Music Therapy Profession:
Current Status, Priorities, and Possible Future Directions

DISSERTATION

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Abstract

The purpose of this study was to examine and understand the present status of the field of music therapy by investigating important areas that affect the daily experience of music therapists across the United States and impact the development of the profession.

The field of music therapy is in a constant state of change, relentlessly setting new goals in order to advance as a profession and to further its acceptance. Six overarching questions guided the study: 1) what experiences affect the professional growth of music therapists? 2) what are the opinions of music therapy faculty and members of the American Music Therapy Association regarding the undergraduate music therapy education requirements? 3) what are the most important achievements of the music therapy profession and what are its current challenges? 4) what are current research trends in music therapy and are there areas that require further research attention? 5) what are the long-term goals of the music therapy profession? and 6) how is music therapy portrayed in the media?

Participants for this study were ten music therapy faculty, seven active leaders of the American Music Therapy Association, and one additional individual who had served the field in a leadership capacity for many years but was currently neither a music therapy faculty nor active leader. Hour-long individual interviews were carried out over the telephone with each of the eighteen participants. The interviews were recorded, transcribed, and mailed for a member check. Results indicated that music therapists’ professional growth is directly influenced by their years of formal education,
their mentors, and communities of practice. Participants consider the strength of the undergraduate curriculum is that it is built upon articulated competencies. At the same time, most feel the curriculum is very full, leading to students graduating with underdeveloped skills in certain areas. The unification of the National Association for Music Therapy and the American Association for Music Therapy was considered one of the field’s most important achievements to date, while the small size of the profession was perceived as the biggest challenge. Some participants would like to see increased use of qualitative methodology in music therapy research, as well as studies that clearly describe the music therapy process. Additional research in the areas of autism and teaching and learning was deemed necessary. The top goals for music therapy include growing the size of the profession and gaining greater levels of respect, recognition, and acceptance within the medical field. Participants of this study think that media portrayals of music therapy have improved in the last few years. Many attributed the general public’s greater awareness of the profession to recent representations in books, movies, and news broadcasts, suggesting these are effective means of educating the public about music therapy.
This document is dedicated to all of the clients who have participated in my music therapy sessions over the last eight years. Your strength, courage, resiliency, and sense of humor brought daily inspiration and joy to my work.
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Publications


Fields of Study

Major Field: Music
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Chapter 1: INTRODUCTION

History of Music Therapy

The use of music for the treatment of disease is not a new concept. In ancient times, chants, incantations, and rhythms were used by priests and witch doctors to heal physiological or psychological ills believed to have been caused by evil spirits. For thousands of years, it was assumed that music possessed supernatural powers which could heal the sick directly or through a higher force such as a tribal god (Gfeller, 1990). Throughout the 20th century, the applications of music in medicine have been studied by the scientific community in a systematic fashion (Hyde, 1924; Cherry & Pallin, 1948; Ellis & Brighouse, 1952; Locsin, 1981; Charlesworth & Nathan, 1987; Wiand, 1997). The establishment of music therapy as a formal field of study in the 1950’s led to the use of music as therapy in a variety of clinical settings such as medical hospitals, special education schools, psychiatric facilities, and nursing homes (American Music Therapy Association [AMTA], 2011a).

Establishment of Music Therapy as a Formal Field of Study

The first college course in music therapy was offered at Columbia University in the year 1919. Taught by musicians who had experience working with post-war Canadian soldiers, the course was titled “musicotherapy.” Early music therapy professors recommended students interested in the field of music therapy not only
possess knowledge in music, but also in the areas of physics, psychology, anatomy and physiology (L’Etoile, 2000). Around the 1940’s, music therapist and psychiatrist Ira Altshuler and music therapy pioneers Willem van de Wall and E. Thayer Gaston sought to elevate music therapy to an “organized clinical profession,” and made great efforts from an educational and structural standpoint (AMTA, 2011a). In 1944, Roy Underwood, a music educator from Michigan State University, established the first university curriculum leading to a baccalaureate degree in music therapy. However, it was not until 1952 that the National Association for Music Therapy (currently the American Music Therapy Association) and the National Association of Schools of Music (NASM) adopted the first official undergraduate music therapy curriculum (L’Etoile, 2000).

**Music Therapy Today**

The field of music therapy has evolved greatly over the last sixty years, and today there are over 5,300 music therapists working in the United States (Certification Board for Music Therapists [CBMT], 2011a). Music therapists help individuals reach predetermined goals using music as the therapeutic medium. Individuals of all ages and levels of functioning benefit from this therapeutic modality. Music therapists serve many different clinical populations including Alzheimer’s and dementia, autism, mental health, developmentally disabled, traumatic brain injury, medical/surgical, and substance abuse disorders. Nursing facilities, long-term rehabilitation units, medical and psychiatric
hospitals, hospice programs, and schools are among the types of settings that employ music therapists.

The music therapist is an integral part of the client’s interdisciplinary treatment team. A client may be referred to music therapy to work on individualized goals of a cognitive, social, emotional, and physical nature. Examples of goals may include decreasing pain perception, elevating mood, restoring physical functioning and skills, facilitating speech development, and reducing anxiety and stress. Music therapists use singing, songwriting, lyric analysis, music and imagery, vocal and instrumental improvisation, and receptive music listening among other techniques to help their clients achieve their goals.

The field of music therapy is represented by the American Music Therapy Association (AMTA). Established in 1998 through the unification of the former National Association for Music Therapy (NAMT) and the American Association for Music Therapy (AAMT), the AMTA’s mission is to “advance public awareness of the benefits of music therapy and increase access to quality music therapy services in a rapidly changing world” (http://www.musictherapy.org/). The membership of the AMTA is made up of approximately 3,800 individuals, which includes music therapy professionals, music therapy students, associates, patrons, and honorary life members (AMTA, 2011e).

The music therapy profession has placed tremendous importance on research activity since its inception as a formal field of study. Two major journals, The Journal of Music Therapy (JMT) and Music Therapy Perspectives (MTP) publish the contributions of members of the field and related professions. The AMTA also publishes a quarterly
in-house newsletter titled *Music Therapy Matters*, that focuses on “AMTA business and activities, current happenings in the allied health field, employment trends and opportunities, and topical items of general interest about music therapy” (http://www.musictherapy.org/research/pubs/). Additional publications by AMTA include *Music Therapy ENews*, an electronic newsletter that provides updates concerning the profession to its subscribers; *Imagine*, an annual online magazine pertaining to early childhood music therapy; and monographs on various topics related to clinical practice (AMTA, 2011f).

Over its sixty year history, the field of music therapy has made tremendous progress in multiple areas including education and training, clinical practice, research, and advocacy. It has witnessed the establishment of multiple professional organizations, a credentialing board, and over seventy undergraduate and graduate trainings programs around the country. The profession of music therapy has testified its benefits in front of the United States Senate, has developed research journals, and has expanded in terms of specializations and areas of practice (Appendix A).

**Need for the Study**

The proposed study seeks new knowledge for members of the music therapy community (music therapy faculty, board members, clinicians, and students) concerning important areas that affect the daily professional experience as well as the development of the field. This study will obtain a current snapshot of areas such as professional growth, education and clinical training, victories and challenges of the profession,
current research trends as well as research needs, long-term goals, and media portrayals of music therapy in order to inform members of the music therapy community of where they stand as a profession, where the field is heading, as well as what changes need to occur internally so that proposed goals can be achieved.

Music therapy is a relatively new field when compared to other allied health professions such as physical therapy and speech and language pathology. It is also one of the few healthcare professions that is rooted in art as well as science. Throughout its sixty years as a formal field of study, the profession has undergone multiple changes. It is a critical time in its history to step back and evaluate where we have been and how we evolved to where we stand today.

In comparison to other healthcare professions such as nursing, social work, and physical therapy, the field of music therapy is rather small in size, with approximately 5,300 music therapists practicing in the United States (CBMT, 2011a). In terms of gender and ethnic diversity, the majority of music therapists are Caucasian females (AMTA, 2011e). Among the other helping fields, music therapy is “one of the few remaining professions where entry is at the bachelor’s level” (AMTA, 2011d). All of these factors, coupled with difficult economic times pose challenges for many music therapists across the country.

The field of music therapy is in a constant state of change, relentlessly setting new goals in order to advance as a profession and to further its acceptance. The purpose of this study will be to shed light on some of the most important issues the field is currently facing, as well as reflect on sixty years of remarkable history,
accomplishments, and challenges. I intend for this study to benefit the profession as a whole, providing an opportunity for readers to learn what it is that we are after; and what are our plans to succeed. This study will serve to unify the thoughts, experiences, opinions, and suggestions of important members of the music therapy community.

Statement of the Problem and Purpose of the Study

My personal and professional experiences as a music therapist have led me to the many questions the proposed study aims to address. Where do we currently stand as a profession regarding issues that affect our daily work? How do we stay current alongside other healthcare professions? More importantly, what are our long-term goals? Conducting a series of interviews of music therapy faculty and board members of the American Music Therapy Association will help to provide answers to these questions.

Music therapists use music based interventions to help clients achieve goals of a cognitive, physical, social, and emotional nature. Music therapists assess the needs of their clients, and develop plans of action. Once implementation of the treatment plan begins, the music therapist is constantly evaluating, modifying, and enhancing the original plan. Music therapists have the pleasure of using music as the therapeutic tool to help their clients reach their fullest potential, making the therapeutic modality unique among other allied health professions. This uniqueness is both positive and negative, as lack of understanding, experience, and acceptance can result from people’s misconceptions and predetermined opinions about the profession; bringing an array of
daily challenges for the music therapist, including workplace isolation and feelings of burnout.

This study will help to consolidate multiple perspectives. It will attempt to situate, unify, and inform members of the profession, including students, young professionals, and experienced clinicians. Jensen and McKinney (1990) suggested undertaking a study where a group of the most prominent therapists in the field were closely studied in order to understand their work and their areas of competence. Experienced music therapists, such as those participating in the study, have had time to reflect on their careers. Because of this, they have an understanding of the field’s present status and are in unique positions to describe plans for a stronger future.

Research Questions

I have developed six overarching research questions that will guide this study. The research questions are directed to uncover issues related to:

1. What experiences affect the professional growth of music therapists?
2. What are the opinions regarding the undergraduate music therapy education requirements?
3. What are the most important achievements of the music therapy profession, and what are its current challenges?
4. What are the current research trends in music therapy? Are there areas that require further research attention?
5. What are the long-term goals of the music therapy profession?
6. How is music therapy portrayed in the media?

**Operational Definitions**

**American Association for Music Therapy (AAMT):** A national music therapy organization established in 1971 as a result of philosophical differences among NAMT members.

**American Music Therapy Association (AMTA):** Present national organization representing music therapists across the United States. Established in 1998, the AMTA is a result of the unification of the NAMT and the AAMT.

**AMTA Policy on the Use of Acronyms:** Based on this new policy, acronyms following a person’s signature will be limited to academic degrees, MT-BC, other credentials, licenses, state registries, National Music Therapy Registry designations, and music therapy professional designations from other countries. Acronyms gained through the completion of specialized trainings such as Neurologic Music Therapist (NMT), Nordoff-Robbins Music Therapist (NRMT), and Neonatal Intensive Care Unit-Music Therapist (NICU-MT) should not follow the person’s signature. Rather, the specialization should be spelled out below the person’s name. The AMTA Policy on the Use of Acronyms (2011g) states:

*AMTA and CBMT are actively working to increase recognition of the music therapy credential, MT-BC. At the same time, acronyms for completion of*
trainings have proliferated, creating confusion among consumers, employers, legislators, and other external constituents…. AMTA has concluded that potential damage to the profession from continued use of acronyms for specialized and advanced trainings far outweighs reasons for continued use.

**Art Therapy:** Formalized as a mental health profession in the 1940’s, the American Art Therapy Association (AATA) defines art therapy as “the therapeutic use of art making, within a professional relationship, by people who experience illness, trauma, or challenges in living, and by people who seek personal development” (http://www.americanarttherapyassociation.org/aata-aboutus.html). The role of the art therapist is to stimulate the client to manifest his/her creative process in order to increase physical, mental, and emotional well-being. The AATA was founded in 1969 and today represents more than 5,000 people related to the field.

**Behavioral Music Therapy:** Supported and developed by E. Thayer Gaston and other early music therapy pioneers, behavioral music therapy conceives music as a kind of learned human behavior; its goals being to modify unwanted behaviors using music interventions as reinforcement. Initially, behavioral music therapy practitioners were characterized as somewhat radical and empirically oriented, reducing the music therapy process and research to modify only overt behaviors, leaving little room to uncover mental processes and rejecting the idea that behavior disorders were symptoms of hidden emotional conflicts. Presently, music therapists of this orientation utilize a more
cognitive behavioral approach rather than solely behavioral principles (Standley, Johnson, Robb, Brownell, & Kim, 2004).

**Bonny Method of Guided Imagery and Music (GIM):** A music therapy approach influenced by the transpersonal and psychodynamic traditions; the main goal being to allow the client to obtain awareness of his or her personal situation and to overcome what has precluded personal growth. According to this method, the path to expand a client’s consciousness implies an inner confrontation, which is resolved through the use of imagery, classical music, and the counseling facilitated by a trained professional (Burns & Woolrich, 2004).

**Certification Board for Music Therapists (CBMT):** “An autonomous certifying agency that grants credential recognition to music therapists who have met predetermined CBMT standards and who continue to engage in professional growth and development through the CBMT Recertification Program” (http://www.cbmt.org/frequently-asked-questions/).

**Continuing Music Therapy Education (CMTE):** Education music therapists receive post completion of the music therapy degree. CMTE may take the form of conferences, workshops, online courses, and self-study classes. A music therapist must accumulate 100 credits of CMTE per 5 year cycle in order to maintain certification through the CBMT.
**Dance/Movement Therapy:** A health-related field based on the foundation that body, mind, and spirit are interconnected and help to integrate the personality. Professionals of the field believe that dance/movement allows self-expression and furthers “the emotional, cognitive, physical and social integration of the individual” (http://www.adta.org/). Dance/movement therapists are represented by the American Dance Therapy Association (ADTA), founded in 1966.

**Entry-Level:** “Entry-level study includes practical application of music therapy procedures and techniques learned in the classroom through required fieldwork in facilities serving individuals with disabilities in the community and/or on-campus clinics” (http://www.musictherapy.org/careers/employment/). Currently, the baccalaureate degree in music therapy imparts entry-level competencies and allows for professional practice in the field.

**Internship:** The extensive clinical experience that begins following the completion of the music therapy coursework. “The music therapy internship lasts a minimum of 900 hours or any greater length of time needed to fulfill the clinical training requirement of 1200 hours” (American Music Therapy Association, 2012b).

**Levels of Practice:** The *Advisory on Levels of Practice in Music Therapy* differentiates two Levels of Practice within the profession:
• Professional Level of Practice: “based on the AMTA Professional Competencies acquired with a baccalaureate degree in music therapy or its equivalent, which leads to entrance into the profession and Board Certification in Music Therapy” (http://www.musictherapy.org/members/advancedcomp/).

• Advanced Level of Practice:

  Based on the AMTA Advanced Competencies, which is defined as the practice of music therapy wherein the music therapist applies and integrates a comprehensive synthesis of theories, research, treatment knowledge, musicianship, clinical skills, and personal awareness to address client needs. A music therapist at an Advanced Level of Practice has at least a bachelor’s degree or its equivalent in music therapy, a current professional designation or credential in music therapy … professional experience, and further education and/or training…. It is anticipated that in the future music therapists at the Advanced Level of Practice will hold at least a master’s degree in music therapy that includes advanced clinical education (http://www.musictherapy.org/members/advancedcomp/).

**Master’s Level Entry:** For a number of years, the AMTA has considered moving the entry-level of the profession to the Master’s degree. *Master's-Level Entry: Core Considerations* and *Master's-Level Entry: Moving Forward* are two advisories created by the Education and Training Advisory Board (ETAB) to explore this potential change.
Music Therapist-Board Certified (MT-BC): National credential granted by the Certification Board for Music Therapists “to identify music therapists who have demonstrated the knowledge, skills and abilities necessary to practice music therapy at the current level of the profession” (http://www.cbmt.org/fact-sheets/mt-bc-fact-sheet/).

Music Therapy: The AMTA defines music therapy as “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” (http://www.musictherapy.org/about/musictherapy/).

National Association for Music Therapy (NAMT): Established in 1950, the NAMT was the first official organization for music therapy in the United States.

National Association of Schools of Music (NASM): “Founded in 1924, is an organization of schools, conservatories, colleges and universities with approximately 636 accredited institutional members. It establishes national standards for undergraduate and graduate degrees and other credentials” (http://nasm.arts-accredit.org/).

National Music Therapy Registry (NMTR): Created for those music therapists who chose to keep their professional designations of Registered Music Therapist (RMT), Certified Music Therapist (CMT), and Advanced Certified Music Therapist (ACMT) instead of obtaining board certification through the CBMT. Prior to the establishment of
the AMTA, music therapists who had successfully completed an NAMT or AAMT approved education and clinical training program were awarded the stated professional designations.

**Neurologic Music Therapy (NMT):** Advocates of the NMT approach emphasize that music therapy must rest on scientific evidences to have a respectful place among professional communities. Practitioners of NMT receive training in courses related to the human nervous system (neuroanatomy and neurophysiology, brain pathology, and rehabilitation of motor and cognitive functioning) so they can design music therapy interventions which will address multiple sensorimotor, speech and language, and cognition problems (Clair & Pasiali, 2004).

**Nordoff-Robbins Music Therapy (NRMT):** The Nordoff-Robbins or Creative Music Therapy approach is based on the assumption that within each human being there is an inborn musical self or a ‘music child,’ that can be awakened through improvised music-making between the client and therapist. As the music therapist stimulates the innate musical capacity of the client, he/she facilitates resolutions of psychological difficulties. “Nordoff-Robbins clinicians focus on long-term therapeutic growth, which is characterized by expressive freedom and creativity, communicativeness, self-confidence and independence” (Aigen et al., 2004).
Personal Reflections

The present study investigates perspectives concerning six important areas within the music therapy profession: professional growth of music therapists, education and clinical training, current status of the profession, research, long-term goals, and portrayals of music therapy in the media. When I initially engaged in this study, it was my goal to obtain an in-depth understanding of these different areas. While I think there is great breadth to the study, and I certainly captured a considerable amount of complexity, perceptions, beliefs, and opinions through my interviews, the depth of the findings could have been greater had I limited the number of topics I set out to explore.

The participants in this study discussed important issues pertaining to the field of music therapy, many of which have affected their careers in a direct manner. It is important to recognize that participants’ opinions are based on their personal experiences and belief systems. In other words, their unique status within the field of music therapy (for example, number of years in the profession, university affiliation, role within the AMTA, and theoretical orientation) heavily weighed on their views. Because of this, I was cautious when drawing generalizations, constantly considering participants’ biases and subjectivities as well as my own.

The interviews conducted for this study were carried out over the telephone. The building of rapport, which is an important component to qualitative research, was disrupted by not only the lack of face-to-face contact, but also by the time allotted for the interviews, as I had informed participants the conversation would take approximately forty-five minutes of their time. In addition, I did not personally know the participants,
yet I asked them questions which at times led to discussions of sensitive issues. It is possible in-person interviews could have led to additional knowledge or slightly different results.

Further research is needed in order to obtain greater understanding of the multiple factors that have a direct effect on the topics discussed in this study. The challenges the music therapy profession is currently facing are complex. It is almost impossible to isolate solutions and predict outcomes, as internal and external forces directly influence the events taking place. Therefore, additional research in each of the areas explored in this study will enhance the knowledge needed to solve problems.

Lastly, it was my privilege to interview the study participants. Their willingness to share meaningful and often challenging experiences that shaped their careers, affected them on a personal level, and at times resulted in self-reflection and even the questioning of their professional identity, were invaluable not only for the purposes of this study, but also for my personal insights and professional growth.
Chapter 2: REVIEW OF LITERATURE

The present chapter is divided into three parts. Part I provides a review of the most important organizations and documents pertaining to the field of music therapy. Part II includes an overview of the music therapy baccalaureate degree and clinical internship as well as a review of the published literature concerning music therapy curriculum and clinical training. Part III encompasses a comprehensive literature review in relation to burnout issues in music therapy.

Part I

National Association for Music Therapy

The first formal meeting of the NAMT took place in New York on June 2, 1950. The members of this new organization, many of whom had been considering the idea of establishing an association since the late 1940’s, were concerned with formalizing music therapy as a profession and, therefore, approved “a constitution and bylaws, developing standards for university-level educational and clinical training requirements, making research and clinical training a priority, creating a registry and, later, board-certification requirements, and publishing research and clinical journals” (http://www.musictherapy.org/about/history/). The establishment of the Registered Music Therapist (RMT) credential was one of the most remarkable actions taken by the
NAMT, as it certified that the music therapist had met the standard education and clinical training required by the association. In 1964, the NAMT published the first volume of the *Journal of Music Therapy*. Twenty years later (1984), *Music Therapy Perspectives* was published (Davis, Gfeller, & Thaut, 1999).

**American Association for Music Therapy**

The American Association for Music Therapy (AAMT), formerly known as the Urban Federation of Music Therapists, was founded in 1971 as a result of philosophical differences concerning clinical approach and education among members of the NAMT (Davis et al., 1999). Music therapy graduates of AAMT-approved academic programs received the designation of Certified Music Therapist (CMT) and Advanced Certified Music Therapist (ACMT). In 1980, the AAMT published its own official journal of clinical training and practice titled *Music Therapy*. By the mid 1990’s, the association had grown to approximately 700 members (AMTA, 2011a).

**American Music Therapy Association**

Established in 1998 through the unification of the National Association for Music Therapy (NAMT) and the American Association for Music Therapy (AAMT), the American Music Therapy Association (AMTA) is the “single largest music therapy association in the world, representing music therapists in the United States and in over thirty countries around the globe” (http://www.musictherapy.org/about/history/). The mission of the AMTA is “to advance public knowledge of the benefits of music therapy
and to increase access to quality music therapy services in a rapidly changing world” (http://www.musictherapy.org/). The AMTA serves as an advocate for the profession at the state and federal level, and is committed to the development of the field in multiple areas including education, clinical training, professional standards, credentials, and research.

The AMTA is governed by a fifteen member Board of Directors responsible for the overall management of the association. An Assembly of Delegates, in charge of setting policies, is constituted by “representatives from each of the Association's seven regional chapters” (AMTA, 2011b). These smaller chapters, governed by executive boards of elected officials, serve to support the profession and its members at the regional level, adopting “the purposes and goals of the Association,” conforming to the Association’s Bylaws, and seeking the Association’s formal approval for its constitutions and/or bylaws (http://www.musictherapy.org/members/bylaws/). The seven regional chapters are: Great Lakes (Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin); Mid-Atlantic (Delaware, District of Columbia, Maryland, New Jersey, New York, Pennsylvania, Virginia, West Virginia); Midwestern (Colorado, Iowa, Kansas, Missouri, Montana, Nebraska, North Dakota, South Dakota, Wyoming); New England (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont); Southeastern (Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee); and Western (Alaska, Arizona, California, Hawaii, Idaho, Nevada, Oregon, Utah, Washington). Fourteen standing committees emerge from the AMTA and represent the areas of Academic Program Approval,
The AMTA has produced a series of official documents that guide and support the organization as a whole and reflect its mission and values. These documents include the Professional Competencies (Appendix B), Standards of Practice, Code of Ethics, and Education and Clinical Training Standards, which will be discussed later in this chapter.

Profile of the Members of the AMTA

On an annual basis, the AMTA administers a survey to its members that captures relevant, up-to-date information related to demographics, employment, salaries, and education. The document produced as a result of this survey is titled *Descriptive Statistical Profile of the AMTA Membership* and is published annually in the AMTA Member Sourcebook. Over the next several pages, data derived from this survey is discussed.

According to the *Descriptive Statistical Profile of the AMTA Membership* (AMTA, 2011e), 3,394 individuals held membership with the AMTA in 2010. The majority of this membership was comprised of music therapy professionals (MT-BC/ACMT/CMT/RMT) followed by students at the undergraduate and graduate levels. Approximately 95% of the members (3,212) resided in the United States, followed by members spread across thirty-two other countries with the highest memberships being in
Japan (72), Canada (30), and South Korea (14). Other nations represented in the membership profile included Taiwan, Germany, Great Britain, Ireland, Israel, and Australia.

The AMTA membership largely comprises individuals holding bachelor’s degrees (38%), Master’s (25%), and Doctorate (6%). The remaining 31% is assumed to be mostly student members. In terms of gender and ethnic diversity, 87% of the members are females and 13% are males. Caucasians/whites comprise the largest ethnic group (87.3%), followed by Asians/Asian Americans (7.3%), African Americans/Blacks (1.6%), and Hispanics/Latino (1.5%).

According to the same report, music therapists serve a diverse group of clinical populations. These populations have been divided into “umbrellas,” each encompassing multiple diagnoses. The five major umbrellas served by music therapists are mental health (18.5%) including individuals with behavioral disorders, eating disorders, emotional disturbances, forensic status, mental health diagnoses, post-traumatic stress disorder, and substance abuse problems; developmentally disabled (13.9%) including children and adults with autism, developmental disabilities, and Rett Syndrome; the elderly (9.4%); Medical/Surgical (9.1%) including clients with AIDS, cancer, chronic pain, medical/surgical needs, and terminal illnesses; and Neurological Disorders (5%) including patients with Parkinson’s and limited neurological functioning. The remainder 41% accounts for all other populations served by music therapists that did not fit under the five major population categories.
The salary of the AMTA members varied according to years of experience, population/setting/age group served, geographic location, job title, and type of employment (private practice versus employed by an agency). The average reported full time salary for 2010 was $47,899, with salaries ranging from $20,000 to $156,000. For those music therapists with ten or less years of professional experience, the average annual salary was $41,802. According to the report, music therapists’ salaries tended to be higher if they lived in the New England ($53,250) and Western ($53,382) regions and were employed as a music therapy faculty ($61,570) or in an administrative ($52,282) position. Music therapists serving clients with AIDS ($53,472) and eating disorders ($51,940) made approximately $10,000 more than those music therapists serving Alzheimer’s/Dementia ($44,086) populations.

In regard to jobs created and jobs lost, thirty-five new full time positions were established in 2009. Of these jobs, 10 were in the self-employed/private practice category. Schools, nursing homes, and child/adolescent treatment centers were major areas for job growth as well. As for jobs lost, nineteen positions were eliminated during 2009. Reasons for eliminating positions included cut back of jobs (7), closure of music therapy programs (4), the facility housing the program closed (3), and other undisclosed reasons (5). The majority of the new jobs created were located in the Southeastern region (11), while the majority of the jobs lost were located in the Western region.

Concerning third party reimbursement for music therapy services, approximately 18% of the individuals who completed the survey reported receiving some type of third party reimbursement. The funding sources most frequently reported were private pay.
(19%), state funding (18.5%), budgeted by facility/hospital (12.7%), and grants (11%). The funding sources reported less frequently included TRICARE, private insurance plans, Medicaid, Medicare, and endowments.

Music therapy survey respondents reported obtaining financial assistance from their employers for various professional activities. More than three-fourths of survey respondents reported receiving assistance such as paid leave for professional events (14%), continuing education (11.7%), state/regional conferences (9.1%), and AMTA annual conference (8.2%). Employers also provided monies for music therapy program budgets. Approximately 40% of respondents reported receiving a purchasing budget of $1-$1,000 from their employer, while 25% reported receiving approval for purchase by individual expense.

**American Music Therapy Association Official Documents**

Similar to other healthcare professions, the field of music therapy sits on a strong foundation of values and standards that guide the clinical practice and professional conduct of members of the field. Among the most important documents reflecting the profession’s mission and values is the Standards of Clinical Practice, a comprehensive document “designed to assist practicing music therapists and their employers in their endeavor to provide quality services” (http://www.musictherapy.org/about/standards/). The Standards of Clinical Practice addresses common principles which should apply to all areas of music therapy work. These include protocols music therapists should adhere to when providing services to their clients such as the procedure of referral and
acceptance, assessment, treatment planning, implementation, documentation, and termination. Participating in continuing education and seeking professional supervision are also standards within the general section of this document. Specific principles for ten clinical areas of music therapy practice (addictive disorders, consultant, intellectual and developmental disabilities, educational settings, older adults, medical settings, mental health, physical disabilities, private practice, and wellness practice) are also outlined in the document (AMTA, 2012).

A second important official document is the Code of Ethics, which serves to “define tenets of professional conduct for practicing music therapists” (http://www.musictherapy.org/about/requirements/)

The members of the American Music Therapy Association, Inc., hereby recognize and publicly accept the proposition that the fundamental purposes of the profession are the progressive development of the use of music to accomplish therapeutic aims and the advancement of training, education, and research in music therapy. Our objectives are to determine and utilize music therapy approaches that effectively aid in the restoration, maintenance, and improvement in mental and physical health. To that end, we believe in the dignity and worth of every person. We promote the use of music in therapy, establish and maintain high standards in public service, and require of ourselves the utmost in ethical conduct (http://www.musictherapy.org/about/ethics/)

The Code of Ethics applies to all practicing music therapists holding the MT-BC credential, those holding professional designations through the National Music Therapy
Registry (RMT/CMT/ACMT), as well as music therapy students and interns receiving clinical supervision. The Code of Ethics delineates ethical conduct in all areas affecting clinical practice including professional competence and responsibilities, general standards, relationships with clients/students/research subjects, relationships with colleagues, relationships with employers, responsibility to the community/public, responsibility to the profession/association, research, fees and commercial activities, announcing services, education (teaching, supervision, and administration), and implementation (AMTA, 2008).

A third important document for the field is the Professional Competencies (Appendix B), which “provide a definition of the current entry level skills of a music therapist who has completed either a bachelor’s degree or its equivalent in music therapy” (http://www.musictherapy.org/about/requirements/). AMTA approved colleges and universities use these competencies to build their music therapy curriculum. Similar to the Standards of Practice, the Professional Competencies are re-evaluated on a regular basis “to ensure consistency with current trends and needs of the profession and to reflect the growth of the knowledge base of the profession” (http://www.musictherapy.org/members/advancedcomp/). The competencies encompass the areas of music foundations (music theory and history, composition and arranging, and skills in major performance medium, keyboard, guitar, voice, percussion, non-symphonic instruments, improvisation, conducting, and movement); clinical foundations (exceptionality, principles of therapy, and the therapeutic relationship); and music therapy (foundations and principles, client assessment, treatment planning, therapy
implementation, therapy evaluation, documentation, termination/discharge planning, professional role/ethics, interdisciplinary collaboration, supervision and administration, and research methods), (AMTA, 2009).

**Certification Board for Music Therapists**

The mission of the Certification Board for Music Therapists is to define the body of knowledge that represents competent practice in the profession of music therapy; to create and administer a program to evaluate initial and continuing competence of this knowledge; to issue the credential of MT-BC to individuals that demonstrate the required level of competence; and to promote music therapy certification (http://www.cbmt.org/fact-sheets/cbmt-definition-fact-sheet/).

The Certification Board for Music Therapists (CBMT) is an independent, non-profit organization accredited by the National Commission for Certifying Agencies. Established in 1983, the CBMT is the only organization that certifies music therapists to practice music therapy at the national level (CBMT, 2011a). In order to obtain the MT-BC credential, the music therapy student must complete all required music therapy coursework including the clinical internship. He/she is then eligible to sit for the certification exam administered by the CBMT. Upon successful completion of the three hour examination, the individual will be awarded the credential of Music Therapist-Board Certified (AMTA, 2011c).

The content found within the CBMT examination is based on the ever evolving CBMT Scope of Practice for Board Certified Music Therapists. Every five years, a team
of content experts in the field analyze, evaluate, and make necessary expansions to the content in order to maintain currency with up-to-date music therapy practices. “The CBMT Scope of Practice defines the body of knowledge that represents competent practice in the profession of music therapy and identifies what an MT-BC may do in practice” (www.cbmt.org/upload/CBMT_SOP_2011.pdf). The Scope of Practice is divided into four broad content outline areas which are: assessment and treatment planning, treatment implementation and termination, ongoing documentation and evaluation of treatment, and professional development and responsibilities (CBMT, 2011b).

**National Music Therapy Registry**

Prior to the establishment of the American Music Therapy Association in 1998, music therapists who had completed an AAMT or NAMT approved academic program, were awarded the Registered Music Therapist (RMT), Certified Music Therapist (CMT), or Advanced Certified Music Therapist (ACMT) professional designation (National Coalition of Creative Arts Therapies Associations, n.d.). The National Music Therapy Registry (NMTR) was created for those music therapists who chose to keep their designation of RMT, CMT, or ACMT instead of obtaining board certification through the CBMT. It was understood at the time of the registry’s inception that it would expire in 2020, requiring all practicing music therapists to pursue the MT-BC credential at that time. “AMTA and CBMT have worked collaboratively to establish the MT-BC credential as the recognized credential in the field and to have it acknowledged by
government agencies, employers, and consumers”

(http://www.musictherapy.org/assets/1/7/Advisory_on_Acronyms_June_2011.pdf).

Part II

Colleges and Universities Offering Music Therapy

Currently, over seventy American colleges and universities offer music therapy as a program of study. The NASM and the AMTA serve as accrediting bodies for these programs. The music therapy baccalaureate degree, which currently provides entry into the profession, is divided into three main areas of study: musical foundations (45%), clinical foundations (15%), and music therapy coursework (15%). Musical foundations studies include courses in music theory, music history and literature, applied music, ensembles, secondary instruments (piano, voice, guitar, and percussion), conducting, composition, and arranging. The clinical foundations portion of the degree encompasses courses in human development, exceptionality and psychopathology, and therapeutic principles. Music therapy studies comprise entry level competencies in the areas of music therapy foundations, principles, methods and techniques, client assessment and evaluation, music and special populations, psychology of music, and supervised practica.

In addition to the three main areas, liberal arts or general education courses (20-25%) and electives (5%) are required. Following the completion of the coursework (approximately four years from the start of the degree), the music therapy student enters a six month (or 900+ hour) supervised clinical internship with a population of his/her
choice. Upon satisfactory completion of the internship, the student is eligible to take the music therapy national board certification exam, which will earn the beginning professional the Music Therapist-Board Certified (MT-BC) credential (AMTA, 2011c).

**Music Therapy Baccalaureate Degree**

The undergraduate degree in music therapy prepares the student to work with individuals of all ages and functioning levels using music as the therapeutic medium. The NASM (2003) and the AMTA Professional Competencies (2009) highlight essential competencies (those necessary “must-haves”) expected of baccalaureate music therapy graduates. These include musical foundations in voice, guitar, and keyboard; including the ability to play/sing at sight, transpose, improvise, accompany self/ensembles, and knowledge of traditional and popular repertoire. Music therapy graduates are also expected to possess knowledge and performance ability on a variety of percussion instruments sufficient enough to lead rhythm-based experiences for their clients. In addition, the NASM and the AMTA specify competencies related to conducting, composition and arranging, and movement. Conducting abilities should be sufficient to allow the therapist to lead both small and large vocal and instrumental ensembles while conducting basic patterns with technical accuracy. Composition and arranging skills permit the music therapy graduate to compose simple songs with simple accompaniment, as well as “arrange, transpose, and simplify music compositions for small vocal and nonsymphonic instrumental ensembles” (NASM, 2003, p. 93). Movement skills include
the ability to direct improvised and structured movement exercises and to move expressively to music.

Essential competencies concerning clinical foundations include understanding of normal and exceptional human behavior (causes and symptoms of major exceptionalities), as well as clinical terminology and classification systems. Baccalaureate music therapy graduates must also demonstrate basic knowledge concerning the dynamics and processes of the therapeutic relationship, both with individuals and groups; and knowledge of the major therapeutic approaches (for example, humanistic, behavioral, person-centered, and psychoanalytic). Music therapy foundations include knowledge of the principles, history, and philosophy of music therapy; the application of music therapy methods and techniques to various client populations; and the methods, procedures, and techniques for client assessment, evaluation of music therapy effectiveness, documentation of progress, treatment planning and implementation, and termination. An understanding of the professional role and professional ethics, standards of practice, interdisciplinary collaboration, supervision, administration, and research methods applicable to the field is also expected.

In addition to the discussed classroom competencies, music therapy students engage in a series of supervised practica throughout their degree. According to the NASM (2003), students should be exposed to a “representative range of client populations in a variety of settings under qualified supervision” (p. 94). Practicum experiences should be designed for the student to apply the theoretical and practical
knowledge they have acquired in the classroom and should be set up so that students develop the necessary skills for successful transition to the internship setting.

**Music Therapy Curriculum Literature**

The vast majority of literature concerning music therapy curriculum was published between the late 1970’s and mid 1990’s. As compared to published research regarding the clinical applications of music therapy or studies demonstrating the effectiveness of music therapy intervention, literature focusing on music therapy curriculum is scarce. The literature that has been written focuses primarily on problems within the curriculum, particularly the discrepancy between what is often emphasized and taught, versus what is actually needed as a professional music therapist (Brookins, 1984; Nicholas & Gilbert, 1980).

Madsen (1965) published an early article suggesting changes in the curriculum. He argued that the music therapist “is not a physician, psychologist, psychiatrist, social worker, and, specifically, he is not an applied performer or conductor” (p. 83). Rather, the music therapist combines elements from these different fields in the therapeutic process. Therefore, it must be determined if the given curriculum will provide the student with the necessary tools needed to perform such unique work. Madsen suggested concentrating on essentials and eliminating nonessentials. In 1965, his proposed changes included reducing the music history requirements to one general music history course, which would cover a vast amount of literature and would be taught by a music therapist. He stated “the music therapist is not an aesthetician or historian, he is a therapist” (p. 84).
Additional suggestions included reducing the years of applied music studies to one year: “the primary job of a music therapist is not performer or composer in residence within the clinical institution; he is a therapist” (p. 84) and reducing the years of music theory to only one. Through a series of follow-up studies, it was found music theory is “one of the least essential requirements even for the band, orchestral, or choral teacher” (p. 84). Making these changes would free approximately 14-18 hours in the curriculum, which could then be spent on music therapy courses, research, field work, and observation.

Alley (1978) discussed the state of the music therapy degree in the late 1970’s, pointing out the curriculum requirements had remained virtually unchanged since being established in 1952. She attributed this to the music therapy program being housed within schools of music and being subject to NASM requirements, where the primary focus falls on applied music expertise, extensive music theory and history studies, and functional instruction in secondary instruments.

A number of surveys have been administered to professional music therapists in order to capture their perceptions concerning the undergraduate music therapy education requirements. In a study conducted by Braswell, Maranto, and Decuir (1979), participants were asked which course requirements should be raised, stay the same, or be lowered. Survey results indicated participants wanted more courses in piano, recreational music, psychology, and music therapy, with music therapy courses receiving the highest rating. Similar to Madsen (1965), the most frequently cited courses that should be reduced were music theory (24.02%), music history and literature (20.67%), and major instrument and performance (14.52%).
In a later study by Braswell, Decuir, and Maranto (1980), music therapy clinicians, educators and interns rated the importance of specific entry-level skills on a nine-point scale. Those skills concerning knowledge of the music therapy research, clinical, and theoretical literature were rated lowest. More practical or “everyday” skills concerning patient ethics, approaches to therapy, and session planning were rated highest. In the area of music foundations (which encompasses the core music requirements), 40% of the skills listed were rated below the midpoint. Among the lowest were music history, music theory, form and analysis, orchestration, and minor instruments. Functional skills concerning the knowledge of secondary instruments as for example “plays commonly used strums on the guitar” (p. 146) were rated well above the midpoint.

A greater emphasis on practical knowledge was also found within the results of a study conducted by Petrie (1989). In a survey of professional music therapists (educators, clinical training directors, and practicing clinical therapists) participants suggested that in the “ideal curriculum,” greater attention would be placed on functional music skills and the understanding of all handicapping conditions. A decreased emphasis would be placed on research and traditional music skills.

Jensen and McKinney (1990) collected music therapy curricula information from 66 colleges and universities. Similar to the studies discussed above, the authors found that certain areas bearing little direct application to the work of a music therapist were highly emphasized, while other areas considered “crucial” and “central” to the practice of music therapy were given little emphasis. The authors suggested a close examination of
music theory, music history, and applied music courses in order to evaluate their applicability to daily music therapy practice.

In a more recent study, Groene and Pembrook (2000) found music therapy faculty continued to desire changes towards more coursework promoting practical music skills. Faculty members considered the often required instrument technique classes (strings, brass, and woodwinds) as unnecessary for the role current music therapists play in the clinical setting. They reasoned that in the past, music therapists worked in facilities housing hundreds to thousands of residents. Creating patient bands or orchestras in order to reach a greater number of clients was often part of the therapeutic process. Today, the majority of music therapists work in smaller institutional settings, where small group and individual work dominates. Because of this, “smaller ensemble and individual therapy technique classes such as hand percussion, functional guitar, functional piano, improvisation, electronic sensory music systems, popular music ensembles, and similar courses” (p. 98) would be more useful and applicable.

**Music Therapy Clinical Internship**

The American Music Therapy Association requires that students complete 1200 hours of clinical training prior to graduation. Approximately 200 of these hours are attained through a series of practicum rotations in the students’ Junior and Senior years. The remaining 1000 hours are accounted for in the music therapy internship.

The internship process is a challenging experience from the start. During the last year of academic studies, students apply to approximately three internships of their
choice. Interviews, auditions, and in-depth written reflections are part of the internship application process. The clinical internship serves as a transitioning point between being a student and becoming a professional music therapist. It is a time when students have the opportunity to integrate and polish the theoretical and practical skills obtained during their previous years of academic studies.

As interns, students receive supervision from either the clinical internship director or the supervising music therapist(s). In order to provide supervision to students, internship directors and designated supervisors must meet specific criteria which includes having graduated from an approved AMTA training program, being board certified, having a minimum of two years (supervising music therapist) or three years (clinical internship director) of professional experience, completing the Continuing Music Therapy Education (CMTE) course on intern supervision, being a member of the AMTA, and demonstrating evidence of pursuing continuing education (AMTA, 2012b). Often, the internship is one of the last times the music therapist will receive close supervision by a credentialed music therapy professional, as research shows that two-thirds of practicing music therapists, including clinical internship directors and supervising music therapists, do not receive adequate professional supervision (Jackson, 2008).

The characteristics of internship directors have been studied by researchers in the field. Tanguay (2008) found 90% of clinical internship directors are females with approximately 16 years of professional experience. These professionals had held the title of internship director for 7.7 years and almost half had supervised ten interns or fewer. Educational levels among directors varied: 36% had a bachelor’s degree, 46% had a
master’s degree or higher, and 3% had a doctoral degree. Eighty-one percent of the clinical directors surveyed had completed the 5 hour CMTE course.

According to the AMTA’s Internship Approval Committee (2010), the music therapy internship can be divided into five distinct stages: orientation stage (month 1), learning stage (months 2-3), development stage (month 4), maturation stage (month 5), and entry-level professional stage (month 6). During each of these phases, the intern has a unique set of needs. The role of the supervisor is also in a constant state of change, particularly when delineating boundaries, offering support, outlining expectations, and promoting the intern’s independence.

**Music Therapy Clinical Internship Literature**

Similar to the research literature concerning music therapy curriculum, studies pertaining to clinical internship are limited. Among the recurrent themes found in the literature are students’ concerns, perceptions, and emotions surrounding the internship/practicum experience (Madsen & Kaiser, 1999; Wheeler, 2002; Grant & McCarty, 1990), students’ clinical behaviors exhibited during music therapy sessions (Darrow, Ghetti, &Johnson, 2001), characteristics of internship supervisors and directors (Tanguay, 2008), means for delivering feedback (Furman, Adamek, & Furman, 1992), and issues related to university-affiliated music therapy internships (Miller & Kahler, 2008).

Research has shown that students experience an array of emotions and concerns prior and during the music therapy internship. Madsen and Kaiser (1999) found that pre-
internship students experience fears related to not being adequately prepared to succeed in their internships. Many worry about the relationships they will develop with their supervisors, their liking of the placement, as well as their therapeutic effectiveness with clients. Grant and McCarty (1990) found that throughout the internship, students experience an array of emotions, and that their feelings toward the internship, typically varying from month to month, are often influenced by factors such as marital status, and whether or not they are in a paid or unpaid position and are in a placement with a population of their choice.

Supervision practices that support students’ success in the clinical setting have been studied by multiple researchers. Furman, Adamek, and Furman (1992) evaluated the effectiveness of an auditory device in transmitting feedback to students during their sessions. They found students receiving feedback through the auditory device scored higher on the Standley Group Activity Leadership Skills Checklist (a commonly used assessment tool) as compared to students in the control group. In a similar study, Adamek (1994) found students who received immediate feedback through an auditory device while doing a session scored higher in the areas of direct client contact; specifically in helping clients participate in activities, providing specific reinforcement, and exhibiting appropriate body proximity. In a study of clinical internship directors, the most frequently used supervision techniques included co-leading sessions, providing observation and feedback, and reviewing assignments with the student (Tanguay, 2008).

Research has identified student clinical behaviors that lead to effectiveness in the therapeutic setting. Darrow, Ghetti, and Johnson (2001) found that students considered
“personable” were more effective clinicians; as were the students who built strong rapports with their clients. They also found that quality of musical behaviors delivered (singing, playing instruments, and active listening) was more important than quantity with respect to clinical success.

Students engaged in clinical work have specific needs that only their supervisors can meet. Wheeler (2002) interviewed music therapy practicum students and found that students desire more orientation (to the actual setting), structure, and information when beginning a new practicum. Students expect for their supervisors to support and respect them but also offer feedback that will contribute to their improvement. In addition, students would like more advice from their supervisors concerning session planning. Knight (2008) also conducted a study assessing the needs of pre-internship students. Results showed students are highly concerned with “finding out what will be expected of me as an intern” (p. 84); whereas internship supervisors are more concerned with assisting students in accurately diagnosing their clients’ needs. Students and supervisors differed in their concerns over “communicating with facility staff” and “maintaining client confidence” (p. 75); with students reporting a lower level of concern as compared to supervisors.
Introduction to Burnout

All professionals are at risk for burnout. Those in the helping professions (such as teaching, nursing, social work, and music therapy) are especially susceptible to this phenomenon, as they are often the people who are the most committed to their jobs (Fowler, 2006; Larson, 1993 as cited in Clements-Cortes, 2006; Maslach, 2001; Sprang, Clark, & Whitt-Woosley, 2007). This has come to be known as compassion fatigue, a stress-related side effect of knowing about and being involved in dramatic and potentially fatal events in clients’ lives (Clements-Cortes, 2006; Sprang et al., 2007). Indeed, for healthcare workers, the severity of their patients’ diseases is a predictor of their own levels of compassion fatigue and burnout (Sprang et al., 2007).

The most frequently recognized explanation of burnout comes from Maslach (1976, 1982, 1998), who describes burnout as consisting of a triad of elements. First, there is emotional exhaustion, the most commonly reported and frequently studied dimension of burnout (Maslach, 2001). Resulting from heavy workloads, a lack of perceived emotional support, as well as a heightened and persistent level of job stress, emotional exhaustion may lead to frequent absences, finding scapegoats for problems, poor productivity, anxiety, irritability, and depression (Bitcon, 1981; Clements-Cortes, 2006; Fowler, 2006; Maslach, 2001).

The second component of burnout is depersonalization, an intentional detachment from others, especially those receiving care. In healthcare, depersonalization often
begins with good intentions--an attempt at remaining detached from patients in order to protect oneself from emotional burdens--but can sometimes go too far. In these cases, the healthcare provider has little concern or empathy for patients, leading to negativity, intolerance, and cynicism (Maslach, 2001).

It is possible that the aforementioned elements of burnout may lead to the third: lack of personal accomplishment. With this third dimension comes reduced productivity, a lack of professional growth, increased feelings of incompetence, low self-actualization, and inefficacy (Maslach, 1976, 2001; Wright, 1997). Not surprisingly, there is a negative relationship between emotional exhaustion and work performance (Wright, 1997). Additionally, some of the decline in perceived personal achievement can be attributed to low self-esteem, as even if a practitioner is successful in her job, she may not recognize this due to high levels of cynicism and exhaustion. Research has shown that people with high self-esteem have lower levels of depersonalization and exhaustion (Clements-Cortes, 2006).

**Burnout in Music Therapy**

Little research has been done concerning the burnout music therapists may face; however, what has been done has been congruent and on par with studies in other areas of healthcare. Similar to other fields, the most common stressors for a music therapist are heavy workloads, low pay, conflicting philosophies within the workplace, and few opportunities for advancement. Other stressors include inappropriate referrals, over-
policing or neglect by administrators, short staffing, and required overtime (Bitcon, 1981; Clements-Cortes, 2006; Oppenheim, 1987; Vega, 2010).

Specific to music therapy, though, is the emotional toll of working with other professionals who do not understand or value the role of the music therapist. Several participants across many studies expressed frustration over being disrespected, unappreciated, and misunderstood by their peers (Bitcon, 1981; Clements-Cortes, 2006; Vega, 2010). Stories of nurses interrupting critical moments in therapy sessions to comment on the beautiful music being made, doctors mistaking a music therapist for a guest entertainer or volunteer musician, and people making comments like, “You are so lucky; you get to sing songs all day,” permeated the lives of the four participants in Clements-Cortes’ (2006, p. 33) qualitative study.

Feeling that others do not understand one’s job creates feelings of isolation, which, in return, can cause burnout (Clements-Cortes, 2006). Making matters worse is the reality that many music therapists are already physically isolated, as they are often the only music therapist on staff at their facilities. Research has shown that working with other music therapists improves job satisfaction, as does the ability to talk to knowledgeable others (Fenlason & Beehr, 1994; Vega, 2010). With a negative relationship between social support and job stress (Fenlason & Beehr, 1994), music therapists have to work extra hard to overcome feelings of isolation in the workplace.

Additionally, some music therapists are in a unique position in that they are expected to raise funds for their program. While fundraising in medical professions is not unprecedented, it is not usually the employees themselves advocating their work to
donors. As a result, some music therapists have to juggle the pressures of accomplishing their jobs with the uncertainty that holding those jobs is dependent upon their abilities to convince others to donate funds (Clements-Cortes, 2006).

Rates of burnout for music therapists have remained fairly stable over the past few decades. Oppenheim (1987) found that, of 239 music therapists surveyed for the study, the majority of the participants scored in the medium range of burnout on the Maslach Burnout Inventory (MBI) (1996). Approximately 12% of respondents scored at the high level of burnout. At the time, their most frequently cited criticisms were in regards to poor administrative support, low pay, holding responsibilities outside of their field, and lack of respect from their peers.

In 2006, Fowler found that music therapists scored at the midpoint for burnout among other professionals who completed stress profile tests. Results of the study indicated that music therapists have low levels of depersonalization (a higher level of depersonalization would indicate a higher degree of burnout) with no significant difference found between men and women.

More recently, Vega (2010) found similar results. In an examination of 137 music therapists from across the nation, she found that 11% of participants had high levels of burnout indicated by the MBI (1996). Overall, the participants had average scores for emotional exhaustion, and very low scores for depersonalization and personal accomplishment. A very low score for depersonalization is congruent with the findings of the study, as high levels of depersonalization and emotional exhaustion would have resulted in a greater percentage of music therapists with high burnout. A low score in
personal accomplishment is also congruent with the results as it is indicative of some level of burnout. This may help give credence to the criticism of many music therapists that there are few opportunities for rewards or professional advancements within the field, one of the major contributing factors to burnout. Indeed, less than 1% of participants had low levels of burnout.

In the same study, Vega (2010) examined the personality traits of music therapists to determine if there is a relationship between personality and burnout in the field. Emotional sensitivity was the personality trait most often exhibited by her participants, providing some insight into the low levels of depersonalization reported in her own and others’ research. Additionally, she found that anxiety significantly predicts emotional exhaustion in music therapists, while dominance significantly predicts personal accomplishment.

There is evidence that those who have remained in the field the longest have the lowest rates of burnout. Fowler (2006) found that the music therapists who have been in the field the longest have higher rates of cognitive coping strategies and higher feelings of personal achievement, possibly as a result of reporting low feelings of threat and receiving positive feedback over longer periods of time. Concurrently, Fowler (2006) points out the methodological limitations of conducting burnout, well-being, and longevity studies; as those music therapists who left the profession due to dissatisfaction or other factors are not represented in the samples studied. Overall, though, music therapists are remaining in the field longer now than they once did. Through the 1980’s, therapists practiced for three to six years (Braswell, Decuir, & Jacobs, 1989 as cited in
Vega, 2010). Over time, this has increased from five to ten years (Cohen, Hadsell, & Williams, 1997 as cited in Vega, 2010) to what is now estimated to be thirteen to fourteen years (AMTA Sourcebook, 2004 as cited in Vega, 2010).

**Burnout Prevention**

It may not be possible to reverse the effects of burnout (West, 2009), so it is imperative that music therapists are trained in coping strategies prior to entering the field, in addition to supportive sessions throughout their career. Rowe (1999) found that healthcare providers who received short, but frequent, coping refresher sessions over the span of two years showed consistent declines in burnout. Their peers who received one longer, more intense course showed temporary declines in burnout, but burnout levels increased again over time. Both courses taught participants how to create coping strategies as well as how to address problems in the workplace proactively and positively.

In-service training as specific to one’s field as possible may also be beneficial to music therapists. Those who work with geriatric populations receive the same undergraduate training as those who work with children, however, there are different emotional and cognitive challenges within both areas. Coping strategies targeted for one area of professional work may help to alleviate emotional exhaustion in music therapists. This is confirmed by Sprang et al. (2007), who found that healthcare professionals in trauma-related fields who received training specific to trauma work had higher levels of compassion satisfaction (the positive end of the compassion fatigue spectrum) than their peers without such training.
Additional coping strategies offered by those who have practiced music therapy for several years include: keep in touch with other professionals, maintain a healthy diet, read for fun, exercise, allow unplanned chunks of time in one’s schedule, take vacation time, learn to perceive office work as integral to one’s job – not just a frivolous task, make music, develop a hobby, continue one’s education, conduct research, set personal and professional goals, prioritize time to family and friends, attend professional conferences, and maintain a sense of humor (Bitcon, 1981; Clements-Cortes, 2006; Fowler, 2006; Wilhelm, 2004).

Summary

Music therapy has evolved tremendously over the last 60 years. The establishment of the National Association for Music Therapy in 1950 marked an important milestone for the profession, formalizing music therapy as a field of study and providing representation at the national level. Beginning with a single bachelor’s program at Michigan State University in 1944, degrees in music therapy are now offered in over 70 American colleges and universities. Presently, over 5,300 professionals provide music therapy services to children and adults across the United States.

Founded in 1998 through the unification of the National Association for Music Therapy and the American Association for Music Therapy, the American Music Therapy Association has worked diligently to raise awareness of the field among the general public and various professional communities. It has advanced the profession in important areas including education and clinical training, research, credentials, and professional
standards. Over the years, the AMTA has developed a series of guiding documents that reflect the mission and values of the organization. In this chapter, the Professional Competencies, Code of Ethics, and Standards of Clinical Practice were reviewed.

An examination of the literature concerning music therapy curriculum, clinical internship, and burnout indicates further research in these areas is needed. The majority of the studies pertaining to music therapy curriculum were published in the 1980’s and 1990’s, and evaluated the curriculum’s effectiveness and relevance to professional music therapy practice. The clinical internship literature also dates back to the 1980’s and 1990’s, and the issues studied relate to methods of supervision, students’ emotional stages prior and during the internship, characteristics of internship directors and supervisors, and students’ clinical behaviors. Over the last 30 years, the field of music therapy has expanded in multiple ways, including the number of clinical populations served and the specializations awarded through unique university programs and continuing education trainings. As a result, the Professional Competencies have continued to expand, as has the CBMT’s Scope of Practice. These advances in the profession call for current research in the areas of curriculum and clinical training, in order to ensure music therapy students are receiving the most pertinent education for current professional practice.

Lastly, the review of literature concerning burnout indicates music therapists are at high-risk for experiencing this phenomenon, particularly because of the emotionally exhausting nature of their jobs. Further research in this area could shed light on
successful prevention strategies and coping mechanisms specific to the needs of music therapy professionals.
Chapter 3: DESIGN AND METHOD

The purpose of this study was to provide members of the music therapy community (music therapy faculty, board members, clinicians, and students) with a picture of the current status of the field, including its priorities and possible future directions. My research questions were directed to uncover issues related to:

1) What experiences affect the professional growth of music therapists?
2) What are the opinions regarding the undergraduate music therapy education requirements?
3) What are the most important achievements of the music therapy profession, and what are its current challenges?
4) What are the current research trends in music therapy? Are there areas that require further research attention?
5) What are the long-term goals of the music therapy profession?
6) How is music therapy portrayed in the media?

Rationale for Research Perspective

A qualitative research approach served as the foundation for this study. Qualitative studies aim to contextualize, understand, and interpret “how the various participants in a social setting construct the world around them” (Glesne, 2006, p. 4). The researcher observes participants in natural environments, searching for patterns,
pluralism, and complexity in that which is being studied. Qualitative studies provide thick, rich descriptive write-ups so that the reader is able to center herself within the research context. Personal involvement as well as empathic understanding with the participants is part of the research protocol. “Qualitative research methods are used to understand some social phenomena from the perspectives of those involved, to contextualize issues in their particular socio-cultural-political milieu, and sometimes to transform or change social conditions” (Glesne, 2006, p. 4). As this study sought to examine the current status of the field of music therapy as well as plans for the future of the profession through the opinions and perspectives of music therapy faculty and board members, I considered a qualitative research approach to be most appropriate.

**Participant Selection**

A purposive or judgmental sampling and procedure was used to select participants for this study. Purposive sampling involves utilizing the researcher’s “experience and knowledge to select a sample of participants that they believe can provide the relevant information about the topic or setting” (Ary, Jacobs, and Sorensen, 2010, p. 429). It is a common practice for qualitative researchers to be purposeful in selecting their participants and settings. In qualitative research, “sampling is almost never representative or random but purposive, intended to exploit competing views and fresh perspectives as fully as possible” (Guba & Lincoln, 1981, p. 276). A variation of purposive sampling, known as “maximum variation sampling” was utilized in the selection of participants. Maximum variation sampling entails selecting participants who
will serve the purpose of maximizing differences on specified characteristics. “This type of sampling reveals differences but may also identify commonalities across the units” (Ary et al., p. 429).

The participants for this research study were college and university professors of music therapy and active members of the American Music Therapy Association (AMTA). As the field of music therapy is female dominated, the majority of the participants selected were women. As part of the selection criteria, I decided that all participants to be interviewed would have the Music Therapist-Board Certified (MT-BC) credential or the Registered Music Therapist (RMT), Certified Music Therapist (CMT), or Advanced Certified Music Therapist (ACMT) designation as well as a minimum of four years of professional experience.

Seventy-one American colleges and universities offer degrees in music therapy. When considering the seven regions of the AMTA, the number of degree programs per region is as follows: Mid-Atlantic (17), Great Lakes (16), Southeastern (15), Midwestern (8), Southwestern (6), Western (6), and New England (3). Based on the number of degree programs per region, I interviewed one music therapy faculty per region for those regions with eight or fewer schools offering music therapy as a major, and two music therapy faculty per region for those regions with nine or more schools offering music therapy as a major. I selected eight as the cut-off number as the highest number of schools per region was seventeen (Mid-Atlantic). In total, eighteen music therapy faculty and board members participated in the study: Mid-Atlantic (2 faculty, 1 board member), Great Lakes (2 faculty, 1 board member), Southeastern (2 faculty, 1 board member),
Midwestern (1 faculty, 1 board member), Southwestern (1 faculty, 1 board member), Western (1 faculty, 1 board member), and New England (1 faculty, 1 board member). An additional participant who had served the field in a leadership capacity in the past years was also interviewed.

To select specific participants from the seven regions, multiple criteria were established in addition to those mentioned above. First, in order to obtain a heterogeneous sample, I chose to interview faculty from various therapeutic approaches; selecting four distinct and broad orientations in the field: Behavioral Music Therapy, Nordoff-Robbins Music Therapy, Bonny Method of Guided Imagery and Music, and Neurologic Music Therapy. One faculty member was interviewed per therapeutic approach. Longevity in the field was established as another eligibility criterion, and I interviewed both junior and senior music therapy faculty. Two faculty members belonging to each of these categories were interviewed. In addition, I interviewed two members of the association who had received Lifetime Achievement Awards, the highest honor given by the AMTA. For participant selection of the active board members of the AMTA, I interviewed past as well as current presidents/president elect/vice presidents/vice president elect from each of the seven regions. An additional participant who currently was not serving as a professor or board member but had provided years of service to the profession in an important capacity was also interviewed.
**Procedure**

A structured phone interview was the primary source for collecting data for this research study. Based on the selection criteria, a list of potential participants was created. The contact information for these participants was gathered from the 2011 AMTA Member Sourcebook, an annual publication that contains the names, postal/email addresses, and phone numbers of all registered members of the association. Once the contact information had been gathered, potential participants were emailed and asked to participate in the study (Appendix C). If a response was not obtained from the potential participant, after seven to ten business days following the initial email, a follow-up email was sent. If the potential participant declined to participate in the study, another participant of similar characteristics was contacted and asked to participate. For those music therapy faculty and board members who volunteered to participate in the study, a date and time was scheduled for the phone interview.

**Interview Method**

I began the interviews by reading a verbal consent script to the participant (Appendix D). Through the verbal consent script, the participants were informed of their right to withdraw from the study at any time, the right to decline to discuss any issue or answer any question(s), that their name, professional role, or school affiliation would not be linked to anything they said, and that all data would be kept confidential. The participants were also informed that the interviews would be recorded and that after
the interview had been transcribed, the audio recording would be deleted. All participants agreed to be interviewed and recorded after the consent script was read.

Phone interviews were recorded using a Tascam DR – 05 handheld recorder and transcribed on a laptop computer using the audio player software Express Scribe, which allowed for control of playback speed and supported the use of a foot pedal. Following the completion of the interview, participants were mailed a thank you card that included the contact information for the researcher and research adviser (Appendix F). Once the interviews had been transcribed, participants were emailed a copy of the transcript to check for accuracy and make any desired changes.

All digital and transcribed data collected for this study were kept on thumb drives and a 3-ring binder in a locked filing cabinet inside the researcher’s office. Per university Internal Review Board guidelines, the participant data will be properly disposed, destroyed, or deleted five years following the closure of the study.

Data Analysis

The present research study sought to explore six major areas concerning the music therapy profession including: professional growth of music therapists, curriculum, strengths and recommendations for continuation of successful practice, current research focus, history and future directions for the field, and portrayal of music therapy in the media. Through thematic analysis, “a process that involves coding and then segregating the data by codes into data clumps for further analysis and description” (Glesne, p. 147), similarities and differences were drawn. According to Glesne (2006):
Data analysis involves organizing what you have seen, heard, and read so that you can make sense of what you have learned. Working with the data, you describe, create explanations, pose hypotheses, develop theories, and link your story to other stories. To do so, you must categorize, synthesize, search for patterns, and interpret the data you have collected (p. 148).

Steps in the data analysis process included transcribing and printing the interviews, reading each transcript several times, categorizing the themes and patterns found into a list of *a priori* codes, and underlining and making notes of emerging themes.

**Coding of the Data**

In order to categorize the data, I developed a list of *a priori* codes which emerged directly from the interview questions. I assigned a specific color to each of the *a priori* codes so that the resulting data segments would be easily distinguishable. Fourteen codes emerged and they were as follows:

- Professional growth of music therapists
- Personal and professional rewards
- Personal and professional challenges
- Professional supervision
- Collaboration and networking
- Education and clinical training
- Internship
- Present status
- Long-term goals
- Music therapy research
- History
- Documentation
- Advocacy
- Mass media
In order to support intercoder dependability (reviewed later in this chapter), I developed a coding agreement that I as well as two independent coders who assisted with this portion of the study would utilize. The coding agreement included the following criteria:

1) Utilize the operational definitions provided for each of the *a priori* codes to guide the coding process.

2) Segment large chunks of text that clearly represent the *a priori* code and mark all parts of the code: beginning, middle, and end to facilitate the data analysis process.

3) Look for emerging/recurrent themes that do not fit into any of the *a priori* codes and underline in black.

**Operational Definitions of the Codes**

**Professional growth of music therapists:** the skills or knowledge music therapists gain (post initial music therapy education) which optimize personal development and job growth (career advancement). This can include: advanced degrees, continuing education, attending conferences and training sessions, mentoring, and participation in communities of practice.

**Personal and Professional Rewards:** refers to positive experiences music therapists have had with their clients, students, and colleagues as well as the recognition they have
been given by peers and organizations (for example, academic institutions, employment facility, American Music Therapy Association, and the *Journal of Music Therapy*).

**Personal and Professional challenges:** refers to challenges music therapists have had with clients, students, colleagues, organizations (academic institutions and employment facility), administrators, and the general public. It also concerns burnout issues among music therapists.

**Professional Supervision:** “supervision includes, but is not limited to, formal and informal observation and interaction in the areas of: direct patient contact, evaluation and documentation, treatment planning, supervision, participation in interdisciplinary didactic sessions, team involvement, participation in training sessions, and staff relationships” (http://www.musictherapy.org/careers/national_roster_internship_guidlines/).

**Collaboration and networking:** any time a music therapist works with an individual person, group, or association in order to create or to share session plans, research, and exchange ideas. This can also include providing or receiving emotional support from colleagues and members of the music therapy and/or outside communities.

**Education and clinical training:** the theoretical and practical knowledge acquired by music therapy students during their years of study. Any reference concerning the AMTA Professional Competencies, AMTA Standards for Education and Clinical Training,
curricular structures as defined by the National Association of Schools of Music (NASM), practicum experiences, curriculum highlights of specific university programs, personal and professional attributes of music therapy faculty, entry-level competencies/curriculum, and degree programs.

**Internship:** the extensive clinical experience that begins following the completion of the music therapy coursework. Includes goals, supervision, and potential challenges that may arise during the internship.

**Present status:** the current state of the music therapy profession in regard to its acceptance within the medical and/or educational community, challenges it is currently facing (economy, employment, size of the profession, certification and licensure, reimbursement, public perception); or recent accomplishments (1998-2012) that have strengthened the profession.

**Long-term goals:** what the participants hope the field will accomplish in the next ten to fifteen years. This includes growth of the profession in terms of its members, areas served, jobs, state licensure, reimbursement, and recognition by the general public, medical profession, and educational community. It also includes plans for master’s level entry.
**Music therapy research:** systematic investigations done to establish facts, analyze information, and reach new conclusions. Includes the Strategic Priority on Research, research designs, methods of inquiry, and areas of research (for example, clinical populations, teaching and learning, and professional development).

**History:** unique events that shaped the music therapy profession, such as the establishment of the National Association for Music Therapy and the American Association for Music Therapy, the merging of these two associations into the AMTA, the establishment of a music therapy curriculum in the 1940’s, the adoption of the first music therapy curriculum by the National Association of Schools of Music and the NAMT, the establishment of music therapy training programs in American colleges and universities, and the formation of the Certification Board for Music Therapists.

**Documentation:** the practice of maintaining accurate and complete records on the diagnosis, treatment, outcomes, and care of all clients (Davis, Gfeller, & Thaut, 1999).

**Advocacy:** refers to various efforts made by the American Music Therapy Association and its members to promote and support the field.

**Mass Media:** this refers to all media technologies conveying both accurate and inaccurate information about music therapy to large audiences through mass communication. Media technologies include newspapers, magazines, movies, radio,
television, CD’s, DVD’s, and the internet including email, social media, blogging, and websites.

Methodological Validity

A series of steps were taken to ensure that the data collected for this study was trustworthy and reliable. These steps included:

1. Triangulation of the data. Data for this study were collected from different data sources: music therapy faculty and board members of the AMTA who differed in philosophical approaches to music therapy, years of experience, and geographical location. Triangulation of the data is a qualitative research practice in which the investigator uses multiple data collection methods in order to increase confidence in the research findings (Glesne, 2006).

2. Member-check. A verbatim transcript of the interview was sent to participants to ensure accuracy. Participants were asked in the email to read over the transcript in order to make sure they were well represented and to make any desired changes to their statements. Member-checking includes sharing various aspects relevant to the investigation with the participants (interview transcripts, analytical thoughts, final report) to ensure they are being represented in an accurate manner (Glesne, 2006).

3. Peer debriefing of the findings. Peer debriefing allows the researcher to become aware of his/her posture towards the data gathered as well as the conclusions obtained. The process of peer debriefing can serve as an opportunity to explore
“aspects of the inquiry that might otherwise remain only implicit within the inquirer's mind” (Lincoln & Guba, 1985, p. 308). A music therapy colleague and a retired professor of educational psychology served roles for peer debriefing.

4. Clarification of researcher bias. I maintained a reflective journal through the duration of the interviews. The purpose of the journal was to examine personal assumptions and subjectivities concerning the topics explored.

5. I used rich, thick descriptions in the presentation of the data which will allow for readers to “enter the research context” (Glesne, 2006, p. 38).

6. Face Validity. Defined as “the extent to which examinees believe the instrument is measuring what it is supposed to measure” (Ary et al., p. 642). The interview questions (Appendix E) were reviewed and rated by a panel of experts, in this case, two music therapy faculty and one AMTA board member. The three individuals received the interview questions through email and were asked to rate the adequacy of each question on a seven-point likert scale. They were also asked to rate the overall assessment of the instrument as well as provide suggestions for changes or additional questions. Opinions were also obtained estimating the approximate length of time questions would take, and the level of participant comfort surrounding the questions. The interview questions were refined based on their comments and suggestions.

7. Intercoder Dependability. In order to assess the consistency of the content analysis, I asked two independent coders (a music therapist and a retired educational psychology professor) to code five of the eighteen interviews. I then
compared my coded transcripts with each of the two independent coders’ transcripts. As Ary et al. (2010) stated “to enhance reliability, the researcher wants to demonstrate that the methods used are reproducible and consistent, that the approach and procedures used were appropriate for the context and can be documented, and that the external evidence can be used to test conclusions” (p. 502).
Chapter 4: PRESENTATION OF THE DATA

The purpose of this study was to obtain a comprehensive picture of the present status of the field of music therapy by investigating topics that affect the daily professional experience of music therapists and directly impact the future of the field. To obtain the study data, I interviewed eighteen members of the music therapy profession: ten music therapy faculty, seven active members of the board of the American Music Therapy Association (AMTA), and an additional member who had served the field in an important capacity for many years. The participants I chose to interview differed in their approaches to music therapy, years of experience in the field, roles they had played within the AMTA, and geographic location.

In this chapter, I present the data collected through the phone interviews. First, I review the \textit{a priori} codes and changes that occurred to the original list of codes throughout the data analysis process. Then, I discuss the methodological validity of the study in relation to the intercoder dependability results. What follows is a presentation of the data pertaining to each of the \textit{a priori} codes.

\section*{Categorization and Changes to the Codes}

In order to categorize the data, I developed a list of \textit{a priori} codes that emerged from the interview questions. The original list of \textit{a priori} codes were:

\begin{itemize}
  \item Professional growth of music therapists
\end{itemize}
- Personal and professional rewards
- Personal and professional challenges
- Professional supervision
- Collaboration and networking
- Education and clinical training
- Internship
- Present status
- Long-term goals
- Music therapy research
- History
- Documentation
- Advocacy
- Mass media

As I coded the data, I began to see codes that overlapped with each other and on that basis, the following codes were merged: Professional supervision and Collaboration and networking were merged with Professional growth of music therapists; Advocacy and History were merged with Present status; and Internship was merged with Education and clinical training. In order to accommodate the merging of codes, the operational definitions of the codes found in Chapter 3 were expanded. Following content analysis of approximately half of the interviews, I eliminated Documentation as references to this code were minimal and the data provided did not pertain to the purposes of this study. Through merging and elimination, the final list resulted in the eight following codes:

- Professional growth of music therapists
- Personal and professional rewards
- Personal and professional challenges
- Education and clinical training
- Present status
- Long-term goals
- Music therapy research
- Mass media
In order to code the data, I read each transcript several times. The data segments that emerged from the content analysis were placed under their respective codes, and when appropriate, organized in a hierarchical order based on the frequency with which they were mentioned by the interviewees, with the ones mentioned with the most frequency placed on top and those with less frequency towards the bottom.

**Intercoder Dependability**

As explained in the methodological validity section of Chapter 3, two independent coders examined and coded five of the eighteen interview transcripts. In order to obtain the rate of intercoder dependability, I compared each of my coded transcripts to those of the independent coders. For each transcript, I calculated the total number of coded sections. Then, I added up the number of times the independent coder and I agreed on a code and the number of times we disagreed. The number of agreements was then divided by the total number of coded sections and the rate of agreement was obtained. To calculate overall dependability with each of the independent coders, the rate of agreement obtained for each of the five transcripts were added and divided by five.

Through this calculation, it was determined that the agreement rate with coder one was 85.24%. The agreement rate with coder two was 85.40%. Overall, the agreement rate among the two independent coders and me was 85.32%.
Participant Profiles

Participants for this study were music therapy faculty and active members of the American Music Therapy Association (current or past Presidents, Vice-Presidents, President-Elect, or Vice President-Elect), with an additional participant who had served the profession in a leadership capacity. The participants interviewed ranged in professional experience from four to forty-five years. Their combined years of experience was 462 years with the average length being 25.6 years. All but two of the participants had at least a master’s level education, with seven of the eighteen interviewees holding a doctoral degree. The participants’ undergraduate education included degrees in music therapy, music therapy equivalency, philosophy, and psychology. The participants held advanced degrees in the fields of music therapy, creative arts therapies, education, counseling, music education, special education, and counselor education. Seventeen participants held the Music Therapist-Board Certified credential (MT-BC). One participant held the Advanced Certified Music Therapist (ACMT) designation. Additional credentialing and specializations of participants included Neurologic Music Therapist (NMT), Neonatal Intensive Care Unit-Music Therapist (NICU-MT), Nordoff-Robbins Music Therapist (NRMT), Fellow of the Association for Music and Imagery (FAMI), Licensed Professional Counselor (LPC), and Licensed Mental Health Counselor (LMHC). Almost all study participants were currently serving roles in the AMTA at either the regional or national level. All participants had served a role within AMTA or the previous NAMT/AAMT at some point throughout their professional histories. Involvement with the Association included
serving on the Board of Directors, serving in specific committees, serving as an
Assembly Delegate, and serving as President, Vice-President, President-Elect, or Vice
President Elect for one of the seven regions. Many of the participants also held
professional responsibilities that included serving on the editorial boards of journals such
as the *Journal of Music Therapy*, *Music Therapy Perspectives*, and *Arts in
Psychotherapy*; being part of a Certification Board for Music Therapy committee; and
taking leadership in their state’s music therapy organization and/or their state’s State
Task Force for Music Therapy Recognition.

Additionally, the participants who were music therapy faculty served multiple
roles within their colleges and universities. Those who did not hold a faculty designation
held important roles within their communities. Of the eighteen participants I interviewed,
eleven remained active music therapy clinicians working with diverse populations
including children and adults with autism, behavioral disorders, cancer, chronic pain,
developmental disabilities, mental health diagnoses, and neurological impairments.

The interviewees represented differing theoretical approaches to music therapy,
this evident by the different credentialing and degrees. While most had many years of
service, I was able to obtain perspectives from younger music therapists by interviewing
participants who had served the profession for ten years or less. Geographic diversity
was also great among the participants, with fifteen states represented in the study:
Alabama, Arizona, California, Colorado, Florida, Indiana, Massachusetts, Michigan, New
York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, and Texas. Many
of the participants interviewed had been recognized through awards by the AMTA at
some point throughout their professional careers. The awards received by the participants in the study included Lifetime Achievement Award, Professional Practice Award, Fultz Research Fund, Special Presidential Award, Award of Merit, Presidential Award – Commission Member, Service Award, and the Research/Publications Award. Some of the participants had been recipients of more than one of the awards mentioned.

Results

The following section contains a presentation of the data pertaining to the eight a priori codes (Professional growth of music therapists, Personal and professional rewards, Personal and professional challenges, Education and clinical training, Present status, Long-term goals, Music therapy research, and Mass media). In order to enhance and facilitate understanding for the reader, direct quotes from the interviews have been included. Tables containing the data reduced to a list format are provided at the end of each code discussion. This section will also present three recurring themes that emerged from the data analysis: “talking about music therapy,” “clinician-based research,” and “music therapy students’ skewed realities.”

Professional Growth of Music Therapists

Professional growth of music therapists included questions such as “What has contributed to your success as a music therapy professional?” and “What were some of the most important experiences that contributed to your growth as a music therapist?”
An important number of participants mentioned their education, first and foremost, as one of the most significant elements that contributed to their success in the field. Other important factors that led to success and increased professional growth included having mentors, collaborating and networking with music therapists as well as professionals from outside fields, taking continuing education, attending conferences, and staying on top of current music therapy research (see Table 1).

Many interviewees discussed the importance of surrounding themselves by a community of music therapists, with whom to bounce ideas, share the ups and downs of the daily professional experience, and seek emotional support. One participant stated:

There’s a great quote “in community we divide our pain and we multiply our joy.” . . . . What I notice is that music therapists who are plugged into their professional community stick around, and music therapists who are plugged in seem happier, more confident, more accomplished, more successful.

Another participant with similar beliefs disclosed that the main reason for why she has lived in the same city for years is because of the community of professionals she has built over time: “Being connected to a local community of music therapists has been huge for me. I’m so grateful for that because I know that’s not true for a lot of people.” Participants acknowledged it is not always easy for music therapists to develop a community of practice, particularly if they are the only music therapist in the facility in which they work or they live in a city or state with few professionals. Respondents discussed that serving the AMTA, whether at the national, regional, state, or local level could provide similar benefits to belonging to a close community of practice. One music
therapist advised taking advantage of today’s technology and arranging for frequent conference calls with others. She discussed regularly using websites such as FreeConferenceCall.com, a program that allows for multiple callers to simultaneously be on the same line. The participant suggested one of the biggest challenges for many professionals is taking the initiative to seek supportive relationships with others and finding the time to participate in peer mentorship and networking. She also mentioned music therapists do not always realize the importance of these activities for professional growth. “You just have to first of all know that you need that, whether it’s you are seeking out someone more experienced for supervision or you just want to talk to other music therapists and address an issue and get ideas.” One of the interviewees with approximately eight years of professional experience added the following regarding supervision:

I am not sure that it is stressed enough in the practice for young professionals. I think that is kind of said but I am not sure it is really stressed, including showing new professionals resources on how to find supervision. I think that is vital to success and also in eliminating the burnout rates that we have.

Teaching and supervising students were also mentioned as factors that contributed to professional growth, and the interviewees acknowledge obtaining great levels of satisfaction from seeing their students grow as both a therapist and a person.

To see your students as they go forth. Several of mine have gone on to earn advanced degrees and are now in college teaching positions themselves. Many
have made marks in the field in their own way, which is very rewarding. It’s like having your kids grow up and see how well they have done.

Working with students also allowed the professional music therapist to reflect on his/her own career and strengths, and to identify areas for continued growth. One respondent discussed supervising practicum students “really forces me to grow and to evolve as a therapist.”

Other unique aspects that were mentioned as having a positive impact on one’s career included having an educational background in a different field before becoming a music therapist. One professor commented, “My undergraduate degrees were not in music therapy, they weren’t even in music. They were in philosophy and psychology; so I feel like I had a really well-rounded and firm grounding in some areas that were just so fundamental to human knowledge and healthcare.” Coming from a popular music background rather than a classical music background was also discussed as contributing to personal success in the field:

I was pretty much a self taught pianist, guitarist, bass player. Throughout high school, college, and post college I did the rock band thing, and I learned all about how to be together with people in music. So understanding how to function with people in music, how to deal with personalities in music, was really a great preparation for music therapy.

Additional contributing factors included identifying issues within the field that interest the professional on a personal level and therefore fuel their research, desire to
present on the topic, and specialize in the particular area; and working in well-funded clinical programs, where a great level of autonomy is given.

Table 1

*Interviewee Comments Related to Professional Growth of Music Therapists*

<table>
<thead>
<tr>
<th>Most Frequently Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education (11/18 participants)</td>
</tr>
<tr>
<td>Mentors (10/18)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sometimes Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being part of a music therapy community (7/18)</td>
</tr>
<tr>
<td>Collaborating/networking with other music therapists and health care professionals (6/18)</td>
</tr>
<tr>
<td>Continuing education (5/18)</td>
</tr>
<tr>
<td>Readings/staying current (5/18)</td>
</tr>
<tr>
<td>Conferences (4/18)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Least Frequently Mentioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional supervision (1/18)</td>
</tr>
<tr>
<td>Being a knowledge seeker (1/18)</td>
</tr>
<tr>
<td>Constantly evaluating one’s own work (1/18)</td>
</tr>
<tr>
<td>Learning from students (professors) and clients (clinicians) (1/18)</td>
</tr>
<tr>
<td>Supervising students (allows for self-reflection) (1/18)</td>
</tr>
</tbody>
</table>
Table 1 continued

<table>
<thead>
<tr>
<th>Experience</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having autonomy in one’s job</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Working in a well-funded clinical program</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Having rich employment experiences</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Educational background in a different area</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Coming from a pop music background rather than a classical music background</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Having a peer supervision group</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Continuing to build musical skills</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Engaging in research</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Having family support</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Finding issues within the field that interested me on a personal level and led to research and presentations</td>
<td>(1/18)</td>
</tr>
<tr>
<td>Taking risks with employment</td>
<td>(1/18)</td>
</tr>
</tbody>
</table>

**Personal and Professional Rewards**

In order to understand what music therapy professionals consider to be some of the most meaningful aspects of their work, I asked questions such as “What have been some of the most rewarding experiences in your career as a music therapist?” A great number of the participants considered working with clients and observing their transformations and positive responses to music as the most rewarding aspect of their professional experience. One music therapy professor who remains an active clinician
comments, “It’s the part of my job I have always loved the most and I have spent 30 years trying to make sure that I have a job where I can still do clinical work.” Witnessing developments in the field and achieving professional milestones such as becoming a professor, obtaining a leadership role within the AMTA, or having the opportunity to serve as editor of various important documents pertinent to the field of music therapy were also mentioned (see Table 2).

Personal and professional rewards also resulted from influencing others to pursue music therapy as a field of study, serving as a mentor to students and interns, and knowing they were affected in a positive manner. One interviewee shares:

Something that has been rewarding is seeing some people that I had previously spoken with or had shadowed me decide to take on music therapy as a career…. That says that I had some sort of an influence on them, deciding what their career path would be.

Learning and drawing inspiration from both students and clients, being recognized through awards, publications, unique employment positions, conference invitations, and being in the company of other highly respected music therapy professionals were stated as well. One music therapist shared the experience of participating in one of AMTA’s committees early on in her career, and the excitement she felt while working with other music therapists she had always admired: “I remember sitting there thinking ‘who am I to be sitting in a room with these people? Let alone weekends with these people for four years?’ …. I felt it was such a huge responsibility.”
For those music therapists who serve as professors, seeing their students develop skills results in much satisfaction.

I like working with students who are just starting out and have so much enthusiasm…. I get to see them transform and grow, both personally and professionally as they move through the program. To me that is really exciting and probably why I continue to teach.

Table 2

*Interviewee Comments Related to Personal and Professional Rewards*

**Most Frequently Mentioned**

Working with clients and seeing transformations, progress, their gains, emotional responses to music, and hearing from them years later (16/18 participants)

**Sometimes Mentioned**

Preparing students to be music therapists, watching them grow, having their lives changed by positive educational experiences (7/18)

**Least Frequently Mentioned**

Being rewarded with unique employment and leadership positions (3/18)

Witnessing developments in the field (2/18)

Learning from students (2/18)

Being part of “think tanks” (2/18)

Recognition through awards and publications (1/18)

continued
Table 2 continued

Influencing others to seek careers in music therapy (1/18)

Solidifying ability to work with clients in a special setting (1/18)

Being invited to small conferences (1/18)

Being in company of people you admire (1/18)

Gaining inspiration from clients facing difficult situations and overcoming them (1/18)

Taking part in committees within the AMTA (1/18)

_______________________________________________________________________

Personal and Professional Challenges

Questions such as “What are some of the challenges you have faced as a music therapist, both in the academic and clinical setting?” and “What advice would you give to beginning professionals to prevent burnout and have long, fulfilling careers in the profession?” provided valuable information concerning common challenges faced by music therapy professionals on a frequent basis.

Two major areas were consistently brought up by many of the participants. These areas were the lack of understanding surrounding the field of music therapy both from the medical profession as well as the general public, and dealing with financial struggles that interfere with daily practice (see Table 3). As for the lack of understanding, participants discussed not being viewed as an equal therapy to fields such as physical and occupational therapy, and not being recognized and accepted by people outside of music therapy. A professor with over 30 years of experience in the field comments:
There is a fundamental disconnect in people’s mind between music as therapy or a healing discipline. I give talks and speeches all the time when I point out music can help us with this, music can help us with that, and they get it. But I can’t go and talk to every single person in the state.

Having to constantly define music therapy to others, being part of a small field which frequently results in work isolation, and feeling the need to defend the effectiveness of music therapy were also mentioned.

It is such a common thing, the lack of understanding from the public about what music therapy is. That we have to continually educate, and have our elevator speech ready to go at any time. I think that issue causes us to question our identity. I think that is one factor in increasing burnout and actually people leaving the field, because you can only do that so many times before you start to really wonder “who am I?, what am I doing?”

Financial struggles participants discussed included maintaining a successful private practice in today’s economy, dealing with reimbursement/waiver/grant issues, having low salaries, and losing hourly contracts as well as part-time or full-time positions due to budget cuts. One participant reflected on an especially difficult experience resulting from the recession a few years back. She discussed many of the music therapists in the area had been working in private practice and with the recession, budgets were cut and music therapy services were negatively affected. “They eliminated the payment for music therapy. A hundred people lost their jobs.” She continued to say “I have been around long enough to have seen this before, but you get to the point when you
say ‘when is it that we are not just going to automatically be cut?’” Other challenges included feeling isolated from other music therapists (particularly for those working in facilities where they were the only music therapy professional), experiencing burnout, and working with challenging clients.

Table 3

Interviewee Comments Related to Personal and Professional Challenges

Most Frequently Mentioned

Lack of recognition, understanding, and acceptance (8/18 participants)

Economic challenges for music therapists: discontinued contracts, difficulty finding/maintaining employment, low salaries, building a practice out of waiver/reimbursement programs, lack of funding (7/18)

Sometimes Mentioned

Constantly defining and explaining music therapy to others (3/18)

Being isolated from other clinicians (3/18)

Feeling the need to convince others about the effectiveness of music therapy (2/18)

Educating others about what we do, our value, so they take us seriously (2/18)

Least Frequently Mentioned

Experiencing burnout (1/18)

Not being viewed equally to other allied health professionals/other therapies (1/18)

Being part of such a small field (1/18)

continued
Table 3 continued

Overwhelming number of contact hours (1/18)

Respect from other music educators: Music therapy is not the place you send bad musicians (1/18)

Learning to speak in medical terminology (1/18)

Deal with the skepticism that comes from the medical profession (1/18)

Automatically getting cut due to lack of funding (1/18)

Believing music therapy is superior to other therapies (1/18)

Being aggressive when the field is misrepresented (1/18)

Feeling part of a group while being an international student (1/18)

Successfully maintaining a private practice (1/18)

Getting referrals from psychologists and psychiatrists for your private practice (1/18)

Questioning our identity (1/18)

Working with challenging clients (aggressive, nonresponsive) (1/18)

Realizing I don’t always know it all (1/18)

Respondents had an immense amount of knowledge to offer young music therapists so that they too could have fulfilling careers and prevent burnout which is so common for those in helping professions. All of the advice provided was relevant to having a successful career and burnout prevention, so I present the data together even though the responses were generated from two separate questions.
Music therapists suggested that young professionals should take continuing education classes, stay connected to the music therapy community both personally and professionally, attend conferences, stay current through readings, seek supervision, and collaborate and network with others in order to promote continued growth. Serving music therapy through state and regional music therapy organizations or the AMTA, specializing in an area of music therapy (NMT, NRMT, GIM, NICU-MT), pursuing research ideas, and developing versatile musical skills on as many instruments as possible were also suggested. Personal attributes that would contribute to professional growth included being creative, flexible, and thinking “outside the box” (see Table 4).

Many of the interviewed music therapists consider “maintaining a strong personal connection to music” (either through playing in a community ensemble or regularly “jamming with others”) and “using music for one’s own satisfaction and stress relief” as two of the most important ways to prevent burnout. One professor tells her freshman music therapy students “Continue to make the music you love.” She explains many music therapists get “burned out” on music, as they provide it for their clients on a daily basis and often have to practice so much for their work. As if speaking directly to young professionals, she continues to stress:

Stay connected to the music, go deeper in the music, keep learning, stay connected to other musicians and other music therapists, challenge yourself musically, take an improvisation class, take advantage of those opportunities, with other music therapists especially, to feel that deep connection that you can get from playing music with people who are like minded.
Other helpful tips included exercising, having outside interests, relying on family and friends for emotional support during difficult times, participating in therapy (not exclusive to music therapy), and seeking variety in one’s clinical practice (see Table 5). A professor with close to 50 years of experience discusses:

   Burnout has never even occurred to me, even at this point in my career. My advice to young people is to do what you love to do and to get somebody to pay you for it… Avoid the kinds of job situations that you don’t enjoy and find the one’s you really love. You don’t burnout when you are enjoying yourself.

    Another professor suggested not being afraid to change jobs and try out a new clinical population. “It is a much bigger smorgasbord now than it was some years ago; and if you feel you have sort of run your course in working with one population, it’s fairly easy to retool and shift to another.”

    One professor suggested facing challenges with a strong, positive attitude.

    The reason why I say that is that the challenge itself, a lot of times, can be taken negatively. But the challenge itself can also inspire a person to move up to another notch. . . . Definitely look at the challenge from a very humorous perspective. If you can laugh out loud you will be able to work on that situation with confidence.
Table 4

*Interviewee Comments Related to Advice for Young Professionals (presented in alphabetical order)*

- Attend conferences
- Collaborate with other professionals
- Consider private practice
- Develop versatile musical skills
- Know the research
- Network
- Pursue research ideas
- Seek supervision
- Serve the profession
- Specialize in an area of music therapy
- Stay current through readings
- Take continuing education
- Think outside the box, be creative and flexible
### Table 5

**Interviewee Comments Related to Advice for Burnout Prevention**

<table>
<thead>
<tr>
<th><strong>Most Frequently Mentioned</strong></th>
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<tbody>
<tr>
<td>Use music for self (8/18 participants)</td>
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</table>

<table>
<thead>
<tr>
<th><strong>Sometimes Mentioned</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Have music therapy friends (5/18)</td>
<td></td>
</tr>
<tr>
<td>Take continuing education (4/18)</td>
<td></td>
</tr>
<tr>
<td>Find variety in your clinical practice (2/18)</td>
<td></td>
</tr>
<tr>
<td>Seek supervision (2/18)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Least Frequently Mentioned</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage stress (1/18)</td>
<td></td>
</tr>
<tr>
<td>Engage in physical fitness (1/18)</td>
<td></td>
</tr>
<tr>
<td>Have outside interests (1/18)</td>
<td></td>
</tr>
<tr>
<td>Rely on family and friends for support (1/18)</td>
<td></td>
</tr>
<tr>
<td>Participate in individual/group therapy (1/18)</td>
<td></td>
</tr>
<tr>
<td>Take every single challenge as a moment to problem solve and shine (1/18)</td>
<td></td>
</tr>
<tr>
<td>Never live in black and white (1/18)</td>
<td></td>
</tr>
<tr>
<td>Find a job that you really love (1/18)</td>
<td></td>
</tr>
<tr>
<td>Stay involved in the field (1/18)</td>
<td></td>
</tr>
<tr>
<td>Network with other professionals (1/18)</td>
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</tbody>
</table>
**Education and Clinical Training**

An important portion of the interview concerned discussing the present undergraduate music therapy requirements as specified by AMTA and NASM. I asked participants questions surrounding the strengths and challenges of these requirements, and what changes, if any, they would like to see made. I also asked participants to pinpoint what they perceived as the most important goals that should be accomplished during the music therapy internship. In addition, I invited faculty to speak about highlights of their own academic programs.

It became clear through the coding of the interviews that participants valued the system of competency-based music therapy education and saw this as a strength of the music therapy undergraduate curriculum. One professor states “I think the strength is that we are competency-based, that we can articulate specific competencies that we think music therapists should have and that we know how to teach them.” Clinical experiences beginning early in the degree and the large scope of skills that are covered at the undergraduate level (for example, music therapy techniques, populations, and secondary instruments) were also considered strengths. Many of the participants suggested the undergraduate degree adequately prepares a generalist and that the breadth of the material taught at this level exemplifies the diverse scope of practice of a music therapist (see Table 6).

I think a strength is that it does show the spectrum of what we do as music therapists at that beginning competency level …we don’t know if they (students)
will work with children, or adults, or in psych, or in more of a behavioral setting, so I do think it’s important for them to get that large scope of practice.

Participants discussed a number of challenges pertaining to undergraduate music therapy education, many of them suggesting that the strengths of the degree are also its biggest challenges. A great number of the participants agreed that the number of requirements set by AMTA and NASM is currently too high, resulting in a very full curriculum (see Table 6). Many think there is not enough time in the baccalaureate degree to teach all that is required. “I see how much these students have to do in four years. They have to become excellent musicians, they have to become excellent therapists and understand therapy, and they have to become excellent music therapists.”

One of the participants discussed that with so much information introduced to the students, it is possible they graduate from their programs feeling overwhelmed. “I feel that when our students leave, they are almost confused because there is so much information.” Another participant suggested that developmentally, the students are not ready to understand certain concepts in therapy, as they have not had the life experiences necessary to fully empathize with individuals facing complex situations. He comments, “It’s not their fault and it’s not the fault of educators. Developmentally they’re still adolescents. Adolescence now, from neuroscience and neuroanatomy understandings continues at least through age 24.” The participant thinks if music therapy were at master’s level entry, students would be more mature to understand the complexities of therapy and therefore, be more effective clinicians. Some suggested introducing so much information so quickly to students who may not be ready to absorb and process its
complexity may contribute to the rates of burnout and attrition among beginning music therapists.

Issues surrounding heavy loads of general education requirements and core music requirements were also conferred by the interviewees. Music therapy faculty talked about finding creative ways to match required general education courses to specific music therapy competencies, in order to not further overload students.

I did the best I can to match what classes will help with the competencies that they are supposed to have with the general education requirements. So if they have a requirement of science, they can take Human Anatomy instead of Geology. They have behavioral science requirements and the psychology classes slide right in there great. I do as much of that as I can but I can’t do it 100%.

Others attempted to overcome this challenge by “infusing” general education requirements into the music therapy coursework. This way, “it’s being spun with a music therapy relationship to it rather than just having the student kind of put it together themselves.” At times though, no matter how hard professors tried, university guidelines for general education requirements got in the way. One professor gave the example of successfully using a human anatomy class to fulfill one of the science requirements until the science department decided it would no longer accept it as a general requirements science class. “Now our students have to take two science classes plus Anatomy and Physiology. Those kinds of things I literally have no control over. That is very frustrating as an educator.” Another professor discussed how many of her students have to take courses in the summer in order to avoid paying overload charges during the spring
and fall semesters. She commented having to take summer courses to stay on schedule poses an economic challenge for many students.

Some of the participants, particularly the faculty members interviewed, believe that the heavy loads of general education requirements take away much needed time from music therapy coursework and clinical experiences. Others implied that spending so much time on general education requirements, as well as core music requirements, resulted in the students leaving their programs with underdeveloped clinical and music therapy-relevant musical skills. A number of the interviewees spoke about the difficult nature of trying to blend the Professional Competencies with the NASM requirements; suggesting the required coursework does not necessarily reflect current practice. Participants’ responses were congruent with the research findings on this topic, which have looked closely at the music theory, music history, applied lessons, and classical ensemble requirements and argued their applicability to music therapy.

I’d like to see some flexibility in terms of things like music history requirements. It’s hard because you want people to be well rounded and knowledgeable music students and understand this massive Western music history, but then I really see that students are lacking in their understanding of Eastern music, other cultural music, even American popular music that is really applicable to our practice.

Another faculty shared the same opinion regarding the core music requirements. While acknowledging the importance of high musicianship and understanding of classical music foundations, the participant reflected on the length of time spent in courses that will not necessarily make the student a better music therapist.
Taking four semesters of really advanced theory, advanced ensembles for four semesters, lessons on their primary instrument for four semesters. The things that are really good are the functional piano and functional guitar, the voice work. The fact that so many music therapy programs are in schools and colleges of music where people have to have such an advanced level…

Only one participant spoke about this issue in a very different manner, supporting the core music requirements and discussing how music therapists could utilize advanced knowledge in areas such as music theory to improve their musicianship in the clinical setting. The participant provided the example of using advanced theory knowledge to create interesting harmony on the piano. She suggested music therapists need to be open to using these advanced skills in the clinical setting:

I had a gentleman at the nursing home who loved classical music. With my skills in vocal performance … I was able to sing some arias with him. Surprisingly enough, just because of the satisfaction of the intellectual need, his behavior outbursts were way better controlled. Things like that, you would think “how would this be significant?”…. Real musical accomplishment could become a very effective therapeutic tool. You just have to open up to opportunities like this to become effective in your practice.

Other interviewees mentioned that even though the bachelor’s degree continues to be a 4 to 5 year degree in most institutions, the list of Professional Competencies continues to expand.
I think that there’s too much in the undergraduate curriculum; way too much. We don’t have time in four years plus an internship to reach all of those competencies…. I’m a big supporter of the idea to have us move to master’s level training to be a music therapist. (Students) get their music education at the undergraduate, including the things that are important for music therapy such as guitar, improvisation, etc. Even some observation skills, learning goals and objectives, writing behavioral objectives, and that kind of thing. I think you need that extra time to really develop the therapist.

Aside from the challenges mentioned, which were agreed upon by most of the music therapists interviewed, individual participants brought up a series of interesting points. One of the participants talked about a great level of variation existing from one academic program to another in terms of the clinical and musical preparation of their graduates. A second participant discussed how undergraduate programs expose students to a wealth of information, but much of it gets lost because students specialize or gain in-depth knowledge in very little. A third participant reflected on the non-inclusive nature of most undergraduate music therapy degrees across the United States, which restrict jazz students and pop musicians from entering their programs.

I think in a way we have closed our doors to a lot of people who potentially could become great music therapists. I only know of two or three schools … that allow people to start the study of music therapy at the master’s level without having any sort of undergraduate degree in music. So to me, the whole challenge is this fundamental contradiction in our field. We say music therapy is a healthcare
profession if you look at the AMTA definition. Yet our training programs are almost exclusively located in schools or colleges or departments of music and that to me is just a fundamental contradiction.

Table 6

Interviewee Comments Related to Education and Clinical Training: Strengths and Challenges of the Undergraduate Music Therapy Requirements

<table>
<thead>
<tr>
<th>Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Most Frequently Mentioned</strong></td>
</tr>
<tr>
<td>Competency-based (6/18 participants)</td>
</tr>
<tr>
<td>Covers a large scope of skills (music therapy techniques, instruments, and populations) (5/18)</td>
</tr>
</tbody>
</table>

| **Sometimes Mentioned** |
| Clinical experiences begin early in the degree (4/18) |
| Adequately prepares a generalist (3/18) |

| **Least Frequently Mentioned** |
| Music-focused degree (1/18 participants) |
| Infusion of multi-cultural education into the curriculum (1/18) |

continued
Table 6 continued

Challenges

*Most Frequently Mentioned*

Curriculum is very full, too many requirements (9/18)

*Sometimes Mentioned*

Some graduate with underdeveloped musical skills on secondary instruments (4/18)
A lot of variation in competency levels across schools (4/18)
Students are exposed to so much but specializing in so little (3/18)
Heavy loads of general education requirements (3/18)
Entry Level is at Bachelor’s (3/18)
Some graduate with underdeveloped clinical skills (3/18)
Curriculum includes material that is too advanced for the students’ emotional development (2/18)
Difficult to blend professional competencies with NASM requirements (2/18)
Heavy loads of core music requirements (2/18)

*Least Frequently Mentioned*

Students are graduating with very basic skills (1/18)
Internship is too long (1/18)
Coursework does not accurately reflect current practice (1/18)

continued
Table 6 continued

Non-inclusive nature of most degree programs which restrict jazz and pop musicians from entering the program (1/18)

Bound by our lengthy curriculum and our requirements to stay small as a field (1/18)

Two different models of internship (university-affiliated versus AMTA National Roster) and levels of supervision (1/18)

Practicum supervision is not always provided by a MT (1/18)

The music therapy internship was also a topic of conversation, as I was interested in learning about the participants’ goals and thoughts surrounding the internship experience. Participants overwhelmingly described the internship as the transitioning point into the professional world. Phrases such as “to synthesize information, develop self-awareness, independence, confidence, flexibility, and intuition” were frequently mentioned (see Table 7). Participants highlighted the importance of the depth of knowledge that is gained through the internship versus a once or twice a week practicum, as the student is able to get the “full picture” of the client’s course of treatment, therapeutic goals, and overall scope of the agency. One professor described the internship as a time to develop and understand “professional behavior, the overall planning for how to set up a program or run a program and how it interacts with an interdisciplinary team, and the course of treatment for clients across time.” Another important aspect of the internship is that it provides many opportunities for students to interact with other healthcare professionals and learn “office dynamics.”
A few of the participants went even further into the value of the internship experience, discussing that during these six months, students have an opportunity to begin the development of their own unique approaches to music therapy, as well as develop the “ability to listen to their patient’s statements and their music” rather than focusing extensively on their “outputs” as a therapist.

One professor advised that to have a positive internship experience, students should come into the internship setting with humility and an open mind. “Leave it all in the doorway” and tell yourself “I will learn…. I will put all of my trust in my supervisors and the academic person that I was close to who set me up for something good.”

Table 7

Interviewee Comments Related to Music Therapy Internship (presented in alphabetical order)

| Allows for student interactions with other treatment team members |
| Assists in developing one’s unique clinical approach |
| First moment of reality check |
| Help students synthesize information |
| Helps the students develop self awareness, independence, intuition, flexibility, understanding of their own competencies, self-confidence and taking life seriously |
| Helps the students form a plan for post internship |
| Helps to develop ability to listen to their patient’s statements and their music and create musical environments that encourage patient and client musical responses |

continued
Table 7 continued

Helps to develop good assessment and documentation skills
Increased depth of knowledge about overall scope of agency and client goals
Provides hands-on experience
Prepares students for a smooth transition into the professional world
Provides opportunities for interns to bring weaknesses up to professional level
Provides real world experience
Students get to practice actively using music in therapy
Teaches how to set up a music therapy program and establish course of treatment

I was interested in learning what professors perceived to be highlights of their school’s undergraduate music therapy program (see Table 8). Professors took pride in having music therapy faculty colleagues who were strong researchers, had unique specialties and teaching philosophies, and continued to engage in clinical work throughout their academic careers. Serving as supervisors for their students’ practicum rotations, having an active research lab where students could collaborate with faculty, and being housed in strong schools and colleges of music that offered unique ensemble opportunities were also mentioned.

Faculty members also highlighted aspects concerning the strategic sequencing of the music therapy coursework; introducing improvisational methods early on; having a high number of practica their students could engage in during their four years of
schooling; and providing learning opportunities where students of different levels
(undergraduate, equivalency, and graduate) could study and learn from each other by
participating in the same class. One professor discussed incorporating a novel that
emphasized the use of music in healing rituals across cultures of the world. Another
mentioned the positive learning experiences that arose from PhD students teaching some
of the undergraduate classes, as these students had recently worked as clinicians, were
familiar with current popular music, and were more experienced in incorporating certain
technologies such as the iPad and iPhone in their sessions. Having university affiliated
music therapy clinics and being in large metropolitan areas with diverse clinical settings
for practicum and internship were also mentioned as strengths of their programs.

Table 8

Interviewee Comments Related to Music Therapy Faculty: Educational Program
Highlights (presented in alphabetical order)

<table>
<thead>
<tr>
<th>Active research labs</th>
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<tbody>
<tr>
<td>Classes taught by PhD students: more recent in clinical work and the use of technology</td>
</tr>
<tr>
<td>Core faculty is in charge of supervision</td>
</tr>
<tr>
<td>Creative teaching/assignments</td>
</tr>
<tr>
<td>Evidence-based practice programs</td>
</tr>
<tr>
<td>Introducing improvisation early in the degree</td>
</tr>
<tr>
<td>Large metro area with diverse practicum settings</td>
</tr>
</tbody>
</table>
Many practicum rotations

Mixed classes (undergraduate, equivalency, and master’s students combined)

Non-faculty, community practicum supervisors have the same theoretical orientation as the student’s faculty

Opportunities for students to collaborate with faculty

Program housed in a strong school/college of music

Sequencing of coursework

Specialized faculty

Teaching philosophy – eclectic versus specific

University-affiliated music therapy clinic

Participants offered suggestions for changes they would like to see made to the undergraduate requirements (see Table 9). It became clear that each participant had a specific aspect he/she would like to see changed. It was also evident respondents had been contemplating these changes for some time and had multiple supporting reasons for the modifications. An unprioritized list of proposed changes follows:

1. Secondary instrument classes should be taught by music therapists and be music therapy specific. For example, class guitar should include repertoire, strumming patterns, and other mastery skills relevant to the clinical setting.
2. Improvisational music skills should be introduced early in the undergraduate degree, as they take time to develop. These courses should be taught by music therapists rather than jazz or other music faculty.

3. Students should be encouraged to make greater use of their primary instrument in the clinical setting rather than always rely on secondary instruments. One interviewee suggested:

   I wish that they (faculty) could encourage them to learn how they can use their major instrument when it’s not piano or guitar or voice in music therapy. Now they wouldn’t have to use them 100 percent of the time, but that’s their true voice and they could really learn to use that interactively with other people in music therapy sessions.

4. Students could select a line of practice or a population in which they wish to specialize from early in their undergraduate education in order to gain in-depth knowledge and skills.

5. The internship experience should be shortened to a semester rather than six months. One therapist explained:

   The six month internship does not correspond to a semester; it creates huge problems for kids on financial aid, it creates registration problems, it creates them getting incomplete grades, and if they are on financial aid, the incomplete interferes with that. If they are foreign students it interferes with visa status…. Most other professions have quit having an unpaid, prolonged period of internship, and I would like to see our field reconsider that.
6. Faculty should evaluate their students’ musical competencies early in the program and design individualized plans that would address the specific areas that require growth.

7. The curriculum should include some education on how to advocate for the profession as advocacy is an important part of the music therapist’s professional experience.

8. The undergraduate degree should be treated as a healthcare profession rather than a music degree. A few of the interviewees suggested the field is in some contradiction by defining itself as a healthcare field yet giving great emphasis to core music requirements.

9. The entry into the profession should shift to the master’s level. If this is not a possibility at this time, the number of practicum requirements at the bachelor’s level should be increased. Another suggestion would be to formally emphasize and enforce the Levels of Practice.

Table 9

*Interviewee Comments Related to Suggestions for Changes to the Undergraduate Requirements (presented in alphabetical order)*

| Add heavier hours of practica to bachelor’s if not moving to a master’s |
| Adhere to Levels of Practice instead of moving to the master’s |
| Encourage students to use major instrument more |
| Improvisation methods taught by MT’s |

continued

97
Table 9 continued

Incorporate advocacy education
Incorporate more improvisational music skills from the beginning
Internship should occur while the student is still enrolled in classes
MT specific classes for secondary instrument requirements
Narrow-in education/Select a line of practice
Secondary instrument classes taught by MT’s
Shorten the internship experience
Tighten up musical competencies – design individualized program
Treat undergraduate curriculum as a healthcare profession versus music degree

Table 10

*Interviewee Comments Related to Additional Thoughts on the Undergraduate Requirements (presented in alphabetical order)*

- Add marketing, business planning, advocacy education to competencies
- Certain skill-sets belong at the graduate level: GIM
- Importance of continuously moving forward, based on the demands of the times
- It’s a challenge to set up practica around student’s school schedule
- Schools with a cognitive behavioral approach prepare students much better to chart progress, write goals, articulate responses

continued
Table 10 continued

Students leave confused from the bachelors due to so much information

Transitioning into the real world seems daunting for many students

Underdeveloped musical skills a result of decreased music education in grades k-12

Unrealistic practica experiences for students during schooling result in disappointments in the real world setting

Present Status

Through this section of questions I was interested in what members of the field perceived as major accomplishments for the profession. I asked questions such as “What have been some of our most significant successes as a profession?” and “What do you think has contributed to the success of the field?” I also asked participants to identify challenges the field is facing and to consider what needs to be done to overcome these challenges.

A large number of the participants believe the unification of AAMT and NAMT into the present AMTA is one of the field’s biggest accomplishments. By becoming one organization, “we endeavored to create a big tent where all perspectives and ways of working are used.” Having “one national organization that represents all music therapists” speaks “volumes to the world.”

Many participants reflected on the times when the two organizations existed. Some thought that for a field as small as music therapy, having two distinct organizations
did not make sense. “When I started graduate school in 1980 and there were these two separate associations with two different philosophies and two different kinds of training, I’m thinking ‘You know, for a field this small, that just seems really counterproductive’.”

Another participant talked about how as a young student she questioned the need for two associations, and at times felt more similarities than differences existed between the two.

“When I was a student I would interact with students from NAMT schools and we would say ‘What kinds of classes do you have?’ ‘Oh, I have the same classes!’ ‘What textbooks do you use?’ ‘Oh, I’m using some of those same textbooks!’.” Initially we would say “Why do we have two associations?”

Other participants shared feeling some hesitation when the two associations decided to merge. “There were a lot of people who were really skeptical about it, very unhappy, and felt like the missions of the different associations would just get blurred.” However, most participants agree that unification brought strength to the profession, and while different approaches to music therapy continue to exist, it is that diversity that helps us reach an enormous client-base.

In so many ways, we are so broad now. We have all models from psychodynamic to Neurologic Music Therapy and everything in the middle. It’s exciting and frustrating at the same time because you can’t do it all at once. I think it has really made us pay attention and learn from each other, and know there is no truth for the “Big T.” There’s an appropriate protocol somewhere for every client that we see.
Participants also perceive the recognition the field of music therapy and the AMTA are receiving from members of the medical community as another important accomplishment for the profession. Many participants think more people and clinical settings are now aware of music therapy and that the modality has become more widely accepted. Participants attribute these changes to a strong research base, acknowledging that research has driven the field of music therapy since its inception as a formal field of study in the 1950’s. Crediting music therapy pioneers E. Thayer Gaston and William Sears, one participant states:

They (pioneers) were adamant in laying a foundation of accountability through research, through documentation, through using the best practices of social science research so that we could document exactly what we were doing.…

We can look people in the eye and talk their talk because we use quantitative research primarily and that has been sort of the coin of the realm in social science and medical science.

According to the participants, the wide distribution of the *Journal of Music Therapy* and *Music Therapy Perspectives* across so many universities, the variety of research approaches (quantitative, qualitative, and mixed methods), and the recent collaborative research efforts with fields such as neuroscience have all resulted in more recognition for the field.

Other important accomplishments widely mentioned by respondents included the establishment of one credential (MT-BC); the recent licensures in Nevada, North Dakota, and Georgia; the development of specializations such as Neurologic Music Therapist
(NMT) and Neonatal Intensive Care Unit Music Therapist (NICU-MT); and the Senate Hearings on Aging. Greater levels of acceptance among members of the profession belonging to different therapeutic approaches, the establishment of Continuing Music Therapy Education, the development of reimbursable music therapy protocols, and the establishment of the State Task Forces were also discussed (see Table 11).

Multiple respondents acknowledged the advocacy efforts led by the AMTA. One participant shares: “I think the fact that we have such a strong national association…. They have done an outstanding job over the last many, many years, putting us where we need to be.” Many agree that the AMTA has continuously fought so that music therapists receive “recognition, reimbursement, and respect” from various professional communities and the general public.

Among the most frequently mentioned challenges were the small size of the field, the reduced membership in AMTA (in comparison to the actual number of board certified music therapists in the United States), and the attrition of professionals following the first couple of years of professional experience (see Table 11). Participants discussed a number of common factors that lead to feelings of burnout, which over time, result in the loss of professionals. Among these factors were the low number of “viable career paths for music therapists,” low salaries, lack of respect and recognition, and challenging economic times (primarily for those working in private practice). A few of the participants think moving to master’s level entry would in part solve this problem.

I am hoping that moving to a graduate education entry level will change this because people with graduate degrees are eligible for higher positions; they get
paid more, they have more prestige, more responsibilities in the position. So it is almost like if you create the people who can do more advanced work then the positions will be created for the people to do that work and then people will have a longer career path to follow.

Other participants felt completely the opposite, stating that moving to master’s level entry would deepen the problem, as it may deter young students from pursuing the degree in the first place and it would reduce the number of professionals entering the field. It was suggested this could be a dangerous move for the profession, as currently, the demand for music therapists is increasing, and there are opportunities where music therapy positions open, but a music therapist is not available to fill the job. One professor shared:

I think the demand is really burgeoning. People say “I’d like to have that service,” and the availability of a board certified music therapist is not always adequate to the number of places where people would like to have the service, so they may go with something else, a sound healer, a music practitioner, people that we would consider lesser trained. So it is very important that we keep our standards up and our enrollments as high as we can, even though we have to maintain our quality, so that we can fill the available positions and develop the desirable positions.

The lack of ethnic and gender diversity in the field was discussed by a number of the participants. One interviewee suggested looking at this problem closely:
We don’t educate minorities very well about our field. Why not have some of our literature in Spanish? I wish we could develop a study group to why we do not have many minorities in our field. Why is it 82-86 percent female? There are many explanations for that, but you see a lot more males … in art therapy. Dance/movement therapy we can understand why there are fewer men. Some of it has to do with public education, so that people learn more.

Issues with reimbursement and maintaining jobs were also of concern. A music therapist who provides services to clients through her private practice comments:

I think we still have to fight every day to justify our services, to justify paying for our services. It’s not an automatic thing like physical, speech, occupational therapy. We still have to work at it all of the time. That’s a big challenge.

A number of the participants discussed that the differences that currently exist within members of the field regarding what is considered “legitimate” music therapy practice pose challenges for the profession. Some participants referred to this professional discourse as “Who owns the truth over the Big T.”

My one fear is that because of the narrowed view of what constitutes legitimate practice… I see some forms of music therapy that argue that they are the only way music therapy should be practiced. That if music therapy is going to be accepted in medicine or scientifically, it must be done this way. I think that is a very dangerous attitude…. I think it is the diversity of approaches that can meet the needs of a diversity of people which is most important, rather than adhering to a very narrowed view of what constitutes legitimate, scientific practice. Music
therapy is both an art and a science, and both facets have to be on there in order to do the work most effectively.

Despite unification in 1998, a number of the participants stated contention among the different “camps” remains, and it is impacting the profession in a negative manner. One participant referred to the different approaches to music therapy as a form of “branding,” which results in a clear separation among music therapy professionals. Rather than being the “field of music therapy,” he believes it becomes more individualized, as if saying “well, the music therapy that I do...” In general, those who spoke about this issue feel that overall, the relationships between members practicing different theoretical approaches have improved. “You are always going to have people who are in different camps, so to speak. But I feel that people are a little bit more open to other approaches than maybe they were ten years ago.”

One participant discussed AMTA’s recent decision to limit the use of acronyms as a step in the right direction when it comes to unifying members of the AMTA. “We’re trained as music therapists, and then there are these other directions to go in, but you need to hold fast to and identify yourself as a music therapist first. I think that’s a really huge development in our field.”

Another challenge mentioned was the people at the outskirts of the field calling themselves music therapists. One interviewee suggested that many music therapists feel pressure to “acknowledge” and validate the work of sound healers and music-thanatologists. “Even the AMTA takes a stand to accept. They accept music healers to present at conferences. There’s a kind of friendly relationship with people who are music
“healers.” One professor considered the recent media coverage of music therapy has exacerbated this problem, stating:

Because of our recent popularity and publicity, everybody thinks they are a music therapist and people really don’t understand the exhaustive preparation process and that there is a training program that has as much in therapy and in psychology as it does in music; and all of those volunteer musicians are missing that training.

One participant suggested the AMTA should create stricter guidelines for dealing with these types of situations as the individuals and professions making these claims send out confusing messages about what is music therapy to an already confused general public. “I’m in favor of making separation between what is music therapy and what is music healing, and I think that we really need to take leadership.” It was suggested the AMTA take an even more aggressive stance in monitoring all claims surrounding what is music therapy, by keeping a close eye on news stories (particularly those on the internet) as the freedom to “post anything and everything” results in vast amounts of misinformation. One respondent commented it would benefit the field to have legal ownership of the phrase music therapy:

Music therapy is not legally protected. I’ve noticed that there are organizations that say they’re doing music therapy in facilities and they’re not doing music therapy, they can’t say that. But really they can because we don’t have any protection over the phrase; which doesn’t allow us to really tell them ‘you have to stop saying that, what you’re doing is misleading.’ It’s dangerous in certain circumstances and circles to be going around and saying that.
Additional challenges discussed included the constant fight to justify the profession and gain respect from other professionals, and the lack of understanding surrounding music therapy. One participant advised that aside from the AMTA and the CBMT, it is the daily responsibility of all music therapists to advocate and educate others about the field; and that when doing this, they should clearly articulate the education and clinical training involved in becoming a music therapist. The *Standards of Clinical Practice, Professional Competencies, Code of Ethics*, the board certification exam, and the research findings should also be incorporated into these conversations. It was advised by one professor that we do our best to “kindly” educate others, and to never take a defensive stand, as it could lead to loss of credibility. “I just had to assume that people didn’t know what music therapy really is and that they were relying upon their own fantasies.” The participant suggests it is our job to kindly help correct these “fantasies.”

One music therapy clinician believes one of the biggest challenges affecting professionals is the stringent research politics that currently prevent music therapy research from being carried-out in various types of institutions. “I know here we have issues if an academic is trying to meet the university IRB and the hospital IRB and they don’t agree on what they need … It becomes really quite burdensome … That discourages research in some way.” She suggested music therapists need to “learn to play the system better plus the system needs to settle down a little bit and make sure that it is consistent.”
Table 11

Interviewee Comments Related to Present Status: Successes and Challenges

Successes

*Most Frequently Mentioned*

- Unification of NAMT and AAMT (7/18 participants)
- Licensure (Nevada, North Dakota, and Georgia) (6/18)
- Research (6/18)
- Public recognition by the media, medical community, and general public (6/18)
- AMTA’s advocacy efforts/Government relations efforts (5/18)

*Sometimes Mentioned*

- Establishment of MT-BC (4/18)
- Senate Hearings on Aging (3/18)
- Reimbursable music therapy protocols (3/18)
- Development of specializations (NMT, NICU MT) (2/18)
- More unity within members, caring to advance field (2/18)

*Least Frequently Mentioned*

- Interest from other professions for partnering in research (1/18)
- Possible movement towards master’s degree (1/18)
- Being able to articulate what MT can do for someone (1/18)
- Establishment of CBMT (1/18)

continued
Table 11 continued

Establishment of CMTE’s (1/18)

CBMT’s advocacy efforts (1/18)

Many models from which to approach the work (1/18)

Many people returning to school for advanced degrees (1/18)

The constant need to defend our field has helped us (1/18)

Decision to limit acronyms (1/18)

State Task Forces (1/18)

Moving AMTA to Washington (1/18)

Establishment of PhD programs (1/18)

Challenges

*Most Frequently Mentioned*

Small size of field (7/18)

Discourse among the different theoretical approaches (6/18)

*Sometimes Mentioned*

Lack of understanding from general public/professional communities (3/18)

Tough economic times (3/18)

Small membership in AMTA (2/18)

Attrition of professionals (2/18)

Multiple definitions of music therapy according to theoretical approach (2/18)

continued
Table 11 continued

Non-music therapists calling themselves music therapists (2/18)
Constant fight to justify services (2/18)

Least Frequently Mentioned

Research (politics/lack of IRB in agency) (1/18)
Lack of ethnic/gender diversity in the field (1/18)
Obtaining reimbursement (1/18)
Maintaining jobs (1/18)
Shortage of funding for music therapy services (1/18)
Perception by others: auxiliary service (1/18)
High demand for music therapists in certain areas but lack of MT-BC to fill the job (1/18)
General misunderstanding of what qualifies someone as a music therapist (1/18)
Not having ownership over the phrase “music therapy” (1/18)
Validity of the therapy as perceived by other healthcare professionals (1/18)
People at the outskirts of our field: music healers (1/18)
Acceptability of music therapy research (1/18)
Burnout (1/18)
Long-term Goals

I asked participants to discuss their hopes and wishes for the future of music therapy by asking questions such as “Where do you hope to see the field in 10-15 years?” and “What needs to happen within the profession for future growth and progress?” The majority of the participants hope for the field to grow in size (see Table 12). One participant states “I would like to see the number of board certified music therapists triple. I’d like to have the problem of too many music therapists.” Many wish for music therapy to be considered at the same level of such related fields as speech and language pathology and occupational therapy, and be unquestionably used across the spectrum of disabilities, disorders, and illnesses. One interviewee comments “I would love to see in all agencies where there is occupational therapy, physical therapy, and speech therapy, which are always the standard three, I want to see music therapy as part of that, as the norm.” Music therapists wish for the treatment modality to be readily available to all clients, “so that they can make a choice whether to have music therapy” as part of their medical treatment. Adds another participant “My humble wish would be that we will be treated the same as other professionals in the healthcare and educational field.”

Eligibility for reimbursement was also considered an important long-term goal. One music therapist states:

That is kind of a benchmark we are looking for to show that we have been fully accepted as a part of the treatment process. We have done remarkably well not to be getting that reimbursement. There are people who pay for these services.
An increase in salaries so that a music therapist’s income is comparable to those of other healthcare professionals was also mentioned.

Participants wish for music therapy to be a “household name” in the near future. One professor who remains an active clinician comments “I would hope that in ten to fifteen years when you tell someone on a plane that you are a music therapist you will not have to go into a long explanation. That is one of my personal goals in life!”

The individuals interviewed hope for state recognition through licensure in all states, as well as many more music therapy training programs around the country. Some wish to see more specializations focused on advanced levels of work. Others hope music therapists will become more united as a profession and accepting of the different therapeutic approaches. One participant gave a unique response to this question, stating how the more society embraced the arts; the greater level of acceptance music therapy would receive. She discusses:

I would love for society in general to embrace more traditional beliefs that art and music are central to the culture and that they are important to our development as human beings. That it is important for us to understand our history, our culture, and our world so that we value music again in the way that I am talking about; as a society that will better value fields like music therapy because it becomes an important part of our humanity and our health.
Table 12

Interviewee Comments Related to Long-term Goals

Most Frequently Mentioned

Increasing the number of music therapists (10/18 participants)

Music therapy will be considered at the same level as speech pathologist, physical therapy, and occupational therapist (7/18)

People will know what music therapy is (6/18)

Sometimes Mentioned

MT will be reimbursable (4/18)

Profession will be at master’s level entry (4/18)

Members of the profession will become more united and accepting of various therapeutic approaches (2/18)

More music therapy training programs around the country (2/18)

Least Frequently Mentioned

State recognition through licensure in all states (1/18)

Music therapists will be serving the entire spectrum of disabilities, disorders, and Illnesses (1/18)

Many specializations (1/18)

Focused on advanced levels of work (1/18)

More music therapy-specific PhD programs (1/18)

Music therapy will be mandated in certain levels of education and healthcare (1/18)

continued
Table 12 continued

More music therapists will have PhD’s (1/18)
There will be a journal of music therapy education (1/18)
Music therapy will be readily available for people who need it (1/18)
Music therapy will be unquestionably used (1/18)
Continue to develop new areas of practice (1/18)
Society will embrace the arts (1/18)
________________________________________________________________________

Either through spontaneous conversation or the specific interview questions, the topic of moving certification to master’s level entry was often discussed throughout the interviews. Participants in this study were clearly divided on the matter (see Table 13). Ten of the participants were firm on the necessity to move to master’s level entry, while five of the participants expressed completely opposite opinions. The remaining three participants questioned the proposal, and expressed feelings of neutrality towards the issue, often leaning more towards a no than a yes.

Those in favor of moving towards master’s level entry felt it would equalize music therapy with all of the other expressive arts therapies and allied healthcare fields where certification is granted at the graduate level. Moving to the master’s would also allow students more time to establish strong musical and clinical competencies and gain the emotional maturity necessary to be a therapist. Supporters of the move think it is impossible to adequately teach all of the competencies during a four year bachelor’s.
They also believe music therapy has gained enough “complexity and sophistication” to warrant a master’s degree, and that more respect and recognition would be received by having a higher level of education.

Those who opposed the potential move also cited a number of reasons that pertained to the individual student as well as the field as a whole. Considering the profession of music therapy, related fields having a master’s degree is not a strong enough justification to make such a move. Adding the extra two years of education would reduce the number of professionals entering the field, and make the degree less attractive to potential students who would not only have to consider a much lengthier and expensive education, but also more years before being able to get a job and financially support themselves. It was thought that all of this would negatively affect the growth of the profession, which is something that most of the interviewees considered one of the biggest challenges to the field. Aside from direct effect on the profession, the colleges and universities that currently offer only a bachelor’s in music therapy would find themselves in difficult situations, having to develop graduate programs, rearranging content of existing programs, and hiring new staff. Those in favor of staying at bachelor’s level entry felt most schools adequately prepared students to enter the workforce and that more schooling, especially when delivered in “one lump” would not necessarily turn out a more competent professional. One participant who was not in favor of moving to master’s level entry stated:

I think we need levels of practice. I think we need to take out some of the stuff from the undergrad and say that when you finish with an undergrad degree you
may do X, Y, and Z. This is your scope of practice. You can go back into a master’s and you can add to that. You can do X, Y, and Z but you can also do A, B, and C with master’s level. . . . We need to give some credibility to people who finish a bachelor’s and allow them to do certain things in music therapy.

Table 13

*Interviewee Comments Related to Move to Master’s Level Entry: Pros and Cons (presented in alphabetical order)*

<table>
<thead>
<tr>
<th>Pros</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other allied health professionals are at graduate level entry</td>
</tr>
<tr>
<td>Practice has gained enough complexity and sophistication to warrant a master’s</td>
</tr>
<tr>
<td>Teaching it all at the undergraduate level is unrealistic</td>
</tr>
<tr>
<td>Will allow more time for students to establish competencies (specifically in developing more adequate musical and clinical skills)</td>
</tr>
<tr>
<td>Will allow more time for emotional maturity to develop</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cons</th>
</tr>
</thead>
<tbody>
<tr>
<td>All schooling in one lump does not make for a better professional</td>
</tr>
<tr>
<td>Art therapy and dance/movement therapy do not have high levels of recognition even though they are at master’s level entry</td>
</tr>
<tr>
<td>Eighteen to twenty-two year olds are not ready to commit to such lengthy education</td>
</tr>
<tr>
<td>It would hurt the schools that currently do not offer the master’s degree</td>
</tr>
</tbody>
</table>

continued
Table 13 continued

Market should decide this for us
Our work should fuel and drive the profession, not our level of entry
Preparation is sufficient at the bachelor’s level
Related fields at graduate level entry does not justify this move
Restricts people from coming into the field (the time it will take to graduate is a deterrent)
Will make it less attractive to a high school student as they will think about having to wait 5 or 6 years before getting a job
Will reduce the number of professionals entering the field
Will result in an expensive/lengthy education

Following the master’s level entry discussion, I asked those participants who opposed the move if they saw areas of practice where an advanced degree would be beneficial. I specifically asked if they thought music therapists in supervisory roles should have advanced education. The response to this question was also somewhat divided (see Table 14). Some of the participants thought an individual with an advanced degree had a better understanding of teaching, learning, supervision, and research, and therefore, would interact better with the student. Other participants did not feel it was always necessary, and that it depended on the individual providing the supervision. In general, participants felt it would be ideal for supervisors to have an advanced degree, but it was not always necessary or realistic.
Table 14

Interviewee Comments Related to Requirement of the Master’s Degree for Music Therapists in Practicum/Internship Supervisory Roles (presented in alphabetical order)

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ideally all music therapists in supervision roles should have graduate degrees</td>
<td>A master’s degree is not always necessary; it depends on the individual providing supervision</td>
</tr>
<tr>
<td>Individuals with a master’s degree have greater research knowledge and research informs practice</td>
<td>Experience versus education</td>
</tr>
<tr>
<td>Supervisor has achieved an advanced level of practice</td>
<td>Unrealistic in small towns</td>
</tr>
<tr>
<td>Supervisor may be more up-to-date with current music therapy practices</td>
<td></td>
</tr>
<tr>
<td>Supervisor would have a better understanding of teaching/learning</td>
<td></td>
</tr>
</tbody>
</table>

As far as overcoming challenges and recommended changes, participants offered a disparate array of possible solutions or plans of action which included (see Table 15):

1. Increasing availability of music therapy information to the general public.
2. Recruiting students of different ethnicities and socio-economic backgrounds.
3. Increasing outreach efforts in inner-city and rural high schools.
4. Developing music therapy materials in other languages in order to educate American non-English speakers.

5. Recruiting music therapy students from related fields such as music education, performance, nursing, and psychology.

6. Developing short-cuts for music therapy education for specific types of people such as pop musicians, nurses, and psychology graduates who wish to pursue a career in music therapy. One participant stated “I think there are a lot of musicians out of jobs that would like to help people but they are not willing to go through the training and the years to become a music therapist.” The participant suggested providing these types of people with a “short-cut” to music therapy education, where they would only need to learn the skills and competencies necessary to do music therapy with a specific population. “In a short-cut approach you can’t be an MT-BC across the board, but you could be a music therapist for mentally handicapped children in a special education program.” Another participant suggested opening the doors to pop and jazz musicians who would like to study music therapy but are currently not eligible because they lack a classical music background.

7. Increasing advocacy efforts within the AMTA in order to make music therapy a highly recommended service for a person’s medical treatment.

8. Setting stricter guidelines for the design and implementation of randomized controlled trials (RCTs) in music therapy.

9. Moving to master’s level entry.
10. Closely monitoring public media and correcting instances when music therapy is misrepresented.

11. Promoting the music therapists, rather than just the music.

What we have forgotten to do is promote music therapists. I think when people hear music therapy they think we are saying that music somehow cures people of things and they don’t believe that. I think that what we have to promote is the importance of music as an experience as Ken Bruscia would say, “Guided by a trained therapist.”

12. Training and empowering music therapists so they are strong advocates for the profession.

Table 15

*Interviewee Comments Related to Suggestions for Overcoming Challenges (presented in alphabetical order)*

| Availability of music therapy materials in Spanish |
| Closely monitor public media for any misrepresentations of music therapy |
| Develop shortcuts for music therapy education |
| Greater outreach efforts to high school students |
| Greater outreach efforts to inner city/rural schools |
| Increase advocacy efforts |
| Increase availability of music therapy information to the general public |

continued
Table 15 continued

Promote the music therapist, not just the music
Recruitment through related fields
Set stricter guidelines for the design and implementation of RCTs
Train/empower music therapists to be strong advocates for the field

Music Therapy Research

Overall, study participants were very satisfied with the research that has been produced in music therapy in the last sixty years. Respondents see music therapy as a leader in research among the creative arts therapies, and believe that research initiatives such as the Fultz Research Award have encouraged professionals of all types to engage in research activities. Some participants highlighted and were in favor of the use of quantitative approaches in music therapy, as it is the “coin of the realm in social science and medicine.” Many participants also acknowledged and were pleased with the special interest the field of neuroscience has given to music therapy.

Many of the interviewees used words such as “wonderful,” “strong,” “important,” and “effective” to discuss the AMTA’s 2005 research initiative. They thought it had stimulated research activity among professionals and elevated the caliber of the studies. One respondent comments, “Watching the quality of the research and how much it has evolved is just amazing. People have gotten much more skilled and much better at producing.” Another interviewee talked about the importance of research for a
profession that serves such diverse populations: “The focus on research is excellent because with evidence-based practice we need research and being that we are such a large field with varied populations, that equates to needing a lot of research in a lot of different areas.”

A number of the participants pointed out challenges surrounding research in music therapy (see Table 16). Some shared that many clinicians do not feel they have sufficient knowledge to conduct research studies, and that difficult experiences getting through universities’ Institutional Review Boards (IRB) can also discourage research activities among young professionals. Other challenges that surfaced included weak design and implementation protocols in music therapy research; lack of research in important clinical areas; and a shortage of funding availability for music therapy studies. One interviewee with a strong history of research activity discusses this issue. “We need ways to stimulate the nation’s research community to attend to the possibilities of music therapy and begin to fund it. We have not broken into funded research very much. Each individual person is doing it on their own rather than doing a national thrust.”

Participants had the opportunity to name areas where they would like to see increased research activity (see Table 17). The areas most frequently mentioned were autism (all ages) and teaching and learning (non-clinical). Additional areas to expand the literature included at-risk populations, special education, Alzheimer’s/dementia, teen and young adult violence, cardiac rehabilitation, diabetes, mental health, significance of symptom improvement (long-term effects), preventative areas, music therapy and wellness, the use and effectiveness of music therapy assessment tools, music therapy
protocols and their systematic applications in the clinical setting, and the use of technology in therapy.

A few of the participants suggested conducting studies to determine which types of people pursue degrees in music therapy in order to market the field to individuals with those characteristics and potentially increase our numbers. Others suggested continuing to study the important problems of burnout and attrition in music therapy. One of the participants would like to see an increase in cost-effectiveness studies, stating that very few currently exist and these are the studies healthcare professionals and decision makers wish to see. Another participant would like to see more research on the style of music used in therapy.

A number of specific recommendations for future research activities were provided. These included conducting more research studies that looked at the processes taking place in the music therapy session. In other words, conducting research that “tells the whole story.” One professor discusses:

I think there are other means of knowledge acquisition that would very much be important for music therapy and a lot of people have talked and written about this. Obviously the whole qualitative research, the phenomenological research, the things that look at the process. . . . I think there’s a lot of research avenues in complexity science that would be very meaningful to music therapy. There are tests and statistics that show you what factors are influencing the system, meaning the client and their reaction more than others; and I think that would be incredibly valuable research for music therapy.
One of the participants suggested it would be beneficial if researchers developed a line of research and focused on it for many years. She added “Unless somebody takes that as their focus, and they just do it for years … the body of research does not grow very well.” Using this approach to conducting studies would result in important contributions to the research literature in specific clinical areas.

Table 16

*Interviewee Comments Related to Music Therapy Research: Strengths and Challenges (presented in alphabetical order)*

<table>
<thead>
<tr>
<th>Strengths</th>
<th></th>
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<tbody>
<tr>
<td>Frequent use of quantitative methodology: coin of the realm in social science and medicine</td>
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<tr>
<td>Fultz Research Award has encouraged professionals to do research</td>
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<tr>
<td>Leader in producing research among creative arts therapies</td>
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<tr>
<td>Recent increased involvement with the field of neuroscience</td>
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<table>
<thead>
<tr>
<th>Challenges</th>
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<tbody>
<tr>
<td>Clinicians don’t always feel they have the knowledge to do research</td>
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<tr>
<td>Most music therapy research is non-funded</td>
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<tr>
<td>More phenomenological, qualitative research that tells the whole story</td>
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<tr>
<td>More research is needed for a field that serves such diverse populations</td>
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<tr>
<td>Music therapy needs research that looks at the process</td>
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continued
Table 16 continued

Need clinicians to develop a line of research and focus on it for many years
Need more clinicians to do research, not just academics
Research politics: issues with IRB
Small subject pools
Weak experimental designs

Table 17

Interviewee Comments Related to Areas of Music Therapy Practice Requiring Additional Research

Most Frequently Mentioned
Autism (all ages) (4/18)
Teaching and learning (3/18)

Sometimes Mentioned
Mental health (2/18)
Special education (2/18)

continued
Table 17 continued

*Least Frequently Mentioned*

At-risk youth (1/18)
Teen and young adult violence (1/18)
Alzheimer’s/dementia (1/18)
Preventative areas (1/18)
Cardiac rehabilitation (1/18)
Diabetes (1/18)
Burnout of music therapists (1/18)
Significance of symptom improvement (length of time) (1/18)
Music therapy protocols: are we systematically implementing our treatments and approaches (1/18)
Cost-effectiveness studies (1/18)
Popular music and its value in music therapy (1/18)
Research on the styles of music used in therapy (1/18)
Wellness (1/18)
Personal attributes of music therapists (1/18)
Music therapy assessment tools (1/18)
Use of technology in music therapy: pros and cons (1/18)
Music Therapy in the Media

The last section of questions concerned portrayal of music therapy in the media. Most participants agreed the portrayal of music therapy by means of mass communication has improved in recent years. More and more, articles and news stories are mentioning research related to music therapy when telling their stories and show a client and therapist working together. Many of the participants suggested that any publicity is good publicity and that the more music therapy becomes part of the popular culture through movies, books, internet pages, and magazine articles, the more aware people will become of its existence (see Table 18). One respondent states:

I’ve always been a really big advocate of reaching people however you can. I think books and movies is how a lot of people are going to find out about it. . . . I feel like those are just as valuable as research; because I feel like the average American isn’t going to be looking in research journals. That doesn’t matter, they need to see it on the nightly news, they need to read about it in a book.

All interviewees agreed that the last year had been a strong year for music therapy in the public media, more so than any other year in its history. The tremendous work with Senator Gabrielle Giffords, Jodi Picoult’s novel Sing You Home, and the motion picture The Music Never Stopped (Appendix G) were mentioned over and over as some of the most important ways music therapy was promoted to the general public.

Despite the perception that media portrayals of music therapy have become more accurate in recent years, most participants felt there was still room for improvement. Many suggested that when the media covers a story about music therapy, they have a
predetermined agenda of what they want to hear and write about. Participants made statements such as “general media doesn’t go into subtle issues” and “general media finds sensational ways to describe the work of a music therapist as well as the therapeutic outcomes.” Many mentioned the media often refers to the work as “the magic of music” or “the healing power of music,” never bothering to discuss the training, qualifications, and work being done by the music therapist engaging with the individual. One interviewee expresses her frustrations:

It’s something that frankly you have to take a lot of aspirin, and keep on top of, and try to guide them as much as possible, talking about the 1200 clinical hours, and the full curriculum, and the board certification exam, and the continuing education, and our Standards of Practice, and Code of Ethics, and all those kinds of things and maybe they will weave some of that in, so that people will not just think that it is somebody with a harp and guitar and two drums that came in to play for them.

Some suggested the media assumes that the music alone caused the change, and fail to discuss the therapeutic process and what the therapist did with the music to effect change in the client. Many of the participants were frustrated with the stereotypical portrayals of music therapy that continue to exist, for example, the volunteer who plays guitar in the hospital being called a music therapist, the media referring to the field as “musical therapy,” and music being considered a “miracle cure.”

Every time somebody calls me and asks for an interview I start very openly and honestly and go “listen I don’t want to burst your bubble but I know that you have
a copy editor or somebody that’s really going to want to put *The Healing Power of Music* as the headline. . . . *The Healing Power of Music* as a headline sort of means, well what’s the purpose of a therapist? Did the client do any work on this?” . . . Whenever something is for mass consumption it has to be boiled down, and you can’t boil down therapy.

Participants suggested it should be stressed to the journalist or reporter who is writing the story that the specific qualifications of a music therapist need to be mentioned when discussing music therapy. Also, that it would be beneficial to have additional monitoring, particularly on the internet, in order to catch and make corrections when music therapy is being misrepresented. Regardless of moments of misrepresentations, most participants were of the opinion that whether accurate or not, “there is no such thing as bad publicity.” One participant shared she has received many calls from potential music therapy clients as a result of the recent media exposure. Though not always accurate, the exposure opens a window of communication that previously did not exist.

The three minute segment on the six o’clock news, where typically they will get into all the magic of music, voodoo stuff; it’s getting music therapy out there. I’m not sure that people take the six o’clock news that seriously anyway, so the exposure can be very good because then people call and you can teach them a little more about it.

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### Table 18

**Interviewee Comments Related to Music Therapy in the Media**

<table>
<thead>
<tr>
<th><strong>Pros</strong></th>
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<tr>
<td>Representations of music therapy in pop culture effectively promote the field to the masses: The Music Never Stopped (Pearson), Senator Gabrielle Giffords’ recovery, Sing Me Home (Picoult) (9/19)</td>
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<tr>
<td>Portrayal of music therapy by the media is improving (8/18 participants)</td>
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<tr>
<td>Any publicity is good publicity (3/18)</td>
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<table>
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<tr>
<th><strong>Cons</strong></th>
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<tr>
<td>Frustrating/stereotypical portrayals continue to permeate: music lady, volunteer, entertainer, musical therapy, miracle cure, magic of music (5/18)</td>
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<tr>
<td>The healing power of music: does the therapist do any work? (3/18)</td>
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<tr>
<td>Media does not discuss qualifications and training when talking about music therapy (3/18)</td>
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<tr>
<td>Media often declines to discuss the therapy process (2/18)</td>
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<tr>
<td>Media has an agenda of what they want to hear and write about (2/18)</td>
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<tr>
<td>General media does not delve into therapy (2/18)</td>
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<tr>
<td>Lack of internet monitoring to correct online misrepresentations (1/18)</td>
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<tr>
<td>Credibility often sought from medical doctor or neuroscientist when interviewing a panel of experts including a music therapist (1/18)</td>
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<tr>
<td>It is too complex to portray music therapy accurately (1/18)</td>
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<tr>
<td>Media typically assumes that the music by itself caused the change (1/18)</td>
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Emergent Themes

The participants for the study had a wealth of knowledge and experiences to share and our conversations naturally led to topics outside of the structured interview questions. Three major themes emerged from the data. These were “talking about music therapy,” “clinician-based research,” and “music therapy students’ skewed realities.” In the following section, these themes are discussed.

Talking About Music Therapy

A number of the participants discussed the importance of educating music therapy students and professionals on how to properly talk about music therapy to individuals in various settings. As mentioned previously, some music therapists suggested advocacy education should be included in the undergraduate curriculum. Participants reminisced on occasions when they were completely caught off guard and had to quickly define music therapy and cite clinical examples in a way the listener would understand. Some suggested after years of experience, this may be second nature to many, but for a beginning professional, it may pose a great challenge; especially when the person asking is a doctor or a medical administrator. In discussing professional advocacy for the field, one participant mentioned:

That’s something that I had never learned. . . . I just had to figure that out by myself. Even if students or interns were required to come up with their own elevator spiel before they are released . . . because it’s happened to all of us, where you’re in a hospital setting or in some facility and you have a guitar on
your back and you’re pushing a cart of instruments… People say things to you and ask questions. If you’re caught off guard and don’t know what to say; that doesn’t bode well for music therapists.

Another participant discussed that knowing how to properly talk about the field could sometimes make the difference between landing a job and getting paid for what you love to do versus being unemployed and struggling financially. The participant used the situation of a music therapist attempting to create a job in a new facility in order to illustrate his statement:

If you’re going to go out and get a job, that’s cool, but last time I checked the world doesn’t know that much about music therapy. There are not a whole lot of full time jobs out there. So, how do you sell yourself?

The participant drew a connection between not knowing how to “sell yourself” as a professional with not only having difficulty acquiring, maintaining, and being paid for the services, but also to the slow growth of the field and the high attrition rates. The participant continues:

Personally I feel like we fall on our face as a profession in educating and preparing our field for that kind of growth. After sixty years as a profession there’s only like 5,000 music therapists nationwide. There’s something missing in our professional development called “how to get paid and how to stay in the field and get paid.” Because people don’t know how to get paid so they go find a way to get paid and it doesn’t include music therapy.
The participant ended by stating “You can be a great clinician but it doesn’t matter at all if you don’t know how to articulate what a great clinician you are.”

**Clinician-Based Research**

A number of the participants pointed out the need to encourage clinicians to conduct research studies and to not be afraid to pursue their research ideas. Participants pointed out that many clinicians do not feel they have the necessary knowledge and experience to conduct studies, and despite having the desire, the ideas, and working for a facility that encourages such types of activity, fail to get anything started. “I think we need more efforts in helping clinicians feel more secure in attempting to do research,” stated a participant. “We need more clinicians that are willing to do research in addition to the academics who are doing research.” Another participant pointed out that despite the tremendous emphasis put on research by the AMTA, “It’s still difficult for the average clinician to also be a researcher. I think many don’t know how to do both, or how to incorporate research into their clinical practice.” A third participant suggested taking advantage of the recent interest related fields have given to music therapy and collaborating with professionals who may have more experience conducting studies.

For the research studies the music therapist can provide the clinical work and the researcher can be the one who collects the data and works with the data. . . . It makes our research much cleaner when someone other than the clinician is handling the data.
A fourth participant had a similar point of view, suggesting that pairing with professionals such as neuroscientists would further the level of depth of music therapy research.

I think more and more music therapists need to do more collaborative research. I don’t have the time to learn all about neuroanatomy, to find out what is going on. But there are certainly people who do know and when we collaborate, when we work together, I think we are going to begin to really understand what is going on in the music therapy process. What is the contribution of the music itself? Of the therapist, of the combination? How is it affecting the body, the brain, the energy system? So I really think collaborative research is extremely important right now.

Music Therapy Students’ Skewed Realities

The third outlying point concerns the unrealistic perception many newly graduated professionals have about the reception of music therapy by the general public, including potential employees.

I think it’s hard when you go to school and internship and you almost have this perfect bubble, what your teachers pick out for you to learn and the clients they pick out for you to treat, with all of these objectives in mind. And then you are in the real world and it’s different.

Facing reality, including the lack of knowledge and understanding surrounding music therapy from the general public, the skepticism from the medical profession, and the hierarchy that naturally exists within the various therapies and clinical settings, it is
easy for the student to feel discouraged, isolated, and confused. Another participant added:

It seems to also be a little bit daunting for a lot of our students in making that transition to understand that the rest of the world doesn’t give them four positives for every negative. The rest of the world gives them a lot of negatives.
Chapter 5: DISCUSSION

Restatement of the Purpose and Research Questions

The purpose of this study was to consolidate multiple perspectives concerning issues relevant to the profession of music therapy. Six major topics were explored through a series of interviews with music therapy faculty and members of the American Music Therapy Association. These included factors influencing the professional growth of music therapists, music therapy education and clinical training in relation to the undergraduate requirements, successes and challenges of the profession, music therapy research, long-term goals, and representation of music therapy by the public media.

Overarching research questions guiding the study were as follows:

1. What experiences impact the professional growth of music therapists?
2. What are the opinions regarding the undergraduate music therapy education requirements?
3. What are the most important achievements of the music therapy profession, and what are its current challenges?
4. What are the current research trends in music therapy? Are there areas that require further research attention?
5. What are the long-term goals of the music therapy profession?
6. How is music therapy portrayed in the media?
In Chapter 5, I provide a summary of the findings for each of the research questions, discuss results and implications for the field of music therapy, and offer conclusions and ideas for future research.

**Summary of Findings**

**Research Question 1:** What experiences affect the professional growth of music therapists?

Hahn and Lester (2012) define professional growth as “an intentional process of building knowledge and skills that allows individuals to be effective in their jobs and advance in their careers” (p. 82). The topic of professional growth has been explored in multiple fields including education, nursing, and mental health (Erickson & Noonan, 2012; Pye & Green, 2011; Klein, Bernard, & Schermer, 2011). Since the 1970’s, the field of music education has also seen increased interest in the study of professional growth. Research studies have investigated the factors that contribute to the professional development of beginning and experienced teachers, the cost-effectiveness of providing professional development opportunities for the improvement of teacher retention rates, and the implementation of professional development practices (for example, peer mentoring, workshops, in-services, and learning communities) for the enhancement of teacher satisfaction and efficiency (Bauer, 2007; Bush, 2007; Campbell & Brummet, 2007; Conway & Christensen, 2006; Conway, 2007; Horsley, 2002; Thickstun, 2009).
Participants in the present study referred to their music therapy education as one of the most important components leading to their success in the profession. Participants also discussed gaining tremendous benefits from having mentors, collaborating, and networking with others. These findings support past research studies that indicate those music therapists who work alongside other music therapists or have the opportunity to talk to knowledgeable professionals have higher levels of job satisfaction (Fenlason & Beehr, 1994; Vega, 2010). While the topic of professional development in music therapy has not been largely explored, music therapists have, however, written about the importance of receiving professional supervision during the professional years. Jackson (2008) writes:

Professional music therapy supervision . . . moves into a process that might illuminate, develop, and redefine both parties involved in the supervisory relationship. Professional supervision has the potential to support the continued growth and development of the music therapist, which in turn will benefit the therapist, the clients, and the profession in general (p. 193).

The music therapists interviewed in the present study held professional supervision at high regard. Many discussed the need to take an active role in seeking mentors or supervisors throughout their professional careers and stressed the importance of being proactive in seeking these relationships, as they would be without them otherwise.

The interviewees who had experience teaching and supervising students shared that these facets of their jobs promoted professional growth. Likewise, the music
therapists who serve clients discussed the life-changing experiences that resulted from seeing their clients’ progress and how this directly affected their development as professionals. Other factors contributing to the professional growth of music therapists included attending conferences, reading research journals, and working in a job that provided a great deal of autonomy.

**Research Question 2:** What are the opinions regarding the undergraduate music therapy education requirements?

The undergraduate music therapy requirements have received some attention in the research literature; however, the majority of the available studies are from past decades. Multiple investigators have evaluated the undergraduate requirements closely, and have reported finding incongruities between areas of study that receive great emphasis and take up a large portion of the curriculum, and areas that are given less emphasis and time despite being of utmost importance for professional music therapy practice (Brookins, 1984; Braswell et al., 1979; Braswell et al., 1980; Nicholas & Gilbert, 1980).

Overall, study participants agreed that the greatest strength of the undergraduate music therapy curriculum is that it is built on articulated competencies as specified by the AMTA. Many of the participants think that the introduction of clinical experiences early in the degree is also of tremendous value. A number of the participants suggested the undergraduate degree in music therapy adequately prepares a generalist, providing the
beginning music therapist with the tools he/she needs to successfully engage in clinical work.

Per the participants’ opinions, the strengths of the music therapy curriculum are also its challenges. The number of requirements and courses necessary to successfully cover the *Professional Competencies* is vast, leading to a very full curriculum. Some of the interviewees think too much of the curriculum is taken up by requirements that have little applicability to the work of a music therapist; specifically, the core music requirements of applied studies, music history, and music theory. These findings support the studies discussed in the review of literature found in Chapter 2, including the early research studies of Madsen (1965) and Braswell et al. (1979). Based on these issues, the participants would like to see changes made to the curriculum. Among the most frequently mentioned were spending more time on secondary instrument classes, which would be specific to music therapy and be taught by a music therapist. The suggestion to increase work in the secondary instrument areas supports Petrie’s (1989) investigation of music therapy faculty, clinical training directors, and active clinicians, who proposed that in the “ideal curriculum” more attention would be placed on functional music skills.

**Research Question 3:** What are the most important achievements of the music therapy profession, and what are its current challenges?

The participants of the study consider the unification of the National Association for Music Therapy and the American Association for Music Therapy into the present AMTA to be one of the most important achievements for the profession. The
establishment of one credential (MT-BC), the comprehensive music therapy research base, the recent licensures in Georgia, Nevada, and North Dakota, the diversity of the populations served by music therapists, and the growing acceptance of the modality as an effective form of therapy by the medical community were also considered to be the field’s greatest accomplishments to date. The biggest challenges reported by the participants include the small size of the profession, the prevailing issues of burnout and attrition, the misunderstanding that continues to exist surrounding the field and what qualifies a music therapist, the hierarchy within medical settings, and the contention among members of the field of different theoretical orientations.

Suggestions for overcoming these challenges were provided by the participants, and their responses varied greatly. Some of the interviewees thought that moving to master’s level entry would relieve many of our current challenges, creating longer career paths for professionals and increasing job satisfaction among practitioners. Participants suggested the move would automatically result in a more competent, well-rounded professional, who would be considered more “equal” to other members of the interdisciplinary treatment team. Reimbursement, job salaries, and job security would also be affected in a positive manner. In terms of growing the profession, respondents advised engaging in intensive outreach efforts in order to reach minorities. These findings support Groene’s (2003) investigation where he advised enhancing outreach strategies in order to “attract and retain non-white students and male students to pursue a career in music therapy” (p. 12). Recruiting students from related fields and accepting pop and jazz musicians into music therapy academic programs were also proposed.
Research Question 4: What are the current research trends in music therapy? Are there areas that require further research attention?

Participants suggested that in recent years qualitative research increased in the music therapy literature, primarily for master’s theses and doctoral dissertations. Some have observed that the trend appears to be returning to quantitative studies, and think that it is important to continue to approach research from both methodologies, as they are equally valid and useful. The participants who made these suggestions expressed the importance of conducting studies (whether qualitative or quantitative) that describe interventions in some detail in order to fully understand the dynamics that lead to a particular outcome.

Over eight different clinical populations were highlighted for further research by the participants in this study, with the population most often cited being children and adults on the autism spectrum. Additional populations included at-risk youth, patients with cardiac issues and diabetes, clients with psychiatric diagnoses, individuals seeking wellness, students in special education, and preventative areas. Participants would also like to see more research in music therapy teaching and learning. It was also recommended by one participant that now more than ever, there is a great need for studies that evaluate the cost-effectiveness of music therapy, as having this hard evidence would help to support current major goals for the profession including the pursuit of third party reimbursement, higher salaries, and more equality among healthcare professionals.
**Research Question 5:** What are the long-term goals of the music therapy profession?

Three recurring long-term goals emerged from the interviews. The number one priority for the music therapists who participated in the study was to see the field grow significantly in terms of the number of board certified music therapists practicing in the United States. A second long-term goal was to increase awareness of music therapy across all settings and people, resulting in greater recognition and respect for music therapy professionals. A third major goal was for music therapy to become a reimbursable service. Additionally, music therapists would like to see an increase in their salaries and would like for their services to be “unquestionably used” and “routinely prescribed.”

**Research Question 6:** How is music therapy portrayed in the media?

Participants agree that media portrayals of music therapy have improved in recent years. More so than in the past, current media stories show therapists and their clients actively engaged in the therapeutic process. This is of benefit to the profession, as the dynamics of the music therapy process, represented by the therapist, the client, and the music, are overtly portrayed.

Almost all of the individuals interviewed discussed Jodi Picoult’s book *Sing Me Home* and Jim Kolhberg’s motion picture *The Music Never Stopped*. Participants felt satisfied with the way the profession had been portrayed to the general public, and conferred that the author/director had effectively captured the essence of the field.

Respondents discussed that when music therapy is portrayed, it is important that
the profession is accurately represented, so as to not send erroneous messages to the receiving audience. Participants suggested members of the profession should not feel afraid to make corrections and advocate for accuracy when needed. Writing letters to the editor of the article or directly making a phone call to the broadcasting company were advised.

Discussion

Professional Growth of Music Therapists

The findings from the present study support past music therapy investigations conducted in the areas of professional well-being and burnout. While the topics of professional development, employment satisfaction and longevity, compassion fatigue, and attrition are pertinent to all professions, little research has been devoted to these areas in the field of music therapy. This is of concern, as the studies that have been done show that issues related to burnout, work isolation, and attrition permeate the professional experience of many music therapists across the United States.

The participants of the study openly discussed personal and professional experiences that had contributed to their success in the field, sustaining their motivation and well-being along the way. Considering it an aspect of their professional development, working with other music therapists was overwhelmingly cited by the respondents as one of the most important factors leading to a fulfilling and successful career. It became evident the participants cherished personal and professional contact
with other music therapists, whether through regular supervision meetings, co-leading sessions at work, and/or participating in a community of practice. This finding is supported by the studies of multiple authors including Knoll, Reuer and Henry (1988), Stewart (2000), and Sutton (2002), who found that music therapists who remain connected to members of their field have higher levels of job satisfaction and professional fulfillment. As a strong correlation exists between job satisfaction and professional longevity (Vega, 2010), this is a meaningful finding for the field. Per the results of the present study, growing the size of the workforce is a top priority for the profession of music therapy; therefore, retaining the professionals who are already in the field is an important component for achieving this major goal.

It must be addressed that many music therapists in the United States currently work alone, lacking the support of an understanding, like-minded colleague who can help cope with the many challenges that arise on a daily basis. Per the findings of the study, it is imperative these music therapists are identified and integrated into the overall functioning of the profession, so they remain connected, motivated, and aware that support does exist. With the current prevalence of social media, even those music therapists living in the most remote locations can find communities of support. After a brief search on the social media site facebook, multiple groups created by music therapists working with different clinical populations were found. In these groups, music therapists shared session plans, inspirational stories, struggles with clients, medical staff, employment, and finances, and posed a variety of questions for their peers to answer. It became evident that the groups served multiple purposes to the users, and directly related
to the factors that contribute to a successful career as identified by the participants in the study.

In addition to what has already been discussed, what other advice then, can be given to music therapists so they remain satisfied and connected to the profession? Based on the findings of this investigation, partaking in frequent activities that promote professional development is another important piece. Attending conferences, obtaining a graduate degree, and engaging in Continuing Music Therapy Education were frequently cited by participants as ways to stay motivated and “plugged in.” This reflects the findings of Stewart (2000), whose research showed that music therapists who engaged in personal and professional development had higher levels of job satisfaction.

Some of the participants agreed that returning to school to pursue a graduate degree would not only result in a more competent professional, but that it would also lead to overall well-being and a lengthier career track. Past studies support this finding, indicating that rates of job satisfaction are higher in individuals who have advanced degrees (Cohen & Behrens, 2002) and have remained in the field for longer periods of time (Braswell, et al., 1989). Oppenheim (1987) also supports “continued learning” and being a “goal setter” as ways to cope with daily stressors and therefore, maintain a positive relationship with the field. The participants of the study reflected the latter of Oppenheim’s (1987) findings, suggesting that “taking risks” and “venturing into unfamiliar clinical territory” when feeling burned-out with a job could serve as a fresh start.
Identifying healthful physical and social behaviors to engage in outside of the professional experience were also advised as ways to relieve emotional stress and therefore prevent burnout. Multiple suggestions were provided by the participants of the study, and they included exercising, having hobbies, maintaining a positive attitude, and seeking support from family and friends. This supports Fowler’s (2006) research on the relations between personality characteristics, work environment, and the professional well-being of music therapists. Fowler’s (2006) findings demonstrated those music therapists who engage in a healthy lifestyle have greater professional longevity. Based on the results of the present study and investigations conducted in the past, it is clear that the practice of self-care and continuous professional growth is a necessity to music therapists if they wish to remain in the field.

One factor that has yet to be discussed is the reward music therapists obtain from observing positive changes in their clients and the effects of such experiences on job satisfaction. When asked to speak of the most rewarding aspect of being a music therapist, most of the participants in the study referred to their clinical experiences. Participants spoke about the joys of witnessing transformations in their patients and the inspiration they drew from seeing clients overcome challenging situations. These findings are supported by Hills, Norman, and Forster (2000) who found that music therapists obtained great levels of job satisfaction from engaging in clinical work and observing their clients progress. Based on this, frequent reflection on the positive effect music therapy has over clients may help to counteract some of the negative feelings that may arise over time.
Education and Clinical Training

The findings of the study support past investigations concerning education and clinical training. Collectively, participants spoke of challenges within the curriculum, repeatedly discussing the considerable amounts of general education and core music requirements and the great emphasis that is given to these areas despite their limited application to music therapy practice. Past studies, including those of Madsen (1965), Braswell et al. (1979), and Petrie, (1989) have presented similar arguments, outlining the need for more courses in secondary instruments, music therapy, fieldwork, recreational music, and clinical populations; while reducing the amount of music theory, music history, and applied lessons requirements. Even though over forty years have passed since the publication of the initial studies evaluating music therapy curriculum, very few changes have been made to the issues raised (Groene & Pembrook, 2000). What has continued to change and grow over the years is the number of competencies specified by the American Music Therapy Association.

Participants discussed that these discrepancies, at times, result in music therapy students graduating with underdeveloped musical and clinical skills. Some even suggested that students leave their programs feeling confused and overwhelmed with information. These same participants think these problems could be eliminated if the curriculum was rearranged so that core music, general education, and pre-music therapy coursework were completed at the bachelor’s level; and music therapy coursework, including practica and internship were completed at the master’s level. This change of course, would result in master’s level entry for the profession.
Considering Cohen and Behrens’ (2002) research suggesting that music therapists with advanced degrees have higher levels of job satisfaction and stay in the field significantly longer than those with bachelor’s degrees, a move to master’s level entry would support the growth of the field by potentially reducing the rate of attrition among music therapy professionals. Additionally, an advanced degree may result in higher salaries, increased job opportunities, and greater levels of respect and recognition from peers outside the profession. These factors, cited by the participants of the study as some of the major challenges they have faced throughout their careers, have also been discussed in the literature as direct causes of burnout (Oppenheim, 1987; Bitcom, 1981; Clements-Cortes, 2006; Vega, 2010).

Though moving to master’s level entry is thought by some to be a solution for issues relating to career longevity and burnout, an important number of the participants thought a move to master’s level entry would discourage high school students from considering the profession in the first place. Some suggested moving to master’s level entry would reduce the number of professionals entering the field on an annual basis, contributing to the problem of a small workforce. Considering the difficulties and potential timeframe of making this move, it is possible that subtle modifications could be made to the present undergraduate curriculum so as to ameliorate some of the curricular challenges presented by the participants.

Based on the issues raised concerning underdeveloped musical skills, it may prove useful for music therapy programs to implement a formal assessment of these competencies at the beginning of the student’s senior year, so as to allow time for the
remediation of skills prior to the start of internship. A similar approach could be taken for improving clinical skills prior to graduation. Additional strategies to consider based on the advice provided by the participants of the study include pairing students of different levels (for example a senior student with a junior student) to engage in practica together so they are able to support and learn from each other; sequencing the coursework to allow sufficient time for the development of basic musical and clinical competencies in the classroom (rather than during practica or internship); and supporting the use of the student’s primary instrument in the therapeutic setting.

**Music Therapy Research**

Research activity has been a central feature to the profession of music therapy since its establishment as a formal field of study. Music therapy research is as diverse as the theoretical approaches to music therapy. There are studies using quantitative, qualitative, and mixed methods designs. The modes of inquiry include philosophical, descriptive, experimental, and historical studies (Wheeler, 1995).

In 2005, the AMTA designated research as a strategic priority and developed an operational plan which “addresses the direction of research in support of evidence-based music therapy practice and improved workforce demand; and recognizes and incorporates, where necessary, federal, state and other entity requirements for evidence-driven research as it relates to practice policy and reimbursement” (http://www.musictherapy.org/research/strategic_priority_on_research/overview/). 

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Collectively, the music therapists in the study discussed the importance of continuing to pursue research in music therapy and thought that the successes of the field were partly rooted in a tradition of research excellence. Multiple participants addressed the need for research designs that closely describe the music therapy process. In past years, researchers such as Crowe (2004) have made similar recommendations. Rather than attempting to understand the effectiveness of music therapy by “reducing this process to only small, measurable effects,” Crowe (2004) suggests that “music therapy must be looked at as a whole process in all its frustrating, beautiful complexity” (p. xv). More recently, the *Journal of Music Therapy* established new author submission guidelines, asking contributors “to provide more detailed description of the music interventions and conditions under investigation” (Robb, 2012, p. 2). These changes are congruent with what some of the present study participants suggested.

A number of the interviewees shared their concerns over the current caliber of randomized control trials (RCTs) in music therapy, emphasizing the importance of elevating the quality of future RCTs so as to obtain greater acceptance from the medical community. Specifically, participants were concerned with aspects of the research design, for example sample size, and whether the music therapist was providing the treatment, collecting, and analyzing the data. These concerns are congruent with Bradt’s (2012) recent article that reviews “key design aspects of RCTs and discusses how to best implement these standards in music therapy trials” (p. 120). Following a review of the music therapy research literature, Bradt (2012) found “the need for increased scientific rigor in the design and conduct of RCTs” (p. 146). Some of the participants of the study
highlighted that most music therapy clinicians are typically not heavily trained in research, and therefore, lack education in the areas of research design and implementation. Because of this, challenges arise when submitting research protocols to medical institutions’ Institutional Review Boards or when attempting to publish music therapy studies in journals outside of the field.

Taking into account the concerns of some of the participants of the present study and the recent guidelines for the submission of RCTs by the *Journal of Music Therapy*, it is important to begin to evaluate potential viable pathways to advance research training for music therapy professionals. How does the profession elevate the caliber of the research so that it is more readily accepted by the medical community?

One must consider the already unique aspects of the music therapy curriculum, which presents research methodology components to students from early in the undergraduate coursework through the review of journal articles, case study assignments, and data collection exercises. At the master’s level, requirements are in place for the completion of theses and other research-based special projects. While advanced research education would be received at the doctoral level, it must be considered that the majority of practicing music therapists are at the bachelor’s and master’s level, with a low number of professionals pursuing doctoral degrees. With few PhD’s graduating in music therapy on an annual basis, a challenge exists for elevating the status of the research.

Based on this, it may be beneficial to offer varied levels of research methodology Continuing Music Therapy Education courses at regional and national conferences. Lower level courses could serve as refreshers for those music therapists who have already
taken such classes at their colleges and universities and provide basic knowledge and understanding to those who have not had the opportunity to study research methodology in a formal setting. Higher level courses could provide advanced training pertaining to current guidelines for the publication of RCTs. Forming research groups with more experienced music therapy professionals and engaging in interdisciplinary research collaborations would further support the individual music therapist engaging in the research process and the overall research agenda for the profession.

Conclusions

Advocacy

The participants of the study universally agreed on the continuous need for advocacy among related fields and the general public. Acknowledging the confusion and lack of understanding surrounding the field of music therapy, the interviewees suggested it is the responsibility of every member of the profession, including students, interns, clinicians, administrators, faculty, and board members of the AMTA to advocate for the profession. Distributing music therapy materials to potential consumers and administrators; writing letters, making phone calls, and visiting legislators; speaking publicly about the benefits of music therapy; and providing music therapy research findings to professional associations such as the American Academy of Pediatrics were among the recommendations provided. Additionally, participants suggested that music
therapy students receive education concerning advocating for the field throughout their years of academic training.

**Music Therapy Education and Clinical Training**

Throughout the interviews, much consideration was given to the undergraduate education requirements. Participants of the study raised a number of concerns about the undergraduate requirements and provided thoughtful recommendations for possible changes. While the suggestions have potential benefit, immediate results or changes are unrealistic, primarily due to the number of stakeholders in the education of music therapists. Accrediting boards, university curriculum requirements, type of institution, and faculty expertise are among the factors that directly influence the decision-making process. Because of this, it is recommended productive discussion among music therapy faculty and members of the AMTA center around what to do in order to effect potential change within the various entities rather than exclusively focusing on individual desired changes.

**Master’s Level Entry**

The potential move to master’s level entry was a topic widely discussed in the study, and participants were clearly divided on the matter, presenting a series of strong arguments in support or opposition. Taking into consideration the pressing nature of this matter, what is certain is that regardless of entry to the profession being at the bachelor’s or master’s level, continuing education remains a great need for all practicing music
therapists, as there will still be situations that arise throughout the music therapist’s career for which the individual is directly unprepared.

**Professional Communities of Learning**

Music therapy faculty and board members of the AMTA strongly agreed on the importance of building professional communities of learning in order to reduce the common problems of burnout and isolation among music therapy professionals. Throughout the interviews, participants shared meaningful stories detailing the benefits of participating in learning communities with other music therapists. Often referred to as staying “plugged in,” the gains of such practice included reduced isolation, increased emotional support, and overall professional growth. It was discussed these communities served multiple personal and professional purposes. Having a group of like-minded professionals with whom to share the joys and frustrations of the daily work, solve challenging clinical matters, and obtain ideas for programming were among the benefits mentioned. The participants discussed taking part in such groups provided opportunities for peer-mentorship, collaboration, and professional supervision.

**Continuing Education**

Repeatedly, participants of the study encouraged all music therapists, particularly young professionals, to be continuous learners in order to have long, successful careers. The advice given included reading peer-reviewed journals, attending conferences, taking Continuing Music Therapy Education, learning a new instrument, pursuing short courses
in relevant fields, participating in supervision, seeking mentors, obtaining a graduate degree, acquiring an advanced specialization in music therapy, pursuing research ideas, and collaborating with professionals in related fields. A number of the interviewees referred to themselves as “life-long learners,” and attributed their professional successes to never giving up on the quest for knowledge.

**Growth of the Profession**

The majority of the participants agreed that the top priority for music therapy is to grow in size. While multiple avenues to achieve this goal were proposed, a strong consensus was obtained for taking steps such as advocating for the clinical benefits of music therapy across professional communities and the general public, expanding the research literature in all clinical areas, increasing outreach efforts to attract ethnic minorities and males, and expanding the work settings and clinical populations currently served by music therapists. These recommendations reflect those provided by Groene (2003) in his study concerning healthcare demands and the need for more music therapists in the workforce.

**Limitations and Recommendations for Future Research**

The present study was a best attempt to gain a comprehensive view of current issues and opinions relevant to the profession of music therapy. Through a series of interviews with current leaders and experienced members of the music therapy community, I was able to capture a diversity of perspectives on issues such as
professional development, burnout, music therapy curriculum, long-term goals for the profession, and research needs. While some opinions were in contrast with one another, there were overarching themes across most respondents, including the long-term goal of growing the size of the profession, the need for advocacy among various professional communities, the desire for research studies that clearly describe the music therapy process, and the need for strategic evaluation of the current undergraduate music therapy requirements. Though the findings of the study are useful in understanding the current status of the profession as verbalized by some of its most experienced members, the study was neither a systematic survey of all members nor an examination of music therapy programs in practice. With this in mind, further in-depth investigation of the issues discussed is recommended, as each topic is of importance for the future of the profession. Studies in the area of professional development and burnout could further explore the personality traits, work environment, and education of music therapists who have remained in the field for many years. Studies of those music therapists who have left the field would provide useful information as to why they made the decision to leave the profession and what factors could have prevented this from happening. In the area of music therapy curriculum, it would be of value to conduct a study that analyzes test scores of the Certification Board for Music Therapists’ national examination, in order to identify areas within the Scope of Practice that are typically underscored by test takers. This score analysis could serve to further support advocacy efforts for curricular revisions. Lastly, a study could be designed to measure the effectiveness of an outreach campaign in recruiting students for the profession. Specific outreach strategies could be
employed and each would be evaluated in order to identify its effectiveness for outreach and recruitment efforts. This last recommendation supports specific suggestions provided by the participants of the study to grow the size of the music therapy profession.
REFERENCES


Descriptive Statistical Profile of the 2010 AMTA Membership. Silver Spring, Maryland: American Music Therapy Association, Inc.


National Association for Music Therapy. (Various dates). *Surveys conducted from 1991 through 1996*.


Appendix A: Historical Milestones of the Music Therapy Profession
Historical Milestones of the Music Therapy Profession

1936 – Willem van de Wall publishes *Music in Institutions*, considered the first music therapy textbook.

1940’s – Ira Altshuler, Willem van de Wall, and E. Thayer Gaston play critical roles in establishing music therapy as an organized clinical profession.

1944 – Michigan State University establishes the first bachelor’s level music therapy training program.

1946 – E. Thayer Gaston establishes the first graduate program in music therapy at the University of Kansas.

1950 – National Association for Music Therapy (NAMT) is founded.

1964 – The NAMT publishes the *Journal of Music Therapy*.

1971 – American Association for Music Therapy (AAMT) is founded.

1975 – Passage of Public Law 94-142 Education for all Handicapped Children Act: This law required that all public schools offer equal access to education for children with physical and mental disabilities.

1980 – The AAMT publishes the research and clinical journal *Music Therapy*.

1983 – Certification Board for Music Therapists (CBMT) is established.

1984 – The NAMT publishes *Music Therapy Perspectives*.

1991 – Members of the NAMT provide a testimony on the benefits of music therapy before the Senate Special Committee on Aging.

1991 – As a result of the Senate Hearing, Senate Bill S. 1723 – The Music Therapy for Older Americans Act is created. Through this bill, music therapy is included in
Medicare reimbursement for Partial Hospitalization Programs.

1998 – The American Music Therapy Association (AMTA) is established through the unification of NAMT and AAMT.

2005 – The AMTA Board of Directors designates ‘Research’ as a Strategic Priority.

2011 – North Dakota and Nevada enact music therapy licensure legislation.

2012 – Georgia enacts music therapy licensure legislation.
Appendix B: American Music Therapy Association Professional Competencies
A. MUSIC FOUNDATIONS

1. Music Theory and History
   1.1 Recognize standard works in the literature.
   1.2 Identify the elemental, structural, and stylistic characteristics of music from various periods and cultures.
   1.3 Sight-sing melodies of both diatonic and chromatic makeup.
   1.4 Take aural dictation of melodies, rhythms, and chord progressions.
   1.5 Transpose simple compositions.

2. Composition and Arranging Skills
   2.1 Compose songs with simple accompaniment.
   2.2 Adapt, arrange, transpose, and simplify music compositions for small vocal and nonsymphonic instrumental ensembles.

3. Major Performance Medium Skills
   3.1 Perform appropriate undergraduate repertoire; demonstrate musicianship, technical proficiency, and interpretive understanding on a principal instrument/voice.
   3.2 Perform in small and large ensembles.

4. Keyboard Skills
   4.1 Accompany self and ensembles proficiently.
   4.2 Play basic chord progressions (I-IV-V-I) in several keys.
   4.3 Sight-read simple compositions and song accompaniments.
4.4 Play a basic repertoire of traditional, folk, and popular songs with or without printed music.

4.5 Harmonize and transpose simple compositions.

5. Guitar Skills

5.1 Accompany self and ensembles proficiently.

5.2 Employ simple strumming and finger picking techniques.

5.3 Tune guitar using standard and other tunings.

5.4 Perform a basic repertoire of traditional, folk, and popular songs with or without printed music.

5.5 Harmonize and transpose simple compositions in several keys.

6. Voice Skills

6.1 Lead group singing by voice.

6.2 Communicate vocally with adequate volume (loudness).

6.3 Sing a basic repertoire of traditional, folk, and popular songs in tune with a pleasing quality.

7. Percussion Skills

7.1 Accompany self and ensembles proficiently.

7.2 Utilize basic techniques on several standard and ethnic instruments.

7.3 Lead rhythm-based ensembles proficiently.

8. Nonsymphonic Instrumental Skills

8.1 Care for and maintain non-symphonic and ethnic instruments.

8.2 Play autoharp or equivalent with same competence specified for guitar.

8.3 Utilize electronic musical instruments.

9. Improvisation Skills

9.1 Improvise on percussion instruments.
9.2 Develop original melodies, simple accompaniments, and short pieces extemporaneously in a variety of moods and styles, vocally and instrumentally.

9.3 Improvise in small ensembles.

10. Conducting Skills

10.1 Conduct basic patterns with technical accuracy.

10.2 Conduct small and large vocal and instrumental ensembles.

11. Movement Skills

11.1 Direct structured and improvisatory movement experiences.

11.2 Move in structural rhythmic and improvisatory manners for expressive purposes.

11.3 Move expressively and with interpretation to music within rhythmic structure.

**B. CLINICAL FOUNDATIONS**

12. Exceptionality

12.1 Demonstrate basic knowledge of the potentials, limitations, and problems of exceptional individuals.

12.2 Demonstrate basic knowledge of the causes and symptoms of major exceptionalities, and basic terminology used in diagnosis and classification.

12.3 Demonstrate basic knowledge of typical and atypical human systems and development (e.g. anatomical, physiological, psychological, social.)

13. Principles of Therapy

13.1 Demonstrate basic knowledge of the dynamics and processes of a therapist-client relationship.

13.2 Demonstrate basic knowledge of the dynamics and processes of therapy groups.

13.3 Demonstrate basic knowledge of accepted methods of major therapeutic approaches.

14. The Therapeutic Relationship

14.1 Recognize the impact of one's own feelings, attitudes, and actions on the client and the therapy process.
14.2 Establish and maintain interpersonal relationships with clients that are conducive to therapy.

14.3 Use oneself effectively in the therapist role in both individual and group therapy, e.g. appropriate self-disclosure, authenticity, empathy, etc. toward affecting desired behavioral outcomes.

14.4 Utilize the dynamics and processes of groups to achieve therapeutic goals

14.5 Demonstrate awareness of one’s cultural heritage and socio-economic background and how these influence the perception of the therapeutic process.

C. MUSIC THERAPY

15. Foundations and Principles

15.1 Demonstrate basic knowledge of existing music therapy methods, techniques, materials, and equipment with their appropriate applications.

15.2 Demonstrate basic knowledge of principles, and methods of music therapy assessment and their appropriate application.

15.3 Demonstrate basic knowledge of the principles and methods for evaluating the effects of music therapy.

15.4 Demonstrate basic knowledge of the purpose, intent, and function of music therapy for various client populations.

15.5 Demonstrate basic knowledge of the psychological and physiological aspects of musical behavior and experience (i.e. music and affect; influence of music on behavior; physiological responses to music; perception and cognition of music; psychomotor components of music behavior; music learning and development; preference; creativity).

15.6 Demonstrate basic knowledge of philosophical, psychological, physiological, and sociological bases for the use of music as therapy.

15.7 Demonstrate basic knowledge of the use of current technologies in music therapy assessment, treatment, and evaluation.

16. Client Assessment

16.1 Communicate assessment findings and recommendations in written and verbal forms.

16.2 Observe and record accurately the client's responses to assessment.
16.3 Identify the client's appropriate and inappropriate behaviors.

16.4 Select and implement effective culturally based methods for assessing the client's assets, and problems through music.

16.5 Select and implement effective culturally based methods for assessing the client's musical preferences and level of musical functioning or development.

16.6 Identify the client's therapeutic needs through an analysis and interpretation of music therapy and related assessment data.

16.7 Demonstrate knowledge of professional Standards of Clinical Practice regarding assessment.

17. Treatment Planning

17.1 Select or create music therapy experiences that meet the client's objectives.

17.2 Formulate goals and objectives for individuals and group therapy based upon assessment findings.

17.3 Identify the client's primary treatment needs in music therapy.

17.4 Provide preliminary estimates of frequency and duration of treatment.

17.5 Select and adapt music consistent with strengths and needs of the client.

17.6 Formulate music therapy strategies for individuals and groups based upon the goals and objectives adopted.

17.7 Select and adapt musical instruments and equipment consistent with strengths and needs of the client.

17.8 Organize and arrange the music therapy setting to facilitate the client's therapeutic involvement.

17.9 Plan and sequence music therapy sessions.

17.10 Determine the client's appropriate music therapy group and/or individual placement.

17.11 Coordinate treatment plan with other professionals.

17.12 Demonstrate knowledge of professional Standards of Clinical Practice regarding planning.
18. Therapy Implementation

18.1 Recognize, interpret, and respond appropriately to significant events in music therapy sessions as they occur.

18.2 Provide music therapy experiences to

18.2.1 Change nonmusical behavior;

18.2.2 Assist the client’s development of social skills;

18.2.3 Improve the client’s sense of self and self with others;

18.2.4 Elicit social interactions from the client;

18.2.5 Promote client decision making;

18.2.6 Assist the client in increasing on task behavior;

18.2.7 Elicit affective responses from the client;

18.2.8 Encourage creative responses from the client;

18.2.9 Improve the client’s orientation to person, place, and time;

18.2.10 Enhance client’s cognitive/intellectual development;

18.2.11 Develop or rehabilitate the client’s motor skills;

18.2.12 Offer sensory stimulation that allows the client to use visual, auditory, or tactile cues;

18.2.13 Promote relaxation and/or stress reduction in the client.

18.3 Provide verbal and nonverbal directions and cues necessary for successful client participation.

18.4 Provide models for appropriate social behavior in group music therapy.

18.5 Utilize therapeutic verbal skills in music therapy sessions.

18.6 Communicate to the client's expectations of their behavior.

18.7 Provide feedback on, reflect, rephrase, and translate the client's communications.

18.8 Assist the client to communicate more effectively.
18.9  Sequence and pace music experiences within a session according to the client's needs and situational factors.

18.10  Conduct or facilitate group and individual music therapy.

18.11  Implement music therapy program according to treatment plan.

18.12  Promote a sense of group cohesiveness and/or a feeling of group membership.

18.13  Create a physical environment (e.g. arrangement of space, furniture, equipment, and instruments) that is conducive to effective therapy.

18.14  Develop and maintain a repertoire of music for age, culture, and stylistic differences.

18.15  Recognize and respond appropriately to effects of the client's medications.

18.16  Establish closure of music therapy sessions.

18.17  Establish closure of treatment issues.

18.18  Demonstrate knowledge of professional Standards of Clinical Practice regarding implementation.

19.  Therapy Evaluation

19.1  Recognize and respond appropriately to situations in which there are clear and present dangers to the client and/or others.

19.2  Modify treatment approaches based on the client's response to therapy.

19.3  Recognize significant changes and patterns in the client's response to therapy.

19.4  Revise treatment plan as needed.

19.5  Establish and work within realistic time frames for evaluating the effects of therapy.

19.6  Review treatment plan periodically within guidelines set by agency.

19.7  Design and implement methods for evaluating and measuring client progress and the effectiveness of therapeutic strategies.

19.8  Demonstrate knowledge of professional Standards of Clinical Practice regarding evaluation.
20. Documentation

20.1 Produce documentation that accurately reflect client outcomes) and meet the requirements of internal and external legal, regulatory, and reimbursement bodies.

20.2 Document clinical data.

20.3 Write professional reports describing the client throughout all phases of the music therapy process in an accurate, concise, and objective manner.

20.4 Communicate orally with the client, parents, significant others, and team members regarding the client's progress and various aspects of the client's music therapy program.

20.5 Document and revise the treatment plan and document changes to the treatment plan.

20.6 Develop and use data-gathering techniques during all phases of the clinical process including assessment, treatment, and evaluation.

20.7 Demonstrate knowledge of professional Standards of Clinical Practice regarding documentation.

21. Termination/Discharge Planning

21.1 Inform and prepare the client for approaching termination from music therapy.

21.2 Establish closure of music therapy services by time of termination/discharge.

21.3 Determine termination of the client from music therapy.

21.4 Integrate music therapy termination plan with plans for the client's discharge from the facility.

21.5 Assess potential benefits/detriments of termination of music therapy.

21.6 Develop music therapy termination plan.

21.7 Demonstrate knowledge of professional Standards of Clinical Practice regarding termination.

22. Professional Role/Ethics

22.1 Interpret and adhere to the AMTA Code of Ethics.

22.2 Adhere to professional Standards of Clinical Practice.
22.3 Demonstrate dependability: follow through with all tasks regarding education and professional training.

22.4 Accept criticism/feedback with willingness and follow through in a productive manner.

22.5 Resolve conflicts in a positive and constructive manner.

22.6 Meet deadlines without prompting.

22.7 Express thoughts and personal feelings in a consistently constructive manner.

22.8 Demonstrate critical self-awareness of strengths and weaknesses.

22.9 Demonstrate knowledge of and respect for diverse cultural backgrounds.

22.10 Treat all persons with dignity and respect, regardless of differences in race, religion, ethnicity, sexual orientation, or gender.

22.11 Demonstrate skill in working with culturally diverse populations.

22.12 Apply laws and regulations regarding the human rights of the clients.

22.13 Respond to legislative issues affecting music therapy.

22.14 Demonstrate basic knowledge of professional music therapy organizations and how these organizations influence clinical practice.

22.15 Demonstrate basic knowledge of music therapy service reimbursement and financing sources (e.g., Medicare, Medicaid, Private Health Insurance, State and Local Health and/or Education Agencies, Grants).

23. Interdisciplinary Collaboration

23.1 Demonstrate a basic understanding of the roles and develop working relationships with other disciplines in the client's treatment program.

23.2 Communicate to other departments and staff the rationale for music therapy services and the role of the music therapist.

23.3 Define the role of music therapy in the client's total treatment program.

23.4 Collaborate with team members in designing and implementing interdisciplinary treatment programs.

24. Supervision and Administration
24.1 Participate in and benefit from supervision.

24.2 Manage and maintain music therapy equipment and supplies.

24.3 Perform administrative duties usually required of clinicians (e.g. scheduling therapy, programmatic budgeting, maintaining record files).

24.4 Write proposals to create and/or establish new music therapy programs.

25. Research Methods

25.1 Interpret information in the professional research literature.

25.2 Demonstrate basic knowledge of the purpose and methodology of historical, quantitative, and qualitative research.

25.3 Perform a data-based literature search.

25.4 Apply selected research findings to clinical practice.

REFERENCES


Reuer, B.L. (1987). An evaluation of the National Association for Music Therapy curriculum from the perspectives of therapists, and educators of therapists in view of


Revised 11/30/08

*Current as of 3/09*

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8455 Colesville Road, Suite 1000 | Silver Springs MD 20910 | Phone: 301.589.3300 | Fax: 301.589.5175
February 1, 2012

Dear ___________________,

I am writing to seek your participation in a research study about the current status, priorities, and future directions of music therapy. The study is for my dissertation and will take place during winter and spring 2012. (*Insert personalized sentence according to the individual’s unique role within the academic/organizational setting*). Should you choose to participate, involvement includes a phone interview (about 45 minutes) and a review of the transcribed interview to check for accuracy (about 15 minutes). All information will be kept confidential.

If you are able to assist in this project, please let me know the best way to get in touch with you so I can explain the project and answer any questions. Thanks for considering participation. I would very much appreciate hearing your perspective.

Yours truly,

Alejandra Ferrer, MM, MT-BC
Ph.D. Candidate
Music Therapist
The James Cancer Hospital
Ohio State University
Alejandra.ferrer@osumc.edu
Appendix D: Verbal Script for Obtaining Informed Consent
Hello, my name is Alejandra Ferrer. I am a graduate student at The Ohio State University School of Music, and I am undertaking research that will be used in my dissertation.

The purpose of this interview is to develop a current snapshot of the status, priorities, and possible future directions of the music therapy profession. I am very interested in your opinions concerning important topics within the field of music therapy such as professional growth of music therapists, curriculum, research focus, history, and perception of music therapy by the public media.

The information you share with me will be of great value in helping me to complete this research project. The knowledge gained will serve to inform members of the music therapy community of the current status of the field as well as aid to create awareness of what possible changes could be taken within the profession in order to elevate its status and acceptance in this rapidly changing world.

This interview will take about 45 minutes of your time.

There is a small risk of a breach of confidentiality, but all efforts will be made to keep everything you tell me in the strictest confidentiality. I will not link your name to anything you say in the text of my dissertation or any other publications.

There are no other expected risks of participation.

Participation is voluntary. If you decide not to participate, there will be no penalty or loss of benefits to which you are otherwise entitled. You can, of course, decline to discuss any issue or answer any question as well as to stop participating at any time.

If you have any additional questions concerning this research or your participation in it, please feel free to contact me, my dissertation supervisor or our university research office at any time.

I would like to make an audio recording of our discussion, so that I can have an accurate record of the information that you provide to me. I will transcribe that recording by hand, and will keep the transcripts confidential and securely in my possession. I will delete the
recording after I transcribe it and will email you a copy of the transcription to check for accuracy. The title of the email will be your Last Name – Interview Transcription.

Do you have any questions about this research? Do you agree to participate and may I record our discussion?

If so, let’s begin….
Appendix E: Interview Questions
The purpose of this interview is to develop a current snapshot of the status, priorities, and possible future directions of the music therapy profession.

Please confirm:

Professional Title:
School Affiliation:
Years Active in the Profession:
Level of Education:
Degrees Attained:
Professional Service Responsibilities (University, AMTA, JMT, MTP, CBMT, etc.):

Professional Growth

1. What has contributed to your success as a music therapy professional?

2. What advice would you give young music therapy professionals who are just starting their career?

3. What have been some of the most rewarding experiences in your career as a music therapist?

4. What are some of the challenges you have faced as a music therapist, both in the academic and clinical setting?

5. What were some of the most important experiences that contributed to your growth as a music therapist (clinical practice, education, supervision, etc.)?

6. What advice would you give to beginning professionals to prevent burnout and have long, fulfilling careers in the profession?
Music Therapy Curriculum

1. According to the AMTA Standards for Education and Clinical Training (2011), an undergraduate degree in music therapy should serve to “impart professional level competencies as specified in the AMTA Professional Competencies, while also meeting the curricular design outlined by NASM.” What are your thoughts concerning the current undergraduate requirements as specified by the AMTA?

2. What are the strengths and weaknesses of these requirements?

3. Maintaining a realistic perspective, are there any changes you would like to see made to the undergraduate level requirements?

4. What are the three main goals of the music therapy internship?

5. It has been mentioned in the research literature that some students arrive at their internships with underdeveloped musical skills. How could this be improved?

6. What do you consider curricular highlights of your own program? (faculty only)

Music Therapy Profession

1. What have been some of our most significant successes as a profession?

2. What do you think has contributed to the success of the field?

3. What are some of the biggest challenges you feel the profession of music therapy is currently facing?

4. What do we as a profession need to do to face these challenges?
Music Therapy Research

1. Since the establishment of the Strategic Priority on Research, much of the research conducted by music therapists seeks to support the effectiveness of music therapy intervention with various clinical populations. What is your opinion about the current research focus in music therapy?

2. What areas in the profession do you think require further research attention?

Future of Music Therapy

1. Where do you hope to see the field in 10-15 years?

2. What needs to happen internally within the profession for future growth and progress?

3. What is your opinion regarding the move from a bachelor’s level entry to a master’s level entry for practicing music therapists?

4. Do you think it is important to require a graduate degree in music therapy for those therapists in practicum or internship supervision roles? Why?

Music Therapy in the Media

1. In your experience, do you think the media offers an accurate portrayal of music therapy?

2. Can you share any experiences where music therapy has been well represented or misrepresented by the media?
Appendix F: Contact Information Card
Alejandra Ferrer  
Graduate Student, School of Music  
Music Therapist  
The James Cancer Hospital  
The Ohio State University  
Columbus, OH 43210  
USA  
Phone: 1-614-293-1761  
Email: ferrer.16@buckeyemail.osu.edu

The faculty supervisor for this research project is:  
Dr. Patricia Flowers  
School of Music  
The Ohio State University  
Columbus, OH 43210  
USA  
Phone: 1-614-247-6504  
Email: flowers.1@osu.edu

You may contact Dr. Flowers with questions or if you feel you have been harmed as a result of your participation.

For questions about your rights as someone taking part in this study, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-614-688-4792 or 1-800-678-6251. You may call this number to discuss concerns or complaints about the study with someone who is not part of the research team.
Appendix G: Music Therapy in the Media: Year 2011
Congresswoman Gabrielle Giffords: The Use of Music Therapy in Recovery

- United States Representative Gabrielle Giffords suffered a traumatic brain injury as a result of the January 2011 Tucson, Arizona shootings.

- Congresswoman Giffords received music therapy as part of her intensive physical and speech rehabilitation at the Institute of Rehabilitation and Research (TIRR) in Houston, Texas.

Sing You Home (Book)

- American novel written by author Jodi Picoult.

- Published in March 2011.

- *Sing You Home* debuted at #1 on the USA Today book list.

- The main character in the story (Zoe) is a music therapist. Moments of Zoe delivering music therapy services, advocating for the profession, and defining music therapy are found throughout the book.


The Music Never Stopped (Movie)

- American drama film directed by Jim Kohlberg.

- Premiered at the 2011 Sundance Film Festival.

- Movie is based on Dr. Oliver Sack’s case study “The Last Hippie.”

- Tells the story of Gabriel, a young man with a brain tumor who experiences severe memory impairments. Music therapy assists Gabriel in his recovery from brain tumor surgery.

- Film website: http://themusicneverstopped-movie.com/