

MAXIMIZING REFERRALS AND ACCEPTANCE OF MEDICAL MUSIC THERAPY:
A SEQUENTIAL-EXPLANATORY MIXED METHODS STUDY

A Thesis
by
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Abstract

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This study sought to explore music therapists' experiences of receiving referrals and acceptance or declination of services in medical settings. Through a mixed methods design, this study also elaborates on music therapists' experiences with improving referral quantity and quality and increasing acceptance of services in medical settings. The researcher invited 8,240 music therapists credentialed through the Certification Board of Music Therapists (CBMT) to participate in an online survey constructed by the researcher to provide a baseline for medical music therapists' experiences with referrals and service acceptance. Eligibility for participation was determined through the survey; the full survey was only accessed by eligible participants or those credentialed music therapists with at least one year of experience working in a medical setting (i.e., adult medical hospitals, children's medical hospitals, or Veterans Health Administration medical centers) within the last 10 years. Responses were returned by 512 music therapists, and these responses included 163 from eligible participants. Four survey respondents were selected for

participation in individual follow-up interviews lasting about an hour each to further describe their experiences and to provide suggestions in medical music therapy to improve referrals and increase acceptance of music therapy services. The researcher integrated the findings of the online survey and follow-up interviews to explain the common experiences of medical music therapist with referrals and service acceptance and their recommendations for other music therapists practicing in medical settings. Results of this study indicated a number of methods for improving other healthcare professionals', patients', and families' understandings of and experiences with medical music therapy to increase referral quantity and quality and patient acceptance of services. Findings of this study suggest continued research with these topics in medical music therapy to assess the requirements of music therapists working in medical settings and provide medical music therapists with access to tools and information for improving their practices.

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Chapter 1: Introduction

As a relatively new professional field of work, music therapy in the United States lends itself to doubt, misrepresentation, misunderstanding, and devaluation by other, more established healthcare professionals. Although the healing influence of music to affect health and behavior can be traced back as early as the writings of Plato, the 20th Century music therapy profession is said to have been formally established after World War II by both professional and community musicians who served veterans hospitals around the country, bringing music “therapy” to the thousands of veterans experiencing physical and emotional trauma from the wars. After the recognition for training and demand for academic preparation became evident, Michigan State University established the first academic program in music therapy in 1944 (AMTA, 2020b; Gfeller & Davis, 2008a).

Shortly after the creation of the first training programs, the National Association for Music Therapy (NAMT) was founded in 1950 in order to provide a more formal organization to promote and further the development of music therapy (AMTA, 2020b; Moore, 2015). One of the most significant contributions to the field of music therapy by the NAMT was the creation of the Registered Music Therapist (RMT) designation in order to provide a measure of quality assurance—the first professional standard for music therapy upon which the profession could advocate—to employers and patients of music therapists (Moore, 2015).

In 1971, the American Association for Music Therapy (AAMT)—originally called the Urban Federation for Music Therapists (UFMT)—was formed with similar interests as

the NAMT. Both organizations, the NAMT and the AAMT, heavily encouraged research in music therapy, still furthering grounds for advocacy and developing evidence-based practices for the field (AMTA, 2020b; Gfeller & Davis, 2008a; Moore, 2015).

The Certification Board for Music Therapists (CBMT) was established in 1983 as a third organization with a responsibility for creating and maintaining a certification program for music therapists. Associated with both the NAMT and the AAMT, the CBMT required continuing education and enforced a level of rigor and accountability to support continued advocacy efforts in music therapy (AMTA, 2020b; Moore, 2015). In 1998, the NAMT and the AAMT merged as a unified organization to form the American Music Therapy Association (AMTA, 2020b; Gfeller & Davis, 2008a; Moore, 2015).

Since the conception of the NAMT in 1950, music therapists have been focusing efforts on advancing music therapy practices and advocacy. With only 76 years since the establishment of the first training program in the United States, music therapy is still relatively new when compared to other healthcare professions. In order for music therapists to maximize patient access to music therapy, appropriate referrals to services must increase. Today, many healthcare professionals may not be aware of music therapy, how it is implemented, and how it can benefit patients, limiting referrals to services. With education and advocacy efforts however, the profession is continuing to earn the needed recognition and support of legislators and other healthcare professionals, increasing access to music therapy services for the patients who benefit.

Definition of Terms

Music Therapy

The AMTA (2015) defined music therapy is defined as “the clinical and evidence-based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship” (para. 3) by a board-certified music therapist. The AMTA (2020a; 2020e) further described music therapy as an established allied health profession to address individual, group, family, or community quality of life and improve physical, emotional, cognitive, communicative, spiritual, sensory, and social needs. The involvement in music actively (i.e., by making music) and receptively (i.e., by listening to music) within a therapeutic context strengthens clients’ abilities which are transferred to other areas of their lives. Music therapy is effective in “increasing people’s motivation to become engaged in their treatment, providing emotional support for clients and their families, and providing an outlet for expression of feelings” (AMTA, 2020a, para. 2). According to the World Federation of Music Therapy (WFMT, 2011), music therapy research, practice, education, and clinical training are based on professional standards according to cultural, social, and political contexts.

Medical Music Therapy. Bruscia (2014) defined medical music therapy as the following:

All applications of music and music therapy that provide direct treatment of the medical condition and its symptoms; various kinds of support that may be needed during medical tests, surgery, or procedures; and therapeutic processes that address the emotional, interpersonal, social, spiritual, and ecological needs of the client and family (p. 216).

Ghetti (2013) also provided a definition for music therapy as procedural support to describe pediatric medical music therapy: “pediatric medical music therapy is the use of music and the therapeutic relationship to promote healthy coping and safeguard the child’s psychosocial wellbeing during inpatient and outpatient medical treatment” (p. 4). Music therapists in medical settings provide services to populations with a variety of diagnoses across the lifespan in both inpatient and outpatient healthcare facilities. As a result, patients may receive music therapy in a variety of units including (but not limited to) (a) intensive care, (b) intermediate care, (c) rehabilitation, (d) radiology, (e) oncology, (f) palliative care, (g) neonatal intensive care, (h) pediatrics, (i) medical and surgical care, (j) older adults, (k) emergency department, (l) end-of-life care, (m) psychosocial care, (n) cardiology, and (o) neurology (Allen, 2013; DeLoach, 2018; Shultis & Gallagher, 2014).

Board-Certified Music Therapist

According to the AMTA and the CBMT, a board-certified music therapist is an individual who has “completed the education and clinical training requirements established by the American Music Therapy Association (AMTA), ... holds current board certification from The Certification Board for Music Therapists (CBMT)” (AMTA, 2015, para. 3) and has “demonstrated the knowledge, skills and abilities necessary to practice music therapy at the current level of the profession” (CBMT, 2019b, para. 1). Board-certified music therapists must have at minimum a bachelor’s degree or its equivalent in music therapy. Graduate and doctoral programs are also available in music therapy. There are currently 84 schools in the United States that offer coursework toward board certification and advanced degrees in music therapy that meet the requirements of the AMTA (AMTA, 2020c). Required education and training includes coursework in social sciences, life sciences, music foundations, clinical

foundations, and music therapy practice as well as 1,200 hours of supervised clinical training (AMTA, 2013b). Additionally, continuing education requirements must be met to maintain the credential and currency of music therapy practices (CBMT, 2019a).

The AMTA (2020d) further described the personal qualifications that the ideal music therapist must possess:

Personal Qualifications of a Music Therapist include a genuine interest in people and a desire to help others empower themselves. The essence of music therapy practice involves establishing caring and professional relationships with people of all ages and abilities. Empathy, patience, creativity, imagination, an openness to new ideas, and understanding of oneself are also important attributes. Because music therapists are musicians as well as therapists, a background in and love of music are also essential. (para. 3)

Music may be used therapeutically in medical settings by other types of musicians: (a) music practitioners, (b) harp therapists, (c) music and sound healers, (d) clinical musicians, and (e) music thanatologists (Allen, 2013; AMTA, 2004). Additionally, clinical staff other than music therapists may use music to enhance their interventions (e.g., a nurse singing a song about a bee while administering a flu shot to a child afraid of needles).

However, music therapy differs from these approaches by fostering a therapeutic relationship, working through music interactions, being an active element of the treatment plan, developing individualized goals for specific outcomes, and requiring a board-certified music therapist (Music Therapy Hub, 2019). While many music therapists agree that more music in healthcare can be positive for patients, it is also agreed that the education and training necessary to become board-certified protects patients from potentially harmful

interactions with music. As such, the following uses of music to enhance healthcare while beneficial, are not within the definition of clinical music therapy: an individual in a nursing home listening to music from his young adulthood on an iPod; an individual playing music for a patient in the hospital; medical staff playing music in the background for patients; and other groups of musicians who may use music therapeutically (AMTA, 2020a).

According to the Standards of Clinical Practice (AMTA, 2013a), music therapists are qualified to provide referrals, determine appropriateness of referrals, administer assessments, plan treatments, implement interventions, perform documentation, and determine appropriate termination of services for a variety of client populations. The client populations outlined by the Standards of Clinical Practice include (a) addictive disorders, (b) consultative services, (c) intellectual and developmental disabilities, (d) education, (e) older adults, (f) medical health, (g) mental health, (h) physical disabilities, (i) private practice, and (j) wellness settings.

Other Healthcare Professionals

Where stated, the term “other healthcare professionals” includes any medical, nursing, or allied health staff music therapists interact with in medical settings. These professionals may include, but are not limited to, (a) administrators, (b) physicians, (c) nurses, (d) nursing assistants, (e) physical therapists, (f) occupational therapists, (g) respiratory therapists, (h) speech and language pathologists, (i) social workers, (j) medication technicians, (k) psychologists, (l) child life specialists, (m) other creative arts therapists, (n) chaplains, and (o) other members of the interdisciplinary team. In the context of this paper, this term specifically refers to any professional working outside the field or scope of music therapy or those who have not specifically received the education, training, and certification

as outlined by both the AMTA and CBMT. Additionally, the professionals included in these criteria may have little or no education or exposure to the practice of music therapy, thereby possibly having inaccurate views, misperceptions, or misguided attitudes about the practice.

Interdisciplinary Team. In healthcare, an interdisciplinary team is a group of healthcare professionals consisting of medical, nursing, and allied health professionals from different disciplines who work toward the same goal in order to provide the best outcome for a patient or group of patients (Saunders, n.d.). Together, an interdisciplinary team decides on a plan of care for a patient, including the direction and anticipated outcomes of interventions. In their own discipline or during cotreatment and procedural support, professionals utilize their expertise and scope of practice to provide opportunities for patient changes toward the likely outcomes and anticipated results of treatment.

Cotreatment. According to North Shore Pediatric Therapy (2020), cotreatment sessions “are when two therapists from different disciplines (Speech Therapy (SLP), Occupational Therapy (OT), Physical Therapy (PT), etc.) work together with [a patient] to maximize therapeutic goals and progress” (para. 2). This occurs when two disciplines share complimentary or similar goals as determined by the interdisciplinary team. The Joint Guidelines for Therapy Cotreatment under Medicare stated that cotreatment is appropriate when “practitioners from different professional disciplines can effectively address their treatment goals while the patient is engaged in a single therapy session” (The American Speech–Language–Hearing Association, The American Occupational Therapy Association, & The American Physical Therapy Association, n.d., para. 1). Some benefits of cotreating include cohesive treatment plans that work toward goals in a shorter period of time, encouraging participation and good behavior, collaboration and discussion of the treatment

plan, generalization of skills to other contexts, and assistance in immediate problem solving (North Shore Pediatric Therapy, 2020).

Procedural Support. Child life specialists define procedural support as “support during medical procedures” (p. 131). Gaynard et al. (1990) described procedural support in pediatrics as an intervention involving remaining with a child (when appropriate) during a medical procedure in order to provide support and offer effective coping behaviors. Music therapists may provide procedural support for physicians and nurses during medical procedures (e.g., a blood draw) in order to integrate or distract the patient during unpleasurable experiences and provide coping tools for patients in future procedures.

Music Therapy Advocacy

Advocacy is defined as “the act or process of supporting a cause or proposal” (Merriam–Webster, n.d.). As members of a relatively new allied health profession, music therapists are charged with safeguarding their profession from those who unintentionally misrepresent the field (i.e., those without the proper education, training, and credential to practice music therapy but misname their work as music therapy) and those who are unaware of its efficacy of treatment. In healthcare, music therapists advocate on many levels among other healthcare professionals and the patients being served by the healthcare facility (Moore, 2015). Advocacy may occur on small-scale levels or in individual interactions such as when a music therapist speaks to a patient about music therapy services or explains the significance of music therapy work to another healthcare professional; advocacy may also occur on large-scale levels such as when a music therapist provides an in-service for the staff of a particular hospital unit (Moore, 2015) or presents at a conference of members of another profession.

Medical Hospitals

For the purposes of this study, a medical hospital is defined as inpatient and outpatient institutions providing medical care, surgical care, and therapeutic services to sick or injured patients under the supervision that are typically not available in places of residence (Marcovitch, 2018; Merriam–Webster, n.d.). The National Database of Nursing Quality Indicators as cited by Dunton et al. (2008) defined a hospital as an institution providing diagnostic and therapeutic services for “medical diagnoses, treatment, and care of injured, disabled, or sick persons” as well as “rehabilitation services for injured, disabled, or sick persons” by or under the supervision of physicians (p. 19). The Centers for Medicare & Medicaid Services as cited by Reigart and Posek (2019) defined a hospital as a facility that is “primarily engaged in the provision of inpatient care” (p. 55) and defined inpatient care as requiring medical services “that will span two midnights or more” (p. 59). This study will focus on three types of medical hospitals providing music therapy services: general medical hospitals, children’s medical hospitals, and Veterans Health Administration medical centers.

General Medical Hospitals. The World Health Organization (2019) described hospitals as important structures in health care systems as

health care institutions that have an organized medical and other professional staff, and inpatient facilities, and deliver medical, nursing and related services 24 hours per day, 7 days per week. Hospitals offer a varying range of acute, convalescent and terminal care using diagnostic and curative services in response to acute and chronic conditions arising from diseases as well as injuries and genetic anomalies. In doing so they generate essential information for research, education and management.

Traditionally oriented on individual care, hospitals are increasingly forging closer

links with other parts of the health sector and communities in an effort to optimize the use of resources for the promotion and protection of individual and collective health status. (para. 1–3)

For the purposes of this study, a general medical hospital is described as a medical facility treating an array of medical conditions for patients of all age groups.

Children’s Medical Hospitals. The Children’s Hospital Association (CHA; 2020) describes children’s hospitals as medical facilities specifically designed to meet the unique needs of children delivered by specialized clinicians in specialized environments. CHA (2020) stated that “children’s hospitals serve all kids... children’s hospitals serve kids at each stage of growth and development, requiring differently sized equipment and a range of expertise” (para. 6).

Veterans Health Administration Medical Centers. The U.S. Department of Veterans Affairs described the Veterans Health Administration (VHA) as the largest integrated health care system in the United States consisting of Veterans Affairs medical facilities across the country (2019). VHA medical centers provide medical and surgical services to United States military veterans such as surgery, critical care, mental health, orthopedics, pharmacy, radiology, and physical therapy (U.S. Department of Veterans Affairs, 2019).

Treatment Process in Medical Music Therapy

Music therapists follow a step-by-step method for approaching patients with services and facilitating the processes that subsequently occur (Borczone, 2017). The general guidelines for the treatment process include a referral to music therapy services, assessment and identification of goals and objectives, treatment planning and implementation, evaluation and documentation, and termination of treatment (Borczone, 2017; Gfeller & Davis, 2008b; Hanser, 2018; Wheeler, 2014; Yinger, 2018).

Music Therapy Referrals, Consults, and Orders. Receiving a referral, consult, or order to provide music therapy services in healthcare is the initial step toward making contact with patients and are a necessary step in providing and documenting appropriate and effective clinical work (Gfeller & Davis, 2008b). Referrals help music therapists to identify patients who are in the greatest need of music therapy services (Loewy, 2014) by giving a brief look at the client through information such as age, sex, diagnoses, medications, and other relevant information (Borczone, 2017). Once a referral for music therapy has been made, a presenting problem has been identified and is translated into music therapy goals and objectives that align with the overall treatment plan (Hanser, 2018).

Borczone (2017) stated that referrals may be made by a variety of professionals in clinical settings, most commonly from (a) physicians, (b) social workers, (c) psychologists, (d) teachers, (e) occupational therapists, (f) recreational therapists, (g) speech and language pathologists, (h) physical therapists, (i) art therapists, (j) counselors, or (k) any other professional that may provide treatment referrals; referrals for music therapy may also be made as a joint decision of the interdisciplinary team. Additionally, parents may refer their children, and patients may make self-referrals for music therapy services.

Methods for making and receiving referrals in medical settings include in-person during rounds within a medical unit, in writing, or by page or voicemail; referrals may also be solicited by the music therapist, especially in units with higher concentrations of new staff or in new music therapy programs (Loewy, 2014). The referral process of each institution is unique according to the policies and procedures established by the hospital and its medical staff (Borczone, 2017; Shultis & Gallagher, 2014).

Triage. Music therapists must prioritize referrals in a process of triaging so that the highest priority patients are seen first (Shultis & Gallagher, 2014). Marcovitch (2018) defined *triage* as the act of allocating a degree of priority “so that patients are seen in order of severity rather than according to their time of arrival” (para. 2). The process of prioritizing may be a difficult task, but it is based on levels of patient need (e.g., extreme pain); however, prioritization in other cases may be given to the order of referrals received, patients who have not yet been seen for assessment, proximity of one patient room to another, and specific requests made by hospital staff (Shultis & Gallagher, 2014).

The caseload of music therapists in medical settings is determined by the number and quality of referrals received, typically from other healthcare professionals. This can become challenging if the referrals being seen are not appropriate to the clinical setting. For example, a music therapist could receive a referral from a nurse with the reason, “Patient likes music,” because the patient has had no visitors or is understimulated, but no obvious clinical need is stated. In this case, an appropriate clinical need possibly could have been, “Isolated,” or for, “Social support.” With no clear clinical need, a patient might be overlooked so that the clinical needs of others which are stated more clearly are cared for first. Additionally, if the

music therapist's caseload is already at capacity, the patient may never receive music therapy services due to being discharged or unaccepted by the music therapist into services.

Patient Acceptance of Services. After being accepted by a music therapist for music therapy services, the final decision to accept services is made by the patient or legal guardian of the patient receiving services. One right outlined by the American Hospital Association's (AHA) *Patient Care Partnership* (2003) is the patient's right to involvement in their own care. While many decisions involving patient care are made before a hospital stay, some decisions (especially in emergencies) are made during the hospital stay (AHA, 2003). In order for music therapists to begin services by performing an initial assessment, the patient or guardian must first agree to services.

Summary

In established medical music therapy programs, there is a process that music therapists follow to approach potential patients with services (Borczone, 2017; Gfeller & Davis, 2008b; Hanser, 2018; Loewy, 2014; Shultis & Gallagher, 2014; Wheeler, 2014; Yinger, 2018). Within this process in medical settings, music therapists encounter a number of other healthcare professionals whose expertise lie outside the realms of music therapy practice; these professionals' possible lack of experience or understanding of music therapy may be a barrier for music therapists to provide the appropriate services to patients who may most benefit from them (Borczone, 2017; Hanser, 2018; Loewy, 2014; Shultis & Gallagher, 2014). As such, there may be an additional role of music therapists to advocate for music therapy services in order to increase patient access to these services (Moore, 2015).

Chapter 2: Literature Review

The ability of music therapists in many medical settings to provide the most appropriate services for patients who could most benefit is largely affected by the perceptions of music therapy by other healthcare professionals who provide referrals—or a lack thereof—for music therapy services (Darsie, 2009; Johannessen & Garvik, 2016; Khan et al., 2015; Lane et al., 2018; O’Callaghan, 2001; O’Kelly, 2007; Siegel et al., 2016; Silverman & Bibb, 2018; Staab & Dvorak, 2018); patients, who have the right to accept or decline music therapy services (Kleiber & Adamek, 2013; Lane et al., 2018; McCaffrey & Edwards, 2016; O’Callaghan, 2001; Potvin et al., 2015; Solli & Rolvsjord, 2015; Thompson et al., 2017); and families and caregivers, who reserve the right to make decisions about a patient’s care when the patient is unable to make those decisions on their own (Burns et al., 2015; Gallagher et al., 2017; Lane et al., 2018; McLean, 2016; O’Callaghan, 2001; Schwartzberg & Silverman, 2016). In the workplace, medical music therapists must be able to provide education about music therapy services to positively affect change in the perceptions of healthcare professionals, patients, and families about music therapy to increase quality referral rates and patient acceptance of services (Cooke, 2018; Darsie, 2009; Hanser, 2018; Hense, 2018; Loewy, 2014; Magee & Andrews, 2007; Marom, 2008; O’Callaghan & Colegrove, 1998; O’Kelly, 2007; Shultis & Gallagher, 2014; Silverman & Chaput, 2011).

Perceptions of Music Therapy

When working in healthcare settings, music therapists encounter many types of professional relationships: interprofessional relationships, patient/therapist relationships, and relationships with patient families and friends. Within each of these relationships lie multiple levels of exposure, experience, interpretations of the field of music therapy. Music therapists commonly experience various circumstances of doubt, misrepresentation, misunderstanding, and devaluation of the field of music therapy in healthcare by other healthcare professionals, patients, and families and friends. These misconceptions are held by many healthcare professionals of medical hospitals and long-term care facilities: administrators, physicians, nurses, nursing assistants, physical therapists, occupational therapists, speech and language pathologists, social workers, medication technicians, and other members of the interdisciplinary team (Cooke, 2018).

Perceptions of Other Healthcare Professionals

In healthcare settings, music therapists must navigate multiple levels of interprofessional interactions while practicing in order to educate professionals on medical music therapy practices. This education needs to include reasons for referral, goal and objective areas, and the effectiveness of medical music therapy interventions to address the direction of patient care as determined by the interdisciplinary team. As such, music therapists in medical settings take on the roles of an advocate for music therapy, a team member, and a patient advocate for services. It is common for music therapists working in healthcare to experience challenges related to navigating their interdisciplinary professional relationships (Cooke, 2018). In a small-scale localized fieldwork inquiry on the experiences of three music therapists with experience in healthcare settings, Cooke (2018) found that the

shared challenges of music therapists in healthcare (including a medical hospital and a mental health hospital) included five themes: (a) the misunderstanding of music therapy practice by other healthcare professionals; (b) feeling that their clinical work is minimized or seen as insignificant; (c) feeling that other healthcare professionals underestimate the patients' ability to participate or the music therapists' ability to engage; (d) the misrepresentation of music therapy as leisure activities or entertainment rather than clinical work; and (e) the need for building and maintaining interpersonal relationships with other professionals to increase their understanding and support of music therapy.

Multiple studies have explored the perceptions of music therapy by other healthcare workers (Darsie, 2009; Johannessen & Garvik, 2016; Khan et al., 2015; Lane et al., 2018; O'Callaghan, 2001; O'Kelly, 2007; Siegel et al., 2016; Silverman & Bibb, 2018; Staab & Dvorak, 2018). Each of these studies found that many healthcare professionals who are exposed to music therapy perceive the practice as a positive treatment for patients and helpful for staff in healthcare. In particular, O'Kelly found that many palliative care workers believe music therapy has the potential of a complete or holistic approach and humanizes care. Others found that with exposure to music therapy healthcare professionals perceive it to be inspiring and rewarding (Johannessen & Garvik, 2016; O'Callaghan, 2001), is generalizable (Staab & Dvorak, 2018), and improves resident-staff relationships (O'Kelly, 2007; Staab & Dvorak, 2018). Many of these professionals believe that music therapy should be better integrated into the interdisciplinary healthcare team (Khan et al., 2015; Siegel et al., 2016) to augment and complement care (Silverman & Bibb, 2018) by increasing communication between music therapists and care staff (Staab & Dvorak, 2018) and engaging in more opportunities for cotreatment and procedural support with other professionals (O'Kelly,

2007). Additionally, some healthcare professionals believe that participation in music therapy sessions improves their job performance and satisfaction (Lane et al., 2018; O'Callaghan, 2001; O'Kelly, 2007). Studies concluded that many professionals viewed music therapy as an allied healthcare profession (Khan et al., 2015) and that music therapy programs should be expanded (Khan et al., 2015) to increase access to services (Silverman & Bibb, 2018). However, each of these studies also found challenges with professional perceptions of music therapy.

While many healthcare professionals found music therapy to be a positive asset to medical and mental health care, many of their understandings were found to be inaccurate of the profession (Darsie, 2009; Johannessen & Garvik, 2016; Khan et al., 2015; O'Kelly, 2007; Silverman & Bibb, 2018). Studies found that many healthcare professionals lacked an understanding of music therapists' roles in healthcare (Khan et al., 2015; Johannessen & Garvik, 2016). Silverman and Bibb noted that many healthcare professionals were unaware of the qualifications of music therapists and the required training and skills. Additionally, Khan et al. found that music therapy may be perceived as entertainment for patients by healthcare professionals. Darsie noted significant differences of perceptions between occupations. Child life specialists and other creative arts therapists were less likely to perceive entertainment as a role of music therapists, and nurses and nurse practitioners were more likely to perceive distractions from painful procedures as a role of music therapists in pediatric settings. In a separate study, O'Kelly found that nurses were more likely to be uncomfortable explaining the role of music therapy than were other allied health professionals. Positively, it was concluded by multiple studies (Darsie, 2009; Johannessen & Garvik, 2016; O'Kelly, 2007) that with more exposure and education in music therapy,

healthcare professionals' perceptions were evolving over time. Because of this, it was also concluded that staff should be more educated on the field of music therapy (Johannessen & Garvik, 2016; Khan et al., 2015).

Although many healthcare professionals expressed positive perceptions of the role of music therapy in healthcare, some studies also found that negative perceptions of music therapy also existed among healthcare professionals (Johannessen & Garvik, 2016; Siegel et al., 2016). Some healthcare professionals expressed that music therapy can be challenging to implement in healthcare settings (Johannessen & Garvik, 2016; Siegel et al., 2016). These challenges may be related to financial, communication, and time restrictions. Darsie (2009) found that role conflict may negatively influence the relationship between music therapists and other professionals, particularly child life specialists in pediatric settings. Additionally, some studies found that many physicians expressed disinterest in music therapy and thought negatively about its effectiveness and implementation into the interdisciplinary treatment plan (Lane et al., 2018; O'Kelly, 2007; Siegel et al., 2016). They also found that many nurses had a fear that music therapy could have the potential to be too invasive (Lane et al., 2018; O'Kelly, 2007; Siegel et al., 2016). Choi (1997) found in a survey that psychiatrists in psychiatric hospitals showed the least positive attitudes toward music therapy as an important part of the treatment plan of psychiatric patients. The same study found that psychologists and social workers responded negatively to treatment goals in music therapy that they considered to be in their own scope of practice. Additionally, Choi found that most survey responders reported being unaware of music therapy research.

Hense's (2018) study of the influence of interdisciplinary clinicians' perceptions of music therapy on referrals in a youth mental health service found that those who consistently

made referrals to music therapy viewed the field as strengths-based in the pursuit of wellbeing rather than treating illnesses. Alternatively, those who reported never referring to music therapy described music therapy as a “tool,” expressing more emphasis on medicalized descriptions rather than having interest in the therapeutic benefits of music therapy. Those who reported moderately referring to music therapy described it as a “strategy in facilitating recovery” (p. 23), describing both the process and role of music in treating illness. Hense also found that all clinicians being surveyed reported having interest in attending professional development about the relationship between music and young people’s mental health.

The presented literature reaches consensus with four of the five challenges Cooke (2018) found music therapists face in medical settings: (a) the misunderstanding of music therapy practice by other healthcare professionals (Darsie, 2009; Johannessen & Garvik, 2016; Khan et al., 2015, O’Kelly, 2007; Silverman & Bibb, 2018); (b) feeling that their clinical work is minimalized or seen as insignificant (Johannessen & Garvik, 2016; Lane et al., 2018; O’Kelly, 2007; Siegel et al., 2016); (c) feeling that other healthcare professionals underestimate the patients’ ability to participate or the music therapists’ ability to engage (Lane et al., 2018; O’Kelly, 2007; Siegel et al., 2016); and (d) the need for building and maintaining interpersonal relationships with other professionals to increase their understanding and support of music therapy (Darsie, 2009; Johannessen & Garvik, 2016; Khan et al., 2015; Lane et al., 2018; O’Callaghan, 2001; O’Kelly, 2007; Siegel et al., 2016; Silverman & Bibb, 2018; Staab & Dvorak, 2018). The literature noted no instances of perceptions made by other healthcare professionals that music therapy was strictly entertainment or leisure activity as was found by Cooke. Alternatively, some studies did find that role conflicts between music therapists and other healthcare professionals contributed to

negative perceptions of the field (Choi, 1997; Darsie, 2009). Also, some studies found that one reason other healthcare professionals underestimate patients' abilities to engage in music therapy (as noted by Cooke, 2018) is the perceived invasive nature of the practice (Lane et al., 2018; O'Kelly, 2007; Siegel et al., 2016).

Perceptions of Patients

Most studies involving the perspectives of patients and families receiving music therapy services aim to uncover the experiences of patients and families following their receipt of music therapy rather than viewing their perceptions of music therapy before treatment (Kleiber & Adamek, 2013; Lane et al., 2018; McCaffrey & Edwards, 2016; O'Callaghan, 2001; Potvin et al., 2015; Solli & Rolvsjord, 2015; Thompson, et al., 2017). Each of these studies noted positive experiences expressed by patients including increased relaxation and reduced pain perception (Kleiber & Adamek, 2013; Potvin et al., 2015); increased choice and control (Kleiber & Adamek, 2013); increased therapeutic interactions, interpersonal relationships, and a sense of belonging (Kleiber & Adamek, 2013; McCaffrey & Edwards, 2016; O'Callaghan, 2001; Potvin et al., 2015; Solli & Rolvsjord, 2015; Thompson et al., 2017), increased emotional self-expression (McCaffrey & Edwards, 2016; O'Callaghan, 2001; Solli & Rolvsjord, 2015; Thompson et al., 2017), normalization of experiences (McCaffrey & Edwards, 2016), changes in affect related to musical memories and associations, altered sensory and somatic experiences, empowerment (O'Callaghan, 2001; Potvin et al., 2015; Solli & Rolvsjord, 2015), improved awareness (O'Callaghan, 2001), respite from stress, decreased isolation, (Potvin et al., 2015), increased appreciation of music, increased life reflection, and increased perception of skills (Thompson et al., 2017).

Patients described their music therapy experiences as feeling acknowledged and individualized, strength- and wellness-based (McCaffrey & Edwards, 2016), meaningful, and generalizable (Thompson et al., 2017). Solli and Rolvsjord (2015) found four themes related to participants with psychosis' experiences in music therapy: freedom, contact, well-being, and symptom relief. Women of an outpatient breast cancer group noted wanting more time in their music therapy group (Thompson et al., 2017), and 50% of pre-surgery patients in a study believed listening to music to be more beneficial than any other preoperative activity (Lane et al., 2018). Yinger and Standley (2011) found that the overall mean satisfaction score of patient satisfaction as measured by the Press Ganey survey (Press Ganey Associates, 2009) was an average of 3.4 points higher for patients who received music therapy services compared to those who did not receive music therapy. Additionally, in a study investigating the reasons patients in inpatient settings choose complementary therapies in palliative care, Poonthananiwatkul et al. (2016) found that patients with previous positive experiences in complementary therapies and unsuccessful previous experiences in conventional medicines were more likely to choose complementary therapies.

Each of these studies on patient perceptions show overwhelming support of music therapy to provide a number of benefits by those who have received music therapy treatment (Kleiber & Adamek, 2013; Lane et al., 2018; McCaffrey & Edwards, 2016; O'Callaghan, 2001; Potvin et al., 2015; Solli & Rolvsjord, 2015; Thompson et al., 2017). However, there is a gap in the literature to address the effects that patient perceptions of music therapy services before treatment has on their willingness to accept and engage in music therapy.

Perceptions of Families and Caregivers

Lastly, some studies focus on the perceptions of families and caregivers of patients receiving music therapy services (Burns, et al., 2015; Gallagher et al., 2017; Lane et al., 2018; McLean, 2016; O’Callaghan, 2001; Schwartzberg & Silverman, 2016). In these studies, families of patients express their own benefits when a loved one receives music therapy services: developed identity in relation to the patient, met emotional needs, bridged connections with family member, provided coping tools, afforded a sense of control, educated families (McLean, 2016), and reduced family anxiety (Gallagher et al., 2017; Lane et al., 2018; O’Callaghan, 2001). Burns et al. also noted that families perceived music therapy to better address spiritual needs and to decrease breathing problems in their loved ones in cancer hospice care. Families in a study by Gallagher et al. noted that music therapy decreased pain perception, anxiety, and dis-/stress, as well and improved the quality of life and mood of their loved ones in palliative and hospice care. Similarly to studies on patient perceptions of services, little literature addresses the perceptions of music therapy services by families and caregivers before participation in treatment and the effects these perceptions may have on acceptance rates of music therapy services.

Methods of Referrals

The AMTA Standards of Clinical Practice in Medical Settings Standard 1.0 (Referral and Acceptance) states that clients “will be accepted for music therapy in accordance with specific criteria” (AMTA, 2013a, Item 1.0). Walker et al. (2010) listed the minimal necessary information for an appropriate medical music therapy referral: (a) name, (b) location in the hospital, (c) age, (d) gender, (e) diagnosis, (f) reason for the referral (with appropriate goals and objectives), and (g) contact for the referring agent.

Referral Sources

The AMTA Standards of Clinical Practice in Medical Settings Standard 1.0 (Referral and Acceptance) states that referrals for an initial music therapy assessment may be made by (a) a music therapist, (b) members of other disciplines or agencies, (c) the patient, (d) parents, (e) guardians, (f) advocates, or (g) designated representatives (AMTA, 2013a).

Members of other disciplines and agencies may include any of the following: (a) physicians, (b) nursing staff, (c) social workers, (d) psychologists, (e) physical and occupational therapists, (f) speech language pathologists, (g) social workers, (h) child life specialists, (i) other creative arts therapists, (j) chaplains, and (k) other members of the interdisciplinary team. Walker et al. (2010) categorized referral sources by (a) physician, (b) nurse, (c) social worker, (d) occupational and physical therapy, (e) chaplain, (f) psychologist, (g) physician's assistant, (h) unit clerk, (i) certified therapeutic recreational specialist, (j) music therapist, and (k) patient and family referrals.

In a study of referral trends in both inpatient and in-home palliative care, Horne-Thompson et al. (2007) found that most referrals were generated by the nursing staff, followed by patients, other allied health professionals, medical staff, and families. Alternatively, Gallagher et al. (2017) found that social workers generated the most referrals in palliative care and hospice, followed by nurse care managers, physicians, and nursing staff. Magee and Andrews (2007) reviewed referral trends in a neuro-rehabilitation setting and found that most referrals for music therapy were from multidisciplinary sources, most frequently by teams of speech and language pathologists and occupational therapists. From most frequent to least frequent, this study reviewed single discipline referrals from (a) speech and language pathologists, (b) occupational therapists, (c) psychologists, (d) music therapists,

(e) physical therapists, and (f) others (including social workers, physicians, nurses, dietitians, and patients and families).

Reasons for Medical Music Therapy Referrals

Referrals may be made in medical music therapy to address many different domains:

(a) physical, (b) social, (c) emotional, (d) affective, (e) spiritual, (f) cognitive, (g) communicative, or (h) behavioral. Horne-Thompson et al. (2007) found that most referrals made by medical, nursing, and allied health staff in a palliative care setting were for symptom-based reasons (both physical and psycho-socio-emotional) followed by support and coping reasons. This study also found that patients in this setting most often self-referred based on music interest, isolation, and a lack of socialization. Other reasons in this study included those for (a) comfort, (b) restlessness and distress, (c) communication impairments, (d) cultural, and (e) others. The most referrals made in this study were for individuals with diagnoses of cancer or for individuals who were described as bed-bound or confined to a chair due to a progressed disease.

In another study based in palliative and hospice care, Gallagher et al. (2017) found that referrals were based on reasons by (a) family requests, (b) anxiety, (c) coping, (d) family support and comfort, (e) pain, and (f) self-expression. In an inpatient setting for patients with Huntington's Disease, Daveson (2007) found that most referrals were made due to a need to maintain or improve (a) expressive skills, (b) communication skills, (c) social relationships, (d) physical needs, (e) behavior issues, (f) cognition, and (g) activity levels. Magee and Andrews (2007) found in a neuro-rehabilitation setting that referrals were made to improve—in order of frequency—(a) communication skills, (b) social relationships, (c) emotional

expression, (d) behavior, (e) cognitive function, (f) physical issues, (g) leisure, (h) pre- and vocational skills, and (i) socialization.

Appropriateness of Referrals

Hanser (2018) offered guidelines for possible referral criteria for patients in music therapy: (a) strength in auditory processes; (b) responsiveness to sound or music; (c) physical inactivity or limited mobility; (d) limited cognitive capacity; (e) when confrontive therapies are inadvisable; (f) when compliance is a problem; (g) difficulty communicating or expressing thoughts, feelings, or ideas; (h) difficulty forming interpersonal relationships; (i) limited self-awareness; (j) traditional treatment fail or are contraindicated; or (k) there is a need to find meaning or spiritual significance in life. Additionally, referrals may be appropriate for other purposes when previous experiences and research provide evidence that music therapy interventions have been successful in similar cases.

Contraindications

Hanser (2018) also noted that contraindications should be examined as exclusion criteria for referrals. An example of a contraindication noted by Hanser is for patients with a history of musical involvement but whose musical abilities have been diminished as a result of an accident or disease progression. Some patients with these experiences may experience a greater sense of loss, disparate results from rehabilitative efforts with music, elicited grief, or other experiences of frustration or other feelings that may be counterproductive to the therapeutic goals while attempting to retrain or become involved in music again.

Appropriate Referrals in Medical Music Therapy

Receiving appropriate referrals in medical music therapy is essential for music therapists to provide appropriate care for the most appropriate patients. Hanser (2018)

provided a list of possible domains within which music therapy may positively contribute: (a) communication, (b) cognitive, (c) educational, (d) physical, (e) psycho-social, (f) emotional, (g) self-actualization, (h) daily living, (i) musical, (j) leisure, (k) vocational, (l) spiritual, and (m) quality of life. The goals of medical music therapy are designed to directly address appropriate reasons for referral. For example, if a patient is referred to music therapy because of pain, the music therapy goal will be to decrease pain perception. The following sections address the appropriate referrals and need areas of patients in various medical settings.

Adult Medical Care. Walker et al. (2010) provided the following list of reasons for music therapy referrals in adult medical and surgical hospitals: (a) reduce pain perception, (b) reduce anxiety, (c) provide pre-procedural and procedural support, (d) improve or elevate mood, (e) reduce depression, (f) improve social-emotional support, (g) increase motivation and compliance with rehabilitation or treatment regime, (h) improve multisensory experiences, (i) improve physiological outcomes (blood pressure, respiratory rate, heart rate, oxygen saturations, etc.), (j) improve satisfaction of hospital stay (inpatient), and (k) improve quality of life. Additionally, Gerwick and Tan (2010) provided reasons for music therapy referrals for adults in intensive care: (a) increase comfort and relaxation, (b) provide distraction or refocus of attention, (c) mask environmental stimuli, (d) increase arousal orientation, (e) increase stimulation, (f) increase communication, (g) increase self-expression, (h) improve coping skills, (i) facilitate meaningful interactions, (j) acknowledge medical state, (k) increase feelings of control, (l) maintain identity, (m) explore grief, (n) provide spiritual support, (o) provide family support, and (p) facilitate family communication and connections.

Pediatric Care. In a meta-analysis, Standley and Whipple (2003b) found the documented goals and objectives of 29 studies. The goals included (a) pain reduction and management for invasive procedures, (b) anxiety reduction, (c) infant pacification, (d) decreased respiratory distress, and (e) increased coping skills. Goals obtained from other literature in this study include (a) increased comfort, (b) mood elevation, (c) reduction of developmental regressions, (d) reinforcement and teaching of developmental milestones, (e) improved academic objectives, (f) increased socialization, (g) increased acceptance of medical condition, (h) facilitation of expression, (i) improved physical rehabilitation and development, (j) improved speech and language rehabilitation, (k) increased respiratory capability, (l) improved neurologic development, (m) procedural support, (n) hospice support, (o) sleep inducement, (p) infant relaxation, and (q) parent training and education. Ghetti and Hannan (2008) provided a guide for prioritization of patient referrals in the pediatric intensive care unit: (a) lack of consistent social supports, (b) at risk for psychological upset related to hospitalization and separation from parents, (c) repeated invasive procedures, (d) experience of first hospitalization, (e) impaired communicative functioning due to medical interventions, and (f) not responding to other forms of treatment. Normalization and humanization of experiences in the hospital through music therapy has also been noted as an important area of need in both pediatric and adult settings (Gfeller, 2008; Ghetti, 2013).

Neonatal Intensive Care. Hanson-Abromeit et al. (2008) referred to the music therapy referral criteria developed by Loewy (2000) at The Louis and Lucille Armstrong Music Therapy Program of the Beth Israel Medical Center. Goals of these criteria include (a) enhancing the bond between parent and infant; (b) decrease irritability and crying; (c)

improve respiratory function; (d) increase feeding, sucking, and weight gain; (e) facilitate sedation and sleep to decrease pain perception; and (f) support self-regulation. These criteria are reiterated by Nöcker-Ribaupierre (2013). Three broader bases for clinical music therapy in the neonatal intensive care unit are provided in the literature: (1) to mask aversive environmental stimuli and reduce stress thereby promoting physiological well-being and stability; (2) to assist neurological maturation and teach tolerance to stimulation; and (3) to reinforce nonnutritive sucking (Standley, 2004; Standley & Whipple, 2003a).

Advocacy in the Workplace

In order to combat the possible doubt, misrepresentation, misunderstanding, and devaluation of music therapy by those outside of the field and to improve the quantity and quality of referrals to music therapy services, exposure to music therapy through cotreating, receiving procedural support, and observing is necessary to help supplement healthcare professionals' knowledge and understanding of music therapy practices in healthcare. At this time in the profession's existence, music therapists take on an additional role as an educator and advocate for the efficacy and practice of the field of music therapy. The experiences of music therapists in healthcare settings suggest that continued advocacy and education efforts as well as facilitated exposure to music therapy have positively impacted the perceptions of music therapy by other healthcare professionals. Continued education, advocacy, and exposure by music therapists for other healthcare professionals is essential to the improvement of perceptions and the continued development of the field of music therapy in healthcare (Cooke, 2018).

The CBMT (2015) composed the "Board Certification Domains" for music therapy based on a practice analysis study. These domains include the requirements of music

therapists within the referral process: (a) utilize or develop appropriate, population-specific referral protocols; (b) evaluate the appropriateness of a referral for music therapy services; (c) prioritize referrals according to immediate client needs when appropriate; and (d) educate staff, the treatment team, or other professionals regarding appropriate referral criteria for music therapy based on the needs of the population. Hanser (2018) noted that in most cases, someone other than the music therapists will likely determine, to some extent, who receives music therapy. Because of this, it is evident that referral sources must first be aware of appropriate reasons for referrals and contraindications of music therapy.

Multiple studies have shown the efficacy of in-service and other forms of education to positively affect the perceptions of music therapy and the roles of music therapists to meet clinical objectives by other healthcare professionals (Darsie, 2009; Magee & Andrews, 2007; O'Kelly, 2007; Silverman & Chaput, 2011). Silverman and Chaput also found that an oncology nursing staff predominantly perceived music therapy as music listening (recorded music) before attending an in-service, but the same staff believed live music therapy to be more effective and became more interested in music therapy to enhance patient care after attending an in-service. Hanser (2018) iterated the importance of educating potential referral sources to receive appropriate referrals for music therapy. Loewy (2014) stated that working in settings with those of other disciplines poses challenges for the referral process; other professionals who do not understand the standards of practice in music therapy may limit referral making and access to patients in need of services. Another challenge in some medical settings according to Loewy is when making referrals is limited to critical staff such as doctors or nurses, which could impede integration of services and continuity of care. Hense (2018) discussed that clinicians can be gatekeepers to access in music therapy, finding that

professionals with greater understandings of how music benefits mental health were much more likely to make referrals to music therapy.

Additionally, Magee and Andrews (2007) and O’Kelly (2007) found that referrals for music therapy services are increased with improved perceptions of clinical relevance, the inclusion of music therapists in interdisciplinary team meetings, and increased communication between music therapists and other healthcare professionals. Loewy (2014) also stated that the process of making referrals for services contributes to the continued education and communication among staff. A method of receiving referrals that Loewy described is also a form of staff education as illustrated in the following in-person solicitation of services with a pediatric physician: “This child is afraid of needles. Maybe we can warm her up for surgery tomorrow. I can contact the holding area nurse and anesthesiologist today about escorting her down to provide some music therapy in the holding area and operating room. What do you think?” (p. 429).

Loewy (2014) also described the process of “upgrading” referrals, which occurs when staff of a particular unit of a hospital seemingly are making referrals only for one type of patient or treatment need. This is important to ensure that medical staff does not overlook other patients who may benefit from music therapy services for other treatment needs, and this also ensures that the referrals being made are for the most appropriate reasons and at the most necessary times. Re-education about the scope of music therapy practice with medical professionals and discussions about underlying issues that can be addressed by music therapy help in the process of “upgrading” referrals. Loewy provided another example of dialogue with a physician who made a referral to positively reinforce the referral making process with evidence of efficacy:

Thanks, Dr. Levin, your referral of Sarah for music therapy was invaluable. I noticed that the chart reflected that Sarah hasn't eaten in two days. I invited her to the jam when I received your referral form, where you checked off *fear/anxiety*. After attending the music jam, she went back to her room and ate a yogurt and two pieces of toast. The drum helped her release her tension. Thanks, and please keep those referrals coming! (p. 432)

When implementing new services in music therapy, Ledger et al. (2013) found six strategies to facilitate referrals including (a) colleague education, (b) interprofessional work, (c) flexibility by the music therapist, (d) obtaining evidence of efficacy, (e) time and energy investment, and (f) advocacy. O'Kelly (2007) concluded that more awareness and advocacy for music therapy are needed for the field to continue developing in healthcare.

The presented literature supports Cooke's (2018) suggestion that healthcare professionals' increased exposure to music therapy is essential to combat perceived misunderstandings of music therapy in medical settings (Darsie, 2009; Hanser, 2018; Hense, 2018; Ledger et al., 2013; Loewy, 2014; Magee & Andrews, 2007; O'Kelly, 2007; Silverman & Chaput, 2011). Expanding on this suggestion is the notion made by these studies that improved understandings of music therapy by other healthcare professionals, in turn, improves the integration of music therapists in treatment teams and the quality and rate of referrals in medical settings.

Patient Acceptance and Declination of Music Therapy Services

Before music therapists are able to provide services to medical patients, effective contact must be made with the patients in order for the services to be accepted. The AMTA Standards of Clinical Practice in Medical Settings Standard 1.0 (Referral and Acceptance)

states that “the final decision to accept a client for music therapy assessment will be made by a Music Therapist” (AMTA, 2013a, Item 1.3); however in most medical settings, the final decision to receive music therapy services is made by the patient or by a guardian when the patient is unable to make the decision on their own.

O’Callaghan and Colegrove (1998) first studied the effect of introductions in medical music therapy when engaging with hospitalized cancer patients. In this study, the results found that only 50% of patients initially engaged in music therapy, 22% initially declined services but engaged in therapy later, and 20% of patients did not engage in music therapy. The results also showed that most patients initially engaged when they heard music therapy before verbal contact, their music preferences were discussed, and music was offered with no further mention of music therapy. Most patients declined services initially when discussion of music preferences was not initiated, the music therapy methods were explained, and the benefits of music therapy were explained. Additionally, O’Callaghan and Colegrove found that patients who rated experiencing a moderate level of physical discomfort initially engaged, while most patients who either rated themselves as comfortable or in pain did not engage.

Marom (2008) noted that patients in hospice settings may reject music therapy services as an emotional defense, meaning that music therapists in this case could be challenged to make assumptions about what the patient is feeling and accept patient facades. Shultis and Gallagher (2014) also noted that patients, especially in end-of-life contexts, may be concerned that music will heighten distress. Additionally, Marom stated that family members may reject music therapy services on behalf of their loved one because of transference and countertransference issues that may arise during more fragile states and

times (e.g., during hospitalizations). Another common reservation that patients may have to accepting music therapy services is a lack of a musical background. Shultis and Gallagher described a practice called “case finding,” which is another form of solicitation of services made to patients as time permits in the music therapists’ schedules. In the previous case, it would be important to tell patients that they do not have to have any music experience to be involved in music therapy services.

To increase patient acceptance of music therapy services, O’Kelly (2007) noted that the medical director of a palliative care team recommended music therapists to communicate with patients about music therapy before offering services. Hense (2018) discussed that information sharing in youth mental health—sharing decision-making between the patient and professional—is a core feature of recovery-oriented care and increases the exposure to the option of music therapy.

According to the *Patient Care Partnership* (AHA, 2003), music therapists have the obligation to inform patients of services so that patients may make educated decisions about their care. Patients should be aware of (a) the benefits and risks of each treatment, (b) if the treatment is experimental or part of a research study, (c) the reasonable outcomes of treatments including any long-term effects it could have on the patient’s quality of life, (d) what the patient and family can do after the hospital stay, and (e) any financial consequences of receiving the service (AHA, 2003). Discussing the treatment plan, including the source of the referral, the reason for the referral, and predicted outcomes of music therapy interventions could help patients make more informed decisions and increase the acceptance rate of music therapy services.

There is little literature that has explored the reasons for patient acceptance and declination of music therapy services in medical settings (Marom, 2008; O'Callaghan & Colegrove, 1998; Shultis & Gallagher, 2014), and even less exists that have looked into strategies of increasing acceptance rates of these services (O'Callaghan & Colegrove, 1998; O'Kelly, 2007; Hense, 2018). Each of the strategies to increase patient acceptance of medical music therapy involve the way services are introduced to the patients. While both O'Kelly and Hense suggested that discussing music therapy services with patients before treatment could increase acceptance rates, O'Callaghan and Colegrove found that patients were more likely to accept services when approached with music, rather than therapy, as the primary focus. The literature does not appear to suggest a consensus related to efficacious methods of approaching patients to increase acceptance rates of medical music therapy services.

Statement of Purpose

The purpose of this study is to explore the methods utilized by professional, Board-Certified Music Therapists working in general medical hospitals, children's medical hospitals, and Veterans Health Administration medical centers to maximize referrals and acceptance of music therapy services through increased advocacy and access to music therapy in medical hospitals. Music therapists working in medical hospitals have expressed challenges related to the doubt, misrepresentation, misunderstanding, and devaluation of music therapy by other established healthcare professionals (Cooke, 2018). As a result, medical music therapists have been faced with low referral rates as well as inappropriate referrals (Hense, 2018). Because of this, many patients who have the potential to benefit from music therapy services may not be referred to a music therapist. Another challenge faced by music therapists in medical hospitals is patients who are appropriate for music

therapy services declining music therapy services. The *Standards of Clinical Practice* in music therapy by the AMTA (2013a) stated that the final decision in the process of accepting music therapy services is made by the music therapist; however, it is clear that the final decision to accept or decline services is actually made by the patient referred for music therapy or their guardian.

These barriers in referrals and acceptance inhibit music therapists from providing effective services in medical settings. There is little research available that discusses methods of maximizing referrals and acceptance of music therapy services in medical settings. During a time when increased advocacy and access to music therapy is necessary, it is clear that music therapists require additional support with these challenges. Surveying and interviewing music therapy professionals who work in established medical music therapy programs and gathering the methods they have found to be effective will bring an additional resource for medical music therapists.

Research Questions

The following research questions have been designed by the researcher with a focus to gather methods for medical music therapists to use as a resource in increasing advocacy and access in medical music therapy and maximizing referrals and acceptance of services.

1. What are music therapists' experiences of receiving referrals in medical settings?
 - 1-1. How do music therapists receive referrals in medical settings?
 - 1-2. With what frequency do music therapists receive referrals in medical settings?
 - 1-3. What referral reasons do music therapists receive from other professionals in medical settings?

- 1-4. What methods are utilized by music therapists to improve the quality and appropriateness of referrals in medical settings?
- 1-5. What is their perception of the relationship between other professionals' exposure to music therapy and their frequency and quality of referring to music therapy in medical settings?
2. What are music therapists' experiences of patient acceptance and declination of services in medical settings?
 - 2-1. How do music therapists approach patients during their initial visit in medical settings?
 - 2-2. What is the frequency of patient acceptance of music therapy services in medical settings?
 - 2-3. What reasons do patients provide for declining music therapy services in medical settings?
 - 2-4. What methods are utilized by music therapists to increase patient acceptance rates of services in medical settings?
 - 2-5. What is their perception about the relationship between methods of music therapy introductions to patients and patient acceptance of music therapy services in medical settings?

Chapter 3: Method

The following chapter outlines the research design of this study, including recruitment and criteria for participation in the study, procedures, and means of data collection and analysis. It also details the researcher's experience in relation to the proposed study as a rationale for the inquiry and exploration of potential biases.

Researcher's Lens and Preconceptions

The researcher's experience as a music therapist in healthcare includes work in two acute care medical hospitals in the Southeast United States providing services in general medical settings, intensive care, neonatal intensive care, pediatrics, and cancer care. One hospital had an established music therapy program of about 20 years during the researcher's experiences there. The second hospital had intermittent experience with music therapists but never had an established music therapy program. In these settings, the music therapist worked with many healthcare professionals including physicians, nurses, physical therapists, occupational therapists, speech and language pathologists, social workers, medication technicians, and other members of the interdisciplinary team. While the professionals with whom the researcher worked closest with seemed to be in support of music therapy services, their understanding of the methods and techniques the music therapists implemented during treatment remained unclear. Other professionals that the researcher worked with on less frequent occasions presented their doubts, misrepresentations, misunderstandings, and devaluations of music therapy more readily through misguided comments and playful

remarks. In this setting, it seemed that the exposure to music therapy through consistent and close working relationships with professionals impacted their support of music therapy. Additionally, their willingness to learn and the music therapy team's advocacy efforts impacted their understanding.

The researcher also has almost 2 years of experience as a music therapist in long-term care facilities in the Southeast United States providing services for older adults in assisted living and specialized memory care units. There were few music therapists in the geographic area in which the researcher worked in this setting. Therefore, most of the professionals with whom the researcher worked had no prior experience with music therapy. The healthcare professionals with whom the music therapist worked in this setting included administrators, physicians, nurses, nursing assistants, physical therapists, social workers, medication technicians, and other members of the interdisciplinary team. This setting seemed to generate more curiosity and general interest of music therapy, although much misrepresentation and misunderstanding still occurred. The music therapist spent much time with educational and advocacy efforts in this setting which in turn, generated more interest.

During work as a music therapist in healthcare settings, the researcher experienced various circumstances of doubt, misrepresentation, misunderstanding, and devaluation of the field of music therapy in healthcare by other healthcare professionals. These misconceptions impacted the quantity and quality of referrals given by many healthcare professionals in medical hospitals and long-term care facilities: (a) administrators, (b) physicians, (c) nurses, (d) nursing assistants, (e) physical therapists, (f) occupational therapists, (g) speech and language pathologists, (h) social workers, (i) medication technicians, and (j) other members of the interdisciplinary team. In the researcher's experience with this issue, it was found that

exposure to music therapy either through cotreating or observing helped to supplement healthcare professionals' knowledge and understanding of music therapy practices in healthcare. The researcher also found that it was a duty of music therapists to be able to properly educate and advocate for the efficacy and practice of our field. Additionally, the researcher experienced challenges with patients' perceptions of music therapy that impacted their decisions to accept music therapy services.

This study was conceived from the researcher's interest in learning the experiences of other music therapists who have worked in healthcare settings. The researcher was curious to know if the misperceptions of the field of music therapy by other healthcare professionals and patients was a limited experience for music therapists in healthcare or if this was common with other music therapists in healthcare. If this is discovered to be a shared experience, the researcher is interested in discovering the best practices for maximizing referrals and patient acceptance through increasing advocacy and access to music therapy services in medical settings.

There is a possibility that the methods to be utilized in this study—the online survey and follow-up interviews—can be skewed by the researcher's biases and experiences in medical music therapy through leading questions. Merriam (2002) warned that in qualitative studies, the researcher may indirectly impact a study due to personal biases and subjectivities (p. 5). Therefore, these should be identified and monitor how they could potentially shape the collection and interpretation of data. To attempt minimizing potentially skewed data, the survey will be piloted help to identify potential biases of the researcher before data collection begins, and follow-up interview questions will be reviewed by faculty of the researcher's educational institution.

Research Design

The study follows a mixed methods sequential explanatory design in which quantitative data are collected first, followed by qualitative data to “clarify, contextualize, or address questions that arise from the quantitative results” (Burns & Masko, 2016, p. 601). Burns and Masko claimed that the sequential explanatory design has been used more in music therapy research than any other mixed methods design. According to Tashakkori, Teddlie, and Creswell (as cited in Ivankova et al., 2006), “mixed methods is a procedure for collecting, analyzing, and ‘mixing’ or integrating both quantitative and qualitative data at some stage of the research process within a single study for the purpose of gaining a better understanding of the research problem” (p. 3), as neither method alone is sufficient to capture both the trends and details of a situation. Creswell, Plano Clark, et al. (as cited in Creswell & Clark, 2011) defined the purpose of an explanatory design “to use a qualitative strand to explain initial quantitative results” (p. 82). This study merges a quantitative descriptive survey with a qualitative content analysis of individual interviews with a selected sample of survey respondents. Merriam (2002) explained the purpose of qualitative research as aiming to understand the interpretations of individual realities within “a particular point in time and in a particular context” (p. 5). The researcher utilized this design to gather large-scale data from many music therapists to determine trends and incidence while the second part of the design will give the investigator the opportunity to discuss the issues in further detail with individual music therapists. The data streams informed each other to create a more complete view of advocacy and acceptance of services in medical music therapy settings.

Instrumentation

The researcher created and distributed an online survey (see Appendix A) through Qualtrics, an online survey program, that was emailed to music therapists certified through the CBMT in the United States (Qualtrics, 2020). The online survey gathered demographic data from respondents including (a) age, (b) gender, (c) ethnicity, (d) regional location, (e) years of board-certification, (f) years of experience in medical music therapy, (g) and recency of medical music therapy experiences. The survey also collected data about (a) the populations and units the music therapists' serve, (b) referral sources, (c) referral methods, (d) reasons for referrals, (e) job titles of other healthcare professionals working closely with the music therapists, (f) interactions with other healthcare professionals, (g) advocacy and education efforts, (h) acceptance and declination of music therapy services, and (i) methods to approach patients. Lastly, respondents chose whether to submit anonymously or provide contact information to express interest in participating in the follow-up interviews.

The researcher also created an interview guide (see Appendix B) to conduct semi-structured interviews with four music therapists from the survey respondents. The interview questions were aimed to provide opportunities for elaboration about music therapists' experiences with advocacy, access, referrals, and acceptance of music therapy services in medical settings. Interviews were conducted and transcribed using Zoom technology (Zoom Video Communications, 2020).

Participants

Participants of this study included all music therapists credentialed through the CBMT who opted to receive e-mail communications and who accepted an invitation to

participate by completing the online survey. Those who agreed to participate in an interview were assessed for eligibility and then invited to participate in follow-up interviews.

Recruitment

For the survey, the researcher recruited participants by obtaining the email addresses of board-certified music therapists through the CBMT and sending email messages containing a survey to the music therapists. The email addresses were purchased from the CBMT. A total of 8,240 emails were distributed to all board-certified music therapists; the researcher requested the email addresses of all board-certified music therapists who opted-in to email communications from CBMT rather than only those indicating working in medical settings to include those who may have had previous experience in a medical setting or did not indicate a setting in their CBMT member survey response.

Respondents to the online survey had the option to provide contact information to be considered for the follow-up interviews. Survey respondents indicating having at least one year of experience in medical settings within the last 10 years and interest by providing their name and contact information were eligible for participation in a follow-up interview. The researcher chose four interviewees from eligible respondents to obtain perspectives from participants with varying demographic data, including (a) gender, (b) years of experience in medical music therapy, (c) regional location, and (d) medical setting served as a music therapist. The names of the respondents to the survey who indicated interest in participation in a follow-up interview were randomized into three lists using a secure web-based list randomizer (random.org, 2020). The three lists included individuals indicating music therapy experience in each medical setting addressed in the study (i.e., adult medical hospitals, children's medical hospitals, and Veterans Health Administration medical centers). The

researcher contacted the top name on each list until one participant on each list agreed to participate in an individual follow-up interview. An additional participant from the list of respondents indicating interest in an interview was chosen from the list via convenience sampling to supplement the data.

Exclusion Criteria. Only music therapists who were board-certified through the CBMT at the time of the study and opted-in to email communications through the CBMT obtained a link to the survey. Respondents to the survey who indicated having less than one year of experience as a full-time music therapist in medical settings (i.e., adult medical hospitals, children's medical hospitals, or Veterans Health Administration medical centers) within the last 10 years were excluded from eligibility in participation in follow-up interviews.

Ethical Considerations. The respondents involved in the online survey indicated agreement with a statement of informed consent (see Appendix C) before completing the survey. Participants of the follow-up interviews were provided with consent form (see Appendix D) to be completed and returned electronically in order to ensure appropriate ethical conduct. No identifying participant information was reported to protect the confidentiality of respondents and participants. Individual data, transcriptions, and recordings of participant responses was stored on a password-protected computer and will be disposed of one year following the completion of the study.

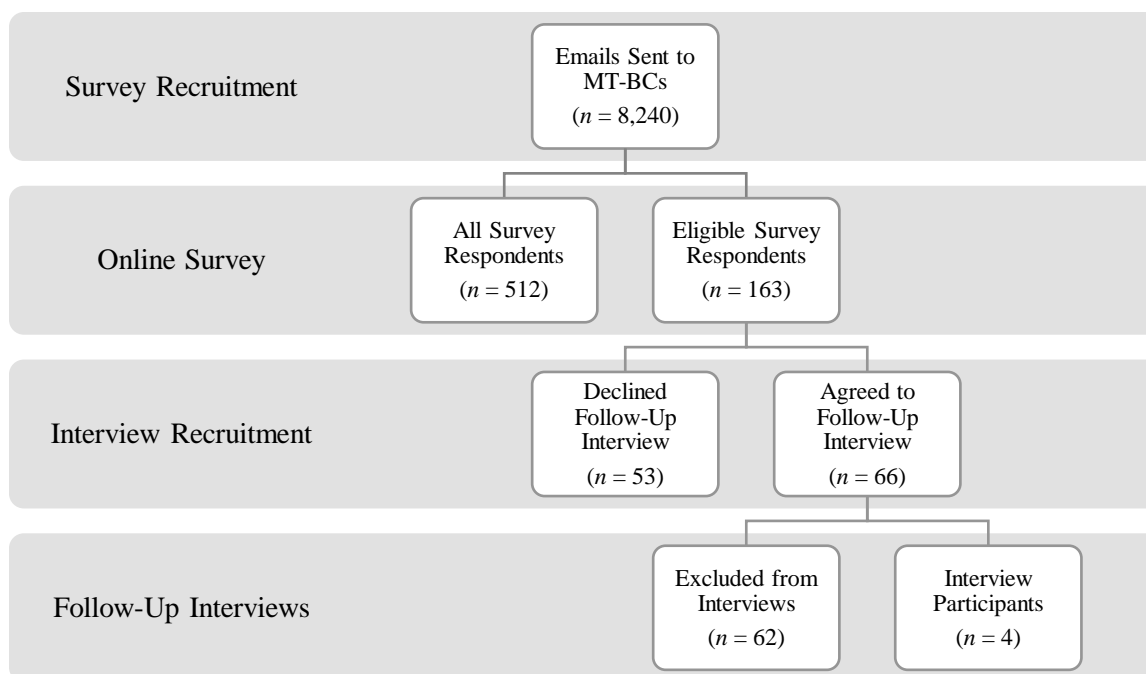
Participant Characteristics

Participants consisted of credentialed board-certified music therapists (MT-BC) with varying levels of experience and education, regional locations, and experiences with patients and other healthcare professionals. A total of 568 surveys were started, and 512 responses

were recorded, indicating a 90% completion rate. Access to the full survey was limited to music therapists fulfilling certain eligibility requirements ($n = 163$). Eligibility for survey completion was defined by the following criteria: a) having music therapy credentials for at least 1 year; b) having at least 1 year of full-time experience in medical music therapy; c) having medical music therapy experience within the last 10 years; and d) having experience in adult medical hospitals, children's medical hospitals, and/or Veterans Health Administration medical centers. Responses from eligible participants were included in the results. Participants for follow-up interviews were chosen from the list of survey respondents eligible to complete the full survey and who indicated interest in a follow-up interview. See Figure 1 for the participant flow throughout the study.

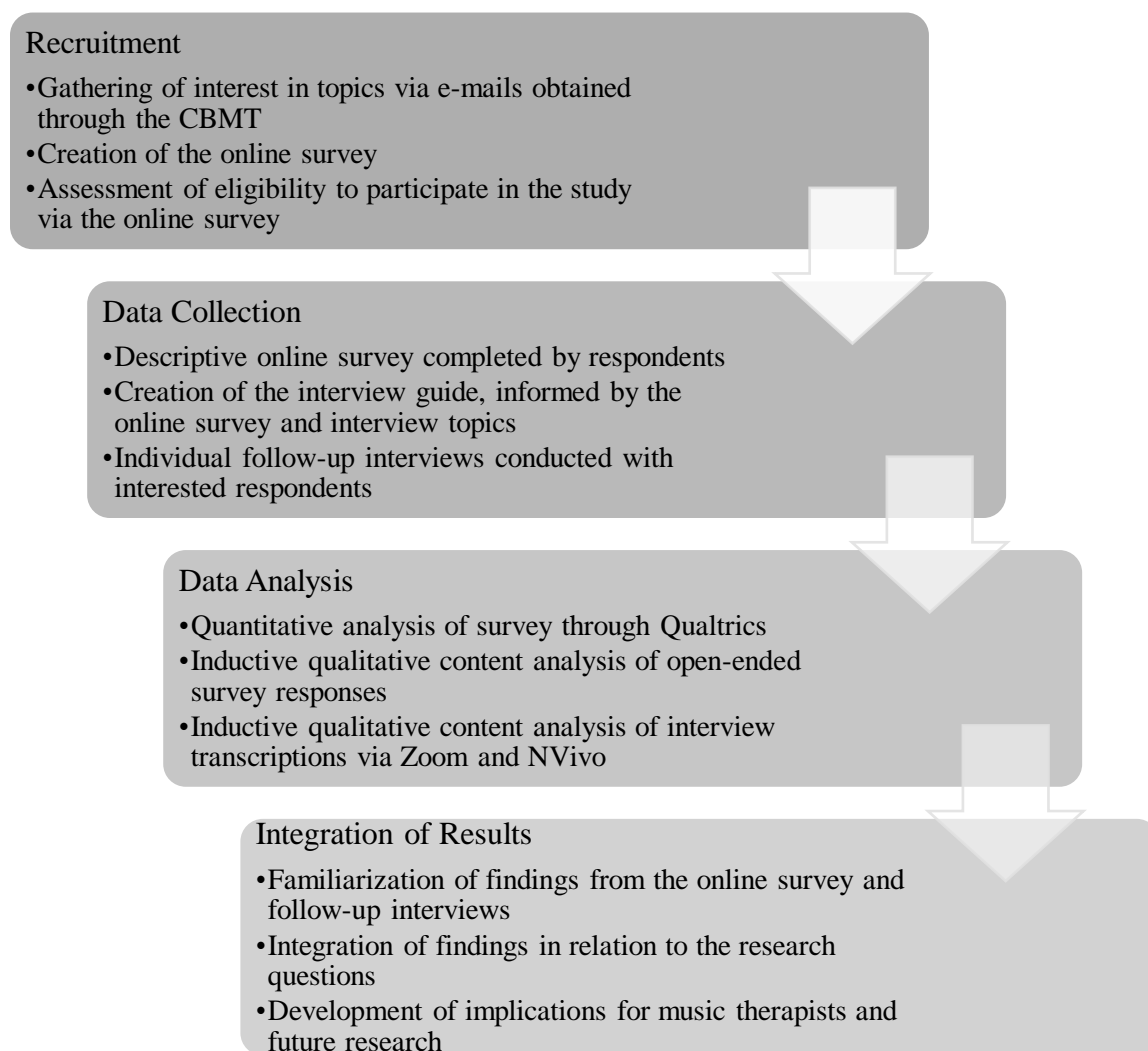
Figure 1

Participant Flow



Procedure

This study consisted of two phases: an online survey and follow-up interviews. The online survey provided an outline for the in-depth inquiry, and the follow-up interviews inquired about participants' detailed experiences in relation to the research questions. Findings of the online survey served as an informant for the interview guide in conjunction with the researcher's own experiences in medical music therapy. As interviews conducted, topics uncovered with participants further served as informants to preceding interviews. See Figure 2 for a flow chart detailing this procedure. The researcher received IRB approval/exemption prior to sending out the survey (see Appendix E).

Figure 2*Flow of the Study**Online Survey*

The survey was sent to participants via email obtained through the CBMT. The initial emails containing a link to the survey and a letter of consent (see Appendices A and C) were sent 30 days prior to the due date. An email reminder was sent following the initial email 14 days prior to the due date. Respondents were able to participate in the online survey at their convenience within the 30-day period. Respondents were asked to recount frequencies of referrals and the sources of referrals, the appropriate and inappropriate reasons for referrals,

opportunities and methods of advocacy with other healthcare professionals, the frequency of patient acceptance and declination of services, effective and ineffective methods of approach to patients during the initial visit, and the demographics of the medical facility they serve or have served within medical music therapy. Additional, general demographic information of the respondents was also collected during the survey.

Follow-up Interviews

Short (45- to 60-minutes), semi-structured interviews were conducted with selected respondents to the online survey. Interviews were conducted at times convenient to the participants. The interviews were conducted individually and privately in closed settings. Prior to meeting, the researcher provided interviewees with an electronic consent form (see Appendix D) to sign and return electronically to the researcher. The interviews were conducted utilizing an interview guide of open-ended questions (see Appendix B). Follow-up questions were utilized for clarification or to gather more information regarding topics brought up through the discussion.

The participants were asked to reflect on previous encounters with other healthcare professionals and patients and recount their interpretations of the perceptions and statements the other healthcare professionals and patients had of music therapy practices. Additionally, the researcher asked the participants to provide details of the methods, quantity, and quality of referrals received for music therapy services. The researcher also asked them to discuss the methods they have implemented to advocate and educate other professionals and the efficacy of these methods to improve the quantity and quality of referrals to music therapy services. Lastly, the researcher asked participants to reflect on patient acceptance and declination of music therapy services, discuss practiced methods of approaching patients who

have been referred for services, and evaluate the efficacy of these methods to improve patient acceptance of services.

Data Collection and Analysis

Data were collected throughout both phases of the research study, and the data from each phase informed the content and structure of the successive phase. The following sections detail the data collection and analysis processes for both phases.

Online Survey Data

Respondents' data from the online survey (see Appendix A) were collected and stored with Qualtrics' secured software. Descriptive data from the online surveys were analyzed through Qualtrics (Qualtrics, 2020). The descriptive data from the survey included the responses to sections pertaining to respondent demographic information, the quantity and quality of music therapy referrals, the frequency and methods of music therapy education for other healthcare professionals, and the frequency of patient acceptance and declination of music therapy services.

The researcher identified themes using the qualitative data from open ended questions in the survey via an inductive qualitative content analysis. The researcher followed the method outlined by Ghetti and Keith (2016) in their guidelines for qualitative content analysis: identify meaning units (or themes), condense and paraphrase, and abstract and categorize. Ghetti and Keith also distinguished inductive analysis as that with "categories arising directly from close examination of the data" (p. 835). The researcher consolidated the open-ended text responses submitted by respondents into similar units of meaning via open coding as they were discovered and grouped these by theme in charts. Qualitative data from the survey included the responses from sections pertaining to experiences of receiving music

therapy referrals, methods for increasing the quality and quantity of music therapy referrals, experiences of patient acceptance and declination of music therapy services, and methods for increasing patient acceptance of music therapy services.

Follow-up Interview Data

The interviews were audio-recorded and automatically transcribed via Zoom (2020) technology with accuracy checking by the researcher. The researcher provided each participant with the transcript of their interview for member-checking to increase the validity of the results. Members were invited to clarify and correct information with the researcher if needed.

Similar to the qualitative data of the online survey, the researcher followed the inductive method of qualitative content analysis outlined by Ghetti and Keith (2016) and described in the previous section. Braun and Clarke (2006) described this process (of inductive analysis) as “data-driven” by which codes and themes are generated without a predesigned template constructed by the researcher’s previous experiences. In this model, the data were collected specifically for the research; Braun and Clarke also stated that because of this, identified themes have the potential to “bear little relation to the specific questions that were asked of the participants” (p. 83). However, Braun and Clarke also noted that—even when utilizing an inductive approach—“researchers cannot free themselves of their theoretical and epistemological commitments” (p. 84), and therefore, themes may still be influenced by the researcher’s previous experiences while not being molded by them.

The researcher identified themes and subthemes that arose as the researcher became familiar with the data from the transcribed interviews. The researcher summarized themes that arose between data sets (i.e., interview transcriptions) as well as those that were specific

to data provided by individual participants. Using a trial version of NVivo software for qualitative data analysis (QSR International, 2020), the researcher classified these themes into the following three categories: content areas (broad clusters of data driven by the research questions), themes (general categories of data generated by participant interview data), and subthemes (specific ideas related to their broader theme categories and supported by interview participant data).

Validity Procedures

The researcher conducted a participatory pilot survey with a small, convenient sample of music therapists with knowledge in medical music therapy to assess the appropriateness of questions to the target population, test the directness of the instructions, and determine if the survey is effective in fulfilling the total purpose of the study. Pilot participants included music therapy faculty members of the researcher's educational institution. Participants in the pilot survey were asked to comment on the validity of the survey's content and construct to appropriately address and measure the intended purposes of the study.

The researcher sent the transcriptions of each follow-up interview to the participants for member-checking to ensure the accuracy of the transcriptions and information gathered. Participants approved the transcriptions and prior to data analysis. Triangulation of perspectives was attempted by recruiting participants with experience as music therapists from differing (a) genders, (b) years of experience in medical music therapy, (c) regional locations, and (d) medical settings served as a music therapist.

Evaluation of the Method

Utilizing a mixed methods approach allowed the researcher to capture potential trends in the effect advocacy has on referrals, access, and acceptance of music therapy services in

medical settings as well as gather in-depth details and knowledge about the experiences of music therapists in these situations. Analyzing data in both quantitative and qualitative designs allowed the researcher to approach these experiences from more than one angle in order to provide the most accurate research for other music therapists in medical settings.

The online survey provided evidence for medical music therapists perceptions of whether advocacy and quantity and quality of referrals are related and whether certain approaches to patients are related to higher rates of acceptance of services. Also, the online survey informed the interview content and structure to gather in-depth insight to the experiences of a smaller pool of music therapists with experience in medical settings.

Merriam (2002) explained that data analysis in qualitative research is simultaneous with data collection to allow the researcher to make adjustments during the research; therefore, each interview served as an informant for the following interview. Semi-structured interviews were an effective method for this inquiry because they allowed space for the participants to share their own personal experiences as music therapists in healthcare settings while allowing the researcher to guide the conversation in ways that address the questions of interest. When topics of interest are addressed by the participants responses to the questions, the researcher was able to supplement the inquiry with follow-up questions for clarification and additional information.

Chapter 4: Survey Results

This chapter will report the results from the 42-item online survey created by the researcher. The information will be presented in sections representing the three main sections of the survey: respondent demographics, referrals in medical music therapy, and patient acceptance and declination of music therapy services. A final section will include concluding questions.

Survey Respondent Demographics

Eligibility was determined by music therapists credentialed through the CBMT who opted-in to email communications and indicated having at least one year of experience as a full-time music therapist in medical settings (i.e., adult medical hospitals, children's medical hospitals, or Veterans Health Administration medical centers) within the last 10 years ($n = 163$). Respondents identified descriptions of their current gender identities as 80.37% female, woman, or feminine ($n = 131$); 16.56% male, man, or masculine ($n = 27$); 1.23% non-binary ($n = 2$); 1.23% other ($n = 2$); and 0.61% prefer not to answer ($n = 1$). The ages of eligible respondents were 34.97% ages 30–39 ($n = 57$), 28.22% ages 21–29 ($n = 46$), 14.72% ages 40–49 ($n = 24$), 12.27% ages 50–59 ($n = 20$), 7.98% ages 60–69 ($n = 13$), and 1.84% ages 70–79 ($n = 3$). Respondents identified their ethnic identities as 81.01% White ($n = 145$); 7.26% Hispanic, Latinx, or Spanish origin ($n = 13$); 5.59% Asian ($n = 10$); 1.68% Black or African American ($n = 3$); 1.68% Middle Eastern or North African ($n = 3$); 1.12% other ($n =$

2); 0.56% Native American or Alaska Native ($n = 1$); 0.56% Native Hawaiian or other Pacific Islander ($n = 1$); and 0.56% prefer not to answer ($n = 1$).

Eligible respondents represented all regions of the AMTA: 28.75% Great Lakes Region ($n = 46$), 20.00% Mid-Atlantic Region ($n = 32$), 15.63% Western Region ($n = 25$), 14.37% Southeastern Region ($n = 23$), 8.75% Southwestern Region ($n = 14$), 7.50% Midwestern Region ($n = 12$), and 5.00% New England Region ($n = 8$). The highest completed level of education of eligible respondents was 45.40% master's degree in music therapy ($n = 74$), 34.97% undergraduate degree in music therapy ($n = 57$), 9.20% master's degree in a related field ($n = 15$), 4.29% equivalency in music therapy ($n = 7$), 4.29% doctoral degree in music therapy ($n = 7$), and 1.84% other ($n = 3$). Many respondents ($n = 112$) indicated other degrees, licensures, certificates, or trainings related to their experience in music therapy (see Table 1).

Table 1*Other Degrees, Licensures, Certificates, or Trainings by Respondents*

Training	Frequency	Percentage
Specialized and Advanced Music Therapy Trainings	119	
<i>Neurologic Music Therapy</i>	50	44.65%
<i>NICU Music Therapy</i>	38	33.93%
<i>Hospice and Palliative Care Music Therapy</i>	12	10.71%
<i>Guided Imagery and Music</i>	11	9.82%
<i>Trainings in Music Therapy in Pregnancy and Birth</i>	4	3.57%
<i>Nordoff–Robbins Music Therapy</i>	2	1.79%
<i>Music Therapy Assessment Tool for Awareness in Disorders of Consciousness</i>	1	0.89%
<i>Vocal Psychotherapy</i>	1	0.89%
Mental Health-Related Trainings and Education	25	
<i>Creative or Expressive Arts Therapies</i>	7	6.25%
<i>Counseling, Social Work, and Clinical Psychology</i>	6	5.36%
<i>Specialized Counseling Trainings</i>	4	3.57%
<i>Trauma and Crisis Trainings</i>	4	3.57%
<i>Undergraduate Psychology Degrees</i>	3	2.68%
<i>Other Mental-Health Related Trainings</i>	1	0.89%
Health and Medical-Related Trainings	22	
<i>Hospice, Palliative Care, and End-of-Life Trainings</i>	13	11.61%
<i>Child Life Specialist</i>	3	2.68%
<i>Brain Injury Specialist</i>	2	1.79%
<i>CPR, Basic Life Support, and First Aid</i>	2	1.79%
<i>Healthcare Administration and Management</i>	2	1.79%
Music-Related Trainings	6	
<i>Early Childhood Music Trainings</i>	2	1.79%
<i>Other Music Degrees</i>	2	1.79%
<i>Therapeutic Drumming Trainings</i>	2	1.79%
Other Related Trainings	4	
<i>Divinity and Religious Education</i>	2	1.79%
<i>General Education Degrees</i>	1	0.89%
<i>Massage Therapy</i>	1	0.89%
<i>Other graduate degrees</i>	1	0.89%
<i>Other Healthcare-Related Trainings</i>	1	0.89%
Different Abilities-Related Trainings	2	
<i>American Sign Language</i>	1	0.89%
<i>Specialized Neuro-divergent and Disabilities Trainings</i>	1	0.89%

Respondents reported having music therapy credentials for 59.51% 1–10 years ($n = 97$), 25.77% 11–20 years ($n = 42$), 9.20% 21–30 years ($n = 15$), 4.91% 31–40 years ($n = 8$),

and 0.61% 41–50 years ($n = 1$). Of eligible respondents, 54.60% reported having 1–5 years ($n = 89$), 24.54% reported having 6–10 years ($n = 40$), 17.79% reported having 11–20 years ($n = 29$), 1.84% reported having 31–40 years ($n = 3$), and 1.23% reported having 21–30 years ($n = 2$). Of eligible respondents, 80.98% reported current experience ($n = 132$), 10.43% reported experience 1–5 years ago ($n = 17$), 6.13% reported experience less than 1 year ago ($n = 10$), and 2.45% reported experience more than 10 years ago ($n = 4$). Of eligible respondents, 35.16% reported working in adult medical hospitals ($n = 77$), 35.16% reported working in children’s medical hospitals ($n = 77$), 25.57% reported working in other healthcare facilities ($n = 56$), and 4.11% reported working in Veterans Health Administration medical centers ($n = 9$). See Table 2 for a list of other healthcare facilities served by eligible respondents.

Table 2

Other Healthcare Facilities

Type of Facility	Frequency	Percentage
Hospice (In-home or in-patient)	31	14.16%
Psychiatric Facility	6	2.74%
Rehabilitation Facility	4	1.83%
Skilled Nursing Facility	2	0.91%
Senior Health Facility	2	0.91%
Prison-Based Medical Facility	2	0.91%
Forensic Mental Health Facility	1	0.47%
Community Health Center	1	0.47%
Cancer Center	1	0.47%
Behavioral Health Facility	1	0.47%

Referrals in Medical Music Therapy

This section of the survey was concerned with how music therapists receive referrals to provide services in medical settings. This section included questions about referral

frequency, appropriateness, reasons, and sources for music therapy in medical settings as well as approaches to educating potential referral sources about medical music therapy.

Frequency and Quality of Referrals

Respondents were asked if they receive or have received referrals from other healthcare professionals to provide music therapy in medical settings. Out of the 148 respondents who answered this question, 90.54% ($n = 134$) answered yes and were eligible to answer remaining questions in this section pertaining to music therapy referrals.

Respondents were asked to estimate how often they receive referrals for music therapy in medical settings. Of those who responded, 37.59% reported receiving 1–5 referrals a week ($n = 50$), 25.56% reported receiving more than 10 referrals a week ($n = 34$), 23.31% reported receiving 5–10 referrals a week ($n = 31$), and 13.53% reported receiving less than 1 referrals a week ($n = 18$). The results indicate 91.73% music therapists in medical settings receive referrals from nurses ($n = 122$). See Table 3 for data related to sources for music therapy referrals.

Table 3*Referral Sources in Medical Music Therapy*

Referral Source	Frequency	Percentage
Nurses	122	91.73%
Social workers	111	83.46%
Physicians	97	72.93%
Chaplains	86	64.66%
Families	82	61.65%
Patients	74	55.64%
Physical therapists	68	51.13%
Child life specialists	68	51.13%
Occupational therapists	66	49.62%
Self	60	45.11%
Speech and language pathologists	57	42.86%
Music therapists (other than self)	46	34.59%
Psychologists	44	33.08%
Other ^a	40	30.08%
Other creative arts therapists	26	19.55%
<i>Art therapists</i>	22	
<i>Dance/movement therapists</i>	5	
<i>Drama therapists</i>	1	
Administration	19	14.29%
Respiratory therapists	15	11.28%

^a Responses included nursing assistants and care technicians (6), massage therapists (6), nurse practitioners (5), hospice and palliative care liaisons (3), nurse care managers (3), recreation therapists (2), energy healers (2), activity professionals (2), physician's assistants (2), yoga specialists (2), artists in residents, expressive arts therapists, pastoral care, volunteers/coordinators, teachers, dieticians, and developmental specialists.

Respondents ranked the top three and lowest three sources of music therapy referrals in terms of frequency in their hospitals. Nurses were ranked as one of the top three sources by 102 respondents and were ranked by 33.22% of respondents ($n = 40$) as the top source for music therapy referrals in medical hospitals. Administrators were ranked as one of the lowest three sources by 68 respondents and were ranked by 73.53% of respondents ($n = 50$) as the lowest source for music therapy referrals in medical hospitals. See Tables 4 and 5 for data related to the top and lowest ranked sources by respondents for music therapy referrals.

Table 4*Top-Ranked Music Therapy Referral Sources*

Referral Sources	Rankings ^a					
	1		2		3	
	#	%	#	%	#	%
Nurses	40	30.08%	42	31.58%	20	15.04%
Child life specialists	27	20.30%	10	7.52%	10	7.52%
Social workers	20	15.04%	23	17.29%	16	12.03%
Physicians	19	14.29%	10	7.52%	27	20.30%
Self	8	6.02%	6	4.51%	7	5.26%
Occupational therapists	5	3.76%	3	2.26%	5	3.76%
Other ^b	5	3.76%	2	1.50%	3	2.26%
Chaplains	3	2.26%	5	3.76%	13	9.77%
Administration	1	0.75%	2	1.50%	0	0.00%
Other music therapists	1	0.75%	4	3.01%	1	0.75%
Psychologists	1	0.75%	6	4.51%	4	3.01%
Families	1	0.75%	7	5.26%	7	5.26%
Other creative arts therapists	1	0.75%	0	0.00%	0	0.00%
Physical therapists	1	0.75%	3	2.26%	6	4.51%
Patients	0	0.00%	4	3.01%	7	5.26%
Respiratory therapists	0	0.00%	1	0.75%	1	0.75%
Speech and language pathologists	0	0.00%	4	3.01%	0	0.00%

^a Ranked from 1 (most frequent) to 3 (third most frequent).

^b Responses included interdisciplinary teams (2), nurse practitioners (2), activity directors, nurse care managers, patient care technicians, physicians' assistants, recreation therapists, and other nursing staff.

Table 5*Lowest-Ranked Music Therapy Referral Sources*

Referral Sources	Rankings ^a					
	1		2		3	
	#	%	#	%	#	%
Administration	50	37.59%	5	3.76%	13	9.77%
Physicians	11	8.27%	12	9.02%	12	9.02%
Respiratory therapists	11	8.27%	24	18.05%	15	11.28%
Speech and language pathologists	10	7.52%	7	5.26%	10	7.52%
Physical therapists	8	6.02%	4	3.01%	9	6.77%
Chaplains	7	5.26%	15	11.28%	12	9.02%
Psychologists	6	4.51%	15	11.28%	11	8.27%
Social workers	6	4.51%	9	6.77%	4	3.01%
Child life specialists	5	3.76%	4	3.01%	4	3.01%
Self	5	3.76%	1	0.75%	2	1.50%
Occupational therapists	4	3.01%	6	4.51%	5	3.76%
Patients	4	3.01%	5	3.76%	8	6.02%
Families	1	0.75%	8	6.02%	4	3.01%
Nurses	1	0.75%	1	0.75%	6	4.51%
Other creative arts therapists ^b	1	0.75%	1	0.75%	0	0.00%
Other music therapists	1	0.75%	3	2.26%	5	3.76%
Other ^c	0	0.00%	1	0.75%	1	0.75%

^a Ranked from 1 (least frequent) to 3 (third least frequent).

^b Response included art therapists.

^c Responses included massage therapists (2) and reiki masters.

Respondents rated the frequency of receiving music therapy referrals for a series of reasons in their hospitals. Respondents reported anxiety most often as the most frequent reason for referrals in medical music therapy. See Table 6 for data related to medical music therapy referral reasons.

Table 6*Frequency of Music Therapy Referral Reasons*

Referral Reasons	Rankings ^a							
	0	1	2	3	4	5	6	7
Anxiety	2	3	3	16	26	30	16	18
Chronic illness	9	4	9	14	16	24	18	17
Normalization	15	12	11	7	20	20	11	15
Ineffective coping (patient)	2	6	8	20	25	21	16	14
Pain	2	6	7	15	26	27	15	13
Isolation	3	8	13	14	24	22	16	11
Depression	5	2	14	24	27	19	14	7
Newly diagnosed	16	14	16	18	14	13	12	7
Sensory stimulation	11	8	13	16	27	15	14	7
Agitation/restlessness	3	3	15	25	21	27	12	5
Motor deficits	19	18	16	16	17	13	6	5
Impaired communication	9	16	24	24	14	13	7	4
Ineffective coping (family)	9	15	14	19	23	16	11	4
Limited support system	7	9	15	15	18	23	21	4
Behavioral disturbance	12	17	23	17	19	14	5	3
Caregiver role strain	20	23	24	19	7	11	4	3
Loss of autonomy	11	20	19	10	19	17	14	2
Low self-esteem	16	29	23	18	12	5	6	2
Procedural support	10	25	22	18	15	10	10	2
Anticipatory grief (family)	10	20	32	21	12	12	5	1
Imminent death	9	2	29	23	15	13	11	1
Ineffective breathing pattern	19	25	32	13	8	9	4	1
Low satisfaction of stay	31	30	19	14	12	3	2	1
Spiritual needs	14	21	27	19	15	12	2	1
Other	39	6	3	1	4	1	6	1
Anticipatory grief (patient)	8	20	35	22	13	10	5	0

^a Rated from 0 (not applicable), 1 (never), 2 (once per month), 3 (2–3 times per month), 4 (once per week), 5 (2–4 times per week), 6 (daily), and 7 (multiple times per day).

Respondents were asked if they received or have received inappropriate referral reasons (e.g., “patient likes music”) or referrals with insufficient information in medical settings. Of the 115 respondents to this question, 86.96% indicated that they do receive inappropriate referrals ($n = 100$) while 13.04% responded that they do not ($n = 15$). Many ($n = 90$) respondents provided inappropriate reasons for referrals. Of these respondents, 73.33%

reported receiving “patient likes music” as an inappropriate reason for music therapy referrals in medical settings. See Table 7 for inappropriate reasons for music therapy referrals in medical settings reported by respondents. Similar responses were consolidated for the table.

Table 7

Inappropriate Referrals for Music Therapy in Medical Settings

Inappropriate Referral Reasons	Frequency	Percentage ^a
Patient likes music	66	73.33%
Patient is bored	47	52.22%
Patient is or was a musician	22	24.44%
Patient needs entertainment	18	20.00%
Patient is nice, fun, or cute	15	16.67%
Patient has a birthday	7	7.78%
Patient wants to play an instrument	7	7.78%
No reason given	5	5.56%
Patient needs to be watched or needs company	4	4.44%
Family likes music	4	4.44%
No referral is inappropriate	2	2.22%
Family or patient is not satisfied with care	2	2.22%
Patient needs structure	2	2.22%
Patient has dementia	1	1.11%
Patient needs to be happy	1	1.11%
Patient is intellectually disabled	1	1.11%
Patient is annoying	1	1.11%
Hospital can get additional billing days	1	1.11%
Staff wants to hear music	1	1.11%
Siblings need to be watched	1	1.11%
Patient cannot have other services	1	1.11%
Patient is too energetic	1	1.11%
Referral is insufficient	1	1.11%
Caregiver needs a break	1	1.11%
Family is nice	1	1.11%
Patient is hard of hearing	1	1.11%
Patient needs to make positive memories during hospitalization	1	1.11%

^a Percentage of question respondents who reported an inappropriate referral reason.

Respondents were asked to rank the top three healthcare disciplines in their hospitals that most frequently refer to music therapy for inappropriate reasons. Nurses were ranked as one of the top three sources of music therapy services for inappropriate reasons in medical hospitals by 77 respondents and were ranked as the top source for inappropriate music therapy referrals in medical hospitals by 53 respondents. See Table 8 for data related to sources of inappropriate referrals in medical music therapy.

Table 8

Sources of Inappropriate Medical Music Therapy Referrals

Inappropriate Referral Sources	Rankings ^a					
	1		2		3	
	#	%	#	%	#	%
Nurses	53	53.00%	18	18.00%	6	6.00%
Physicians	11	11.00%	12	12.00%	10	10.00%
Other ^b	8	8.00%	4	4.00%	9	9.00%
Social workers	6	6.00%	14	14.00%	7	7.00%
Administration	5	5.00%	11	11.00%	4	4.00%
Child life specialists	5	5.00%	6	6.00%	11	11.00%
Chaplains	4	4.00%	8	8.00%	8	8.00%
Music therapists	0	0.00%	1	1.00%	0	0.00%
Occupational therapists	0	0.00%	2	2.00%	1	1.00%
Other creative arts therapists	0	0.00%	0	0.00%	0	0.00%
Physical therapists	0	0.00%	0	0.00%	7	7.00%
Psychologists	0	0.00%	4	4.00%	2	2.00%
Respiratory therapists	0	0.00%	2	2.00%	1	1.00%
Speech and language pathologists	0	0.00%	1	1.00%	2	2.00%

^a Ranked from 1 (most frequent) to 3 (third most frequent).

^b Responses included families (3), nursing assistants (3), patient care technicians (2), patients (2), residents (2), advanced practice registered nurses, child life assistants, clinical technicians, marketing staff, medical assistants, nurse managers, psychiatric technicians, school staff, unit clerks, and volunteers.

Education of Referral Sources

Respondents were asked if they provide in-services or other types of staff education about music therapy to increase the frequency or quality of music therapy services in medical

settings. Out of the 110 respondents who answered this question, 89.09% ($n = 98$) answered yes and were eligible to answer the following questions in this section pertaining to staff education of music therapy.

Patients reported the types of staff education they provide about music therapy in medical settings. Most, or 84.55%, of the respondents reported providing in-services about medical music therapy to hospital staff ($n = 93$). See Table 9 for a list of types of staff education provided by respondents about medical music therapy.

Table 9

Staff Education Techniques for Medical Music Therapy

Type of Staff Education	Frequency	Percentage
In-services	93	84.55%
Word-of-mouth	72	65.45%
New employee orientation	43	39.09%
Unit training	41	37.27%
Pamphlets	39	35.45%
Other ^a	24	21.82%

^aResponses included grand rounds and interdisciplinary meetings (7); news events, articles, and videos (6); open houses, service booths, and posters (4); staff meetings and conferences (4); session observations and cotreatment (2); music therapy services for staff (2); elevator summaries; hospital-wide presentations; continuing education for staff; ride-alongs; chart notes; and verbal follow-ups after sessions.

Respondents were asked for whom they provide staff education about medical music therapy. The top recipients of music therapy education reported by respondents in medical settings were nurses ($n = 87$), social workers ($n = 65$), and administration ($n = 59$). See Table 10 for all healthcare professionals for whom respondents reported providing education about medical music therapy.

Table 10*Recipients of Education About Medical Music Therapy*

Healthcare Profession	Frequency	Percentage
Nurses	87	79.09%
Social workers	65	59.09%
Physicians	64	58.18%
Administration	59	53.63%
Chaplains	50	45.45%
Occupational therapists	46	41.82%
Physical therapists	46	41.82%
Speech and language pathologists	40	36.36%
Child life specialists	37	33.64%
Psychologists	25	22.73%
Music therapists	16	14.55%
Other ^a	15	13.64%
Respiratory therapists	12	10.91%
Other creative arts therapists ^b	12	10.91%

^a Responses included community members (3), massage therapists (2), recreation therapists (2), specialized units (2), clinical leads, home health aides, interdisciplinary teams, marketing staff, medical students, nursing assistants, nursing students, nursing technicians, patients, reiki masters, residents, and teachers.

^b Responses included art therapists (9) and dance/movement therapists.

Respondents were asked if they thought other healthcare professionals in their hospitals misunderstood or misrepresented music therapy. Out of the 125 respondents who answered this question, 77.60% ($n = 97$) answered yes and were asked to report the ways in which they thought other healthcare professionals in their hospitals misrepresent music therapy. Of these respondents, 93 provided ways in which music therapy is misrepresented in their hospitals. A large percentage, or 41.94%, of respondents who provided examples of misrepresentation reported that music therapy was mistaken as entertainment in their hospitals ($n = 39$). See Table 11 for respondent reports of medical music therapy misrepresentation. Similar responses were consolidated for the table.

Table 11*Misrepresentation of Medical Music Therapy*

Example of Misrepresentation	Frequency	Percentage
Music therapy is entertainment	39	41.94%
Misunderstanding of role of music therapy purpose to provide therapy	22	23.66%
Music therapy is nice, fun, or nontherapeutic	17	18.28%
Volunteer musicians mistaken as music therapists or vice versa	6	6.45%
Inaccurate descriptions of music therapy to patients	5	5.38%
Use of terms such as “concert” to describe music therapy	4	4.30%
Music therapy is to give staff a break or watch patients	4	4.30%
Music therapy makes patients happy	4	4.30%
Narrow perception of scope of practice	4	4.30%
Other staff playing live music mistaken as music therapists	4	4.30%
Recorded music by staff as music therapy	3	3.23%
Misunderstanding of required training and education	3	3.23%
Misunderstanding of therapeutic music properties	3	3.23%
Music therapy is to increase patient experience scores	3	3.23%
All patients need or can benefit from music therapy	3	3.23%
Music therapist mistaken as recreation therapist or vice versa	3	3.23%
Music practitioner mistaken as music therapist	2	2.15%
Music therapy is only relaxing or for environmental music	2	2.15%
Music therapy is the same as pet therapy	2	2.15%
Music therapist called names such as “guitar lady”	2	2.15%
Misunderstanding of need for therapeutic process (e.g., assessment, documentation)	2	2.15%
Music therapy is to teach music	2	2.15%
Unaware of music therapy evidence	2	2.15%
Music therapists mistaken as child life specialists	2	2.15%
Music therapy is only for patients who like music	2	2.15%
Music therapy is a gift or a reward	2	2.15%
Music therapy mistaken as play therapy	1	1.08%
Anything musical is music therapy	1	1.08%
Music & Memory program as music therapy	1	1.08%
Music therapists misrepresent music therapy	1	1.08%
Patients have to be musical to benefit from music therapy	1	1.08%
Music therapy is for happy or good patients	1	1.08%
Music therapists should perform for hospital functions	1	1.08%

Effect of Referrals on Services

Respondents were asked if they thought the quantity or quality (i.e., appropriateness or inappropriateness) of music therapy referrals they receive has hindered their ability to

provide services to patients in need in medical settings. Of those that responded, 61.79% answered no ($n = 76$), and 38.21% answered yes ($n = 47$).

Patient Acceptance and Declination of Music Therapy Services

This section of the survey was concerned with patient access to music therapy in medical settings as reported by patient acceptance and declination of services. This section included questions about referral acceptance and declination rates, reasons for patient declination of services, approaches found to increase or decrease patient acceptance of services, and the perceived relationship between patient awareness of music therapy practices and their acceptance of services.

Respondents were asked to estimate the rate of acceptance of music therapy services by patients or families they experience in medical settings. Of those that responded, 65.32% reported a 75–99% acceptance rate ($n = 81$), 25.00% reported a 50–75% acceptance rate ($n = 31$), 5.65% reported a less than 50% acceptance rate ($n = 7$), and 4.03% reported a 100% acceptance rate ($n = 5$). Respondents were also asked if they have experienced declination of music therapy services by patients or families in medical settings. Of the 124 who responded to this question, 79.03% answered yes ($n = 98$), and 20.97% answered no ($n = 26$).

The respondents answering yes to having experienced declination of music therapy services in medical settings were asked to provide reasons for declination given by patients and family members. Out of these 98 respondents, 88.78% reported “patient is tired” as a reason for declination ($n = 87$), 69.39% reported “patient has visitors” as a reason for declination ($n = 68$), 60.20% reported “patient does not like music” as a reason for declination ($n = 59$), 58.16% reported other reasons for declination ($n = 57$), and 10.26%

reported “no reason given” for declination ($n = 31$). Table 12 lists other reasons for declination provided by respondents. Similar responses were consolidated for the table.

Table 12

Other Reasons for Declination of Music Therapy Services in Medical Settings

Reasons for Declination	Frequency	Percentage
Other stimuli or interventions occurring	21	21.43%
Patient is experiencing pain, discomfort, or weakness	16	16.32%
Patient does not want to engage, is uninterested, or “not in the mood”	12	12.24%
Patient’s condition cannot benefit from music therapy or music therapy is ineffective or not needed	7	7.14%
Patient wants quiet or privacy	7	7.14%
Patient is asleep	5	5.10%
Patient is confused or unstable	3	3.06%
Patient does not want “entertainment” or music	3	3.06%
Music will increase emotional sensitivity	2	2.04%
Religious beliefs of patient or family	2	2.04%
Patient does not want therapy	2	2.04%
Patient wants to reschedule	2	2.04%
Patient does not want to share music (i.e., uses personal iPod)	2	2.04%
Patient is already coping well	2	2.04%
Patient is waiting for discharge	2	2.04%
Caregivers are too stressed	2	2.04%
Parents or staff are skeptical	1	1.02%
Patient chooses medication to alleviate symptoms	1	1.02%
Patient doesn’t want to disturb others	1	1.02%
Patient is too sad	1	1.02%
Patient is unable to hear music	1	1.02%

Respondents were asked if they have found their approaches to patient in medical settings to influence acceptance and declination rates of music therapy. Of the 122 who answered this question, 81.97% of respondents answered yes ($n = 100$), and 18.03% answered no ($n = 22$). The respondents answering yes were asked to provide descriptions of the approaches that they have experienced to influence the acceptance and declination of music therapy by medical patients. Approaches that increased acceptance rates of medical music therapy were provided by 95 respondents, and approaches that decreased acceptance

rates of medical music therapy were provided by 81 respondents. See Table 13 for descriptions of approaches to increase acceptance and Table 14 for descriptions of approaches to decrease acceptance. Similar responses were consolidated for the tables.

Table 13

Approaches to Increase Acceptance of Medical Music Therapy Services

Descriptions of Approaches	Frequency	Percentage
Explain role of music therapy, reason for referral, or treatment context	32	33.68%
Introduce by first conversing with patients or families to build rapport and assess needs	26	27.37%
Explain how music therapy can address patient's and family's concerns	23	24.21%
Offer choices (e.g., times, music preferences, interventions) and adapt	15	15.79%
Approach gently, subtly, or genuinely	13	13.68%
Match patient's energy level and need with approach and check-in regularly	12	12.61%
Offer patients to "give it a try" with no commitment	11	11.58%
Lead with or emphasize music rather than therapy	10	10.53%
Screen patient prior to initial session (i.e., chart review)	9	9.47%
Disclose the source of the referral for music therapy	7	7.37%
Offer a fixed choice and appointments (e.g., "music therapy now or at 2:00?")	7	7.37%
Introduce instruments to younger patients or enter room with instruments	5	5.26%
Assure patient that session will not be too long	4	4.21%
Be introduced by colleague who has rapport with patient	4	4.21%
Ask patients about interests and background or "sit" with patient	3	3.16%
Introduce services prior to initial session	3	3.16%
Facilitate a sense of control or autonomy about their treatment	3	3.16%
Follow-up if patient or family declines initially	3	3.16%
Be available and present	2	2.11%
Explain that patient does not need to be musical or engage actively	2	2.11%
Cotreat with other professionals	2	2.11%
Have a high standard for musical and counseling skills	2	2.11%
Be an advocate for the patient's needs	2	2.11%
Speak with easily-understood terms to the patient and family	2	2.11%
Limit yes or no questions or choice	2	2.11%
Wake patient if it is appropriate	1	1.05%
Offer to "sit with" the patient or family	1	1.05%

Explain what music therapy is and is not	1	1.05%
Approach enthusiastically	1	1.05%
Adapt approach dependent on age	1	1.05%
Begin with preferred music	1	1.05%
Be aware of body language	1	1.05%
Offer to provide a relaxing environment	1	1.05%
Offer session as a mutual benefit to patient and therapist	1	1.05%
Offer educational printed materials prior to initial session	1	1.05%
Do not offer false promises or pedal services	1	1.05%
Be culturally aware	1	1.05%
Explain how services are paid for	1	1.05%

Table 14*Approaches to Decrease Acceptance of Medical Music Therapy Services*

Descriptions of Approaches	Frequency	Percentage
State that patient needs music therapy or be too persistent or rigid	11	13.58%
Do not explain music therapy or give vague description	11	13.58%
Have a poor attitude, be distracted, or have little insight	10	12.35%
Overexplain services or overwhelm with information	8	9.88%
Do not provide choices or have little flexibility	6	7.41%
Bring guitar or other instruments into the room during initial introduction or lead with and offer music	6	7.41%
Allow other staff to introduce services	5	6.17%
Solicit services	5	6.17%
Ask if patient wants services	4	4.94%
Offer session at a difficult time for patient or be interrupted during introduction or explanation	3	3.00%
Be inconsistent with scheduling	3	3.70%
Allow patients or families to have unrealistic expectations	3	3.70%
Do not follow up if patient first declines	3	3.70%
Misunderstand cultural traditions and beliefs or language	3	3.70%
Do not communicate with patients or families	2	2.47%
Have poor boundaries or little differentiation with other professions	1	1.23%
Have no opportunity to build rapport	1	1.23%
Have poor proximity to patients with difficult hearing	1	1.23%
Receive inaccurate referrals	1	1.23%
Have weak musical and/or counseling skills	1	1.23%
Be too enthusiastic or eager	1	1.23%
Be unable to explain interventions or services when asked	1	1.23%
Emphasize therapy over music	1	1.23%
Focus only on clinical reasons for therapy rather than ask how patient or family is doing	1	1.23%
Offer services in a way that invites declination (i.e., "We could let them sleep")	1	1.23%
Be timid or tentative	1	1.23%

When asked if they found some patients to be unaware of what music therapy is in medical settings, 100% of respondents answered yes ($n = 122$). When asked if patients in their hospitals were informed about the role and purpose of music therapy before they attempt to conduct an assessment session, 51.30% of respondents answered no ($n = 59$), and

48.70% answered yes ($n = 56$). Respondents were then asked to indicate their perceptions of the relationships between patient and family education of music therapy services and their tendencies to accept or decline services in medical settings. When asked if patients or families who are aware of music therapy practices accept services more often, 37.29% agreed ($n = 44$). When asked if patients or families who are aware of music therapy practices decline services more often, 44.92% disagreed ($n = 53$). When asked if patients or families who are not aware of music therapy practices accept services more often, 49.57% neither agreed nor disagreed ($n = 58$). When asked if patients or families who are not aware of music therapy practices decline services more often, 40.17% neither agreed nor disagreed ($n = 44$). See Table 15 for all results.

Table 15

Perceptions of Relationship Between Music Therapy Education and Service Acceptance

Relationship ^b	Rankings ^a						
	1	2	3	4	5	6	7
Awareness:							
Accept ^c	0	2	2	20	23	44	27
Decline ^d	31	53	10	23	0	1	0
No awareness:							
Accept ^e	5	18	15	58	10	11	0
Decline ^f	2	10	11	47	22	17	8

^a Rankings included 1 (strongly disagree), 2 (disagree), 3 (slightly agree), 4 (neither agree nor disagree), 5 (slightly agree), 6 (agree), and 7 (strongly agree).

^b Relationship of level of awareness of music therapy to tendency to accept or decline services.

^c “Patients or families who are aware of music therapy practices accept services more often.”

^d “Patients or families who are aware of music therapy practices accept services more often.”

^e “Patients or families who are aware of music therapy practices accept services more often.”

^f “Patients or families who are aware of music therapy practices accept services more often.”

Concluding Questions

This section included three open-ended questions to allow respondents to express related thoughts that were not addressed by the survey and to give an opportunity to accept or decline an invitation to participate in a follow-up interview. Respondents were asked what other information they would like to provide regarding the topics of the survey. Additional topics were provided by 46 respondents. See Table 16 for their responses grouped by theme. Respondents were asked if they would like to be considered for participation in a follow-up interview concerning the topics addressed in the survey. Of the 119 respondents who were asked, 55.46% of respondents answered yes ($n = 66$), and 44.54% of respondents answered no ($n = 53$).

Table 16

Additional Topics of Interest Expressed by Respondents

Topics Expressed by Respondents
<i>Theme 1: Need for advocacy and staff education about music therapy</i>
Need for more advocacy and education about music therapy ^a
Need for differentiation between music therapists and other professions that use music
As music therapy awareness increases, demand increases
Music therapy is often misrepresented when music therapist is not present ^b
Education in hospitals is difficult due to the fast-paced nature of the environment and turnover of staff ^b
Need to provide education about music therapy to general public
Staff with little exposure or education of music therapy perceive it as entertainment
Proactive education of music therapy is more effective than defensive education
Sharing patient stories is a great tool for advocacy
Less awareness of music therapy by staff if music therapy is not an established department
Need to show the unique benefits of music therapy that other disciplines cannot deliver
Need for music therapists to be present and seen by medical teams during rounds, in chart documentation, and in-services
Effectiveness of respected physicians as advocates for music therapy
Need for other professionals to be educated about music therapy during pre-professional training

Topics Expressed by Respondents

Theme 2: Needs of music therapists

Need for inclusive and standard source of information for medical music therapy and handbook with agreed terms and interventions
 Need for music therapy specific programs and protocols
 Need for discussion of better practices for termination of medical music therapy services
 Need to seek council from other medical music therapists
 Need for administrative support for medical music therapy ^a
 Lack of support for music therapy as evidenced by low pay and termination of programs
 Size of music therapy program in relation to hospital size and caseload affects services ^a
 Music therapist attitude and relationship with staff greatly affects referrals
 Music therapists may have to provide services outside of their job descriptions to build staff rapport while not being seen as ancillary or non-clinical

Theme 3: Factors related to acceptance and declination of services

Readmission of patients receiving music therapy provides continuum of care and increases acceptance of services ^a
 Ages and personalities of patients and families and therapists affect relationships and approaches used ^a
 High variation in quality and occurrence of how patients are informed about music therapy
 Patient declination of services can be empowering and should be respected
 Patients may initially decline services reflexively or impulsively
 Music therapists may not know the level to which patients or families are educated about music therapy
 Declination of services can be due to many factors, not because the patient does not want music therapy ^b

Other related topics

“Inappropriate” referrals for music therapy are still effective
 Current study being conducted on referral patterns to music therapy in a medical setting
 Need for more studies in these topics
 Music therapists leaving profession due to feeling unappreciated and disrespected as well as burnout
 Hospice settings should be considered for these studies ^a
 Some medical settings mostly use self-referrals for music therapy

^a Topic expressed by two respondents.

^b Topic expressed by three respondents.

Summary of Survey Findings

This section reiterates the main findings of the online survey and discusses implications of the data. The findings are presented in four main categories: (a)

demographics of medical music therapists, (b) referrals in medical music therapy, (c) patient acceptance and declination of music therapy services, and (d) additional information.

Demographics of Medical Music Therapists

Women comprised the largest portion of the music therapy workforce in the United States. The total responses in the AMTA (2019) Member Survey and Workforce Analysis included 87% women (12% men); however, the demographics of the eligible participants of this study found an increase in the number of men (17%) in relation to the number of women (80%), suggesting that in the field of music therapy in the United States, more men worked in medical settings when compared to the field as a whole. A similar difference was noted in relation to participant ages; a majority of respondents in the 2019 AMTA Member Survey and Workforce Analysis indicated a majority of music therapists in the United States in the 20–29 year age range, while a majority of eligible participants were found to be of the 30–39 year age range.

It was also noted that when comparing the level of education music therapists have obtained in the United States, similar differences were found between the 2019 AMTA Member Survey and Workforce Analysis and the demographics of eligible survey respondents. According to the 2019 AMTA Member Survey and Workforce Analysis, a majority of music therapists practicing in the United States are doing so at the undergraduate level (49%). The survey results indicate that a majority of music therapists working in medical settings and who responded to this survey have obtained, at minimum, a master's degree specifically in music therapy (45%).

Referrals in Medical Music Therapy

A majority of music therapists working in medical settings indicated that they receive referrals to provide services from other healthcare professionals. Respondents to the survey indicated that receive referrals from a number of other healthcare professionals in medical settings, with the most common sources of referrals being nurses, social workers, and physicians. Respondents also indicated a number of referral reasons for medical music therapy services, with the most common reasons being to address anxiety, to cope with chronic illness, and to normalize the hospital environment.

A majority of respondents also indicated receiving inappropriate referral reasons for medical music therapy services from other healthcare professionals, with the most common inappropriate reasons including those unrelated to any acute or chronic physical or mental health concerns. The most common sources of what respondents considered inappropriate reasons for medical music therapy referrals were named as nurses, physicians, and social workers—an identical list to the most common sources of music therapy referrals overall, indicating that inappropriate referrals to medical music therapy could be a common experience for medical music therapists.

A majority of respondents specified providing in-services or other types of staff education about music therapy to increase the frequency and quality of referrals they receive in medical settings. The most common settings indicated by respondents for educating staff members about music therapy included both formal and informal educational experiences. Respondents indicated the professionals for whom they provide education about music therapy in medical settings, with the most common being nurses, social workers, and physicians—again, an identical list to the most common sources of music therapy referrals. A

majority of respondents also indicated they believe music therapy has been misunderstood or misrepresented by other healthcare professionals in their hospitals. Even with these challenges, most respondents indicated that they believe their ability to provide music therapy services to medical patients is not hindered by the referrals they receive.

Patient Acceptance and Declination of Music Therapy Services

A majority of respondents indicated experiencing declination of music therapy services by medical patients or families during their careers. The most common reasons respondents indicated for receiving declination of services from patients and families included social reasons for declination (i.e., visitors or disinterest in music). A majority of respondents also believed that their approach to patient and families in medical settings influences their acceptance and declination rates of music therapy services in their hospitals. Respondents considered the approaches they have found to either increase or decrease acceptance rates of music therapy services in medical settings. The most common approaches respondents found to increase acceptance were related to the provision of education about music therapy in treatment contexts for patients and families who show initial hesitance. Alternatively, respondents noted the most common approaches to decrease acceptance of services are related to music therapists' rigidity or paying little attention to patients' needs.

All respondents suggested that medical patients and families may be unaware of what music therapy is in their hospitals, and a majority of respondents indicated that patients and families are not informed about music therapy before attempting to conduct an assessment session, further suggesting a need for medical music therapists to be able to provide sufficient yet efficient education to general populations. A majority of respondents also agreed with the statement that medical patients and families who are aware of music therapy

accept services more often and disagreed with the statement that medical patients or families who are aware of music therapy services decline services more often, indicating that exposure to music therapy may influence patients and families to experience music therapy themselves.

Additional Information

Many respondents provided additional topics of interest related to referrals for medical music therapy services and patient acceptance and declination of these services and a number of suggestions for future research. The topics expressed by respondents related to four themes: (a) a need for advocacy and staff education about music therapy, (b) the needs for music therapists working in medical settings, (c) factors related to patient acceptance and declination of music therapy services, and (d) other related topics. A number of these topics are explored in Chapter 6.

Chapter 5: Interview Results

This chapter will report the results of the four interviews conducted with MT-BCs who indicated interest in the interviews on the corresponding survey to this study. The participants represent each of the three settings focused upon in this study: adult medical hospitals, children's medical hospitals, and Veterans Health Administration medical centers. The interview participants have been given pseudonyms to protect their identities: Simon, Priscilla, Frederick, and Samantha. The results presented below have been sorted into five content areas based on themes and subthemes uncovered during analysis: (a) Staff Perceptions of Music Therapy, (b) Patient and Family Perceptions of Music Therapy, (c) Referrals in Medical Music Therapy, (d) Patient Acceptance and Declination of Music Therapy, and (e) Music Therapist Resilience and Resources. The themes and subthemes are represented in Table 17 by content area.

Table 17

Themes From the Interview Data Categorized by Content Area

Content Area	Theme	Subtheme
Staff Perceptions of Music Therapy	There is a need for more staff education about and exposure to music therapy.	There are varying levels of receptivity to music therapy among staff.
		Staff understanding of music therapy is related to their experiences with music therapy.
		Staff misunderstandings about music therapy are sometimes related to a lack of knowledge about music therapy scope of practice.
	Music therapists need to proactively educate staff about music therapy.	Music therapists need to be accessible and visible in hospitals to increase exposure.
		Education about music therapy can be formal and informal.
		Educating staff about music therapy benefits music therapy practice.
		Music therapists may find allies within hospitals to increase advocacy.
		There are barriers to educating staff about music therapy.
Patient and Family Perceptions of Music Therapy	There is a need for more public education about and exposure to music therapy.	Patients and families may not have a complete understanding of music therapy.
	Music therapists need to proactively educate patients and families about music therapy.	Patients and families are exposed to music therapy in a variety of ways.
Referrals in Medical Music Therapy	The quantity of referrals music therapists receive may affect patient care.	Music therapists must seek referrals to provide services.
		Music therapists must be able to triage and prioritize referrals.
	Music therapists receive referrals in a variety of ways.	Music therapy referrals can be automatic based on diagnoses and conditions.
		Music therapists can receive referrals from staff.
	Referrals can provide implications for music therapists.	Low referrals for music therapy indicate a need to re-educate staff.
		Ineffective referrals are opportunities to educate staff.

Content Area	Theme	Subtheme
Patient Acceptance and Declination of Music Therapy	Patient-music therapist relationships affect patient acceptance of services.	Music therapists must consider patient needs and preferences when offering services.
		Giving patients and families insight into the music therapy process increases acceptance of services.
	Patients' first exposure to music therapy significantly affects their perceptions.	Music therapists alter their approach to patients depending on population.
		Patients and families may be introduced to music therapy through other professionals.
	Music therapists should respect patient autonomy and choice.	Music therapists should assess the reasons patients decline services.
		Music therapists often follow-up with patients after an initial declination.
		Music therapists should ensure patients and families can make an informed decision about care.
Music Therapist Resilience and Resources	Music therapists must practice resilience and assertiveness.	
	Music therapists need access to shared ideas to supplement practices.	

Interview Participant Demographics

Interview participants were selected based on varied characteristics to achieve triangulation of experiences from the number of survey respondents who indicated interest in participation in a follow-up interview. The interview participants include four individuals representing various distinct regional locations and years of experience in medical music therapy settings including adult medical hospitals, children's medical hospitals, and Veterans Health Administration medical centers. Each participant was given a pseudonym to protect their identity: Simon, Priscilla, Frederick, and Samantha. See Table 18 for a condensed look at participant demographics. No individual demographic information has been paired with any pseudonyms to avoid indirectly identifying the participants.

Table 18*Interview Participant Demographics*

Demographic	Category	Frequency	Percentage
Gender Identity	<i>Female, Woman, or Feminine</i>	2	50.00%
	<i>Male, Man, or Masculine</i>	2	50.00%
Age Range	<i>21–29</i>	1	25.00%
	<i>30–39</i>	3	75.00%
Ethnicity	<i>White</i>	4	100.00%
Region	<i>Southeastern</i>	2	50.00%
	<i>Great Lakes</i>	1	25.00%
	<i>Western</i>	1	25.00%
Level of Education	<i>Master’s Degree in Music Therapy</i>	4	100.00%
Medical Experience	<i>6–10 Years</i>	2	50.00%
	<i>1–5 Years</i>	1	25.00%
	<i>11–20 Years</i>	1	25.00%
Medical Setting(s)	<i>Adult Medical Hospital</i>	3	75.00%
	<i>Children’s Medical Hospital</i>	3	75.00%
	<i>Veterans Health Administration</i>	1	25.00%
Other Specializations	<i>Neurologic Music Therapy</i>	3	75.00%
	<i>NICU Music Therapy</i>	2	50.00%

Content Area: Staff Perceptions of Music Therapy***Theme: There is a Need for More Staff Education About and Exposure to Music Therapy***

Music therapists have experienced varying levels of understanding of music therapy by other healthcare professions. The participants discovered that many elements, including previous experiences and general interest in the field, may affect individual staff members’ receptivity toward music therapy in hospitals.

Subtheme: There are Varying Levels of Receptivity to Music Therapy Among Staff. Music therapists encounter varying reactions to music therapy from healthcare professionals. Samantha suggested that differing personalities and previous experiences from training and education could affect an individual’s initial receptivity and understanding of music therapy.

I found that with anything, somebody is going to have a greater interest in my job than somebody else. I've had experiences with residents who have shadowed me or been involved in a session before that have asked amazing follow up questions, wanting to know more about my therapeutic decision-making process and things like that. I've had other residents who kind of take things more at face value, and they are still experiencing more surface level responses, where they're like, "Wow, I've never seen that patient smile before."

Samantha also found that—because music therapy had been established at her hospital for 20 years—each attending physician at her hospital she had encountered had some previous experience with music therapy in some capacity; she stated that some of these attendings have become advocates for the field of music therapy. Contrastingly, Samantha also found that residents of her hospital have generally been more open and thoughtful about learning more about music therapy and suggested that their similar ages may have made the residents more receptive to learning from her.

Music therapists have also encountered hospital staff who have understood and supported music therapy after their first experiences with music therapists. Samantha stated, "I would say, generally speaking, we're very well received." While Frederick has never asked staff members about their understanding of music therapy, he believed that the nursing staff he worked with who experienced music therapy sessions with patients had positive associations with music therapy. "I've never asked any of [the nursing staff] here, but I think like nurses and [Licensed Vocational Nurses], they probably kind of get it on some level." Priscilla's suggested that for some staff, a quick explanation about music therapy can greatly

increase their awareness about music therapy. “I think some of them get it right away when you just say one little sentence.”

Subtheme: Staff Understanding of Music Therapy is Related to Their Experiences With Music Therapy. Participants agreed that staff understanding of music therapy is dependent on the staff’s experiences with music therapy. Participants suggested that exposure to music therapy through co-treating positively impacted other professionals’ perceptions of music therapy by supplementing their own work and increasing the ease of their own treatments with more novel experiences for patients. Samantha described some of her work co-treating with physical therapists, occupational therapists, and speech therapists.

They all have pretty much experienced at least one music therapy procedural support experience before. They very much recognize and support that having music therapy present is going to make their job easier and more effective than if we weren't there. However, some of the benefits music therapists perceived staff finding in their work were not always related to the effectiveness of music therapy. Frederick noted that he believed some staff thought music therapy meant that they were able to take a break from their own work.

Participants have also discovered that staff perceptions and understandings of music therapy is shaped by the settings or units in which they have experienced or observed music therapy. Samantha noted that she had experiences with NICU nurses who, after observing her sessions with NICU patients, were surprised to learn that she uses active interventions with general pediatric patients.

I think the differences of perceptions are very natural, because if you were just a staff member walking down the hallway and you peek your head into a room and saw a music therapy experience, what you would see happening in the NICU compared to

our general pediatrics floor, they look wildly different... That has shown me how the differences in our interventions and some of the goals that we're working towards help to kind of fuel those different perceptions. I think as long as I'm aware of that, it makes it easier just to have those conversations with people.

Samantha distinguished between different units and their individual tendencies to refer to music therapy for specific reasons.

Our pain team is great; they will send me all sorts of consults for like nonpharmacological pain management or for helping with relaxation... Whereas our child life specialists, they know music therapy so well here that they'll give me referrals for a lot more nuanced situations because they have a different insight than some of the other professionals... Our palliative care team is also really good at thinking long term.

Priscilla also noted differing patterns between various units and positions and their perceptions of how music therapy is integrated into treatment plans based on the referrals reasons she has received.

Nurses—if they put a referral in the system—it's usually for a long-term patient, a patient who has had a long hospital stay... If nurses are referring [in person], it's usually for more acute concerns, like agitation or confusion or anxiety or something like that... And then the doctors, because they're psychiatrists, they usually refer for depression or anxiety.

Samantha additionally found that the amount of time she spent on each unit affected the quality of the referrals she received. She noted the differences in the quality of referrals she received from units at her hospital where she provided less music therapy services.

I think that I would receive very thoughtful referrals more often from our rehab therapies if I provided slightly more coverage on the units that they work more primarily on... There's still lots and lots of opportunity for more of those thoughtful referrals, but I just I can't be on all the places.

Frederick has found success in facilitating experience-based education for healthcare professionals to educate about the positive effects of music therapy. He described an instance when he was able to provide an experiential for medical staff in which they participated in music therapy-based interventions for stress reduction.

Subtheme: Staff Misunderstandings About Music Therapy are Sometimes Related to a Lack of Knowledge About Music Therapy Scope of Practice. Music therapists have discovered during their work with other healthcare professionals that some staff members are unaware of the education and training that music therapists receive or the scope of practice within which music therapists practice. Simon described his experience with educating a team of a behavioral oncology department.

The advanced practice nurses are psychiatrists as well, so they can do medicine as well as talk therapy. I was surprised even with them—me, assuming that they had a very well understanding of exactly what I do all day—a lot of them didn't really understand the depth and that there is research to back [music therapy] and that [music therapy] is clinical and evidence based. Some of them didn't even realize how much school we had to go through.

Priscilla noted that she believed some staff viewed her position as entertainment for patients even after she took time to provide further education about music therapy. “Others still think I'm there to entertain people.” Frederick also found that in facilities for which he

was hired in a position with a title other than “Music Therapist,” he more often experienced role confusion—many times being seen as an entertainer—by others even though he was hired to provide music therapy.

I think they kind of blend everything into “activities” and general things to keep [patients] occupied, things to keep them busy. But I do hope they understand that we're not just keeping them entertained and that there are therapeutic benefits to what we're doing.

Additionally, Samantha has experienced staff who believed that some patients may not be able to participate in music therapy because of their condition or that music therapy may work against a patient’s treatment plan. She explained how some of her experiences with nursing staff suggested that some healthcare professionals may believe that patients must participate actively to benefit from services.

I think the most common preconceived notions that we come across is that the patient needs to be active. They need to be able to actively participate. They need to be alert and oriented and that they need to be in a positive mood in order for us to be able to come in... Perhaps they have an IV in one hand and a pic line in another and it's a four-year-old and so they have little braces and “no-nos” that prevent them from being able to take them off or take them out.

Theme: Music Therapists Need to Proactively Educate Staff About Music Therapy

Music therapists approach educating staff about music therapy in a variety of ways. Participants have agreed that proactive and non-defensive approaches minimize potential confusion and misinformation about music therapy between hospital staff. Simon described a highly direct approach to assessing his need to educate staff while simultaneously facilitating

an opportunity to have a conversation about music therapy. “It's something that I just go ahead and try to just put out there—easy peasy, plain and simple to begin with. Like, even as far as to say, ‘What do you think I do?’” He has suggested that actively educating in this way has reduced his need to educate reactively to incorrect assumptions about the field of music therapy. Priscilla supported this view:

I think that's so important to have that attitude of being willing to happily and non-defensively explain your role and then ask, “How can I fit into what you're going through right now? What are you doing to help this patient? What works for you and how can I fit in and help?” I think so many people are defensive when they're met with people who don't understand, and it's so easy to be defensive when we have to defend what we do all the time... I think just being having a very open attitude and asking lots of questions from other people that you know.

Participants have also suggested that taking time to build personal and collaborative professional relationships with other staff members of their hospital has positively impacted staff receptivity to music therapy interventions. Samantha suggested that—especially with NICU nurses who tend to be more protective of patients—building rapport with staff decreases their hesitancy to trust music therapists’ professional judgement.

Especially in areas where nurses tend to be a little more protective, like the NICU or the pediatric ICU. Getting to know those nurses as people has been really paramount to then being able to say, “Listen, I know you're not comfortable with me doing this right now. But this is why I would like to try, and if for some reason the patient’s giving me any kind of sign that I'm the reason causing harm by all means, I will stop and that's okay.” In my experience, that's where I have built the strongest

relationships, especially with our NICU nurses. Now they're to the point where they see me down the hall and they'll come out of the room and say, "Are you coming here?" "I'll respond, "I wasn't, but do you want me to?" And they'll say, "Yes, come in right now,"... It is much harder for them to not hear what I have to say after that. Priscilla found that her professional relationships with other healthcare professionals have been strengthened when she was able to assist with their own interventions through procedural support music therapy. This in turn, she described, increased the likelihood of other healthcare professionals to consider music therapy in the future.

Subtheme: Music Therapists Need to be Accessible and Visible in Hospitals to Increase Exposure. Music therapists have described numerous opportunities to increase exposure of music therapy with other healthcare professionals. Participants suggested that visibility increased the chances of bringing music therapy services to units and patients that could benefit most from music therapy. Priscilla noted that being on the floor as often as she could increased her visibility with other healthcare professionals and her potential for being referred to patients with acute and immediate needs.

If you're on the floor as often as you can be, and a nurse says, "Please see this person right now," that's when you can really get in there and make a little bit of a difference in that moment and then work on a plan for future sessions. I think it's necessary to appear and kind of let yourself be known.

Roles in Departments and Participation in Interdisciplinary Teams. Some participants described how their positions within certain departments and communication with interdisciplinary team members have increased advocacy for music therapy within hospitals. Samantha and Priscilla expressed that their office spaces are shared with other

professionals within their departments and interdisciplinary teams and that their proximity with other healthcare professionals has eased their abilities to educate about music therapy and quickly spread awareness of services. Additionally, Priscilla shared that a music therapist supervises a department of clinical services in her hospital and that having a music therapist in a management position has greatly increased advocacy efforts in the hospital. Priscilla noted that the location of her office, which is central to the medical hospital of her healthcare system, has also increased her visibility with other healthcare professionals by allowing her to be more accessible.

Co-treatment and Observations. Participants agreed that co-treatment with other healthcare professionals has positively affected staff perceptions of music therapy. Simon found that staff members typically noticed benefits of music therapy as a support to their interventions. Samantha described co-treatment and observation opportunities in her hospital with palliative care, spiritual care, physical therapy, occupational therapy, and speech therapy and how these opportunities have increased support of music therapy in her hospital. “So, we’re very, very lucky here; music therapy is incredibly well supported by all of our team members and it’s very, very common to just collaborate on a lot of things.” She has also found that she is able to assume a supportive role in treatment with other healthcare professionals because of her previous experiences.

It’s for procedural support aspects too; I have great relationships with vascular access, phlebotomy especially because they might be getting ready to start a procedure or I’m already in the room and they arrived and I immediately know right then and there. I’ll think, “All right, we’re going to support through this blood draw, or we’re going to

support during this IV access.” They're usually very happy to see me either there already or arriving.

Priscilla mirrored Samantha's experience with co-treatment with wound care nurses.

I have done some co-treatment with the wound care nurses. They would be doing wound vac changes and some complicated wound care—really painful—and I would go in, and we would coordinate the times. I'd go in with them and provide positive distraction or pain management, things like that while they were doing that wound care. I felt like that was really helpful.

Priscilla also described the significance she has found in welcoming other healthcare professionals to observe the work of music therapists as well as in being humble enough to learn from those other healthcare professionals to support her practice.

I can think of some times where one of the other therapists or a nurse will walk in while I'm already in there. I'm always inviting people in... I think that's a really good way to for people to see exactly what you do and how it works... That's kind of good and I always use that opportunity to educate... I think, for the patient, speech therapy has so much knowledge, and they have really great ideas sometimes about creative ways of thinking about communication. Sometimes in that situation, if I find that maybe a patient that I'm seeing is also seeing speech therapy, and I'll ask the speech therapist if I can come shadow.

Samantha also suggested that inquiring with other healthcare professionals about their work with patients helps to facilitate educative opportunities for both music therapists and other staff members. She described opportunities during which she was able to learn from other healthcare professionals during co-treatment.

I was working with a baby in the NICU, and all of the things that I knew weren't working. A physical therapist arrived and she told me, "We want to change this baby's position because of these reasons," and I responded, "My goodness. Tell me more about this." I had the opportunity to ask so many more questions that ultimately, I was seeking her expertise on. I know a lot about music and calming and soothing and developmental aspects within music but this baby needed positioning. I'm not an expert on that so it's moments like that that I'm just like, "Yes, let's learn more about this."

Priscilla found a similar benefit in this inquiry that gave opportunities for other healthcare professionals to inquire about music therapy practices. She also described that facilitating an openness to communicate increases other staff members' receptivity to education about music therapy.

Anytime I've wanted to help people understand what I do, I always try to ask about what they do as well because I think everybody's passionate about something, and especially in healthcare. It makes for good conversation, and also you know that person really understands you after that and you really understand them. If they say something that you might be offended by, you know where it's coming from and you can kind of help that person understand, and they can help you understand. It's good for referrals.

Simon noted the importance also being visible electronically as a music therapist. By documenting music therapy sessions well and recording patients' progress in music therapy, he noticed that other healthcare professionals, including physicians, have been able to learn more about the effects of music therapy on their own time and with reference to patient

conditions they have direct experience with. Simon noted that some physicians who found interest in music therapy notes sought opportunities to observe music therapy sessions.

Subtheme: Education About Music Therapy Can Be Formal and Informal.

Music therapists encounter opportunities to educate other healthcare professionals about music therapy in both formal (i.e., presentations, grand rounds, etc.) and informal (i.e., elevators, hallways, etc.) settings and situations. Participants found that educational opportunities arise frequently in hospitals on situational bases. A common experience is when music therapists were able to educate staff members in response to a misconception or passive encounters in public hospital spaces. Simon provided a suggestion for music therapists to include common reasons for music therapy interventions in hospitals on their business cards to help facilitate educational opportunities that arise. He recounted the following situation in an elevator with another staff member:

I show my badge, and I say, "I'm a music therapist here. Let me give you one of my cards. Here's why I'll go to see people," and I have a list on the back of my card, all referral reasons for me to see anyone: to decrease agitation, confusion, anticipatory grief, combativeness, isolation. So then, once I start rattling those off, they're like, "Oh my God, you're not just a volunteer."

Participants also described formal settings in which they have provided education for staff about music therapy. Simon provided descriptions of music therapy cases and details of music therapy interventions he has found success with immediate outcomes immediate during rounds, staff meetings, and presentations. "Anything that you're sharing with any of these people that you could add your perspective on, a little bit deeper insight into how they're imagining the way that you're going about trying to help these people." Frederick

described participating in weekly and daily team meetings to report his perspective on patient care with other healthcare professionals. Priscilla also spoke about music therapists' participation in morning rounds every week at her hospital. Samantha also shared having many opportunities for formal presentations during pediatric grand rounds in which she shares her experiences with attending and resident physicians.

Additionally, Samantha stated that her hospital is a teaching institution, allowing her multiple opportunities throughout the year to provide education for medical students at their training institution. She also spoke about her passion for providing education about music therapy and admitted that she likely seeks out opportunities to educate other healthcare professionals about music therapy than other music therapists.

Subtheme: Educating Staff About Music Therapy Benefits Music Therapy

Practice. Music therapists have found that utilizing some time to educate staff about music therapy has resulted in positive effects in staff understanding of music therapy. Samantha provided her perceived relationship between her efforts to educate staff and the level of understanding she believes staff in her hospital have about music therapy. She also suggested that having an internship program at her hospital has benefited her abilities to comfortably provide education to staff about music therapy by modeling advocacy efforts for her interns.

But more times than not, people have a good understanding of music therapy and I really believe that it's because I take the time to educate people. I have to do that because I have interns with me all the time.

Subtheme: Music Therapists May Find Allies Within Hospitals to Increase

Advocacy. When music therapists in medical settings are able to build effective working relationships with other healthcare professionals, they may discover that those

professionals—especially physicians—can become great advocates for medical music therapy. Simon found that providing gentle conversations with other professionals about the purposes of music therapy builds trust and understanding and increases collaboration, often resulting in additional advocates and allies for music therapy and improved referrals for services. Samantha also found this to be true of physicians and nurse practitioners who have high levels of respect from other hospital staff members due to their statuses. “All of them are very supportive. They give us a lot of consults. And they also are great champions for us as well.”

Subtheme: There Are Barriers to Educating Staff About Music Therapy. Music therapists may not be able to interact with the numerous staff members that provide services in hospitals due to the high quantity of staff members, the shifts that staff members work, the time restraints of the busy environment, and the rotation of staff. Samantha and Priscilla both noted that it can be difficult to provide comprehensive education about music therapy for hospital staff because of the limited time staff members, including music therapists, often have for such activities. Because of the barriers to education about music therapy in hospital settings, Priscilla suggested that she has found the most success in educating staff when she is able to provide education in short and simple ways yet often.

I think short and sweet and often is what works for me. I tried, when I first started, to hold full in services and have experience-based education things for the nurses and social workers. I would type out all this stuff and laminate it and hang it in every nurse's station, hoping that they would read it. But the thing that has worked for me the best is just trying to fit myself into the meetings that are already scheduled because they're so busy. No one can get together for extra stuff. It's difficult. I try to

adapt to their schedule as far as meetings go, and I try to keep what I say in those meetings and in the hallway and the nurses' stations just as short and sweet as I can and let them know that I'm there to help them with what they're doing.

Content Area: Patient and Family Perceptions of Music Therapy

Theme: There Is a Need for More Public Education About and Exposure to Music Therapy

Participants noted that education about music therapy needs to be addressed community wide rather than remain focused within the hospital. Simon suggested that patients and families may be willing to share their experiences of music therapy with other patients and the community outside of the hospital, providing those without exposure to music therapy a look into what it is like. He also suggested that allowing patients to share their stories have the potential for therapeutic value while simultaneously educating the public about the profession. Simon also found that facilitating a discussion between patients about their experiences with music therapy can “make things normal, creative, and alive.”

Subtheme: Patients and Families May Not Have a Complete Understanding of Music Therapy. Music therapists perceive a varying level of understanding of music therapy by patients and families in medical settings. Participants indicated that patients and families often believe they know what music therapy is and are surprised by their experiences with music therapists. Generally, participants believed that patients and families often mistake music therapy or preconceive music therapy as entertainment before encounters with music therapists. Simon thought that patient misunderstanding of music therapy could be an effect of regional location and suggested that patients from rural areas may have less exposure to or understanding of music therapy. Samantha found that patient and families initially assume

music therapy simply involves listening to recorded music and are often alarmed when the music therapists offers live music and instruments.

Theme: Music Therapists Need to Proactively Educate Patients and Families About Music Therapy

Music therapists have found that patients in hospitals rarely have prior knowledge about or experience with music therapy. Priscilla commented, “It's rare that I'll meet [a patient] who knows about music therapy. Usually, people don't know about it. But it's not hard to explain, and they're mostly able to understand what you do and how it helps.”

Subtheme: Patients and Families Are Exposed to Music Therapy in a Variety of Ways. Music therapists have found that patients and families are first exposed to music therapy during hospitalization one of three ways: by the music therapist alone, by the music therapist with another healthcare professional, or by another healthcare professional alone. Participants suggested that there may be different benefits and disadvantages to each of these approaches. Simon discovered that when music therapy is introduced to patients and families during co-treatment with another professional that music therapy is typically received well by giving patients new experiences to achieve the same goals. Priscilla had a similar thought by facilitating a conversation with patients about music therapy to supplement treatment after observing occupational and physical therapy sessions.

I like to observe what the patient is doing with other therapies so that I can support that and so I can be the most effective. I will ask to shadow occupational therapy, physical therapy, or speech and just see what they're doing and then pick their brain afterward and ask the patient if they would like for me to come up with some ways to reinforce what they're doing in their other therapies.

Simon also noted that he typically facilitated a direct approach to combat misinformation about music therapy with patients by asking, “What do you (the patient) think [music therapists] do?”

Content Area: Referrals in Medical Music Therapy

Theme: The Quantity of Referrals Music Therapists Receive May Affect Patient Care

Music therapists have considered how the number of referrals they receive and the quantity of their caseload could affect their abilities to effectively provide music therapy services to patients. Participants discussed both the limitations that referrals have in providing services to enough patients in hospitals as well as the challenges of balancing too many referrals for services.

Subtheme: Music Therapists Must Seek Referrals to Provide Services. Some music therapists may feel limited by a referral-based system in hospitals. Participants described that there is often a need to seek referrals in medical settings, especially if referral numbers are low. Simon stated that he feels comfortable consulting staff members about the needs of patients to determine if there are any who could benefit from his services.

If I have a small team that gives me a very specific list, and those are the only people that I see, there might only be 10 people on that list, and eight of them say, “Come back later,” it's like, well, what do you do right now? I've always felt proactive, though; I never just want to sit and wait for a referral. If I have a half hour between sessions or a scheduled whatever, I'm gonna go see a nurse and say, “Who's having a hard time right now.” I'll go meet them and see if we can do something for 15 minutes.

He declared that this should be how music therapists work until music therapy is a normalized treatment in all hospitals.

I feel like as music therapists, we should never feel reactive. I feel like until things are so automatic and we are so entrenched in the system, we have to be out and about being seen and noticed and educating... You should never feel that comfortable in sitting in an office waiting for your next referral. Get out on the unit and go talk to some people. I guarantee you'll find someone that is having a hard time.

Priscilla shared this view with Simon:

I would love to have just referrals coming in without me having to do this, but a lot of times I'll just go say, "Is there anybody I can see today? Is there anybody with confusion, depression, anxiety, having a hard time managing pain?" I'll give them a little rundown and they'll usually send me to an appropriate person, and I'll assess the person and come back to that nurse and say, "I think I can be seeing her more often. Would you put in a referral?" And I have no qualms about asking for referrals, either. I think that's okay... I think that's necessary.

She also stated that by doing so, you may be able to treat patients while they are experiencing an acute need rather than waiting for a referral.

You really catch people patients in their moment of when they might need you the most if you're just randomly going over there. If someone sends you a referral for someone and they say she's anxious, you might see them the next day and they might not be in an anxious state like they were when the referral was sent.

Subtheme: Music Therapists Must Be Able to Triage and Prioritize Referrals.

When music therapists receive high amounts of referrals, it may be difficult to determine

which patients are experiencing the most immediate needs for services. Samantha noted the balance between her current caseload and new referrals.

Not only do I have to prioritize referrals that have come in, but I also have to prioritize who really needs me the most today, and that incorporates my entire caseload, everybody that I've been following throughout their hospitalization. I will start by looking into the new referrals or consults that have come through and kind of go through that process like I just described of trying to determine if those needs are imminent—are they time sensitive—and I will also weigh my caseload. I might look at all of our infants with neonatal abstinence syndrome. I look at their withdrawal scores every morning, and if they seem like they're no longer on morphine and they have very low withdrawal scores, I might not run there right now. Or I might see that they're really having a very hard time based off of their scores that I can check in their charts, I might go there first. And I also have to weigh who has been seen this week and who's not been seen.

Samantha also noted the potential negative effects that could occur if she were to attempt seeing more patients than would be therapeutically beneficial.

I wanted to determine if spreading myself so thin across all of our inpatient units was causing psychosocial harm to the patients that I established relationships with and then was not able to follow back up with... I had an example where I had an osteosarcoma patient who could not do physical therapy and she responded so much better when music therapy was there to support and to co-treat and there were times when I could not be there and I could not arrive, either on time or at all. And I really question in those moments if that is better or if it would have been better for her,

psychologically, emotionally, if we had never even offered that opportunity... And that is really what requires us to be so thoughtful about our prioritization. And there are times when I receive a referral, and I look and I see that they're going to discharge tomorrow or the next day. I then decide I'm just not gonna go.

Samantha also spoke about cases during which she had to inform referral sources that she may not be able to immediately follow up with a referral because of her caseload. However, there have been times when educating referral sources about her process of prioritization and triage has resulted in referral sources refraining from referring patients who could benefit from music therapy.

I think there's a pro and a con to that because the pro is that yes, a staff member might be able to see, "You're right. I never thought about that. That's fine. We're totally okay with you coming tomorrow." But the con is that if that happens frequently, then sometimes the nursing staff will say, "I didn't want to call you," because they know you're so busy. Then I actually have to re-educate and say, "Thank you so much for considering my caseload and I appreciate you being thoughtful about that, but please call me when this is happening because if I don't know this is happening. I don't know that I need to be there."

Theme: Music Therapists Receive Referrals in a Variety of Ways

Music therapists may receive referrals directly from other healthcare professionals through methods such as an electronic referral system or by in-person interactions.

Participants also described systems in which referrals for music therapy services have been automatically generated based on conditions and diagnoses of patients.

Subtheme: Music Therapy Referrals Can Be Automatic Based on Diagnoses and Conditions. Simon described his view that certain diagnoses are an immediate indication that a patient may benefit from music therapy services.

I can proactively go to see any of [the patients] just because they have a cancer diagnosis... We know that this is hard for these 10 reasons, and we can help with some of them... If they're admitted for any sort of cancer related pain, I feel like that's an automatic referral. The fact that they're inpatient at all from their cancer diagnosis is usually not for a good reason.

Samantha described the intake process of her hospital that included automatic electronic referrals based on the nursing admission assessment.

Our main referral system comes through the nursing admission process and we have a checklist of common reasons that somebody might benefit from music therapy. A nurse can screen through that form and check boxes if there are any identified needs... We have a couple of consults that are automatic; they are part of our power order system. If [a patient] comes in with a certain diagnosis, you automatically receive a consult. We get automatic consults for our infants with neonatal abstinence syndrome. We always know we're working with all those babies that have that diagnosis.

Subtheme: Music Therapists Can Receive Referrals From Staff. Participants also described referrals from other healthcare professionals that allow open-ended reasons for music therapy referrals. Samantha described consults for music therapy as “free form text of a physician” that indicate why they believe music therapy could be helpful on a case-by-case basis. Priscilla described a similar process for referrals at her hospital.

We are referred through the hospital's digital system, and we're referred the same way that people consult physical therapy or consult chaplaincy or consult any other service in the hospital. They're at the patient page on the computer and they press a little "add consult" button and they type in. As soon as you start typing in music, music therapy comes up and they click on it, and they can add a reason for referral... It's a fill in the blank, and they'll say, patients depressed patient, has low support, patient has a long hospitalization, or patient's confused and agitated, things like that.

Theme: Referrals Can Provide Implications for Music Therapists

Music therapists have been able to make inferences about the needs to educate staff about music therapy based on the referrals that they receive. Participants described indications of both receiving low volumes of referrals for music therapy as well as receiving those that have little information about a therapeutic need for services.

Subtheme: Low Referrals for Music Therapy Indicate a Need to Re-educate

Staff. Priscilla described her thought process related to the frequency of referrals she receives from specific units of the hospital. She concluded that low or no referrals from certain hospital units indicates that there could be an opportunity to educate the unit-specific staff about music therapy. She also found that there has been a positive effect of her ability to round on hospital units and the frequency of referrals that she receives from those units. "I received two pretty solid referrals from just like an hour and a half of rounding... When my census gets low, that's when I round the most." She also found that increasing the ease of the referral process in her hospital helped generate more likeliness of receiving referrals.

I thought it would be such a good idea if I just said, "Yes, physician signature required"... Then as I started working, I noticed that the nurses were more resistant to

refer if they knew it was going to go to a physician. I talked to some physicians about this, and they were under the impression that the only reason they were wanted to sign was that we were going to try to bill. Now I just say to the nurses, “Physician signature not required.”

Subtheme: Ineffective Referrals Are Opportunities to Educate Staff. Participants described needs to re-educate staff members about music therapy in response to misconceptions about appropriateness for music therapy. Simon suggested that it is a common experience for music therapists to need to be assertive to advocate for a patient’s access to music therapy when staff members think that music therapy may not be appropriate for some individuals. “Just be open with all of them and unafraid of anyone, even a doctor and say, ‘I know that I can help this person, even if just by just being a helpful person that has nothing to do with music.’” Samantha shared similar experiences.

It wouldn't be uncommon for me to have to perhaps re-educate a nurse about why I might be specifically helpful for that moment, even if it didn't necessarily meet their previously identified understanding of music therapy. If a nurse says, “Oh, no, they’re really agitated right now. I don't think it's a good time.” I'll say, “Well, actually, this is the perfect time for me.”

A nurse may say, “Oh, well, they can't really play any instruments with you,” because they don't have their hands available. Or they might say, “Oh, they just took like a sedative,” or “they have a PCA button and you know they might fall asleep in a little bit.” And just being able to say in those moments, “We will absolutely take note of those things, and we will work around them and will adapt ourselves, but here the reasons why I still want to go in right now.”

Priscilla also reiterated this with one of her experiences.

A lot of times I'll hear even after I explained what I do, [a nurse will] say, "Oh, [a patient] in room two is so sweet and they would just love to hear you sing." When someone says that to me, I say, "What are their issues that they're having trouble with?" I'll ask really specific questions before I go into the room because I don't want to waste anybody's time. It helps that I work in psych as well because sometimes they'll say, "You don't want to go to that room. He is so angry." And I'll say, "I need to be in that room."... I've noticed that it happens often that they want to refer me to rooms with happy people. They don't think I will be able to handle someone who's agitated or irritable or confused. But it's remedied very soon, because I think once I say, "Here's what music can do," then they're like, "I didn't think of it that way. Yeah, go there."

Contrarily, Simon also found moments when he needed to educate staff about reasons that may not be appropriate for music therapy referrals.

And often the referrals we may get reactively from staff are the "really nice" person ones, or the "bored" ones, or "they love music." This is also an opportunity to engage in a clinical conversation with the staff member to dig a little deeper while conversing about what descriptors I'm looking for with regards to an "appropriate" referral.

Samantha has found instances during which she has received insufficient referrals from physicians, that she is able to use those opportunities to speak with referral sources to clarify patient needs for music therapy while educating sources about appropriate referrals.

For the most part they're fairly gracious in saying, "This was our thought process," or, "In rounds today we thought this might be helpful," and more often than not just

getting that information is enough for me to say, “I trust that treatment plan or that judgment call. I’ll go ahead and follow up with this.”

Content Area: Patient Acceptance and Declination of Music Therapy

Theme: Patient-Music Therapist Relationships Affect Patient Acceptance of Services

Music therapists have discovered the need to be flexible in their approach to patients in order to provide an environment that evokes interest in music therapy while also maintaining an atmosphere that provides patients and families with the ability to make an informed decision about their care. When he has taken time to show patients that he has a genuine interest in their well-being by advocating for patients (e.g., assisting them when contacting their physicians), Simon has found that it becomes easier for him to consistently provide services to individual patients.

I’m an advocate also just for their just normal day to day existence inside the system and an ally all around... They understand I’m really just an extra layer of support; I’m here to help you in any way we can just get through this immediate thing that’s going on. But I can also be a consistent person that’s knocking on your door when things are great and when things are terrible. We don’t have to start from the beginning. Each time we can just press pause.

Simon provided an example of his flexibility as a music therapist, and stated that he believed sessions do not always have to be heavily music-based in order to provide patients the outlet he determines is needed in the moment. “[Sessions] don’t have to be super music based either. It can be more StoryCorps (StoryCorps, 2020) kind of. And since they’re adults, a lot of them are very talkative. They have a lot of stories. They want to share their wisdom.”

Priscilla actually found that leading with music, in some cases, helps to catalyze working relationships with patients.

I try to start with music as much as I can. Preferred music breaks the ice and helps with normalization and helps people feel more comfortable. I always try to start with music unless they're resistant, and then I do talk a little bit first. But I've noticed even the ones who are resistant that as soon as you start playing a favorite song, it changes a little bit at least.

Subtheme: Music Therapists Must Consider Patient Needs and Preferences

When Offering Services. Participants determined that music therapists should be able to assess patients' energy levels and the dynamics of the relationship in order to inform the approach they utilize in offering services to patients. Particularly with adults receiving chemotherapy, Simon spoke about ensuring patients do not feel “bombarded” by the music therapist. “If they think it's going to be something that's annoying, I don't want to start it out being with my guitar being like, ‘Hey!’ It's really just more about matching the scene.” He also suggested that patients may be conscious of time conflicts with other services while in the hospital. “You can even frame it with like a time limit, like ‘I’m only going to be here five or 10 minutes. If you hate it, no worries, I’ll see you later.’” Priscilla commented that, “There's a balance and little intuition necessary to when you go into a room and you don't know the person.”

Simon also considered that many patients may have received new or terminal diagnoses and are feeling anxious or scared, making it even more imperative to ensure music therapists are not contributing to increased nerves. He suggested that this may also provide an opportunity to, “Let them know in a gentle way that we're doing this for their family, that

they can access and listen to it whenever they want. It makes them feel kind of comfortable and relaxed knowing that they're getting some of this preserved.” He also found increased therapeutic alliance when he acknowledged these fears.

Yeah, and just really going head on into it with them. “I’m not afraid of this. I understand that you are.” Offering that affirmation in a proactive way can help stabilize some of the thoughts that are going on, like you’re going to figure something out today. That feels good for anyone to know... I feel like there's so many things that are like reacting to the illness as opposed to their humanity and their spirits. I feel like when we dive into that first we can bring out all those other physical ailments and even emotional ones, but it's by still being very proactive and not being afraid... And we can say, “I know that this is your first treatment. And I know that you might be a little nervous. I'm just gonna hang out just for a minute. You don't have to do anything. Can I get you something to drink? Would you like a warm blanket?” Setting up the room for success before I do anything. I feel like makes them understand that I'm not there to just bother them.

Subtheme: Giving Patients and Families Insight Into the Music Therapy Process

Increases Acceptance of Services. Music therapists have discovered multiple techniques to approach patients in ways that inform them of the role of music therapy in their care, increasing their likeliness of accepting services. Simon spoke about the positive effect of informing patients about the source of their music therapy referral.

I really like coming in with the clout of knowing their doctors as well. And I like to present it even quickly saying, “Hello, my name is [Simon]. I'm one of the music

therapists here. Your doctor and I were just talking, and he thought or she thought that you could use a little extra help today.”

He also spoke about providing patients with specific goals of music therapy interventions and quickly explaining why music therapy could be helpful for their condition. Samantha shared an identical thought:

I'm able to say, “Your nurse actually called me and said that you're really uncomfortable right now and you're dealing with a lot of pain. This is what I can do that might be helpful. Are you willing to give it a try?”

Samantha spoke about the effect of educating families of NICU patients to increase their comfort with music therapy by helping them to participate in the care of their baby.

I think in the NICU... it's providing education to the families about what we can do together. It's even more collaborative. “I'm here to help teach you some tools and resources if you're willing and if that's something that you think would be helpful and you're interested.”

With children, Samantha also discussed how she checks in with parents about their level of understanding about music therapy to determine how she is able to align with their preconceptions while providing additional education.

I might introduce myself and say, “I'm [Samantha]. I'm with music therapy. I wanted to come check in on you all. One of the other staff members thought that you might benefit from our services. Are you familiar with music therapy?” And a parent might respond, “No, but I feel like I can figure out what it is.” And right there it can kind of make or break getting your foot in the door, because if a family member has a very specific idea of what they think you are going to do, and the patient is not fitting into

that mold of what they think is going to happen, they're a lot more likely to just decline right there. Navigating how to politely provide education without diminishing them is really, really crucial... and saying, "Yes, I know that your kiddos really agitated right now and you want them to fall asleep. I can actually help with that."

Frederick discussed an educational approach with adults to differentiate music therapy from other music professionals, including music educators and performers. He has found success in diminishing patient's preconceptions that they would not be able to participate if they are not musical themselves.

I'll go into a very brief description and say... "I'm not a music teacher. I am not here to grade your music ability"... I think that puts a lot of people at ease. That's why I make the distinction... that I'm not a music teacher... and I'm not a performer, because I want them to participate.

Simon also found it helpful to assure patients that they are not expected to be musicians to participate in music therapy.

Even with adults that have had poor experiences in their own life with music who were told to mouth the words or, "You can't sing,"... and there's something lovely about that just feeling alive and that you still can do something, even when you're stuck in this place. But it's my job to figure all that out.

Theme: Patients' First Exposure to Music Therapy Significantly Affects Their Perceptions

Participants noted the importance of the introduction to music therapy that patients receive. Simon highlighted the importance of patients' and families' first introduction to music therapy. "I think that first meeting can either make or break how long you may spend with [patients], not just today, but even in the future."

Subtheme: Music Therapists Alter Their Approach to Patients Depending on Population. Participants described different approaches to introducing music therapy services to patients based on their ages. Samantha described how she approaches children and their parents simultaneously for her initial visit.

I think that I can assess a lot of how somebody is going to respond within the first 3 seconds of walking into the room, or sometimes I have the luxury of somebody's door is open, and I can look in and see what's happening. That usually helps me define how I want to go about engaging with the patient or with a family. If it's a younger kiddo and family's in the room, I will definitely engage with the younger patient and keep things very simple while also sharing some of what I do with the patient and with the family in a way that the parents understand that the patient is not going to necessarily pick up on. Whereas with a teenager, I'll be a lot more explicit and especially depending on the referral reason, I might tell them all of that right then and there, because they're able to comprehend, and they're going to be a lot more curious as too.

Frederick described how he has found success by focusing on the element of music when approaching patients with cognitive impairments and families of those patients at the end-of-life.

It may kind of depend on the resident. If the resident is a little bit more cognitively aware or higher functioning, I may briefly describe what music therapy is. If it's someone that you know does have some kind of cognitive deficit or dementia or something. I may just call it music so we don't have to get into some big long complicated discussion.

Subtheme: Patients and Families May Be Introduced to Music Therapy

Through Other Professionals. Music therapists have described occurrences when other healthcare professionals have introduced patients and families to music therapy services. Participants had differing opinions about the success of allowing others to introduce their services. Samantha suggested that, with patients in acute and medically fragile states, having other staff members introduce music therapy services before she arrives helps patients accept services.

In more acute and medically fragile situations, it is helpful to have had somebody say, “We’re going to have music therapy come by and introduce themselves to you,” because then I arrive and the families say, “Somebody said that you were going to come,” and then they might be more willing to say, “Tell us more about what this really is.”

Contrarily, Simon suggested that patient education of and exposure to music therapy should be facilitated by music therapists in order to decrease misinformation or confusion or music therapist’s roles.

Sometimes, [other healthcare professionals] have no idea that what they’re explaining to these people, what it is that we’re going to be doing. And they might say, “Oh, [Simon] is such a sweetheart, and he’s gonna come sing you a song,” and that is the opposite of what I’m going to come do. I think it is always great if the music therapist is the one introducing the work, as we don’t go around introducing what other medical roles are for the patient with expectations.

Theme: Music Therapists Should Respect Patient Autonomy and Choice

Music therapists have noticed that there is a balance between respecting patients' rights to make informed decisions about their care. At the core of this right is patient autonomy, something that can be strengthened when patients are able to decline music therapy services; however, participants have also discovered that educating patients further by providing details about how the service strengthens their personal treatment plan or by demonstrating some of these effects, patients often then choose to accept music therapy services.

Subtheme: Music Therapists Should Assess the Reasons Patients Decline Services. Participants discussed the significance of determining the reasons patients decline music therapy services. Priscilla discussed that doing so could help music therapists determine a need to follow-up with patients.

A lot of times they will say no because they say they just feel terrible, and my response to that is, "Sometimes when you're feeling your worst is the best time for us to be together because music can be really good for positive distraction." Sometimes I think that it's because they don't know what I do, because it's my first time meeting them. Sometimes I think it is just because they just feel really bad, and they don't want to interact, and I can definitely respect that... If I go back another time and talk with them when they're not feeling so bad, then they're able to understand exactly how we can work through that together if they feel that way the next time I come in. That's helpful to for them to kind of process that when they're not feeling so terrible.

Samantha found that in children's hospitals, parents are often the ones who decide if patients will receive music therapy services. She noted that parents most often decline music

therapy services when the patient is agitated or has not slept, but she has also found that parents sometimes decline services because of the word “therapy.”

Occasionally, I might have a family decline because we use the word therapy. They might not be as open to the psychosocial component. And for the same reasons, they might decline psychology or something like that.

Subtheme: Music Therapists Often Follow-up With Patients After an Initial

Declination. Music therapists have also found that following up with patients after an initial declination of services may open patients and families up to possibilities that enhance their recoveries and experiences in the hospital. Simon noted that, especially for patients who have been resistant to any treatment, it may be more necessary to utilize music therapy as a service that has the potential to increase a patient’s participation in their own care.

Now they might just be resistant to everything. They're going to say no to everything. And that's the real reason why you need to sort of break in to that scene just to try it out. But even then, to me it's okay not to have this.

Samantha shared that she will leave her contact information with patients and families after an initial declination of services to give individuals time to consider music therapy and to reach out when they are ready to participate in such services.

I usually will leave my contact information should they change their mind, and I always ask if it's okay to continue to see like to follow up with them to check in to see how they're doing. Especially with families of teenagers, who often say, “No, I really don't want this,” I'll check in with a teenager and say, “You know, we don't have to do music, but is it okay if I come by in a couple days just to say hi to see how you're doing?” I'll kind of strategize in ways that communicate some kind of follow up.

Priscilla noted that knowing when she should follow-up with patients about music therapy services requires some intuition. She provided an example where she immediately followed-up with a patient by offering one song as a way for the patient to determine if they were interested in a session.

We had two new patients today, and they both said no right away. One patient who said no, I got this feeling not to push. I said, "I'm going to try to come back and see you tomorrow," and asked her what her favorite music was and said that I would see [them] tomorrow. Then the next one... He said, "Not today," and I said, "Well, why don't you just give me an audition. Let me just play one song," and sure enough he was crying. He asked for four more songs, and we had this great conversation. It was wonderful.

Subtheme: Music Therapists Should Ensure Patients and Families Can Make an Informed Decision About Care. While music therapists have found that additional prompting or giving time to patients and families has increased their acceptance of music therapy services, music therapists have also determined that providing a chance for patients to exercise autonomy in their care. Participants have noted that there can be therapeutic power in being given the choice to accept or decline a service that is often uncommon in hospitals. Priscilla discussed that there is a limit to how often a music therapist should follow up with patients so that patients do not feel pressured to accept services they are uninterested in.

I don't make someone say no more than two times. That's my personal rule... If I get persistent no's, usually about the third or fourth time, I'll just sit down with them and say, "Here's what I do. Here's how I think it could help you, but if you are not into

that, that's okay. But I need to know if you want me to not come back again and I'll say that's okay. This is probably the only thing you can say no to in the hospital” and I'll try to lighten it up that way.

Samantha also experienced families finding relief in her willingness to allow space for declination.

It has only happened to me a couple of times where it was clear in the moment that the family did not want me to come back, and I was very explicit in those moments by saying, “It seems like having me be here is making you a little bit uncomfortable. You do not have to participate in music therapy, and I will not be offended if you do not want me to come back. Would you like for me to no longer check in on you?”

The families would respond, “Yes, thank you; so many people come by and we just want a little bit more personal space.” And I respond, “Fine with me. I'm still supporting you by honoring that, that's fine.” I'm okay with those situations as well.

Simon reiterated this stance as well. “If I can help them articulate that without them feeling bad about it, I feel like we've come to a place of understanding that shouldn't hurt either of our feelings.” He approached this by empathizing with the patients:

I realized, coming from their perspective, look at all the people coming into their life every day. How many of them are giving a choice to be in there? This is a door to their room, but it's actually their whole world right now. And they feel gross and they might just not be in the mood right now.

Content Area: Music Therapist Resilience and Resources

Theme: Music Therapists Must Practice Resilience and Assertiveness

Music therapists must often practice resilience in their work, particularly while educating others (and many times, re-educating others) about the field of music therapy and its benefits to patient populations. Frederick suggested that, as music therapy is a relatively newer healthcare field compared to other modern healthcare professions, an increase of public education and advocacy should be a priority for music therapists. Simon agreed and stated that this will be the norm for music therapists, “Until there's a statewide license in every state and until we're paid just like any other psychotherapist or counselor or clinical therapist,” while comparing the development of music therapy to that of psychology. He also warned music therapists about the potential harm that can occur for the field if music therapists react defensively in response to misconceptions about music therapy.

I think that even though it's irritating, we can sort of get bent out of shape and have a chip on our shoulder and feel, in any way, stubborn and have a negative point of view, I feel that only just harms our field... Probably 10 years ago, I was like, “This is just part of the gig.” And it really is. And once you get into that sort of groove with it, it doesn't beat you up as much as it did when you're young. You're not disappointed automatically that someone doesn't know what it is... I don't know what a lot of people do.

Related to dealing with misconceptions about music therapy, participants also noted that developing an ability to be assertive when educating other healthcare professionals is a significant aspect of their work. Priscilla stated, “I think it's good to be a little bit assertive and try to let people know what you do as frequently as you can.” Simon noted the

importance of this when speaking to any healthcare professional and stated, “Don’t be afraid to be articulate with all of these people, whether they’re a doctor and nurse, all the way down to environmental services and who else.” Priscilla also described a sense of gratitude in seeking opportunities to educate others and experiencing receptivity from others:

I think it's so important for medical music therapists specifically to develop an attitude of... grateful helping of others to understand what you do but also asking lots of questions about what other people do and how you fit—your role in that care.

Participants also described the importance of music therapists’ resilience in relation dealing with declination of services by patients. Simon disclosed, “Dealing with that decline to me was like an eagle bruise at first,” and then realized that when patients declined music therapy that, “It's nothing personal, and I don't think it's personal about the field, either.” He also spoke about getting to a place as a music therapist to understand that declination of services is not personal can take some time for new clinicians.

Priscilla described the importance of both resilience in accepting declination of services by patients and also of assertiveness to provide education with patients and follow-up with services. She noted the following when describing an instance of declination:

Sometimes I'll just get the feeling that it's not a good time, and that's okay. I'm never offended, and I'm also real obnoxious and persistence. I always go back. I never completely give up... I am more assertive, sometimes, with a second question.

Samantha found that she often must practice resilience and assertiveness when managing her caseload. She described an example of realizing music therapists, as professionals of a helping field, may need to balance compassion and fatigue when working with patients and their families and balancing her caseload:

I'll get phone calls from patients or from families who say, "We'd really like you to come today," and I'll have to say, "I'm so sorry. I would love to come. And here's why I can't today. Can I see you tomorrow morning first thing?" I teach my interns that, too. And that can be really hard for a lot of people because we are a caring profession. We're in a helping profession. We want to go there. But there's only so many things that are feasible for us. We do the best that we can when making those priority decisions.

Theme: Music Therapists Need Access to Shared Ideas to Supplement Practices

Music therapists may benefit from having access to shared ideas about increasing the potential for advocacy and access of medical music therapy. Participants expressed great interest in this area of study and were eager for the information to be distributed through publication. Priscilla expressed thankfulness that this research was being conducted and excitement to read about this research. Samantha found that the topic of this research was immediately related to challenges she was facing in her work.

I think that the timing of [this research] about referrals and how I prioritize things and all sorts of elements related to that is very fitting because I would say I've hardly done any patient care at all this week... This is an on-topic conversation because we are actually changing our entire electronic medical record system.

She also reiterated the need for sharing this information and concluded that she believed this information should be published in professional music therapy journals.

Summary of Interview Findings

The follow-up interviews provided more descriptive details to supplement the findings of the online survey. Music therapists that participated in follow-up interviews to the

online survey spoke about themes related to five areas of music therapy practice in medical settings including experiences related to (a) staff perceptions of music therapy, (b) patient and family perceptions of music therapy, (c) referrals in medical music therapy, (d) patient acceptance and declination of music therapy, and (e) music therapists' resilience and resources.

Staff Perceptions of Music Therapy

Interview participants spoke about themes related to staff perceptions of music therapy in medical hospitals. An area of need participants noted was for more staff education about music therapy through their exposure to music therapy. Participants described instances of varying levels of receptivity to music therapy among hospitals staff and also noted that staff understanding of music therapy is often relevant to their experiences with music therapy and music therapists. Participants also described how these staff misunderstandings are often related to their lack of knowledge about music therapists' scope of practice.

To reduce misinformation and increase staff understanding of music therapy, participants directed a need for music therapists to proactively educate hospital staff about music therapy. Participants described the benefits of being accessible and visible in hospitals to increase staff's exposure to music therapy to increase other healthcare professionals' direct experiences of music therapy practices and elevate professional relationships between music therapists and other hospital staff members. Participants also described numerous opportunities to provide education to staff about music therapy through both formal (e.g., grand rounds) and informal formats (e.g., elevator speeches). The benefits of providing education in hospitals settings to increase staff understanding were also discussed, and some

participants noted that doing so could create allies for the music therapy profession from other healthcare professions in hospitals, such as with attending physicians who have great influence on hospital procedures and staff. In contrast, participants also noted that there are often barriers to providing education about music therapy to hospital staff due to the fast-paced environment and often high quantity of staff members.

Patient and Family Perceptions of Music Therapy

Interview participants also spoke about themes related to patients' and families' perceptions of music therapy in medical hospitals. Participants found that patients and families may not have a complete understanding of music therapy when they become hospitalized. To combat misperceptions about the field of music therapy and to provide patients and families with more accurate information about music therapy pre-hospitalization, participants suggested that education and advocacy efforts should target the general public first rather than localize efforts within hospitals. During hospitalization, participants also suggested that it is important for music therapists to proactively educate patients and families about music therapy by assessing individuals' understandings about music therapy and providing necessary information. Participants also found that patients and families can be exposed to music therapy in a variety of ways: by the music therapist, by the music therapist with another staff member, or by another staff member alone. Participants also described the benefits and disadvantages of each of these approaches.

Referrals in Medical Music Therapy

Interview participants described their experiences with music therapy referrals in medical hospitals. One theme participants spoke about was the effect that the quantity of referrals they receive to provide music therapy services in hospitals has on their abilities to

provide effective patient care. Participants described their need to seek referrals (rather than wait for other healthcare professionals to refer) to provide music therapy services when they receive low quantities of referrals, have low caseloads, or do not receive referrals from specific hospital units; however, it was also noted that it is important for music therapists to be able to triage and prioritize their referrals to provide music therapy services in hospitals when they experience high quantities of referrals and large caseloads to prevent a low quality of music therapy service.

Participants provided two main procedures in which music therapists receive referrals in medical hospitals: an automatic system based on patient diagnoses and conditions in which electronic referrals are automatically sent based on intake and assessment information provided in patients' electronic charts and one based on other healthcare professionals' manual referrals for music therapy services in which reasons specific to individual patients are indicated. Participants also found that the trends in referrals they experience in medical music therapy have implications for the needs of music therapists to continue providing education about music therapy for hospital staff. In the participants' experiences, receiving low quantities of referrals for music therapy services have indicated a need to re-educate staff; this was also described to be true for a need to provide education to specific hospital units when receiving low quantities of referrals in specific hospital areas. Participants also described the opportunities music therapists have to educate staff when receiving inappropriate or ineffective referrals to provide music therapy services, offering avenues for open communication between music therapists and other healthcare professionals to clarify patient needs and the role of music therapy to address those needs.

Patient Acceptance and Declination of Music Therapy

Interview participants described their experiences with patient acceptance and declination of music therapy services in medical hospitals. Participants found that the relationship between the patient and music therapist can have an effect on patients' and families' acceptance of music therapy services. When approaching patients and families with music therapy services in medical hospitals, music therapists must be able to assess the environment to become aware of patient needs and preferences and shape their approach based on those indications to increase acceptance rates (e.g., a calmer approach in a dark room). Additionally, participants found that offering insight to patients and families about the music therapy process could increase acceptance rates of services by informing patients about the sources and reasons for music therapy referrals and the outcomes that can be expected from music therapy interventions.

Participants also found that patients' and families' first exposure to music therapy in medical hospitals can affect their acceptance of services. Knowing this, participants described differing approaches to offering services for varying patient populations, such as nuanced alterations to their approaches based on patients' and families' abilities to comprehend definitions of music therapy as inferred through patients' ages and medical conditions. As previously noted, participants also found that patients and families are sometimes introduced to music therapy services by other healthcare professionals in medical hospitals. Participants found differing views of the efficacy of this approach, noting that it could sometimes be beneficial for patients and families to expect the music therapist to arrive before the first meeting, but that it could also be detrimental for other staff members to

provide incorrect or misinformed definitions of music therapy to patients and families that alter their expectations.

When discussing patient declination of music therapy services, participants described the therapeutic power patients could find in being allowed to voice declination in a setting in which declination is not often an option in their own care. Participants also determined that patients' autonomy and choice should be respected by music therapists. However, participants have also found that patients and families often initially decline music therapy services without the information necessary to make a fully-informed decision about their care. Therefore, participants noted that it may be necessary for music therapists to be able to determine the reasons that patients or families decline music therapy services and choose whether it would be appropriate to follow-up with more education about music therapy to give patients and families a clearer description about what music therapy would look like in their care. Participants have found that this often leads to higher rates of acceptance of music therapy services by medical patients and families.

Music Therapists' Resilience and Resources

Related to the topics of the online survey and follow-up interviews completed during this study, participants noted that music therapists working in medical hospitals often must develop and practice senses of resilience and assertiveness. These attributes can be helpful for music therapists to prevent burnout that could occur when needing to provide constant education and reeducation about music therapy. By utilizing proactivity and assertiveness to educate staff, music therapists can combat misinformation before it is developed in hospitals. Participants also described a need for music therapists to have access to information related

to practices in medical music therapy to increase support in developing resilience and resources for medical music therapy.

Chapter 6

Discussion

This chapter incorporates the findings of the online survey and the information provided by the interviewees regarding referrals for and patient acceptance of medical music therapy. The main findings of both the survey and the combined interviews are presented. The collective findings are integrated and discussed in relation to the research questions outlined in Chapter 2. This will be followed by the strengths and limitations discovered during this study. The implications of the results from this study and recommendations for future research are also discussed.

Restatement of Purpose

The purpose of this study was to explore the methods utilized by professional, MT-BCs working in adult medical hospitals, children's medical hospitals, and Veterans Affairs medical hospitals to maximize referrals and acceptance of music therapy services through increased advocacy and access to music therapy in medical hospitals. Barriers in referrals and acceptance inhibit music therapists from providing effective services in medical settings. Prior to this study, there was little research available that discusses methods of maximizing referrals and acceptance of music therapy services in medical settings.

Research Questions

The following section addresses the research questions outlined in Chapter 2 and the integrated findings of the online survey and follow-up interviews to address these questions.

The findings are also compared with the known literature regarding the topics inquired by these questions.

What Are Music Therapists' Experiences of Receiving Referrals in Medical Settings?

Music therapists in this study described procedures for referrals in medical music therapy consistent with the current literature at the time of this study (AMTA, 2013a; Borczon, 2017; Daveson, 2007; Gfeller, 2008; Gfeller & Davis, 2008b; Gallagher et al., 2017; Gerwick & Tan, 2010; Ghetti, 2013; Hanser, 2018; Hanson-Abromeit et al., 2008; Horne-Thompson et al., 2007; Loewy, 2000; Loewy, 2014; Magee & Andrews, 2007; Nöcker-Ribaupierre, 2013; Shultis & Gallagher, 2014; Standley, 2004; Standley & Whipple, 2003b; Walker et al., 2010). The following sections integrate the findings of the online survey and follow-up interviews in relation to the literature related to music therapy referrals in medical settings.

How Do Music Therapists Receive Referrals in Medical Settings? Participants of this study described methods for receiving referrals to provide music therapy in medical settings. Interview participants described the different processes of music therapy they have experienced in relation to the procedures established by the respective facilities in which they have worked. This reflects Borczon's (2017) and Shultis and Gallagher's (2014) assessment that the referral process of each institution is unique according to the policies and procedures established by the hospital and its medical staff. Participants also described the methods of referrals in their hospitals. Most music therapists receive referrals to provide services in medical hospitals from other healthcare professionals; however, it has also been stated that music therapists often proactively seek referrals to provide music therapy services, especially when receiving low amounts of referrals. Loewy (2014) agreed that referrals may be solicited

by the music therapist, especially in units with higher concentrations of new staff or in new music therapy programs. Additionally, interview participants described processes for automatic referrals, a practice which has not yet been addressed by the literature. Automatic referrals have been generated both electronically as other healthcare practitioners utilize online charting systems to input diagnoses and patient conditions that warrant immediate referrals for music therapy and by music therapists who generate automatic referrals by seeking specific criteria for patients, such as cancer related pain.

With What Frequency Do Music Therapists Receive Referrals in Medical Settings? Approximately one-third of survey respondents reported receiving an average of 1–5 referrals a week. Other participants indicated receiving referrals to provide music therapy services in medical settings at as low as less than 1 referral weekly and as high as more than 10 referrals weekly. Interview participants noted that the number of referrals they receive in a week can vary depending on how often they are able to round throughout the hospital; their abilities to do so are also affected by their current caseloads. Survey respondents and interview participants frequently named nurses, physicians, and social workers as common sources of referrals for music therapy in medical settings, which is consistent with findings in the literature (Borczone, 2017; Gallagher et al., 2017; Horne-Thompson et al., 2007; Walker et al., 2010).

What Referral Reasons Do Music Therapists Receive From Other Professionals in Medical Settings? Participants described both appropriate and inappropriate reasons that they receive to provide music therapy services in medical settings. The top overall appropriate referral reasons for all medical populations described by participants in this study included anxiety, chronic illness, normalization, ineffective patient coping, pain, isolation,

depression, new diagnoses, sensory stimulation, and agitation or restlessness. Interview participants also described differences in referral reasons they receive based on the varying scope of practice of other healthcare professionals as well as the varying purposes of hospital units, such as referrals for nonpharmacological pain management from pain management team members or referrals from nursing staff to address acute concerns such as agitation. This is consistent with findings by Horne-Thompson et al. (2007) indicating that most referrals made by medical, nursing, and allied health staff in a palliative care setting were for symptom-based reasons. This is also reflected in the specialized guidelines provided by the literature for music therapy referrals in adult medical care (Walker et al., 2010), adult intensive care (Gerwick & Tan, 2010), pediatric medical care (Standley & Whipple, 2003b), pediatric intensive care (Ghetti & Hannan, 2008), and neonatal intensive care (Hanson-Abromeit et al., 2008; Loewy, 2000; Nöcker-Ribaupierre, 2013; Standley, 2004; Standley & Whipple, 2003a).

Participants also indicated occurrences of inappropriate or ineffective referrals for music therapy in medical settings. Frequently noted inappropriate reasons for music therapy in medical settings included the patients' enjoyment of music, patient boredom, patients' musical abilities, patients' need for entertainment, patients' personality traits, patients' birthdays, patients want to learn an instrument, no reasons given, patients need company, and families' enjoyment of music. While survey respondents indicated nurses, physicians, and social workers as the largest source for referrals in medical music therapy, they were also listed as the most common sources for inappropriate referral reasons in medical music therapy.

What Methods Are Utilized by Music Therapists to Improve the Quality and Appropriateness of Referrals in Medical Settings? Participants indicated a number of methods for educating staff members about the role and benefits of music therapy in medical hospitals, including both formal and informal methods of education. This is supported by Moore's (2015) statement that music therapy advocacy occurs on many levels within medical hospitals. Survey respondents indicated that in-services and formal presentations are the most common method for providing education about music therapy, but that this may also occur during interactions with other healthcare professionals in hallways and elevators, through printed materials and digital media, and through effective documentation of music therapy sessions. Interview participants reiterated the use of both formal and informal settings for educating other staff members about music therapy in hospitals, noting that opportunities that allow music therapists to align their efforts with pre-scheduled meetings and interactions that occur throughout the day have been the most effective in the fast-paced environment of medical hospitals.

What Is Their Perception of the Relationship Between Other Professionals' Exposure to Music Therapy and Their Frequency and Quality of Referring to Music Therapy in Medical Settings? Participants described benefits to providing education and exposure of music therapy to other healthcare professionals in medical settings to increase the quantity and quality of music therapy referrals. This is consistent with the multiple studies that have shown the efficacy of in-service and other forms of education to positively affect the perceptions of music therapy and the roles of music therapists to meet clinical objectives by other healthcare professionals (Darsie, 2009; Magee & Andrews, 2007; O'Kelly, 2007; Silverman & Chaput, 2011). Additionally, this is supported by Magee and

Andrews' (2007) and O'Kelly's (2007) finding that referrals for music therapy services have been increased with improved perceptions of clinical relevance.

Interview participants described how referral quality in medical music therapy and education and exposure to music therapy for other healthcare professionals can have a mutually beneficial relationship. This has been evidenced by participants' experiences with increased referral quantity and quality following additional education and their increased efforts to provide education following decreased quantities and qualities of music therapy referrals in medical settings. This is similar to Loewy's (2014) process of "upgrading" referrals by providing reeducation to staff in response to limited referral reasons from other healthcare professionals.

What Are Music Therapists' Experiences of Patient Acceptance and Declination of Services in Medical Settings?

Music therapists in this study described their experiences with patient acceptance and declination of music therapy services as well as strategies they have found to support and hinder acceptance rates of services in medical hospitals. The findings align with results described by the literature (Hense, 2018; O'Callaghan & Colegrove, 1998; O'Kelly, 2007; Marom, 2008; Shultis & Gallagher, 2014). The following sections integrate the findings of the online survey and follow-up interviews in relation to the literature related to patient acceptance and declination of music therapy services in medical hospitals.

How Do Music Therapists Approach Patients During Their Initial Visit in Medical Settings? Interview participants described the significance of genuineness during initial visits to aid in forming quick and effective working relationships with patients in medical settings. Participants concluded that music therapists should take the time to provide

patients with their immediate needs, even those outside of music therapy (e.g., those to provide comfort such as asking nursing staff for water), as well as to proactively assess patients' and families' understanding of music therapy. Participants also described positive effects in incorporating patient preferences and purposefully assessing the environment to match the energy of the space when introducing themselves to patients and families. It was also noted that there may be benefits to focusing on music preferences and experiences when introducing services as well as by leading with explanations of music therapy to facilitate positive changes in patient conditions; participants found that this approach is often shaped by factors that could limit cognitive comprehension (i.e., age, diagnoses, conditions, etc.).

What Is the Frequency of Patient Acceptance of Music Therapy Services in Medical Settings? Respondents to the online survey indicated that a majority of music therapists in medical settings experience high frequencies of acceptance of services. This is similar to findings by O'Callaghan and Colegrove (1998) who found that 72% of hospitalized cancer patients (50% initially and an additional 22% after a follow-up) in a study accepted music therapy services. Interview participants also described the efficacy of following-up with patients after an initial declination of services to increase acceptance rates by offering time-limited experiences, providing additional education about music therapy in the treatment plan, and offering a "trial" intervention. This was described by participants as a way to help facilitate patients and families in making fully informed decisions about their care in accordance with the *Patient Care Partnership* (AHA, 2003).

What Reasons Do Patients Provide for Declining Music Therapy Services in Medical Settings? Music therapists in this study described numerous reasons patients decline music therapy services in medical hospitals. Respondents to the online survey

indicated that most music therapists receive reasons related to patients' levels of tiredness as reasons for declination. Other reasons described by respondents included patient visitors, patients' dislike of music, conflicts with other medical interventions, and patients' preferences to not engage. Respondents also noted patients' experiences of pain or other discomfort as reasons for declination, which is reflected in studies by O'Callaghan and Colegrove (1998), Marom (2008), and Shultis and Gallagher (2014). Interview participants noted hesitance, uncertainty, or a need to maintain some independence during hospitalization as reasons for declination of music therapy services.

What Methods Are Utilized by Music Therapists to Increase Patient Acceptance Rates of Services in Medical Settings? Music therapists have discovered that their approach to patients can have significant impacts on patients' decisions to accept or decline services. Participants of this study described a number of methods for increasing patient acceptance rate of music therapy services in medical settings. The most common approaches respondents indicated to increase acceptance rates of services included the following list:

- Explain the role of music therapy, reason for referral, or treatment context.
- Introduce services by first conversing with patients or families to build rapport and assess needs.
- Explain how music therapy can address the patient's and family's concerns.
- Offer choices (e.g., times, music preferences, interventions) and adapt.
- Approach gently, subtly, or genuinely.
- Match patient's energy level and need with approach and check-in regularly.
- Offer patients to "give it a try" with no commitment.
- Lead with or emphasize music rather than therapy.

- Screen patient prior to initial session (i.e., chart review).
- Disclose the source of the referral for music therapy.

Interview participants reflected many of these approaches for increasing acceptance rates but also noted some differing experiences in these methods. Participants described benefits of both having patients and families informed about music therapy before initial contact and the absence thereof as well as the benefits of both leading with music rather than therapy and vice versa. The benefits of educating patients is reflected in the literature by O'Callaghan and Colegrove (1998) who found that patients more often accepted services when they heard about music therapy before contact with the music therapist. This is reiterated by Hense (2018) and O'Kelly (2007) who concluded that music therapists help patients to become more involved in their care by educating them about music therapy. However, a difference in the literature includes results that found emphasizing music rather than therapy (O'Callaghan & Colegrove, 1998) increased acceptance, while others (Hense, 2018; O'Kelly, 2007) found that comprehensive education about music therapy increased acceptance. Participants also noted that these approaches are often dependent on patient and family demographics, diagnoses, and conditions.

What Is Their Perception About the Relationship Between Methods of Music Therapy Introductions to Patients and Patient Acceptance of Music Therapy Services in Medical Settings? Music therapists have found success in increasing acceptance rates of music therapy services in medical settings as a result of analyzing and adapting their approaches to introducing patients and families to music therapy. Participants described, on average, high levels of acceptance rates for music therapy services in medical settings through showing persistence with patients yet also showing respect for patients' and families'

decisions. Interview participants suggested that there may be an influence on patients' and families' decisions to accept music therapy depending on the source of introductions to music therapy. It was found that when music therapy is introduced to patients by other healthcare professionals, patients and families may experience increased comfort in accepting services when approached by the music therapist, but it has also been noted that allowing other healthcare professionals to introduce services could increase misinformation and alter expectations of services. It has been concluded that the approach to introducing music therapy to patients and families is often dependent on the individual experiences of patients in medical settings.

Methodological Strengths and Limitations

Strengths

Strengths of this study include the recruitment of suitable numbers for the online survey to effectively represent the practice of medical music therapy in the United States. Participants of this study were carefully assessed for eligibility during the online survey to include only participants with relevant experience to the topics addressed in the complete survey and following interviews.

In preparation for the follow-up interviews, the researcher was able to utilize purposeful sampling from the number of eligible survey respondents who indicated interest in further participation. The researcher aimed to include the experiences of varied medical music therapy practitioners with experiences in each setting of focus in this study (i.e., adult medical hospitals, children's medical hospitals, and Veterans Health Administration medical centers) as well as ensuring to include varied representations of regional location in the United States as well as gender.

The use of a mixed methods approach was a further strength to collect descriptive data of a large representation of medical music therapists during the online survey and clarify and saturate the data with qualitative experiences collected during the follow-up interviews. The quantitative data provided a clear and empirical foundational understanding for the qualitative data to provide richer elaborations on and interpretations of the findings. For those participants that began the online survey, 90% completed the complete survey for which they indicated eligibility, showing a strong amount of interest in this area of music therapy. Additionally, 55% of eligible respondents to the online survey indicated interest in participating further in follow-up interviews on the topics addressed in the online survey.

A final strength of this method is the researcher's interest and experience in this area of music therapy. The researcher's previous experiences and interest provided the researcher with a sense of need for further research in this area of medical music therapy and an outline for inquiry into the topics addressed by this study. While recognizing the influences of past experiences and interest, the researcher was also able to address potential biases of this study and minimize their effects through scrutiny in wording survey and interview questions.

Limitations

As the researcher was unable to only notify potential participants meeting the criteria of the study due to this information being unavailable prior to receiving survey responses, the researcher chose to invite all credentialed music therapists through the CBMT who opted-in to email communications, increasing opportunities for ineligible participants to skew data. Although the study's focus was for music therapists with experiences in adult medical hospitals, children's medical hospitals, and Veterans Health Administration medical centers, participants with experiences in other medical settings were considered during data

collection. Interpretations of the terminology related to medical settings may have also varied among participants, and music therapists working in non-medical hospital settings (e.g., psychiatric and behavioral health hospitals) provided responses in the online survey as a result. This may have shaped an incomplete or skewed view of medical music therapy in the data. The length of the survey—requiring about 30 minutes of participants' time to complete—may have also created a bias in data collection for participants who were willing to spend more time completing the survey than those who were less willing to spend such time. Additionally, the use of the online survey to serve as a gatekeeper for participants' eligibility to complete follow-up interviews limited the researcher's ability to sample music therapists who would have been eligible for participation but either did not complete the survey or did not agree to participate in interviews.

Although the researcher recruited a small sample of music therapy mentors affiliated with the researcher's academic institution to pilot the online survey, the participants in the pilot survey did not meet the requirements for eligibility in the study. This could have affected the potential validity of the questions to address the experiences of participants with eligibility for completion of the study. Many survey questions provided options for respondents to indicate choices to match their experiences as well as options to provide open-ended responses. Limiting responses to these options may have influenced respondents to answer in certain ways that they may not have originally thought important without being provided those options, while leaving other questions to be open-ended may have resulted in inaccurate interpretations by the researcher.

Lastly, even with an awareness of bias and practices to minimize their effects on the study, the researcher acknowledges that bias in research may not be fully diminished. The

researcher could have influenced the data and the results while serving as the instrument for data collection and interpretation due to the subjective nature of humans.

Implications for Medical Music Therapists

Music therapists have expressed the significance of educating other healthcare professionals and patients of medical hospitals to maximize the quantity and quality of referrals to provide music therapy services and to increase the potential for patient acceptance of these services. The high return rate of the online survey and the large amount of interest by survey respondents to participate in follow-up interviews indicated to the researcher that these topics in medical music therapy are current need area of music therapy practitioners.

The results of this study imply that music therapists working in medical settings should begin to practice more proactively to prevent misconceptions and misrepresentations of music therapy by other healthcare professionals and to increase the understanding of music therapy's role in healthcare treatment by both healthcare professionals and patients and families. Looking at survey results that indicate the top sources of referrals to music therapy are also the sources that most often provide inappropriate referrals to music therapy suggests that medical music therapists may need to continue providing education and reeducation for potential sources of referrals in medical settings. It has also been indicated that healthcare professionals have views and perceptions about music therapy that are relevant to their own positions and experiences with music therapists in specific units of hospitals, limiting their view of music therapists' scope of practice; this implies for music therapists that providing additional and comprehensive education and exposure to music therapy (e.g., cotreatment) could benefit other healthcare professionals' overall views of the field. The need for music

therapists to be accessible has implications for the location of music therapists' office spaces in relation to the hospital, suggesting that music therapy offices centrally localized in hospitals afford music therapists with greater abilities to be present on the floor and more easily accessed by other healthcare professionals and patients. This also suggests that documentation of music therapy sessions in medical settings should be written in language that allows other healthcare to comprehend the unique interventions and benefits that result from those interventions.

The results indicate that time restrictions and the fast-paced environment of medical settings make educating other staff members about music therapy difficult. This implies that music therapists should be flexible and strategic in their efforts to provide education and should consider limiting their efforts to short interactions with other staff members.

Additionally, the need to reeducate other staff members about music therapy implies to music therapists that these interactions may need to occur frequently during their work in medical hospitals.

It has also been found that other healthcare professionals and patients may experience difficulty differentiating music therapists from other healthcare providers that utilize music in their practices and music volunteers, implying that music therapists should work to highlight the unique benefits of music therapy that other disciplines cannot deliver while educating others about the field. A related indication made by this study is the need to focus on advocacy and education about music therapy with community outreach rather than localizing efforts within hospitals to improve music therapy understanding for patients prior to their hospitalizations.

When approaching patients and families about potential music therapy services in medical settings, it has become clear that music therapists find it useful to have insight about patient and family backgrounds and to have abilities to assess the environment of patients' rooms to evaluate what approaches may be most successful to introduce music therapy. This implies that music therapists need to use the resources available to them to make informed decisions such as carefully reviewing patient charts, observing patient interactions outside of music therapy sessions, and engaging in opportunities to cotreat with other healthcare professionals. However, the researcher also warns music therapists against systematically labeling and categorizing patients and families based on narrative information gathered through charts and to form their own relationships through the interactions that develop through treatment.

Other topics discussed in this study imply that music therapists practicing in medical settings could benefit from interacting more assertively with other healthcare professionals and patients while educating about music therapy and seeking referrals rather than reacting to misinformation or referrals of low quality or quantity. Participants suggested that referral-based systems for practicing music therapy could limit music therapists and prevent medical patients who could benefit from receiving services, making it necessary for medical music therapists to seek opportunities to provide services. Participants also described automatic referral systems that help to prevent barriers between patients and music therapy services. This implies that medical music therapists might suggest similar systems in their hospitals that automatically generate referrals to music therapy based on symptoms and diagnoses that are assessed during hospitalization intake assessments. The same considerations should be made by music therapists experiencing high quantities of referrals to music therapy services

that hinder their practice by overextending their abilities with large caseloads. This implies for medical music therapists that an important skill in this work is the ability to triage and prioritize referrals.

Related to other healthcare professionals' limited perceptions of music therapy and occurrences of high volumes of referrals that can be difficult for music therapists to manage is a potential need for medical hospitals to consider expanding music therapy services by hiring multiple music therapists. Music therapists working in medical settings with other music therapists may also consider the potential benefits of specialized training to provide effective music therapy interventions across multiple units of medical hospitals rather than attempting to expand one's caseload to encompass all areas of hospitalization.

The demographics of the survey respondents who were eligible to complete the survey imply that a majority of music therapists working in medical-based settings have completed graduate-level training in music therapy. This is a difference from the demographics of the 2019 AMTA Member Survey and Workforce Analysis respondents—a majority of whom indicated no further education after undergraduate-level training. The researcher suggested that this statistic may indicate a number of relationships between music therapy education and practice in medical music therapy:

- Music therapists with graduate-level training are more likely to have interest for working in medical settings.
- Medical-based employers prefer to hire music therapists with graduate-level training.
- OR Music therapists have discovered a need for more advanced and specialized training in music therapy to work in medical-based settings.

Future Research

A number of suggested research topics developed as the researcher became familiarized with the data of this study and during discussions with participants of follow-up interviews. One area of significance was the change in demographics found in comparing that of eligible participants for this study and all survey respondents and demographics of the AMTA member survey (2019), suggesting that medical music therapy may require more advanced training in music therapy as evidenced by the increase in proportion of master's level music therapy practitioners in medical settings or that hospitals might more often seek individuals with master's degrees. The following questions arose:

1. What additional training do music therapists need to work in medical settings?
2. What qualifications do medical settings prefer when hiring music therapists?

Participants suggested that the topics addressed in this study should continue to be studied with considerations for a wider inclusion criterion of medical settings, such as with music therapists working in long-term medical settings including hospice settings, traumatic brain injury settings, skilled nursing facilities, etc. There may be interesting findings and differences in the experiences of music therapists working in acute medical care settings and long-term medical care settings, especially considering patient exposure to music therapy and their preconceptions prior to receiving music therapy intervention.

One interview participant noted the differences in staff understanding and receptivity to music therapy they experienced when comparing previous positions and their relevant job titles. The participant noted that for the positions that specified a title as “music therapist” created less role confusion in their places of employment. A study investigating the experiences of music therapist practicing in medical settings with various job titles such as

“activities therapist” or other related titles may further highlight the significance of one’s title.

Other participants noted the differences of receptivity to music therapy they have experienced with attending physicians and newer physicians in their respective hospitals. One participant noted that they felt other healthcare professionals—including physicians—who were younger (i.e., closer in age to the participant) expressed more interest in music therapy and willingness to learn from the participant about music therapy in medical care. The participant suggested it could be interesting to investigate how their relationships with attending physicians and their receptivity toward music therapy evolved as the participant ages.

More research should be invested into the perceptions of music therapy medical patients and their families experience before receiving music therapy services in medical settings. The literature suggests that patients who receive music therapy in medical settings believe the services benefit their hospitalization (Kleiber & Adamek, 2013; Lane et al., 2018; McCaffrey & Edwards, 2016; O’Callaghan, 2001; Potvin et al., 2015; Solli & Rolvsjord, 2015; Thompson, et al., 2017). However, the literature does not explore the preconceptions patients and families have about music therapy before first exposure to a music therapy session that may influence their decisions to accept or decline services. Participants suggested potential benefits and disadvantages of music therapy introductions to patients by other healthcare professionals. Although one participant did suggest music therapists directly ask patients about their understandings of music therapy, patients’ and families’ baseline understandings of the field remain unknown to music therapists in wider contexts.

Beneficial information could be uncovered from studies investigating the experiences of medical music therapists and the perceived benefits or disadvantages when other healthcare professionals introduce music therapy services to patients compared to when they are introduced by the music therapist. Also, an updated study looking into the introduction of music therapy to medical patients and the associated benefits of the various approaches—such as medical music therapists who emphasize the music rather than “therapy” in sessions and vice versa—could better inform current practices in medical music therapy. These benefits in relation to specific patient populations could also be investigated.

Another consideration that was not included in this study was the relationship between the size of hospitals or hospitals systems medical music therapists serve and the size of the music therapy departments or number of music therapists working in those hospital systems. This relationship could affect the quantity of referrals individual music therapists receive and the overall caseloads they experience in medical settings. A study investigating this relationship could give music therapists a clearer look at trends of music therapy referral frequency in medical settings.

Conclusion and Summary

This study provides insight into the experiences of music therapists in medical settings, the challenges that are commonly faced in dealing with referrals from other healthcare professionals to provide services and patient acceptance and declination of services, and the solutions that current music therapists have found to reduce these challenges. Participants in this study detailed suggestions for music therapists currently working in medical settings and those with intentions to pursue work in medical settings. Topics explored in this study reflect the findings of music therapy literature and expand upon

the understandings and scope of the current literature. Continued research into the experiences of medical music therapists is recommended to contribute to the evolving and expanding resources available in this area of the field of music therapy.

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Appendices

Appendix A

Online Survey Questions

MAXIMIZING REFERRALS AND ACCEPTANCE OF MEDICAL MUSIC THERAPY: A SEQUENTIAL-EXPLANATORY MIXED METHODS STUDY

The purpose of this survey is to gain insights from medical music therapists' experiences with methods to increase referral frequency and quality and patient acceptance of services.

The survey consists of 42 questions and should not take more than 30 minutes to complete.

If you have any questions regarding the survey, please contact:

Clayton J. Cooke, MT-BC, Principal Researcher, cookecj@appstate.edu, 910-584-5281;

Dr. Christine Leist, Faculty Chair, leistcp@appstate.edu, 828-262-6663;

or the Institutional Review Board at Appalachian State University, irb@appstate.edu.

Section 1:

Demographic Information

1. How do you currently describe your gender identity?

Choose:

Female, woman, or feminine

Male, man, or masculine

Non-binary

Other (describe)

Prefer not to answer

2. What is your age in years?

Choose:

21–29

30–39

40–49

50–59

60–69

70–79

80 or above

3. What is your ethnicity?

Choose all that apply:

Asian

Black or African American

White

Hispanic, Latinx, or Spanish Origin

Middle Eastern or North African

Native American or Alaska Native

Native Hawaiian or Other Pacific Islander
Other (describe)
Prefer not to answer

4. In what region of the AMTA do you currently practice?

Choose:

Great Lakes Region
Mid-Atlantic Region
Midwestern Region
New England Region
Southeastern Region
Southwestern Region
Western Region

5. What is your highest completed level of education in music therapy or related degree?

Choose:

Undergraduate degree in music therapy
Equivalency in music therapy
Master's degree in music therapy
Master's degree in a related field
Doctoral degree in music therapy
Doctoral degree in a related field
Other (list all others)

6. Please indicate any other degrees, licensures, certificates, trainings, etc. you have received that are related to your work in medical music therapy.

7. How long have you been a credentialed music therapist?

Choose:

Less than 1 year
1–10 years
11–20 years
21–30 years
31–40 years
41–50 years
51–60 years
More than 60 years

If at least 1 year: See Question 8

If less than 1 year: Thank you for your time and participation in this survey.
 Your response has been recorded.

8. Have you practiced music therapy as a full-time employee or contractor with full-time hours in a medical setting (e.g., adult medical hospital, children's medical hospital, Veterans Health Administration medical centers, etc.)?

Choose:

Yes

No

If yes: See Question 9.

If no: Thank you for your time and participation in this survey.

Your response has been recorded.

9. How many years (combined) have you practiced music therapy as a full-time employee or contractor in a medical setting?

Choose:

Less than 1 year

1–5 years

6–10 years

11–20 years

21–30 years

31–40 years

41–50 years

51–60 years

More than 60 years

If at least 1 year: See Question 10.

If less than 1 year: Thank you for your time and participation in this survey.

Your response has been recorded.

10. When was your most recent practice in medical music therapy?

Choose:

Current

Less than 1 year ago

1–5 years ago

6–10 years ago

More than 10 years ago

If less than 10 years ago: See Question 11.

If more than 10 years ago: Thank you for your time and participation in this survey. Your response has been recorded.

11. In what type of medical setting(s) have you practiced music therapy?

Choose all that apply:

Adult medical hospital

Children's medical hospital

Veterans Health Administration medical center

Other (list all others)

Section 2

Referrals in Medical Music Therapy

12. Do/have you receive(d) referrals from other healthcare professionals to provide music therapy in medical settings?

Choose:

Yes

No

If yes: See Questions 13–21.

If no: Skip to Question 22.

13. How often do you receive referrals for music therapy in medical settings?

Choose:

Less than 1/week

1–5/week

5–10/week

More than 10/week

14. From what sources do you receive referrals for music therapy in medical settings?

Choose all that apply:

Administration

Chaplains

Child life specialists

Families

Music therapists (other than yourself)

Nurses

Occupational therapists

Patients

Physical therapists

Physicians

Psychologists

Respiratory therapists

Social workers

Speech and language pathologists

Yourself

Other creative arts therapists (list all)

Other (list all others)

15. In terms of frequency of referral, rank the top three sources of music therapy referrals in your hospital(s). (1=most frequent, 2=second most frequent, 3=third most frequent)

Rank:

Administration

Chaplains

Child life specialists

Families

Music therapists (other than yourself)

Nurses

Occupational therapists

Patients

Physical therapists

Physicians

Psychologists

Respiratory therapists

Social workers
Speech and language pathologists
Yourself
Other creative arts therapists (list all)
Other (list all others)

16. In terms of frequency of referral, rank the lowest three sources of music therapy referrals in your hospital(s). (1=least frequent, 2=second least frequent, 3=third least frequent)

Rank:

Administration
Chaplains
Child life specialists
Families
Music therapists (other than yourself)
Nurses
Occupational therapists
Patients
Physical therapists
Physicians
Psychologists
Respiratory therapists
Social workers
Speech and language pathologists
Yourself
Other creative arts therapists (list all)
Other (list all others)

17. Rate the average frequency of receiving music therapy referrals for the following reasons in your hospital(s) using the numerical system below.

Reasons for Referral:

Agitation/restlessness
 Anticipatory grieving (patient)
 Anticipatory grieving (family)
 Anxiety
 Behavioral disturbance
 Caregiver role strain
 Chronic illness
 Depression
 Imminent death
 Impaired communication
 Ineffective breathing pattern
 Ineffective coping (patient)
 Ineffective coping (family)
 Isolation
 Limited support system

Loss of autonomy
 Low satisfaction of stay
 Low self-esteem
 Motor deficits
 Newly diagnosed
 Normalization
 Pain
 Procedural support
 Sensory stimulation
 Spiritual needs
 Other (list all others)

Rate:

0: Not Applicable
1: Never
2: Once per month
3: 2–3 times per month
4: Once per week
5: 2–4 times per week
6: Daily
7: Multiple times per day

18. Do you receive inappropriate referral reasons (i.e., “patient likes music”) or referrals with insufficient information in medical settings?

Choose:

Yes

No

If yes: See Question 19–20.

If no: Skip to Question 21.

19. What inappropriate referral reasons do you receive in medical settings? (List all)

20. Rank the top three healthcare disciplines in your hospital(s) that most frequently refer to music therapy for inappropriate reasons. (1=most frequent, 2=second most frequent, 3=third most frequent)

Rank:

Administration
Chaplains
Child life specialists
Music therapists (other than yourself)
Nurses
Occupational therapists
Physical therapists
Physicians
Psychologists
Respiratory therapists
Social workers

Speech and language pathologists
Other creative arts therapists (list all)
Other (list all others)

21. Do you provide in-services or other types of staff education about music therapy to increase the frequency or quality of music therapy referrals in medical settings?

Choose:

Yes

No

If yes: See Questions 22–23.

If no: Skip to Question 24.

22. What type of education do you provide for other healthcare professionals about music therapy in medical settings?

Choose all that apply:

In-services

Pamphlets

Unit training

New employee orientation

Word-of-mouth

Other (list all others)

23. For whom do you provide educational services about music therapy in medical settings?

Choose all that apply:

Administration

Chaplains

Child life specialists

Music therapists (other than yourself)

Nurses

Occupational therapists

Physical therapists

Physicians

Psychologists

Respiratory therapists

Social workers

Speech and language pathologists

Other creative arts therapists (list all)

Other (list all others)

24. Do you think other healthcare professionals in your hospital misunderstand or misrepresent music therapy?

Choose:

Yes

No

If yes: See Question 25.

If no: See Question 26.

25. In what ways do you think other healthcare professionals in your hospital misrepresent music therapy? (List and describe all)
26. Do you think the quantity or quality of the music therapy referrals you receive hinders your ability to provide services to patients in need in medical settings?
- Choose:*
- Yes*
- No*

Section 3

Patient Acceptance and Declination of Music Therapy Services

27. Estimate the rate of acceptance of music therapy services by patients or families you experience in medical settings.
- Choose:*
- Less than 50%*
- 50–75%*
- 75–99%*
- 100%*
28. Have you experienced declination of music therapy services by patients or families in medical settings?
- Choose:*
- Yes*
- No*
- If yes: See Question 29.
- If no: Skip to Question 30.
29. What reasons have you received from patients and families for declination of music therapy services in medical settings?
- Choose all that apply:*
- Patient is tired*
- Patient does not like music*
- Patient has visitors*
- No reason given*
- Other (list all others)*
30. Have you found that your approach to patients in medical settings influences their acceptance and declination of music therapy services?
- Choose:*
- Yes*
- No*
- If yes: See Questions 31–32.
- If no: Skip to Question 33.

31. What approaches to patients have you found to increase acceptance rates of music therapy services in medical settings? (Describe all)
32. What approaches to patients have you found to decrease acceptance rates of music therapy services in medical settings? (Describe all)
33. Have you found that some patients are unaware of what music therapy is in medical settings?
Choose:
 Yes
 No
 If yes: See Questions 34–38.
 If no: Skip to Question 39.

34. Are patients in your hospital informed about what music therapy is before you attempt to conduct an assessment session?
Choose:
 Yes
 No

For Questions 35–38, please indicate how strongly you agree or disagree with each statement related to patient acceptance and declination of music therapy services in medical settings (1=Strongly disagree, 7=Strongly agree).

35. Patients or families who are aware of music therapy practices accept services more often.
Choose:
 1: *Strongly disagree*
 2: *Disagree*
 3: *Slightly disagree*
 4: *Neither agree nor disagree*
 5: *Slightly agree*
 6: *Agree*
 7: *Strongly agree*
36. Patients or families who are aware of music therapy practices decline services more often.
Choose:
 1: *Strongly disagree*
 2: *Disagree*
 3: *Slightly disagree*
 4: *Neither agree nor disagree*
 5: *Slightly agree*
 6: *Agree*
 7: *Strongly agree*

37. Patients or families who are not aware of music therapy practices accept music therapy services more often.

Choose:

- 1: Strongly disagree*
- 2: Disagree*
- 3: Slightly disagree*
- 4: Neither agree nor disagree*
- 5: Slightly agree*
- 6: Agree*
- 7: Strongly agree*

38. Patients or families who are not aware of music therapy practices decline services more often.

Choose:

- 1: Strongly disagree*
- 2: Disagree*
- 3: Slightly disagree*
- 4: Neither agree nor disagree*
- 5: Slightly agree*
- 6: Agree*
- 7: Strongly agree*

Section 4

Concluding Questions

39. What other information regarding these topics do you wish to provide?

40. Would you like to be considered for participation in a follow-up interview concerning the topics mentioned in this survey?

Choose:

Yes

No

If yes: See Questions 41–42.

If no: Thank you for your time and participation in this survey.
Your response has been recorded.

41. Please provide your name in the space below.

42. Please provide your email address in the space below.

Thank you for your time and participation in this survey. Your response has been recorded.

Appendix B

Follow-up Interview Guide

MAXIMIZING REFERRALS AND ACCEPTANCE OF MEDICAL MUSIC THERAPY: A SEQUENTIAL-EXPLANATORY MIXED METHODS STUDY

1. Could you tell me about the healthcare setting(s) in which you practice/have practiced medical music therapy?
 - a. How big is the healthcare setting(s) in which you have practiced medical music therapy?
 - b. Do/did you serve the whole facility?
 - c. Were/are you a full-time employee or a contractor with full-time hours?
 - d. How long did/have you work/ed in this setting? Do you still work there?
2. Could you tell me about the music therapy program in which you practice/have practiced medical music therapy?
 - a. How long has the music therapy program in your hospital been established?
 - b. At your place of employment, how many music therapists are/were employed there?
3. Could you tell me about the professional relationships between the music therapists and other healthcare professionals in the healthcare setting(s) in which you practice/have practiced medical music therapy?
 - a. Do you cotreat with other healthcare professionals?
 - b. Do other healthcare professionals observe your work?
4. From your perspective, what level of understanding do the other healthcare professionals you work with have about music therapy?
 - a. Can you tell me about a time while working in this setting that you think music therapy may have been misunderstood by another healthcare professional?
 - b. What are some things that others have said about music therapy in professional settings that you think misrepresented the field?
5. What is the referral process like in your hospital?

- a. How often do you receive referrals for music therapy in your hospital?
 - b. What level of appropriateness or sufficiency do the referrals you receive tend to have?
 - c. Have you noticed differences in the quality or quantity of referrals received from different types of healthcare professionals? If so, what are the differences? Do referrals with higher quality come from other healthcare professionals with more exposure and education in music therapy?
6. Do you think other healthcare professionals need more education about music therapy?
 - a. If so, are you able to provide music therapy education to other healthcare professionals in your hospital?
 - b. If so, in what ways?
7. Do you think that the quantity and quality of the referrals you receive impact the access patients have to music therapy services? If so, in what ways?
8. What are your experiences of patient and/or family acceptance and declination of music therapy services in your hospital?
 - a. What reasons have patients or families given for declining music therapy services?
 - b. What techniques for approaching patients do you utilize during initial visits with patients and families?
 - c. Have you found that certain techniques work better or worse to increase patient/family acceptance of services? If so, what are they?
9. From your perspective, what level of understanding do the patients and families you work with have about music therapy?
 - a. How have patients and families viewed your position as a music therapist or the field of music therapy as a whole?
 - b. How are patients introduced or exposed to music therapy in your hospital(s)?
10. Is there any additional information you would like to provide that is related to these topics?

Appendix C

Informed Consent for Participation in the Online Survey

MAXIMIZING REFERRALS AND ACCEPTANCE OF MEDICAL MUSIC THERAPY: A SEQUENTIAL-EXPLANATORY MIXED METHODS STUDY

Dear Board-Certified Music Therapist,

You are invited to participate in a survey concerning the trends of advocacy and access in medical music therapy to maximize referrals and patient acceptance of services as a board-certified music therapist through the Certification Board for Music Therapists. This survey is part of a research study being conducting at Appalachian State University to fulfill thesis requirements for the Master of Music Therapy degree.

Your contact information is being used with permission from the Certification Board for Music Therapists. Qualtrics, the online program where the survey is located, is a secure site, and it neither stores nor tracks your email address. The information you provide will remain anonymous, and responses will not be attached to your email address unless you choose to voluntarily provide your contact information. The researcher will have no access to email addresses of those who participate or do not participate in the study, and the researcher will not have the ability to link e-mail addresses to responses unless this information is voluntarily provided by respondents. All data will be presented anonymously by the researcher, and the anonymous data will be included in the researcher's master's thesis, and the study may be submitted for publication and presentation at AMTA conferences.

All participation and disclosure of contact in this survey is voluntary, and there are no consequences if you decline to participate or decide to discontinue participation at any time. No foreseeable risks are associated with completing this survey, and respondents will receive no compensation for completing this survey. You will be asked to complete questions regarding demographic data and experiences of referrals and patient acceptance in medical music therapy; this process should not take more than 20 minutes. If you are willing to participate, please continue to access the online survey by following the link posted below.

By submitting responses to the survey, you are consenting to participate and acknowledge that you are at least 18 years old, have read the above information, and provide your consent to participate under the terms above. You can choose to respond to all, some, or none of the items.

Please complete the survey by November 17, 2019.

Thank you for your participation,

Clayton J. Cooke, MT-BC, Principal Researcher
Candidate for Master of Music Therapy
Appalachian State University, Hayes School of Music

Appendix D

Informed Consent for Participation in Follow-Up Interviews

MAXIMIZING REFERRALS AND ACCEPTANCE OF MEDICAL MUSIC THERAPY: A SEQUENTIAL-EXPLANATORY MIXED METHODS STUDY

Principal Researcher: Clayton J. Cooke, MT-BC; cookecj@appstate.edu, (910) 584-5281

Faculty Chair: Christine P. Leist, Ph.D., MT-BC; leistcp@appstate.edu, (828) 262-6663

Dear < >.

As part of my thesis requirements for the Master of Music Therapy degree at Appalachian State University, I am conducting interviews on music therapists' experiences of referrals and patient acceptance of music therapy services in medical settings as a follow-up to responses received through an online survey. I would like for you to participate in an interview on the above topic because of your background in music therapy in healthcare and response to the survey question to be considered for participation.

The interview will be held in a location of the participant's choice or via webcam and will last approximately 30–60 minutes. I will record the interview. The digital file from the recording will be securely stored, password protected, and deleted before April 30, 2020. The recording will be listened to by myself and members of my thesis committee and transcribed. The use of pseudonyms for all people and place names will allow each participant's personal identity and the identity of anyone mentioned in the interviews to be kept confidential. The information from the interviews will be used in my thesis and may be considered for publication or presentation at AMTA conferences.

There are no risks or benefits for participants in this study that extend beyond the opportunity to tell your stories. There is no compensation for participation. Participants' rights include the following: the right to decide not to participate in this project, the right to refrain from answering a question during the interview, the right to review the interview transcript, and the right to withdraw from the project within 10 days of the completion of the interview.

For questions, you may contact myself or Dr. Christine Leist at the contacts listed above.

I have read and understand the Informed Consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent:

Participant signature

Date _____

Sincerely,

clayton c. ke, MT-BC

Clayton J. Cooke, MT-BC

Appendix E

Letter for IRB Approval/Exemption

Date: Tue, Oct 8, 2019, 1:24 PM

From: IRB; irb@appstate.edu via adminliveunc.onmicrosoft.com

To: cookecj@appstate.edu
leistcp@appstate.edu

To: Clayton Cooke
School Of Music
CAMPUS EMAIL

From: [Name], IRB Administrator

Date: 10/08/2019

RE: Notice of IRB Exemption

STUDY #: 20-0076

STUDY TITLE: MAXIMIZING REFERRALS AND ACCEPTANCE OF MEDICAL MUSIC THERAPY: A SEQUENTIAL-EXPLANATORY MIXED METHODS STUDY

Exemption Category: 2. Survey, interview, public observation

This study involves minimal risk and meets the exemption category cited above. In accordance with 45 CFR 46.101(b) and University policy and procedures, the research activities described in the study materials are exempt from further IRB review.

All approved documents for this study, including consent forms, can be accessed by logging into IRBIS. Use the following directions to access approved study documents.

1. Log into IRBIS
2. Click "Home" on the top toolbar
3. Click "My Studies" under the heading "All My Studies"
4. Click on the IRB number for the study you wish to access
5. Click on the reference ID for your submission
6. Click "Attachments" on the left-hand side toolbar
7. Click on the appropriate documents you wish to download

Study Change: Proposed changes to the study require further IRB review when the change involves:

- an external funding source,
- the potential for a conflict of interest,
- a change in location of the research (i.e., country, school system, off site location),
- the contact information for the Principal Investigator,
- the addition of non-Appalachian State University faculty, staff, or students to the research team, or

- the basis for the determination of exemption. Standard Operating Procedure #9 cites examples of changes which affect the basis of the determination of exemption on page 3.

Investigator Responsibilities: All individuals engaged in research with human participants are responsible for compliance with University policies and procedures, and IRB determinations. The Principal Investigator (PI), or Faculty Advisor if the PI is a student, is ultimately responsible for ensuring the protection of research participants; conducting sound ethical research that complies with federal regulations, University policy and procedures; and maintaining study records. The PI should review the IRB's list of PI responsibilities.

To Close the Study: When research procedures with human participants are completed, please send the Request for Closure of IRB Review form to irb@appstate.edu.

If you have any questions, please contact the Research Protections Office at (828) 262-2692 ([Name]).

Best wishes with your research.

Websites for Information Cited Above

Note: If the link does not work, please copy and paste into your browser, or visit <https://researchprotections.appstate.edu/human-subjects>.

1. Standard Operating Procedure #9:

<http://researchprotections.appstate.edu/sites/researchprotections.appstate.edu/files/IRB20SOP920Exempt%20Review%20Determination.pdf>

2. PI responsibilities:

<http://researchprotections.appstate.edu/sites/researchprotections.appstate.edu/files/PI20Responsibilities.pdf>

3. IRB forms:

<http://researchprotections.appstate.edu/human-subjects/irb-forms>

CC: Christine Leist
School Of Music

Vita

Clayton J. Cooke, MT-BC was born in Fayetteville, NC to Stephen and Angela Cooke. He graduated from Cape Fear High School in Vander, NC in June 2012. The following Fall, he began studying at East Carolina University, and in May 2016 he completed coursework for the Bachelor of Music degree in music therapy and music performance with a concentration in classical saxophone, graduating *Magna Cum Laude*.

Clayton completed a clinical music therapy internship in Charleston, SC at Trident Medical Center and Palmetto Music Therapy, LLC., and he obtained board certification in music therapy in September 2017. In May 2018, Clayton completed dementia specialist training through the University of South Carolina after working for nearly two years with older adults in assisted living and memory care. He is experienced with a variety of medical populations including neonatal intensive care, pediatric health, adult general medical, adult intensive care, cancer care, end-of-life care, assisted living, and specialized memory care.

In the Fall of 2018, Clayton began study toward the Master of Music Therapy degree at Appalachian State University and accepted a graduate assistantship as a music therapy supervisor for undergraduate clinical students in specialized memory care group settings. While at Appalachian State University, he provided individual music therapy services to hospitalized patients in intensive care and patients receiving hospice care. In addition, he is completing a graduate certificate in Expressive Arts Therapy.

Following graduation, Clayton will begin his position as a music therapist at the Camp LeJeune Naval Medical Center in Jacksonville, NC through the Creative Forces: NEA Military Healing Arts Network, a program prioritizing the creative arts therapies to promote health, wellness, and quality of life for military patients, veterans, their families, and caregivers. Clayton is a member of the American Music Therapy Association, the Music Therapy Association of North Carolina, National Music Honor Society *Pi Kappa Lambda*, and Expressive Arts Therapy Honor Society Orchesis.