CREATING NEW MUSIC THERAPY PROGRAMS IN MEDICAL SETTINGS: A PHENOMENOLOGICAL INQUIRY

A Thesis
by
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Abstract

CREATING NEW MUSIC THERAPY PROGRAMS IN MEDICAL SETTINGS:
A PHENOMENOLOGICAL INQUIRY

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This phenomenological study explored the process of starting a medical music therapy program at facilities that did not previously have one. The unique experiences of five music therapists who started new medical music therapy programs were explored using thematic analysis of transcripts of semi-structured interviews. Results indicated that participants had difficulties breaking into established systems, occasionally experienced tension with other co-workers and volunteers, and sometimes felt isolated during the process. Despite challenges, however, experiences were generally positive due to the passion for the work which enabled them to persistently advocate, network, innovate, and engage in self-care necessary to fuel the ongoing work required of the process. Many other factors helped during the process such as personality traits of the music therapists, the support of other music therapists and professionals from other disciplines, and shifting perspective. A need for business education emerged in the results, which remains a topic of exploration for music therapy educators which may be addressed through incorporating workshops, electives, or continuing education. Future research

could include survey research which would provide a larger sample size and more generalizable results, as well as provide insight for how the experience of starting a medical music therapy program could be affected by varying demographics.

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Table of Contents

Chapter 1

Introduction

According to the 2018 American Music Therapy Association (AMTA) Member Survey and Workforce Analysis, the top five settings in which music therapists worked at the time were mental health, intellectually disabled populations, medical/surgical populations, elderly and Alzheimer's populations, and neurological disorders. Despite medical populations being in the top five populations of the workforce survey, only 14% of 522 survey respondents reported practicing music therapy in a medical setting (AMTA, 2018a).

The National Institute of Health's (NIH) National Center for Complementary and Integrative Health (NCCIH, 2018) website has links to articles referencing the benefits of music therapy for individuals with autism spectrum disorder (ASD), impairments of cognitive function, dementia, and Alzheimer's disease, substance use disorders, and depression. However, it does state that NIH is developing "a comprehensive research agenda on the use of music in health settings" based on promising research demonstrating benefits for a number of populations, including stress reduction among children coping with cancer treatment, emotion mediation for people with anxiety and depression, and pain management (NCCIH, 2018, para. 4).

According to Standley (2014a), due to the passing of the Affordable Care Act in 2013, an emphasis has been placed on the American healthcare system to reduce medical costs while improving patient satisfaction. Despite a changing political landscape and constantly evolving healthcare system, the rising interest in evidence-based interventions, cost-effective treatment,

decreased length of stay, and emphasis on psychosocial interventions suggests that medical facilities are becoming more aware of the benefits of music therapy (Loewy, 2015; Standley, 2014a).

As members of interdisciplinary medical teams, music therapists play an integral role. Being admitted to a medical facility, or witnessing and accompanying a loved one's journey through hospitalization, often evokes unique emotional, spiritual, physical, social, and cognitive challenges (Loewy, 2015; Shultis & Gallagher, 2015). Because music therapists are trained to address needs in each of these domains, they are an invaluable and versatile asset to a medical team (AMTA, 2018b). While chaplains, social workers, psychologists, and other members of interdisciplinary medical teams often address psychosocial goals with patients and their families in medical settings, the conduit of music is beneficial in ways that verbal language is not (Kreitler & Kreitler, 1972; O'Callaghan, McDermott, Hudson & Zalcberg, 2013).

Kreitler and Kreitler (1972) described five aesthetic properties of music which substantiate its value in the therapeutic process. First, people have their own unique expectations about music and an intrinsic belief in the value of music, which may increase their readiness for emotional involvement upon hearing it. Second, it provides aesthetic distance, which allows the listener to review a situation in a more objective fashion, also contributing to its ability to evoke emotion. Third, this aesthetic distance allows the listener to project feelings onto the music, therefore intensifying or personalizing any provoked conflicts in order to work through them. Additionally, the listener may hear repressed or suppressed wishes in the music and address them after identifying them in an external, and socially acceptable, medium. Finally, music can be interpreted differently by each individual, allowing for a diverse and personalized experience,

and for sharing of those personalized experiences with a therapist or in a group (Kreitler & Kreitler, 1972).

Mood management and behavioral change are facilitated by the properties of iso-principle and entrainment, which is using music to match an individual energetically and then facilitating transition to another, desired, energy state by changing the music (Heiderscheit & Madson, 2015). For instance, if a patient is resisting physical therapy, music may meet him in his agitation. A music therapist can musically meet him in this space, perhaps matching outbursts with loud dynamics, sharp articulation, and pauses in the music, and may help him entrain to a more mellow, stable, and agreeable state for which therapy to occur by gently moving into a more legato style, bright, but not jarring, dynamics, and steady tempo. In both physical and cognitive rehabilitation, the ability of music to access both hemispheres of the brain simultaneously is beneficial in that it provides access to old information storage through new and different neuropathways than those accessed previously without music (Baker & Tamplin, 2006). For these reasons, medical professionals are recognizing the benefits that music therapists can bring to their interdisciplinary teams (AMTA, 2018b; NCCIH, 2018) especially with continued education from music therapists (Darsie, 2009; Silverman & Chaput, 2011).

According to the 2018 AMTA Workforce Analysis Survey, in the year 2018, 96 new full-time music therapy positions were created. The statistics showed that “over six times more positions were created than were eliminated in 2017” (p. 24). While interest in the profession is surging (AMTA, 2018a), the statistics show that there is room for growth in regards to need for music therapists in medical settings if only 14% of practicing music therapists who completed the survey work in medical settings (AMTA, 2018a). This study aims to further examine

obstacles faced by music therapists when developing a new program in a medical setting as well as resources for overcoming these challenges.

Definition of Terms

Music Therapy

According to the AMTA (2018b), music therapy is defined as a clinical and evidence-based practice that uses music to work towards specific, non-musical goals through a therapeutic relationship between a client and a Board-Certified Music Therapist (MT-BC). Music therapists work with individuals from the beginning of life to the end of life in a variety of settings, for example, from the neonatal intensive care unit to nursing homes and hospices. Other settings where music therapy occurs includes schools, medical hospitals, psychiatric hospitals, mental health centers, correctional facilities, rehabilitation centers. Working in these settings, music therapists develop, implement, modify, and evaluate treatment for individuals with various cognitive, emotional, social, or physical goals. MT-BCs use music therapeutically by engaging clients in expressive music therapy such as creating music, as well as engaging clients through receptive music therapy such as moving to, discussing, or listening to music. It is through the relationship and rapport built with the therapist by doing so that creates dynamic change (AMTA, 2018b).

Board-Certified Music Therapist

MT-BCs are required to have a minimum of a bachelor's degree or its equivalent in music therapy, which includes extensive coursework in musical, clinical, and music therapy foundations and principles. This includes significant coursework in psychology, anatomy and physiology, music theory, music history, music performance, and music therapy-specific courses.

A minimum of 1,200 clinical training hours are required, including a minimum of 900 hours in an internship that is supervised by an experienced MT-BC. Although music therapy is currently a bachelors-level entry profession, there is current debate among the AMTA community regarding a shift to masters-level entry (Wylie et al., 2017).

Others Who Use Music in Clinical Settings

Although there are many individuals who use music therapeutically in clinical settings, there are major differences among their roles and educational backgrounds. These are reflected in their titles, which differentiate them from music therapists. Frequently, many types of musicians are found in hospice and palliative care settings, as well as medical hospitals. Other titles of individuals who use music therapeutically include: music practitioners, harp therapists, music or sound healers, clinical musicians, or music thanatologists (Appendix A).

The training of music practitioners requires 72 hours of class time and 20 hours of clinical training to earn the credential certified music practitioner. Their goal is to "enhance the healing atmosphere" by playing live music in a medical facility, home care, or hospice setting (Music for Healing & Transition Program, 2018b). The music is played by the practitioner for the patients, often in lobbies or at bedside and without an individualized plan. They use voice and a variety of instruments (Music for Healing & Transition Program, 2018a).

Harp therapists are harpists who are comfortable with both notated music and improvisation who work in both acute and long term health settings. They receive special standardized training through the International Harp Therapy Program (IHTP) which covers interpersonal skills, special needs training, and an 80-hour supervised internship (IHTP, 2017). Harp therapists provide either a receptive music experience or engage the client in music-making through harp instruction. According to IHTP's website, goals contributing to the client's

wellbeing in this discipline include emotional, physical, mental, and spiritual goals (IHTP, n.d.). They may also work as part of vibroacoustic therapy, biofeedback/relaxation, or even in corporate settings for stress management (AMTA, 2004).

Music or sound healers require no formal training and incorporate more esoteric philosophies into their practice. Their focus is on attuning vibrations of instruments, voice, Tibetan singing bowls, or tuning forks to balance vibrations in the physical or auric body to "transform energy to heal and transform" (Goldman, 2003). The founder of Sound Healers Association is quoted on the Sound Healers Association website (2018) saying,

> modern science is now in agreement with what the ancient mystics have told us—that everything is in a state of vibration, from the electrons moving around the nucleus of an atom, to planets and distant galaxies moving around stars (Sound Healers Association, 2018, What our experts are saying, para. 1).

Clinical musicians are certified by a program created by a certified music practitioner. The program is a home study program for "early intermediate" musicians that is possible to complete entirely online or with in-person support and culminates in a 40-hour internship (AMTA, 2004). An individual can become certified by completing Level 1 and Level 2 of this program. Clinical musicians respond to client needs in the moment at bedside, but do not complete documentation (AMTA, 2004).

Certified music thanatologists are musicians working in palliative or comfort care who provide receptive music for clients as they transition from life to death. They complete an extensive 2-year training with the Chalice of Repose Project, which requires a year-long clinical internship, a professional paper, and at least 900 contact hours in musical, medical, clinical, and interior areas, leading them to the certification from Music-Thanatology Association

International. The primary goals of music thanatologists are to enhance quality of life and increase comfort for the dying and their loved ones during this complex transition, specifically through letting go (Music-Thanatology Association International, 2008).

Additionally, there are many groups of volunteer musicians that one may encounter in medical settings. Oftentimes, they are musicians with varied backgrounds and a specific repertoire that they play for medical patients. While all of these various modalities have benefits, it is important to differentiate between these and music therapy. Shultis and Gallagher (2015) described a popular model of incorporating music in hospitals; some selected musicians are permitted to play music in lobbies or waiting rooms, but MT-BCs are the only musicians in the hospital who work directly with patients due to having adequate training to deal with whatever emotional issues may potentially arise from the music (Shultis & Gallagher, 2015, p. 451).

Facilities Where Medical Music Therapy Occurs

General hospitals. The World Health Organization defines hospitals as:

> health care institutions that have an organized medical and other professional staff, have inpatient facilities, and deliver services 24 hours per day, 7 days a week. They offer a varying range of acute, convalescent and terminal care using diagnostic and curative services (World Health Organization, 2018a, para. 1).

Pediatric hospitals. Pediatric hospitals are hospitals that serve neonates through adolescents 18 years of age. According to Kinnear and O'Toole (2015), however, young adults who need specialized care or who have experienced repeated hospitalization in childhood often will continue to receive services at a pediatric hospital due to the skill of the specialists who work at these facilities. In the same study, Kinnear mentioned that admissions of patients aged 18-21 increased 50% between 1999 and 2009. The Children's Hospital Association (CHA) has a

directory of over 220 children's hospitals in the United States (Children's Hospital Association, 2018). CHA emphasizes that children's hospitals are child-centric and require specialists, services, and technology that cater to different stages of child development (Children's Hospital Association, 2018).

Acute inpatient rehabilitation center. According to Intermountain Healthcare (2010), acute inpatient rehabilitation is a program that helps individuals overcome obstacles resulting from an accident or disease to work towards successful daily functioning. Common diagnoses in acute inpatient rehabilitation include but are not limited to stroke, brain injury, spinal cord injury, neurological conditions or traumatic brain injury. These facilities typically have an interdisciplinary team of physicians, nurses, and social workers, as well as speech, physical, occupational and other therapists who facilitate intense rehabilitative training every day to help an individual regain functioning in activities of daily living (Intermountain Healthcare, 2010).

Veterans Health Administration medical center. According to The U.S. Department of Veterans Affairs, Veteran's Health Administration (VHA) medical centers "provide a wide range of services including traditional hospital-based services such as surgery, critical care, mental health, orthopedics, pharmacy, radiology,…physical therapy,...audiology and speech pathology,…geriatrics, neurology, oncology,…organ transplants…" and other specialty services (U.S. Department of Veterans Affairs, 2018). Those who served in the active military, naval, or air service are generally eligible for services, unless they left dishonorably, as well as members of the Reserves or National Guard who completed their full period of duty. Certain dependents also qualify for services.

Medical Music Therapy

Music therapy is used with individuals in medical settings across the span of ages. Common functions of music therapy in this setting include pain management; reduction of stress, addressing trauma, and fear; developing self-awareness and self-regulation; facilitating emotional expression; strengthening connections to positive resources and a patient's support system; assisting with acceptance of current diagnosis, functioning, and quality of life; providing procedural support; improvement of memory and cognitive functioning; and more (Loewy, 2015; O'Callaghan, Forrest, & Wen, 2015; Shultis & Gallagher, 2015; Standley, 2014b; Tamplin, 2015).

Music therapy in the neonatal intensive care unit. Music therapy has several main goal areas with premature infants. Some of the highest need areas for humans in this delicate state are improving oxygen saturation levels, increasing tolerance for positive sensory stimulation, developing nonnutritive sucking patterns to improve feeding that therefore leads to weight gain, decreasing length of stay, and securing and developing positive parent-infant attachment relationships (Standley, 2014b).

Medical music therapy for adults. Adults receiving music therapy services in medical settings are referred by other medical staff, interdisciplinary staff, family members, or occasionally, by themselves. They are typically seen in "inpatient units, specialized intensive care units, procedural rooms, operating rooms, delivery rooms,…waiting rooms,…outpatient waiting areas,…rehabilitation units, clinics or outpatient locations, and patient homes" (Shultis & Gallagher, 2015, p. 442). Music therapists work with patients anywhere from one session to continued treatment throughout multiple years and often work with patients and families from the moment of diagnosis through procedures, treatments, managing effects of treatments, to end

of life care. Some units on which is common for patients to receive medical music therapy services include cardiology, hematology/oncology, nephrology, urology, pulmonary, bone marrow transplant, organ transplant, surgery, neurology, palliative care, rehabilitation, and chronic pain. Techniques such as song choice and discussion, songwriting, music assisted relaxation, improvisation, entrainment, and instrument playing are used as means to address non-musical goals such as increased emotional expression, behavior change, facilitating positive staff/family social interaction, increased quality of life and patient satisfaction, physical rehabilitation, pain management, and increased relaxation (Shultis & Gallagher, 2015, pp. 441–452).

Medical music therapy for children. Music therapy is used with children from neonates, infants, school-age children, and adolescents through age 18 in some of the same medical units as adults. However, hospitalized children experience similar stressors to those experienced by hospitalized adults but experience them in a unique way. Due to specific stages of child development, children have additional factors that shape the hospitalization experience that adults do not have (Robb, 2003).

Piaget's Stages of Cognitive Development (Robb, 2003, pp. 31–35) and Erik Erikson's Stages of Psychosocial Development (Robb, 2003, pp. 31–35) outline typical challenges and milestones for each age group that affect how a child may experience illness, pain, and hospitalization. For instance, in Piaget's Formal Operational Stage within ages 11–15 as well as Erikson's "identity v. role confusion" during the same period, it is typical for adolescents to have a heightened awareness of self and how others perceive them and being in a hospital can add to feelings of isolation and low self-esteem (Robb, 2003). In music therapy, opportunities for self-expression can facilitate feelings of agency and control as well as social support. For example,

patient-directed songwriting or song selection for listening can help explore emotions related to hospitalization, and creating a musical video production to share with friends and family can help to mitigate feelings of helplessness, apathy, or isolation (Robb, 2003). Similarly, during infancy, music therapy helps form secure attachment relationships between the patient and family despite feelings of helplessness and bring normalcy to a foreign environment that is not ideal for typical development (Robb, 2003).

In a pediatric hospital, music therapists may work closely with the child life department, recreation therapy, creative arts therapies, rehabilitation, social work, pastoral care, child and adolescent psychiatry, or outpatient clinics (Loewy, 2015). Within these settings, sessions may occur at bedside, in playrooms, or in groups, particularly in therapy or rehabilitation settings.

Music therapy for treating traumatic brain injury or neurological disorders. Individuals with acquired or degenerative neurological disorders such as a traumatic brain injury, spinal cord injury, Parkinson's disease, Huntington's disease, or multiple sclerosis can also benefit from music therapy. From diagnosis or onset of decline, these disorders often lead to drastic changes in daily functioning, both for a patient and the family. Effects include motor deficits such as unsteady gait, tremors, muscle spasticity or weakness; decreased cognitive abilities such as changes in attention, awareness, memory, problem solving and impulsivity; and changes in expressive and receptive communication. Not only are there challenges in these areas, but these have an ever expanding effect into larger psychosocial needs as a result, such as depression as individuals notice their own decline, family caregivers burn out, and patients lose motivation to continue rehabilitation exercises (Tamplin, 2015, p. 456).

Music can be a powerful tool for individuals who have neurological damage for this reason: Music is motivating. Particularly in terms of repetitive rehabilitative exercises, music can

help provide a refocus of attention, help with muscle relaxation, and help an individual to feel in control of their experience. At a time when control is affected by an individual's own physical limitations and perhaps changes in daily functioning and communication abilities, participating in music therapy allows choice and autonomy (Tamplin, 2015). More physically demanding music interventions such as instrument play or gait training to a rhythm are useful when stimulating neuroplasticity and to practice functional skills, while less physically demanding interventions such as songwriting or listening are more useful as a disorder progresses, when psychosocial goals are addressed, or when relaxation is needed (Tamplin, 2015). Altenmüller and Schlaug (2013) wrote that research has supported the idea that music directly corresponds with neuroplasticity and has physiological impacts on the rewiring of neuropathways in the brain which leads to positive rehabilitative change. Music therapists may utilize specialized techniques to work with patients in ways that capitalize on the findings of this research.

Neurologic music therapy. According to the Academy of Neurologic Music Therapy, Neurologic Music Therapy (NMT) is:

> a research-based system of 20 standardized clinical techniques for sensorimotor training, speech and language training, and cognitive training. Its treatment techniques are based on the scientific knowledge in music perception and production and the effects thereof on nonmusical brain and behavior functions (The Academy of Neurologic Music Therapy, 2018b).

This approach to music therapy focuses specifically on the effect rhythms have on neuropathways in the brain in regards to rehabilitation. NMT is used frequently with individuals who have experienced strokes, Parkinson's disease, cerebral palsy, muscular dystrophy, Alzheimer's, traumatic brain injury, autism, and other neurological diseases and disorders. MT-

BCs must complete a 30-hour specialized training in order to be designated as a Neurologic Music Therapist (The Academy of Neurologic Music Therapy, 2018a).

Music therapy at the end of life. Although hospice work is its own entity in music therapy practice to which music therapists devote their entire careers, medical music therapists also work closely with patients and families at the end of life and in palliative care due to the nature of the medical population. It is important to note that these populations overlap in both adult and pediatric care. According to O'Callaghan, Forrest, and Wen (2015), hospice care is considered care for an individual who has the prognosis of 6 months or less to live. Hospice falls under the umbrella term of palliative care, which is a type of care that focuses on improving quality of life not curing a disease for patients facing life-threatening illness and their families (World Health Organization, 2018b). Music therapists help address complex emotional issues surrounding death, degenerative illness, and loss, enhance coping, and provide strategies for symptom relief and relaxation. They may also facilitate exploration of spirituality if led there by the patient. Common interventions include improvisation, songwriting, music-assisted relaxation, guided imagery, creation of a legacy project, and music listening (O'Callaghan, et al., 2015).

Summary

There are multitudes of benefits of incorporating music therapy into medical settings (DeLoach & Cevasco-Trotter, 2014; DeLoach & Peyton, 2014; Loewy, 2015; O'Callaghan et al., 2015; Robb, 2003; Rushing & Barragan, 2014; Shultis & Gallagher, 2015; Standley, 2014b; Tamplin, 2015). However, there are many challenges that come with convincing non-music therapists and establishing new positions in medical settings, including: gaining funding, and starting, establishing, and growing a program at a facility that does not have one. This study

seeks to explore different strategies music therapists have taken to pursue this endeavor as well as how this process could go more smoothly.

Chapter 2

Literature Review

Throughout history, music has been used as a healing tool. This history extends back through 5000 B.C., where in ancient Egypt, both priests and physicians were required to be musicians since healing was so inextricably linked with music (Brooke, 2006). From healing chants, to using music to achieve homeostasis to balance Hippocrates' four humors, to the prescription of musical modes in Greek culture, to relieving preoperative anxiety in hospitals, music has a longstanding partnership with healing (Brooke, 2006; Crowe, 1985). In fact, the profession of music therapy began in veteran's hospitals after World War I and World War II when musicians of various backgrounds played music for patients (AMTA, 2018c). Due to the veterans' emotional and physical responses from this experience, a need for people who did this work grew, as did a need for formal training for the individuals providing the music (AMTA, 2018c). As a result, the profession as a whole became formally organized in a lasting way in 1950.

Uses and Goals Addressed in Music Therapy

Crowe (1985) highlighted the many roles of music therapy in medical settings as she outlined the need to generate further research and employment in this area. She described the ability of music therapy to reduce stress and promote relaxation, assist during childbirth, provide nonpharmacological pain management, increase emotional expression due to situational anxiety and depression, increase self-awareness, and provide spiritual support during times of trial. Since

then, countless studies have detailed the many physical, cognitive, emotional, spiritual, and social benefits of music therapy in a medical setting.

Dileo and Bradt (2009) listed benefits of medical music therapy as improved physical functioning, decreased pain perception, increased relaxation through reduced physiological arousal, enhanced social functioning, psychological functioning and quality of life, increased cognitive functioning, support for spiritual and existential needs, and behavioral change. Gooding (2014) cited a multitude of studies highlighting the benefits of music therapy. The outcomes described in these studies include changes in perceived pain, anxiety, stimulation, mood/depression, coping skills, communication skills, motor skills, reality orientation, respiratory functioning, respiratory issues, relaxation, physiological outcomes, social support, normalization of the environment, comfort, and self-esteem.

Considerations When Designing a Program

Although published at a time when literature on the topic was sparse, Crowe's (1985) early proposition for how to approach the introduction of music therapy to a medical team still stands. She recommended the process of (a) working within the structures of existing staff development programs such as in-service, rounds, department meetings, and trainings to present and advocate; (b) citing research often and advocating for more in the profession; (c) conducting a set number of "pilot sessions" for staff to observe as an introduction to the profession; (d) presenting documentation of a sample means of assessment, specific goals and objectives, treatment plan, and evaluation; and (e) acquiring the knowledge to apply for grants, as it is an invaluable skill to have when positions could be funded by public or private grants. DeLoach and Cevasco-Trotter (2014) provided an in-depth, detailed account of a glimpse into grant writing for music therapy with the intent of helping a music therapist with this goal.

Years after Crowe's article, Rushing and Barragan (2014) referred to some of the same techniques to develop a program. They suggested that the program developer sort through her own ideas and expectations for the program. This included (a) deciding on a level of care (primary, on the floor with primary care physicians and nurses, or secondary or tertiary, an outpatient or specialized setting); (b) creating a personal mission statement (What gaps existing in current care will be filled by this role? What unique contributions can be offered?); (c) determining what referral will look like (Is there one already in place? If not, what will a new one look like and how will it be created?); and (d) doing extensive research about medical music therapy in order to be able to communicate research findings to the right people (pp. 40–41). Rushing and Barragan detailed a plan of program development beyond brainstorming which included: (a) differentiating whether it will include a benefitted employee, per diem employee or contractor employee; (b) determining sources of funding; (c) identifying resources; (d) developing a proposal; and (e) considerations for program implementation and patient-centered care (pp. 39–58).

Cost-effective treatment. Crowe (1985) viewed music therapy as a cost-effective intervention on the cusp of the development of research focused on cost-benefit. She noted that providing research highlighting the cost-benefit of music therapy would help to generate employment in healthcare settings when advocating to management. Due to the little research present in this area at the time of this finding, she proposed her own rationale for music therapy being a cost-effective treatment. She stated that music therapy programs have a relatively low starting cost compared to other treatment modalities. She also described music therapy as a flexible intervention that is applicable throughout many areas of the hospital and able to meet a wide variety of goal areas. Another cost-effective advantage of music therapy she cited was its

ability to serve many patients through a single staff member in group work. And finally, Crowe proposed that since music therapy helps to reduce stress, healing occurs more quickly, which could lead to a reduced stay and lower costs for medication.

Years later, the music therapy research community has become well-aware of costs and benefits of medical music therapy. Rushing and Barragan (2014) cited cost-effective returns of treatment as reduction in measurable pain, anxiety, and length of stay, as well as reductions in medications used. Patient surveys also indicated higher satisfaction ratings with hospital care, which increases likelihood of returning to the same facility (Loewy, 2015, p. 425; Rushing & Barragan, 2014, pp. 47, 50).

Funding. According to Rushing and Barragan (2014), funding for music therapy positions in healthcare settings operate from one fiscal year to another and come from individual units' budgets, endowments or private donors, grants, reimbursement, revenue retention or university affiliations (p. 43). DeLoach and Cevasco-Trotter (2014) provided a detailed description of how to write grants for federal, corporate, professional or university-related grants.

It is important to note that funding for these positions is often in flux and grants are not steadfast. Ledger (2010) found that 4 out of 12 participants had lost funding for their position or had their hours cut, and many more stated that they could not rely on hospital management to sustain funding. Many felt insecure if funding for their position was charity-based (Ledger, 2010). Fund insecurity only bolsters the need for additional training in this area for music therapists.

Current Staff Perceptions

Crowe (1985) stated, "Music in general, and music therapy specifically, are frequently perceived as expensive, unnecessary luxuries" (p. 47). Therefore, music therapists constantly

battle to communicate about their profession to others in the healthcare setting and continually educate and advocate. According to a study done by Silverman and Chaput (2011), prior to an in-service, nurses and social workers perceived music therapists as frequently using recorded music, CDs, and receptive methods of intervention. Darsie (2009) found that interdisciplinary staff's perspectives about the role of music therapy varied depending on their profession. She found that physicians, nurses, psychologists, and social workers assumed that music therapy had more of an entertainment role outside of medical procedures, while child life specialists and creative arts therapists did not. It was also assumed by the same groups that it was the music therapist's job to provide distraction during a procedure, while child life specialists understood that this was primarily their responsibility (Darsie, 2009). These findings demonstrate the need for further education of other professional staff in healthcare settings.

The effects of educating the interdisciplinary team. Rushing and Barragan (2014) suggested multiple key components of interdisciplinary education. First, they stated that it is important for the music therapist to know with whom he or she is speaking. It may be more beneficial to explain how certain music therapy interventions might work on a specific unit when speaking with nursing staff; however, it may be more beneficial to discuss cost-benefit analysis and patient satisfaction with administrators (pp. 41–42). When speaking with hospital administration and advocating for music therapy services, Rushing and Barragan suggested that the proposal appeal to "head, heart, and wallet"; the latest research in medical music therapy interventions and outcomes to appeal to the mind, anecdotes or videos to appeal to the heart, and research relating to return on investment and medical cost benefits to appeal to the wallet (p. 49). They also offered several ways to go about education: describing a session, sharing news

footage, or bringing an article that addresses specific interests of those with whom you are speaking (p. 42).

Silverman and Chaput (2011) studied the impact of a 20-minute educational in-service about music therapy with 19 surgical oncology nurses and one social worker on the floor. The in-service focused on interventions targeted towards meeting specific clinical objectives in surgical oncology. The researchers used a questionnaire in a pretest/posttest design to assess the participants' perceptions of how strongly music therapy could be used to meet these objectives. They gave the respondents an opportunity to comment at the end of the questionnaire about what music therapy was or what it looked like on the unit. They provided an in-service to all three shifts consisting of a slideshow, which included a definition of music therapy, an overview of music therapists' training, a review of the literature of the use of medical music therapy, results from a music therapy study at the same hospital, and common interventions used specifically in surgical oncology. Results indicated an increase in 11 out of 13 items—6 of which were statistically significantly increased. Enthusiastic comments were left in the free response section of the posttest questionnaire as well. This study highlights an idea for future research: Is a live demonstration of an intervention, video of an intervention, or anecdotal information most influential at an in-service?

Darsie (2009) provided some insight into the value of video in-service as an educational tool. She administered a pretest/posttest survey regarding the perceived role of music therapists among 17 members of an interdisciplinary pediatric oncology team including physicians, nurses, psychologists, social workers, child life specialists, and creative arts therapists. This team consisted of people who had worked on the unit for at least 3 years and had observed a music therapist work on the unit for 20 hours per week. A 25-item Likert scale was administered that

detailed 25 roles in the pediatric oncology setting and the participants were asked to rate the appropriateness of the role to music therapy both before and after a 5-minute video in-service. Results showed that although most participants on the team rated the responsibilities of music therapists fairly high before the in-service, there was a significant increase among perception of music therapists' roles in assessment, goal setting, and procedural support after the video. This demonstrated that despite witnessing music therapy in a healthcare setting, continued education is beneficial in defining roles of the profession on an interprofessional team.

Notably, DeLoach and Peyton (2014) emphasized the value of showing up as a means of education (p. 93). In summary, remaining visible helps to keep referrals coming and be remembered by donors, administrators, and decision makers. Some suggestions of how to do this included attending rounds, joining a committee at the hospital, finding an advocate in a co-worker who will promote services to other members of the healthcare team, generally maintaining contact with other professionals (pp. 92–93).

Role ambiguity. Darsie (2009), defined the term *role ambiguity* as others having a different understanding of a role than the person performing the role does. She cited this as a cause of workplace tension and eventually burnout. The article stated, "similarities in professional objectives and treatment modalities can result in overlapping role expectations and misconceptions about areas of responsibility and scope of authority, thus increasing the likelihood of tension among members of an interdisciplinary treatment team" (p. 48). To remedy this, Darsie recommended that music therapists reference goals and objectives when educating other professionals. Notes about professional boundaries were also included, since an example of role ambiguity would be to ask a music therapist to play music for entertainment purposes.

Interestingly, although music therapists may feel misunderstood due to the lack of visibility of the profession, other professionals reported similar frustrations about others' misunderstanding of their roles on an interprofessional team (Darsie, 2009; Ledger, 2016). Darsie mentioned nurses, social workers, and child life specialists as professionals who also experience role ambiguity in a healthcare setting, indicating a need to educate others about the specific duties of their profession. Ledger referred to this as the *Knowing Paradox,* or "[belief] that [one] understood others' contributions to the team, yet perceived that they were misunderstood in return" (p. 881). This lack of clarity often contributes to underutilization as well as burnout due to perceived lack of respect (Darsie, 2009; Ledger, 2016).

Interprofessional collaboration. Partnering with universities may also be beneficial in establishing a new program, according to Ledger (2010). In narrative summaries detailing the experience of starting a new music therapy program in a healthcare setting, several music therapists explained that partnering with nearby universities helped by providing funding for music therapy research at the facility, utilizing students to expand awareness and visibility of the profession, and having an affiliation to credit when negotiating with managers. Seeing other professionals collaborate with university music therapy students helped the therapist to feel more accepted at the facility as well (p. 143).

Organizational change. Ledger, Edwards, and Morley (2013) examined the process of creating a new music therapy position in a healthcare setting from an organizational change perspective. Dawson (2003) defined organizational change as "new ways of organizing and working" (p.16). Viewing music therapy as a form of organizational change provided some insight. First and foremost, it was made clear that the process of introducing any type of structural change to a healthcare organization is slow, nonlinear, and affected by many outside

factors. Changes in economic climate, healthcare policy, management, and clinical staff often produce setbacks and have to happen at the right time (Ledger et al., 2013). Ledger et al. (2013) noted some additional obstacles to overcome for music therapists, such as (a) changing negative impressions left by a previous musician, (b) building trust, (c) recognizing gatekeepers, (d) obtaining access to patients, (e) finding gaps that music therapy could fill, and (f) establishing music therapy as an integral part of healthcare. They also warned that a psychotherapeutic intervention may be threatening to a medical model, resulting in potential resistance from staff.

Ledger et al. (2013) included techniques music therapists could employ to help with the process of overcoming these obstacles. For instance, they noted that other staff were more open to change when involved in the process of making the changes. Collaboration and team-work using straightforward language was effective, as well as listening to other colleagues present and share about their own work. They also found that music therapists most commonly spoke with intermediaries rather than management and suggested connecting with management if possible. Relatedly, they suggested not taking it personally when hearing negative opinions of those who have little impact in the hiring process.

Benefits for medical staff. Not all studies indicated negative relationships between other professionals and music therapists. Loewy (2015) stated that not only should music therapists communicate openly, report back with staff after referrals, and include staff in sessions, but that therapists also can foster team cohesion through holding weekly community jams, music meditations, or environmental music therapy (p. 438). Depending on the music therapy program's mission, supportive services for staff also may be appropriate in healthcare settings (DeLoach & Peyton, 2014, p. 93).

DeLoach and Peyton (2014) stated that whether services are for the patients or scheduled for the staff, music therapy affects staff by boosting morale, providing stress reduction, or shortening the length of procedures due to patient relaxation and cooperation. (pp. 93–94). Ledger (2016) supported these findings, citing several studies that indicated benefits for staff as well as patients and their families. O'Callaghan and Magill (2009) stated that hospital staff who witnessed music therapy sessions perceived their place of employment as one that values patient care, leading to increased workplace satisfaction.

Personal Accounts of Position Development

From the information gathered through her narrative inquiry, ethnographic field work, and arts-based research of 12 music therapists from Australia, Canada, Ireland, the United Kingdom, and the United States who detailed their experiences in position development, Ledger (2016) outlined the steps that a music therapist is required to take to develop a new music therapy position in a healthcare setting. She stated that not only are music therapists required to create the positions, they are also required to introduce the idea of music therapy to managers and professionals, demonstrate its value for health and well-being, and ensure that the position is secured with adequate time and effort. Additionally, some other obstacles faced by new music therapists potentially include (a) lack of supervision, (b) limited resources, (c) the pressure to perform and represent the profession well after continued advocacy, (d) cultural differences, (e) misunderstandings of the profession and role ambiguity, (f) distinguishing music therapy from other uses of music at the facility, and (g) gaining access to patients. For these reasons, the experience of creating a new position is intensely personal and dependent on many factors.

Through written, unprompted narratives from the music therapists and reflective poetry from the researcher, observation of therapists, and interviews with some of the therapist's

interprofessional colleagues, common themes were identified as being part of the therapist's process in starting a new position. These included "going solo, looking for a home, building relationships, accepting the challenge, insecurity, investment, and development takes time" (Ledger et al., 2013, p. 718). Service development strategies also were identified as "educating, interprofessional working, remaining flexible, generating evidence, investing time and energy, and relying on advocates" (Ledger, et al., 2013, p. 718). Of note, the researchers in this study assumed that music therapists would have a unique set of challenges as entrepreneurs in the healthcare setting. However, according to the researchers, music therapists encountered similar challenges to those other professionals also experienced while starting a new service.

Despite some optimism, excitement, and perhaps a "honeymoon phase," all therapists in the study described creating a new position as a challenge, difficulty, or struggle, with 6 out of 12 participants stating that they had considered leaving and giving up at one point or another (Ledger, 2010). This reinforces the fact that systems need to be in place to best support those in this process. Additionally, it raises questions about personality traits that would be beneficial for this work due to perspective and resilience when faced with challenges.

On the other hand, Rushing and Barragan (2014) noted that music therapists already possess many regularly used skills that help prepare them for the challenge of starting their own program. For instance, "planning and organizing, developing preventative measures, adapting in the moment to change, encouraging problem solving, anticipating challenges, breaking down tasks to meet individual needs, and evaluating outcomes" are all helpful skills that music therapists frequently draw upon (p. 39). It is only a matter applying these skills to develop a program.

Sources of Support

Steering groups. The existing literature stresses interprofessional collaboration during the development of a new music therapy program (DeLoach & Peyton, 2014; Ledger et al., 2013; Ledger, 2016; Rushing & Barragan, 2014). Ledger (2016) suggested the development of a "steering group," or a group consisting of staff, clinicians, managers, and community representatives to endorse a new position and encourage its growth. Ledger et al. (2013) noted an example of a new recreational therapy service promoted by a "steering committee of clinicians, managers, and financial employees" (p. 727, para. 2). Because of this, there was strong managerial support leading to stable funding for the position. This implies that similar guidance and reinforcement for a new music therapy position may be beneficial.

Supervision. Another valuable source of support for individuals who create new music therapy positions is supervision. Supervision by MT-BCs exists in student pre-internship clinical work, during internship, and professionally, yet it is only required during pre-internship clinical work and internship (AMTA, 2018e). According to O'Callaghan, Petering, Thomas and Crappsley (2009), professional clinical supervision is useful to process unresolved issues related to clinical work.

According to Ledger (2016), "all of the literature from within and outside music therapy indicates that start up work is rarely straightforward and requires processes of adaptation and reflection in context" (p. 876). She cited lack of supervision and professional support as obstacles faced when developing positions in the healthcare setting. In fact, in her doctoral thesis, she stated that 2 out of 11 interviewed therapists who had started new positions in a healthcare setting cited professional supervision as a critical component of starting a program independently (Ledger, 2010, p. 131).

Some literature exists regarding professional supervision in the field. Through a survey of Australian music therapists regarding professional supervision, Kennelly et al. (2012) found that 42% of respondents did not receive supervision at all, while 67% of professional music therapists who did receive supervision paid for their supervision themselves. Those who received supervision did so from music therapists or other professionals. Respondents indicated that not only can access to supervisors with relevant experience be difficult, but affording the supervision can be difficult as well (Kennelly, Baker, Morgan, & Daveson, 2012). Ultimately, in the professional world it is up to the therapist to seek her own supervision.

Austin and Dvorkin (2001) satiated this unmet need for supervision by creating a peer supervision group with other music therapists. In their rationale for doing do, they stated that it was to create a space to consult with one another about work-related challenges and successes, combat feelings of isolation, encourage empowerment through validation, and provide emotional release and opportunities for work-related, cathartic self-expression. This group met once monthly for several years. In this particular case, it was noted that there was no difference in power dynamics, and participants got to experience parallel process with one another as equals (Austin & Dvorkin, 2001).

Training. In addition to professional supervision, Ledger (2016) stated that there is a dire need for additional training to support the development of new positions in music therapy (Ledger, 2016, p. 876). Currently, there is no required component of music therapist training about program development (AMTA, 2018e). Specifically, Loewy (2015) indicated the need for music therapist training in grant writing and program building.

Statement of Purpose

The purpose of this study is to explore professional perspectives on creating a new music therapy program in a medical setting. Many newly certified MT-BCs find themselves at a loss when searching for employment, often requiring a move to a new community, while medical facilities exist in or around most communities. According to Ledger et al. (2013), "as music therapy is a relatively new healthcare discipline, most music therapists are required to introduce, uphold, and develop an inaugural music therapy post in a setting where music therapy has no existing contextual frame" (p. 715). While the need is present in these communities, advocacy among other professionals from varying disciplines often presents a challenge, especially when considering limited funding or few pre-existing resources such as other music therapists in the community with whom to network. It is also clear from the literature that there is a need for music therapists to seek additional support while going through this transition, as many report feeling isolated, insecure, uncertain, or tempted to give up on their pursuit (Ledger, 2010; Ledger et al., 2013). Interviewing professionals who have gone through the process of starting their own positions in medical music therapy and consolidating their narratives and perspectives will bring awareness of opportunities for support and resilience for future MT-BCs who aspire to do the same.

Research Questions

The following questions designed by the researcher aim to create a foundational base of knowledge regarding support and resilience for entrepreneurial music therapists in medical settings.

1. What structures in music therapists' educations (pre-internship education, clinical training, internship, CMTEs) did they find helpful in the development their own medical music therapy programs?
2. What educational gaps have music therapists who have developed their own programs found that presented challenges during position development?
3. How is medical music therapy funded and how does this affect longevity of the program?
4. How does a music therapist who started a new program in a medical facility establish herself among a pre-existing medical community?
5. What are the benefits and challenges of incorporating volunteer artists and musicians into program development?
6. What peer or professional supervision would be helpful during the process of starting a new program?
7. What common motivating factors are helpful to motivate music therapists to endure challenges and overcome obstacles as they establish a music therapy program in a medical setting?

Chapter 3

Method

This section outlines criteria for participation in the study. It also details the research design and means of data collection, as well as procedure and data analysis.

Research Design

This study was a phenomenological inquiry. The purpose of phenomenological inquiry was described by Jackson (2016) as "to explore and explicate the nature of a phenomenon through first-person experience" (p. 441). The emphasis of phenomenological research is on using subjective experience to find a "generalizable *truth"* about a phenomenon (Jackson, 2016, p. 441). In this study, a semi-structured qualitative interview design guided this inquiry, generating conversation with set questions, yet permitting the participant to elaborate if needed.

Participants

The five participants were chosen through criterion sampling, with specific criterion being that they must be MT-BCs who started music therapy programs in medical settings that did not previously have music therapists. Part-time and full-time programs were eligible, and the programs must have been created within the past 15 years. The facility where they started a program must be a general hospital, pediatric hospital, Veteran's Affairs hospital, or acute rehabilitation center. It was determined that if more than five MT-BCs volunteered to participate in this study, they would be chosen based on the type of facility at which they started a program to ensure the study covers as wide of a variety of settings as possible. Participants could have

been working or retired as perspectives from various generations were considered to be beneficial.

Five women agreed to participate in the study. Of the participants who responded to the online recruitment post, three started programs in pediatric hospital settings, one started a program in a general hospital setting, and one started programs in both a general and a pediatric hospital. Their experience ranged from having started a program within the past 2 months, to having started a program 14 years prior to the time of the interview and they represented three of the seven regions of the AMTA. To ensure confidentiality, they will be referred to by the following pseudonyms: Kelly, Autumn, Nikki, Michelle, and Rachel.

Recruitment

Recruitment occurred through snowball sampling; through word-of-mouth as well as through a group on a popular social media network website consisting exclusively of music therapists. They were recruited on a volunteer basis via email or message through social media describing the study. Participants were chosen due to the order of response to an online recruitment post, which was deleted after the study to conceal their identities.

Procedure

The video interviews were conducted over Zoom (Zoom.us), as it has the capability to record and transcribe calls. Prior to the call, consent forms (Appendix B) were sent to all participants via an electronic form, and verbal consent was obtained at the beginning of every call to make sure the information procedure was understood. The recording of the call was recorded to the researcher's password-protected ZoomCloud account and automatically transcribed by Zoom. Each transcription was downloaded using a program called BBEdit and consequently edited and verified by the researcher alongside the corresponding video. The

researcher provided opportunities for member checking of the transcriptions to increase validity of the results by sending them to participants who approved the transcript and provided modifications to clarify concepts.

Data Collection

Since there are no existing interview formats concerning music therapists' experience creating new positions in medical settings, the researcher created *Perspectives in Music Therapy Position Development in Medical Settings* (Appendix C). The interviews were semi-structured, using the 20 open-ended questions as guidelines, but allowed for additional contributions from the participants and additional questions to follow-up with participants' answers. The questions addressed the educational backgrounds of the therapists, as well as their experience of creating and establishing a new position in a medical setting, including logistical and psychosocial components of the process. The interview also provided an opportunity for participants to suggest additional resources or training opportunities that would benefit someone who is working towards position development.

Data Analysis

The researcher examined answers from each interview question and analyzed the data for themes across participants' responses using McFerran and Grocke's (2007) method of phenomenological microanalysis. These authors detailed a seven-step procedure for critical analysis of qualitative data using a specific method. In their method, the interview is transcribed, condensed into "Key Statements," further broken down into "Structural Meaning Units" and "Experienced Meaning Units," and eventually reduced to the "Individual Distilled Essence." From here, "Collective Themes, Global Meaning Units and the Final Distilled Essence" are

measured to formulate results from the data collected. This method has been previously used in music therapy research (McFerran & Grocke, 2007; Waller-Wicks, 2018).

Once the transcribed interview responses were sorted into key statements, these were further sorted into categories, which led to the creation of meaning units (for instance: prior experiences, obstacles and motivations during program development, sources of support, etc.). Structural meaning units within the key statements were identified and marked into separate, color-coded categories in the transcript based on content (McFerran & Grocke, 2007).

Further distilling occurred when creating experienced meaning units, which focused on the implicit meaning behind each response. Individual distilled essences were created from these structural units. To ensure validity, the researcher used the participants' language when describing their experience and maintained open communication with participants for their input when necessary (McFerran & Grocke, 2007).

Common themes, significant themes, and individual themes were identified and compared in the study using the process of imaginative variation, or the the process in which the researcher draws her own connections to reveal the essence of the underlying experiences described in the interviews (Moustakas, 1994). Common themes were defined as themes found in every interview, while significant themes were defined as themes found in most interviews. Individual themes were entirely unique to one or two individuals (McFerran & Grocke, 2007). To see data with a fresh perspective, each structural meaning unit was further color-coded and reorganized by theme, and the essence of each unit was extrapolated from each color-coded category. From this, global meaning units (GMUs) encapsulating all titles and categories of data were created. Consequentially, a final distilled essence was compiled as a narrative summary

from the researcher and concrete statement of the data (McFerran & Grocke, 2007). Implications of the data in regard to the research questions will be proposed by the researcher.

Chapter 4

Results

This chapter details the findings from the interviews. Each GMU is presented, including common, significant, and individual themes supported by direct quotations from participants, as outlined by Table 1. The final distilled essence of the collective phenomena from the study will conclude the chapter.

Table 1

Global Meaning Units and Themes Derived from Participant Interviews

Global Meaning Units (GMU)	Themes for each GMU
GMU 1: Medical music therapy programs originate from various types of connections and attempts to meet diverse needs.	Sometimes, facilities seek music therapists to start a program. (Significant Theme 1)
	Personal connections may or may not be helpful during program development. (Significant Theme 2)
	Sometimes, music therapists seek facilities at which to start a program. (Significant Theme 3)
GMU 2: Prior work experience, mentors, coursework, clinical work, and continuing education all contribute to the success of building a new medical music therapy program.	Prior clinical work in a medical setting is useful when developing a medical music therapy program. (Common Theme 1)
	Information in both educational coursework and continuing education is helpful. (Common Theme 2)
	Running a private practice provides skills helpful to developing a medical music therapy program. (Significant Theme 4)
	Work experience outside of the field of music therapy provides useful skills helpful to developing a medical music therapy program. (Significant Theme 5)
	Mentors provide insight that can be useful when developing a medical music therapy program. (Significant Theme 6)

Table 1 Continued

GMU 3: While music therapists have various opinions about resources and educational standards related to program development, there is a common interest in incorporating business knowledge into music therapy training.	There are gaps in providing business knowledge during training. (Common Theme 3)
	While there are limited relevant resources in the literature available to music therapists starting a medical music therapy program, there are some which music therapists identified as helpful in development of a medical music therapy program. (Significant Theme 7)
GMU 4: Although often funded by philanthropy, longevity of the program is generally not affected due to preventative measures and planning.	Medical music therapy is often funded by philanthropy. (Common Theme 4)
	If preventative strategies are implemented, philanthropy does not have to negatively impact the longevity of the program. (Common Theme 5)
	It is helpful to be specific when constructing a budget and have concrete figures to share with administration in charge of resource allocation. (Significant Theme 8)
GMU 5: Introducing music therapy to an established interdisciplinary team requires ongoing education, finding other staff who support the profession, and innovation.	Music therapists use in-the-moment education and advocacy, formal and informal in-services, and staff meetings to educate other staff. (Common Theme 6)
	Appropriate referrals can be addressed with innovative techniques and increased communication among staff. (Common Theme 7)
GMU 6: Music therapists' interaction with other staff influences the effectiveness of a new program.	Due to the novelty of the field, music therapy is frequently met with staff uncertainty. (Common Theme 8)
	In general, medical music therapy is supported by interdisciplinary staff and bolstered by collaboration with other professionals. (Common Theme 9)
	Music therapists help overall staff wellness in medical settings, which in turn helps the music therapy program. (Significant Theme 9)
	Occasionally, tension can arise between music therapists and other staff. (Significant Theme 10)
GMU 7: When there are volunteer musicians at the facility, collaboration between music therapists and volunteers results in more appropriate patient experiences with music, although music therapists may not have time to devote to these efforts.	Staff from other disciplines do not confuse the work of volunteer musicians and music therapists. (Significant Theme 11)
	Working with volunteers presents benefits and challenges, yet, music therapists are generally willing to act as a consult when these challenges arise. (Significant Theme 12)
	Music therapists feel better about volunteer musicians when there is a vetting process, such as belonging to an organization. (Individual Theme 1)

Table 1 Continued

	Some music therapists do not prioritize collaboration with volunteers. (Individual Theme 2)
GMU 8: Music therapists approach program development as a collaborative effort between other peers and professionals, either in music therapy or a related field, locally or remotely, and readily seek help when needed.	Local supports include music therapists and professionals from other disciplines. (Common Theme 10)
	Supervision with other music therapists often happens remotely and social media is a helpful communicative tool in the music therapy community. (Significant Theme 13)
GMU 9: Starting a medical music therapy program comes with emotional and professional challenges.	Working in a hospital system comes with administrative duties which can inhibit music therapists from clinical work. (Common Theme 11)
	A great threat to music therapists who started their own medical music therapy program is the risk of burnout from constant advocacy. (Significant Theme 14)
	The rate at which the program develops can be discouraging. (Individual Theme 3)
	Some music therapists perceive the isolation that accompanies being in a rural location as an additional challenge when starting a medical music therapy program. (Individual Theme 4)
GMU 10: Music therapists draw from resources to help them work through obstacles during program development.	Passion for the field of music therapy is the biggest motivating factor to continue the work. (Common Theme 12)
	Self-described personality traits such as being curious, persistent, analytical, organized, warm, confident, patient, thick-skinned, charismatic, having a desire to be a pioneer in the field, and the ability to be positive were identified as being helpful to the work of starting a new program. (Common Theme 13)
	Reaching out to others for support is helpful. (Significant Theme 15)
	Creating boundaries is vital to prevent burnout. (Significant Theme 16)
	Shifting perspective helps with coping with obstacles. (Significant Theme 17)

GMU 1: Medical music therapy programs originate from various types of connections and attempts to meet diverse needs.

Significant Theme 1. Three participants had the experience of someone at a medical facility seeking them out to start a program. Kelly's first point of contact was someone from the hospital's foundation who heard her sing at a nursing luncheon and approached her about starting a program after hearing she was a music therapist. Autumn began the program after doing clinical work as a student in a music therapy pilot study that had been implemented by a neighboring university. Rachel connected with the pediatric hospital, since they had received a grant and looked to a local organization where she was working at the time for a contracted employee. Although initially a contracted employee, she started the program and was eventually hired directly. The general hospital had music and art therapy in place at a corporate level, yet not at the particular location for which she was sought out.

Significant Theme 2. Some personal connections were beneficial when starting new medical music therapy programs. Autumn and Nikki both had experience working as a student in the hospitals at which they eventually built a program. However, Kelly had the experience of initially contacting a different hospital due to a personal connection prior to the hospital where she has now built a program. The first site was a failed attempt. She explained that the business model of the first establishment placed little emphasis on the person, and the doctors were disinterested in her presentation about music therapy and walked out without questions or comments. Despite the connection she had, she did not feel support or benefits from that connection.

> Even though my friend knew the benefits of music therapy, she wasn't a champion for it. She was kind of like "Alright, I'll let you come in and talk because you're my friend." (Kelly)

Significant Theme 3. Although she did not end up working there, Kelly's first attempt at starting a new medical music therapy program was a cold proposal to a facility. Michelle and Nikki took it upon themselves to propose new programs to hospitals as well.

> So really it was…setting up meetings and sending emails, making phone calls, sending proposals to basically anybody who would listen to me. (Nikki)

Michelle explained that being isolated in her region, coupled with the passion for the field, motivated her to begin conversation about pitching a program.

> I just knew that I wanted to be in a pediatric unit and I actually didn't see myself coming back home after being in [city] and kind of all over, but once I got home, then I just saw this need for music therapy. Because when I came back home, I was the only board-certified music therapist in the whole city. (Michelle)

GMU 2: Prior work experience, mentors, and clinical work all contribute to the success of building a new medical music therapy program.

Common Theme 1. All participants had prior experience in medical settings, whether in practicum or internship. Kelly and Nikki's internship was at a children's hospital, Rachel's internship was at a general hospital, and both Autumn and Michelle did practicum work in medical settings. These experiences ignited passion for the work.

> It was just . . . my last practicum. And that's where I knew that I wanted to be in the medical setting. . . . The whole inspiration why I wanted to be in the medical setting was because of that one practicum and practicum supervisor. . . . They gave me all my tools. (Michelle)

Common Theme 2. When asked about coursework that was beneficial in their experience of program development, some interviewees mentioned explicitly related material such as how to present music therapy to a group of people unfamiliar with the field. For instance, Michelle prepared a proposal booklet for each person she was advocating to at a meeting and provided flash drives containing corresponding information to each person attending, and stated that she knew to do that specifically from information learned in school.

Continuing education was also useful. Although not directly related, Kelly mentioned that networking and conversation in a perinatal music therapy course she took had been helpful during her journey. Rachel explained various forms of continuing education that have been helpful to her and could be helpful to other therapists.

> I've gotten a lot from conferences too, I have to say. I have never gone to the big national conference, but I go to a lot of little local things when they're about pediatrics, or they're about . . . pain or anything that's relevant to what I do. And you always come away from those things with some really cool new tips from another therapist who just thought of something in a different way than you'd thought of it. (Rachel)

> [Facebook group *Music Therapy Ed*] . . . they offer CMTEs [Continuing Music Therapy Education courses] of course . . . a few of their courses are about starting private practices, but I believe one of them might actually be about . . . pitching to facilities. . . . I think part of their purpose is to . . . give people documents and things and resources. It can be really helpful. (Rachel)

Significant Theme 4. Three interviewees had experience running their own private music therapy practices. Some knew they wanted to pursue private practice work with the intent of learning business skills, while others found it to be useful, but it was not their initial motivation for the work.

> I did choose an internship with a subcontracting business . . . with a private practice here in [state] so that I could learn more about business aspects of private practice before I decided what type of job to pursue. (Autumn)

Some music therapists started a private practice more out of necessity. Motivation to do so was due to living in an isolated location, or lack of job opportunities, yet they found it to be valuable for business skill development.

> [During] my crash course of trying to run a private practice . . . I found out business is not one of my strong points, but I definitely found out marketing techniques that helped me in proposing my ideas . . . realizing what businesses were looking for . . . how to present myself like a professional… (Michelle)

Significant Theme 5. Interviewees mentioned work experiences outside of the field of music therapy as being useful in their pursuits. Rachel ran her own practice in massage and

somatic psychotherapies, and Autumn worked in a variety of small businesses as an administrative assistant. These positions provided experiences that translated easily into program development, such as networking and advocating.

> Having been trained in . . . a completely different field but one that involved working with clients and trying to help them feel better, I think that informs a lot of how I think about the work, so that was helpful. And then having had to advocate for that work, obviously in a different way than advocating for this, but that helps. You know, anytime you've had some practice explaining what you do and how it can help someone I think that really carries over. (Rachel)

> I think having worked in small businesses really helped to see . . . how did they connect with the community? How do you read your audience as far as your customer base? (Autumn)

Some mentioned that working in other fields provided new perspectives which ended up being valuable to their work.

> Funny enough, just being a preschool teacher for a year . . . really, really solidified my love of working with kids and just gave me a different perspective on childcare. It's also nice to kind of get a perspective of working with children without major disabilities . . . so just to kind of have as many perspectives as possible was really important. (Michelle)

> I think working as an administrative assistant was a big part of it. . . . You learned about how administrators work when you do that. (Autumn)

Significant Theme 6. A lot of learning was attributed to neither coursework nor work experience, but rather, to positive mentors encountered along the way. Mentors served as role models of character and sources of knowledge that wasn't always presented in classes. Three interviewees elaborated on the contributions of their mentors.

> [Professor] is really good about asking for help and modeling asking for help. So I think having been trained by people who are like, you know what, let's phone a friend. Let's call and ask somebody for help. I think that was huge. And I don't know that I see that in the younger generations of therapists. The younger therapists that I meet are like, "No, I'm going to do it myself." I'm like, "Actually, you should probably ask for help." (Autumn)

> I think also, just . . . the older I get and the more I work, I realized how much of an impact [mentors] had . . . especially with my music therapy mentors and my internship

> supervisor, so you realize how much of an impact a positive mentor can have on you. I think that definitely, really gave me the confidence to be able to do what I'm doing. (Nikki)

GMU 3: While music therapists have various opinions about resources and educational standards related to program development, there is a common interest in incorporating business knowledge into music therapy training.

Common Theme 3. All five interviewees spoke about the lack of business education in their training and their desire for a "business track" or course. Specific skills that were noted as need areas included: accounting, getting clients, advocacy, project management, leadership, understanding corporate systems, promotion, budgeting, program expansion, talking to donors, grant-writing, and practical knowledge about tax deductions and student loan repayment.

> I really think as a profession, we need to start looking at even if we're not training managers, helping them understand business. Like what happens in the machine of a school or a hospital, because I don't think music therapists understand enough to know how to go out, you know, it's not fair for us to expect them to create their own jobs. Like they don't even know how to do their job yet. (Autumn)

> It's almost like it's somehow a rite of passage that most of us have to go through in doing this, kind of piece together private practice work. (Michelle)

Some participants commented on how packed the music therapy curriculum is, and how that might present difficulties for the inclusion of business education. Yet, they provided innovative solutions. Kelly stated that it would not even have to be in the form of a semester-long class, and Rachel and Michelle backed this.

> I do think it would be really great to have some kind of a course, even if it was like a one-day workshop. . . . I don't know if it would have to take a whole semester of class time, but just some introductions to maybe, how to write a proposal for a program and how to grant-write and things like that. . . . I do think that would be really helpful, because I suspect a lot of us are going to find ourselves in that position throughout our careers. If more of us were prepared to go to facilities that didn't have music therapy and start it, I think that's where the field should be headed because there're so many places that we could be helpful and we're not even in there yet. (Rachel)

> It should be part of the curriculum . . . though it's not even offered as like an elective . . . music therapy business skills or something. (Michelle)

> I would make a requirement for CMTEs . . . like project management, business, leadership, whatever, and not everybody's gonna be a business owner, but just understand the basics. . . . Yeah, music therapy is awesome, but nobody cares if it won't pay the bills. (Autumn)

Autumn spoke to how the field shifting to a masters-level-entry profession could allow more time to incorporate these skills.

> If I were designing a program . . . I would tell people to get a BA in music. To get your four-year degree and get a four-year degree that you could do something else with if you need to, because you can't do anything with a music therapy degree if you decide not to be a music therapist. That's too bad. You're out. You're all out of money. So, get your four-year degree. And then, get your master's degree in music therapy because then that solves the argument of "We only have 120 hours, we can't cover all this stuff." Like, well it's because in the last 20 years the needs have changed so much. We've learned so much. There's so much research out. So, let's get the humanities under our belt. Let's get your music skills done. If I audition another music therapist who can't read music I'm gonna cry. Like board-certified. . . . So, at the master's level, I think that's where you take some leadership classes. I think that if you made it a six or seven-year degree like OT is, or PT . . . you would have time to develop those things. (Autumn)

Significant Theme 7. Nikki, Kelly, and Autumn all mentioned limited textbook resources related to medical music therapy program development, and emphasized the need for more literature. Autumn reiterated that most of what she learned was from experience, not textbooks or courses. However, some written resources that were mentioned as being useful included *Music, Medicine, and Miracles* by Amy Robertson, books about standards of practice in medical music therapy, and the yearly AMTA *Sourcebook*, as it provides updated salary and budget information.

GMU 4: Although often funded by philanthropy, longevity of the program is generally not affected due to preventative measures and planning.

Common Theme 4. All six programs started by the five women interviewed in this study were initially grant-funded.

> Unfortunately, . . . the stark reality is that most of the time . . . most music therapy programs are not going to grow unless there's a donor or grant. (Nikki)

Nikki happened to be researching position funding in the pediatric music therapy community, with whom she was well-networked, and shared the following:

> About 50% of programs are funded through philanthropy. So only half of programs are actually budgeted by the hospital and the other half are either grants or endowments. (Nikki)

Despite philanthropy being the start for all six programs, four of the six have eventually become absorbed by the organizational budget of the hospitals and are no longer funded by philanthropy. Two interviewees spoke specifically about their personal involvement with ensuring funding in the form of seeking donors, working with committees, or writing grants.

> At the children's hospital, since I've been there for years, I've always been a part of renewing the grants, writing the grants, helping tell the grant stories and be a part of that process there. (Rachel)

Knowing how much money was available from a donor served as a reference for future action regarding program funding.

> [The general hospital] was one individual donor. My boss told me how much money was there, which was really helpful to know. So I know that we have several years at the number of hours that I'm using right now before that money would run out and we would need some other source. . . . I guess since I don't have anyone I work for there right now, I will probably have to be the one who goes out and looks to renew a grant from somewhere as the time draws near. (Rachel)

> I'm working with an organization right now with our foundation to hopefully get an endowment for another full-time position here. So, we are trying to get them to make a 3-year commitment. Yeah, so that hopefully by the time we start . . . getting close to . . . that 3-year mark, we either have another donor identified or we're able to get it into the budget by that point so that it's not going to be cut. (Nikki)

Common Theme 5. Nikki and Rachel mentioned the fact that most donors are happy to fund one to two years of a program, but the program's existence is threated if funded by

philanthropy unless large endowments from wealthy donors are projected to last over a decade. Rachel even lost her position for 4 months at the children's hospital for that reason.

> It's always under threat . . . you know, grants run out, the endowments run out, and the hospital isn't willing or isn't able to pick them up so they just let them go. And the program ceases to exist. (Nikki)

However, all five interviewees came up with preventative measures to combat the threat of programs ending. Autumn mentioned how important it was to convey the demand for music therapy when too many referrals were made. Tracking data was of also of particular importance, as showing the value of the program to administration is a way for the hospital to invest in it.

> You're trying to apply your common sense and kind of say, okay, well we've got to track numbers because someone's going to want to see that eventually for the grants and you know, we want to keep track of good success stories so that we can show the program works. (Rachel)

> It was finding ways to demonstrate the impact we were having on whatever was important to them at the time . . . I built the template for the electronic medical records . . . and so I built it based on what do I want to know every month, every quarter, every year . . . If I wanted to do a research project about my career, what would I want to know? (Autumn)

> You need to be able to prove why they should be paying you to be there when they're not going to be getting any reimbursement back. So, talking about the cost saving analysis. So, talking about how music therapy can improve patient satisfaction scores and HCAHPS [Hospital Consumer Assessment of Healthcare Providers and Systems] scores, which is huge. That's a huge, huge buzz word in the medical world is HCAHPS scores, patient satisfaction and family centered care. And there is research out there that shows how music therapy improves HCAHPS and patient satisfaction. (Nikki)

These efforts, as well as presence and letting the work speak for itself, created appreciation for music therapy within the staff, and thus, a feeling of necessity among the medical team.

> I mean, luckily, I had a lot of really wonderful administrators and a lot of the doctors and nursing managers and [others], who really saw the benefit and saw the worth in music therapy and really pushed and advocated for me to be able to start the program up here. So, it . . . became a budgeted position. (Nikki)

> I think they could still do their job without it, but I think everyone has seen just, it really does make our hospital experience better for our families. (Kelly)

Additionally, the president of Autumn's hospital described music therapy as "relatively cheap," and therefore easily incorporated into the budget. Showing the cost effectiveness through data was an important step in making this happen. Aside from its benefits, the intrigue of music therapy can work to a program's benefit. Autumn mentioned visibility in the news as a strategy to preserve the program.

> And you know, the wow factor…The horse and pony show is pretty awesome. So, we generate a lot of positive PR for the network. I made it a point at least once a year to . . . have one of the therapists in the local media. (Autumn)

Significant Theme 8. Even if a hospital has financial resources, it is up to the therapist to be the one that takes on the responsibility of knowing how to allocate funds.

> So even though I had somebody who was kind of like "We know we want you here and we have money," I still needed to really be the one to say, "Here's how you implement a good program in this unit." (Rachel)

When asked where to look to find budgeting information, Nikki had a couple of suggestions.

> It's doing your research. . . . It's looking at what do music therapy salaries look like in your state? In your region? For the level of education that you have? For the population that you're looking at? . . . Putting together all of those numbers . . . The *AMTA Sourcebook* that comes out every . . . year, we all have that information. So, we can bring that to the hospital and say, look, this is the average salary. This is the salary range for this state, this area, this population, this type of facility. (Nikki)

> And also doing research and asking around different music therapists in whatever area you're looking to work in. And saying, hey . . . people always don't like to talk about money and salaries . . . but it's really important. (Nikki)

Rachel had advice as well: to make sure to separate instrument costs from salary when writing grants, because the specifics of language may prevent later use of funds in ways that would be beneficial to the program. If obstacles with allocation arise, however, she recommended getting creative and working within the funding from an umbrella department such as Child Life or Recreation Therapy to meet the program's needs.

Additionally, Michelle recommended including not only instruments and salary in the budget, but an extended wish list to maximize demands.

> One of the most important things I heard of specifically about . . . coming up with your supply list is shoot for the moon and then you can always kind of whittle it back from there. And I know that really helped me . . . Same with your budget. Like include your salary, but also include continuing education . . . Budget for national conference every year or regional conference or whatever you prefer. You know, just to have all of that and then they expect it every year, too. . . . I think that's really helpful, even like dues, you know AMTA professional costs, think of everything that goes into being a professional. It really gets expensive. But if they can budget for it, I mean, those are huge benefits . . . a part of it is definitely advocating, I mean, because facilities are not going to know . . . to allow for all of these extra expenses every year. (Michelle)

She recommended the same for salary: to aim big and see what the facility offers in response.

GMU 5: Introducing music therapy to an established interdisciplinary team requires ongoing education, finding other staff who support the profession, and innovation.

Common Theme 6. Although Michelle did not have experience on the floors yet due to her recently started program, all other music therapists spoke to the necessity of in-the-moment education. Nikki spoke specifically about needing to continually educate new medical students, especially by gently questioning the clinical need when they made inappropriate referrals and using that as a teachable moment. Some ways to provide this spontaneous education were described by Kelly, Autumn, and Rachel. Sometimes, it takes explicitly describing the work, and others, it takes time and exposure.

> I do a lot of . . . in the moment education, and so . . . if I have a nurse that I am wanting to work with a patient I'll say “Well here's what I was thinking of doing, here's what my goals would be, and here's what I'm hoping the outcome is,” so it's kind of more of like a quick, 5-minute . . . educational moment. (Kelly)

> I think we did a good job educating and we also were always very open about asking staff to shadow us or inviting them to be a part of a session. (Autumn)

> And then . . . the longer you're there, the more people happen to walk in and see a session or if you do procedural support so the medical staff is in the room and they see what you're doing . . . those kinds of things gradually build peoples' understanding. (Rachel)

> I think the most helpful thing I've found is finding a couple of people that I can really talk to in depth. Like I think in-services and things like that are important, but you can't always get everybody, they don't always pay attention, or they may get the information, but it doesn't really click for them until they start to see it in action. (Rachel)

While unplanned educational moments fostered increased understanding, formal and informal in-services proved to be important as well. Michelle, Autumn, Kelly, and Rachel all mentioned making sure to educate nursing staff during meetings even for 5 or 10 minutes, or through providing handouts. These opportunities led to further understanding of music therapy's role.

> So I haven't had a lot of opportunity yet, but I have gone to one of the nursing meetings. So I made them a handout and just kind of told them . . . what would make a really good referral, what music therapy is, [and] showed them like a short video. Just kind of explained my role and how it differs from Child Life. (Michelle)

> We did do a nice little kind of informal in-service for the oncology nurses in the unit at [general hospital]. That was really nice. So they all just kind of took a quick 10-minute break and came and sat with me. So I couldn't give them a ton of information, but I did give them something on paper and I tried to really highlight "These are the top reasons to refer . . . I'm not just playing for people . . . music therapy really can change your brain chemistry and impact your pain," and trying to cover the top things that I thought were the most relevant because I didn't have a lot of time with them. And they've been pretty good. It's a small enough unit that not every nurse made it to that, . . . but some of the ones that did . . . give me really good referrals at this point. (Rachel)

Autumn, Rachel, and Kelly all spoke about formal in-services they provided at the hospital, while Michelle described the prospect of recording a future in-service as her program gets established.

> The cool thing with our hospital is that they oftentimes will record those presentations and then they can be assigned to employees as required . . . education, so then . . . I would like that to be assigned to all of our pediatric staff because my short . . . 5-minute, 10-minute plug in the nursing meeting is going to make some kind of difference, but it would be nice if they can really sit down and have like an hour-long kind of presentation. So, I think that'll be probably in our future. (Michelle)

Common Theme 7. Interviewees recalled inappropriate referrals, stating that oftentimes, they were made because there was a misunderstanding in an area that required more education.

All five interviewees detailed innovative ways to address these and encourage appropriate referrals. Michelle stated that she plans to use the technique “Referral of the Day,” to motivate staff and heighten awareness of the benefits of music therapy with friendly competition.

> With the referrals, too, I was speaking to a Child Life Specialist, actually, and they had a program going when they first started . . . "Referral of the Day." And then they would give out . . . a candy bar and . . . a little card [saying] "Referral of the Day" and then write down . . . what the referral was . . . like “You referred the six-year-old boy to me. And you're right. He was very withdrawn, he opened up a lot . . . with music, and we worked on coping skills.” . . . It kind of encourages them to look for appropriate referral pieces and . . . [it’s] fun. (Michelle)

Rachel, Nikki, and Kelly utilized flyers and “cheat sheets” to educate other staff. Rachel provided written guidelines to child life specialists, detailing when music therapy may complement child life interventions or when to refer to music therapy to work in ways child life could not. Nikki made sure to leave lists detailing reasons for referral on bulletin boards in nursing break rooms. Kelly noticed that others were feeling particularly confused about her role in the NICU and decided to take action.

> I was finding that the NICU didn't really know what to do with me . . . The other day [I] sat down, and wrote out, I think the title of it was “Appropriate Uses of Music Therapy in the NICU,” and then in parentheses I put “When to Call the Music Therapist” with little smiley faces...so now they have four or five different ways that they can look at and go, “Okay, we have this baby, here's what's going on with them, let's look at Kelly's little handy-dandy music therapy cheat sheet and see if any of what she can do lines up with the things that this baby needs.” (Kelly)

Autumn emphasized the importance of following up with staff who made referrals to music therapy in person to either ask questions about the reasons for the referral or explain how the session went and what goals they were able to address.

GMU 6: Music therapists' interaction with other staff influences the effectiveness of a new program.

Common Theme 8. The need for the educational outreach described earlier is often related to the fact that many staff members have never encountered music therapy before. Thus, due to all interviewed music therapists' needing to educate, especially in the moment, it was inferred that staff was unclear about music therapists' goals and objectives This is exemplified by the following:

> [In the children's hospital]. . . . Sometimes the staff are freaked out. . . . If you're on the infant unit and you have medically fragile infants, and you wheel the cart onto the unit, the nurses will sometimes be like, "Oh my god, don't go in there! He's medically fragile," because they think that all this stuff means that you're going to do something really stimulating and raucous. So then you've got to educate staff enough for them to not be freaked out that you want to go in there. . . . It's an ongoing thing. (Rachel)

Interviewees also described apprehensive reactions, or confusion, in response to music therapists.

> I would see some doctors in the hall and they kind of give me this look like "Huh," and their head goes to the side and they're like "What is that?" (Kelly)

Not one interviewee let this halt her progress; rather, they all described it as a need for advocacy and education.

Common Theme 9. All five interviewees described working with other professional staff as a generally positive experience. Autumn explained that various strategies including thinking like other clinicians, simply being seen, and being a team player helped her to establish herself in the hospital.

> We made sure to take our lunches in different nursing lounges, and to go to events and to really just be seen. Because . . . there's three of you in the building with 2000 staff. You need to make sure they know who you are. (Autumn)

Nikki echoed these suggestions and added that coming in with an unassuming attitude based in wanting to help worked to her benefit.

> The biggest thing is . . . when I first started . . . I reached out to those people and said, "Hey . . . can I shadow you for a day? . . . Tell me about what you do." So kind of making them feel like . . . I'm not stepping on toes. I'm not . . . barging in. I want to be like "How can I best help you?" (Nikki)

Kelly noted that simply being present, speaking confidently as the expert in her field, and being able to convey her goals to other professionals helped to foster collaboration. All interviewees spoke to the effects of working and speaking assuredly to other professionals, and all reported an increased sense of collaboration and appropriate referrals.

> [About the burn team.] I started working with them and showing them how music therapy can help . . . especially during procedures. [For] any burn patient that comes in now, an automatic order is placed for music therapy. And they won't start a burn dressing change until we're there. Yeah, so they're a huge support of us. (Nikki)

> Now I'm getting so much response from the staff I almost can't get to it at all, so they've now kind of come to see . . . how they can use me, and they are using me in that way which is awesome. So, it's been well-received. (Kelly)

> [Child Life] I found that some people there were so happy I was there and . . . really appreciated that there were things that where music therapy could enhance . . . or help . . . support what they did. (Rachel)

> And then there were others - like, even if a child life specialist was there and they'd already made a plan . . . they would also ask me to join them because they recognized that the music would affect the whole room. . . . We were . . . relaxing the staff and . . .the parents. . . .So, I would find some specialists were like, "I just love having you there, it changes the whole feel of the room and you do what you do while I do what I do and they work together well." (Rachel)

Although Michelle has yet to begin working with patients, she has already felt warmth from other staff.

> [NICU walk-around] The thing they all said is, "I'm so excited you're here," you know, and that was all separate, they're all in separate rooms, but they each individually said that and I really felt they're genuine . . . so that was really exciting. . . . One specifically mentioned . . . "We're having a lot of issues with opioid-addicted babies," so they think that music therapy will help that population a lot too. (Michelle)

Autumn also spoke to specific administration championing music therapy as a contributing factor to feeling supported. In particular, she mentioned the influence of supportive leadership.

> So, I was really lucky. I had three different sets of administrators over all the years and the first two sets were incredibly supportive and I really didn't have any barriers, like they would come to me and say, "Hey, we have a question about this. Is this something you can look at? Does it make sense?" . . . I was really this allowed to be the subject matter expert. (Autumn)

> I was lucky to have a lot of really great female leaders who would make sure I was included. (Autumn)

Significant Theme 9. Not only do music therapists and other staff members collaborate for the patients, but music therapists contribute to staff wellness as well by providing music-assisted relaxation for staff. Rachel and Nikki both provide these groups for staff, and Michelle described her ideas about implementing that type of group when she begins clinical work.

> We call it *Caring for the Caregivers*. So, we do music-assisted relaxation sessions with our nursing staff. Our nursing and support staff. . . . That's a big, big top hot topic . . . is reducing burnout and improving overall staff wellness. (Nikki)

> [Is it well attended?] It depends on the week . . . but we keep some stats and data on everything. . . . We have . . . cards that they fill out. . . . They rate their stress and anxiety level and their overall mood at the beginning of the session, and then we have them read it again at the end of the session, as well as their overall experience, and if they would recommend the group to another family. . . . We keep data on all of those so that we can show . . . even if it's not like super well-attended . . . we're having a statistically significant impact on the stress and anxiety level of these parents. And to be able to bring that to . . . our administrators and to our quality control team, that's huge. . . . They definitely are impressed by that when we can show that we are making statistically significant differences. (Nikki)

Rachel reported that groups for staff helped rapport build between staff and music therapy as well, which led to more appropriate referrals as well. She referred to the groups as "free advertising for the music therapy program."

> I think the other thing is it really helps the staff better understand music therapy because they're experiencing it. . . . All of a sudden, it clicked for them differently because they experienced it. So, [I] think it's really an important part of a program. (Rachel)

She also addressed scheduling conflicts that staff wellness groups can present, since clinical staff are so busy. She divided the lunch break into 20-minute segments, so people could choose which

type of relaxation experience to attend. For instance, guided relaxation, rhythmic entrainment, or singing bowls. Rachel was open to meeting the staff's needs and always followed up with surveys for specific feedback of what to include or omit for future sessions.

Significant Theme 10. While most interactions with other staff were positive, some moments of tension were reported. Autumn stated that tension was often just with individuals who were cranky. Nikki reiterated this by explaining one scenario she had with a physical therapist; yet, the tension seemed unique to the personality of the physical therapist.

> There's one PT, in particular, she works in the NICU and apparently . . . I've been told by other people, it's not just me. She does this with everybody, but she's very territorial . . . and when I started working in the NICU she was very, very protective of any patients that we had that we were both seeing. Like she would stand there and watch me . . . most of the PTs are awesome and we have a super duper close, wonderful relationship with them. It was just that one. (Nikki)

Some tension had more dramatic effects on the programs, however. Rachel and Autumn both had particularly challenging conflicts arise with fellow staff or administrators. Rachel often felt like her efforts were obstructed by the child life department in which the music therapy program was housed. One child life specialist (CLS) in particular became her supervisor and exhibited "obstructionist," "competitive" behaviors towards her, including keeping her from speaking and presenting at in-services, preventing her from receiving referrals that could go to child life, and even preventing her from representing music therapy as a separate discipline from child life.

> [Child Life] And I definitely found that some people seemed a little threatened, like they wanted to be the ones that could help a kid. It was very interesting. It was just almost like you know, "No, I don't need you on this case. I'm not making a referral to you," kind of thing. That was surprising to me, I guess, when you think about it a lot of people go into helping professions because they really want to help, and I think some people maybe get a little caught up in being the one who helps, or being the one who can come back and say, "I got that kid through this procedure today." . . . So, it was interesting. I hadn't thought about it before, but it kind of makes sense that it happened. . . . I found there were some people that would never call me for procedural support, even though I could help. (Rachel)

> It is interesting to see that when you have an overlap, there are some people that are going to sort of feel like "I don't need you here because I can do what you do." That was probably the toughest negative thing for me. (Rachel)
>
> And I think [Child Life is] also a profession that has to work really hard to be understood, and so I think it's probably easy for them to feel like their jobs are threatened, just like we feel like our jobs are threatened. (Rachel)

On a larger scale, Autumn struggled with a third set of administrators who eventually drove her out of the hospital. The researcher thinks this story is important to include in the present findings.

> We got a new set of administrators that were like worst case scenario and some of the things that happened were really unbelievable. . . . I've worked in leadership and taken a lot of leadership training, and I was like, I have never heard of this . . . I'm back in school, trying to get another degree so I can find another job.
>
> So, we have this beautiful space for a few years and we get this new hospital president. And within 6 months, he was like, "We're moving this." And I was like, "Well, the thing is, all these donors that paid for this, like multiple six figure donors, those were estate gifts and they're not dead yet. This is not . . . ethically, this is not okay." And so, he wanted to turn the department into something that wasn't music therapy.
>
> It just got worse by the month. I didn't have any input into the new space. They were moving it to the end of a hallway. A dead-end hallway where nobody would be, it was going to be like a third of the size. So, I wouldn't be able to do all the things we had done. They were taking the piano that had been bought for us and moving it to a lobby.
>
> One of the conversations that we had . . . made me so angry, because he's like "Well, we're going to have a listening room. I've talked to the architects and that's the thing to do. So, we're going to have these chairs with speakers on them like you have at the airport and you're going to manage these iPads that people can listen to music." And I'm like, "We are crawling all over this building all the time. How have you missed what we do?" So . . . it came back to the code of ethics. Like, no, that is not what we do. I have stakeholders in the staff in the donors in the patients. No. And so I knew by standing up for that I would lose my job, but I couldn't not. I was respectful. I'd never publicly said anything. . . . I just made it a policy to not talk about it because I needed to be blameless.
>
> It's one of those things where like, you can have all the leadership and business training. And you can do all the most amazing things in the world but you get a grumpy administrator that wants it to be all about them, and that's it. (Autumn)

This was all summed up nicely by Rachel:

> There's a lot of politics in hospitals, sadly. . . . Things just don't always get done in the best way. (Rachel)

GMU 7: When there are volunteer musicians at the facility, collaboration between music therapists and volunteers results in more appropriate patient experiences with music, although music therapists may not have time to devote to these efforts.

Significant Theme 11. Autumn, Nikki, and Kelly all agreed that despite volunteer musicians being present in the hospital, other hospital staff understood the difference between their role and music therapy's role. Autumn constructed a survey asking the nursing staff about that specifically, and found that nurses always knew how the two varied. Kelly stated that there was a chaplain who played his guitar around the hospital, but who generally did not come to the NICU where she worked, leaving little room for confusion. Overall, this was not a concern.

Significant Theme 12. Four interviewees detailed the various benefits and challenges of working with volunteer artists and musicians. Benefits included bringing music to patients who may not have a clinical need for music therapy, positive press release for the program's involvement with community, environmental music in the lobby areas, and offering other types of interactions with arts, musical or visual, outside of music therapy.

> So, it was really positive. I wanted to offer all the different types of interaction. It's not . . . just about music therapy. (Autumn)

Although there are many positives, difficult aspects of having volunteers in the hospital arose as well. However, all four music therapists were willing and able to brainstorm more productive ways to best serve the patients utilizing volunteers and help implement these changes. Nikki mentioned a particularly challenging moment when high school musicians came to the children's hospital to volunteer. Despite having a conversation before the visit about what to expect and what types of music they should prepare, she described it as

> A horrible, uncomfortable experience. . . . It was a disaster. . . . I was physically uncomfortable. . . . They had no idea what to do. It was awful. (Nikki)

After that encounter, she made sure to personally give volunteers plenty of tips beforehand, such as to talk to the patients about the instrument they play. She learned she could also recruit volunteers from other organizations in general. Rachel provided a paid training to volunteers from the local symphony who wanted advice about how to use music more mindfully in a hospital environment when volunteering.

> They had reached out to someone at [university] and asked to have somebody come in and speak to them about the work and how to do it in a more mindful, sensitive way. And whoever they reached at [university] . . . called me up and said, "Do you want this job?" And so I put a training together for them because they had a little grant funding and they were commissioning this training. And it was really great. It was great that they wanted it. They were really well-intentioned people, but when I heard some of the stories of what they were doing, I thought . . . there's a lot to be improved on here. So I was glad they had asked. (Rachel)

Michelle, who had not yet begun her clinical work in the new program, intended to be involved with volunteer efforts and provide guidance to their journey in a medical setting.

> I did let them know that I can help coordinate . . . volunteer efforts. Definitely . . . even if they wanted to audition . . . or, just to kind of help educate them too on how to be most beneficial for whatever environment they're put in. (Michelle)

Individual Theme 1. Due to the challenges Nikki encountered when working with volunteer musicians, from that point on, she decided to only work with volunteers from organizations. Organizations she listed included Musicians on Call, Ukulele Kids Club, the symphony, and a local university. She specifically stated,

> I put my foot down with volunteer resources and said look, anybody who comes to you for music needs to go through me . . . they will need to audition for me. (Nikki)

Individual Theme 2. Nikki stated that she did not work with volunteer musicians, because she was too busy and it was not a priority.

> I haven't really started like a regular volunteer music program here . . . because I just really just don't have the time to be able to deal with that. And I really had to push that

> with our lady from volunteer resources because she gets people contacting her a lot about, “Oh, I'm a musician and I want to come play in the hospital.” (Nikki)

Nikki occasionally supervised members of a local symphony, but when they visited, they would host small concerts from the creative arts therapy room, and she was minimally involved.

GMU 8: Music therapists approach program development as a collaborative effort between other peers and professionals, either in music therapy or a related field, locally or remotely, and readily seek help when needed.

Common Theme 10. All five interviewees described the development of their programs as collaborative efforts. Locally, three interviewees consulted other music therapists who lived nearby for opinions about various peer supervision questions, such as budget questions, ideas for new interventions, and even opportunities to collaborate. Other local professionals were also mentioned as sources of support, including an interviewee’s husband with prior business experience and hospital workers in hospice, chaplaincy, palliative care, social work, child life, or psychology.

Significant Theme 13. More commonly, interviewees referred to consulting other music therapists in remote places due to seeking certain expertise or limitations of living in a rural area. Two interviewees traveled to visit and observe other music therapists at similar facilities, three interviewees stressed the importance of networking and asking questions via the social media group exclusively for the music therapy professional community, and three interviewees referred to connections made in their own educational and professional communities. Through these relationships, support, second opinions, and answers to many questions were found.

> I'm a firm believer in that we don't have to reinvent the wheel every time. (Nikki)

> It's really cool to see how much the field is kind of growing into trying to support each other and share resources. I think we need that because so many of us feel like we're out

there alone and sometimes we're the only ones where we work and it helps everybody to grow their own careers and expand the profession. (Rachel)

GMU 9: Starting a medical music therapy program comes with emotional and professional challenges.

Common Theme 11. All interviewees emphasized the extensive amount of preparatory work that goes into starting a program before clinical work can begin, and additionally, what continues after a program is started. This included creating charting templates for electronic medical record systems, getting position descriptions written and approved, figuring out logistics for interns or program expansion, and more. These tasks were described as necessary work that sometimes prevented music therapists from seeing their patients.

> A big part of starting and running your own program too is all of the administrative work and all the extra stuff that goes into it that is not clinical by any means. . . . I spend a huge chunk of time . . . talking to the foundation, . . . donors, . . . presenting, doing in-services . . . working with the grant writers and advocating . . . answering emails or phone calls, people asking about services. So, a huge chunk of your time is taken up with administrative work. Especially when you're starting a program . . . you need to be doing all of those in-services all the time to make sure that you're getting appropriate referrals and making those connections. . . . You have to develop your own documentation and charting system, working with the IT department and getting that done. So, there's so much that goes into it that you don't realize until you're doing it. (Nikki)

> We have to figure out like the music therapist job code, we're making all the charting templates and all that. So, I haven't even started seeing patients yet because it's all preparation. So, we've been preparing and then even though we've had that job description and stuff typed out and submitted for weeks, it's still not switched over so I still can't see patients. (Michelle)

> It also just takes forever to get anything done in a hospital, like stuff just moves so slowly. Like I'm supposed to be at [general hospital] starting to do work for their hospice department too, and that's been like “any moment now I'm going to start,” for like 10 months. (Rachel)

Significant Theme 14. Four interviewees identified constant advocacy as a struggle and source of burnout.

> I think one thing that contributes to burnout is you will be talking about what is music therapy until you die. (Autumn)

> I definitely think the biggest challenge is always that people just don't know what you do, you know? (Rachel)

However, if a music therapist prepares to do that work as a part of his job description, that may be a helpful way to combat burnout.

> I think it's important to kind of make peace with the idea that you'll always be advocating. That it's actually part of the job. . . . It feels like you won't always have to do it, but you will. (Rachel)

> Even when you start a program that's not the end of it . . . if you're going to start a program, especially in a new place that's never had a program before, you need to be ready to be to always be advocating, always be educating and to kind of develop a thicker skin, for me. Because not everyone is going to be on board. (Nikki)

Some personality types thrive with this dedication to lifetime education and advocacy.

> For me, I love doing that. I love giving in-services, giving presentations, advocating for services, advocating for what we are and who we are and what we do, but that's not for everybody. I know it can get really tiresome. (Nikki)

Individual Theme 3. Relating to Common Theme 11 is the theme of impatience for the rate at which programs develop. Kelly and Michelle in particular struggled with this. Kelly had a failed attempt to start a program at a hospital prior to where she eventually started one, and described feeling discouraged at her idea of starting a medical music therapy program at all. It took two and a half years from the time Michelle first contacted the hospital where she started her program to the time the program started.

> I had no idea it was going to take that long . . . that really was the hardest thing about this whole process, to be honest . . . I lost faith, a lot of times, that it was going to happen. . . . I started looking for jobs elsewhere . . . around the country, not even in . . . the city, obviously, because there is nothing else . . . I was starting to have serious . . . I didn't think it was going to get going at all. But I'm really glad that I waited now. (Michelle)

Individual Theme 4. Two interviewees mentioned living in a rural location as a factor that may have influenced their program development. These interviewees stated that it was

difficult to sell music therapy because people did not know what it is. There were few music therapists in the states these interviewees were from, and thus most people they spoke with had never seen or heard of music therapy. They also spoke to limitations in regards to networking and getting to conferences. Coincidentally, these two interviewees both sought out additional travel to observe other music therapists in their specialty settings so they could continue to educate themselves, since local resources were often nonexistent.

GMU 10: Music therapists draw from resources to help them work through obstacles.

Common Theme 12. Despite the many challenges that come with the responsibility of creating a new medical music therapy program, the biggest motivator mentioned by all interviewees was the passion and love for the work.

> I think just my passion for music therapy and . . . me knowing what it could bring and being confident that I did have something to bring to the table even if it took other people a little while to get it. (Kelly)

> I knew it was the right thing to do. Um, I loved the work. I mean there was, you know, the selfish part, the ego part. I just love the work. (Autumn)

A large part of the passion for the work stems from the knowledge of what music therapy could do for patients and their families.

> I think it's just how much you know the patients would benefit from it. . . . Just believing in the work and knowing how powerful it can be and really wanting it to be there and be available for patients. (Rachel)

> Keeping everything in perspective that . . . even though it's . . . horrible and heart wrenching, it's the fact that we can bring some comfort and solace into one of the most raw and vulnerable times in a family's life. That's something that's not to be taken lightly. And knowing how much of a difference we make. And how much that means to the family and to the patients. That's kind of what helps me get . . . through it. (Nikki)

Rachel stated the importance of enjoying the therapy component of the work, saying that she believes people are more likely to burn out giving therapy all the time if their hearts are not in the work.

Common Theme 13. All interviewees were able to identify parts of their personality that they believed to be helpful in the development of their programs. Some important traits included: curious, persistent, analytical, a desire to be a pioneer in the field, organized, warm, confident, patient, thick-skinned, charismatic, and the ability to be positive. Several interviewees mentioned the ability to walk the lines between persistent and annoying, and straddle the lines between objective and subjective. Being curious, analytical, objective, and charismatic, for instance, could lead to doing detailed research about the neural mechanisms at work behind music therapy interventions, conversing to medical professionals about it, and gaining support from them, and opening up a new position.

Significant Theme 15. Four interviewees stressed the importance of social support in dealing with obstacles surrounding their work. Kelly, Rachel, and Nikki explained that other staff at the hospital were tremendous sources of support. Sharing experiences with CLSs, nurses, and psychologists were helpful. Having other staff members reach out and tell them they had read their notes on a shared patient, finding another staff member who championed their work, or having coworkers to process with were valuable.

Self-care often involved relational forms of support as well. Autumn and Kelly mentioned that their spouses provided support in the forms of processing or taking on extra errands to help out during stressful times. Nikki and Autumn advocated for having a personal therapist as a resource for self-care, or finding other outlets such as acupuncture and massage. Another form of support mentioned was having an intern to help alleviate some stress from a full workload. Nikki explained how helpful that had been to her, and Rachel had considered this possibility as well, but was met with logistical challenges preventing this.

Significant Theme 16. Maintaining boundaries also contributed to self-care. Mentally taking a break from challenges with advocacy and deciding to choose when to pick a battle and when to let an issue rest was a form of doing so.

> There were days I was just so frustrated with the advocacy issues I'd tell myself, "I don't care. I'm not going to spend any energy on that today. I'm just going to keep my head down and do my job and just really focus on making sure the patients get what they need." But at some point to keep the program thriving and keep it funded and all of that, you've got to be ready to . . . dive back in there and do it. . . . It's kind of a back and forth, like sometimes you need a break from it because it can just get really frustrating and it can cloud all your successes. (Rachel)

> Also knowing when it's not worth fighting the battle . . . because there's going to be people that . . . it doesn't matter. You could show them every amazing thing in the world. They don't care. So . . . it's . . . knowing when to fight and when to kind of be like, "You know what? Okay, I'm just gonna walk away. You can do this. Your way." (Nikki)

Creating boundaries in space and time was another method. For instance, Autumn and Nikki made sure to take advantage of days off and go home early when needed on emotionally difficult days.

> I had a nice job with paid days off, [so] . . . using those and taking holidays. (Autumn)

> [coping with death] Um, you know, some days I just come back to my office and cry for a while and then go home early. (Nikki)

Making sure not to take on too many responsibilities at work was also a meaningful boundary to create.

> And just being really careful not to take on a bunch of other stuff. So, a lot of music therapists have two or three jobs. I couldn't do that. I had the one job. (Autumn)

Significant Theme 17. Overwhelmingly, shifting perspective to focus on why music therapists do the work they do, finding gratitude, and practicing patience helped them persevere through challenges. In regards to patience with advocacy or scheduling, it was important for interviewees to remember that it was not personal.

> [In regards to advocacy] I think [you] just kind of have to grow a tough skin and know that it's not personal. Most of the time it's not personal. They just don't understand what we're doing. (Nikki)

> I've been thinking about music therapy and researching music therapy and studying it for 20 years, but the person I'm talking to, this may be the first time they've heard the words "music therapy." (Kelly)

> [Recognizing busy nature of staff] So just trying not to take that personally when they didn't get back to me . . . that was helpful too. (Michelle)

One helpful way to shift perspective was finding gratitude, or "looking for the wins," as Rachel described it.

> I've got to manage my own reaction sometimes too just, you know - again, that negativity bias, and just remember that person was happy the music was there and it lifted their spirits, and . . . it doesn't matter really if they get it. On some level it matters if administration gets it and they keep us around, or if we get the right referrals because somebody really understands when we can help. But at another level, if people are just happy to have music there, that's a great thing too. (Rachel)

Kelly expressed feeling like there was always more she could be doing, as she worked 10 hours per week. To cope with this, she would focus on what she *could* accomplish within that time.

> There's just . . . kids I miss because I'm not here and there's things I can't do because I'm not here every day and I've just kind of had to say "Okay I'm here today. What can I do today . . . in this moment?" (Kelly)

> There's days where I won't have any referrals and I kind of just sit in my office and go well what am I gonna do? . . . I have to remind myself this is making a difference and it is important work. . . . I think that was really motivating. (Kelly)

Final Distilled Essence

These five music therapists shared detailed accounts of their medical music therapy program development. Overall, starting a medical music therapy program can be tiring, challenging, and exciting, while simultaneously bringing a deep sense of fulfillment and purpose. Music therapists who start their own medical music therapy programs must have the drive to do the work, since it requires a lifetime of advocacy and fighting for recognition and funding.

Educational background and previous connections can be helpful in program development; however, the majority of skills necessary are learned through experience and exploration. Most music therapists identified a need for more business skills in the training of music therapists, regardless of their intended focus. Although a majority of medical music therapy programs are funded by philanthropy, knowing existing research and tracking data of the new program can help the longevity of the program when advocating to administration and donors. Collaboration with volunteers can be beneficial to patients, but time consuming for the music therapist. Throughout this process, it is helpful to seek out others for support, both professionally and personally, to prevent burnout and gather energy and knowledge necessary to persevere.

Chapter 5

Discussion

The purpose of this study was to examine the process, including navigating successes, strategies, and challenges, of developing medical music therapy programs. Some of the biggest hurdles included navigating working within a hierarchical institution and learning the politics that come with working in that setting. Yet, the resilience, innovation, and dedication to the work that the participants embodied that helped them succeed despite these challenges came across in the findings. Thematic analysis of the five phenomenological interviews yielded 10 general meaning units, including 17 significant, 13 common, and four individual subthemes. This section will discuss similarities and differences of the findings in comparison to the existing literature, propose future implications of the research, and consider implications and limitations of the present research.

Communicating Effectively

An overarching finding of the interviews was that a large amount of success in program development can be attributed to communicating effectively, which is consistent with the findings in the existing literature. For instance, Rushing and Barragan's (2014) sentiment that it is essential to speak to "head, heart, and wallet" when promoting a program was echoed in all interviews. Knowing the research behind the work and being able to communicate that to others in a language they understand is an invaluable skill when it comes to advocating, and in turn, creating, building, and sustaining a successful program (Crowe, 1985; Rushing & Barragan,

2014). The ability to change the content of what is said depending on with whom conversation is happening was a pervasive sentiment in the present interviews. Several participants highlighted the importance of being able to present literature backing the work to others as well, after absorbing a thorough knowledge of the inner workings of interventions themselves. Additionally, the ability to speak to specific gaps in the facility that music therapy would be uniquely able to address was something mentioned that was consisted with the literature (Rushing & Barragan, 2014).

One component of communicating effectively is working with co-workers from other disciplines openly. Several participants mentioned the importance of reporting successful sessions to others to foster an understanding of the work among a larger team, being present, and being a helpful contributing member on a team. As bolstered by the findings of DeLoach and Peyton (2014) and Rushing and Barragan (2014), these behaviors can lead to finding advocates from other disciplines who understand and value the work of music therapists, becoming "champions" of the work, and often giving the most appropriate referrals.

Silverman and Chaput's (2011) study suggested future research investigating which type of outreach most effectively portrays music therapy in a way that other medical staff understand. The present study shows that there is no one, "superior" way to communicate what music therapy is. Everything from physical copies of therapist-made informative books, articles from the literature, flash drives, handouts, formal and informal in-services, participating in rounds, and inviting others into sessions for observation were effective.

Support and Pride in Work

Contrary to the music therapists interviewed by Ledger (2010), the interviewees in the present study seemed generally to feel supported and optimistic about their futures. Ledger's

findings stated that 6 out of 12 considered leaving their programs due to the challenges of starting them. This originally led this researcher to question the resilience of the music therapists in Ledger's study. In contrast, only 1 of 5 participants in the present study left the job she started, and it was not her choice, but the administration's. In fact, she mentioned a grieving process that accompanied leaving due to her love of the work. Additionally, in Ledger's study, 4 out of 12 had lost funding or had their hours cut. One participant in the present study lost her job temporarily due to philanthropic funding, but shortly thereafter returned. Ledger (2010) stated that participants were insecure about the longevity of their program's funding, while in the present study, all participants felt confidently about their funding, despite some of it being from philanthropy. Generally, there was a sense of assurance at the longevity of the program.

Ledger's study included participants from Australia, Canada, Ireland, the United Kingdom, and the United States. Thus, perhaps in other countries, music therapy had differing recognition and visibility than in the United States, which could have contributed to this divergence. Another major difference between the studies is that Leger's study included ethnographic fieldwork, thus, she was present on-site at one participant's workplace during 15 separate occasions. From this perspective, she observed the music therapist's interactions with staff, interviewed staff with whom she interacted, and documented exact words and phrases from her participant, as well as her own perceptions of "sadness, tiredness, or busyness" (p. 115). This real-life perspective may have shaped her perception in ways that a semi-structured interview may not. Perhaps the 9 years that have passed have contributed to the divergence in the findings, yet, it seems unlikely that music therapy would gain significantly more recognition in such a small amount of time. These differences may also be attributed to who the unique participants were. Each music therapist had an entirely unique set of circumstances including education, life

experiences, geographical location, administration, etc., which led to great variation in their experience of the process.

Another difference from the literature that contributed to this sense of confidence in the work was staff support from other disciplines. Silverman and Chaput (2011) found that other professions did not understand what music therapists did. Participants in the present study, however, stated that doctors, nurses, managers, psychologists, CLSs, hospice workers, and members of palliative care all promoted, championed and understood the work that music therapists do. It seems that the efforts made by this study's participants to include others in their work profoundly impacted this relationship and understanding.

Uniqueness

One predominant finding of the present research was how relationships with administrative staff can shape the success of the development of a program. Two participants mentioned how the progress of their work was significantly inhibited by tense relationships with staff who had some type of authority over them. This leads to the question of whether or not this is unique to music therapy specifically, or whether tension among coworkers is a more pervasive experience among other professions as well when starting a program. Ledger et al. (2013), stated that other professionals have similar difficulties as music therapists when developing and implementing a program. Darsie (2009) and Ledger (2016) cited *role ambiguity* as a large factor in tension and burnout and surmised that it was common among other professionals as well. This is an appropriate term to summarize the likely cause of tension between Rachel and her fellow CLS, as the territorial attitude of the CLS and obtrusive behaviors as her "supervisor" might have been due to feeling threatened by having similar job duties. Thus, it can be inferred that CLSs might also feel threatened due to role ambiguity, and on a larger scale, feeling misunderstood

may present difficulties in the workplace. Autumn's conflict with administration involved more of a power dynamic as it came from organizational administration. However, it is an important reminder that this type of interaction may occur at any workplace with a hierarchical power structure, despite the quality of the work provided by the employee (Dawson, 2003; Ledger et al., 2013).

Some strategies to reduce perceived role ambiguity lie in continued advocacy. One method would be a handout delineating the difference between music therapy and other disciplines, like child life. Additional continued methods of education include those described by interviewees such as in-the-moment education, in-service, and staff meetings. However, as the results from the study indicate, others may attempt to obstruct these methods. It seems that music therapists may need to be comfortable respectfully confronting those who inhibit these methods of advocacy, and to feel confident speaking to authority.

One of the most significant challenges cited was burnout, specifically from advocacy. Any job requiring breaking new ground into a hierarchical, political institution presents challenges; thus, this is not entirely unique to music therapy. While this may feel heightened at a place with a new program, it is common for music therapists in general to feel this way. According to the Certification Board for Music Therapists (Lundeen-Smith, 2018), there are just over 8,000 currently certified music therapists in the country; thus, this may be an indicator that the field is still gaining recognition as a whole in the country. However, there are factors unique to a medical setting that may contribute to burnout from advocacy; all of which were mentioned by interviewees. Maintaining funding may increase pressure to continue talking to donors, proving worth by tracking data to demonstrating demand, and presenting findings to administration. There is also the necessity to continually educate new medical students and

clinical staff. Teaching hospitals rotate new staff through the facility regularly, and with that comes an increased need to educate. Additionally, the need for appropriate referrals requires ongoing education, reminding staff of the importance of clinical need when requesting services.

With the small body of music therapists in the United States, however, comes some unique advantages as well. Three interviewees referenced reaching out to others in the music therapy community for advice during and throughout the course of their program development. An advantage of a unique, niche field is the collaborative spirit that accompanies its small community. Other professions may have this as well, but it has definitely proven to be an asset to those interviewed for the sake of this project.

Education

Participants reiterated the findings of Lowey (2015) and Ledger (2016) in suggesting that music therapists receive more business training in their educations to get a better understanding of budgeting, project management, leadership, accounting, understanding corporate systems, grant-writing, and other skills specific to program development. The current requirements for undergraduate music therapy curriculum include thorough training in musical foundations (music theory, composition, history, applied music, conducting, functional guitar, piano, and voice, and improvisation), clinical foundations (abnormal psychology, human development, theoretical models of therapy, the therapeutic relationship), music therapy-specific coursework (assessment, evaluation, methods, clinical work, music therapy with various populations), and general education (English, math, social sciences, humanities, etc.), leaving only 5% of coursework for electives, according to the AMTA (2018d). Music therapists are required to be well-versed in music, psychology, science, therapeutic skills, and clinical skills, and can become board-certified

after an undergraduate education or its equivalent that includes internship. The comprehensive nature of the training of music therapists leaves little room for additional coursework.

However, participants were creative in their responses for ways to include this training despite this rigorous curriculum. Some propositions of how this would occur included one-day workshops, elective courses, an optional "business track" in the curriculum, or required continuing education credits related to business practices. It is implied that this material may be creatively incorporated into existing educational structures or completed after graduation through these models. Many participants stated that despite possessing an entrepreneurial spirit as a music therapist, it is valuable information for all. This researcher would agree, as regardless of population served, music therapists will undoubtedly find themselves working in a hierarchical system where these skills would be useful. Whether or not a music therapist holds leadership positions, they will find themselves on the receiving end of leadership decisions made at an administrative level. Having knowledge about how these systems operate could potentially better equip music therapists to advocate for themselves, when these decisions impact them in unexpected ways.

Limitations

Due to the fact that this study is a phenomenological inquiry, results are informative, but not generalizable. They summarize the experience of five female professionals, and represent opinions of one snapshot in time. Despite the limitation of sample size, there is some diversity among the participants in terms of location and when they started the program. They ranged from having started a program 14 years ago to 2 months ago, thus gathering information from different parts of the program development process, and represented three regions of the AMTA. Michelle had not yet started clinical work at the hospital, so she had a fresh perspective of the initial

process of development, including the more administrative work, which was a valuable perspective to have paired with the clinical experience of the other four.

Music therapy is a female-dominated profession with 87% of music therapists being women (AMTA, 2018a). Therefore, it is representative of the gender distribution of the profession that all participants in the present study were female. Nevertheless, this researcher believes that the findings might have been different if male perspectives were included. One participant mentioned the influence of gender in her battles with administration and stated she felt that having encouraging female leaders who intentionally included her was beneficial to the success of her program development. Due to the time constraints placed on gathering data for this thesis, participants were chosen based on a first-come, first-serve basis. If time allowed, diversity of genders would have been encouraged, as well as a variety of types of facilities. Respondents predominantly worked at pediatric hospitals, although program developers at general hospitals were also included. No participants had experience with program development at Veteran's Affairs hospitals or acute rehabilitation facilities, thus limiting the range perspectives in the findings. However, due to the fact that four out of five respondents developed programs in pediatric hospitals, a more in-depth view into experiences unique to that setting was valuable.

It is important to note that the researcher neglected to include a personal epoché, or a subjective account of her expectations of findings including biases, prior to gathering data. This is a common part of the phenomenological inquiry process (McFerran & Grocke, 2007), but in the rush of beginning to collect data due to time constraints on the thesis, this step was overlooked. Writing an epoché may have been beneficial in identifying specific places where bias occurred in the research.

Implications for Future Research

Some participants mentioned the limited amount of literature on the subject of program development. Thus, this study was an attempt at contributing to the literature available on the subject. Although it has provided an overview, it would be beneficial to continue to develop research in the area of music therapy program development, specifically, research that could be generalizable. A future survey could reach a larger number of participants and thus a broader range of perspectives in a study that may be a more representative sample of all music therapists. There was a presentation at the 2018 national AMTA conference about a group of music therapists examining trends and best practices in pediatric medical music therapy throughout the country through surveys, which could be a research model to adopt for program development as well (AMTA, 2018d). It would be beneficial for a task force of music therapists who developed their own programs to assemble and adopt a similar research design to explore trends specific to program development.

Participants' statements implied that there was less fear of discontinued funding in pediatric settings due to people's innate desire to help children; thus, these findings contribute to an understanding of the impact of philanthropic funding on the longevity of programs. This researcher believes that general hospitals may be faced with greater challenges in regards to ensuring funding for adults, as people seem to feel more sympathy and generosity towards children. Additionally, general hospitals might find advocacy more difficult, as music just seems to make sense when working with children. Many children are exposed to music in school settings, have musical toys, and hear many lullabies in their first years of life. However, at least in American societies, this researcher believes that music begins to take less prominence with age, and is not recognized as being as important for adults. Despite many similarities in program

development among pediatric and general medical settings, it would be intriguing to do a widespread survey to examine the differences in advocacy and funding are between pediatric and general settings for these reasons.

Survey research would ideally diversify the demographics of research participants, providing for more perspectives. In a similar vein, a follow-up study with the same design exclusively examining males' experiences in medical music therapy program development would be interesting to compare with this all-female study.

Additionally, Ledger (2010) included an interview with a healthcare manager as part of her ethnographic research on the subject of medical music therapy program development. Perhaps a future design of this type of study would include an additional semi-structured interview for healthcare managers through which their perspectives would be included and compared to those of music therapists to broaden the lens through which program development is seen. Viewing this solely from the perspective of music therapists may be limiting.

Summary and Conclusion

This study sought to examine the perspectives of music therapists who started their own medical music therapy programs and their experiences during the process. Five music therapists were interviewed and shared strategies of breaking ground at new medical facility, as well as challenges and successes along the way. Results from the interviews indicated that starting a new program can present challenges due to working in a hierarchical, political, facility, including issues with funding, volunteer collaborations, and role ambiguity. However, there were also many positive interactions with others in the machine of a hospital. The work of starting a new program requires persistence, advocacy, passion for the work, confidence being an expert in the field, and a collaborative spirit.

While the present study provided insight into these experiences, there is room for continued exploration of the topic of program development. Future research may explore a wider range of perspectives through a survey design or by incorporating perspectives from other people involved in organizational change, such as healthcare managers. It is important to recognize that experiences vary greatly depending on unique experiences and circumstances, and thus, although there are some generalizable emergent themes, there is no formula for program development. Influential factors might include prior work and life experiences, education, the identity of the therapist, networking, and trial and error. Regardless of the different paths it takes for music therapists to arrive at the point of starting a new program, it is important that they do. The present researcher believes that there will be an increase in demand for complementary treatment methods in medical settings as the opioid crisis in the country worsens. As pharmacological methods become more negative in the public eye, a push for integrative medicine has become more prevalent. As music therapy gains recognition, if music therapy programs are going to be integrated into more medical facilities, it is going to take educated, motivated, persistent, passionate therapists to establish them.

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Appendix A

OVERVIEW OF MUSIC MODALITIES

MUSIC MODALITY	PRACTICING TITLE CREDENTIALS	DEFINITION	ORGANIZATION INFORMATION
MUSIC THERAPY	Minimum: Bachelor Degree in Music Therapy with completion of a Clinical Training Internship. Masters and Doctoral Degrees are available for Music Therapy. Credential: Music Therapist-Board Certified (MT-BC)	Music Therapy is the specialized use of music in the service of individuals with needs in mental health, physical health, habilitation, rehabilitation or special education.	American Music Therapy Association (AMTA) 8455 Colesville Road, Suite 1000 Silver Spring, MD 20910 301-589-3300 fax 301-589-5175 www.musictherapy.org Certification Board for Music Therapists (CBMT) 506 E. Lancaster Ave. Suite 102 Downingtown, PA 19335 1-800-765-CBMT (2268) www.cbmt.org
MUSIC USES IN MEDICAL TREATMENT	entry-level degree and applicable credential(s) in the respective profession	Music uses in medical treatment refers to the application of music in the treatment and prevention of physical illness and disease.	No formal organization resource: Heal, M. & Wigram, T. (Eds.) (1993). *Music Therapy In Health and Education.* London: Jessica Kingsley Publisher.
MUSIC PRACTITIONERS	72 hours of class time 20 hours of clinical training Credential: Certified Music Practitioner (CMP)	Music Practitioner's recognize music with therapeutic enhancement to the healing process and the life/death transition.	Music for Healing and Transition Program (MHTP) 22 West End Rd. Hillsdale, NY 12529 mhtp@ben.net www.mhtp.org
HARP THERAPY	Harp Therapist Harp Practitioner	Harp Therapy is a general term used to describe the continuum of types of therapies in which the harp is used in institutional or clinical settings.	International Harp Therapy Program (IHTP) info@harptherapy.com www.harptherapy.com http://harprealm.com www.healingharp.com www.refalo.com/healingharp
MUSIC HEALERS SOUND HEALERS	No Formal Training Music Healer Sound Healer	Music/Sound Healing is the therapeutic and transformational uses of sound and music.	Sound Healers Association www.soundhealersassociation.org www.careofdying.org www.musichealer.org www.healingsounds.com www.healingmusician.com
CLINICAL MUSICIAN	Completion of Home Study Course Advanced Certified Clinical Musician	Clinical Musicians play healing music at the bedside of hospitalized patients.	The Clinical Musician's Home Study Course www.laurieriley/com/harpmed/level1.htm
MUSIC THANATOLOGY	Two year training program Certified Music-Thanatologist	Music Thanatology is a palliative medical modality employing prescriptive music to tend to the complex physical and spiritual needs of the dying.	www.music-thanatologyassociation.com

Prepared by the AMTA Professional Advocacy Committee, November 2004

Appendix B

Informed Consent Document

Creating New Music Therapy Positions in Medical Settings: A Phenomenological Inquiry

Principal Investigator: Kathryn Marie Esposito
Department: School of Music
Contact Information: PI Kathryn Esposito: espositok@appstate.edu, (802) 578-9338;
Faculty Thesis Chair Dr. Cathy McKinney, mckinneych@appstate.edu, (828) 262-6444
This research is funded by: N/A

Consent to Participate in Research
Information to Consider About this Research

I agree to participate as an interviewee in this research project, which concerns exploring perspectives of position development in medical music therapy. The interview will take place once over Zoom, and consists of 20 open-ended questions. The interview should take no longer than an hour. I understand the interview will be about my personal experience in position development at a medical setting, including challenges, successes, and sources of support.

There are minimal foreseeable risks associated with my participation. This study may benefit other music therapists interested in program development, as well as provide education for those in related medical professions.

The interview will occur through video call using Zoom and will be recorded and transcribed. The video recordings of the interview will be deleted by the researcher after transcription. Quotations without identifiers may be cited in the researcher's thesis.

Kathryn Esposito will have ownership of the transcripts from the interview and transcription will be kept securely in her possession and deleted after publication of the research. Participants will not receive compensation for the interview. The interview is voluntary and there are no consequences for choosing not to participate or withdrawing at any time.

For questions about this research project, participants can call Dr. Cathy McKinney at (828) 262-6444 or the Appalachian Institutional Review Board Administrator at 828-262-2692, through email at irb@appstate.edu or at Appalachian State University, Office of Research Protections, IRB Administrator, Boone, NC 28608.

This research project has been classified as exempt on October 12, 2018 by the Institutional Review Board (IRB) at Appalachian State University.

Appendix C

Perspectives in Music Therapy Position Development in Medical Settings

1. How long have you been working as a music therapist?
2. How long did you work at the facility where you started a program? Are you still employed there?
3. Please describe any prior business experience/coursework before you started this program.
4. What prior experience did you have working in a medical setting prior to starting a medical music therapy program?
5. What prompted you to start a program at the facility in which you started one?
6. Did you have any personal connections at the facility where you started your program?
    a. If not, whom did you first contact at the facility?
7. What forms of educational outreach/advocacy did you do to introduce the program?
    a. Have you continued to do this since your program has been established?
8. Did you speak to managers, consultants or intermediaries when establishing the program? How did this affect the process or the effectiveness of your proposal?
9. Where does funding for this position come from? How could this potentially affect the longevity of the program?
10. Do you feel like you had access to adequate resources to start the program?
11. What were the biggest challenges you faced and how did you overcome them?
12. What continued to motivate you despite these obstacles?
13. In your experience, have referrals been appropriate? If not, how have you addressed this?

14. Describe your experience of starting employment among a pre-established interprofessional team.
    a. Do you feel as though your program is well-received by other staff? Patients?
    b. Did you feel supported as you started this program? By whom?
15. What has your experience been as far as encountering other paid or volunteer artists or musicians? Have you collaborated?
16. Throughout the creation of the program and as a current employee, did you seek professional or peer supervision? In what ways did this decision contribute to your experience?
17. Is there anything in your pre-professional training that you feel prepared you for the challenge of starting your own position? If so, what helped?
18. What changes, if any, do you think could be implemented in pre-professional training to best prepare future entrepreneurial music therapists?
19. Do you feel like you possess certain personality traits which contributed to the development of a new music therapy position? Please elaborate.
20. Do you have any additional comments about your experience starting a position that you would like to share?

Vita

Kathryn Esposito was born in Kingston, New York, to Mark and Linda Esposito. She graduated from Bellows Free Academy in St. Albans, Vermont, in 2009. Later that year she began her studies at the University of Vermont, where she received her Bachelor of Arts degree with majors in Music and Psychology in 2013. She spent the next two years pursuing her 200-hr. Yoga Teacher Training and devoting time to national community service as a corps member in the AmeriCorps National Civilian Community Corps in the Southwestern region of the United States. She began the combined Equivalency/Master of Music Therapy program at Appalachian State University in the fall of 2015. In the December of 2017, she completed her 6-month, full-time music therapy internship at the Children's Medical Center of Dallas in Dallas, Texas. The following January, she earned board-certification as a music therapist and returned to Appalachian State to complete the requirements for the Master of Music Therapy degree with a specialty area in expressive arts therapy. In March 2019, Kathryn relocated to the Durham, North Carolina, area where she works full-time as a music therapist at Central Regional Hospital. She will receive her Master of Music Therapy degree in May of 2019.