

MUSIC LESSONS PROVIDED TO CLIENTS, BY MUSIC THERAPISTS:
A DESCRIPTIVE STUDY OF CURRENT PRACTICES IN THE UNITED STATES

A THESIS

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DEDICATION

I am dedicating this thesis to all my clients in the past, now, and in the future.

Many prospective students and people I pass in life mention that music therapy to them is “helping people with music,” but what they don’t know is what this profession has taught me. These clients are the ones helping me.

They have taught me to see the beauty in the world, to live each happy moment in the fullest each time. To relish in the joy music brings. To sing every word with passion. To acknowledge the sorrows, no matter how small, and to reach out for help when we need it. To hold on to the people we love extra tight. You just never know when it will be the last time. I am honored to be a part of your journey.

Thank you for changing my life. I hope we can continue to change yours for many years to come together.

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These people have changed me in the formative years of my life. I hope to return the passion.

ABSTRACT

KATIE LYNN LOPEZ

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The purpose of this descriptive study was to determine current practices of board-certified music therapists in the United States who provide music instruction or music lessons to clients as part of their professional practice. It is known anecdotally that music therapists provide music instruction, but the practice of ongoing systematic use of music instruction as an intervention has not been exclusively studied or unanimously defined in the literature. This survey sought to define the current scope of practice. Participants reported providing music instruction to Autistic individuals the most. Additionally, the most commonly reported goal domains and highest percentage of perceived benefits were musical, cognitive, and fine motor skills. Further research with a larger sample size could potentially identify trends to guide data-driven research.

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CHAPTER I

INTRODUCTION

Music greatly impacts a person's emotions throughout the lifetime and forms the first building blocks of communication and interaction with the world (Hargreaves & Lamont, 2017). The more one prefers a selection of music, the greater the capacity for emotional impact. Trevarthen and Malloch (2000) explained the early developmental connection formed when an infant hears music combined with their caregiver's voice. Gold et al. (2013) postulated that musical utterances precede verbal language, which goes beyond the capabilities of verbal communication alone by assigning meaning to inflection and free expression. A natural way to interact with music is by learning how to sing or play an instrument.

Music impacts many areas of the brain involved with learning, perception, timing, coordination, and pattern-recognition (Polen et al., 2017). Furthermore, learning music is associated with positive effects on the brain, motor coordination, and personal self-outlook (Bergman et al., 2014). The neurological benefits of learning music were captured in neuroimaging studies included motor coordination acquisition, advancement in working memory, and auditory processing (Schlaug et al., 2005; Sissela et al., 2014). The impact of learning music is linked to children's positive academic performance in school (Cabanac et al., 2013; Frischen et al., 2021).

For children, the positive effects of music learning are documented in both academic achievement and social emotional development during school-age years. Music lessons is shown to have a positive impact on IQ and general cognitive abilities (Costa-Giomi, 2014; Schellenberg, 2016). Results of quantitative studies utilizing pretests and posttests show that music lessons have both temporary and long-term impact on cognition and executive functioning

(Bergman et al., 2014; Hogenes et al., 2014; Piro & Ortiz, 2009; Portowitz & Klein, 2007; Roden et al., 2012). Based on the results of these studies, studying music benefits children's social-emotional development. Positive outcomes correlate to music instruction's impact on children's sense of self and self-determination (Küpers et al., 2014), self-concept (Degé et al., 2014), and self-esteem and self-efficiency (Hallam, 2016).

Children are not the only group who receive benefits from music instruction. Smith et al. (2022) studied the impact of singing lessons with older people. Over 90% of the study's participants reported improvements in physical well-being. Additionally, it was noted that positive mental health outcomes included elevated mood and decreased depressive mood swings. Hogenes et al. (2014) reviewed 24 empirical studies targeting music instruction's impact on adolescents', adults', and older adults' cognitive, social-emotional, and motor skills. Researchers found all but three cognitive studies results reflected positive benefits in these areas. The researchers concluded that music lessons could potentially develop an overall and lasting benefit throughout a person's lifetime.

Music Therapy Defined

Music therapy is the evidence-based profession in which musical experiences facilitated by a board-certified music therapist are utilized to improve the client's quality of life (American Music Therapy Association [AMTA], 2005). Domains that are addressed in music therapy treatment include but are not limited to physical, mental, emotional, developmental, social, or spiritual well-being. Bruscia (2014) defined music therapy as:

... a reflexive process wherein the therapist helps the client to optimize the client's health, using various facets of music therapy experience and the relationships formed through them as the dynamic force of change. As defined here, music therapy is

the professional practice component of the discipline, which informs and is informed by theory and research. (p. 36)

These musical experiences may be receptive, re-creative, improvisational, or compositional and are modified for each client's background and treatment needs. Re-creative experiences include, but are not limited to, a music therapist or the client themselves recreating pre-composed music with voice and/or instrumental accompaniment (Bruscia, 2014). When creating, discussing, and processing musical experiences in a closed setting, a relationship is formed that opens the opportunity for a client to experience a new way of thinking and/or behaving. Relationships also form between the client and the music they are experiencing. These connections, known as intramusical connections, are therefore made between the client's mind and aspects of the music itself (Bruscia, 2014). Additionally, clients can also experience intermusical relationships, or the relationships formed when at least two people share a music experience together. The intermusical relationships are represented by and through the shared music experiences (Bruscia, 2014).

Music therapists use instruments to accompany themselves singing and to facilitate sessions. They also engage clients in instrumental and vocal interventions for the purpose of re-creating or improvising – depending on the client's ability and comfort level. Instrument play and singing is used as a tool to address specific fine motor, gross motor, breathing, cognitive, and other health-related skills. Although music therapists primarily focus on non-musical goals, the training required to facilitate the music experiences positions music therapists to also facilitate music lessons as a part of the therapy experience (AMTA, 2005). However, little published research exists surrounding the specific use of music lessons by music therapists in their practice.

This descriptive study sought to examine the current practices of music therapists in the United States who identify as clinicians providing music instruction or lessons to clients. This researcher utilized an online survey, sent to board-certified music therapists in the United States, to answer the following research questions:

1. What are the current practices of board-certified music therapists who provide music instruction or music lessons to clients?
2. What is this type of service commonly called?
3. How are these services paid for?
4. What clienteles receive music lessons that are provided by a music therapist?
5. What musical and nonmusical goals are targeted within a music lesson format?

CHAPTER II

LITERATURE REVIEW

Overview of Re-Creative Music Therapy

In clinical music therapy practice, interventions used to address goals are categorized into four types: compositional (writing original music), improvisational (unplanned and non-repeatable music), receptive (listening), and re-creative experiences (Bruscia, 2014). In re-creative experiences, a client and music therapist work collaboratively to reproduce a familiar and pre-composed song in any style of the client's choosing (Polen et al., 2017).

As veterans returned from WWII with devastating physical and mental trauma, music therapy as a clinical practice was originally centered on the re-creative experience (Crowe, 2007). Patients learned to play an instrument or sing music familiar to them with the common collaborative goal of performing as an end-result (Crowe, 2007). Because of this, early music therapy heavily relied on individual instruction of vocal and instrumental techniques that were later incorporated into a group performance.

Bruscia (2014) differentiated “re-creative” experiences from “performing” as a listening audience is not involved in a music therapy session. Re-creative experiences are shared solely by the therapist and client in the closed and private therapy space. Bruscia (2014) expanded upon the process of re-creative experiences as “rendering, reproducing, realizing, or interpreting any part or all of an existing musical work” (p. 132). Examples of potential goals to be addressed with re-creative interventions include but are not limited to: development of motor skills, memory skills, adaptive skills, processing auditory stimuli, temporal responses, empathizing with others, experiencing and releasing emotions, and fostering a sense of community, and group cohesion (Bruscia, 2014). Re-creative interventions are ideal for clients who need a high degree

of structure considering the expectation of re-creating a familiar song (Polen et al., 2017). Re-creative experiences also address the development of interpersonal and collaborative relationships (Polen et al., 2017).

As defined by Bruscia, instrumental recreation involves producing sound on an instrument in a predetermined way, imitating sounds, reading music notation, playing in an ensemble or private lesson structure, or playing with the aid of a recording in the background (Bruscia, 2014). Vocal recreation involves singing songs, singing from pre-written notation, speaking or chanting on pitch, rehearsing as a choir, imitating vocal sounds, individual voice coaching or instruction, or lip syncing to a recording (Bruscia, 2014). Performing serves as a potential result of ongoing recreative experiences. The performance itself ranges from informal to formal as appropriate or desired by the client. The client may participate in planning the performance event itself (Polen et al., 2017).

Singing, like speech, contains elements of frequency, variability, vocal intensity, rate, rhythm, and use of diction (Cohen, 1992). Because singing is classified as an automatic speech skill, in the same category as cursing or reciting a poem, it is more readily recalled than a sentence (Lucia, 1987; Sacks, 2007). Music can act as a catalyst, reintroducing the damaged areas of the brain to language embedded in familiar tunes (Sacks, 2007). Thaut (2005) referred to therapeutic singing as the use of singing activities to facilitate initiation, articulation, and development of language as well as increasing respiratory function. Similarly, rhythm in song acts as a pace keeper, prompting breathing to cue the output of verbalization in time with natural speech patterns (Tamplin & Baker, 2017).

Overview of Current Music Instruction in Music Therapy

Music instruction in music therapy is defined and discussed briefly in music therapy literature as a possible intervention within the re-creative scope (Bruscia, 2014). The terminology and scope of practice varies by population, individual client, and personal philosophy of each music therapist (Bradt, 2013; Bruscia, 2014; Hintz, 2013; Gardstrom, 2013). Goal areas addressed also vary widely depending on the population as well as specific adaptations the music therapists must utilize to best meet the needs of their clients.

Terminology of Music Instruction in Music Therapy

Hintz (2013) referred to music instruction in the context of individuals experiencing developmental delays as “adapted music lessons” (p. 63). Adapted music lessons are described as one-on-one interventions typically teaching voice, piano, and guitar (Hintz, 2013). Based on the varying level of independence and need for support in the developmental health population, parents and caregivers are most often the party seeking services and evaluations for their loved ones or charges (Hintz, 2013). Therapists often emphasize repetition and structure as a foundational element to address the goals these clients often need addressed (Sokira, 2013). The primary distinction between traditional and adapted lessons is the focus on clinical goals rather than musical goals alone (Sokira, 2013). Bruscia (2014) defined this level of therapy as augmentative when using music instruction to develop adaptive behaviors and skills such as developing recreational skills. The music therapist, as part of standard practice, evaluates the client’s baseline level of functioning to determine how they are best motivated, process instructions, and any physical or emotional supports needed to be most successful. This evaluation influences the most appropriate instrument for a particular client’s strengths and goal areas (Hintz, 2013). Music therapists assess any developing frustration, as well as how clients

best comprehend instrumental or vocal instruction techniques. Because the goals associated with adapted music lessons are extra-musical, music therapists rely on their clinical training to design and facilitate lesson experiences to benefit clients' needs as determined at the time of the evaluation (Hintz, 2013).

Music instruction in the mental health setting is defined by Eyre (2013) as “teaching a client how to play an instrument in order to evoke and work through therapeutic issues” (p. 346). Gardstrom used the term “adaptive lessons” when referring to music therapists' ability to minimize the effect of potential learning deficits when giving music instruction (2013, p. 629). In the experience of Ghetti and Hannan (2008) who worked with incarcerated youth, “therapeutic music instruction” is the terminology used when clients address nonmusical goals by learning to play a musical instrument (p. 662).

Ghetti also used the term “therapeutic music instruction” to describe the benefit a hospitalized child receives from the process of learning and/or playing an instrument (2013, p. 160). In this definition, the musical skills acquired during music instruction are a secondary gain of the primary goals addressed during the re-creative intervention process.

Bruscia (2014) defined the levels of didactic practices, the use of teaching music experiences to promote developmental or adaptive needs. The distinction of music lessons in therapy is the knowledge gained and the process of learning it impacting multiple areas that enhance the quality of a clients lived experiences (Bruscia, 2014). He further distinguishes auxiliary didactic practices not considered music therapy because the experiences are not intended to be interventions to address a therapeutic goal. Falling under this auxiliary level of practice is music instruction, the instruction of non-disabled individuals with addressing goals that interfere with the production of their music, in contrast with the same term used by Ghetti

(2013) and Eyre (2013). Bruscia explained that within the augmentative didactic lens of music therapy, an entry-level of practice, the term instructional music therapy to describe using “music learning experiences to address the therapeutic needs of the client” within a private lesson experience (2014, p. 214). Within a higher level of music therapy, intensive didactic practices, instructional music psychotherapy uses music instruction outside of the developmental goal perspective as a context for addressing the client’s psychotherapeutic goals (Brusica, 2014).

Goal Areas Addressed During Music Instruction in Music Therapy

Potential goal areas vary widely based on the level of support each client needs. For individuals diagnosed with autism spectrum disorder (ASD),¹ common clinical goals include acquiring new academic or life skill information, practical communication skills, diverse and shifting attention, engaging with others or joint attention, and responding to sensorial stimuli (Hintz, 2013). Cognitive sequencing, motor coordination and control, emotional awareness, and self-regulation are skills that potentially generalize outside of music therapy sessions to improve clients’ quality of life and increase their autonomy (Polen et al., 2017). Instrumental and vocal exercises create an opportunity for the client to address fluidity in speaking response, social engagement, motivation to interact, and adjusting in real time as one does similarly in verbal or nonverbal interactions (Sokira, 2013). The predictable structure and flexibility of singing increases fundamental language comprehension and manipulation needed to make communication feasible and increase potential feelings of accomplishment (Bruscia, 2014). Examples of these foundational skills can include starting and stopping based on auditory and body language cues, reciprocal imitation, synchrony, and matching musical elements such as

¹ Some individuals in the autistic community prefer the term “autistic” or “autism spectrum condition” or “on the spectrum.”

speed and volume of sound (Bruscia, 2014). These skills can lead to increasing clients' independence and creativity (Ghetti & Hannan, 2008).

For autistic clients needing less support, more emphasis is placed on the development of leisure or vocational skills, tolerating frustration, increasing self-esteem, and refining intricate and abstract social skills (Sokira, 2013). Adapted lessons provide a space for clients to develop a sense of how others view them, self-monitoring and self-correcting their performances, and developing critical and original thinking skills (Hintz, 2013). For clients diagnosed with attention deficit hyperactivity disorder (ADHD), lessons aid in the development of motor organization and planning, internalized perception and response to timing, increasing the capacity of their working memory, as well as their awareness of self (Frith, 2003).

Clients with a learning disability benefit from re-creative music therapy interventions such as adapted lessons because there is a familiarity with the preferred music that encourages the accomplishment of motor timing and auditory correlation to make an accurate recreation of the song (Frith, 2003). The multi-sensory interaction between the various stimuli needed to play an instrument or sing is particularly beneficial in this niche population (Molnar-Szakacs & Heaton, 2012). Songs create a unique opportunity to incorporate vocabulary, category organization, and other abstract concepts in a comprehensible and attainable format that capitalizes on the strengths of these clients (Molnar-Szakacs & Heaton, 2012).

For adolescents in mental health facilities, clients are often faced with diminished cognition, diminished auditory discrimination, complete lack of motivation, despondency, overwhelming internal stimuli, and social isolation (Gardstrom, 2013). Some goals that can be addressed with therapeutic music lessons are building trust within the therapeutic relationship, increasing working memory, increasing motivation and attention, increasing self-esteem, and

increasing peer interaction. Some may also benefit from lessons as a form of reality orientation (Gardstrom, 2013).

Incarcerated adolescents may have similar situations of social isolation and complex disconnections from interpersonal relationships. Not only does playing an instrument or singing offer an outlet for self-expression to elevate mood, it is also a tool for creating a reciprocal relationship with the therapist and authoritative adults in general (McFerran & Wigram, 2010). Meeting musical goals requires accountability that increases self confidence that can transfer to nonmusical goals (McFerran & Wigram, 2010).

Within the medical setting, therapeutic lessons address many of the diagnoses presented to a music therapist working in the hospital. Playing a wind instrument can be used as an intervention to address cystic fibrosis, asthma, or other pulmonary disorders (Griggs-Drane, 2009). Children utilize instruments, such as recorders, to improve respiration that can diminish following major surgery (Lowry, 2019).

Other goals include increasing prolonged attention as well as self-esteem (Lanzilotti et al., 2019). Lowry et al. (2019) described this type of intervention as a catalyst for beneficiary gains for clients both during the process of music instruction as well as the satisfaction of the end result after sessions conclude attributed to the musical skills gained. It can be particularly beneficial for clients resistant to therapy in general or those who have extended hospital stays. Developing a coping mechanism to express and improve mood can positively affect clients by providing a tangible goal outside of their physical health and wellness concerns (Lanzilotti et al., 2019).

Bradt (2013) described the use of therapeutic music lessons to address long-term cognitive deficits due to prolonged hospitalization of pediatric oncology patients. The children also

experience an increased sense of autonomy and regain empowerment from the lack of control over their physical condition (Bradt, 2013). Clients also benefit from self-expression via music experiences to emotionally cope with their diagnosis and treatment (Bradt, 2013).

Potential Adaptations Used by Music Therapists in Music Instruction

To accomplish maximum independent use of instruments, adaptations are often necessary in order to accommodate the physical or cognitive support needs of each client (Sokira, 2013). Modified teaching strategies such as color-coding, labeling, enlarged notation, or musical mnemonic aids can be utilized to increase accessibility in this population to remember rhythms, notation, or music theory concepts (Hintz, 2013). Instruments adaption is potentially required to increase the tonal quality of the client's musical output. Examples include textured, weighted, or altered mallets for clients with Rhett syndrome who experience decreased fine motor skills in their hands (Sokira, 2013). It is also possible to adjust the standard physical positioning of the client or instrument to increase accessibility; additionally, instruments may be played in unconventional ways such as with a client's head, feet, or eye movement to utilize their strengths to increase interaction (Sokira, 2013).

When working with adolescents in mental health facilities, Doak (2013) found that rote music learning, or playing via imitation, and utilizing a nontraditional notation system increased accessibility during music instruction. With increased feelings of success, a subsequent increase in motivation is observed in clients (Doak, 2013; Gardstrom, 2013). Instrumental and vocal exploration through improvisatory play was a way to remove potential barriers and create a more welcoming invitation to creating music (Doak, 2013). Chords and riffs were also simplified at times to make guitar and piano more accessible (Doak, 2013).

Within the medical setting, instrumental techniques are potentially a physical barrier for a multitude of reasons related or unrelated to their hospital stay. Adaptive devices such as a guitar barre, dulcimer, strum stick, or slide in addition to alternative tuning on the guitar increases accessibility (Bradt, 2013). Because recreative experiences are process-centered rather than product-centered, melodies are sometimes simplified or altered to accommodate the client's abilities and help them feel successful and empowered (Allen, 2013). Modified mallet handles or other physical instrument adaptations are needed in cases where they increase accessibility to the client (Bradt, 2013). Therapists also utilize hand-over-hand assistance as needed and facilitate motor movements until independence is established (Bradt, 2013).

Overview of Research on Music Instruction in Music Therapy

This section reviews research regarding the use of music instruction and is organized by population. There are few publications specifically isolating the use of therapeutic music instrument lessons and singing lessons. Rather, much of the literature explored the general application of music therapy.

Developmental Health

Montello et al. (1990) tested rhythmic music training in three phases on children with various learning, emotional, and behavioral disorders. Rhythmic concepts were taught in three phases. The first phase involved teaching quarter and eighth notes conceptually and verbally. The second phase entailed playing the notes on rhythmic instruments. In the third phase, subjects participated in improvisational music such as copying modeled rhythms by the therapist, looping the same rhythm continuously, and finally allowing the children to take turns leading their own original rhythms. The teachers reported that the children demonstrated increased attention, focus, and concentration both during the task and in the days after the experience (Montello et al.,

1990). The researchers attributed the change in behavior to the structured way the music experiences allowed the students to express their usual energy in an appropriate setting. This resulted in a secondary gain of music therapy aiding in self-expression and emotional regulation.

Mental Health

Within the mental health setting, case studies are used to describe the in-depth approach catering to a variety of client presentations both throughout therapy and in contrast with other clients. As a way of establishing rapport and a trusting relationship with the client, Metzner (2010) recounted the use of music instruction as a starting point for reality orientation. The music lessons provided a foundation for trust and rapport-building that expanded into intensive improvisatory music that can address symptoms of psychosis. By playing the guitar, the client focused on organizing and developing his thoughts rather than distinguishing reality from his hallucinations.

Free et al. (1986) also described using music instruction as an initial phase for working with particularly paranoid or withdrawn music therapy clients. By building a foundation in music theory, clients felt empowered to participate in songwriting and improvisation. Houghton et al. (2002) used the same approach to improve self-discipline, build frustration tolerance, and increase cognitive skills with his client. Music instruction provided an opportunity for the client to gain insight as well as acquire community involvement skills (Houghton et al., 2002).

Tysmans (1986) encouraged a client to participate in flute lessons as a way of increasing motivation through a meaningful and concrete activity that resulted in spontaneous verbal communications. Throughout the music lessons in this case example, the client also experienced significant breakthroughs in decision-making that benefited her practical life skills outside sessions. Tyson (1979, 1982) described two separate clients benefiting from music lessons within

the therapy session. Tyson (1979) utilized lessons to recreate classical compositions to retain reality orientation as well as access and process traumatic experiences elicited by the music. Later, Tyson (1982) conducted vocal lessons, including traditional warm-ups such as humming and breathing, to encourage better diaphragm support. Through a psychoanalysis framework, the client's posture and vocal technique issues manifested from repressed traumatic experiences (Tyson, 1982). By addressing these musical issues, the client was able to consciously address and heal past trauma.

Gold et al. (2013) conducted a quasi-experimental study to ascertain if individual music therapy experiences, including instrumental and vocal music instruction, demonstrated improvement in adolescent clients' self-esteem, self-image, and attention through music exploration and mastery. One hundred thirty-six young clients were recruited to an outpatient program and were compared with prospective patients on a waiting list for the program. It was the first study of its kind to test the clinical efficacy of music therapy on adolescents in mental health facilities. The children and their parents reported significant improvements compared to the control group in all four variables tested including mood, regulation, motivation, and engagement (Gold et al., 2013). Gardstrom (2013) added that incarcerated adolescents felt empowered by the sense of responsibility and cooperative relationships experienced in music lessons. In addition to the knowledge gained on care and maintenance of instruments, lessons allowed for a leisure activity in a facility devoid of positive opportunities (Gardstrom, 2013).

Clark and Harding (2012) conducted a systematic review of literature analyzing the outcomes of singing as a therapeutic approach in psychosocial outcomes of clients. Of the 11 quantitative studies, only three of the studies (Myskja & Nord, 2008; Takahashi & Matsushita, 2006; VanderArk et al., 1983) examined active singing instruction as an independent variable.

Two of the studies compared group to individual singing while the last study compared group singing with no therapeutic singing. Three of the studies showed significantly improved psychosocial measures while the remaining eight had nominal improvement or inconclusive results (Clark & Harding, 2012). Self-reports showed significant improvement in client mood, satisfaction, and quality of life. The researchers suggested that there are many qualitative effects of music lessons that are not included in the study.

A recent case study detailed the use of “Coffee House,” a community music therapy performance initiative that offered adolescents in mental health settings an opportunity to share their progress in music therapy with their family as well as their larger care team (Mitchell, 2021). The perspectives of seven clients and 11 staff members were collected through semi-structured interviews. The results showed that through the course of instrumental or vocal music instruction within the therapy setting had an increased bond between patients and their therapists, an increased sense of self-identity, and an improved perception of clients by staff members (Mitchell, 2021). Clients waived their privacy rights to share their learned songs with staff; by inviting staff into sessions to hear their music, clients had an improved self-image. Klyve and Rolvsjord (2022) published a series of case studies involving children in mental health care who benefited from the self-expressive outcomes of learning an instrument. One child played the guitar as a way of expressing and regulating themselves as he participated in the study. He emphasized certain words with notes he played on the guitar to add meaning and/or tone as well as exploring ideas and thoughts through the sounds he made. He expressed that music could “speak emotions” (Klyve & Rolvsjord, 2022, p. 17).

With limited research pertaining to individual instrumental and vocal instruction, more research is needed surrounding the current utilization of these interventions in the music therapy

profession. Additionally, to the best of the researcher's knowledge, no unified definition exists among all music therapists despite similar terminology used interchangeably between populations. There is no current workforce data on the prevalence of these interventions across the profession. The field could benefit from a detailed look at current practice, to fully understand the overall scope across settings and clients.

The purpose of this study was to determine the current use of music lessons by music therapists in their practice in the United States. The following research questions guided the study: 1. to identify current practices of music therapists providing music instruction in their practice, 2. what terminology do music therapists use to describe music instruction services, 3. how are the services funded, and 4. what clients are receiving these services, and what goals are addressed during music instruction?

CHAPTER III

METHODOLOGY

To better understand the practice of music lessons or instruction within clinical music therapy practice, the researcher designed a cross-sectional survey to determine the current practices of music therapists in the United States as shown in Appendix A. The researcher used PsychData as the online survey instrument. The study was approved by the researcher's thesis committee, the Graduate School, and the Texas Woman's University Institutional Review Board (IRB).

Participants

Participants for this study included music therapists working in the United States.

Requirements to participate included:

- current board certification in music therapy
- included music lessons in their professional practice in the last 5 years

Exclusion criteria in this descriptive study included:

- lack of accredited credentialing such as music therapist board certification (MT-BC)
- music therapists who have not used music lessons in their practice in the last 5 years
- working outside of the United States
- music therapists who cannot read or write in English
- individuals under the age of 18

Holding current board certification ensured respondents adhere to the code of ethics and standards of practice outlined by Certification Board for Music Therapists (CBMT, 2020). In order to establish current practices, the time frame of 5 years was implemented to ensure relevant data was collected. The use of a descriptive survey serves as a baseline in determining the use of

music lessons as an intervention in music therapy and the trends that are present currently in the United States.

Design

The researcher designed a cross-sectional, descriptive study (see Appendix A). A descriptive study was chosen to “describe responses to the independent, mediating, or dependent variables” (Creswell & Creswell, 2018, p. 137). A cross-sectional design was implemented to capture current data now rather than collect data over time (Creswell & Creswell, 2018). The cross-sectional descriptive study was most appropriate to answer the research question because, to the best of this researcher’s knowledge, no published studies exist that define the current practice of music lessons in the music therapy setting.

Data Collection

The participants completed the online survey via PsychData to ensure the best possible opportunity for confidentiality. This study entailed a researcher-designed survey with questioned modified from previous descriptive music therapy studies (Kern et al., 2013; Kern & Tague, 2017). The survey required approximately 20 minutes to complete.

Survey Instrument

The survey contained 40 questions and contained the following four sections:

Demographic Questions

- AMTA region of United States
- Additional credentialing
- Highest level of education completed
- Total years of experience in music therapy

Client Information

- Diagnoses
- Age of clients
- Facilities where music lessons are given
- Source of referrals
- Percentage and number of clients receiving lessons

Clinical Practice

- Average duration of session
- Average cost per session
- How rate is determined
- Percentage of clients receiving lessons
- How many clients are referred for lessons first
- How many clients are referred for therapy first
- When is assessment for lessons conducted
- What instruments are taught
- What adaptations are used by therapists

Goals Addressed

- What goals are addressed in music lessons
- Perceived effectiveness of music lessons by goal domain
- Objectives addressed by goal domain

Survey participants were given seven questions within these four sections to write their own responses. The question where missing options could be filled in were referral sources, facilities where lessons occur, and adaptive techniques utilized. Open responses without multiple

choice included: the terminology the music therapist utilizes in their practice, populations in their music therapy practice, additional credentialing, and a question asking therapists what “additional comments or thoughts they would like to share.”

Procedure

Once the researcher received IRB approval, they purchased a list of email addresses from the CBMT. The email list contained all registered board-certified music therapists in the United States who agreed to receive emails for research participation. The researcher sent an email (see Appendix B) including a link to the study through PsychData. After the initial email invitation was sent, a reminder email was sent 2 weeks after. The survey was open for 30 days.

Potential participants indicated their interest by clicking on the survey link at the bottom of the solicitation email. This link led recipients to the opening page, which contained the study description, inclusion criteria, and a consent button for recipients to click if they consented to participate. Clicking on this consent button that stated “I Agree” also confirmed that the participant self-identified as eligible to participate.

Participants could withdraw from the study at any time by simply exiting the survey. Incomplete surveys were disregarded as they did not contain answers to questions where data was gathered. Once the survey closed, this researcher downloaded the data and compiled descriptive statistics of the descriptive data.

Data Analysis

The researcher analyzed the statistical data populated through PsychData’s visual histogram system. Descriptive statistics were used to report percentages of each response compared to the total number of participants in the survey or automatically through PsychData though the results display feature which populates percentages, number of participants selecting

each response, and visual bar graphs to represent the data. Responses from open ended questions were grouped by frequency. Themes from the final question asking for open comments were analyzed for frequency of words used and topics reported in their responses. The thesis advisor provided feedback on the themes.

CHAPTER IV

RESULTS

The researcher sent the survey invitation email to 9,654 board certified music therapists that were included on the purchased email list. Of the 9,654 music therapists contacted to participate in the study via the mailing list, 52 emails were no longer in use. 304 therapists opened and initiated the survey. Two participants did not agree to the informed consent and did not continue the survey. A total of 184 participants completed the survey. The rate of participation for this study was 2%.

Demographic Information

Music therapists were asked how many years of experience they have, their education level, the region in which they work, as well as to list any additional credentials they hold. Most respondents (55%) had worked in the field for 10 years or less and had a bachelor's degree in music therapy. The number of years' experience of the participants was somewhat evenly distributed, as shown in Table 1. The majority of participants (66%) completed an undergraduate degree in music therapy. A breakdown of educational background is also shown in Table 1. Participants represented an even distribution across regions with a slightly greater concentration in the Great Lakes and Mid-Atlantic regions, both at 20%. All remaining regions are depicted in Table 1. Participants were also asked to list any additional credentialing they obtained. The most frequently reported certifications reported included the following: neurologic music therapy (20), neonatal intensive care unit (20), music education (11), non-profit management (7), licensed creative arts therapist (4), and Nordoff-Robbins music therapy (2).

Table 1*Participant Demographics*

Demographic Question	Participant data	
	<i>n</i>	%
Years experience		
0-5 Years	58	31.0
5-10 Years	46	24.0
10-15 Years	23	12.4
15-20 Years	14	07.5
20-25 Years	12	06.5
25-30 Years	8	04.3
30+ Years	2	13.4
Education		
Bachelors in music therapy	123	66.0
Masters in music therapy	51	27.0
Masters in another field	22	11.0
Master's equivalency in music therapy	20	10.0
Bachelor's equivalency degree	18	09.0
PhD in another field	9	05.0
PhD in music therapy	3	01.0
Region		
Great Lakes	37	20.6
Mid-Atlantic	37	20.6
Southeastern	26	14.4
Southwestern	23	12.8
Western	23	12.8
Midwestern	18	10.0
New England	16	08.9

Current Practices

Type of Instruction Provided

Participants were asked what types of instruction they provide and were given the option to write in any instruments not represented in the available choices. A visual representation of these findings is shown in Table 2.

Table 2

Instrumentation Instructed by Music Therapists

Instrument	<i>n</i>	%
Piano	88	28.0
Guitar	75	24.0
Ukulele	47	15.0
Voice	48	16.0
Drums	19	7.2
Strings	18	6.0
Woodwind	10	3.0
Brass	4	6.0
Other	4	6.0
Digital Audio	2	0.6

Note. *Contains single occurrence answers including recorder, harmonica, xylophone, and music theory.

Structure of Music Lessons in Professional Practice

To understand to what extent music therapists use music lessons in each of their clinical practice, participants were asked the number of clients in their practice receiving music lessons (see Table 3). Participants were also asked what percentage of their caseload receive these music

lesson services, shown in Table 3. Additionally, participants were asked the average duration of each music lesson session. Fifty-five percent of participants reported music lessons lasting 30 minutes and 25% reported 45-minute duration. The remaining 20% of participants reported having 1-hour music lessons. When asked the frequency of music lessons on average, 87% of participants answered weekly with the remaining 13% answering bi-monthly.

Table 3

Number of Music Therapists' Caseloads Receiving Music Lessons

Numeric Criteria	<i>n</i>	%
Percentage of Caseload		
< 10%	61	32.0
10-20%	32	17.0
20-30%	28	15.0
30-40%	12	06.0
40-50%	7	04.0
50-60%	7	04.0
60-70%	6	03.0
70-80%	6	03.0
80-90%	2	01.0
Number of Clients		
1-5 Clients	94	53.1
5-10 Clients	46	26.0
10-15 Clients	15	08.5
15-20 Clients	13	07.3
20-30 Clients	3	01.7
30+ Clients	6	03.4

To understand the assessment and referral process for music lessons, participants were asked three questions to determine how and when this decision is made. Participants were asked what percentage of their music lessons began with music therapy first versus the percentage of clients that start with music lessons first, outlined in Table 4. Table 4 also demonstrates the results of the question on the source of referrals for music lessons each participant reported. Additionally, participants were asked where referrals for music therapy initiate from in their practice and is reported in Table 4.

Table 4

Referral Origin Information

Referral Criteria	Music Lessons First		Music Therapy First	
	<i>n</i>	%	<i>n</i>	%
Percentage of caseload referred for services				
25%	65	41.9	55	36.7
50%	20	12.9	23	15.3
75%	31	20.0	27	18.0
100%	39	25.2	45	30.0
Music Lesson Initiation Time				
Initial inquiry	66	37.5		
Client interest beyond sensory stimulation	38	21.6		
Assessment	38	21.6		
Foundation attention skills acquired	9	05.1		
Spontaneously	9	05.1		
Referral Source				
Client		58.0		
Parents/caregiver		54.0		
Private practice		36.0		

Referral Criteria	<i>n</i>	%
Program referral		22.0
Doctor/nurse		22.0
Facility		22.0
Other*		19.0
Community program		17.0
Special education teacher		14.0
Band/Orchestra director		8.0
State-funded program		6.0

Note. *Other refers to after-school programs, business referrals, word-of-mouth, or community outreach events

Resources and Materials Used

Participants were asked to select any resources they used to facilitate music instruction in their practice. Alternative music notation (31%) includes visual aids, braille music, and non-standard notation. Instrument adaptation (15%) includes guitar slides, barre buddy, and alternative tunings. Alternative communication (29%) includes verbal or musical prompts and Augmented and Alternative Communication (AAC) device. Alternative techniques (80%) include modified fingering, improvisation, and audiating, or playing by ear or rote copying rather than reading music notation. Sensory breaks (11%) include non-music activities or fidget toys.

Descriptive Terms Currently Used by Music Therapists

One open-ended question asked participants what term they use to describe the lessons they offer as part of their practice. A visual representation of current terminology used by music therapists is shown in Table 5.

Table 5*Descriptive Terminology of Music Instruction in the Music Therapy Profession*

Terminology	<i>n</i>	%
Adaptive Lessons	123	67
Music Therapy	66	36
Therapeutic Lessons	26	14
Session	10	5
Modified Lessons	3	2
Traditional Lessons	8	4
Music Education	7	4

Funding Source for Services

Two survey questions targeted the cost for music instruction services. Almost half of the participants (49%) reported charging between \$40-90 per hour. In freeform comments at the end of the survey, two participants stated that there was not an answer option for free services and did not feel that the choice \$0-10 was adequate to represent their answer.

The majority of music lessons are funded by private pay (54%). Hospitals comprised 29% of music lesson funding sources. Medicaid (17%), community programs (16%), and schools (15%) accounted public programs supporting music lessons. Other sources (21%) accounted for the remaining music lesson funding sources and included retail stores, churches, and nursing homes.

Clienteles Served

To answer Research Question 4, what clientele receive music lessons, participants were asked the age and diagnoses of their clients. Participants were able to select as many options that

applied. The majority of clients receiving music instruction were between the ages of 6-30 years old. See Table 6 for the complete list.

Table 6

Ages of Clients Receiving Music Instruction

Age in Years	Percentage Reported
0-6	25
6-12	66
12-18	69
18-30	52
30-60	33
60+	25

An open-ended question allowed participants to list all client groups receiving music instruction or lessons. Participants reported a total of 55 unique diagnoses that were organized by the current researcher into four main categories: neurodiverse, medical, developmental or congenital, and mental health. A visual representation of the diagnoses reported in each of those categories is shown in Table 7.

Table 7*Diagnoses of Clients Receiving Music Instruction Reported by Music Therapists*

Diagnoses	Number Reported		Diagnoses	Number Reported	
	<i>n</i>	%		<i>n</i>	%
Developmental			Mental Health		
Physical Disability	43	15.0	Anxiety	21	17.5
Learning Disability	42	14.6	Mental Illness	17	06.0
Down Syndrome	26	09.2	Depression	14	05.0
Cerebral Palsy	22	07.8	Behavioral Health	13	04.6
Intellectual Disability	19	08.2	PTSD	8	02.8
Special Needs	8	02.8	Psychiatric	7	02.5
Speech Delays	4	01.4	Bipolar	3	01.0
Medical					
TBI	14	05.0	Neurodiverse		
Oncology	9	03.2	ASD	119	42.0
Pediatric	5	01.7	ADHD/ADD	75	26.0
Stroke	4	01.4	*Other	35	12.3

Note. *Other includes singular reports of dyslexia, dementia, epilepsy, geriatric, orthopedic, hypertension, arthritis, eating disorder, sexual abuse, mutism, emotional needs, rare genetic disorders, foster care, and agenesis corpus callosum. Duplicate reports included cognitive delay, Apert, and William's Syndrome, hospice, Parkinson's, Sickle Cell Anemia, neurological impairment, suicidal ideation, attachment disorder

Targeted Goals and Objectives

Participants were asked what goals they address during their music instruction or lesson sessions. Music skills were the highest goal addressed by participants (82%), followed by cognitive skills (78%). A visual representation of goals addressed by domain is represented in Table 8. The top two most reported objectives are additionally listed.

Table 8*Goal Domains Addressed in Music Instruction by Music Therapists*

Goal Domains	%
Music Skills	82
Differentiated Rhythms	72
Correct Pitches	72
Cognitive	78
Sustained Attention	82
Memory	78
Fine Motor	73
Finger Individualization	83
Strength	56
Emotional	62
Self-expression	77
Express appropriately	64
Social	61
Turn Taking	62
Conversation	60
Communication	56
Stating a choice	67
Musical communication	57
Life Skills	50
Recreation/leisure	81
Confidence	80
Gross Motor	41
Crossing the midline	57
Elbow bending	43
Spiritual	15
Expressing	47
Mindfulness	39
Other	5

Perceived Benefit

Participants of this survey were asked two questions to determine, based on their professional experiences, how effective music instruction during the music therapy session is on client goal outcomes. Overall, 69% responded they found them effective with 26% responding they felt they are somewhat effective. Of the participants' surveys, 2% found them somewhat effective, and 1% found them not effective. Table 9 represents the results of the question asking each participant their opinion on the perceived effectiveness of music lesson in each goal domain.

Table 9

Perceived Benefit of Music Instruction in Music Therapy by Goal Domain

Goal Domains	Not Effective		Somewhat Ineffective		Somewhat Effective		Very Effective	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Musical	0	0.0	2	1.1	26	14.0	150	84.0
Fine Motor	1	0.6	2	1.1	24	13.6	150	84.0
Cognitive	1	0.6	1	0.6	32	18.0	142	80.0
Communication	3	1.7	7	3.9	63	35.4	105	59.0
Emotional	4	2.3	13	7.4	63	35.0	96	54.0
Gross Motor	6	3.4	15	8.6	64	37.0	84	51.0
Life Skills	6	3.4	20	11.4	62	35.4	57	49.7
Social	7	4.0	8	4.5	92	82.0	69	39.0
Spiritual	23	18	23	18.0	68	41.0	48	29.0

Themes in Open Responses

When analyzing the 42 open ended responses made by music therapist participants, five themes emerged from repeated words and topics: diversity in nonmusical goals addressed, decisions behind referral processes, diversity in definition, training as a music therapist, and difficulty generalizing information. The first theme was the diversity in non musical goals addressed by music lessons in music therapy. Participants stated that some clients had a mixture of music and non-musical goals, such as a participating in a performance. Some chose not to assign goals at all to normalize the experience, but that the wholistic intentionality within teaching pedagogy brought about secondary gains. Four participants stated that their ultimate goal was to have a performance for clients to participate. Goals reported by participants to be left out were confidence building, executive functioning or life skills goals such as organizing practicing time, and breath support.

The second theme was the decision behind the referral process and initiating lessons. Participants reported that not all clients referred are appropriate for lessons. Client preference and autonomy were highly valued in the comments as an integral part of the decision, such as a graduation to lessons following therapy or as a way for the client to continue the relationship. Participants noted a general positive regard for recognizing and utilizing client's strengths and abilities, including beliefs that anyone can learn with the right existing supports. In two cases, participants reported traditional lessons provide supplemental income to the private practice.

The third theme was the diversity in definition and how it varies across audiences. One participant stated that having a lack of distinction and unified understanding of the nuances in definition impeded defining the scope of practice. One participant mentioned the stigma attached

to the term adapted lessons which has the potential to turn away both caretakers and clients from necessary supports that come with the service.

The fourth theme was the training as a music therapist. One participant commented that the unique training of music therapists sets the profession apart for music lessons for any kind of student. Another participant said that the training specifically gives music therapists the skills to uniquely adapt. A distinct lack of training in music lesson teaching in music therapy training was noted connecting to a point made that, from an ethical perspective, pedagogy training is necessary to teach lessons.

The final theme was difficulty generalizing. Six participants stated it was difficult to determine cost as it is decided by the facility. Three participants stated that it is difficult to generalize goals across their practice because they work in several populations. One participant said that it is difficult to generalize facilities due to the diversity of their caseload.

CHAPTER V

RECOMMENDATIONS AND CONCLUSIONS

The purpose of this survey was to collect data on the use of music instruction by music therapists in the United States. The research questions sought to determine the current practices of music therapists providing music instruction, what this service is commonly called, how the services are paid for, what clientele receive these lessons, and what musical and nonmusical goals are targeted within the lessons.

Demographics of Music Therapist Providing Services

Overall, based on the results, the use of music lessons was higher in the Mid-Atlantic and Great Lakes regions. This could suggest a higher occurrence in this area or a higher response rate of survey participants and that the Great Lakes and Mid-Atlantic regions are two of the largest regions in AMTA. Regarding future research, these regions may have a greater concentration of music lessons in music therapy or increased motivation to participate in studies involving these interventions.

Demographical results of this study aligned with the AMTA Workforce Analysis (2021). This survey of practicing music therapists reported that their survey also yielded that half (51%) of respondents had been practicing 10 years or less compared to this survey's demographics of 55% practicing 10 years or less. The AMTA Workforce Analysis reported nominally higher representation of doctorate degrees (8.4%) compared to this study (6%). In contrast, this survey represented a higher percentage of music therapists with bachelor's degrees (75%) compared to the AMTA analysis (43%), which potentially demonstrates a lower undergraduate level membership in AMTA to respond. The master's degree representation for this survey (48%) aligned with the workforce analysis responses (48%). Due to the similar demographics of this

study compared to the demographic information of the profession at large, there is an even representation of years' experience and educational background represented in the data presented.

The music therapist participants identified in Table 1 encompassed a wide range of educational experiences and additional credentialing in the music therapy field and/or in adjacent professions. This could reflect the level of practice and purpose in music lessons the therapists are qualified to provide as defined by Bruscia (2014). Augmentative music therapy, including music lessons in the therapy setting, is described as an entry level of practice for music therapists because the developmental goals do not involve processing the self-reflective process with the client (Bruscia, 2014). This could account for the 85% of respondents identifying as entry level music therapists with bachelor, bachelor equivalency, or master equivalency degrees and 31% with less than 5 years of experience (Table 1) responding to the survey.

Current Practices

Based on the responses from participants of instruments taught, specifically the prevalence of piano and guitar, as well as voice and ukulele instruction, this aligns with three of the four instruments on which music therapists are trained (AMTA, 2005). Additionally, other reasons for the high percentage of these instruments is accessibility, versatility of their use, and/or the demand of these instruments by clients, and ability to adapt or incorporate alternative visual aids or resources. The prevalence of these instrument choices in music lessons is potentially determined by both the therapist's and client's access to them. Neither Bruscia (2014) or Polen et al. (2017) specified any one instrument that recreative music is appropriate for, but rather that the choice of instrumentation should reflect the goals targeted as well as client preference. The use of digital music as a medium for musical exploration has not been addressed

in the current music therapy literature in terms of music lessons or in the recreative music therapy domain despite two separate reports (see Table 2) of its utilization in this survey.

The adaptations used (see Table 9) most often by participants were alternative forms of communication and alternative music notation. These adaptations align with both Sokira (2013) and Hintz (2013)'s recommendations for adaptation including: color-coding, labeling, enlarging, or mnemonic aids. The prevalence of alternative communication techniques was a notable find from the results of this survey question due to the absence of its mention in the literature. Reports of AAC devices during music lessons in music therapy, a common communication alternative in the developmental health, is novel to current literature. Overall, the majority of participants (85%) did not alter how an instrument is played. This may indicate the client's goal is to play the instrument in traditional ways or that the client does not benefit from or need adaptations.

Additionally, 77% of participants noted 30-45 minute music lessons were appropriate for the clients they serve. Although participants were not asked for factors that impacted lesson length, possible explanations could include the clients' ages, needs and goals, as well as financial or scheduling needs. Based on the number of clients and percentage of each therapist caseload containing music lessons as part of therapy (see Table 3), music lessons did not comprise the majority of 67% of the participants' caseloads. However, 10% reported that it was nearly their entire caseload of music therapy clients. Additional research is needed to identify what factors influence music therapists decision to add music lessons to their caseload and influencing factors into the percentage of music lessons compared to music therapy sessions.

Participants reported an even distribution of whether clients begin music therapy lessons initially or at some point during the therapy relationship. The most common answers were that the decision of which option is needed is made during the initial inquiry (37%) and assessment

stage (21%). This reflects guidelines by Hintz (2013) regarding the developmental health perspective. Hintz recommended that the appropriateness of lessons should result from the evaluation, noting a client's general capacity to attend to a task as well as their music instrument preference compared to their physical abilities to feel most successful (Hintz, 2013). However, 63% participant incorporate music lessons after therapy has progressed beyond the initial assessment phase. This indicates music therapists identify their clients may benefit from lessons instead of therapy after working with their clients for a while once rapport has been established and the therapist had more understanding of their strengths and needs. Twenty-one percent of participants acknowledged that one foundational skill that prerequisites music lessons is intentional instrument playing or vocalizing beyond sensorial stimulation. This suggests that for these therapists, the client benefits from recreative purposes rather than solely receiving sensorial input. This was not a stipulation for beginning music lessons addressed in the literature by Sokira (2013) who suggested that music lessons are a way to establish joint attention and sensory regulation. However, it is possible that therapists use this milestone as a way of distinguishing music lessons from recreative music lesson experiences in music therapy.

As shown in Table 7, most participants (58%) identified that the client themselves initiates the decision to begin music lessons within music therapy. The guidelines established in the adult, mental health, and pediatric models establish music lesson initiation is based on the client's interest in the recreative process (Allen, 2013; Bradt, 2013; Eyre, 2013). This is an important aspect of music therapy in empowering and supporting our client's autonomy, decision making, and desire to active participate in their services. Additionally, 54% of participants reported parents and caretakers as the second most common referral source. These results were

also explained by Sokira (2013) and Hintz (2013), who noted that the most common referral source are parents and caregivers when beginning the assessment process.

Terminology to Describe Music Lessons in Music Therapy

Adapted lessons were the highest reported term (67%) used by music therapists when describing the use of music lessons in their personal music therapy practice. This could potentially imply that these participant are focusing on developmental and life skills goals (Hintz, 2013; Sokira, 2013) at an auxiliary level to address music expression goals (Bruscia, 2014) or at an augmentative level where quality of life goals are addressed with music skill acquisition as a secondary gain (Gardstrom, 2013). No participant reported using instructional music therapy or instructional music psychotherapy (Bruscia, 2014), meaning none of the participants use music lessons at the intensive music therapy level or do not align with this definition in their practice.

The term therapeutic lessons was used by 14% of participants. This could result from Bruscia's (2014) auxiliary definition of using music experiences with the primary goal of recreation of precomposed sound without therapeutic goals. It could also reference the use of music lessons with the musical goals as the secondary gain with quality of life goals serving as the primary therapeutic purpose (Gardstrom, 2013; Ghetti, 2013). Additional research is needed to identify what factors influence the term used by music therapists including how the term is introduced during music therapy education. The remaining 8% of participants using the terms traditional lessons and music education could possibly represent the therapists who use music lessons without goals attached. Some participants mentioned in the last open comment question about normalizing the lessons experience and not utilizing potentially stigmatizing terminology distinctions like "adapted lessons." It could also refer to music lessons given to students who are

not clients and do not have therapeutic goals but the music lessons serve as supplementary income.

Funding Sources of Music Lessons in Music Therapy

Based on the data, over half of the participants (54%) reported they utilize music lessons through their private practice. This aligns with findings by Bruscia (2014) and Hintz (2013) that music lessons often occur in private practice due to the frequent one-on-one structure most associated with music lessons. Additionally other funding sources participants reported from hospital expenses or programs accounts for the experiences is similar to Eyre (2013) and Allen (2013)'s studies. This study adds to existing literature with the data surrounding funding from Medicaid or waiver clients (17%) receiving lessons, music lessons in community programs (16%), and other sources of funding.

Clients Receiving Music Lessons in Music Therapy

According to the results of this survey, the average music therapist providing music instruction sees clients between the ages of 6 and 30 years old. The prevalent age bracket reflects the literature of recommended age groups to receive these services (Allen, 2013; Bradt, 2013; Eyre, 2013; Hintz, 2013; Polen et al., 2017). More research is needed to determine what factors might contribute to the high percentage of individuals receiving lessons in the 6-30 year range.

Overall, a wide range of clientele are served through music lessons by board-certified music therapists. This seems to indicate the range of individuals served, specifically rarer diagnoses with little to no available published research. ADHD and ASD were reported most frequently, which supports the literature that these diagnoses are particularly receptive to this kind of intervention (Hintz, 2013; Sokira, 2013). The high representation of mental health diagnoses reflects various researchers (Allen, 2013; Bradt, 2013; Ghetti, 2013; Eyre, 2013) who

have noted music lessons addressing therapeutic goals for mental health concerns in children, adolescents, and adults are effective. Music lessons used to address a plethora of medical health and wellness goals reported in this study also aligns with the literature representation of this population (Allen, 2013; Bradt, 2013).

Musical and Non-Musical Goals Addressed

Participants reported using music instruction most commonly to address music-related goals (82%) followed closely by addressing fine motor skills (78%) and cognitive skills (73%). These three goal areas make sense considering most instruments require individual or collective manipulation of buttons, keys, or strings to produce sound, eye-hand coordination, visual or auditory tracking, and understanding when and how to change dynamics, tempo, and other musical changes. However, 18% of participants providing music lessons in therapy do not track or address music related goals as an aspect of therapy. More research is needed surrounding factors that influence music therapists' decisions to set goals in their music lessons.

At least 41% of participants reported addressing each goal domain except for spiritual. Additionally, the utilization of every objective across each goal domain indicates the wide variety in application of music instruction from music therapists. This also reflects the importance of the music therapist factoring in a multitude of complex facets represented in the literature during the assessment or therapy process when formulating goals (Bruscia, 2013; Polen et al, 2017). Finally, the majority of participants (69%) indicated they felt music instruction was somewhat or very effective. The findings that music lessons to address goal areas are effective are supported by several researchers (Allen, 2013; Bradt, 2013; Bruscia, 2014; Eyre, 2013; Hintz 2013).

Limitations

Several limitations occurred throughout this study. One limitation was the small survey response size. Only 2% of board-certified music therapists responded to this study. Although not all music therapists may provide music lessons, a higher response rate will contribute to greater understanding of this topic. Another limitation was the short time frame of 30 days to respond. This could have left potential participants with insufficient time to participate. Additionally, due to the research design, participants were not able to provide in-depth responses or rationales around implementing music lessons. Finally, although the goal domains and objectives listed in this survey were informed from other published literature, several participants noted additional goal areas not available as an option.

Recommendations for Future Research and Clinical Practice

Future research could include gaining more information into factors that influence music therapists' decisions to provide music lessons, why they choose the term for their services, and what challenges they have encountered. Additionally, future researchers could study data-driven trials on the effectiveness of clinical music instruction by a music therapist on the cognitive skills of clients. Future research could include the impact of music lessons with specific populations. Additionally, future researchers could conduct interviews with music therapists to better understand their experiences and what skills and training they received during their education to prepare them for providing music lessons. Finally, future researchers could work to identify how a model or theory of music lessons and a uniform definition or term could benefit music therapy and advocacy efforts.

Conclusion

This survey sought to describe the use of music instruction by music therapists, as well as report on the approaches and structure of music lessons in this capacity. Based on the results, music therapists provide music instruction through diverse clinical approaches based on their client's needs. This study provided baseline data surrounding clientele receiving music therapy (i.e., client age, diagnosis), current practices and goal domains as addressed in music instruction, instrumental or vocal choices utilized by clients, funding sources of music instruction in music therapy (i.e., hospitals, private practice), and statistics of current terminology used to describe music instruction within their practice. This study can influence the focus of future clinical studies to solidify best evidenced-based practice of clinical music instruction within the scope of professional practice. Music therapy and non-music therapy professionals can incorporate findings from this study to improve music instruction resulting in improving client's overall quality of life.

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APPENDIX A

SURVEY

Informed consent

	I agree	I disagree
<p>*1) Your participation in the survey is voluntary. You may withdraw at any time. Do not include any confidential client information in your survey. There are 43 questions. 3 questions are required and cannot be skipped including how long you have practiced, how recently you have practiced, and your definition of music lessons in therapy. You must be 18 years or older and have a board certification or other credentialing as a music therapist. Due to the online nature of the survey it is a potential risk to lose confidentiality which will be mitigated by keeping information on a password locked computer owned by the researcher. By clicking "I agree" you consent to participate by filling out the survey.</p>	<input type="radio"/>	<input type="radio"/>

Continue ONLY when finished. You will be unable to return or change your answers.

Continue »

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***2)** Do you currently or in the last five years offer/offered music lessons as part of your music therapy practice?

- ☐ yes (continue) [Value=1]
☐ no (thank you for taking part, you do not need to continue) [Value=2]

Context Information :

***3)** What term do you use to describe the music lessons that you provide?

(1000 characters remaining)

4) What are some ways you receive music lesson referrals?

- ☐ Client [Checked=1]
☐ Special education teacher [Checked=1]
☐ Integrated education teacher [Checked=1]
☐ Doctor/nurse referral [Checked=1]
☐ Program referral [Checked=1]
☐ Parents [Checked=1]
☐ Facility [Checked=1]
☐ Medicaid [Checked=1]
☐ Private practice [Checked=1]
☐ Band/orchestra/choir director [Checked=1]
☐ State funded program [Checked=1]
☐ Community program [Checked=1]
☐ Other (please specify) [Checked=1]

5) What are the facilities where you provide music lessons? Check all that apply: :

- ☐ Private practice [Checked=1]
☐ Public schools [Checked=1]
☐ Private school [Checked=1]
☐ Charter school [Checked=1]
☐ Home health/Medicaid/CLASS [Checked=1]
☐ State Waiver Program [Checked=1]
☐ Hospital [Checked=1]
☐ Facility [Checked=1]
☐ State funded program [Checked=1]
☐ Community program [Checked=1]
☐ Other (please specify) [Checked=1]

6) What is the average duration of your music lesson times?

- ☐ less than 30 minutes [Value=1]
☐ 30 minutes [Value=2]
☐ 45 minutes [Value=3]
☐ 1 hour [Value=4]
☐ more than 1 hour [Value=5]

7) How much do you charge per hour of music lessons? (If per half hour, add two 30 minute lessons together for total cost per hour)

- ☒ \$0-10/hour [Checked=1]
- ☐ \$10-20/hour [Checked=1]
- ☐ \$20-30/hour [Checked=1]
- ☐ \$30-40/hour [Checked=1]
- ☐ \$40-50/hour [Checked=1]
- ☒ \$50-60/hour [Checked=1]
- ☐ \$60-70/hour [Checked=1]
- ☐ \$70-80/hour [Checked=1]
- ☐ \$80-90/hour [Checked=1]
- ☐ \$90-100/hour [Checked=1]
- ☐ \$100-120/hour [Checked=1]
- ☐ \$120-140/hour [Checked=1]
- ☐ \$140-160/hour [Checked=1]
- ☐ \$160+/hour [Checked=1]

8) How is your rate determined?

- ☒ Myself [Checked=1]
- ☐ Facility [Checked=1]
- ☐ Client [Checked=1]
- ☐ Market area research [Checked=1]
- ☐ Sliding scale [Checked=1]

9) Think of all the clients that you provide music lessons to. What percentage of these clients were referred to you for private music lessons FIRST?

- ☐ 25% [Value=1]
- ☐ 50% [Value=2]
- ☐ 75% [Value=3]
- ☐ 100% [Value=4]

10) What percentage of these clients were referred to you for music therapy sessions FIRST?

- ☐ 25% [Value=1]
- ☐ 50% [Value=2]
- ☐ 75% [Value=3]
- ☐ 100% [Value=4]

11) Think of how you began your relationship with your private lesson clients. At what point in the relationship did you decide to provide music lessons?

- ☐ During initial inquiry [Value=12]
- ☐ Assessment [Value=1]
- ☐ 1st session [Value=2]
- ☐ First quarter [Value=3]
- ☐ Annual [Value=4]
- ☐ When foundational attention skills are established [Value=5]
- ☐ When foundational music skills are established [Value=6]
- ☐ When foundational cognitive skills are established [Value=7]
- ☐ When foundational gross/fine motor skills are established [Value=8]
- ☐ When it is determined to be age-appropriate [Value=9]
- ☐ Spontaneously [Value=10]
- ☐ When the client shows interest in an instrument beyond sensorial stimulus [Value=11]

12) What are the ages represented in your music lesson clients? Check any that apply.

- ☒ 0-6 [Checked=1]
- ☐ 6-12 [Checked=1]
- ☐ 12-18 [Checked=1]
- ☐ 18-30 [Checked=1]
- ☐ 30-60 [Checked=1]
- ☐ 60+ [Checked=1]

13) List all of the client groups (autism, blind, etc) that are represented in your music lesson practice:

(1000 characters remaining)

Scope of Goals

14) Check any goals that are addressed during music lessons in music therapy:

- ☒ Social skills [Checked=1]
☒ Fine motor skills [Checked=1]
☒ Gross motor skills [Checked=1]
☒ Cognitive skills [Checked=1]
☒ Spiritual goals [Checked=1]
☒ Emotional goals [Checked=1]
☒ Communication goals [Checked=1]
☒ Life skill goals [Checked=1]
☒ Musical skills [Checked=1]
☒ Other: [Checked=1]

15) In my opinion, music lessons in music therapy sessions are generally:

- ☒ No effective [Checked=1]
☒ Somewhat not effective [Checked=1]
☒ Somewhat effective [Checked=1]
☒ Effective [Checked=1]

In my opinion, I think music lessons are effective in addressing the following domains:

	Not effective	Somewhat ineffective	Somewhat effective	Very effective
16) Social Skills	<input type="radio"/> [Value=1]	<input type="radio"/> [Value=2]	<input type="radio"/> [Value=3]	<input type="radio"/> [Value=4]
17) Fine Motor Skills	<input type="radio"/> [Value=1]	<input type="radio"/> [Value=2]	<input type="radio"/> [Value=3]	<input type="radio"/> [Value=4]
18) Gross Motor Skills	<input type="radio"/> [Value=1]	<input type="radio"/> [Value=2]	<input type="radio"/> [Value=3]	<input type="radio"/> [Value=4]
19) Cognitive Skills	<input type="radio"/> [Value=1]	<input type="radio"/> [Value=2]	<input type="radio"/> [Value=3]	<input type="radio"/> [Value=4]
20) Spiritual Goals	<input type="radio"/> [Value=1]	<input type="radio"/> [Value=2]	<input type="radio"/> [Value=3]	<input type="radio"/> [Value=4]
21) Emotional Skills	<input type="radio"/> [Value=1]	<input type="radio"/> [Value=2]	<input type="radio"/> [Value=3]	<input type="radio"/> [Value=4]
22) Communication Skills	<input type="radio"/> [Value=1]	<input type="radio"/> [Value=2]	<input type="radio"/> [Value=3]	<input type="radio"/> [Value=4]
23) Life Skills	<input type="radio"/> [Value=1]	<input type="radio"/> [Value=2]	<input type="radio"/> [Value=3]	<input type="radio"/> [Value=4]
24) Musical Skills	<input type="radio"/> [Value=1]	<input type="radio"/> [Value=2]	<input type="radio"/> [Value=3]	<input type="radio"/> [Value=4]

25) Within the social skills domain, which objectives do you address:

- ☒ Greetings [Checked=1]
☒ Conversation [Checked=1]
☒ Cooperative play [Checked=1]
☒ Identify preferred behavior [Checked=1]
☒ Identify preferred language [Checked=1]
☒ Turn taking [Checked=1]
☒ Situational awareness [Checked=1]
☒ Inviting to engage [Checked=1]
☒ On topic conversation [Checked=1]
☒ Transition skills [Checked=1]
☒ Conflict resolution [Checked=1]
☒ Not throwing objects [Checked=1]
☒ Listening without interrupting [Checked=1]
☒ Sharing [Checked=1]
☒ Accepting personal space boundaries [Checked=1]
☒ Do not address [Checked=1]
☒ Not Listed [Checked=1]

26) Within the fine motor skills domain, which objectives do you address:

- ☐ Finger individualization [Checked=1]
- ☐ Contrary movement [Checked=1]
- ☐ Cooperative movement [Checked=1]
- ☐ stretching/flexibility [Checked=1]
- ☐ Strength [Checked=1]
- ☐ Adaptability [Checked=1]
- ☐ Holding objects [Checked=1]
- ☐ Do not address [Checked=1]
- ☐ Not Listed [Checked=1]

27) Within the gross motor skills domain, which objectives do you address:

- ☐ Balance [Checked=1]
- ☐ Crossing the midline [Checked=1]
- ☐ Raising arms [Checked=1]
- ☐ Opening arms [Checked=1]
- ☐ Elbow bending [Checked=1]
- ☐ Do not address [Checked=1]

28) Within the cognitive skills, which objectives do you address:

- ☐ Memory [Checked=1]
- ☐ learning rules/guidelines [Checked=1]
- ☐ symbology [Checked=1]
- ☐ sequencing [Checked=1]
- ☐ Attending [Checked=1]
- ☐ mirroring/copying [Checked=1]
- ☐ Terminology [Checked=1]
- ☐ Counting [Checked=1]
- ☐ Comprehension [Checked=1]
- ☐ Sustained attention [Checked=1]
- ☐ Selected attention [Checked=1]
- ☐ Divided attention [Checked=1]
- ☐ Long-term memory [Checked=1]
- ☐ Working memory [Checked=1]
- ☐ logic/reasoning [Checked=1]
- ☐ Auditory processing [Checked=1]
- ☐ Visual processing [Checked=1]
- ☐ Processing speed [Checked=1]
- ☐ Pitch perception [Checked=1]
- ☐ volume /dynamic perception [Checked=1]
- ☐ Rhythm change perception [Checked=1]
- ☐ Rhythm constancy perception [Checked=1]
- ☐ Identifying melody [Checked=1]
- ☐ Abstraction [Checked=1]
- ☐ Identify patterns [Checked=1]
- ☐ Do not address [Checked=1]

29) Within the spiritual domain, which objectives do you address:

- ☐ Identifying [Checked=1]
- ☐ Expressing [Checked=1]
- ☐ Practicing [Checked=1]
- ☐ Meditating [Checked=1]
- ☐ Improvisation [Checked=1]
- ☐ Mindfulness [Checked=1]
- ☐ Composition [Checked=1]
- ☐ Do not address [Checked=1]

- 30) Within the emotional domain, which objectives do you address:
- ☐ identify [Checked=1]
 - ☐ regulate [Checked=1]
 - ☐ express appropriately [Checked=1]
 - ☐ Self-expression of emotions [Checked=1]
 - ☐ Expressing an abstract thought [Checked=1]
 - ☐ describe [Checked=1]
 - ☐ accepting approval/disapproval [Checked=1]
 - ☐ receive feedback/ criticism [Checked=1]
 - ☐ accepting no as an answer [Checked=1]
 - ☐ Do not address [Checked=1]
- 31) Within the communication skills domain, which objectives do you address:
- ☐ Verbalizing sounds [Checked=1]
 - ☐ Verbalizing words [Checked=1]
 - ☐ Stating a choice [Checked=1]
 - ☐ Filling in a word/lyric [Checked=1]
 - ☐ ASL/alt communication [Checked=1]
 - ☐ ACC device [Checked=1]
 - ☐ Musical communication/dialogue [Checked=1]
 - ☐ Do not address [Checked=1]
- 32) Within the life skills domain, which objectives do you address?
- ☐ problem solving [Checked=1]
 - ☐ Confidence [Checked=1]
 - ☐ Resilience [Checked=1]
 - ☐ gathering information [Checked=1]
 - ☐ decision making [Checked=1]
 - ☐ recreation/leisure [Checked=1]
 - ☐ Do not address [Checked=1]
- 33) Within the musical domain, which objectives do you address:
- ☐ Pitch identification [Checked=1]
 - ☐ Reading music [Checked=1]
 - ☐ Playing dynamics [Checked=1]
 - ☐ Playing correct pitches [Checked=1]
 - ☐ Playing different rhythms [Checked=1]
 - ☐ Playing correct rhythms [Checked=1]
 - ☐ Singing and playing at the same time [Checked=1]
 - ☐ Expressing ideas musically [Checked=1]
 - ☐ Identifying chords [Checked=1]
 - ☐ Do not address [Checked=1]
- 34) What adaptive tools are used in your musical lessons? Select all that apply:
- ☐ Visual aids [Checked=1]
 - ☐ Adapted instruments [Checked=1]
 - ☐ Adapted guitar picks [Checked=1]
 - ☐ Barre chord buddy [Checked=1]
 - ☐ Guitar buddy [Checked=1]
 - ☐ Stickers/cards [Checked=1]
 - ☐ Visual overlay (such as identifying piano keys or guitar strings/frets) [Checked=1]
 - ☐ Tactile playdough for hand strength [Checked=1]
 - ☐ Fidget toys [Checked=1]
 - ☐ Manipulatives (stick on, velcro, communication card) [Checked=1]
 - ☐ Sensory toys/tools [Checked=1]
 - ☐ Reward chart [Checked=1]
 - ☐ Non-music breaks [Checked=1]
 - ☐ Sensory breaks [Checked=1]
 - ☐ Playing by ear [Checked=1]
 - ☐ Alternative note notation [Checked=1]
 - ☐ tactile prompts [Checked=1]
 - ☐ verbal directions [Checked=1]
 - ☐ musical prompts [Checked=1]
 - ☐ Other (please specify) [Checked=1]

Client demographics:

35) How many clients do you provide music lessons to?

- ☐ 1-5 [Value=1]
☐ 5-10 [Value=2]
☐ 10-15 [Value=3]
☐ 15-20 [Value=4]
☐ 20-30 [Value=5]
☐ 30+ [Value=6]

36) In general, how often do your music lesson clients have sessions?

- ☒ weekly [Checked=1]
☐ biweekly [Checked=1]
☐ monthly [Checked=1]
☐ bimonthly [Checked=1]
☐ every few months [Checked=1]
☐ once a year [Checked=1]

37) What percentage of your caseload is dedicated to music lessons?

- ☐ less than 10% [Checked=1]
☐ 10-20% [Checked=1]
☐ 20-30% [Checked=1]
☐ 30-40% [Checked=1]
☐ 40-50% [Checked=1]
☐ 50-60% [Checked=1]
☐ 60-70% [Checked=1]
☐ 70-80% [Checked=1]
☐ 80-90% [Checked=1]
☐ 90-100% [Checked=1]

Demographic information:

•38) How many years total have you been practicing music therapy?

- ☐ 0-5 [Value=1]
☐ 5-10 [Value=2]
☐ 10-15 [Value=3]
☐ 15-20 [Value=4]
☐ 20-25 [Value=5]
☐ 25-30 [Value=6]
☐ 30+ [Value=7]

39) Check all that apply relating to your music therapy education history:

- ☐ completed a bachelor equivalency degree [Checked=1]
☐ completed a bachelor's degree in music therapy [Checked=1]
☐ completed a master's equivalency degree in music therapy [Checked=1]
☐ completed a graduate degree in music therapy [Checked=1]
☐ completed a graduate degree in a field other than music therapy [Checked=1]
☐ completed a PhD degree in music therapy [Checked=1]
☐ completed a PhD degree in a field other than music therapy [Checked=1]

40) Please list any additional credentialing you hold:

41) Please indicate the AMTA region where you live

- ☐ Great lakes region [Value=1]
☐ Mid Atlantic region [Value=2]
☐ Mid western region [Value=3]
☐ New England region [Value=4]
☐ Southeastern region [Value=5]
☐ Southwestern region [Value=6]
☐ Western region [Value=7]

42) Any additional comments or thoughts you would like to share?

(1000 characters remaining)

APPENDIX B

RECRUITMENT LETTER

Dear Music Therapists,

My name is Katie Lopez, and I am a board-certified music therapist and graduate student at Texas Woman's University. I am conducting a research survey for my thesis entitled, *Music Lessons Provided to Clients, by Music Therapists: A Descriptive Study of Current Practices in the United States*. You have received this email from me because you opted to receive email requests via CBMT. This is a research study.

This study will attempt to determine the current practices of board-certified music therapists who provide music instruction or music lessons to clients as part of their professional practice. It is known anecdotally that many music therapists provide various forms of music instruction or music lessons to clients. What is not known is what this type of service is commonly called; how are these services paid for; what clientele receive these services, and benefit from, music lessons that are provided by a music therapist; and what musical and nonmusical goals are targeted within a music lesson format. My research question is: *What are the current practices of Board-Certified music therapists who provide music instruction or music lessons to clients?*

The online survey will be conducted through Psychdata. It will take approximately 20 minutes of your time. Questions will include your background and training; how long you have worked as a music therapist; to whom do you provide music lessons; and what sorts of goals do you address. If a participant provides free text responses that violate any sort of confidentiality (such as any confidential information about any music therapist or client), that survey will be discarded.

You are eligible for this study if you are a board-certified music therapist who provides music lessons currently or in the last 5 years or music instruction to clients as part of your professional practice. Completing the survey is completely voluntary and you may withdraw at any time without penalty.

Because the survey is conducted online, there is a potential risk for loss of confidentiality and all email downloading and Internet transactions.

Texas Woman's University's IRB has approved this research. If you are interested in participating, please click on the following survey link:

<https://www.psychdata.com/s.asp?SID=19550>