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A Survey of Music Therapists Working in Medical Hospitals

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A SURVEY OF MUSIC THERAPISTS WORKING IN MEDICAL HOSPITALS

By

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ABSTRACT

While researchers have documented the clinical use of music in medical settings, little is known about music therapists working in this setting. The purpose of the present study was to examine the demographics, educational and clinical backgrounds, music therapy practice, and employment conditions of music therapists currently working in medical hospitals. A 50-item survey was designed and electronically mailed to music therapists (N = 199) identified by the American Music Therapy Association (AMTA) as working in medical hospitals in 2006 and having valid electronic mail addresses. Forty-six respondents completed and returned the survey via either electronic mails (n = 35) or postal mails (n = 11). Results indicated that most respondents (97.8%) were Board-Certified and reported working a mean of 14 years in the music therapy profession. Respondents indicated diverse opinions concerning the influence of internship population choice on obtaining current employment as evidenced by large standard deviations. Respondents reported they participated (97.8%) and presented (78.3%) at music therapy conferences, conducted research in hospitals (43.5%), supervised interns (43.5%) and practica students (30.4%), and provided in-services at the hospitals (87%). Multiple funding sources for music therapy positions were indicated, with the majority of them (67.4%) were being funded by the hospital budget. Descriptive results concerning a music therapy practices and employment conditions in the medical settings were also presented and analyzed.
INTRODUCTION

Since the development of the music therapy profession after World War II, there has been a vast amount of research supporting its effectiveness in a wide variety of healthcare and educational settings (AMTA, 2007a). Medical practice in Veteran Hospitals was one of the earliest practices in music therapy. Since then, researchers and clinicians have continued to document the benefits of music therapy in medical settings. It has been shown that music therapy techniques reduce anxiety, reduce perception of pain, benefit psychological adjustment to trauma, and reduce stimulus deprivation (Cassidy & Ditty, 1998; Curtis, 1986; Maslar, 1986; McDonnell, 1984; White, 1992). Unlike most medical treatments or medications, music has few, if any, unwanted side effects (Standley, 2003).

In spite of the literature base supporting clinical uses of music in medical treatments, little is known about the actual music therapists in this setting. Research concerning music therapists in a specific practice is valuable as it describes where and how music therapy services are being offered, thus informing researchers and clinicians of the strengths of the profession and areas for future concentration and study (Silverman & Hairston, 2005). Therefore, it is crucial to examine current clinical trends of music therapy in medical settings.

Review of Literature

Definition of Medical Music Therapy

With the ongoing research and clinical work of clinicians and researchers, music therapy has become a recognized profession in numerous settings. Currently, music therapists work in multifarious settings such as psychiatric hospitals, rehabilitative facilities, medical hospitals, outpatient clinics, day care treatment centers, agencies serving developmentally disabled persons, community mental health centers, drug and alcohol programs, senior centers, nursing homes, hospice programs, correctional facilities, halfway houses, schools and private practice (AMTA, 2007b). As the applications of music therapy become more diverse, it is important to provide a definition for purposes of communication and advocacy.
Bruscia was one of the pioneers in the field. In his book “Defining Music Therapy”, Bruscia (1989) delineated several areas and levels of practices. The four levels of practice were auxiliary level, augmented level, intensive level, and primary level. The use of music in auxiliary level was for non-therapeutic but related purposes, whereas music or music therapy in augmentative level was used to support other treatment modalities. Music therapy took a central and independent role in addressing the client’s needs in the intensive level. For primary level, music therapy took an indispensable or singular role in meeting the clients’ therapeutic needs to induce changes in their lives.

Bruscia also noted that music could be used in medical settings, which included all applications of music or music therapy to facilitate medical treatment, prevention of disease or injury, or to support the patient during treatment or convalescence. However, the medical treatment of musicians for health problems resulting from musical involvement was not included, unless music was used in the process (Rider, 1987).

He further explained his terminology to clarify the definition of medical practice. The term “Music in medicine” referred to the music used to influence the patient’s physical, mental or emotional states before, during, or after medical treatment. “Music therapy in medicine” is the use of musical experiences and the therapist-client relationship developed as a means of helping medical patients gain greater control over their illness, treatment, or convalescence. To Bruscia (1989), medical practice included “music in medicine” at the augmentative level, and “music therapy in medicine” at the intensive or primary level.

Maranto (1989) shared similar views with Bruscia. He classified medical music therapy into five categories: 1) music as medicine; 2) music in medicine; 3) music therapy and medicine; 4) music therapy as medicine; and 5) music therapy in medicine. Each category was differentiated by the role of music in treatment and the significance of the therapeutic relationship. In the categories “music therapy and medicine”, “music therapy as medicine” and “music therapy in medicine”, the therapeutic relationship was respectively considered an equal role of importance, a more important role, and a supportive role to medical treatments.

Based on Bruscia’s definition, Maranto (1989) stated that there were several requirements of medical music therapy: a client with some type of medical need,
therapeutic goals based on initial diagnostic intakes and ongoing assessments, a trained
music therapist, musical experiences within the treatment session, and a therapeutic
relationship developed between the client and the therapist. According to Maranto
(1989), medical music therapy refers to the functional uses of music in medical
specialties, such as surgery or cardiac care.

The above definitions by Bruscia and Maranto include requirements, levels, and
areas of treatments, which are generally accepted as the working definition of medical
music therapy. Currently, American Music Therapy Association (AMTA) provides a
precise and inclusive definition of music therapy in the population “music therapy and
medicine” as follows:

“Music Therapy is the clinical and evidence-based use of music interventions to
accomplish individualized goals within a therapeutic relationship by a
credentialed professional who has completed an approved music therapy program.
It is an established health service similar to occupational therapy and physical
therapy and consists of using music therapeutically to address physical,
psychological, cognitive and/or social functioning for patients of all ages. Because
music therapy is a powerful and non-invasive medium, unique outcomes are
possible. In addition to its applications with hospital patients, music therapy is
used successfully with persons of all ages and disabilities.” (AMTA, 2006c)

Development of Music Therapy in Medical Hospitals

The connection between music and medicine is ancient. In all probability, it dated
back to Paleolithic times (West, 2000). Myths and narratives on the healing power of
music have been found in most cultures. One of the best known in the Western
hemisphere is the story of Saul and David, where King Saul’s torment by an evil spirit
was relieved by David’s harp music (Wigram, 2002). From 800 A.D. to 1800 A.D.,
music and medicine were considered inseparable and were an integral part of a
physician’s training and practice (Kuemmel, 1978).

According to Kuemmel (1978), the earliest hospital where music was continuously
presented can be traced to Cairo around 1284. However, in hospitals of the Western
world at that time, especially in Rome, music was not used therapeutically. Instead, it was
reserved for religious services and was available to the orphans housed on the hospital grounds as music instruction. During the 17th century, controversial philosophical literature appeared doubting the therapeutic use of music. It was not until late 18th century that the impact of music on human beings was recognized in a highly complex nature. Kuemmel (1978) reported that the search for effective therapeutic music began in earnest during the 18th century. Although an affinity existed between the fields of music and medicine, the two fields diverged during the late 18th and 19th centuries (Boxberger, 1962).

Taylor (1981) presented a chronological report of music in general hospital treatment from 1900 to 1950. In his article, Taylor described that renewed interest was directed toward the use of music in hospitals with Edison’s invention of the phonograph in 1877 and the introduction of commercially feasible disc records in 1896. He also noted that music was used as both a diversion and a sleeping aid during the day and at night. While music helped mitigate fears of operations in operating rooms, it also provided assistance during administration of local anesthesia (Boxberger, 1963).

The first official acknowledgement of possible therapeutic applications of music in general hospital treatment was attributed to Dr. Evan O’Neill Kane (Taylor, 1981). In 1914, Dr. Kane’s letter was published in the Journal of the American Medical Association and noted a phonograph was used in the operating room to calm and distract patients before general anesthesia and during local anesthesia (Kane, 1914, p.1829).

During the first half of the twentieth century, the most extensive account of music in general hospitals concerned its use in conjunction with anesthesia and analgesia (Taylor, 1981). The cornerstone of this movement was the published text by Dr. Esther Gatewood in 1920 where she advocated a physiological explanation for changes in the type of musical selection most enjoyed at different times (Gatewood, 1921). She described a gradual mood change, which later became known as the “iso-principle” (Taylor, 1981). Gatewood (1921) further offered a scientific basis for music’s beneficial effects. She suggested that two separate sensory stimuli entering the nervous system simultaneously tended to neutralize each other. Only the stronger, more persistent stimulus can enter the consciousness. Hence, when an individual focused on a single stimulus such as music, other stimuli could be neutralized or ignored.
In 1929, the first permanent commitment to hospital music was made with the construction of Duke University Hospital (Taylor, 1981). The hospital provided radio broadcasts for all inpatients through earphones encompassing sponge rubbered and cushioned reception units. Speakers were mounted on walls of the children’s floor, the infants’ floor, the ward utility room, the preparation room, and the recovery room to allow music while waiting, during monotonous tasks, and during recovery (Pickrell, Metzger, Wilde, Broadbent, & Edwards, 1950). As there were increasing publications and research describing music in hospitals, interest in the therapeutic use of music was also spreading to other treatment areas such as in obstetrics and gynecology (Taylor, 1981). The fact that music did not interfere with operating room techniques and could be changed for each patient to provide optimum diversion indicated it was the best means of overcoming fear and objections to chemical agents (McGlinn, 1930). McGlinn suggested that obstetricians and gynecologists should employ music as it provided a diversion and a better atmosphere for surgical patients. Furthermore, music served to relax the tension of operators and attending personnel and entertain the operating room suite force during preparation and cleanup procedures. He also reported that many hospitals were using radio broadcasts to accompany local anesthesia in children’s tonsillectomies.

In 1935, Best and his dentist associates discovered that bone-conducted sound inclined to supersede air transmitted vibrations and that patients tended to concentrate on music. They experimented with various areas of the skull with the conclusion that amplifiers applied to the “mastoid portion of the temporal bones offered by far the best conduction” (Best, 1935, p.265). By introducing music directly into the auditory centers of the brain by bone conduction, the unpleasant noises associated with the grinding of teeth became less audible to the patients. Thus, music was used to mask sounds that could be associated with pain or anxiety.

During the 1940s, the therapeutic use of music in hospitals was becoming more widely studied (Gilliland, 1956; Pickrell, Metzger, Wilde, Broadbent, & Edwards, 1950). Gilliland’s (1956) experiments attempted to demonstrate the influence of music to elicit physiological changes such as enhanced body metabolism, increased or decreased muscular energy, accelerated respiration with decreased regularity, changes in cardiovascular response, lowered thresholds for sensory stimuli, and increased internal
glandular secretions. Pickrell and associates (1950) examined the use of music in all phases of the surgical procedure and in other hospital departments. Their goal was to eliminate fear, establish confidence, and allay apprehension by producing a congenial atmosphere. Meanwhile, radio-phonograph music was used to provide pleasure for children and to facilitate custodial care in the pediatric ward.

Following World War II, the military began to examine the usefulness of medical applications of music in hospitals for wounded and disabled veterans (Taylor, 1981). In 1947, a group consisting of the retired Army Surgeon General, the Chief of the Navy’s Bureau of Medicine and Surgery, and the Veterans Administration Chief of Medical Services ruled that music could not be classified with quinine, penicillin, and infrared treatment as a therapy (Lewis, Burris-Meyer, & Cardinell, 1947). However, the beginning of the music therapy career in the United States was mostly attributed to the volunteer musicians playing music in Veterans Hospitals for traumatized soldiers (Davis, Gfeller, & Thaut, 1992). The patients’ notable physical and emotional responses to music led doctors and nurses to request the hiring of musicians by hospitals and it became evident that prior training was needed for hospital musicians before entering the facility (AMTA, 2007d).

Despite the work and research completed during the first half of this century, published reports of music in physical medicine were widely scattered among journals and periodicals. Physicians and other professionals interested in such research had no complete and readily available source of information. As a result, many investigations were begun with the belief that each was original (Taylor, 1981). With formation of the National Association for Music Therapy (NAMT) in 1950, an organization became available for presentation and publication of music therapy applications. As a result, the number of published studies describing music therapy in general hospitals increased substantially. In 1998, the former NAMT and the former American Association of Music Therapy (AAMT) unified to become the American Music Therapy Association (AMTA), which is now the largest professional association using music in therapy in the United States. Music therapy in medical hospitals continues to grow as an evidenced-based profession.
Music Therapy Research and Current Practice in Medical Hospitals

Medical music therapy services have been established nationwide in children’s hospitals, cancer settings, and general medical facilities (Standley & Walworth, 2005). According to the statistical profile of 2006 AMTA membership, it is reported that currently 10% of the nation’s music therapists are serving in medical/surgical settings (AMTA, 2006). With the rapid growth of music therapy in these settings, the diverse body of research literature serves as a valuable resource for clinicians and researchers.

Standley (2000) performed a meta-analysis of medical research to provide a viable means of integrating the diverse results in the literature. From a total of 92 music medicine studies meeting the research criteria, the overall effect size for the designated primary dependent variables was 1.17, which indicated the average therapeutic effect of music in medical treatment was more than one standard deviation greater than the same treatment without music (Standley, 2003). The meta-analysis also provided some important generalizations about the use of music in medical treatment. It was found that women respond to music with greater effect than do men. Children and adolescents responded with greater effect than did adults and infants. For music and pain perception, it was reported that music’s effects were greatest when the patient experienced some pain, but music became less effective as the pain increased. Live music had a much greater effect than did recorded music, while preferred music had the greatest effect. The results from this study not only affirmed the therapeutic value of music in medical setting, but also provided a general guideline for clinicians to effectively apply music for patients’ greatest benefit.

Medical music therapy programs provide quality music therapy services to patients based on established practices and approved hospital protocols (Standley, 2003). Currently, such programs typically consist of a diversity of services with specific treatment goals to serve the comprehensive scope of possibilities in the medical environment. In a medical music therapy clinical program described by Standley and her colleagues (Standley, 2005), music therapy has been successfully applied in numerous areas such as the Newborn Intensive Care Unit (NICU), Pediatric Intensive Care Unit (PICU), oncology, the rehabilitation center, orthopedic/neurology areas, labor and delivery/antenatal care units, emergency services, outpatient pediatric rehabilitation, and
adult day services. Treatment goals may include, but are not limited to, enhancing neurological development by multimodal stimulation, decreasing need for sedation and reducing anxiety during procedures, reducing use of post-operative medications and relieving side-effects of anesthesia, reducing physiological distress in pain management, elevating mood and improving quality of life, and facilitating difficult or extended labor, (Nguyen, Jarred, Walworth, Adams, & Procelli, 2005).

Survey Research in Music Therapy

Survey research has been a widely used and acknowledged method in music therapy publications (Braswell et al., 1979; Jones, 2006; Register, 2002; Taylor, 1987; Toppozada, 1995; Wyatt & Furioso, 2000). With survey techniques, it may be possible to generalize about an entire population by drawing inferences based on data drawn from a smaller portion of that population (Rea, 1997).

Braswell, Maranto, and Decuir (1979) studied the clinical practice of music therapy through a comprehensive survey. The survey encompassed four areas: the institutions where music therapists work, personal data, clinical practice, and university and clinical training. The broad range of issues included in their survey served as important avenues for communication among all members, particularly between field workers and academicians (McGinty, 1980). Additionally, together with a survey of duties and responsibilities of music therapy positions (McGinty, 1980) and a survey about functions of a music therapist (Lathom, 1982), these data served as a valuable reference for use in curriculum design, certification test development, standards of practice, and the design of clinical training programs (Lacy & Hadsell, 2003; Lathom, 1982; Wyatt & Furioso, 2000).

After two decades, researchers have shown renewed interest in evaluating trends and studying music therapy practice in specific populations using survey techniques (Codding, 2002; Lacy & Hadsell, 2003; Silverman & Hairston, 2005). Lacy and Hadsell (2003) examined music therapy practice as an occupation and its viability as a means of earning a living in the Southwestern Region of the AMTA. It was found that music therapists in the Southwestern Region earned their incomes through a variety of means, including contracts, employment, private clients, special music education, adapted music teaching,
applied music teaching, music performance, mental health services, retail sale of MT paraphernalia, and miscellaneous. Codding (2002) studied the demographics, conditions of employment, service provision, assessment, therapeutic objectives, and related value of music therapists working in correction/forensic psychiatry through a comprehensive survey, which provided important information to understand the actual practice of music therapists working in this specific setting. A similar survey was completed by Silverman and Hairston (2005) concerning music therapists in private practice. The findings were beneficial toward understanding music therapists in private practice in order to evaluate future development of the profession.

Today, the Internet has become an extremely rich source of information (Johnson, Geringer & Stewart, 2003). Popular for its abundant sources of information and convenient means of communication, the Internet provides survey researchers with many new opportunities (Zhang, 1999). Zhang (1999) summarized the pros and cons of electronic mail surveys compared with conventional mail surveys. The research costs for an Internet-based survey were relatively low and a large number of individuals could be reached efficiently. A shorter turnaround time could be expected and it could readily reach potential respondents in geographically remote areas. When the nature of a research topic was sensitive, Internet-based surveys offered a means to reach a specific niche of participants. They may increase respondents’ motivation to participate by providing a dynamic/interactive survey process. Errors from transcription and coding could also be reduced. However, there are a number of potential problems and concerns unique to Internet-based surveys. Biased samples and biased returns could occur due to the unequal access to the internet and survey of potential respondents. Also, differences in comfort with internet survey formats, self-selection in Internet-based surveys, and doubtful validity of respondents may be other problem areas. Other concerns may include variation and difficulty in reporting response rates, impersonalized survey requests, and more expertise required for survey researchers (Zhang, 1999).

Recently, music therapy researchers have explored applying electronic mail surveys in their studies. Two published research articles were found in the music therapy literature surveying music therapists using electronic mail (Jones, 2006; Silverman & Hairston, 2005). When discussing the response rates of traditional and electronic mail
survey, Jones (2006) indicated the return rate of completed surveys by electronic mail in her study was respectable and comparable to mailed surveys in music therapy, while Silverman and Hairston (2005) reported that the return rate of their electronic mailed survey was lower than the return rate of other recently published music therapy survey studies. Nevertheless, both studies affirmed the value of Internet-based research as technology advances.

Purpose of Study

The purpose of this study was to provide demographic information and a professional profile about music therapists specifically working in medical hospital settings and a description of their music therapy practice and employment conditions in the hospitals. Additionally, it presents data that may be used for practitioners in the clinical field, to those who are considering the field as a future occupation, and to educators of future music therapists.
METHOD

Research Participants

Participants were members of the American Music Therapy Association (AMTA) who had identified themselves as working in medical hospitals in the 2006 AMTA database (AMTA, 2006). The survey was designed to be delivered via electronic mail (email), and thus, only members in the medical setting with valid electronic mail address were included in the study. There were 199 music therapists who met criteria for inclusion in the study.

Survey Instrument

A 50-question survey regarding music therapists working in medical hospitals was constructed by the researcher, and revised and edited by six music therapists practicing in medical hospitals and one university professor (see appendix). The survey consisted of four parts: demographics (9 questions), educational background and clinical experience (6 questions), music therapy practice (25 questions), and employment conditions in hospitals (10 questions).

For the purpose of this study, hospitals were categorized according to medical conditions of patients and the ownership of the hospital. Two types of hospital identified by medical conditions of patients were “general hospital” and “specialized hospital”. “General hospital” indicated those with the full range of medical conditions for which most people require treatment, while “specialized hospital” focused on a particular disease (cancer, rehabilitation, etc) or condition, or in one type of patient (children, elderly, etc). There were three types of ownership recognized: voluntary, proprietary, and government-supported. “Voluntary hospital” was defined as a non-profit community facility operated by religious or other voluntary auspices; “proprietary hospital” was defined as a profit-making institution owned by corporations or by individuals; and “government-supported hospital” was defined as a non-profit institution owned and operated by federal, state, or local government, that received its largest funds from public tax support. For the questions concerning client populations served during internship,
populations were categorized according to the 2006 AMTA statistical profile (AMTA, 2006).

The five clinical techniques were adapted from Codd (2002). Her study included five clinical models recognized in the 1999 World Congress of Music Therapy and two additional clinical models. Music therapists indicated these five clinical techniques as the techniques that they most strongly identified with: “Behavioral Music Therapy - Madsen”, “Clinical Improvisation – Bruscia”, “Nordoff-Robins Technique”, “Guided Imagery (GIM) – Bonny”, and “Benezon Music Therapy”.

Procedure

Surveys with cover letters were electronically mailed to all the participants (N=199). The cover letter explained the purpose of the research and provided the contact information of the researcher. Participants were informed that their participation was voluntary, and consent was implied upon completion of the survey. Instructions concerning completion of the survey and returning it to the researcher electronically were provided. To provide a method for complete anonymity and to encourage participants with all levels of technical expertise to respond, participants had the option to receive, complete, and return the survey via postal mail. A stamped return envelope with printed survey was provided upon request. Follow up emails were sent after two weeks to participants who had not responded.
RESULTS

Of the 199 emails sent to the participants, 19 emails were undelivered, leaving an assumed delivery of 180. The researcher received 58 (32.2%) responses from the participants. Twelve of the 58 surveys were excluded from the survey analysis as six respondents indicated that they were no longer working in a medical setting, three respondents were on leave and three returned surveys that were unable to be analyzed. The remaining 46 surveys met criteria for inclusion in the study. Thirty-five of these 46 surveys were received via e-mail while 11 of them were received via postal mail. Thus, the response rate for data analysis was 26%.

Table 1 lists the percentage distribution of respondents and that of AMTA membership by region (AMTA, 2006). Most participants were located in the Great Lakes and Mid-Atlantic regions. Comparison between the sample to the overall AMTA data show that the sample for this study was highly representative of the profession’s regional distribution.

TABLE 1
Comparison of regional distribution between the sample and AMTA Membership

<table>
<thead>
<tr>
<th>Region</th>
<th>Frequency (%) of Respondents</th>
<th>Frequency (%) of AMTA Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Great Lakes</td>
<td>12 (26.1%)</td>
<td>245 (22.2%)</td>
</tr>
<tr>
<td>Mid-Atlantic</td>
<td>10 (21.7%)</td>
<td>317 (28.7%)</td>
</tr>
<tr>
<td>Midwestern</td>
<td>6 (13%)</td>
<td>90 (8.1%)</td>
</tr>
<tr>
<td>New England</td>
<td>3 (6.5%)</td>
<td>64 (5.8%)</td>
</tr>
<tr>
<td>Southeastern</td>
<td>6 (13%)</td>
<td>138 (12.5%)</td>
</tr>
<tr>
<td>Southwestern</td>
<td>2 (4.3%)</td>
<td>72 (6.5%)</td>
</tr>
<tr>
<td>Western</td>
<td>7 (15.2%)</td>
<td>145 (13.1%)</td>
</tr>
<tr>
<td>Outside the US</td>
<td>0 (0%)</td>
<td>35 (3.2%)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>46 (100%)</strong></td>
<td><strong>1,106 (100%)</strong></td>
</tr>
</tbody>
</table>

Participants were asked a series of multiple-choice and open-ended questions. These questions and responses are shown in Table 2. The high percentage (95.6%) of female participants in this study indicated that most music therapists working in medical hospitals were female. Compare with the gender distribution of AMTA Membership (Female 86.8%), it was shown that medical settings comprised a higher percentage of female music therapists than the overall music therapy profession. More than half of the respondents reported they were below 40 years of age. Thus, most music therapists in the
medical field are slightly younger than those in all other areas of music therapy (AMTA, 2006).

Almost all of the music therapists in this setting were Board Certified (MT-BC). When asked about the music therapy credentials or designations required for employment in the hospital, majority of the respondents reported that MT-BC was specifically required, while a few of them reported that any music therapy credentials or designations were accepted. Most participants reported their job title as “music therapist”, which indicated a higher percentage than that of the overall music therapy profession (AMTA, 2006).

Of the music therapists ($n = 44$) who had indicated their educational level, all reported they had completed their baccalaureate degrees. Among the 44 respondents, half of them reported having a master’s degree, with fourteen (31.8%) being in music therapy or music related fields, and eight (18.2%) being in other related fields. Of the three respondents reported having a doctoral degree, two were in music therapy and one was in music education. Compare to the 2006 AMTA Sourcebook, these music therapists working in medical field were more educationally advanced than those in other areas. In addition, a great number of the respondents ($n = 27; 58.7\%$) reported having one or more additional certifications or licenses. Additional certifications or licenses included Neurologic Music Therapy ($n = 10$), Licensed Professional Counselor ($n = 4$), Licensed Creative Arts Therapist ($n = 3$), Neonatal Intensive Care Unit Music Therapist ($n = 2$), Licensed Social Worker ($n = 2$), teacher certification ($n = 2$), Certified Child Life Specialist ($n = 1$), Grief Recovery Specialist ($n = 1$), Certified Brain Injury Specialist ($n = 1$), Certification in the Bonny Method of Guided Imagery and Music ($n = 1$), Certified Educator of Infant Massage ($n = 1$), and German Diploma in Music Therapy (FH) ($n = 1$).

More than half of the respondents reported employing one or more additional music therapists in their hospital. One participant reported their hospital employed five music therapists. There were numerous respondents reported that there was at least one music therapy internship position at their hospital. The number of internship positions ranged from one to four, with two intern positions being the most common. Approximately thirty percent of the respondents reported that there were music therapy practica students at
their hospital. The number of music therapy practica students ranged from one to ten students, with two practica students being the most common.

Respondents worked equally in general and specialty hospitals. Most music therapists worked in voluntary hospitals. Participants were surveyed about the funding sources of music therapy positions in the hospitals. More than one funding source was indicated by numerous respondents ($n = 19; 41.3\%$). The majority of participants reported they were funded by hospital budgets or grants. Other funding sources included foundations, reimbursement, private contract, and other. The grant proposals were mostly written by music therapists and other professionals in hospitals.

Respondents were asked to categorize their music therapy service by number of patients. The majority of respondents reported they provided both individual and group music therapy services in the hospital, while just one respondent reported only group music therapy was provided. A great number of the respondents reported the music therapist alone was responsible for the music therapy session design, while some respondents reported that they designed the session with the interdisciplinary team.

Respondents indicated that patients were referred through multiple methods. The greatest percentage of patients was referred verbally from other professionals in the hospital. Other more common referral methods were specific patient group and computer-based referral. Professionals whom referred patients to music therapy services most frequently were nurses, child life specialists, physicians and social workers.

When questioned about documentation methods, all respondents reported documentation was required in their hospitals. Majority of them used the same documentation method as other medical staff in the hospital, while some used self-developed music therapy documentation methods. A small percentage of respondents reported they used both methods.

More than forty percent of the respondents reported working as part time (working less than 32 hours per week). Of the remaining twenty-seven (58.7\%) full time music therapists, most of them (41.3\%) reported working 40 hours per week. One respondent reported working “50+” hours per week. Among the 27 full time music therapists, twenty-five (54.3\%) responded to the question about their annual salary range. All of the full time music therapists reported having an annual salary of $30,000 or above. The
average annual salary of music therapists in medical settings is higher than that in AMTA Sourcebook (2006).

Participants were asked about their allocation of time during the work week. They indicated that almost half of their time was spent on conducting music therapy sessions, and the remaining time was spent on doing administrative work, documentation, and communication with other professionals.

Concerning internship experience, twenty-five (54.3%) of the respondents reported having experience in multiple client populations during their internship. Most respondents reported working with Medical/Surgical and Mental Health populations during their internship. When asked about their opinions in the importance of population during internship that best prepared a music therapy student to work as a music therapist in hospitals, most respondents indicated Medical/Surgical setting \( (n = 35) \). The respondents were also asked to rate the extent in which they agreed or disagreed that, “the area of population served during my internship had a direct influence on obtaining my present hospital position”, in a scale of 1 to 7, with 7 represented “strongly agree”. The results (See Table 3) revealed the diverse opinions on the influence of internship population and obtaining hospital positions.

### TABLE 2

**Questions and Responses**

<table>
<thead>
<tr>
<th>Question</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( n ) responses</td>
</tr>
<tr>
<td>Gender Female</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Age range 20-24</td>
<td>2</td>
</tr>
<tr>
<td>25-29</td>
<td>5</td>
</tr>
<tr>
<td>30-34</td>
<td>8</td>
</tr>
<tr>
<td>35-39</td>
<td>10</td>
</tr>
<tr>
<td>40-44</td>
<td>5</td>
</tr>
<tr>
<td>45-49</td>
<td>5</td>
</tr>
<tr>
<td>Above 50</td>
<td>11</td>
</tr>
<tr>
<td>Professional Title MT-BC</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>CMT</td>
</tr>
<tr>
<td></td>
<td>RMT</td>
</tr>
<tr>
<td>Educational Level Baccalaureate</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>Master</td>
</tr>
<tr>
<td></td>
<td>Doctoral</td>
</tr>
<tr>
<td>Types of Hospital</td>
<td>General</td>
</tr>
<tr>
<td>-------------------</td>
<td>---------</td>
</tr>
<tr>
<td></td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Funding Sources</th>
<th>Hospital Budget</th>
<th>Grant</th>
<th>Foundation</th>
<th>Reimbursement</th>
<th>Others</th>
<th>Private Contract</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>31</td>
<td>17</td>
<td>10</td>
<td>5</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>67.4%</td>
<td>37%</td>
<td>21.7%</td>
<td>10.9%</td>
<td>10.9%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Grant Proposals</th>
<th>Other Professionals</th>
<th>Music Therapists</th>
<th>Grant Writers</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>8</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>47.1%</td>
<td>41.2%</td>
<td>29.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Types of MT service</th>
<th>Individual &amp; Group</th>
<th>Individual only</th>
<th>Group only</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>39</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>84.4%</td>
<td>13.3%</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MT session design</th>
<th>MT (self)</th>
<th>Interdisciplinary Team</th>
<th>MT staff</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>97.8%</td>
<td>21.7%</td>
<td>13.0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Professionals referring MT patients</th>
<th>Nurse</th>
<th>Child Life Specialist</th>
<th>Physician</th>
<th>Social Worker</th>
<th>OT, PT, &amp; RT</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>32</td>
<td>23</td>
<td>22</td>
<td>22</td>
<td>19</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>69.6%</td>
<td>50%</td>
<td>47.8%</td>
<td>47.8%</td>
<td>41.3%</td>
<td>34.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Documentation Methods</th>
<th>Stand doc in hospitals</th>
<th>Self-developed</th>
<th>Both methods</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>63%</td>
<td>26.1%</td>
<td>10.9%</td>
</tr>
</tbody>
</table>
Participants were asked a series of questions that required quantitative answers. These descriptive statistics of responses are depicted in Table 3. Participants reported they had been working in medical hospitals for a mean of 11.12 years. Compared with previous studies in other settings (Braswell, Maranto, & Decuir, 1979; Codding, 2002; Silverman & Hairston, 2005), the medical settings consisted of more experienced music therapists. Furthermore, an increase in longevity was found in the medical field.

Large ranges were shown in the number of individual and group patients seen per week, indicating the diverseness of medical music therapists’ caseloads. From the mean value of the data, it can be derived that there were approximately a mean of three groups and eighteen individual patients per week.

Respondents were asked to rate the extent they agreed or disagreed, in a scale of 1 to 7 (with 7 represented “strongly agree”), concerning a series of sentences about their employment conditions. The high mean rating of their enjoyment of working in the hospital indicated a high job enjoyment level. A high mean rating was also found in the aspect where respondents reported music therapy was accepted as a profession and appreciated in their hospitals. These data are congruent with previous studies (Braswell, Decuir, & Jacobs, 1989; Braswell, Maranto, & Decuir, 1979; Silverman & Hairston,
2005). Lowest rating is found in the hospital support for music therapy, but this is still in the higher satisfaction range.

**TABLE 3**

*Descriptive Statistics of Quantitative Questions*

<table>
<thead>
<tr>
<th>Measure</th>
<th>N</th>
<th>Minimum</th>
<th>Maximum</th>
<th>Range</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internship influence on present job positions</td>
<td>46</td>
<td>1</td>
<td>7</td>
<td>6</td>
<td>4.67</td>
<td>2.10</td>
</tr>
<tr>
<td>Number of years working at present hospital</td>
<td>46</td>
<td>1</td>
<td>29</td>
<td>28</td>
<td>8.41</td>
<td>7.04</td>
</tr>
<tr>
<td>Number of years working in any hospitals</td>
<td>46</td>
<td>1</td>
<td>36</td>
<td>35</td>
<td>11.12</td>
<td>8.88</td>
</tr>
<tr>
<td>Number of years working in any settings</td>
<td>46</td>
<td>1</td>
<td>36</td>
<td>35</td>
<td>14.04</td>
<td>9.43</td>
</tr>
<tr>
<td>Number of individual patients seen per week</td>
<td>43</td>
<td>2</td>
<td>50</td>
<td>48</td>
<td>17.97</td>
<td>11.99</td>
</tr>
<tr>
<td>Number of group patients seen per week</td>
<td>39</td>
<td>2</td>
<td>125</td>
<td>123</td>
<td>23.21</td>
<td>28.77</td>
</tr>
<tr>
<td>“I am satisfied with my current work load.”</td>
<td>45</td>
<td>1</td>
<td>7</td>
<td>6</td>
<td>5.00</td>
<td>1.49</td>
</tr>
<tr>
<td>“I would prefer to increase my current workload.”</td>
<td>45</td>
<td>1</td>
<td>7</td>
<td>6</td>
<td>3.22</td>
<td>1.89</td>
</tr>
<tr>
<td>“I enjoy my job in the hospital.”</td>
<td>45</td>
<td>5</td>
<td>7</td>
<td>2</td>
<td>6.47</td>
<td>.66</td>
</tr>
<tr>
<td>“I feel music therapy is accepted in the hospital as a profession.”</td>
<td>46</td>
<td>3</td>
<td>7</td>
<td>4</td>
<td>5.65</td>
<td>1.12</td>
</tr>
<tr>
<td>“I feel music therapy is appreciated in the hospital.”</td>
<td>46</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>6.11</td>
<td>1.10</td>
</tr>
<tr>
<td>“I feel that most of the professionals in the hospital are supportive toward music therapy as a profession.”</td>
<td>45</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>5.49</td>
<td>1.24</td>
</tr>
<tr>
<td>“I feel that the hospital provides enough support to current music therapy services.”</td>
<td>46</td>
<td>1</td>
<td>7</td>
<td>6</td>
<td>4.63</td>
<td>1.64</td>
</tr>
</tbody>
</table>

Table 4 represents the respondents’ involvement in music therapy conferences and activity at their hospitals. Results indicated music therapists in the medical field were highly involved in the profession. Almost all participants participated at music therapy conferences and a majority of them had presented at conferences. Over forty percent of
the respondents reported they conducted research in their hospitals. A great number of respondents provided in-services in their hospitals. Of those who reported that in-services were provided, there was a wide range in the frequency that in-services were provided. It was indicated that in-services were provided as frequently as “5 days per week” to as infrequently as “twice in 4 years”.

TABLE 4
Involvement in Music Therapy Conferences and Activity at Hospital

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate at Music Therapy Conference</td>
<td>45 (97.8%)</td>
<td>1 (2.2%)</td>
</tr>
<tr>
<td>Present at Music Therapy Conference</td>
<td>36 (78.3%)</td>
<td>10 (21.7%)</td>
</tr>
<tr>
<td>Conduct research in hospital</td>
<td>20 (43.5%)</td>
<td>26 (56.5%)</td>
</tr>
<tr>
<td>Provide in-services</td>
<td>40 (87%)</td>
<td>6 (13%)</td>
</tr>
</tbody>
</table>

Respondents were asked to select all populations to which their hospitals provided services. Results are depicted in Table 5. The greatest discrepancy was found in the “prenatal” population: while twenty (43.5%) hospitals provided services to the “prenatal” population, only less than half of them (17.4%) provided music therapy services to this population.

TABLE 5
Populations for which hospitals provide medical services and music therapy services

<table>
<thead>
<tr>
<th>Population</th>
<th>% hospitals providing medical services</th>
<th>% hospitals also providing music therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal</td>
<td>20 (43.5%)</td>
<td>8 (17.4%)</td>
</tr>
<tr>
<td>Infants</td>
<td>35 (76.1%)</td>
<td>31 (67.4%)</td>
</tr>
<tr>
<td>School age children</td>
<td>39 (84.8%)</td>
<td>36 (78.3%)</td>
</tr>
<tr>
<td>Adolescents</td>
<td>39 (84.8%)</td>
<td>37 (80.4%)</td>
</tr>
<tr>
<td>Adults</td>
<td>29 (63%)</td>
<td>24 (52.2%)</td>
</tr>
<tr>
<td>Seniors</td>
<td>26 (56.5%)</td>
<td>21 (45.7%)</td>
</tr>
</tbody>
</table>

When asked to rank five departments/units in the hospital where music therapy services were most frequently provided, it was indicated that music therapy services were provided in a variety of departments/units in the hospital. Participants reported that the Oncology/Hematology department received music therapy services most frequently. When asked about the five musical instruments used most frequently in the hospital, “voice” ranked the first while “guitar” ranked the second. Other musical instruments not shown in the table included drums (n = 12), auxiliary percussions (n = 8), Orff instruments (n = 4), harp/autoharp/folk harp (n = 4), xylophone (n = 3), lyre (n = 2).
boom whacker \( n = 1 \), Indian flute \( n = 1 \), clarinet \( n = 1 \), cello \( n = 1 \), oboe \( n = 1 \), Native American flute \( n = 1 \), recorder \( n = 1 \), and harmonica \( n = 1 \).

TABLE 6
Ranking of Department/Unit receiving music therapy services and musical instruments used most frequently

<table>
<thead>
<tr>
<th>Ranking</th>
<th>Department/Unit</th>
<th>Instrument</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Oncology/Hematology</td>
<td>Voice</td>
</tr>
<tr>
<td>2</td>
<td>Pediatrics/ Pediatric Intensive Care Unit (PICU)</td>
<td>Guitar</td>
</tr>
<tr>
<td>3</td>
<td>Inpatient Rehabilitation</td>
<td>Hand percussion</td>
</tr>
<tr>
<td>4</td>
<td>Intensive Care Unit (ICU)</td>
<td>Piano/Keyboard</td>
</tr>
<tr>
<td>5</td>
<td>Mental Health</td>
<td>Q-chord/Omnichord</td>
</tr>
</tbody>
</table>

Participants were asked to rate how often they use the five selected music therapy techniques. Responses were then ranked in order and a Friedman Analysis of Variance test was performed to determine if there were differences between the five techniques used by medical music therapists. Table 7 summarizes the results of the computations. Results indicated that “clinical improvisation” was used more frequently than the other four techniques, whereas “Benezon Music Therapy” technique was used less frequently. The small significance level (<.05) indicates that at least one of the techniques differs from others. A Wilcoxon Signed-Rank test was then performed to determine differences in the distributions of the five techniques. Significant differences were found between all paired combinations of the listed techniques, except that between clinical improvisation and behavioral music therapy.

TABLE 7
Friedman Analysis of Variance test

<table>
<thead>
<tr>
<th>Technique</th>
<th>Mean Rank</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Improvisation</td>
<td>1.71</td>
<td>.72</td>
</tr>
<tr>
<td>Behavioral Music Therapy</td>
<td>2.11</td>
<td>1.08</td>
</tr>
<tr>
<td>Nordoff-Robins Technique</td>
<td>3.21</td>
<td>1.08</td>
</tr>
<tr>
<td>Guided Imagery</td>
<td>3.59</td>
<td>.96</td>
</tr>
<tr>
<td>Benezon Music Therapy</td>
<td>4.39</td>
<td>.65</td>
</tr>
</tbody>
</table>
DISCUSSION

The return rate of this study was 32.2%, which was lower than that of previous music therapy survey research in other settings (Codding, 2002; Silverman & Hairston, 2005). This survey consisted of 50 questions which encompassed a broad range of issues including demographics, educational and clinical background, music therapy practice, and employment conditions in the hospital. The length and complexity of the survey may have reduced some potential participants’ motivation to complete the survey, thus affecting the return rate. Another reason may be the technology expertise needed in completing the survey in electronic format. Of the 46 music therapists who had completed the survey, 35 responded via electronic mail while the remaining 11 responded via postal mail. While some respondents sought additional instructions in filling out the survey in electronic format, some expressed appreciation for this paperless method and suggested other web-based survey tools (e.g., surveymonkey) for future research. Although web-based research is not yet common in the music therapy field, it has great potential to develop. Researchers may continue to explore, develop, and employ this area of technology.

Data indicated that the mean duration of total practice in this setting was 14 years, which is slightly longer than that (12.8 years) in private practice (Silverman & Hairston, 2005). Moreover, 23.9% of the respondents reported working more than 13 years at their present facility, which represented a slightly greater percentage than that (17%) in correctional psychiatry setting (Codding, 2002). According to the data presented by Braswell, Maranto, and Decuir in 1979, the average length of practice at that time was 3.98 years. Compared with this and other recent studies in other settings (Codding, 2002; Silverman & Hairston, 2005), an increase in longevity was found in the medical field. It would seem that employment conditions of the music therapy profession are more favorable in medical music therapy than in previous years and thus, more of these music therapists chose to remain in the field.

More than half of the respondents reported having earned a graduate degree and having one or more additional certifications or licenses. It would seem that music therapists working in the medical setting may have received additional or advanced
training. Although it is not necessary to attain a higher qualification for working in the medical setting, music therapy students or music therapists interested in this setting may consider equipping themselves with related trainings to remain competitive in the field.

Results indicated the credential “MT-BC” was specifically required in 63% of the hospitals where respondents worked, indicating the awareness of board certification in medical settings. While the Certification Board of Music Therapists (CBMT) strives to assure the continued competence of the music therapy profession, it also advocates and promotes music therapy certification. The results attest to the ongoing efforts of CBMT and revealed that future advocacy and education will be vital.

It is noteworthy that music therapists working in medical settings are greatly involved in the profession. Almost all of them (97.8%) participated at conferences. Their involvement also included presenting at conferences, conducting research in hospitals, supervising interns and practica students, and providing in-services. It would seem that music therapists who work in the constantly evolving medical setting are more willing to become involved in the profession.

Concerning the ownership of hospitals where music therapists are employed, there appears to be a discrepancy between voluntary hospitals (60.9%) and the other two types of hospitals (19.6%, 15.2%). However, according to the annual survey of the American Hospital Association (AHA) in 2005, the proportion of voluntary hospitals (n = 2,958; 59.9%), proprietary hospitals (n = 868; 17.6%), and government-supported hospitals (n = 1,110; 22.5%) approximated the present findings, indicating the discrepancy reflected the actual hospital distribution in United States. Compared to the actual hospital distribution, the only difference was the relatively fewer government-supported hospitals employing music therapists. Perhaps additional advocacy is needed to extend music therapy services in the government-supported hospitals.

Of interest is the finding in the prenatal population. Results revealed that there was a large discrepancy in the number of hospitals providing prenatal services, and the number of hospitals providing music therapy services to the prenatal population. While numerous music therapy studies have demonstrated the significance of music therapy for the prenatal population (Allison, 1991; Browning, 2001; Codding, 1983; Hanser, 1983), it would appear that music therapy is not widely implemented in this population.
Additionally, this area is so new that it has not had time to be reflected in clinical practice. Perhaps, in addition to demonstrate the effect of music, future studies could emphasize the implementation of music therapy services in the prenatal population so that more patients could benefit.

Of concern is that 42% of the music therapists were working part-time in this setting. This may be due to a lack of full-time music therapist positions, the possibility of working multiple part-time jobs, or family-based choices of music therapists. Further research is warranted to investigate the reasons behind a high percentage of part-time medical music therapists. Nevertheless, it is predicted that the profession of music therapy needs to increase its number to meet an increased demand in healthcare settings (Groene, 2003). In developing the strategies and action plans for this concern, it would be prudent to take working patterns into consideration, or inaccuracies in estimations may occur.

High job enjoyment level was reported by most respondents, which was in congruence with previous studies (Braswell, Decuir & Jacobs, 1989; Braswell, Maranto & Decuir, 1979; Silverman & Hairston, 2005). It would appear that music therapists working in medical hospitals were pleased with their jobs and spent a longer time in the field. In addition, the mean rating of music therapists’ perceptions concerning their jobs indicated that music therapy was appreciated in the hospital. The result of positive perceptions concerning the music therapy profession is in congruence with previous research findings (Choi, 1997).

On account of the consistently high means, it would imply that most respondents were satisfied with their working environment. However, it was found that respondents only slightly agreed that the hospital provided enough support to current music therapy services. For the development of music therapy programs in medical hospitals, further research is needed to identify the kind of “support” expected and possibilities in receiving adequate support. This could constitute an area for future investigation.

Limitations of the Study

Since the survey study was conducted via electronic mail, the sample who responded may be more advanced in utilizing technology and more apt to become involved in the
profession. Therefore, cautions should be taken in interpreting and generalizing the results.

The broad range of issues included in this study served as initial data for further research. It would have been advantageous to analyze specific areas of interest, or to compare results with other studies in order to draw in-depth conclusions. For example, it would have been beneficial to identify the music therapy resources and support needed for each population in medical hospitals for those music therapists who want to start a new program in a hospital, or for current music therapists who want to expand their music therapy programs.

Conclusion

This study presented a broad range of information about music therapists working in medical hospitals. Results may be useful for preparation for music therapists interested in the medical setting, for program development, for educating future music therapists, for evaluating trends in the field, and for further research.
APPENDIX A

Survey
Dear fellow Music Therapists,

Survey on Current Music Therapy Practice in Medical Hospitals

I am a master's student under the direction of Dr. Jayne Standley in the Music Therapy Program, College of Music at Florida State University. As a part of my thesis, I am conducting a study on the implementation of music therapy services in medical hospitals. Clinical experience, employment condition, educational background, and the demographics of music therapists currently practicing in this setting will also be examined.

As you are listed in the 2006 AMTA database as practicing in a hospital setting, you are cordially invited to participate in the study. Participation involves filling out a questionnaire, which takes approximately 10 minutes to complete. It can be returned by email, by the [Submit by Email] button at the end of the questionnaire. Questionnaires returned by email will be kept completely confidential. If you wish to print it and send it by regular mail, which ensures complete anonymity, please feel free to select the [Print Form] button and mail to the address below:

Cho-wai Joyce Lam
151 Bliss Dr. Apt 11
Tallahassee, FL 32310

A stamped envelope will be provided upon request. All returned questionnaires will be number coded and no individual will be identified in any publication as a result of this survey.

Your participation is completely voluntary. By returning the questionnaire, you grant consent of your participation. You may choose not to participate and can withdraw at any time. Data will only be accessible to the researcher and will be destroyed at the completion of the study.

Participants should understand that no medical service and/or financial assistance will be provided for injuries that might happen while taking part in this study. If you have any questions or concerns, please feel free to contact me or my advisor Dr. Jayne Standley, by phone or by email. If you have any questions concerning your rights as a participant, you can contact the Chair of the Human Subjects Committee, Institutional Review Board, through the Vice President for the Office of Research of Florida State University at (850) 644-8633. The results of this study can be sent to you upon request.

Your participation in this study is greatly appreciated. It is hoped that your contribution will benefit the understanding of current music therapy practice in hospital settings. I am most grateful for your help.

Sincerely,

Cho-wai Joyce Lam
(850) 345-2809
milsurvey.hospital@gmail.com or cl04f@fsu.edu

Dr. Jayne Standley
(850) 644-4565
jstandley@mailer.fsu.edu
Florida State University
College of Music
Tallahassee, FL 32306-1180
A Survey of Music Therapists Working in Medical Hospitals

Instruction: Please check or write in the appropriate response for each of the following items.

1. Demographics
   1. Gender  
      - Female
      - Male
   2. Age  
      - Under 20
      - 20-24
      - 25-29
      - 30-34
      - 35-39
      - 40-44
      - 45-49
      - 50 & above
   3. Professional Title(s) - Please check all that apply.  
      - MT-BC (Music Therapist - Board Certified)
      - RMT (Registered Music Therapist)
      - CMT (Certified Music Therapist)
      - Others - Please specify: ____________________________
   4. Music Therapy Credentials or Designations required for employment as a music therapist in your hospital  
      - Any music therapy credentials or designations (MT-BC, RMT, CMT) are welcomed
      - MT-BC is specifically required
      - Others - Please specify: ____________________________
      - None required
   5. Your job title is: ____________________________
   6. Number of year working as a Music Therapist at your present hospital: (Please round to the nearest year)  
      __________
   7. Number of year working as a Music Therapist in any Hospital: (Please round to the nearest year)  
      __________
   8. Total number of year working as a Music Therapist in any settings: (Please round to the nearest year)  
      __________
   9. Your present Hospital is located in:  
      - Great Lakes Region
      - Mid-Atlantic Region
      - Midwestern Region
      - New England Region
      - Southeastern Region
      - Southwestern Region
      - Western Region
      - Outside the US

28
II. Educational Background and Clinical Experience

10. Degree(s) that you hold - Please check all that apply
   □ Doctoral       □ Master
   □ Baccalaureate □ None of the above (Please go to question 11)

11. Please specify the degree(s) that you hold:
    Doctoral: 
    Master: 
    Baccalaureate:

12. Do you hold any additional certification or license
    □ Yes       □ No
    If yes, please specify:

13. Population served during your own clinical internship - Please check all that apply.
    (Categorization according to AMTA 2006 Member Source Book)
    □ Mental Health       □ Medical/Surgical
    □ Developmentally Disabled □ Neurological Disorders
    □ Elderly & Alzheimer's
    □ Others - Please specify:

14. From your point of view, which population served during clinical internship would best prepare a music therapy student to work as a music therapist in hospital? Please prioritize your opinion by ranking 1 to 6 in the boxes. 1 represents the most relevant and 6 represents the least relevant.

   □ Mental Health       □ Medical/Surgical
   □ Developmentally Disabled □ Neurological Disorders
   □ Elderly & Alzheimer's
   □ Others - Please specify

15. Please rate the extent in which you agree or disagree with the following sentence.
    "The area of population served during my internship had a direct influence on obtaining my present hospital position."

   | Strongly Disagree | | | | | | Strongly Agree |
   | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
   | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
III. Music Therapy Practice

16. Number of music therapists working in your hospital (Including you):

17. Number of music therapy internship position(s) available in your hospital:

18. Number of music therapy practicum student(s) in your hospital:

19. Do you participate in music therapy conferences?
   □ Yes  □ No

20. Do you present at music therapy conferences?
   □ Yes  □ No

21. Do you conduct research at your hospital?
   □ Yes  □ No

22. Which of the following best describes the hospital that you are working at?
   □ General Hospital - Hospitals set up to deal with the full range of medical conditions for which most people require treatment.
   □ Specialized Hospital - Hospitals specialized in a particular disease (cancer, rehabilitation, etc.) or condition, or in one type of patient (children, elderly, etc)

23. Which of the following best describes the hospital that you are working at?
   □ Voluntary Hospital - A non-profit community facility operated by religious or other voluntary auspices
   □ Proprietary Hospital - A profit-making institution owned by corporations or by individuals
   □ Government-supported Hospital - A non-profit institution owned and operated by federal, state, or local government, that receives its largest funds from public tax support

24. Which of the following describes the funding source for music therapist in your hospital?
   (Please check all that apply)
   □ Grant  □ Private Contract  □ Foundation
   □ Hospital Budget  □ Reimbursed services
   □ Others Please specify:

25. If you choose "Grant" in the question 24, who is/are the person who wrote the grant proposal?
   (Please check all that apply)
   □ Music therapist in the hospital  □ Grant writers
   □ Other Professionals in the hospital
   □ Others Please specify:

26. Type of music therapy that your hospital provides:
   (Please check all that apply)
   □ Individual  □ Group

27. Number of patients in a music therapy group (0 if there is no music therapy group):
28. Number of individual music therapy patients per week

29. Number of group music therapy patients per week

30. How are patients referred for music therapy services in your hospital? (Please check all that apply)
   □ Verbal referral from other professionals in the hospital
   □ Fax referral from other professionals in the hospital
   □ Computer-based referral from other professionals in the hospital
   □ Specific patient group is automatically referred to attend regular music therapy sessions
   □ All patients in the hospital are referred to music therapy service
   □ No referral required
   □ Others. Please specify:

31. Which of the following professionals refer patients to music therapy services most frequently?
   □ Physicians
   □ Nurses
   □ Social Workers
   □ Child Life Specialists
   □ Occupational, Physical or Respiratory Therapists
   □ Others. Please specify:

   □ Referrals not from other professionals

32. Which of the following age groups does your hospital serve? (Please check all that apply)
   □ Pre-natal
   □ Adolescents
   □ Infants
   □ Adults
   □ School age Children
   □ Seniors

33. Which of the following age groups receive music therapy services in your hospital?
   (Please check all that apply)
   □ Pre-natal
   □ Adolescents
   □ Infants
   □ Adults
   □ School age Children
   □ Seniors

34. Please list up to five departments/units in your hospital where music therapy services are most frequently provided. (For example, Oncology, Emergency Department, etc)

   1
   2
   3
   4
   5
35. Please list up to five musical instruments that you use most frequently in your hospital
(Voice is considered a musical instrument)

1. 
2. 
3. 
4. 
5. 

36. The following clinical models were recognized as the five music therapy clinical models used worldwide in the 1999 World Congress of Music Therapy. How often do you use each of the following technique?

<table>
<thead>
<tr>
<th>Clinical Model</th>
<th>Least frequently</th>
<th>Most frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Behavioral Music Therapy</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>2. Clinical Improvisation</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>3. Nordoff-Robins Techniques</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>4. Guided Imagery (GIM)</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
</tr>
<tr>
<td>5. Benezon Music Therapy</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
<td>○ ○ ○ ○ ○ ○ ○ ○</td>
</tr>
</tbody>
</table>

37. Who is responsible for the music therapy session design? (Please check all that apply)

☐ Music therapist alone
☐ Other music therapy staff
☐ Medical staff
☐ Interdisciplinary team members
☐ Others, Please specify: ________________

38. Which method do you use for documenting your music therapy session?

☐ No documentation required
☐ Self-developed music therapy documentation method
☐ Same documentation method as other medical staff in the hospital.

39. Are music therapy in-services provided in your hospital?

☐ Yes
☐ No

40. If you choose "Yes" in question 39, how often are the music therapy in-services provided?
(For example, once a week, twice a month ....etc)

____________________________________________________________________

IV. Employment Condition in Hospital

41. Average working hours per week: ___________
42. Hours spent on each of the following items per week:

1. Planning music therapy sessions
2. Conducting music therapy sessions
3. Documentation
4. Administrative work
5. Communication with other professionals in the hospital
6. Other. Please specify: 

43. Your annual salary range is:
- $20,000 to $30,000
- $30,000 to $40,000
- $40,000 to $50,000
- $50,000 to $60,000
- Above $60,000

Please check the appropriate response for each of the following items.

<table>
<thead>
<tr>
<th>Strongly Disagree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5 6 7</td>
<td></td>
</tr>
</tbody>
</table>

44. "I am satisfied with my current work load."   0 0 0 0 0 0
45. "I would prefer to increase my current work load." 0 0 0 0 0 0
46. "I enjoy my job in the hospital." 0 0 0 0 0 0
47. "I feel music therapy is accepted in the hospital as a profession." 0 0 0 0 0 0
48. "I feel music therapy is appreciated in the hospital." 0 0 0 0 0 0
49. "I feel that most of the professionals in the hospital are supportive toward music therapy as a profession." 0 0 0 0 0 0
50. "I feel that the hospital provides enough support to current music therapy services." 0 0 0 0 0 0

Thank you very much for completing the questionnaire.
Please return it through email by clicking the "Submit by Email" button,
or mail a printed questionnaire to the following address:

Cho-wai Joyce Lam
151 Bliss Dr, Apt 11,
Tallahassee, FL 32310

Your participation is greatly appreciated!
APPENDIX B

Human Subject Committee Approval Letter
APPROVAL MEMORANDUM

Date: 12/13/2006

To: Cho-wai Lam
151 Bliss Dr. Apt# 11
Tallahassee, FL 32310

Dept.: MUSIC THERAPY

From: Thomas L. Jacobson, Chair

Re: Use of Human Subjects in Research
A Survey of Music Therapists Working in Hospital Settings: Demographics, Education Background, Clinical Experience, Music Therapy Practice, and Employment Condition

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and two members of the Human Subjects Committee. Your project is determined to be Exempt per 45 CFR § 46.101(b) 2 and has been approved by an accelerated review process.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If the project has not been completed by 12/12/2007 you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

Cc: Dr. Jayne Standley
HSC# 2006.0989
REFERENCES


**BIOGRAPHICAL SKETCH**

<table>
<thead>
<tr>
<th><strong>Name</strong></th>
<th>LAM, Cho-Wai</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Date of Birth</strong></td>
<td>August 19(^{th}), 1982</td>
</tr>
<tr>
<td><strong>Place of Birth</strong></td>
<td>Hong Kong, China</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td>Bachelor of Arts in Music</td>
</tr>
<tr>
<td></td>
<td>The Chinese University of Hong Kong, Hong Kong</td>
</tr>
<tr>
<td></td>
<td>Degree awarded in May 2004</td>
</tr>
<tr>
<td></td>
<td>Master of Music in Music Therapy</td>
</tr>
<tr>
<td></td>
<td>Florida State University, Tallahassee, FL</td>
</tr>
<tr>
<td></td>
<td>Expected graduation in May 2007</td>
</tr>
<tr>
<td><strong>Professional Experience</strong></td>
<td>Music Therapy Internship</td>
</tr>
<tr>
<td><strong>Experience</strong></td>
<td>Wolfson Children’s Hospital, Jacksonville, FL</td>
</tr>
<tr>
<td></td>
<td>February – July 2006</td>
</tr>
<tr>
<td><strong>Honorary Society</strong></td>
<td>Pi Kappa Lambda</td>
</tr>
</tbody>
</table>