improvisation, music assisted relaxation, music listening (score-10 in each one), and followed by each other (Sukumaran, 2016).

Bowers and Wetsel (2014) the utilization of music therapy in palliative and hospice care that music therapist should understand and inform to others providers and patients also about the unique abilities of music to reduce three symptoms, anxiety, depression, and pain, through activation of the limbic system as well its ability to promote feelings of peace, forgiveness, and resolution for patients at end of life clearly (Bowers & Wetsel, 2014).

Another gap revealed in the literature is the needed of music therapy clinical evidence-base to support a clinical work in Thailand. Throughout literature review analyzing, the reasons may consist with (1) Several health care providers in Thailand, especially physician, and nurses, lacking of good enough knowledge about palliative care, and good death; (2) Because the music therapy is a newly subject used as alternative medicine in Thailand. thus, tend to scarce of music therapy evidence-based and knowledge to use in medical care in Thailand related palliative care and a good death.

Also, several studies were done by health care provider, especially nurse, who refer to music or music therapy, and used as an intervention to support and facilitate curative care, palliative care, and end-of-life care in cancer and many kinds of patients in different goals such as weaning, and pre-post operation. Many of these studies need knowledge support to make clear between *music in therapy* versus *music as therapy* to support the operation to improve the optimum quality of life (QOL) in palliative care patient with cancer who should deserve an appropriate quality of death as good death.

CHAPTER III
METHODOLOGY

The study aims to collect music therapy research and dissertation to suggest the use of music therapy interventions in palliative care following music therapy theories, and principle focuses on good death concept. In addition, this is not only to support good death concept, but will be analyzing in this study other knowledge on music therapy that will be beneficial to others student and researcher especially in the medical field. Hence interventions, assessment tools, and results that answers the questions, what music therapy interventions able to apply to Thai palliative care patients with cancer within Thai culture context and medical practice in Thailand. Through analyzed relationship between a “good death” concept and music in music therapy.

3.1 Research design

This documentary research will use Content Analysis or Documentary Analysis Method, the category of qualitative, to analyze documentation by use of descriptive design to answer research questions.

Mention by Holsti (1996), defining a content analysis as “any technique for making inferences by objectively and systematically identifying specified characteristics of messages” (Holsti, 1969). It has been defined as systematic, replicable technique for compressing text documentation based on explicit rules of coding (Stemler, 2001). Content Analysis is a kind of research method that has three different distinct approaches which include conventional, directed, and summative used for interpreting meaning from the content of data and document by collected and analyzed. The difference factor among three type include coding schemes, origins of codes, and threats to trustworthiness, the separation was related to the research question or purpose of the study (Hsieh & Shannon, 2005).

The goal of content analysis aims " to provide knowledge and understanding of the phenomenon under study" (Hsieh & Shannon, 2005). Moncthai Tieanthong, Ph.D., suggest the purposes of documentary analysis as follow; (1) to study fact of phenomenon or events both of past and present by searching, and collecting documentations, (2) to study attribute of texts or words involved with expected subjective from those documentations, (3) to analyzing relationship between contents of textbooks or academic books related to research goals or purpose of the studies, (4) to assess documentations by comparing with another one, (5) to consider difficulty of documentations, (6) to study relationship between contents and other documents, and (7) to consider contents in different books with the same topic that has different authors (Tieanthong, 2016).

3.2 Procedure

To answer research questions, the procedures of content analysis will be as following:

1. After concrete research question, research will link researched question to theory and define researched design to develop categories and a coding scheme.

2. Collect the documents and data from international and domestic source by searching online on Google scholar, and Mahidol university database, and searching paper documentary at all branch of Mahidol libraries. To collect all data, keywords used to search consist with good death; peaceful death; death and dying; palliative care and/or palliative with cancer; quality of death and dying; music therapy, associated with interventions; Cancer; end of life, and terminal Illness.

3. Investigate validity, reliability, and objectivity of documentations are meet to criteria used to evaluate the quality of research in the conventional positivist research paradigm.

4. Set the frame of content and chapter.

5. Categorize the data in each chapter.

6. Select the research related to research topic and objectives

7. Reading, coding, and analyzing content to answer research questions.

3.3 Inclusion and exclusion criteria

The research inclusion

1. The research was done with cancer patients. All participants or at least one of the three has to be identified as palliative care patient with cancer, end of life, hospice, terminal illness, advanced cancer or dying.

2. Music therapy interventions that are to be used in these research has to base on music therapy evidence-based includes done by trained music therapist (Music Therapist – Board Certified) or analyzed through a trained music therapist, the reference to music therapy research and practice, or controlled by trained/professional music therapist.

The exclusion criteria include

1. The research does not show music therapy evidence-based such as research from a trained music therapist; not controlled by a trained music therapist

2. The research done with the pediatric patient would be eliminated.

CHAPTER IV
RESULT

"Good death is inherently related to a good life because life and death are always companion"
- Hilliard (2005)

A good death is the follows the living a life well lived. The quality of life is like a very big umbrella consisting of several attributes and for palliative care patient with cancer, the quality of life that leads to quality of death includes four areas which are physical, psychological, social, and spiritual these can be call a holistic care in a medical perspective.

There is a different perspective of quality of life and death in palliative care. In health care providers' perspective, physical management is the most important area that physician concern. Despite nurses' perspective who may not only be concern with physical or symptom management but also psychological needs such as to accept dying, relief from psychological problem, Depression, anxiety, isolation, but the big question throughout reviewing the literature is "what's patients want to have a good quality of death" What a good death is for people who is with dying state while waiting for death in palliative care unit, because the good or bad death is an individual perspective Refer to research question as what is the relationship between a "good death" concept and music in music therapy with Thai palliative care patients with cancer in a Thai culture and medical perspective in Thailand? According to the research question, it has two subjects inside of them; (1) music therapy intervention to support a good death in palliative care cancer patient; and (2) suggestion for Thai palliative care patient with cancer to be involved with culture and medical perspective.

This chapter will answer the question through reviewed article following research criteria aim to present music therapy interventions, goals, its result, and other information of research.

4.1 Music therapy interventions to support good death

Music therapy interventions have many attributes agglutinate into this terms. This part will show the result through Table 4.1, explained, and analyzed music therapy interventions in palliative care patient with cancer. These studies were done with cancer patients. All participants or at least one of the three has to be identified as palliative care patient with cancer, end of life, hospice, terminal illness, advanced cancer or dying. The number of cancer patient show in the channel N/CA, N = number of all participant and CA = cancer patient. The capital L means to live music, and R means to recorded music.

Table 4.1 Reviewed Articles

Title	N/CA	Method	Purpose	Intervention	MT Goal/focus	L	R	MT Assessment	Finding
A post-hoc analysis of music therapy service for residents in nursing homes receiving hospice care (Hilliard, 2004)	80/20	Ex-post facto Randomized	To evaluate length of life, time of death in hospice care patient	Cognitive behavioral include music therapy singing with guitar/piano/monochord accompaniment, instrument playing, song parody, songwriting, rhythmic improvisation, and vocal improvisation.	Focuses on cognitive patterns, cognitive re-framing, emotional expression, and physical (gaining of insight, conflict resolution, and behavior modification).	✓		N/A	No significant differences on the time of death but, significant differences in the length of life for those receiving music therapy.
Creative songwriting in therapy at the end of life and in bereavement (Heath & Lings, 2012)	8/1	Case study	To descript author experience of the therapeutic relationship	Songwriting	Bereavement management	✓		N/A	Songwriting has a powerful from storytelling and self-expression through therapeutic relation and facilitate communication
The effect of music therapy on anxiety in patients who are terminal ill (Horne-Thompson & Grocke, 2008)	25/6	Randomized-controlled by systematic ransom sampling with pre-post design	To examine the effectiveness of a single music therapy session	Playing live familiar music, singing, music and relaxation, music and imagery, improvisation, music assisted counseling, reminiscence, and listening to recorded music.	Reducing anxiety	✓	✓	ESAS, heart rate	1. Significantly reduce pain for the experimental group (p=0.005). 2. Significantly reduced tiredness (p=0.024)and drowsiness (p=0.018)after music therapy

** N/CA: N= number of participants, CA= Number of cancer patient, N/A= Not available, L=Live music, R=Record music*

Table 4.1 Reviewed Articles (cont.)

Author (Year)	N/CA	Method	Purpose	Intervention	MT Goal/focus	L	R	MT Assessment	Finding
Music therapy in palliative care (Warth, Keßler, Hillecke, & Bardenheuer, 2015)	84/41	Randomized controlled trial	Trial	Live music–based relaxation exercises by voice and music improvisation, played live on a monochord.	Promoting relaxation, And well-being, and acute pain,	✓		VAS, Heart rate variability and health-related to QOL, EORTC QLQ-C15-PAL	1. Significantly (p <0.001 and p = 0.013 respectively) 2. HF changes in heart rate variability (p = 0.01)
Music therapy reduces pain in palliative care patients: A randomized controlled trial (Gutgsell, Margevicius, Harris, & Wienck, 2013)	200/ 174	Pre- and post-tests	To determine the efficacy of a single music therapy session	Music therapist-guided autogenic relaxation and live music	To reduce pain	✓		Face, Legs, Activity, Cry, Consolability Scale, Functional Pain Scale	Significantly greater pain decrease (P < 0.0001)
Music therapy with persons who are indigent and terminal Ill (Mramor, 2001)	1/3	Case study	To address music therapy process	Live music provide by therapist, listening to recorded music, singing together, playing and instrument, song lyric interpretation, songwriting, music for relaxation imagery	To improve quality of dying	✓		N/A	Positive change by patient self-report
Spirituality, psychotherapy and music in palliative cancer care: Research projects in psycho-oncology at an oncology center Switzerland (Renz, Schütt Mao, & Cerny, 2005)	251	Research project (case study review)	Trial	Music-meditated active imagination, and music guided relaxation	Spirituality support	✓		N/A	Spirituality support has ability to healing and dying, and support reality.
The effect of music therapy on the quality and length of life of people diagnosed with terminal cancer (Hilliard, 2003)	80	Randomized experimental-control group	To evaluate the effects of music therapy on quality of life, length of life in care, physical status, and relationship of death occurrence to the final music therapy interventions	Song choice, music-prompted reminiscence, singing, live music listening, lyric analysis, instrument playing, song parody, singing with accompaniment using the ISO principle, planning of funerals or memorial services, song gifts, and music-assisted supportive counseling. (all music selected)	To improve Quality of life	✓		Hospice Quality of Life Index-Revised (HQLI-R), Palliative Performance Scale (PPS)	1. High score of QOL 2. PSS no significant in physical function

** N/CA: N= number of participants, CA= Number of cancer patient, N/A= Not available, L=Live music, R=Record music, QOL=Quality of life, EORTC QLQ-C15-PAL= A shortened questionnaire for cancer patients in palliative care by European Organization for Research and Treatment of Cancer*

Table 4.1 Reviewed Articles (cont.)

Author (Year)	N/CA	Method	Purpose	Intervention	MT Goal/focus	L	R	MT Assessment	Finding
The effect of music therapy on the spirituality of persons in an in-patient hospice unit as measured by self-report (Wlodarczyk, 2007)	10/5	The Single Subject A-B-A-B Design	To determine the effect of mu- sic therapy on the spirituality	Playing guitar and singing patient preferred music; music- making such as singing and improvising on a variety of percussion, pitched and un-pitched instruments, songwriting, sing-a-longs with family and friends, music for prayer or worship, and patients and family members dedicating "gift songs" to each other in memory of a loved one.	Goals changed daily include facilitating interaction with the patient and family, facilitating relaxation skills, increasing communication & socialization, elevating mood, decreasing isolation, redirecting from, & reducing, perceptions of pain, providing spiritual support, addressing a variety of emotional issues, and increasing overall QOL	✓		18item Likert Scale of 6 degrees adapted from the Spiritual Well-Being Scale	Significant increase in spiritual well-being scores on music days (N= 10, d= 1, p = .01).
The use of music therapy to address the suffering in advanced cancer pain (Magill, 2001)	3	Case study	To investigate existential the use of music therapy to address the suffering	Vocal techniques, listening base on patient preference music, and live instrumental techniques, mindful music listening, creating personal recording(song legacies)	Diminish the awareness of pain, suffering, and engage psychoemotional process aim to improve comfort, peace of mind, and QOL	✓	✓	MT ongoing assessment	MT can provide moment of release and restore a sense of identity and existential meaning, improve comfort and redirection from pain.
A pilot study on effectiveness of music therapy in hospice in japan (Kikuta, 2009)	10	Conduct small group	To determine the effect of MT intervention	Live music listening provide by therapist base on patient preference music	To improve quality of life	✓		Self-rating Depression Scale (SDS), Profile of Mood States (POMS)	Significant lower cortisol level (p = .0316) and positive change in SDS and POMS
The impact of music therapy versus music medicine on psychological outcomes and pain in cancer patients: a mixed methods study (Bradt, Potvin, Kesslick, Shim, Radl, Schriver, Gracely, & Komarnicky-Kocher, 2015)	31	Mixed	To compare the impact of music therapy (MT) versus music medicine (MM) interventions	Interactive music making with a music Therapist base on patient needs include sing and/or play an instrument along to a familiar song or improvised melody, co-created instrumental or vocal improvisations, songwriting, or music-guided breathing exercises with verbal processing of emotions and thoughts evoked by the music	To enhance Symptom management, psychological and pain	✓		N/A	1. 77.4 % of participants expressed a preference for MT sessions. 2. Positive result in mood, anxiety, relaxation, and pain

** N/CA: N= number of participants, CA= Number of cancer patient, N/A= Not available, L=Live music, R=Record music*

Table 4.1 Reviewed Articles (cont.)

Author (Year)	N/CA	Method	Purpose	Intervention	MT Goal/focus	L	R	MT Assessment	Finding
Favored subjects and psychological needs in music therapy in terminal ill cancer patients: a content analysis (Preissler, Kordovan, Ullrich1, Bokemeyer, & Oechsle, 2016)	41	Qualitative content analysis prospective semi-structured "field notes"	To find favorite psychosocial needs.	Listening to relaxing music; listening to music related to therapeutic issues (all performed by the Therapist) and music-led imagination or Guided Imagery and Music	To enhance psychosocial needs.	✓		N/A	Nine main dimensions of psychosocial needs.
Lyrical themes in songs written by palliative care patients (O'Callaghan, 1996)	39	Content analysis	To find themes in songwriting	Songwriting	To support physical, psychosocial, and spiritual needs	✓		N/A	Eight themes that emerged in the songs were: self-reflections, compliments, memories, reflections upon significant others (including pets), self-expression of adversity, imagery, and prayers
Music therapy with imminently dying hospice patients and their families: facilitating release near the time of death (Krout, 2003)	5/3	Case study	To prove research objective	Music listening provided by music therapist associate with family member singing base on patient preference song, and verbal discussion.	To facilitate release near the time of death between family and patient	✓		N/A	MT intervention has role by helping family and patient involved in the last hours of life
Bringing music to life: a study of music therapy and palliative care experiences in a cancer hospital (O'Callaghan, 2001)	207	Content analysis	To survey understanding in MT program of patient, visitor, staff	Instruments playing, compose song, lean to play music instruments, music listening	To improve positive experience	✓		N/A	Patient report a positive result with music therapy

** N/CA: N= number of participants, CA= Number of cancer patient, N/A= Not available, L=Live music, R=Record music*

The result shows 16 articles matches to the research criteria. 61 interventions, separates into 15 type of interventions report in Table 4.2 type of music therapy interventions. The separated criteria of the music therapy intervention included (1) type of music, live and recorded; (2) type of participation, individual and group; and (3) interventions' method or approaches.

Table 4.2 Type of Music Therapy Interventions

No.	Interventions	n.	N.
1	Instrument playing and/or improvisation		9
2	Music listening		
	a. Listening to live music	*7*	*9*
	b. Listening to recording music	*2*	
3	Singing		
	a. Singing	*5*	7
	b. Group song singing	*2*	
4	Songwriting		7
5	Music Guided Relaxation(Music and relaxation, Music base exercise, Music Guide Autogenic, and Music Guide Breathing exercise)		4
6	Guide Imagery and Music (GIM)		4
7	Song gifts/song legacies		3
8	Music Reminiscence		2
9	Song lyrics interpretation or analysis		2
10	Music assisted counselling		2
11	Song parody		2
12	Vocal improvisation/Vocal technique		2
13	Song choice		1
14	Music for prayer		1
15	Music-Meditated active		1

** n. = number of the studies that use this minor intervention, N. = Number of the studies that use this intervention*

The most music therapy intervention that was found is Instrument playing or improvisation (N=9) (N.=number of the studies that use this intervention) followed by Music listening (N=9) that separate into two type, live (n=7) (n.= number of the studies that use this minor intervention), and recorded (n=2). Songwriting (N=7), followed by Four type of Music Guided Relaxation (N=4) include Music and relaxation, Music base exercise Music Guide Autogenic, and Music Guide Breathing exercise. Guided Imagery and Music (GIM) (N=4) were separate out of music and relaxation group because GIM is an approach that needs to be trained as professional. There are two volume among these interventions as the following Music assisted counseling; Music Reminiscence; Song lyrics interpretation or analysis; Song Gifts;

Song parody; and Vocal improvisation/Vocal technique. Followed by Song choice (N=1), Music for prayer (N=2), and Music-Meditated active (N=2).

Furthermore, the *n.*was trying to separate the number of minor interventions to make it clear because some of the intervention has different music element therapeutic include the different therapeutic between used live and recorded music, singing and group singing, and different techniques among four types of Music Guided Relaxation.

Music therapy interventions most found in this study are Instrument playing or improvisation (N=9). According to Magill (2001) live instrumental music can be inviting and adapted to meet client (or patient) needs to facilitate patient and family as same as improvisation, the next step of instrument playing, that Magill identify as creative exploration through improvise can provide release, expand awareness, enhance relatedness, and encourage a sense of control (Magill, 2001). Not only instrumental improvisation but also vocal and rhythmic were used to do improvise in music therapy intervention that has benefit for palliative care patient as promote length life (Hilliard, 2004). Moreover, instrument playing was associated with singing familiar song to improve symptom management, stress, pain, and mood (Bradt, Potvin, Kesslick, Shim, Radl, Schriver, Gracely, & Komarnicky-Kocher, 2015). Not only instrument playing but also learning to play instrument both individual and as group session can improve in positive experiences to the palliative patient (O'Callaghan, 2001). Instrument playing has effect to terminal illness cancer patient who has limit of the movement, perception, suffer from pain, tiredness, and drowsiness as the result shows that music therapy can be a stimulating and uplifting experience for palliative care patient, and redirection to anxiety leads to reduce the perception of pain (Horne-Thompson & Grocke, 2008).

It should have a good enough reason why instrument playing and/or improvisation (N=12) (Hilliard, 2004; Horne-Thompson & Grocke, 2008; Mramor, 2001; Warth , Keßler, Hillecke, & Bardenheuer, 2015; Hilliard, 2003; Wlodarczyk, 2007; Magill, 2001; Bradt, Potvin, Kesslick, Shim, Radl, Schriver, Gracely, & Komarnicky-Kocher, 2015; O'Callaghan, 2001) most used in palliative care patient with cancer throughout ,analyzed found that (1) instrument playing can provide several goals for patient as facilitating physical movement, redirection from anxiety,

and stress (psychological), and facilitate social and communication (social) through group session with family or healthcare providers (music therapist) at the same time; (2) instrument playing used to associate with singing to promote engagement to create a therapeutic relationship between patient and music therapists; and (3) music therapists may select instrument playing to match patient abilities in the study because of several patient limitations such as cannot speak or therapists aim to redirect from pain through focus on playing an instrument.

Music listening (N=9) has a few differences between live music listening (n=7) (Mramor, 2001; Hilliard, 2003; Magill, 2001; Kikuta, 2009; Preissler, Kordovan, Ullrich1, Bokemeyer, & Oechsle, 2016; Krout, 2003; O'Callaghan, 2001) and recorded music listening (n=2) (Horne-Thompson & Grocke, 2008; Mramor, 2001) as (1) function of music and music elements describe as the difference of timbre, dynamic, music instrument, sound color, and et al. between live music and recorded, while live music has the ability to adapt, but recorded music has limitations; and (2) music therapy procedure in this study is that live music are always provided by music therapists such as Krout' study (2003) and recorded music need some equipment such as headphone, such as through Mindfulness-Based Stress Reduction (MBSR) program (Warth, Keßler, Hillecke, & Bardenheuer, 2015). In addition, both live music and recorded music listening are based on patient preferred music, Thus the result showed a significantly high level of live music listening.

Singing (N=8) (Hilliard, 2004; Horne-Thompson & Grocke, 2008; Mramor, 2001; Hilliard, 2003; Wlodarczyk, 2007; Bradt, Potvin, Kesslick, Shim, Radl, Schriver, Gracely, & Komarnicky-Kocher, 2015) seem to be the second step of music listening and are based on patient preference music. Singing can be a reaction happening from listening to music and also has the reaction for body movement from listening to music. It is beneficial in all areas for patients' needs, in this study shows that even some patient may have an embarrassment to emit their voice but in music therapy non-musical goals are a primary essential goal that all music therapists have to emphasize. It has different between singing (n=5) and group song singing (n=2), procedure and setting, that singing is an individual session, but group song singing is a group session, patient, family, and/or other patients.

Songwriting (N=7) (Hilliard, 2004; Heath & Lings, 2012; Mramor, 2001; Wlodarczyk, 2007; Bradt, Potvin, Kesslick, Shim, Radl, Schriver, Gracely, & Komarnicky-Kocher, 2015; O'Callaghan, 1996; O'Callaghan, 2001) is the fourth level of music therapy interventions in this study. Mention by O'Callaghan (1996), the study of lyrical themes in songwriting by palliative care patients presents that songwriting is a worthwhile technique for palliative care patients with cancer because the lyrical themes suggest that the process may aid in meeting their physical, psychosocial, and spiritual needs, and the well-being of their families, maintenance of a sense of purpose and worth (Frampton, 1986) and self-fulfillment (Connell, 1989). Moreover, lyrics in a song may lead patients to think about their future living and some of the self-reflections can also be associated with patient's personal growth. Song themes and frequency of songs containing the themes consist of six domains of messages (in 56 songs, 87%), self-reflections (in 42 songs, 66%), compliments (in 32 songs, 50%), memorieS (in 29 songs, 45%), reflections upon significant others, including pets (in 20 songs, 31%), self-expression of adversity (in16 songs, 25%), imagery (in11 songs, 17%), and prayers (in 7 songs, 11%) (O'Callaghan, 1996).

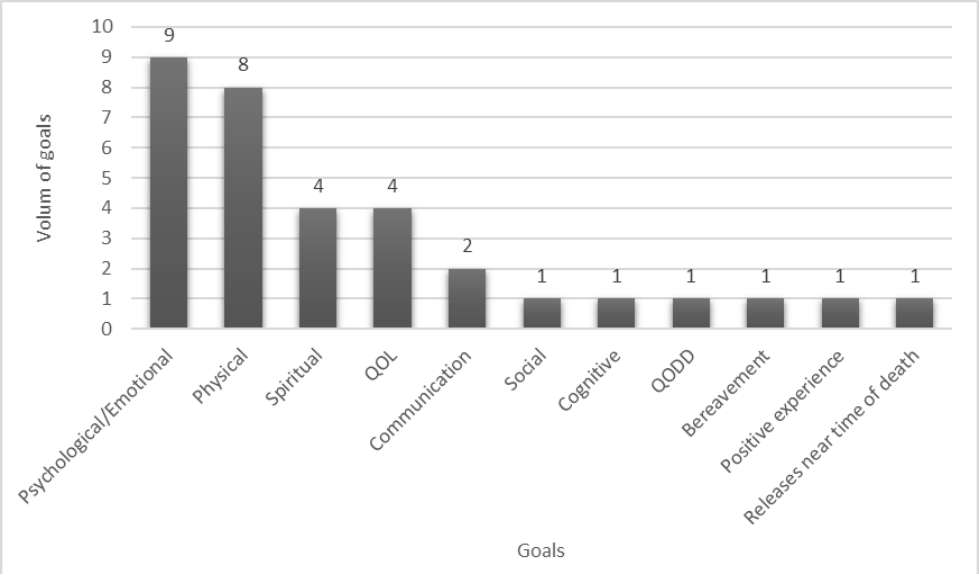
According to O'Callaghan' study, songwriting has more benefit to patient and family covered in psychosocial, spiritual needs, and the well-being because it provides patient and family to be able to express their feeling, communicating not only to each other but also with themselves, Moreover, songwriting becomes song legacy or song gifts after its done. Family or anyone who expresses loves for the patient may provide the song they compose together with the patient to remind them to their loved as Caspar, a case study (Heath & Lings, 2012).

Music Guided Relaxation (N=4) consist of four different kinds of Music and relaxation (Horne-Thompson & Grocke, 2008), Music base exercise (Warth, Keßler, Hillecke, & Bardenheuer, 2015), Music Guide Autogenic (Gutgsell, Margevicius, Harris, & Wienck, 2013), and Music Guide Breathing exercise (Bradt, Potvin, Kesslick, Shim, Radl, Schriver, Gracely, & Komarnicky-Kocher, 2015). The different among them not only the mane but also process, but has the same purpose that aims to release stress, physical relaxing, reduce pain, relief from anxiety, and modulate mood. Guide Imagery and Music (GIM) (N=4) (Horne-Thompson & Grocke, 2008; Mramor, 2001; Renz, Schütt Mao, & Cerny, 2005; Preissler, Kordovan,

Ullrich1, Bokemeyer, & Oechsle, 2016) were separated from Music Guided Relaxation because it needs doing by therapists who are specially trained. Thus if grouping Music Guided Relaxation intervention combined with GIM, the music guided group has eight interventions equal to singing.

In conclusion, music therapy intervention was selected under patient therapeutic goal related to clinical evidence-based. But, it may not be the best intervention that covered in all area because it has innumerable factors in music therapy interventions.

The goals of music therapy of these research founded 33 goals separated into 11 groups including social and physical, consisting of (1) reduce perception of pain, and physical relaxation (2) psychological and emotional management; (3) cognitive (4) communication, (5) spiritual support (6) improve Quality of Life (QOL) (7) improve Quality of death and dying (QODD) (8) bereavement management (9) improve positive experience (10) support releases near time of death, and (11) social support presented in visual graph as figure 4.1 music therapy intervention goals. The result shows that most music therapy goals used to addressing in palliative care patient with cancer is emotional and psychological goals (N=9), followed by physical (N=8), Quality of Life (QOL) (N=4), and spiritual (N=4), communication (N=2), and others. The separated criteria of music therapy goals followed by music therapy treatment goals were identified in these studies.



***** *QOL= Quality of Life, QODD=Quality of death and dying*

Figure 4.1 The goals of music therapy intervention

The psychological and/or emotional goals were describe as emotional expression, and psychological symptoms which include psychosocial, a mental health that patient reaction to their illness such as grief, and psycho-emotional (a mental health problem). Physical includes pain management or to reduce the perception of pain, and promote physical relaxation. QOL is a primary goal of the palliative patient covered in four areas, physical, psychological, social, and spiritual followed WHO definition of palliative care. Peace of mind is contained in spiritual goals in this study because Magill (2001) already mention to psycho-emotional process that is related to psychological aspect, pain, and QOL (Magill, 2001). The number that is shown above in the graph bar is a number of goals that was identified in these studies, some of these studies may have more than one goal among them.

According to the research question are that, what music therapy intervention that decent for support of good death in Thai palliative care patients with cancer within Thai culture context and medical practice in Thailand. To answer this question trough relationship of good death" concept and music in music therapy, the Table 4.3 Music therapy intervention and goals show relation between music therapy intervention and goals that analyzed from the result in this study to inform the purpose and goals of each intervention. Next, these interventions will have comparison with good death elements that separate in five groups, Physical, Psychological, Social, Spiritual, and Other.

The result in 4.3 shows that Instrument playing or improvisation covers eight goals followed by singing, songwriting covered in seven goals of each one, and music listening, six goals covered in live music and five goals in recorded music. Relating to a ranking of music therapy intervention which was used in palliative care patient with cancer, in this study shows that Instrument playing or improvisation is the most used.

Moreover, the result in Table 4.3 emphasized that psychological goal is the most setting to improve quality of care in palliative care patient with cancer, followed by QOL, spiritual, and QODD. In the last, each music therapy interventions have more than one benefit that fits into 11 goals of music therapy relating to patient needs.

Table 4. 3 Music therapy intervention and goals

Music Therapy interventions	Goals											
	Physical	Psychological	Social	Spiritual	Communication	Cognitive	QOL	QODD	Bereavement	Experience	Time of death	
Instrument playing and/or improvisation	✓	✓	✓		✓	✓	✓	✓		✓		1
Music listening												3
a. Listening to live music		✓		✓			✓	✓		✓	✓	
b. Listening to recording music		✓		✓			✓	✓		✓		
Singing												2
a. Singing	✓	✓	✓	✓	✓	✓	✓					
b. Group song singing	✓	✓	✓	✓	✓		✓	✓				
Songwriting		✓		✓	✓	✓		✓	✓	✓		
Music Guided Relaxation (Music and relaxation Music base exercise, Music Guide Autogenic, and Music Guide Breathing exercise)	✓	✓		✓			✓	✓				
Guide Imagery and Music (GIM)	✓	✓		✓			✓					
Song gifts/song legacies		✓		✓	✓		✓	✓				
Music Reminiscence		✓		✓			✓					
Song lyrics interpretation or analysis		✓	✓	✓			✓	✓				
Music assisted counselling		✓				✓						
Song parody	✓	✓				✓	✓					
Vocal improvisation/Vocal technique	✓						✓					
Song choice							✓					
Music for prayer				✓	✓			✓				
Music-Meditated active		✓		✓				✓				
Total	***7***	***14***	***4***	***12***	***6***	***5***	***13***	***10***	***1***	***4***	***1***	

The assessment that used to assess in music therapy intervention in this study found 12 assessments identified, but has one study to shows the use music therapy ongoing assessment by not identified or explained in the study; and not available (N/A) in 9 studies. The assessment was found to include Edmonton Symptom Assessment System (ESAS), heart rate; Visual Analogue Scale (VAS), Heart rate Variability (HRV) and health-related, EORTC QLQ-C15-PAL, the 15item Quality of Life (QOL) questionnaire; Face, Legs, Activity, Cry, Consolability Scale (FLACC), Functional Pain Scale (FPS); Hospice Quality of Life Index-Revised (HQLI-R), Palliative Performance Scale (PPS); 18item Likert Scale of 6 degrees adapted from the Spiritual Well-Being Scale; Self-rating Depression Scale (SDS), and Profile of Mood States (POMS).

Finally, the finding shows most of the studies has significantly positive result, but two studies have no significant result as no significant differences on the time of death (Hilliard, 2004), and PSS no significant in physical function (Hilliard, 2003). These assessment tools will be explained in detail in 4.2 the result of assessment tool in music therapy for palliative care patient with cancer.

4.1.1 Analyzed of Music Therapy goals and interventions for palliative care patients with cancer

Music Therapy has been used properly to improve the quality of life in palliative care patients with cancer under the law and government support, with a board-certified licensed registered, but in Thailand, music therapy is a new profession that people may not be familiar with.

Music therapy is use for rehabilitating, correctly in palliative care patient in several countries. The primary goal of palliative care patients is to promote their quality of life (QOL) by alleviating a psychological disease, support social skill, maintain cognitive skill, pain management, improve comforts, and ameliorate spiritual distress in every stage of a disease until the last moment of their life, the dying stage.

Music therapy intervention, music therapists use methods such as songwriting, music listening, instrument improvisation, lyric analysis, Music Guided Imagery (GIM), and music therapy relaxation techniques to improve individual objective to treat individual needs of patients and their families receiving care, the treatment strategy used multiple interventions by individual subjects. The use of music therapy as alternative medical to promote quality of life for palliative care patients for their difference needs. Music therapy has many approaches for different patient needs in several countries based on many factors such as culture, social, legislation, religion and other. Music therapy interventions engage in palliative care approaches for each part by different applications such as music listening, song writing, music guided imagery, instrument improvisation, individual singing and group singing, music therapy relaxation techniques, music therapist- guided autogenic relaxation and live music, music Progressive Muscle Relaxation (PMR) (Gutgsell, et al, 2013), music with verbal counseling, and more. This study found that most of the music therapy

intervention use more than one approach for one music therapy session to support the different need of patients.

Hilliard (2005) state that the goals of music therapy intervention for palliative care included physical, psychological, social, and spiritual that all for promoting quality of life (Hilliard, 2005) cover in four areas. (1) Physical goals, management of general distress, symptoms such as anxiety, depression or fear, will reduce pain through a direct inference on pain, because pain is also one of the most common symptoms for palliative care patients, therefore reducing pain refer to symptom management, and is an important goal in music therapy (Hokka et al, 2014). (2) Psychosocial goals of palliative care patients is to aid psychosocial symptoms such as to reduce anxiety, to reduce depression, to reduce fatigue or to reduce grief ,these were emphasized in palliative care approach are emotional needs, that mention for relaxation included in this part, For many patients can find results with significant anxiety which can with supporting sleep, enjoyment of life, interpersonal relationship, (3) Social goal refer to relationship between patients and their caretaker or family which influences their quality of life (QOL) both side of physical needs and psychological needs, and (4) spiritual goal, many health care professional and physicians recognize their patient's spiritual needs as important routine of palliative care by the using of psychotherapy, relaxation exercise, and music therapy approaches for the spiritual care of patients with palliative care (Renz, Mao, & Cerny, 2005). Notice that the relationship between palliative care goals and music therapy goals are related.

According to above, music therapy addressing several patients' needs in palliative care. Referring to Russell E. Hilliard who collected music therapy treatment by review case studies research in hospice and palliative care music therapy to guided music therapy program in hospice and palliative clinical care, music therapy enhances goals as following: *"developing therapeutic rapport; providing comfort; encouraging familial communication and support; managing pain and symptoms; reduce anxiety; mastering activities; offering a sense of comfort and spiritual support; facilitate closure; providing means of emotional expression and expression of grief; reducing stress; enhancing family coping skill; working through denial and isolation; increasing independence; self-esteem, non-verbal communications and breath*

capacity; maintaining feelings of self-worth and dignity; helping patients and family regain a sense of control; planning memorial or funeral services or special event such as birthdays or wedding; confronting death (consciously and subconsciously); gaining insight; elevating mood; and increasing quality of life (Colligan, 1987; Foxglove & Tyas, 2000; Hilliared, 2001, 2003; Mandel, 1989; Marr, 1996; Munro, 1984; O'Callaghan, 1984, 1966b; O'Connor, 1989; Robertson-Gillam, 1995; Starr, 1999; Trauger-Querry & Haghighi, 1999; and Weber, 1996)".

One of music therapy intervention may enhance more than one goals, physical, psychological, social, and spiritual. For example, instrument playing can facilitate physical movement and reduce depression at the same time so that it is difficult to specify that which one is an appropriate intervention in each goal. The detail as the following will present through analyze the result of this study separates into 11 goals relate on research result.

1. Physical goal: Music therapy interventions is always created based on patient needs, Physical problem in palliative care patient with cancer is cancer pain, causing from cancer disease itself and the side effect of treatment, especially advanced malignancy, that are the key components for appropriate or good death (Hilliard, 2005). Music Therapy offers a non-pharmacologic and safe alternative for pain, the research shows the result of pain scale score (pre-posttest) significantly greater in music therapy group, 200 sample size, who receive music therapy intervention incorporating therapist-guide autogenic relaxation and live music was effective in lowering pain in palliative care patient (P> 0.001) (Gutgsell, Margevicius, Harris, & Wiencek, 2013). The use of vocal techniques, listening, and instrumental techniques facilitate patient' movement not only can help diminish the awareness of pain but also engage psycho-emotional process, music were use in the session based on patient preferences of music and surveillance of needs also live music and recording music. Vocal techniques provided by Magill include: toning the singing with vowel sounds in different pitches to release tension and enhance awareness; chanting meaningful world chosen by therapist or patient compose with simple melodies to foster communication and relaxation; pre-composed song to improve reminisce and articulate thoughts and feelings, song writing to facilitate expression and sense of identity; melodic improvisation to facilitate relax breathing, and counteract sense of isolation; imagery

in music to facilitate relaxation, and redirection of thought and enhancing of mood; and music therapist's song composition to reflect meaningful event. Instrumental and Listening Techniques provided in the research include; playing instrument of live music; creative exploration to provide release, expand awareness, enhance relatedness, and encourage a sense of control; recorded instrumental music to offer pleasurable stimulus related to pain stimuli; mindfulness music listening to facilitate body movement with awareness; and creating personal recording as legacy (Magill, 2001).

2. Psychological goal: Instrument playing or improvisation has benefited in several areas and psychological is one of those areas. Woldarczyk (2007) invited research participants to engage music therapy session through improvising on variety of percussion, pitch and un-pitched while playing guitar and singing patient song choice to redirection from pain (Woldarczyk, 2007). The study of quality and length of life of cancer patients with terminal illness uses music therapy interventions, behavioral approach was designed to treat and identified problems to support emotional expression through live musical dialogue that all music used in this study utilized live music, and music selected-preferred by patient (Hilliard, 2003).

The songwriting offers emotional expression and complex feeling, challenging deep thought-provoking, valuable of contributing understanding in terminal illness, death, and loss. The therapeutic relationship in this session is created to support and encourage physical, mental, social, emotional, and spiritual well-being (Heath & Lings, 2012). The randomized control design with 25 terminals III in-patients, age between 18-90, shows a single music therapy session, 20-40 minute, significant reduction in anxiety followed Emotion Symptom Assessment System (ESAS), and heart rate by the use of music therapy intervention as following: playing live familiar music, singing, music and relaxation, music and imagery, improvisation, music assisted counseling, reminiscence, and listening to recorded music (Horne-Thompson & Grocke, 2008).

3. Social goal: Woldarczyk (2007) suggest music therapy intervention goals were change daily, relating to patient need and one of the goal is to increase socialization through music therapy group session the possible as group song singing, songwriting, and instrument paying

4. Spiritual goal: Music and message as a part induction at unconscious, offering experience to the patient exposed with the stage between awareness and dream world to generate deep release so music guide relaxation and music mediated imagination are two interventions used in the session. The result shows 98 participants of 135 has a positive effect with spiritual experiences by music therapy combined with body relaxation and Klangreisen, a soft of music-meditated active imagination (Renz, Schutt Mao, & Cerny, 2005). The effect of 30 minutes of music therapy session in hospice to support spiritual needs in in-patient hospice were positive. Music therapy interventions as playing guitar and singing patient preference music; facilitate patient song choice lets the patient music-making as singing, improvisation on percussion (pitch and un-pitch instruments); songwriting; music as a life review stimulus; sing-a-long with family and friend (group song singing); music for player or worship; and compose "gift song" between patient and family. The goals of music therapy changes daily related to patient situations but the main goal is spirituality to facilitate interaction between patient and family, increasing communication and socialization, facilitate relaxation, evaluating mood, decreasing isolation, redirection, reduce the perception of pain, providing spiritual support, addressing emotions, and increase the quality of life. The result shows the significant positive result with music therapy group (78.5%) compared with a non-music group (73.95) by self-report in 18-item Spiritual Well-Being Questionnaire (Wlodarczyk, 2007).

5. Communication goals: Instrument playing or improvisation, songwriting, song gifts/song legacies, and music for prayer used for facilitating communication in a different way. Wlodarczyk (2007) state that music therapy intervention can facilitate interaction between patient and their family through music interaction in several music therapy interventions as above (Wlodarczyk, 2007).

6. Cognitive goals: The cognitive behavioral approach is use to improve cognitive function to facilitate emotional expression and resolution behavioral. its intervention is use to improve cognitive function including singing, rhythmic improvisation, and vocal improvisation (Hilliard, 2004).

7. Quality of Life (QOL): QOL is a primary goal of palliative care patient that cover all patient needs. Music therapy intervention is use to improve QOL have to be base on patient needs as Magill (2001) state that music therapy is a treatment

modality of great diversity that can offer a range of benefits to the patient in advance cancer (Magill, 2001). Music therapy reduces stress level thereby play a positive role in improving patient' quality of life by the use of live music listening base on patient preference (Kikuta, 2009).

8. Quality of death and dying (QODD): Music therapy interventions as instrument playing or improvisation, listening to live and recorded music, group song singing, songwriting, GIM, and lyrics analysis were shows in Marnor' (2001) study to improve quality of dying for terminal III cancer (Marnor, 2001).

9 Bereavement: Songwriting can help patient and their family walk though grief and Bereavement by offer emotional expression through; lyrical, provide understanding of the experience of terminal illness, death and loss (Heath & Ling, 2012).

10 Improve positive experience: Instrument playing, songwriting, music listening, and learning to play music instrument can improve positive experience to palliative care patient with cancer in hospital (O'Callaghan).

11. Facilitate near the time of death: Listening to live music provide by music therapy associated with verbal discussion with patient and family has beneficial to facilitate imminent time of death (Krout, 2003).

These are the goals and music therapy intervention that was found in this study and is the relation between the intervention and the good death. The elements of good death will help to shape the relationship between music therapy and itself more clearly.

The elements of good death will help to shape the relationship between music therapy and itself more clearly. The elements were separate into two sides, healthcare providers' perspective include physician and nurse, and religious perspective, Buddhism, Christian, and Islam. The attribute of a good death among four functions that physician and nurses are concern have been selected in Table 4.4 the elements of good death in provider' perspective. The attribute of a good death in religious perspective shows in Table 4.5 the elements of good death in religious' perspective.

Table 4.4 The elements of Good death in healthcare provider' perspective

Elements of Good death	Physician	Nurse
Physical		
Relief from Pain	✓	✓
Control and autonomy of curing		✓
Place to die/Peaceful environment		✓
Preparing for death (Legacy and burden)		✓
Peaceful	✓	
Normal cycle birth and death/normal death		
Not prolong life		
Psychological		
Aware of dying		✓
Accept dying		✓
Has decision		✓
Relief from psychological problem, Depression, anxiety, isolation	✓	✓
Social		
Surrounded with family and love one		✓
Spiritual		
Hope		✓
Readiness an preparing for death (mind)		✓
Peace of mind		
Understanding in death		
Live with good life/ followed religious' principle		
Connection with God		
Death with awareness		
Other		
Timely	✓	✓
Readiness and preparing for death		✓
Rational/coherent	✓	
Effectiveness communication with team, patient and family	✓	
Autonomy of curing		✓
Quality of medical care	✓	✓
Dignity; Has decision making		✓
Live with good life/ followed religious' principle		

According to Table 4.4 shows the value of different areas of concern related to good death between physicians, and nurse's perspectives shows that physicians most concern in matter that include time, rational/coherent, effectiveness communication with team, patient and family, and quality of medical care and not shows concerning about *Spiritual* in literature review as same as nurses, the result shows high level of *Other* include timely, readiness and preparing for death, autonomy of curing, quality of medical care, dignity; Has decision-making. Timely and quality of medical care are two elements that both physician and nurse concern.

Table 4.5 show the elements of good death from a religious' perspective. From Buddhist perspective, spirituality has been the concern on peace of mind, understanding of death, and death with awareness are the elements Buddhist are the concern with, while Christian needs are the connection with God. Buddhist and Islam both has concerned on living a good life and following religious' principle. Moreover, Buddhist, Christian, and Islam are concern on being Surrounded with family and loved one.

Table 4.5 The elements of good death and religious' perspective

Elements of Good death	Buddhism	Christian	Islam
Physical			
Relief from Pain	✓	✓	✓
Control and autonomy of curing			
Place to die/Peaceful environment			✓
Preparing for death (Legacy and burden)			
Peaceful			✓
Normal cycle birth and death/normal death	✓		
Not prolong life	✓	✓	✓
Psychological			
Aware of dying	✓		
Accept dying	✓		✓
Has decision			
Relief from psychological problem, Depression, anxiety, isolation			
Social			
Surrounded with family and love one	✓	✓	✓
Spiritual			
Hope			
Readiness an preparing for death (mind)	✓		
Peace of mind	✓		
Understanding in death	✓		
Live with good life/ followed religious' principle	✓		✓
Connection with God		✓	
Death with awareness	✓		
Other			
Timely	✓		
Readiness and preparing for death			✓
Rational/coherent			
Effectiveness communication with team, patient and family			
Autonomy of curing			
Quality of medical care			
Dignity; Has decision making		✓	
Live with good life/ followed religious' principle	✓		✓

In summary, the result shows that nurses have concerns are on physical as much as psychological and is higher comparing with the physician, and other religions but, Islam has the same level of physical concern comparing with the nurse. Pain is the major element that healthcare providers and religion approved agreed following by not prolonging life but not for healthcare providers. In a psychological area, it is to accept dying as a high level of the element in the psychological area. being surrounded by family and loved ones is the only one element in the social area that shows nurse, Buddhist, Christian, and Islam have their common concern. The comparison graph between healthcare providers' perspective and religious' perspective shown in Figure 4.2 comparison graph.

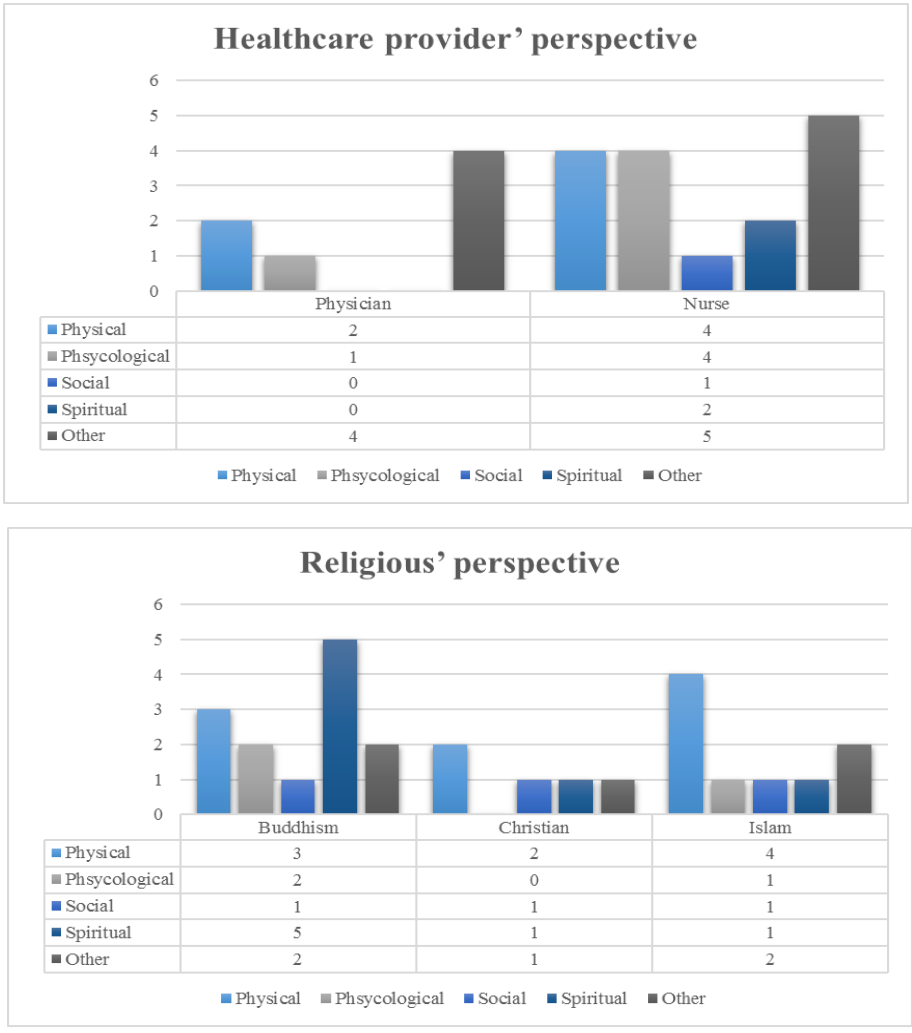


Figure 4.2 Comparison graph

In addition, the nurse are people who has the high level of concern in every area of good death, not only from patient's perspective but also their clinical performance in Others area such as time, readiness and preparation for death, the autonomy of curing, quality of medical care, and dignity by providing decision making to patients. Moreover, the importance of element of good death for music therapy is the element of good death will help music therapists create and shape their interventions by considering from five areas, *Physical, Psychological, Social, Spiritual*, and *Other*, shown in table 4.4 and 4.5

4.1.2 Relationship between music therapy intervention and good death

The element of good death are separated into five areas as physical, psychological, social, spiritual, and other this part analyzes the relation of music intervention following good death element.

1. Physical: Reduce perception of pain is the first priority needs that is shown in the music therapy research result in this study. Notice that reason to reduce the perception of pain is seeming to make sense than just reduce pain, because of pain being an individual perspective and it is not completely disappearing. Mention by a cancer patient who has to encounter different type of pain because of cancer itself. Pain theory as Gate Control Theory or Spinal Gate Control Theory of Pain develop by Malzack and Wall in 1965 (Trout, 2004) should be helpful in this case and facilitate pain management. The pain theory gives information that functions is an inference to pain which explain as Body-Self Neuromatrix including three factors such as cognitive-related brain area, sensory-signaling systems, and emotional-related brain areas. Various music therapy intervention aims to reduce the perception of pain by redirection. It is seen that cognitive, sensory signal and emotional are related to the perception of pain in other words exactly some music therapy interventions work on psychological function may have an effect on the perception of pain. The intervention such as playing instrument of live music, singing, Progressive Muscle Relaxation or music therapist-guided autogenic relaxation and live music is beneficial to redirection from pain through the use of music element and therapeutic function by music

therapists to meet physical goals. To conclude, the relation between music therapy and cancer pain is that music therapy can help patient redirected from pain perception.

2. Psychological: psychological problems in cancer patient are anxiety, depression, fatigue, fear, psychosocial, bereavement, and grief, these are tendency caused by cancer pain. Most types of music therapy intervention found in this study covered in the psychological area. help patient redirected from pain perception. Cancer patient usually encounters anxiety, fear, and depression, psychosocial problem, and grief in common and are normal responses caused by body image changes that have impact on self-esteem and confidence. American Cancer Society (2016) stage that up to 1 in 4 people with cancer have clinical depression as same as anxiety and fear may occur through cancer treatment and recovery. In addition, American Cancer Society suggests the strategy to help patient with cancer problem by promote physical activity, especially mild exercise, invite patient do meditation, prayer, or other types of spiritual support if it helps, and deep breathing and relaxation exercises. Refer to all above, the primary goal of psychological symptom should be to improve self-awareness to make unconscious to conscious, relaxation, and recovering to self-esteem. Various music therapy interventions could be facilitating breathing exercises, relaxation, being in consciousness, and express their feeling such as GIM, Music Progressed Relaxation or guide-auto genic, music guided to relaxation, music-meditated active imagination, live music listening, music assisted counselling, and songwriting. Thus the relation between music therapy and psychological problems is that music can create the structure in that activity through the use of the therapeutic function of music to help the patient be self-awareness, and relief from pain at the same time in some intervention to reduce depression, anxiety, fear, psychosocial, and grief.

3. Social: Music therapy group session (at least 2 persons) is a good opportunity to create social skill in this case. The music therapy interventions is possible to be set up in the group the setting, patient and family or patient with the caretaker or healthcare providers, such as song lyrics interpretation or analysis, improvisation, group song singing. On the other hand, even if without other as mentioned above, patients and music therapists could be participating as the group through therapeutic relationship. therapeutic function of music to help the patient have self-awareness, and relief from pain at the same time, some intervention is to

reduce depression, anxiety, fear, psychosocial, and grief. The element of good death inside social needs is surrounded by family and loved one. Thus the word love seems to be an important component for those people to be surrounded to patient from a different relationship. One important music therapy principle is therapeutic relationship or relationship between a healthcare professional and patient that has the effect of treatment as same as the therapeutic function of music (Wigram, Pedenrsen, & Bonde, 2002). Moreover, Wlodarczyk (2007) state that music therapy can indeed play a strong role in the counseling area in palliative care patient with cancer in the hospital and their family (Wlodarczyk, 2007). In conclusion, a relationship between music therapy and social needs is therapeutic relationship through music therapy interventions.

4. Spiritual: Spiritual is an individual perspective. Throughout human development history, spiritual was a component of three fundamental for the human being, body, mind, and spiritual, that is a difficult to define this concept (Huitt & Robbins, 2003). Spiritual seem to be far from medical performance but this literature shows changes in the perspective of healthcare providers; Spiritual care was emphasized in health care especially end of life care setting with the use of spiritual assessment. Mention by a systematic review of the literature with spiritual care at the end of life cares shown that 248 sources literature from 17 different countries found that 41% of literature done by UK accountant and 35% of literature done by US accountant. (Holloway, Adamson, AcSherry, & Swinton, 2010). Magill (2001) state that music therapy can be the voice for inner emotional and a link to inner strengths, providing the moment of release, and restoring a sense of identity and existential meaning.

Those process of music therapy can open doorways during time of pain and loss, ultimately leading to improved comfort, insight, and intimacy with other. Music therapy intervention as music-meditated imagery seem to be created to support spiritual needs directly because of good death element, as peace of mind seem to be a primary result to continue to other spiritual needs, hope, readiness and preparing mind for death, understanding of death. In terms of religion, to connect to God, and death with awareness could enhance through music therapy intervention as music listening, instrument playing as improvisation that aimed to express feeling, expand awareness,

provide release, and exploring insight of mind as creative exploration technique. On the other hand, live with good life and/or followed religious' principle will be omitted in this study because it cannot adjudge in a short term at the end of life.

Thus if fundamental of human being is included with the body, mind, and spiritual, music therapy intervention presented in this part shows benefit to enhance the quality of life in halfway of music therapy for palliative care patient with cancer, Even if the relationship between music therapy and spiritual could not be identified because of spirituality is an individual perspective and has different elements among three religion, but it may have some explanation to give benefit of music to support spiritual need as music can lead to peaceful moment through music therapy intervention to facilitate prayer moment, to help patient enter into themselves, support exploring insight of mind, induction the connection with God, and to support dying process.

5. Other: In the other area consist of timely; readiness and preparation for death; rational/coherent, effectiveness communication with the team, patient and family; autonomy of curing; Quality of medical care Dignity; Has decision making; live with good life/ followed religious' principle. These are mixed elements that physician is the person who is most concern in this study because several elements are related to clinical practice except live with good life/ following religion's principle, Music therapy is use to improve the quality of life for palliative care patient with cancer to make them have better quality before death will. According to this reason, music therapy can reduce clinical burden and improve the quality of clinical care as a team for physician and nurse. Music therapy uses to improve the quality of life for palliative care patient with cancer to make them has better quality before death will come up, Because of these reason music therapies can reduce clinical burden and improve the quality of clinical care as a team for physician and nurse. The relation between music therapy intervention can improve the quality of clinical care to facilitate good quality of clinical process and patient dying process.

The relations between music therapy intervention and good death through analyzing the relation of music intervention associated with good death element shows that therapeutic function of music is the answer because of (1) each music therapy intervention was created based on clinical goals to address non-musical treatment

goals as shown in the result, (2) music therapy intervention is not used only music, but also therapeutic relation and other clinical techniques such as counseling, therapists-guided, and music performance skill of therapists related to clinical goals, (3) and therapeutic function of music was used to build the rapport between music therapists and patients aimed to clinical result related to treatment goals.

Thus the result indicates that the relationship between music therapy (and music therapists) and good death is the relationship between therapeutic function of music and the element of good death, Moreover, to assess patient progression result in music therapy the assessment tools is an important instrument.

4.2 Assessment tool in music therapy for palliative care patient with cancer

Assessment is the second step of music therapy process, referral, assessment, treatment, and evaluation, to assess strength, weakness, and find out real client needs and also one of important music therapy documentation, referral, assessment, and progress note.

The assessment tools were found in these studies are 12 assessments include Edmonton Symptom Assessment System (ESAS), heart rate (Horne-Thompson & Grocke, 2008); Visual Analogue Scale (VAS), Heart rate variability and health-related, Quality of Live (QOL) (Warth , Keßler, Hillecke, & Bardenheuer, 2015); Face, Legs, Activity, Cry, Consolability Scale (FLACC), Functional Pain Scale (FPS) (Gutgsell, Margevicius, Harris, & Wienck, 2013); Hospice Quality of Life Index-Revised (HQLI-R), Palliative Performance Scale (PPS) (Hilliard, 2003); 18item Likert Scale of 6 degrees adapted from the Spiritual Well-Being Scale (Wlodarczyk, 2007); Self-rating Depression Scale (SDS), and Profile of Mood States (POMS) (Kikuta, 2009). These assessments are a medical assessment tool that designed to assess the clinical result that music therapists can use them to assess patient progression as ongoing assessment, the assessment tool used to assess the clinical result for a session.

Mention from Music Therapy (MT) Ongoing assessment (Magill, 2001) in Magill' study (2001) use to assess the result in music therapy session. This music therapy assessment, comprehensive, logical, and important, truly functional for clinical application (Borczon, 2007) may know as IMTAP. Mention by American music therapy association (AMTA), IMTAP or Individualized Music Therapy Assessment Profile is the standard music therapy assessment that board-certified or registered music therapist is use particularly for children, adolescent with multi-level, cover in five domain of non-music and also music, and can be adapted apply to other populations despite not specifically being in palliative care yet.

Those assessments were found in these studies are the medical assessment tools. The ESAS, VAS, FLACC, and FPS were used to assess pain level (physical); the SDS, and POMS were used to assess psychological status; 18item Likert Scale were designed to assess spiritual well-being; the HQLI-R, a self-report tool, was used to measure the quality of life (QOL) consist of six domains physical health, psychological well-being, social relationship, satisfaction with the environment, and overall quality of life; EORTC QLQ-C15-PAL designed to assess the quality of life in cancer patient, adapted and validated for palliative care; and PPS were used for measurement of performance status in palliative care that usually used to assess physical status of the palliative patient. Moreover, heart rate and/or HRV were used to assess the quality of health in palliative care patient with cancer combined with other assessment. The assessment tools of the quality of dying through Mramor's study (2001) not available because the result of the study shown as a qualitative descriptive through a case study design (Mramor, 2001).

To assess a quality of death following a good death concept in this study these assessment tools could be used to assess fits into four areas, physical, psychological and/or emotional, social, and spiritual, of patient treatment goal to measure the Quality of Life throughout alive time. These assessment tools also used to predict the level of pain and suffering, mood condition, spiritual well-being, social response, and overall quality of life that are related to a good death element. To measure pain level in the physical area, music therapist has been used ESAS, VAS, FLACC, and FPS to assess perception of pain as the pre-post session. Music therapists used the PPS score as an information to create the kind of interventions and level of

music therapy activities. The HQLI-R was designed for hospice care that the music therapist is used to assess the quality of care and to measure the result of music therapy intervention. The question in HQLI-R pertains to various aspects of quality of life including physical, relationship, psychological, spiritual, and financial issues (Hilliard, 2003). Moreover, to assess the quality of life in palliative care patient with cancer, music therapist used the EORTC QLQ-C15-PAL to assess the effect of music therapy intervention through the level of pain, sleeping, tiredness, and psychological condition as depression.

Heart rate and/or HRV could give more information about patient status as pain level, physical, emotional, and mood status while doing music therapy session and pre-post session. Heart rate variability is an indicator of autonomic nervous system function and used to draw inferences on the cardiovascular activity. Thus low heart rate variability as an index of emotional dysregulation is associated with a range of psychiatric and psychosomatic illnesses (Warth, Keßler, Hillecke, & Bardenheuer, 2015). Throughout the result not found an assessment tool are used to assess the quality of death even if found the research that aims to improve the quality of dying as music therapy with persons who are indigent and terminally III (Mramor, 2001). But the assessment of the quality of death will suggest in the recommendation part in chapter five in this study as The Quality of Dying and Death Questionnaire (QODD).

The progression that got from these assessment helps to measure the quality of care for music therapists through collection and evaluation the progression of each session. The evaluation has effect to predict the quality of death in palliative care patient with cancer from the result of the quality of life.

4.3 Music therapy interventions to support a good death in palliative unit to suggested for Thai palliative care patients with cancer in Thai hospital

Music therapy interventions grouping, shows in the result. In this study will select some interventions which was analyzed to suggest for Thai palliative care with cancer to lead them has the optimum quality of life and death.

Mention from research result, the music used in music therapy session based on patient needs as the music came from patient-preferred especially in music listening both live and record. Music style is a one of music element that has effect from cultural but does not concern more than spiritual orientation and even if spiritual was relating to religion. Several areas in social have concern in culture topic also in medical music therapy. Culture is one of an essential topic in music therapy framework in global that has the effect to the human in several aspects attitude, liking or disliking, taste, believe, lifestyle, these was pressed in art, architecture, costume, music, and also in personality. Music therapy theory suggests relation between culture diversity and music therapy subject under the topic culture-centered ecological music therapy mention to Brynjulf Stige (2002), author.

Cultural understanding is an important component thus the music therapist should emphasize. Thai people are always surrounded by music that has the role in several areas in Thai culture, but not music therapy, especially in medical care. The point is not a style of music therapist will use because this information could be read in a patient' medical history or through assessment but the therapeutic relationship is the key.

The use of music therapy with palliative care patient with cancer who as soon as they move to terminal illness and final stage at the end is a challenge for music therapist in Thailand to engage in suffering situation with making music to different patient and family who has various attribute and background that has effect directly with their attitude and opinion to the use of music in medicine. Because in Thailand, music was used in several ceremonies within the positive meaning such as wedding, ordination ceremony, and in pleased condition, on the other hand, music performed again in funeral not in the moment of dying or before thus music in palliative care or crisis illness may not be pleasing for most Thai people so what is the key to helping music therapist engaging in medical setting?

At present, several hospitals in Thailand bring the music performance playing into hospital area, in music therapy called music ambient, to the modified atmosphere and Thai people usually called music performance played into hospital area that music therapy but it is would rather not be a therapy yet followed music therapy principle and definition. On the other hand, several healthcare providers as

physician, nurse, and multidisciplinary team has been put music into clinical care and that the research and study done in Thailand shows really positive effect in their perspective through the result. Music therapy has been provided properly by trained music therapist in Thailand since 2010 as the pilot project by cooperation between board-certified music therapist (MT-BC), Dr. Dena Register, board-certified music therapist, and College of Music, Mahidol University and cooperation of Siriraj hospital. This is a big change for the use of music in a medical setting in Thailand related to the music therapy principle as the difference between music as stimulus, music as therapy, music in therapy, and music as communication and social interaction. Mention to Ruud (1990), presented a model of for level of music above as following:

Music as stimulus provide in physiological level is a corresponding to music as a physical sound phenomenon focus on physiological effects and medical potential of music

Music as therapy provide in syntactical level, is a corresponding to music as aesthetic focus on a precise description and interaction of music elements, their role in the musical process, their interplay and function in their therapeutic

Music in therapy provide the semantic level, is a corresponding to music as expression and meaning message or the music or its reference to an internal or external world focus on the interpretation of the music as metaphor, icon, index or symbol, and the meaning of music for a client, the interplay, and therapeutic relationship.

Music as communication and social interaction provides in the pragmatic level, is a corresponding to music as a social interaction focus the potential of musical interaction and its effect in treatment.

According to the level of music above that shows a relationship between music and functions are use as a therapeutic treatment and this is the good suggestion to guide beginning the use of music in Thai medical setting. According to the result of this study, music therapy intervention that decent for Thai population are include as following: **(1) Instrument playing and/or improvisation; (2) Music listening; (3) Singing (4) Songwriting; (5) Song lyrics interpretation or analysis; (6) Music assisted counseling; (7) Song parody; (8) Song choice; and (9) Music-Meditated**

active. While some intervention is *Not yet* as shown in Table 4.6 music therapy intervention use to adapt for Thai palliative care patients with cancer.

Because the gaps consist two domains as music therapy knowledge and profession personnel that has limited trained as same as trained music therapist while in the music the key to helping music therapist engaging in a medical setting is a relationship between the therapeutic function of music, treatment, and patient need. According to nine interventions were suggest, it could be grouping into three groups relate to Thai culture and for level of music, music as stimulus, music as therapy, music in therapy, and music as communication and social interaction.

Table 4.6 Music therapy intervention use to adapt for Thai palliative care patients with cancer

Music Therapy interventions	**Aware**	
	Yes	**Not yet**
Instrument playing or improvisation	✓	
Music listening *a. Listening to live music* *b. Listening to recording music*	✓	
Singing *a. Singing* *b. Group song singing*	✓	
Songwriting	✓	
Music Guided Relaxation (Music and relaxation Music base exercise, Music Guide Autogenic, and Music Guide Breathing exercise)		✓
Guide Imagery and Music (GIM)		✓
Song gifts/song legacies		✓
Music Reminiscence		✓
Song lyrics interpretation or analysis	✓	
Music assisted counselling	✓	
Song parody	✓	
Vocal improvisation/Vocal technique		✓
Song choice	✓	
Music for prayer		✓
Music-Meditated active	✓	
Total	***9***	***6***

1. Instrument playing and/or improvisation, music listening (live and recorded), singing (individual and group), and song choice provide in the level of music as stimulus, and music as therapy. Instrument playing were used in a different pattern. Music therapist will be playing patient preferred music on guitar, facilitating patient song choice via printed song book, and leading the patient in music making by

singing and improvising on a verity of percussion pitched and un-pitched instrument (Wlodarczyk, 2007). Live instrumental music techniques can be inviting and can be adapted to meet patient needs such as invited patient and family to participate in music by playing in desired instrument (Magill, 2001). Improvisation is different from Instrument playing in purpose and process. According to Hilliard (2004), the rhythmic improvisation is the use of un-pitched instrument playing that aim to orientated around growth and development in functional domain such as social, emotional, communicative, physical bases on individualized assessment and planning. The process of music improvisation designed base on therapeutic aims. The process of the music improvisation is based on therapeutic aims. The process could be used music or music and verbal, structured or unstructured. The important part of these interventions is the role and relationships between music, clients or patients, and therapists who will become a facilitator. The role of music is an intermediate to create a therapeutic relationship between patient and therapists. While therapists have to establish personal relationship with patients by themselves to accomplish therapeutic aims. In addition, music improvisation should be playing as group (Hilliard, 2004; Gardstrom, 2007).

Music therapist usually uses live music listing provided to the patient, not only in live music listening interventions but also other interventions. The process in live music listening session the role of therapists is not only playing music while the patient has role as a listener but they are having an interaction. The verbal discussion is possible to appear in this session thus the therapists must have the ability to do verbal discussion as counseling level. Even verbal discussion as counseling may not appear in the session but an ability to establish engagement will be requested from therapists to create the therapeutic relationship and facilitate patient engaged with musical such as singing and song choice. Moreover, Hilliard (2003) explain about live music as finally, the implementation of music therapy included many varying types of techniques, and the only aspect which was controlled for was that all the interventions utilized live music. (Hilliard, 2003; Magill, 2001; Mramor, 2001; Nakayama, 2009).

2. Songwriting, song lyrics interpretation or analysis, music assisted counseling, and song parody provide in music as stimulus, music as therapy, music in therapy, and music as communication and social interaction. Baker & Wigram (2005) define songwriting as the process of creating, notating and/or recording the lyrics and

music within a therapeutic relationship to address psychological emotional, cognitive and communication needs of the client. Moreover, Heath & Lings (2012) state that the song can be felt as owned by the client and expressive of his or her personal needs, feeling and thought. This involves maintaining a delicate sense of agency and balance to ensure that client's own creative sense of self is maintained at the heart of the work (Heath & Lings, 2012; Baker & Wigram, 2005). Songwriting is a powerful intervention to help patients express their feeling and processing their thoughts associated with cancer but it has a few limitation as patient's cognitive and perception, and physical abilities. The structure of songwriting in music therapy is complicated. The therapists must provide as facilitator by the use of musical theory and elements of music, and verbal discussion skill to facilitate patient express their feeling transformed to the words to create lyrics. Song parody (Hilliard, 2004) is a rewriting the lyrics of songs based on therapeutic themes, a step down of songwriting. A music therapist has the role to facilitate patient creating an original song of worship or help the patient write a parody of a pre-existing song. Song lyrics interpretation usually know as lyrics analysis. Song lyrics interpretation or analysis may work after songwriting and song parody is done to help patient interpret and realized their feeling and thought. The song was used to analyze will be offered or selected by therapist relate to treatment goals and therapeutic aim (O'Callaghan, 1996). In these sessions, music therapist has the role as a facilitator to support verbal discussion, and reflex patient's expression thus verbal discussion skill are needed.

The music assisted counseling is the use of music-assessed supportive counseling. The music therapist will have to train a counseling skill to work in this part with a good quality as same as musical skill, and other clinical skill. This intervention used the music as therapeutic tool to lead patient to realize themselves, feeling, memories, illness, and death, combined with verbal counseling (Hilliard, 2003). Music therapist may use live music listening and facilitate patient to engage music by singing or playing unpitched instrument to create therapeutic relationship before verbal discussion as counseling. Wlodarczyk (2007) state that music therapy can indeed play a strong role in that counseling area in terminally ill patients and their families to support their spirituality (Wlodarczyk, 2007).

3. Music-Meditated active provide in music as stimulus, music as therapy, and music in therapy. Mention to Renz, Schütt Mao, and Cerny (2005), this intervention guiding patient to the threshold between awareness and the dream word where message and impulse of the conscious arise generating a deep lease through music. Music therapist will be use guided relaxation to induction patient to music meditated imagination by the use of music and dialogue (Renz, Schütt Mao, & Cerny, 2005).

In addition, Live music interventions allow the therapist to change musical qualities as patients' needs dictate and the music was used in these interventions are based on patient preference (Hilliard, 2005).

Nine interventions were selected because suitable for everyone' ability; easy to do and understanding; good for build relationship and rapport between music therapist and patient; and composition in many interventions.

In conclusion, the result in this study shows music therapy intervention that came from music therapy research through practice related to the professional principle from trained music therapists use to improve the quality of life for palliative care patient with cancer and pass the carefully analyzed to find music therapy intervention used for Thai patient. Mention to the quotation in the first page in this chapter as "*Good death is inherently related to a good life because life and death are always companion"* (Hilliard, 2005). Music therapy has benefit to improve the quality of life in various aspect cover in physical, psychological, social, cognitive, behavior, communication, spiritual, quality of dying, and dying process. Moreover, music therapy intervention selected based on several factors but the patient need is the most important factor as found in the result as patient preference music, patient ability, and goals of music therapy changes daily to fit patient ability and need.

CHAPTER V
DISCUSSION AND RECOMMENDATION

This chapter presents both discussion and recommendation. The discussion presents Good death and music therapy in palliative care patient with cancer in Thailand. In terms of recommendation, this chapter provides clinical process, the reason for music therapy referral, ISO principle and Therapeutic Function of Music, designed music therapy assessment tools, and good death assessment tool adapt from Quality of death and Dying questionnaire (QODD) in Thai version (QODD-TH) use to assess for music therapy. The future research will provide in a final part.

5.1 Discussion

5.1.1 Good death and music therapy in palliative care patient with cancer in Thailand

The element of good death consists of five domains, physical, psychological, social, spiritual, and other. Pain consist of the physical area that is everyone concerns and could be a fountainhead of every problem. Cancer patients have to encounter with several kinds of pain in a different cause, cancer itself, and treatment. Music has been provided in several hospitals in Thailand such as a music ambiance, music in therapy, and “the use of music to...” Musical has been used as a different strategies that aims at clinical result in the hospitals in Thailand by the nurse, physician, and other healthcare providers not only in clinical practice level but also in experimental research level. The intervention that is usually found in experimental research are listening to recorded music such as listening to recorded music to reduce pain on postoperative of patients undergoing general surgery (Im-erb, Kongchoom,

Rimsueb and et al, 2005) as presented in the literature review in this research (2.4.3 Music therapy knowledge and research in Thailand).

According to the result of this study, instrument playing, music listening (live and recorded), singing (individual and group), and song choice are suggested to adapt to use for Thai patients, it will have a positive effect on the physical area. According to the result of this study, instrument playing, music listening (live and recorded), singing (individual and group), and song choice are suggested to adapt to use for Thai patients, it will have a positive effect on the physical area. Besides, listening and singing are not too bizarre for Thai culture, even the playing of musical instrument, those musical instruments especially the un-pitch instrument such as shaker, drum, and tambourine.

Physiological part is about the awareness of dying and acceptance ,these are the two factor that nurses and Buddhist have on concerns, but It is noteworthy that relief from the psychological problem, Depression, anxiety, isolation are that which nurse and physician focused may involve with two primary outcome as mention above, which are awareness of dying, and its acceptance, Because depression, anxiety, isolation are reflexive symptoms that causing the patient who are trying to accept and ready to be aware of death. This analyzes is trying to prove that healthcare providers, especially the physician, may be concern on psychological, and spiritual through providing the best clinical practice. According to the result of this study, songwriting, song lyrics interpretation or analysis, music assisted counseling; and song parody may be provided in the psychological need because the primary goal of those interventions are aimed to manage psychological symptom. Songwriting is ranked at the second level in this study, and were used in palliative care patient with cancer, Songwriting is an intervention that has the procedure based on music therapy principle and practice, Thai people may not be familiar with counseling. Music assisted counseling is the use of therapeutic function of music aimed at clinical result that may be seen in psychotherapy session as *Music in Therapy* and it is not music therapy. In addition, songwriting will be mentioned in the peak experience part, but does not have any role in the level of music as therapy, its closer to music as communication and social interaction level.

Being Surrounded by family and love one are issue in a social area that nurse, Buddhist, and Christian are the concern with It seems not complicated for the patient to have family around them, but what did they do while they have valuable time, and its limit is an essential thing to consider Thus several music therapy interventions could answer the question of valuable and limited time. Music therapy group song singing combine with playing percussion instrument is easy for everyone and it has more benefit.

Spirituality is one very sensitive area especially from the religious perspective and nurse as shown in this study but the result did not find any mention on physician on this topic, There is a different element of good death in spirituality area among nurse and each religion but, has same element was shared between Buddhist and Islam as live with good life and/or follow the religion‘s principle, Buddhist is the group who’s most concern on spiritual area including hope, readiness and preparation for death (mind), peace of mind, understanding of death, live with good life and/or following religion’s principle, and death with awareness, It is Noticed that Buddhist seems serious and concern about the stage of mind in dying process thus it has several interventions in music therapy use to support spiritualties such as improvisation in instrument playing and improvisation, songwriting, music reminiscence, and music meditation.

The intervention that seems to be appropriate to adapt for use with Thai palliative care patient with cancer is a Music-meditated imagery or Music-Meditated active because 94.6% of Thai populations are Buddhist (Official Statistic Thailand, 2014) and meditation is a general practice for Buddhist. The purpose of life for Buddhist is nirvana, freedom from the endless cycle of personal Reincarnations (Wikipedia, 2016). The Reincarnations define as the philosophical or religious concept that an aspect of a living being starts a new life in a different physical body or form after each biological death. It is also called rebirth or transmigration and is a part of the Saṃsāra doctrine of cyclic existence (Wikipedia, 2016). Buddhism has been mentioned into almost every Thai palliative care manual for example, *Nurse: Being with the Dying,* the nurse' manual for end-of-life practice produce by Thonhprateep, king Chulalongkorn university press show that Thai Buddhist believed that some kinds of illness is the result of Karma and cancer was accused as suspect because of

diagnosed, and progression that could not be predict and could not be detected until it occurs in the last stage in metastatic. For some sect, of the Thai Buddhist, Music and music therapy is not usually used in some situation and music is not permitted to be provided because the music was specified as nauseate or restless.

Stated by religion, art, music, poetry writing of Buddhadasa Bhikkhu (2004) *"Music has the power to enhance and to press passion, do not fall into its trap even chant"* as same as in compliance for ordained that has pledged as *"priest(monk) do not entertain themselves with singing, listen, dance or sing and play music or any other kind of entertainments"* So music is a taboo for Buddhist practice, but not so in this century because music or music elements such as melody, dynamic, rhythm are contained in chanting and provided in several occasion in Buddhist rites and ceremonies such as psalm, litany, and meditation. Awareness of self throughout dying is the element of good death which is found only in Buddhism. Mention by Chalat Vorayanyong, Thai Music therapist since 2009 now working as a professional music therapist in Germany. Vorayanyong has suggested music and mindfulness intervention to present a valuable of the use of music adapting to Thai Buddhism through conversation between his friend, Kim, and an Australia monk who was ordain to Buddhism of Thailand, are as following:

Kim: The use of music to facilitate mindfulness that chalet did is accordance Buddhism principle?

Monk: It is not the middle path, but can help with calming, after calming it helps with the sense of more humanity and ready to practice the dharma

Vorayanyong got inspiration for his master degree research from this particular conversation, which is Mindfulness, and Music Therapy. In addition, he suggests that music may not be appropriate for the initial, medium, and high level of mindfulness but it is appropriate for people who have a psychological problem such as distracted, confused, depression, stress, anxiety until it effects their life. The use of music in this case seems to be like preparing for complete mindfulness (Vorayanyong, 2015).

This is an example of the use of music relating to Buddhist practice to step closer to dying process and should be adapted appropriately for the medical setting. A music therapist may be starting with support of clinical care with others healthcare

providers. In addition, bereavement care is a goal in palliative care patient especially near time of death. Bereavement is the state or fact of being bereaved or deprived of something or someone that a sorrow feeling or grief will occur at this stage. Mention by The Scottish Government, Edinburgh 2008 presented the better concept of bereavement care in palliative care as show at the Figure 5. 1 as following (The Scottish Government, 2008)

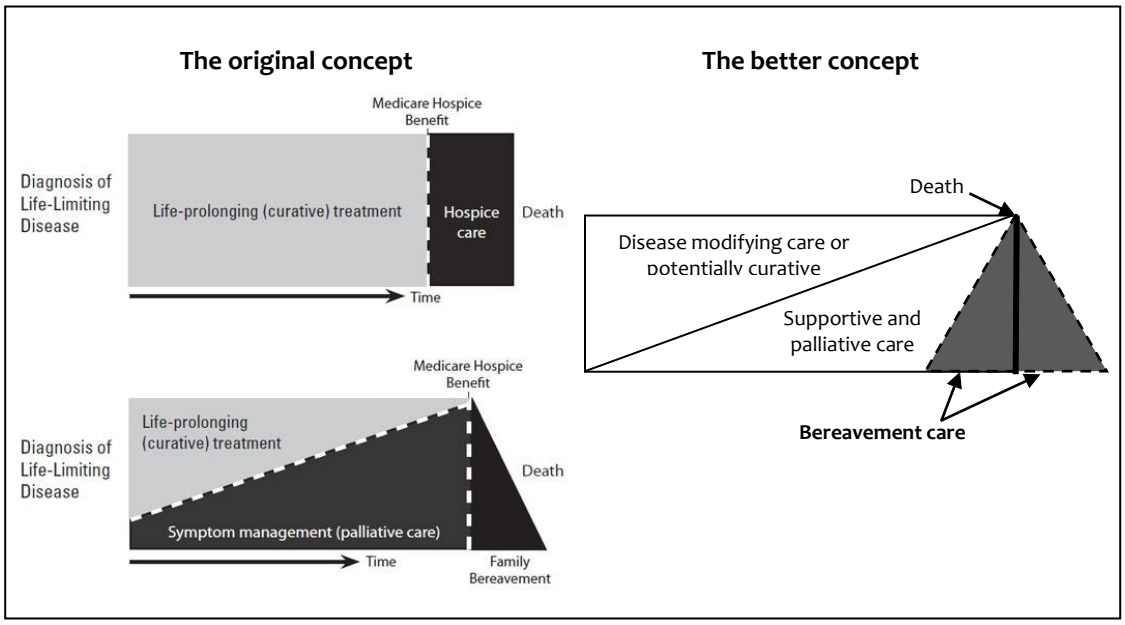


Figure 5.1 The better concept of bereavement care (The Scottish Government, 2008)

Patient and family in palliative care usually go through the stage of Grief especially near time of death. What are needs of patient in palliative care? According to literature review shows that most palliative care patient with cancer needs are, to improve the optimum quality of life while they're alive. Despite this the quality of life has various minor attribute and is an individual perspective in finally. Patient and family in palliative care usually go through Grief especially near time of death. What are needs of patient in palliative care? According to literature review shows that most palliative care patient with cancer needs are, to improve the optimum quality of life while they're alive, Despite the quality of life has various minor attitude and is an individual perspective in finally. The hidden purpose of this research is trying to discover the gap between healthcare provider perspective and patient with or without their families while collected and analyzed literature aims to search for appropriate

music therapy intervention to fit in the gap and to answer the research question. The anticipatory grief seems to be good enough theory used to explain what patient, family, and healthcare provider have to encounter.

Death always leads to grief and bereavement to the family who loses their love ones, The Anticipatory Grief or 5 stages of grief is sadness that would happen before real losing and end, when the expected losing occur, thus the sadness will be reducing by time (Coombs, 2010). The word grief is translated from the old French word "grave" meaning a heavy burden. A physician, Olasinde, stated that grief is the psychological and emotional reactions to the loss of someone or something dear to you (Olasinde, 2012). The process of losing occur on physical, thought, emotional, and psychosocial and the process always changes, switching from stage to stage lifelong, for helping human to go through grief of losing, sadness, and bereavement (Farrell & Bunyan, 2012).

Everyone who is losing have to face with the grief, Not only family members or caretaker and patients themselves, but also multidisciplinary team such a physician, nurse, and music therapist. Grief is divided into two type, normal grief, and pathological grief or complicate grief. Normal grief is the reaction of emotion, psychological, and behavioral of losing, such as sadness, and crying thus the word grief in this situation may be called bereavement reaction or bereavement process that has 3 stages include (1) numbness, shock, disbelief, and denial occur around 2-3 hours in this stage followed by (2) Depression syndrome, person who encounter with depression will stay with this stage around 2-3 weeks and usually sadness, crying, insomnia, eating problem, and unstable routine, but not too long more than 6 months. (3) Recovery stage, people will have to accept with losing and prepare themselves to normal life (Pirapol, 2007). Pathological grief or Complicate grief is abnormal emotional expression in time period and spectrum such as, withdrawing, even though losing or on the other hand overwhelming expression, includes: (1) prolong grief 6-12 months, (2) hypertrophic grief leading to depression disorder, and anxiety, (3) delayed grief does not show emotional expression to losing or mood disturbance in 2 weeks, (4) unresolved grief, and (5) traumatic stress disorder (Khongthong, 2013).

Mention by Elisabeth Kübler-Ross (1969, 2003) who developed Anticipatory grief or 5 stage of grief based on experiment with over two hundred

terminally ill patients, the reaction to grief speared in 5 stage consists of (1) denial and isolation, (2) anger, (3) bargaining, (4) depression, and (5) acceptance, presented the progression of states as following:

1. Denial is a temporary defense for human and it has different action among each individual, it refers to the capacity to acceptance of fact which is a natural perfectly of human defense mechanism thus people may shock and isolate. Some question such as “I’m fine”, “This can't be happening, not to me”, “No, it’s not true.” or “I don’t believe it” may appear in this stage thus isolation was a result of denial.

2. Anger is an inevitable part of grief or the substituting stage of denial, people at the anger stage may possibly be angry with themselves or with others and irrational.

3. Bargaining is the normal reaction because of helplessness and vulnerability feeling, people may negotiate with a higher power such as God to protect themselves from the painful reality.

4. Depression is a reaction to practical implications relating to the loss refer to pre-acceptance or accepting of the reality, People would be feeling sad, regret, fear, uncertainty and understand their situation in this stage.

5. Acceptance is the last stage of grief, sadness and hopeless may be present at this time. The reaction depends on the individual situation and each of their personalities.

Most palliative care patients will encounter with these statuses and feel from the denial to the acceptance, on the other hand, some patients have to face with these griefs alone without their families or their loved one so they have to deal with the death by themselves. In addition, Sánchez (2007) presented the Dying Stages Model of Kübler-Ross in visual as figure 5.2 Kübler-Ross Dying Stages Model.

In addition, when patient knows their timeline of survivor they might have 3 New stage of dying as (1) Stage of Facing the threat, the first stage when patient has received bad news from physician report patients tend to denial, depressed, ridicule, or fictitious accept dying; (2) Being ill stage, various mood, emotion, and feeling confused occur in this stage, sleep and breathing problems, more depressed, reliance on others; and (3) Last stage, physical degeneration appears clearly such as change in breathing, fluid and food decrease, Withdrawal, trying to say goodbye, doing pleased

things, Gasping breathing and no awakening in the last minutes (Crossroads Hospice, 2016).

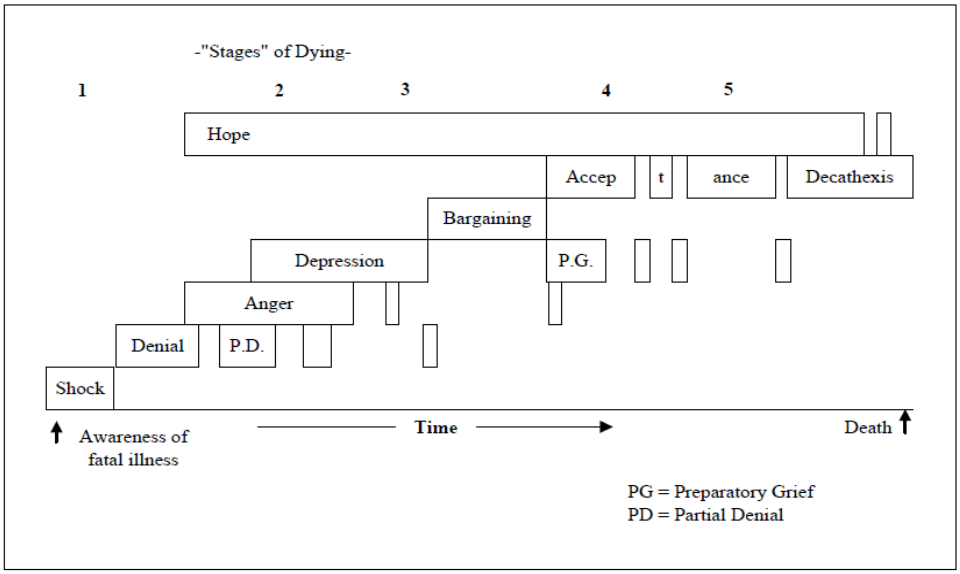


Figure 5.2 Kübler-Ross Dying Stages Model (Kübler-Ross, 1969)

Every moment as above happen with patients who have to walk through dying process. Mention to Phra Pisan Visalo (2010) followed Buddhism principle *"No one can't bring anything with them when death occurs, only merit and demerit to hereafter"* Phra Pisan Visalo record in the books " A remind to death" (translated into English by researcher).

Music therapy as songwriting can provide the opportunity to express complex feeling as share important insight and feeling is not death in bereavement care to help a patient and their family walk through grief (Heath & Lings, 2012). In addition, Chanting has the power to improve spirituality. Buddhism, Christian, and Islam are having a chanting for a different purpose and it usually for prayer. Mention by Renz, Schutt Mao, and Cerny (2005), music-meditated imagination used to support spiritual in the study with 251 palliative care cancer patient who has different religious respect, Protestant, Catholic, Muslim, Orthodox, Atheist, Buddhists, and Hindus in Switzerland.

Those music therapy interventions seem to be easy to provided by everyone who has good enough musical skill but, why music therapy need to be done by a trained music therapist. In terms of recommendation will give more detail.

5.2 Recommendation

Recommendation is presented with music therapy clinical process, reason for referral, ISO principle, Therapeutic Function of Music (TFM) (music therapy principle), and assessment tools aim to guide music therapy program for palliative care patient with cancer in hospital setting to increase quality of death.

5.2.1 Clinical process

Referral is the first gate that makes patient meets with the music therapist. Music therapy clinical process has 4 step as (1) referral, (2) assessment, (3) treatment, and (4) evaluation, these all process has a minor detail

1. Referral means to music therapist as referred patient from other healthcare provider and some situation may come from visiting patients and by the physician or other healthcare provider' s suggestion. The music therapist will get patient primary information from medical history chart and/or another report, reading the document carefully is the responsibility of therapist.

2. Assessment has three primary types, first initial assessment should be completed prior to starting treatment to find personal ability, needs, strengths, and weakness to formulate treatment goals. Patient' domains that music therapist should have assessed including non-musical domain, physical, psychological, communication, cognitive, social, and also musical domain, musical skill, music preference, and response to music. All domains can assess through music therapy assessment session, by reading patient documentation from medical team or observed from other treatment (Choen & Gerice, 1972; Lipe, 2001; Punwar, 1988). Second, the comprehensive assessment will be completed when patient is referred for music therapy service only and the third assessment is ongoing assessment is track functional levels and progress through the treatment process (Douglass, 2006; Gfeller, Davis, 2008).

3. Treatment will follow treatment plan composed by treatment goals, receive from assessment, objectives, interventions, and ongoing assessment.

4. Evaluation is the result of treatment music therapist have reported after the last session is done and progression note is one of an evaluation report.

According to four step of music therapy clinical process is not a complicated model at the beginning till the end from hospital setting in Thailand, but need the introduction to other healthcare providers and essential information is music therapy process and its benefit associated patient treatment goals.

5.2.2 Reason for music therapy referral in palliative care

Refer by Wlodarczyk (2007, 2014) suggest the reason music therapy referral in palliative and end-of-life care (EOL) in hospital in Medical Music Therapy: Budding a Comprehensive Program in hospital report the effectiveness of music therapy for palliative care and EOL that music therapy has shown effective in reducing perception of pain and improve physical comfort, improving mood, reducing fatigue, facilitate relaxation, increasing self-expression, and performing spiritual well-being (Belgrave et al. , 2001; Hilliard, 2005a, 2005b; O' Kelly, 2007; Wlodarczyk,2014) . Multidimensional symptoms usually occur with palliative and EOL patient, are categorize into three goals area, physical, psychological, and spiritual, a music therapist may have a referral in the different objective The reason for referral to music therapy will be as following:

Physical goals: Mention to the result in this study, pain is the main key of physical symptom for a cancer patient, that may cause other problems. In physical area patient with cancer may encounter with pain, discomfort, nausea, vomiting, also anxiety and agitation that are the component of shortness breathing, heart palpitations, restlessness, and insomnis (Wlodarczyk, 2014). Common reasons referral was decreased the perception of pain, decreased discomfort, and increase relaxation (DiMaio, 2000; Groen, 2007; (Hilliard,2002, 2005a, 2005b; O'Callaghan, 1996b).

Psychological goals: Grief is one of psychological condition that patient and their family must encounter and music therapy can provide help them go through and support each stage of grief.

Spiritual goals: It is normally for palliative care and EOL patient to usually explore the meaning of life and wonder about the moment of death increase spiritual support through music, opportunities for worship, and opportunities for spiritual expression (Belgrave et al. , 2001; Foxglove & Tyas, 2000; Wlodarczyk, 2007).

5.2.3 ISO principle and Therapeutic Function of Music

The purpose of this part is aim to explain why those music therapy interventions were shows above can support good death in palliative care patient with cancer trough music therapy theory and principle consist with (1) ISO principle, and (2) Therapeutic Function of Music (TFM), as following.

1. ISO principle: ISO means to "equal" designed to matching music with individual ability, mood, emotional behavior in personal stage or level. The music and its elements must appropriate with therapeutic situation dependent to the particular need of an individual. The element of music such as tempo, volume, duration, have to match with individual at that time and purpose of treatment as (1) need for rehabilitation to develop skills that are needed but not already at the present; (2) need for rehabilitation to reestablish lost skill or to replace old skills; and (3) needs for therapy aim to change behaviors on more immediate basis to provide relief for troubling condition (Michel & Pinson, 2005).

2. Therapeutic Function of Music: Therapeutic Function of Music (TFM) is *"the direct relationship between the treatment goal and the explicit characteristics of musical elements, informed by a theoretical framework and/or philosophical paradigm in the context of a client"* developed by Dr. Deanna Hanson-Abromeit (Hanson-Abromeit, 2013). TFM consist of Musical elements, Theoretical Framework, Purpose of the musical element, and Explicit description of the musical element that has benefit for music therapists as guide the using of music appropriately for an individual needs and also guide to create music therapy interventions (SenaMoore & Hanson-Abromeit, 2015). Table 5.1 try to explain the attribute of the musical element consisting of timbre, rhythm, tempo, pitch, melody, phrasing, dynamic, lyrics, form, harmony, and style, that relates to beneficial used in music therapy. Each musical elements have their own attribute use to make music and use in music therapy that will explain in table 5.1.

Therapeutic function of music, and ISO principle have been mentioned in the research in this study because of these are an important principle that a trained music therapist has to use them to created music therapy intervention and build a therapeutic relationship with the patient.

Table 5.1 Attribute of Musical elements and Music Therapy

Musical Elements	Attribute	Music therapy
Timbre (or sound color)	The tone quality of the music, the different sound made by the instruments used.	Sound color Creates a rich musical product and complexity; Cooperative element
Rhythm	The effect created by combining a variety of notes with different durations. Consider syncopation, cross rhythms, polyrhythm' s, duplets and triplets.	Provide structure; Steady beat, pulse for movement; Synchronizes area of brain responsible for motor control with physician movement (entertainment)
Tempo	The speed of the music	Prompt response according to whether the music is simulative or seductive
Pitch	Register (high or low keys)	Indicate direction; supports contour of physical movement or vocal strength; facilitate communication, indicates articulation and inflection; words paired with melody carry the message
Melody	The effect created by combining a variety of notes of different pitches.	
Phrasing	Grouping of consecutive melodic notes	
Dynamic	Loud or soft of sound	Indicates force of task; in communication indicates voice inflection and syllabic emphasis; used to cue attention, start or stop.
Lyrics	Words	Enhance the message, communicating; express felling
Form	Binary, ternary, strophic, through-composed	Provide structure; facilitate turn and tacking and support practice of sustained, selective, and divided attention; provides practice for sequencing and multi-step direction
Harmony	Chord, progression, consonance, dissonance, key, tonality, atonality)	Consonance and dissonance used to support improvisation and crest/release tension; creates a rich musical product; support expression and contribute to form Major Key = happiness, Minor Key=sad or angry; used to practice alternating attention functions of sustained, selective, and divided attention.
Style	A kind of music such as pop, jazz, country.	Increase dopamine and support felling

5.2.4 Designed music therapy assessment tools

Any information from hospital medical can initiate the review before the visit to patients, medical record, basic demographic information, recent medical history, physical limitation, psychological status, communication limitation, and other assessment from others healthcare providers. According to Bruscia (1999), the proposed of music therapy assessment is the assessing to linked with objectives relating either to diagnosis, description, interpretation, prescription or evaluation (Wigram, 2007) . Magill (2001) presented in the study as music therapists must, therefore, perform comprehensive assessment which includes a close view of patient's social, culture, and medical history, current medical status, and the way in which

emotional are affecting the pain (Magill, 2001). Moreover, this undertaken aim to prescribe music therapy course and identifying the reason why the patient should use music therapy intervention. To identify the domain for assessment appropriate with patient music therapist must be aware in all information of all source as Bruscia suggest a comprehensive list of assessment domains in table 5.2 as following:

Table 5.2 The domains of assessment in music therapy

Domain	Focus of Assessment
Biographical	All those forms of data relating to the client's past
Physical/Medical	Physical Measures
Behavioral	All aspects of behavior
Functional	Assessment of functional skills
Developmental	Where is the client in their growth pattern their development stage
Musical	How does the client relate to music
Experiential	What is the client's perception, philosophy of life and
Interpersonal	The intermusical and interpersonal relationship between the

In addition, because of several music therapy assessment tools have been created for a specific population mention Layman and other (2002) Tony Wigram casually suggest a useful and clear overview of the varieties of music therapy assessments to guided music therapy assessment tools created (Voice: A World Forum for Music Therapy, 2011; Wigram, Pedenrsen, & Bonde, 2002). Music therapy assessment are separated in to three parts followed Hanser (1999): first, Initial Assessment aim to find treatment goal was performed at the beginning; second part is Comprehensive Assessment which was used when patient is referred to music therapy session only; third, On-going Assessment is the systematic observation assessment usually used pre-, midland post-treatment to observation appropriate technique is most suitable for patient (Hanser, 1999; Wigram, 2007). Table 5.3 shows the overview of the varieties of music therapy assessments model guided to designed music therapy assessment tools.

For cancer patient, music therapist may use varying assessment modalities Down McDougal Miller and Clare O' Callaghan suggest three methods to approach with cancer patient as following: (1) patient and therapist both have awareness of needs that they feel or may came from referral from other health care providers; (2)

Music therapist may feel about patient needs through medical team meeting or reading patient medical document; and (3) therapist has no pre-existing knowledge of patient (Miller & O'Callaghan, 2010).

Table 5.3 Overview of the varieties of music therapy assessments model

Purpose	Function
Diagnostic assessment	To obtain evidence to support a diagnostic hypothesis
General assessment of client	To identify the general needs of the client from a holistic perspective and recommend relevant intervention
Assessment of music therapy intervention	To obtain evidence supporting the value of music therapy as an intervention
Initial; Assessment prior to treatment	To determine in the first two-three session a therapeutic intervention relevant to the client.
Long Term Music Therapy assessment; Assessment of effectiveness of treatment	To evaluate over time the effectiveness of music therapy

5.2.5 Good death assessment tool

How to measure the quality of death? It is a question hard to find its domains The Quality of Dying and Death Questionnaire (QODD), publish and used in two stage at the begin as Oregon since 1997 (The Oregon Death with Dignity Act (ODDA) 3 allows a patient to request a lethal dose of medication from a physician for the purposes of self-administration) and developed by University of Washington since 2009, seem to be one of iota tools use to assess the quality of death after that (Smith, Goy, Harvath, and Ganzini, 2001).

Mention by Engelberg (2006) and Steinhauser (2000), through the study of quality of death and dying in patients who request physician-assisted death, produce by Smith, and other (2001), the quality of death and dying is comprised of a variety of elements including symptom management, treatment in accord with patient wishes, psychological health, spiritual and existential well-being, social support, and the experience of death (Engelberg, 2006; Steinhauser, 2000; Smith, Goy, Harvath, and Ganzini, 2001).

Downey and Herting (2009) presented that QODD is a 31-items questionnaire to suggest approaches for conceptualizing the " good death" and may assist in interpreting patterns arising in empirical data, the scale rating is from 0-100

(the higher score indicate the better quality than lower score (Curtis & et al, 2002)) done by family, caretaker, or others health care providers by observed or asking from patients. The study designed by interviewing three samples of decedents who died in a different place and period of time and the result shows that the QODD might benefit from the use of composite measures representing the four identified domains, Symptom Control, Preparation of Death, Connectedness, and Transcendence, that adapted from 31-iteams with six domains include Symptoms and Personal Control (6 items), Preparation for Death (10 items), Moment of Death (3 items), Family (5 items), Treatment Preferences (3 items), and Whole Person Concerns (4 items) adapt to 17-items but that future expansion and modification of the questionnaire are in order (Downey, and Herting 2009). Halesis and others (2010) also study about QODD.

The goals of the study were to identify the quality of dying and death measurement tools and to determine their quality and the result shows that QODD was best validated and the most widely studied and used (Hales, Zimmermann, & Rodin, 2010).

To construct a model of latent variable fundamental domains of the 17-items Quality of Dying and Death (QODD) questionnaire Downey, and others used exploratory factor analysis within the confirmatory analysis framework and data provided by 205 family members and friends of decedents in Missoula, Montana. The result was analyzed QODD was a single global quality measure of dying and death and suggest QODD needs provide insufficient evidence for guiding clinical practice, evaluating interventions to improve the quality of care, or assessing the status or trajectory of individual patients (Downey, Curtis, Lafferty, Herting, & Engelberg, 2010). The study of quality of death in bereaved caretaker's perspective presented, the 31-items of QODD were studied to increase the interpretability of quality of dying and death measures, and to measure the quality of dying and death in advanced cancer patients and the result shows that to evaluated the quality of death and dying multiple different perspectives and standards of comparison should be a fundamental. family is also an important target of dying process, and rated moreover 99.8% (N= 402) of family or caregiver in the study (Hales, 2015). In addition, QODD were translated to Thai version by Jutarat Mesukko (2010), nurse, but for the pediatric patient (Mesukko, 2010).

In conclusion, the 31-items of QODD were studied approved validity and reliability thus QODD reliability and validity enough to measure the quality of death (Curtis, Patrick, Engelberg, Norris, Asp, & Byock, 2002; Patrick, Engelberg, Curtis, 2001).

Quality of Death and Dying (QODD) designed to assess the quality of care done by healthcare providers was rated from observation consisting of six domains separate into three parts, level has 0-100 came from total point of 10 questions at first part while the second and third part consists with YES/NO question with rating scale. Downey and another grouping all questions into six domains as table 5.4.

Table 5.4 Six domains in Quality of Death and Dying (QODD)

Domains	**Questions**
SYMPTOMS AND PERSONAL CONTROL	Pain under control Control over what was going on Ability to feed him/herself Control of bladder and bowels Breathing comfort Sufficient energy
PREPARATION FOR DEATH	At peace with dying Unafraid of dying Untroubled about strain on loved ones Healthcare costs covered Spiritual advisor visits Spiritual ceremony before death Funeral arrangements in order Goodbyes said Attendance at important events Bad feelings cleared up
MOMENT OF DEATH	Place of death Having others present at time of death State of consciousness in moment before death
FAMILY	Time with spouse/partner Time with children Time with other family/friends Time alone Time with pets
TREATMENT PREFERENCES	End-of-life care discussions with doctor Means to hasten death, if needed Use or avoidance of life support
WHOLE PERSON CONCERNS	Ability to laugh and smile Physical expressions of affection Meaning and purpose in life

According to the domains in table 5.4, based to design the quality of death and dying in Thai version and also transform its name to Quality of Death and Dying Thai version (QODD-TH). All domains will fit into this Thai version questionnaire and reform appropriate to Thai populations. QODD-TH separate into four part include (1) Information of patient and informant, (2) informant' experience from patient, (3) patient's reaction, and (4) the quality of the moment of death thus all information will rate from informant's perspective.

Part 1 information of patient and informant, consist of patient' part, informant has to be filled with patient' s name, sex, age, HN number diagnoses, and ward, and informant part include informant' s name, position or relationship with patient, date and time of assessing, and a number of assessment. In part 2, informant' experience from patient, were added Visual Analogue Scale (VAS) into channel on the top of number to facilitate feeling expression that reflexes from situations from excellence to terrible by circle around number 10 to 0 under the condition in table 5.5.

The quality of this part will summarize by the sum of all rating from 19-items, 190 points. The point separate into six groups as 190 - 160 = Excellence, 159 - 130 = Good, 129 - 100 = Good enough, 99-70 = Not good enough, 69- 40 = A quite bad, below 39 = Bad, but those rating is not enough to decide absolutely if patient already has good death or not because this part is designed to predict the quality of death and also for care planning.

Table 5.5 Explanations of rating scale

Rating	Explanations	Rating	Explanations
10	Excellence	5	Not good enough
9	Very good	4	A quite bad
8	Good	3	Bad
7	Good enough	2	Not good at all
6	A quite good	1	Poor
		0	Terrible

Part 3, patient's reaction, aims to observe patient's reaction while admitted in palliative care unit to assess psychological needs need and timeline include refuse dispatches life or CPR, refuse respirator, refuse medicine induction to reduce pain,

request for active Euthanasia, receive appropriate information about illness from physician or healthcare providers, and also added suggestion section in this part for giving other information patients reaction The 4th part is the quality of moment of death will be assessing only after patient dies with peaceful death, awareness of self while dying, unafraid of dying, having family or others at time of death, good bye side/ give parting instructions/ without burden concern, death in peaceful and pleased environment, receive dignity throughout dying process, receive spirituality support.

All ratings from the 2nd part to 3rd part will be summarized to find appropriate care for the patient while the sum of all rating is for assessing good death. 203 is the maximum rate for QODD-TH but if some domains report as Non-available or Don't know those point will be cut off from the sum. Rating explanation will be as following: 203 - 169 = Good death, 168 – 135 = Good enough death, 134-101 = A quite good death, 100-67 = Not good enough death, 66- 33 = Not good death, below 32 = Unpleased death. QODD-THAT don't have 'bad death' the reason is the dignity of humanity because everyone deserved good death in any way, anyhow, the death and the word bad death is never pleased to their family and anyone who love them. QODD-TH version will have presented in Appendix E.

5.3 Future research

This research aims to make aware of the relationship between music and good death and collated music therapy intervention as a guideline for the future research should be concentrating at near to dying process, the purpose is to know the step to what good death in dying process because each religion mentions the stage of mind at the last moment to be very important they believe in life after death and life in the future world. The recommendation is future research should have designed by reviewing this suggestion as following:

1. Music therapy process to support good death or dying process, and bereavement.

2. Analyze music interventions in process and/or the effect in end-of-life care patient to support good death.

3. Selecting music therapy intervention in this research use to design experimental research.

4. Thai culture and the use of music therapy in End-of-Life care.

5. Music therapy and good death from patent's perspective.

In addition, the researchers found some research gaps through this study as the process of music therapy intervention, such as doing plan, designing of therapeutic function of music, ongoing assessment, and music therapists reaction to the patient or therapeutic response between therapists and patient.

The culture and medical in Thailand are not familiar with the use of music therapy even though they may have studied about music in/as cure that usually uses pre-recorded music as a primary intervention but it is not music therapy or music as therapy yet it is close to music in therapy. Moreover, the use of music therapy in clinical setting is always based on an evidence-based thus the power of music should be proving by empirical research. The culture is the mains key for study; Music therapy in the clinical setting has been proved an evidence-base in several countries in worldwide in a different clinical performance with each population. Thai population needs an evidence-base to prove how music therapy works with them in every kind of patient, i.e. children, adult, stroke patient, music therapy in Operative, psychiatric, pediatric. Death is the true thing that everyone will meet at the end of life not only cancer patient but also everyone, same as the quality of life which is important too so future research of music therapy in the clinical setting in Thailand relate to palliative care patient should be related to the quality of life associated with dying process support.

In conclusion, a good death is not a new concept in medical, but it is the concept that may not get enough concern especially in psychological and spiritual areas from healthcare providers. The reason why music therapy is not widely implement in the process of good death, besides a lack of professionally trained music therapists, and lack of the clinical evidence-base. Thus the future research is appropriate to support and continue this research and should be concentrating with quality of life and dying process for searching what real patient need or good death in their perspective.

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APPENDICES

APPENDIX A

PALLIATIVE PERFORMANCE SCALE (PPS)

%	Ambulation	Activity and Evidence of Disease	Self-Care	Intake	Conscious Level
100	Full	Normal Activity No Evidence of Disease	Full	Normal	Full
90	Full	Normal Activity Some Evidence of Disease	Full	Normal	Full
80	Full	Normal Activity with Effort Some Evidence of Disease	Full	Normal or Reduced	Full
70	Reduced	Unable Normal Job / Work Some Evidence of Disease	Full	Normal or Reduced	Full
60	Reduced	Unable Hobby / House Work Significant Disease	Occasional Assistance Necessary	Normal or Reduced	Full or Confusion
50	Mainly Sit/Lie	Unable to Do Any Work Extensive Disease	Considerable Assistance Necessary	Normal or Reduced	Full or Confusion
40	Mainly in Bed	As Above	Mainly Assistance	Norma or Reduced	Full or Drowsy or Confusion
30	Totally Bed Bound	As Above	Total Care	Reduced	Full or Drowsy or Confusion
20	As Above	As Above	Total Care	Minimal Sips	Full or Drowsy or Confusion
10	As Above	As Above	Total Care	Mouth Care Only	Drowsy or Coma
0	Death	-	-	-	-

APPENDIX B

การแบ่งระดับผู้ป่วยที่ได้รับการดูแลแบบประคับประคอง
(Palliative Performance scale version 2: PPS v2)

ระดับ PPS	การเคลื่อนไหว	การปฏิบัติกิจกรรมและการดำเนินโรค	การดูแลตนเอง	การรับประทานอาหาร	ระดับความรู้สึกตัว
100 %	เคลื่อนไหวปกติ	ทำกิจกรรมและทำงานได้ตามปกติ ไม่มีอาการของโรค	ทำได้เอง	ปกติ	รู้สึกตัวดี
90 %	เคลื่อนไหวปกติ	ทำกิจกรรมและทำงานได้ตามปกติ มีอาการของโรคบางอาการ	ทำได้เอง	ปกติ	รู้สึกตัวดี
80%	เคลื่อนไหวปกติ	ต้องออกแรงอย่างมากในการทำกิจกรรมตามปกติ มีอาการของโรคบางอาการ	ทำได้เอง	ปกติ หรือ ลดลง	รู้สึกตัวดี
70 %	ความสามารถในการเคลื่อนไหวลดลง	ไม่สามารถทำงานได้ตามปกติ มีอาการของโรคอย่างมาก	ทำได้เอง	ปกติ หรือ ลดลง	รู้สึกตัวดี
60 %	ความสามารถในการเคลื่อนไหวลดลง	ไม่สามารถทำงานอดิเรก/งานบ้านได้ มีอาการของโรคอย่างมาก	ต้องการความช่วยเหลือเป็นครั้งคราว	ปกติ หรือ ลดลง	รู้สึกตัวดี หรือ สับสน
50 %	นั่ง/นอน เป็นส่วนใหญ่	ไม่สามารถทำงานได้เลย มีการลุกลามของโรคมากขึ้น	ต้องการความช่วยเหลือในการปฏิบัติกิจกรรมบางอย่าง	ปกติ หรือ ลดลง	รู้สึกตัวดี หรือ สับสน
40 %	นอนอยู่บนเตียงเป็นส่วนใหญ่	ทำกิจกรรมได้น้อยมาก มีการลุกลามของโรคมากขึ้น	ต้องการความช่วยเหลือเป็นส่วนใหญ่	ปกติ หรือ ลดลง	รู้สึกตัวดี หรือ ง่วงซึม +/- สับสน
30 %	อยู่บนเตียงตลอดเวลา	ไม่สามารถทำกิจกรรมใดๆ มีการลุกลามของโรคมากขึ้น	ต้องการการดูแลทั้งหมด	ปกติ หรือ ลดลง	รู้สึกตัวดี หรือ ง่วงซึม +/- สับสน
20 %	อยู่บนเตียงตลอดเวลา	ไม่สามารถทำกิจกรรมใดๆ มีการลุกลามของโรคมากขึ้น	ต้องการการดูแลทั้งหมด	จิบน้ำได้เล็กน้อย	รู้สึกตัวดี หรือ ง่วงซึม +/- สับสน
10 %	อยู่บนเตียงตลอดเวลา	ไม่สามารถทำกิจกรรมใดๆ มีการลุกลามของโรคมากขึ้น	ต้องการการดูแลทั้งหมด	รับประทานไม่ได้	ง่วงซึมหรือไม่รู้สึกตัว +/- สับสน
0 %	เสียชีวิต	-	-	-	-

หมายเหตุ +/- หมายถึง อาจมี หรือไม่มีอาการ

APPENDIX C

Edmonton Symptom Assessment System (ESAS)

Please circle the number that best describes.

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst possible pain
No fatigue	0	1	2	3	4	5	6	7	8	9	10	Worst possible fatigue
No nausea	0	1	2	3	4	5	6	7	8	9	10	Worst possible nausea
No depression	0	1	2	3	4	5	6	7	8	9	10	Worst possible depression
No anxiety	0	1	2	3	4	5	6	7	8	9	10	Worst possible anxiety
No drowsiness	0	1	2	3	4	5	6	7	8	9	10	Worst possible drowsiness
No shortness of breath	0	1	2	3	4	5	6	7	8	9	10	Worst possible shortness of breath
Best appetite	0	1	2	3	4	5	6	7	8	9	10	Worst possible appetite
Best feeling of wellbeing	0	1	2	3	4	5	6	7	8	9	10	Worst possible feeling of wellbeing
Other problem	0	1	2	3	4	5	6	7	8	9	10	Worst possible

Patient's Name _____ Complete by *(check one)*

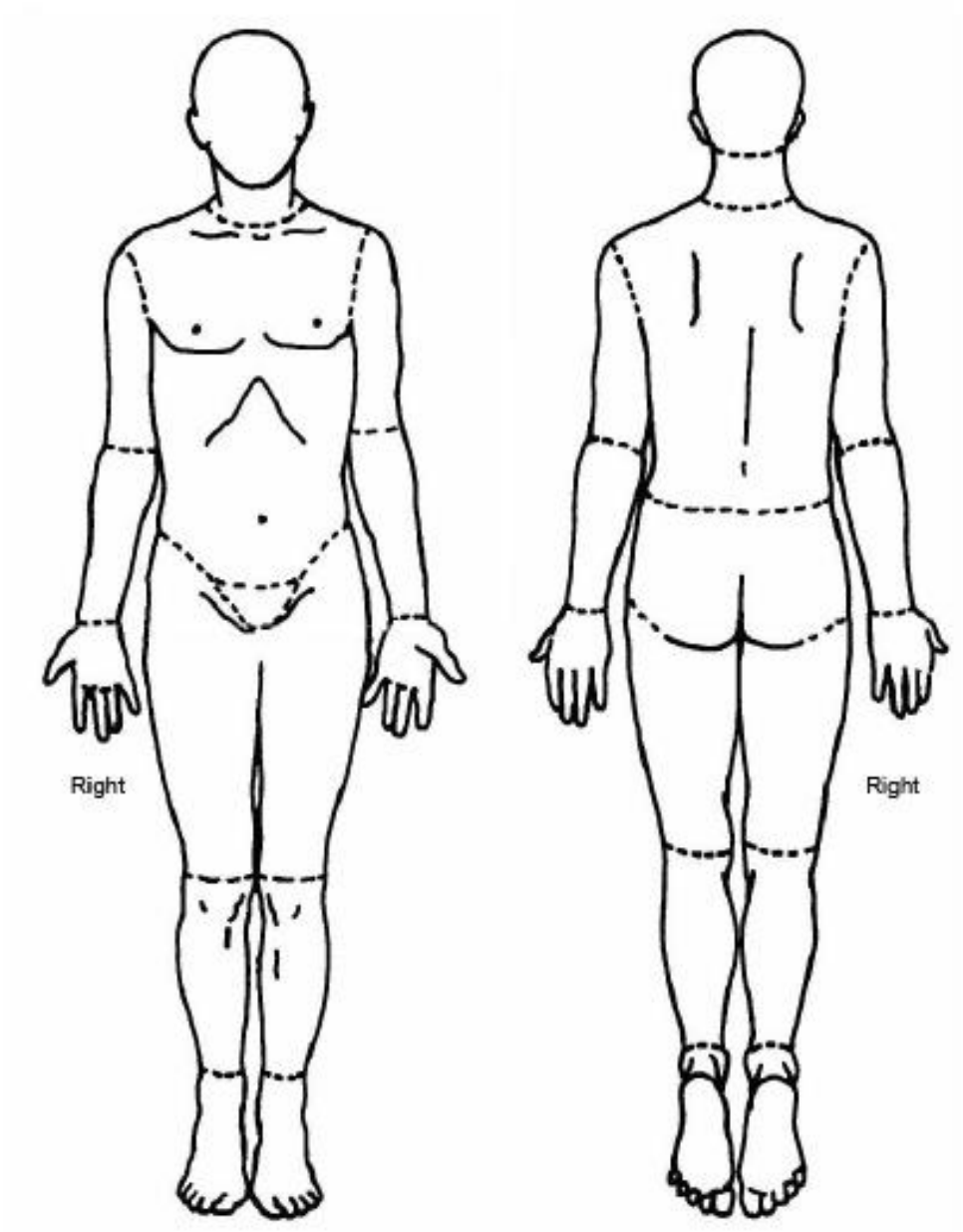
Date _____ Time _____ ☐ Patient

☐ Caregiver

☐ Caregiver assisted

BODY DIAGRAM ON REVERSE SIDE

Please mark on these pictures where it is you hurt.



APPENDIX D

Edmonton Symptom Assessment System (ESAS) ฉบับภาษาไทย

ไม่มีอาการปวด											มีอาการปวดรุนแรงที่สุด
0	1	2	3	4	5	6	7	8	9	10	
ไม่มีการเหนื่อยอ่อนเพลีย											มีอาการเหนื่อย/อ่อนเพลียมากที่สุด
0	1	2	3	4	5	6	7	8	9	10	
ไม่มีอาการคลื่นไส้											มีอาการคลื่นไส้รุนแรงที่สุด
0	1	2	3	4	5	6	7	8	9	10	
ไม่มีอาการซึมเศร้า											มีอาการซึมเศร้ามากที่สุด
0	1	2	3	4	5	6	7	8	9	10	
ไม่วิตกกังวล											วิตกกังวลมากที่สุด
0	1	2	3	4	5	6	7	8	9	10	
ไม่มีอาการง่วงซึม/สะลึมสะลือ											มีอาการง่วงซึม/สะลึมสะลือมากที่สุด
0	1	2	3	4	5	6	7	8	9	10	
ไม่เบื่ออาหาร											เบื่ออาหารมากที่สุด
0	1	2	3	4	5	6	7	8	9	10	
สบายดีทั้งกายและใจ											ไม่สบายกายและใจเลย
0	1	2	3	4	5	6	7	8	9	10	
ไม่มีอาการเหนื่อยหอบ											มีอาการเหนื่อยหอบมากที่สุด
0	1	2	3	4	5	6	7	8	9	10	

ปัญหาอื่นๆ ได้แก่ _____

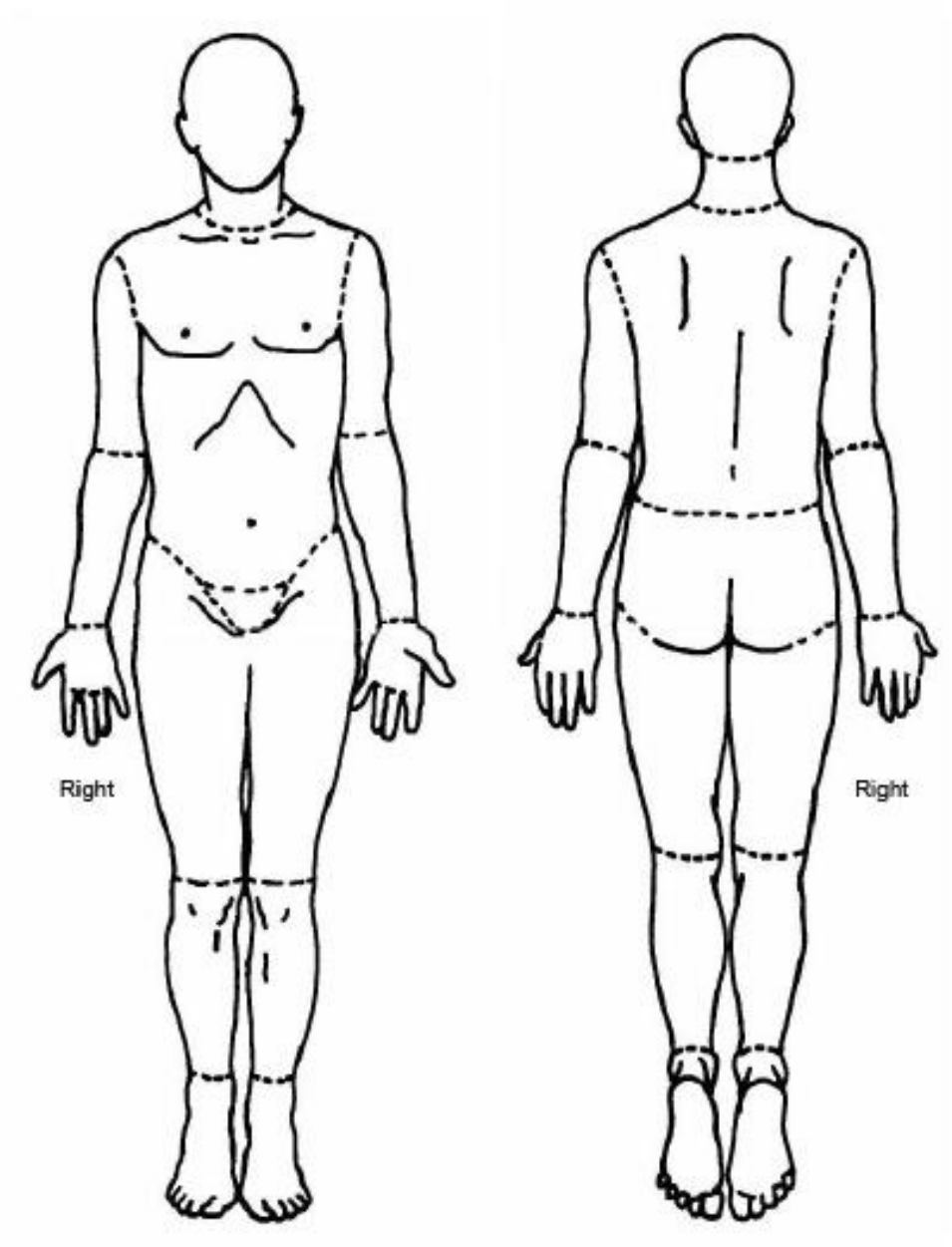
											(ถ้าปัญหาดังกล่าวรุนแรงมาก คะแนน = 10)
0	1	2	3	4	5	6	7	8	9	10	

ชื่อผู้ป่วย_____ ทำโดย ☐ ผู้ป่วย

วันที่ _____ เวลา _____ ☐ ผู้ดูแล

☐ อื่น ๆ ได้แก่_____

กรุณาระบุตำแหน่งที่ปวด



APPENDIX E

QUALITY OF DYING AND DEATH (QODD) IN THE INTENSIVE CARE UNIT – SURVEY FOR NURSES

EXPERIENCES AT THE END OF LIFE

The following questions are about experiences that your patient may have had during the time he/she was in the ICU. Please rate each experience from your perspective, circling a number from 0 to 10. On the rating scale below, 0 = "a terrible experience" and 10 = "an almost perfect experience". If your patient did not have a particular experience, or if you do not know enough to rate it, please check one of the boxes on the right.

	Terrible Experience **Almost Prefect Experience**											Does Not Apply	Don't know
1. Having control of his/her pain	0	1	2	3	4	5	6	7	8	9	10	☐	☐
2. Having control over what was going on around him/her	0	1	2	3	4	5	6	7	8	9	10	☐	☐
3. Breathing comfortably	0	1	2	3	4	5	6	7	8	9	10	☐	☐
4. Keeping his/her dignity and self-respect	0	1	2	3	4	5	6	7	8	9	10	☐	☐
5. Spending time with his/her spouse or partner	0	1	2	3	4	5	6	7	8	9	10	☐	☐
6. Spending time with his/her children	0	1	2	3	4	5	6	7	8	9	10	☐	☐
7. Spending time with other family and friends	0	1	2	3	4	5	6	7	8	9	10	☐	☐
8. Being touched or hugged by loved ones	0	1	2	3	4	5	6	7	8	9	10	☐	☐
9. Having one or more visits from a religious or spiritual advisor	0	1	2	3	4	5	6	7	8	9	10	☐	☐
10. Having a spiritual service or ceremony before his/her death	0	1	2	3	4	5	6	7	8	9	10	☐	☐

EXPERIENCES AT THE MOMENT OF DEATH

The next questions are about your patient's moment of death.

11a. Was anyone, including family, friends or staff, present at the moment of your patient's death? *(Circle one number)*

1 Yes
2 No
3 Don't know **>>>>>>>>>>** *Go to Question 12a.*

b. How would you rate this aspect of your patient's death? *(Circle one number)*

Terrible Experience								**Almost Prefect Experience**		Don't know
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	☐

12a. In the moment before your patient's death, was s/he: *(Circle one number)*

1 Awake
2 Asleep
3 In a coma or unconscious
4 Don't know **>>>>>>>>>>** *Go to Question 13*

b. How would you rate this aspect of your patient's death? *(Circle one number)*

Terrible Experience								**Almost Prefect Experience**		Don't know
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	☐

MEDICAL CARE AT THE END OF LIFE

The following questions are about aspects of medical care that your patient received in the ICU

13a. Did your patient receive mechanical ventilation during his/her stay in the ICU? *(Circle one number)*

1 Yes

2 No

b. How would you rate this aspect of your patient's dying experience? *(Circle one number)*

Terrible Experience										**Almost Prefect Experience**	Don't know
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	☐

14a. Do you think that your patient received the right amount of sedation during his/her stay in the ICU? *(Circle one number)*

1 Yes

2 No

b. How would you rate this aspect of your patient's dying experience? *(Circle one number)*

Terrible Experience										**Almost Prefect Experience**	Don't know
0	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	☐

THANK YOU FOR COMPLETING THIS SURVEY. WE APPRECIATE YOUR HELP.

IF YOU HAVE ANY COMMENTS FOR US,
PLEASE FEEL FREE TO WRITE THEM BELOW OR ON THE BACK OF THIS PAGE.

APPENDIX F

แบบประเมินคุณภาพประสบการณ์ในตอนท้ายของชีวิต

Quality of Death and Dying Thai version (QODD-TH)

คำชี้แจง: แบบสอบถามนี้ใช้เพื่อประเมินคุณภาพในตอนท้ายของชีวิตในผู้ป่วยที่ได้รับการดูและแบบประคับประคอง (Palliative) และผู้ป่วยระยะสุดท้าย (End-of-life) ในการตอบแบบสอบถามขอให้ท่านระลึกถึงสถานการณ์ที่มีผลต่อคุณภาพชีวิตของผู้ป่วยที่ท่านสังเกตเห็นในช่วงเวลาใกล้ที่สุด และตอบคำถามตามความคิดเห็น**ในมุมมองของท่าน**

ส่วนที่ 1 ข้อมูลผู้ป่วยและผู้ให้ข้อมูล

ผู้ป่วย

ชื่อ/นามสกุล: _____ เพศ ◯ ชาย ◯ หญิง ◯ เพศที่สาม ◯ ไม่ทราบ

HN Number: _____ หน่วยที่ผู้ป่วยรักษา (Ward): _____

การวินิจฉัยโรค: _____

ผู้ให้ข้อมูล

ชื่อ/นามสกุล: _____ ◯ แพทย์ ◯ พยาบาล ◯สหวิชาชีพ_____

วันที่ประเมิน: ___/___/___ เวลา: ___/___น. ◯ ญาติผู้ป่วย ระบุ _____

ประเมินครั้งที่ ____ ◯ ไม่ทราบ ◯ อื่นๆ ระบุ _____

ส่วนที่ 2: ประสบการณ์ที่ท่านสังเกตพบเห็น

คำชี้แจง: กรุณาทำเครื่องหมาย ◯ ล้มรอบหมายเลขที่ตรงกับความคิดเห็นของท่าน โดยเรียงลำดับจาก 10-0 ดังคำอธิบายและ / ในช่องไม่ปรากฏหากท่านไม่พบว่าผู้ป่วยได้รับประสบการณ์ใด ๆ หรือ / ในช่องไม่ทราบหากท่านไม่แน่ใจหรือไม่ทราบ

10	ดีมากที่สุด	5	ยังไม่น่าพอใจ
9	ดีมาก	4	ไม่ค่อยดี
8	ดีปานกลาง	3	ไม่ดี
7	ค่อนข้างดี	2	ไม่ดีเลย
6	ดีเล็กน้อย	1	ไม่ดีมากที่สุด
		0	เลวร้าย

ประสบการณ์							**ไม่ปรากฏ**	**ไม่ทราบ**
ความสามารถในการควบคุมอาการปวด	10 9 8 7 6 5 4 3 2 1 0							
ความสะดวกสบายในการหายใจ	10 9 8 7 6 5 4 3 2 1 0							
ระดับเรี่ยวแรงในการดูแลตนเองทางกายภาพ	10 9 8 7 6 5 4 3 2 1 0							
ระดับความสามารถในการควบคุมการขับถ่าย	10 9 8 7 6 5 4 3 2 1 0							
ระดับความมีสติหรือรู้สึกตัว	10 9 8 7 6 5 4 3 2 1 0							
ระดับความสามารถในการสื่อสาร	10 9 8 7 6 5 4 3 2 1 0							
แสดงให้เห็นถึงความเคารพหรือภาคภูมิใจในตนเอง	10 9 8 7 6 5 4 3 2 1 0							
แสดงให้เห็นการยอมรับการอาการป่วยของตนเอง	10 9 8 7 6 5 4 3 2 1 0							
แสดงให้เห็นถึงการยอมรับการเสียชีวิตของตนเอง	10 9 8 7 6 5 4 3 2 1 0							
สภาพอารมณ์โดยรวม	10 9 8 7 6 5 4 3 2 1 0							
ได้รับอำนาจในการตัดสินใจ	10 9 8 7 6 5 4 3 2 1 0							
ได้ใช้เวลาร่วมกับผู้ที่ตนปราถนา/สัตว์เลี้ยงที่รัก	10 9 8 7 6 5 4 3 2 1 0							
ได้ใช้เวลาอยู่กับตนเองโดยสมัครใจ	10 9 8 7 6 5 4 3 2 1 0							
ได้อยู่ในสถานที่/สภาพแวดล้อมที่ปราถนา	10 9 8 7 6 5 4 3 2 1 0							
ได้รับการสัมผัสจากบุคคลที่รัก	10 9 8 7 6 5 4 3 2 1 0							
ได้รับการสนับสนุนทางจิตวิญญาณ เช่น พิธีกรรมทางศาสนาหรือความเชื่อส่วนบุคคล	10 9 8 7 6 5 4 3 2 1 0							
ได้รับโอกาสจัดกิจกรรมพิเศษที่ปราถนา	10 9 8 7 6 5 4 3 2 1 0							
ได้รับการดูแลอย่างสมศักดิ์ศรีด้านร่างกาย	10 9 8 7 6 5 4 3 2 1 0							
ได้รับการดูแลอย่างสมศักดิ์ศรีด้านจิตใจ	10 9 8 7 6 5 4 3 2 1 0							
รวมคะแนน							=	

ส่วนที่ 3: ปฏิกิริยาของผู้ป่วยที่ท่านสังเกตพบเห็น

คำชี้แจง: กรุณาทำเครื่องหมาย / ตรงตามปฏิกิริยาของผู้ป่วยที่ท่านสังเกตพบเห็น และเครื่องหมาย / ในช่องไม่ทราบ หากท่าน **ไม่แน่ใจหรือไม่ทราบ** และสรุปผลรวมของแต่ละองค์ประกอบ โดย /=1

ปฏิกิริยาของผู้ป่วย	**ใช่**	**ไม่ใช่**	**ไม่ทราบ**
ปฏิเสธการยื้อชีวิตหรือ CPR			
ปฏิเสธการใช้เครื่องช่วยหายใจ			
ปฏิเสธการรับยาลดปวด			
เร่งรัดการตายของตนเอง (active euthanasia)			
ได้รับการรายงานหรือข้อมูลเกี่ยวกับสภาวะของตนเองที่เหมาะสมและเพียงพอจากแทย์หรือผู้เชี่ยวชาญ			
รวมคะแนน			

ข้อมูลเพิ่มเติม *(สิ่งอื่นที่ท่านสังเกตพบหรือได้รับรู้จากผู้ป่วย)*:

_____

_____

_____

_____

ส่วนที่ 4: คุณภาพในระหว่างการเสียชีวิต

คำชี้แจง: กรุณาทำเครื่องหมาย / ตรงตามปฏิกิริยาของผู้ป่วยที่ท่านสังเกตพบเห็น และเครื่องหมาย / ในช่องไม่ทราบ หากท่าน**ไม่แน่ใจหรือไม่ทราบ** และสรุปผลรวมของแต่ละองค์ประกอบ โดย /=1

องค์ประกอบในระหว่างเสียชีวิต	**ใช่**	**ไม่ใช่**	**ไม่ทราบ**
เสียชีวิตด้วยอาการสงบ			
มีสติสัมปชัญญะ/รู้ตัวในระหว่างเสียชีวิต			
แสดงให้เห็นว่าไม่กลัวความตาย			
รับรู้/มีบุคคลในครอบครัวหรือเป็นที่รักอยู่ด้วยในระหว่างเสียชีวิต			
ได้กล่าวอำลา/สั่งเสีย/จัดการภาระ/มรดกก่อนเสียชีวิต			
เสียชีวิตในสภาพแวดล้อมที่ปราถนา/เหมาะสม/สะอาด/สงบ			
ได้รับการปฏิบัติในระหว่างเสียชีวิตอย่างสมศักดิ์ศรี			
ได้รับการตอบสนองทางจิตวิญญาณ/ความเชื่อ/ศาสนา ในระหว่างเสียชีวิต			
รวมคะแนน			

ข้อมูลเพิ่มเติม *(สิ่งอื่นที่ท่านสังเกตพบหรือได้รับรู้จากผู้ป่วย/ เหตุการณ์สำคัญที่เกิดขึ้น)*:

_____

_____

_____

_____

ลงชื่อ

_____

(_____)

ผู้ประเมิน

APPENDIX G

<u>แบบประเมินการเข้ารับบริการดนตรีบำบัดสำหรับผู้ป่วยระยะประคับประคอง</u>

<u>Music Therapy Initial Assessment for Palliative Care</u>

<u>คำชี้แจง</u>: แบบสอบถามนี้ใช้เพื่อประเมินการเข้ารับบริการดนตรีบำบัดสำหรับผู้ป่วยระยะประคับประคอง กรุณากรอกข้อมูลให้ครบถ้วน

ส่วนที่ 1 ข้อมูลผู้ป่วยผู้ให้ข้อมูลและนักดนตรีบำบัดผู้ประเมิน

ผู้ป่วย

ชื่อ/นามสกุล: _____ เพศ ◯ ชาย ◯ หญิง ◯ เพศที่สาม ◯ ไม่ทราบ

HN Number: _____ หน่วยที่ผู้ป่วยรักษา (Ward): _____

การวินิจฉัยโรค: _____

วัน/เดือน/ปี เกิด: _____/____/_____ อายุ: _____ ปี ศาสนา: _____ ◯ ไม่ได้นับถือศาสนาใด

ที่อยู่ที่ติดต่อได้:_____

หมายเลขโทรศัพท์: _____

ผู้ให้ข้อมูลร่วม

ชื่อ/นามสกุล: _____ ◯ แพทย์ ◯ พยาบาล ◯สหวิชาชีพ_____

วันที่ประเมิน: ___/___/___ เวลา: ___/___น. ◯ ญาติผู้ป่วย ระบุ _____

◯ ไม่มีผู้ให้ข้อมูลร่วม

นักดนตรีบำบัดผู้ประเมิน

ชื่อ/นามสกุล: _____วันที่ประเมิน: ___/___/___ เวลา: ___/___น. ประเมินครั้งที่ ____

ส่วนที่ 2 ประวัติทางการแพทย์

ประวัติการบำบัด:

ผู้ป่วยได้รักการบำบัดด้านอื่น ๆ ในระหว่างได้รับการประเมินนี้หรือไม่?

◯ ใช่ 1. _____ วัน: _____ เวลา: _____

2. _____ วัน: _____ เวลา: _____

◯ ไม่ได้รับการบำบัดด้านอื่น

◯ ไม่ทราบ

ส่วนที่ 3 ทักษะ

ข้อจำกัดทางกายภาพ:

◯ เคลื่อไหวร่างกายได้ปรกติ

◯ เคลื่อนไหวร่างกายโดยพึ่งพาอุปกรณ์ ระบุ_____

◯ เคลื่อไหวร่างกายได้ลำบาก

ใช้เครื่องช่วยหายใจ

◯ อื่น ๆ ระบุ _____

อาการปวดและความไม่สบายตัว

◯ มีอาการ อธิบาย_____

◯ ไม่มีอาการ

ทักษะการสื่อสาร:

◯ สื่อสารได้

◯ รับรู้ถึงการสื่อสาร ◯ สื่อสารออกมาได้◯ สื่อสารด้วยวจนภาษา◯สื่อสารด้วยอวัจนภาษา

◯ สื่อสารไม่ได้ อธิบายเพิ่มเติม _____

ทักษะดานสังคม:

◯ ปรกติ

◯ ไม่ปรกติ อธิบาย_____

ทักษะด้านอารมณ์:

◯ ปรกติ

◯ ไม่ปรกติ อธิบาย_____

กิจกรรมยามว่าง/การศึกษาหรือความรู้พื้นฐาน:

_____

_____

_____

ทักษะด้านสัทนาการ:

◯ ไม่มี

◯ มี ระบุ_____

◯ ไม่ทราบ

ทักษะด้านดนตรี:

ประสบการณ์ทางดนตรีของผู้ป่วย (เช่น เคยเล่นดนตรี/ร้อง/เต้น)

◯ ไม่มีประสบการณ์

◯ มีประสบการณ์ ระบุ _____

แนวดนตรีที่ชื่นชอบ ระบุ _____

เพลงที่ชอบ_____

◯ ไม่ทราบ

ผู้ป่วยได้รับประสบการณ์ทางดนตรีจากบุคคลในครอบครัวหรือคนใกล้ชิดเป็นประจำ

◯ ไม่มีประสบการณ์

◯ มีประสบการณ์ จาก _____

อย่างไร _____

◯ ไม่ทราบ

<u>ส่วนที่ 3 สำหรับนักดนตรีบำบัดเท่านั้น</u>

การตอบสนองต่อดนตรีในระหว่างการบำบัดหรือการประเมินของผู้ป่วย

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ความสามารถในการตอบสนองต่อดนตรี

◯ ตอบสนองได้

◯ รับรู้ถึงการสื่อสาร ◯ สื่อสารออกมาได้ ◯ สื่อสารด้วยวจนภาษา ◯ สื่อสารด้วยอวัจนภาษา

◯ ตอบสนองไม่ได้ อธิบายเพิ่มเติม

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การทำงานด้านประสาทสัมผัส: กรุณากรอกเครื่องหมาย ✓ ตามคำชี้แจง

คำชี้แจง: 0= สูญเสียการทำงาน 1= ทำงานได้ในระดับต่ำ 2= ดีเล็กน้อย 3= ดีปานกลาง 4= ค่อนข้างดี 5= ดีมาก

ประสาทสัมผัส	0	1	2	3	4	5
การได้ยิน						
รู้สึกถึงการสัมผัส						
การมองเห็น						

ข้อมูลเพิ่มเติม:

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(_____)

นักดนตรีบำบัดผู้ประเมิน

BIOGRAPHY

NAME	Netchanok Singhey
DATE OF BIRTH	2 March 1987
PLACE OF BIRTH	Phrae, Thailand
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