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Music Therapy in Adult Medical Settings: Recommendations and Advocacy for Sustainable Programs

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Music Therapy in Adult Medical Settings: Recommendations and Advocacy for Sustainable Programs



Honors Thesis

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Department: Music

Advisor: Joy Willenbrink-Conte, MA, MT-BC

April 2022

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Abstract

This thesis research provides advocacy, strategies, and recommendations for sustainable music therapy program structures in adult medical settings. A review of the related literature justifies the need for and benefits of music therapy programs in adult medical settings. Recommendations for establishing and growing a music therapy program in these settings are based on semi-structured interviews conducted with three music therapists who have successfully implemented cost-effective and sustainable programs. Important considerations identified for program development include what to incorporate in a development pitch, the workload and wellbeing of the music therapist, and staff perceptions and relationship to the music therapy program.

Dedication

To my parents and family, who have supported me endlessly



**University of
Dayton**

Table of Contents

Abstract	Title Page
Introduction	1
Literature Review	1
Method	8
Results	10
Analysis and Discussion	14
Conclusion	20
References	22
Appendix A	25

Introduction

Music therapy as a treatment modality in medical hospitals is expanding, yet much of that growth appears to be in pediatric as opposed to adult settings (American Music Therapy Association, 2020¹). The aim of this research is to increase understanding of the steps and considerations for program growth in order to catalyze the development of adult medical music therapy programs. Through a literature review of music therapy benefits and semi-structured interviews with music therapy program managers, key themes were identified, including: considerations for music therapy proposals and program pitches, realistic therapist position responsibilities, and the importance of interdisciplinary staff relationships.

Literature Review

Music therapy is a relatively young and evolving healthcare field and profession with a growing body of evidence indicating the benefits of music therapy as a complement to other treatments in adult medical settings. Health is multifaceted and music therapy has the ability to influence multiple dimensions of health simultaneously. In 2009, Schlaug stated:

[music] places unique demands on the nervous system, leading to a strong coupling of perception and action mediated by sensory, motor, and multimodal integrative regions distributed throughout the brain. Furthermore, listening to music and music making ('musicking') provokes motions and emotions, improves and increases between-subject communication and interaction, and is considered

¹ The survey conducted by the American Music Therapy Association allows single therapists to indicate multiple work settings. Due to survey limitations a comparison of adult medical settings to pediatric medical settings is estimated.

to be and is experienced as a joyous and rewarding activity (Gilbertson, 2013, p. 117-118).

The multidimensional impacts of music therapy are important because, as one example, mental health distress leads to negative trajectories in physical health, such as increased blood pressure, heart rate, and cardiovascular disease. Those with self-reported mental distress are also more likely to make lifestyle choices that contribute to health risks, such as smoking, binge drinking, decreased exercise, and unhealthy diets (World Health Organization, 2004). From the reverse perspective, experiences of physical pain can cause emotional distress and increase the incidence of psychological disorders (Allen, 2013). Thus, it becomes clear that treatments, such as music therapy, that target various dimensions of health hold real holistic health promoting potential.

For the purpose of this literature review, the impacts of music therapy on health are organized by physical and socio-emotional domains. Keywords used to collect relevant literature included “music therapy” in conjunction with the following: “medical”, “hospital”, “oncology”, “surgery”, “pain management”, “adult medical”, “adult medical hospital”, “pain management”, “traumatic brain injury”, “palliative care”, “hospice care” and “neurologic rehabilitation”.

Physical Health

Physical health, for the purpose of this literature review, will encompass motor abilities as a sign of physical health of the body, as well as physiological functioning and experience of pain. Motor skills are especially affected in the case of neurologic conditions such as traumatic brain injury. Music therapy can help extend range of motion

and improve gait consistency and cadence. Music can also help to modulate and regulate physiological functions such as blood pressure, heart rate, and sleep, and can help to distract from and decrease the experience of pain.

Motor System Benefits

Neurologic Music Therapy (NMT) is a treatment model which employs scientific evidence of music therapy's impacts on neurologic symptoms to support improvements in motor function and organization through the modulation of the patient's awareness of movement and access to multiple areas of the brain simultaneously (Vega, 2013).

In a meta-analysis, Mishra et al. found that improvements in motor function such as improved gait velocity (cm/second) and cadence, or steps per minute, as well as a statistically significant improvement in stride length were more likely with music therapy than a control treatment among patients with traumatic brain injury (TBI), (Mishra, 2021).

Physiological Benefits

Physiological health is characterized by sound autonomic bodily functioning. The effects of music therapy on pain and physiological functions of blood pressure, heart rate, and hormonal changes have been studied.

In cardiac units, with no statistically significant differences in the two groups during pre-test measures, blood pressure decreased in music therapy groups while blood pressure increased in the control group (Mandel et. al 2007). Following percutaneous

transluminal coronary angiography, patients engaged in music therapy treatment were found to have increased quality and quantity of sleep (Hewis, 2018).

Pain Management

Music therapy can be a powerful resource in pain management because pharmacological pain treatments often come with risky side effects, such as dependence and addiction or brain fog. Music therapy is a non-pharmacological resource that works by influencing the brain's perception of pain, as well as altering hormones, muscle tension, and anxiety (Allen, 2013). Music therapists focus on immediate needs of the patient in order to mitigate pain, as well as strengthen the patient's coping abilities and resources for their pain management.

In a single session, music therapy led to partial positive effects on decreasing patient fatigue in the emergency department setting (Mandel et. al, 2019). Another study with a control trial, single session music therapy indicated a positive effect on physiological health (Mandel et. al, 2019). In addition to a decrease in fatigue, music therapy treatment decreased stress and pain among patients receiving care in different areas of the hospital (Mandel et. al 2019; Chaput-McGovern & Silverman, 2012). In a study with patients with end-stage liver disease, music therapy participants indicated a ten percent decrease in pain and a 30% increase in satisfaction with their pain management care (Pathania, 2019).

Effects of music therapy on post-operative pain among patients who underwent nasal septal surgery, a common procedure with a painful recovery period, showed that the patients who received music therapy directly before surgery and for two days following

the procedure displayed a significant decrease in post-operative pain scores compared to the control group. Music therapy treatment also led to a reduced need for analgesic painkillers, which also reduced negative side effects and the danger of addiction associated with analgesic use (Gogoularadja & Bakshi, 2020).

Socio-emotional Health

As previously stated, emotional health influences physical health and physiological functioning. In addition, the emotional distress that may result from pain, disease, and the healing process is an important factor affecting patient health and quality of life that should be addressed during hospital care. Music therapy can assist in the formation of coping techniques and provide opportunities for self-expression in order to mitigate the effects of emotional distress on the patient (Allen, 2013).

Symptoms of anxiety and depression are common among patients in the hospital and result from experiences of pain as well as coping with life changes and fears of a health crisis. Procedures may also cause an increase in anxiety, fear, and stress, which can cause slower healing and increased risk of infection due to increased blood pressure, increased serum cortisol levels (i.e., the stress hormone), and decreased immune response (Heiderscheit, 2013).

Anxiety and Depression

Music therapy's effects on socio-emotional health has been highly researched in numerous treatment areas of the hospital setting. In cardiac settings, Mandel et. al found that group music therapy resulted in no significant differences in physiological effects but

improved social functioning and general health at a four-month post hospitalization check in (Mandel et. al, 2007).

Two studies noted significant positive effects of music therapy on improving relaxation and decreasing fatigue and anxiety on a post-surgical oncology unit and a bone-marrow transplant unit (Chaput-McGovern & Silverman, 2012; Rosenow & Silverman, 2014). Music therapy also resulted in decreased anxiety among women receiving chemo and radiation treatments (Hewis, 2018). In a stroke rehabilitation unit, music therapy was also perceived as helpful in lifting the mood of the patients which assisted in the healing and motivation of rehabilitation (Street et. al, 2020).

Procedural Support

Music therapy as procedural support may involve music therapy treatment before, during, or after medical procedures in order to mitigate symptoms such as nausea and anxiety, as well as facilitate relaxation, emotional processing, and coping skill development (Heiderscheit, 2013).

In a study by Hewis, music therapy was utilized during procedures, such as medical imaging, to enhance the patient's experience as well as assist in accurate and clear imaging. Patients who engaged in music therapy while undergoing electrocardiogram-gated myocardial perfusion scintigraphy, an imaging technique that requires immobilization and consistent heart rate, showed clearer scans, and demonstrated decreased anxiety throughout the procedure (Hewis, 2018). In the same study, music therapy resulted in an increase in patient satisfaction when receiving a magnetic resonance imaging (MRI) scan (Hewis, 2018).

End of Life Care

Palliative and hospice care, though not identical services, are facilitated in similar capacities by music therapists in medical hospital settings by supporting patients, and, commonly, their families in the process of death and grieving. Music therapists aim to normalize the process of death and provide spiritual support (Clemens-Cortéz, 2013). Research in this area is greatly focused on caregiver perception of care because there is no opportunity for post-treatment evaluation of those who have passed away.

Interviews with family members of patients who received music therapy perceived that the process resulted in improved breathing in the patient (Burns et. al, 2015). Caregivers also described feeling as though the deceased was assisted in making proper spiritual contact before death (Burns et. al, 2015). Addressing spiritual needs extends beyond possible religious needs or practice, as patients may desire to address themes of purpose, meaning, hope, and transcendence before death. In a study by Balboni (2007), patients reported feeling that religious and medical systems did not fully address their spiritual needs, but spiritual support positively affected their quality of life (Clements-Cortés, 2013).

For familial support after death, families described music therapy as a meaningful and special experience that elicited unexpected, supportive, and even sometimes challenging memories of the deceased (O’Callaghan et. al, 2013; Thompson et. al, 2017). Music experiences assisted in creating a legacy of the deceased both before and after their death. Music elicited some feelings of “... hope of eventually being reunited with the deceased” (O’Callaghan et. al, 2013, p.116). In addition, these caregivers recommended

that other caregivers and their loved ones participate in music therapy as a support during the process of grieving (O'Callaghan, 2013).

Satisfaction in Care

Satisfaction of care is essentially how pleased an individual is regarding their treatment in the hospital setting. High levels of pain and depression while in the hospital leads to decreased satisfaction of hospital care, whereas patients receiving music therapy treatment is found to have been associated with high levels of patient satisfaction (Allen, 2013). When used as a treatment for patients in end-stage liver disease, music therapy as an addition to pain relief protocol resulted in statistically significant improvements in patients' satisfaction with their pain relief treatments (Panthania et. al, 2018). In addition, music therapy was perceived as a positively impacting treatment for acute stroke rehabilitation by both the patients and their caregivers in areas such as verbal communication, motor abilities, and mood (Street et. al, 2020). Hewis also found that music therapy can increase perceived satisfaction with MRI scanning (2018).

Method

Research involved three semi-structured interviews conducted live but virtually using the Zoom(c) video conferencing platform. The interviews ranged from 35 minutes to an hour in duration. Interviews were audio and video recorded, then transcribed by the primary researcher. Interview questions were designed to gather and investigate music therapy staffing information at each hospital, the nature of music therapy patient care and treatment, as well as information pertaining to music therapy funding and program

growth. Interview questions were modified throughout the research process to include information regarding contact time with patients and the work expectations of staff music therapists. Institutional Review Board (IRB) approval and exemption from continued monitoring was obtained from the University of Dayton IRB prior to the interviews being conducted. All interview participants provided written consent to participate in this research study.

Participants

Interview participants were selected due to their status as music therapy team managers and capacity to offer perspective on program development. In addition, it was important that the interviewees were music therapy program managers of hospitals in different geographic regions of the US. This selection process was employed to create a more diverse and generalizable sample, especially considering different laws and regulations in health care and music therapy across different states.

Jennifer Townsend is the manager of creative arts at Houston Methodist Hospital in Houston, Texas. Houston Methodist's creative arts department includes music therapy and art therapy services. Townsend is a music therapist with a history of work in pediatric medical settings and a master's degree from Temple University.

Rich Abante-Moats is the director of integrative and creative arts therapies at Advent Health Hospital in Orlando, Florida. Abante-Moats has focused her clinical practice primarily in medical music therapy since her graduation at Berkeley and was the second full-time music therapist at Advent Health Orlando, previously Florida Hospital.

Abante-Moats manages the music therapy team as well as one art therapist. Her team includes music therapists at the flagship hospital as well as surrounding satellite entities.

Debbie Bates is the music therapy manager at the Cleveland Clinic in Cleveland, Ohio. Bates initially worked as a contracted music therapist for the Clinic before music therapists were hired and their funding integrated into the hospital budget. The program at the Cleveland Clinic also involves research programming and positions within the music therapy program that are not included in the staffing calculations of therapists in the hospital. The Cleveland Clinic also has two satellite hospitals that offer music therapy.

Results

Interview questions were developed after reviewing related literature, and salient topics were delineated as pertaining to staffing, care and treatment, funding, and program growth.

Staffing

Interview questions related to staffing were designed to learn about music therapy staff resources, work expectations, and music therapy staff team size at each hospital. All participant hospital sites include satellite locations that also have music therapists, and those music therapists are included in the calculation of staffing. At all hospital locations, all full-time music therapists average a 40-hour work week and each therapist is provided with a guitar, iPad or laptop, and a cart of various instruments to be utilized clinically. In addition, every program included access to keyboards for the therapists. Each music therapist at Advent Health and Cleveland Clinic was provided their own keyboard. All programs also have access to recording technology, and therapists receive employment

benefits such as health insurance, as well as funding for American Music Therapy Association (AMTA) membership dues or money allocated for continuing education hours, professional development that represents a mandatory requirement for maintenance of music therapy board certification.

In general, a music therapist’s caseload, or number of patients receiving music therapy services, depends greatly on referrals and can vary depending on the acuity and needs of patients in the hospital at any given time. In the case of Advent Health Orlando and the Cleveland Clinic, music therapy caseloads were estimated based on the reported number of sessions within a day and the estimated treatment frequency with each individual patient. It should be noted that not all music therapists (MT-BCs) are employed at the flagship hospital. For this reason, all programs noted a potential and need for growth in order to provide music therapy services as clinically indicated for all patients in the hospital.

Table 1

Comparison of program statistics

<i>Location</i>	<i>Houston Methodist</i>	<i>Advent Health</i>	<i>Cleveland Clinic</i>
<i>Flagship hospital beds</i>	900+ ^a	1200 ^b	1300
<i>No. of MT-BCs</i>	13	10.5	8
<i>Patient to MT-BC Ratio or caseload</i>	12-16/1	~20/1*	~30/1*
<i>Contact Hours</i>	40%	70%	50-70%**

^a(Houston Methodist, 2022)

^b(Advent Health Orland, 2022)

*Estimated by researcher based on frequency of treatment and patient contact time

**Calculated by researcher based on average hours on the hospital floor in an 8-hour workday

Care and Treatment

Care and treatment interview questions were designed to understand the nature of services provided by the respective music therapy programs. These questions were focused on patient access to music therapy and the standard of care within the program. All hospitals included majority inpatient services for most units in the hospital, as well as some form of outpatient services in select areas. Average length of hospital stay, duration of treatment, and session length were also considered when examining the treatment provided by music therapy staff.

All program managers indicated a significant music therapy presence in the intensive care units (ICUs) in their hospitals, including the neurological ICU and neonatal ICU (NICU). Other units wherein patients were commonly referred for music therapy treatment included: general medical, cardiac, orthopedics, surgical, and oncology. Outpatient services are offered within neonatal intensive care units at Advent Health Orlando and neurologic services at Houston Methodist Hospital. All music therapists operate by providing consult driven services, with the exception of Houston Methodist. Houston Methodist hospital music therapists are assigned to specific treatment units and work as a member of that treatment team. Consult driven services require a treatment provider referral for music therapy, whereas music therapists on the treatment units at Houston Methodist may be able to treat patients receiving care on their unit without a specific music therapy referral, though referrals may also be made.

Session and treatment duration for music therapy is determined by patient needs and resources, and can therefore vary greatly, from 15 to 90 minutes sessions, and treatment duration ranging from single session to treatment of over a year during

extended hospitalization. Services for inpatients were an included service at all participant hospitals. The only separately billed services noted were outpatient behavioral health services at Houston Methodist and neonatal services at Advent Health Orlando. In addition to patient services, Houston Methodist music therapists facilitate a staff choir that they identified as a useful tool to improve relationships between music therapy and other hospital staff, and Cleveland Clinic music therapists facilitated staff outreach via song requests and music making throughout the COVID-19 pandemic.

Funding

Interview questions related to funding were utilized to understand funding origin within the program, stages of program development, and present program state, funding source(s), and funding implications for care and treatment and music therapy staffing. In all participant hospitals, the original music therapist salary and benefits were funded at least in part by philanthropy and the staff roles were operationalized into hospital budgets over time. All participants noted exceptions wherein a new music therapist was hired using reallocated budget funds. As music therapy programs developed, the Advent Health Orlando and Cleveland Clinic programs transitioned their budgets to be housed programmatically as an arts and medicine or music therapy program budget respectively. These programs then sourced funding for the music therapists' salaries, benefits, and supplies (i.e., instruments, music technology). Houston Methodist, due to its structure of particular units having dedicated staff music therapists, relies on respective units funding staff salary and benefits, while the music therapy program accepts responsibility for the management of those employees.

Program Growth

All participant hospitals began with a single music therapist and more staff were added to the program as there was interest in the hospital expanding services. As the music therapy staff expanded, there was a need to delineate management for the music therapy team, at which point the programs developed. Houston Methodist and Advent Health Orlando both engaged in pitching expansion of music therapy staffing and related services to hospital leadership, as well as utilizing staff champions as advocates for the growth of the music therapy program and expanded service capabilities. Another notable tool used to propel music therapy program growth was the use of a pilot-program, wherein a music therapist was temporarily placed in a position, creating an opportunity to measure the treatment benefits. This allowed the hospital to note the benefits of music therapy in practice as a tool to justify operationalized funding for that position.

Analysis and Discussion

Interview transcripts were analyzed first by the primary researcher to identify salient themes. The thesis advisor and primary researcher then reviewed and organized the transcripts to identify salient content. After a second analysis of the transcripts, themes were reshaped in order to reflect identified patterns and differences between interview content. The key themes identified include: making a strong pitch for music therapy, therapist position responsibilities, and music therapist and other hospital staff relationships.

Making a pitch

Making a proposal or program pitch to a hospital board or leadership team can be a steppingstone to begin a new music therapy program or position by advocating for the potential value of music therapy services. Based on the interviews, recommendations for these pitches include considering the ways music therapy can bolster the mission and address needs of the hospital and individualizing the presentation to your identified audience members. Abante-Moats recommended utilizing a mixture of research, music, and patient stories as tools to advocate for music therapy. She noted that she finds it very important to utilize music in all of her pitches because music is inseparable from the work of a music therapist. Townsend noted the power of staff champions as music therapy advocates. It seems notable that, at all participant hospitals, non-music therapy and leadership staff were supportive and also advocated for music therapy as a beneficial and essential hospital service in order to receive grants and funding for new programs.

Music therapist pilot positions are utilized not only as a tool for making pitches, but also a way to collect data in context to support a music therapy program proposal. If the hospital is able to temporarily fund a music therapist, the program can then take pretest measures, such as patient satisfaction of care, or any other data point that might be a relevant music therapy treatment goal, and directly compare the pretest measures to the measures after music therapy service provision in order to affirm the benefits of music therapy.

Townsend also noted that pilot positions offer a unique situation where music therapy services may cease after having been in place for a pilot position. In this way, if the hospital decides not to pursue music therapy following the pilot position or is unable

to provide a healthy environment for the therapist with appropriate compensation, the absence of the music therapist may be striking and noticeable. This may provide opportunities for the staff and/or patients to advocate for the return of music therapy after observing or experiencing the benefits. While this is not a guarantee of a pilot program, it is another way that a temporary position can propel program growth and boost recognition of music therapy treatment efficacy and value.

Therapist Position Responsibility

An important theme that was identified from all three interviews as relevant to program building was the importance of ensuring that music therapy position responsibilities are manageable and sustainable. A poor work environment for the therapist can lead to many detrimental issues. If a precedent is set wherein music therapists overextend themselves to treat more patients than they are able, or work more hours than other comparable professions, it is possible that these unsustainable patterns will continue as the program grows and evolves. Not only does this cause issues in hiring and retaining music therapists in positions due to unrealistic work expectations and potential burnout, but it may also encourage hospitals not to hire more music therapists because an individual or small team is overworking to compensate for an unrealistic caseload. In this way, realistic workplace expectations for the music therapist will lead to a more satisfied and engaged workforce, set a healthy precedent for continuous and sustainable music therapy program growth, and boost quality of music therapy care for the hospital.

Burnout

One focus during interviews was exploration of how music therapy programs balance workloads for the music therapist staff. There was a great variety between programs regarding music therapist caseload expectations. Outside of direct patient contact and facilitating music therapy sessions with patients, a music therapist must also complete clinical documentation, prepare music, participate in interdisciplinary team meetings, and may need to engage in self-care practices between sessions, especially in emotionally taxing work environments.

Therapist health and healthy work conditions should be valued not only because of the potential negative effects on the therapist and their treatment efficacy if conditions are poor, but also potential negative effects on the hospital if therapists are not caring for their own health or experiencing poor health because of the workplace environment. According to Freudenberger, burnout is the “... physical, emotional, and mental exhaustion caused by heavy job demands,” (Kim, 2016, p. 17). Burnout is marked by feeling emotionally depleted, unsatisfied with work performance, or having a negative view of one's own personal accomplishments, negative feelings towards clients, and potentially experiencing depersonalization (Kim, 2016). These negative feelings within the therapist cause a decrease in treatment efficacy as well as increased absences and job turnover, all of which negatively affect the hospital and clients the therapist treats.

For these reasons, balancing hospital and patient treatment needs with reasonable expectations for patient contact hours should be considered when establishing music therapy position parameters and considering productivity measures. The music therapy caseload should meet the needs of the hospital or unit but not compromise the health of

the therapist or the efficacy of treatment. Realistic caseloads for music therapists may also highlight when there is a reasonable need for another music therapist to be hired when the amount of referrals exceeds the reasonable workload for the current therapists.

Staff Relationships

Another key factor identified within all interviews was the value of non-music therapy staff relationships and advocacy. While the music therapists cannot control other staff advocacy, this benefit may result from a positive relationship and non-music therapy staff having opportunities to witness the treatment benefits of music therapy. Staff champions are another member of staff who advocate on behalf of the music therapists, which may be beneficial to program growth. This allows a hospital board to hear accounts of music therapy that do not come directly from the music therapy departments.

One potential method of catalyzing this connection could be through staff outreach programs. Houston Methodist, for example, has a staff choir that is facilitated by the music therapists. This may be considered a type of community music therapy where the therapist, or more aptly -- facilitator -- in this case, is a member of the same community as the other participants. This not only increases the visibility of music therapy work to staff from a new perspective, but also fosters an interpersonal connection between the staff members.

Another potential avenue to increase non-music therapy staff engagement with music therapy may be integrating a similar staffing arrangement as Houston Methodist, where the music therapist works as staff on a singular unit. According to a study done by Chang, it was determined that therapists who work closely with an interdisciplinary team

have lower levels of burnout than therapists who are isolated from other staff (2014). This staff configuration may then curate not only relationships with staff who may advocate for the program, but also decrease the likelihood of music therapist burnout, as opposed to a therapist who floats to many different units. While this arrangement may not be feasible at the inception of the program, it seems best that as the program grows, therapists progressively become less isolated from the interdisciplinary team and integrated onto specific treatment units in order to create a community among staff.

Future Research Recommendations

Through this study, many areas for further research have been identified in order to benefit music therapists, programs, and hospitals throughout the country. Further investigation in the following areas will help to create music therapy programs that act sustainably and effectively for their employers and patients.

Burnout and contact hours

While there is research on burnout in the music therapy profession, it may be important to utilize the current literature and future research in order to answer questions regarding workload. Specifically, how does the workload of a music therapist compare to other similar hospital professionals, and what workload configurations decrease burnout and stress on the therapist? In addition, there could be specific investigation of the caseload demands and expectations for high intensity work, such as treatment in ICUs and hospice care, to account for additional stress on the therapist in these treatment settings.

Program funding and structure

When preparing for this study, it became clear that there are extremely few training resources for music therapists related to how to advocate for and pioneer new music therapy programs and positions. More comprehensive research is called for in order to provide a complete view of how program structure affects workplace health, treatment efficacy, and satisfaction of treatment both by other members of staff and patients engaged with music therapy. It would also be beneficial to publish more information on the inner workings of music therapy programming, including funding systems, and care and treatment parameters, to assist burgeoning programs in establishing and growing more effectively.

General versus specialized position effects

Although the program structure at Houston Methodist may be less conventional within medical settings, it seems indicated to pilot research to study the different effects of a specialized or unit specific therapist on music therapy treatment effects and workplace relationships as compared to the conventional general music therapist that travels from unit to unit.

Conclusion

The key steps and considerations identified as essential to music therapy program growth in adult medical settings were: important themes to include in a pitch to a hospital board, the importance of protecting therapist responsibilities, and the value of positive staff relationships. When pitching to a hospital board, it is important to include a variety

of evidence that aligns with the potential needs of the hospital or units where the therapist would provide treatment, as well as include patient stories and music. Pilot positions are also an important tool in order to display contextualized evidence of a music therapist's benefits in a hospital. Therapist responsibilities must be well regulated and monitored in order to maintain a healthy and effective workplace and utilize the full potential of the music therapy team. Positive staff relationships created through collaboration with an interdisciplinary team and staff outreach may increase music therapy advocacy within the hospital.

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Appendix A

Interview Questions

Care and Treatment:

1. How many patients receive music therapy on average at your institution?
 - a. What percentage of the general population of inpatients receives music therapy treatment?
 - b. Do any outpatients receive music therapy?
2. What units receive music therapy?
 - a. Why do certain units receive music therapy over others?
 - b. How long is the average music therapy session?
 - c. How long is the length of music therapy treatment on average?
 - d. What is the cost of music therapy to the patient? Is it an included service, charged to insurance, or paid out of pocket?
 - e. Are music therapists assigned to specific units or areas?
 - f. Are there any community or staff oriented music therapy services provided?

Staffing:

3. How many music therapists are employed at your hospital?
 - a. Are they employed full-time, part-time, or as contractors?
 - b. How many hours do music therapists work per week on average?
 - c. What is a music therapist's average direct contact time with patients?
Is this ideal?
 - d. Is this an ideal number? Is there a need for more music therapists?
4. Do any music therapists hold more credentials beyond MT-BC (Music Therapist - Board Certified)?

Funding:

5. How is the music therapy program funded? (Philanthropically, through hospital funds)
 - a. Has the funding changed over time?
 - b. Is the funding sustainable or will it need to change?
Is there a need for additional funding?
6. What expenses are covered by the funding (staff salaries/wages/benefits, instruments, room space, technology)?

Program Development:

7. How was this program established (what steps were taken)?
8. Who was involved in the program development?
 - a. When was the program established?
 - b. Has the program changed over time (staff growth, resource accessibility, etc.)?
9. What were the challenges in program establishment?
10. What advice would you give to a music therapist attempting to establish a program in an adult medical setting?